Better health programme

NHS
The NHS in Darlington, Durham and Tees

BHP Clinical care standards

BHP Clinical care standards - Urgent & Emergency Care

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator	
1	A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week.	CEM (2011) Emergency Medicine The Way Ahead
2	A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.	CEM (2011) Emergency Medicine The Way Ahead
3	24/7 access to the minimum key diagnostics: - X-ray: immediate access with formal report received by the ED within 24 hours of examination - CT: immediate access with formal report received by the ED within one hour of examination - Ultrasound: immediate access within agreed indications/ 12 hours with definitive report received by the ED within one hour of examination - Lab sciences: immediate access with formal report received by the ED within one hour of the sample being taken - Microscopy: immediate access with formal result received by the ED within one hour of the sample being taken When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours. **NICE Guidelines on Trauma Care – x-ray to report back to the patient before discharge.**	CEM (2011) Emergency Medicine The Way Ahead RCR (2009) Standards for providing a 24-hour diagnostic radiology service
4	Emergency department patients who have undergone an initial assessment and management by a clinician in the emergency department and who are referred to another team, to have a management plan (including the decision to admit or discharge) within one hour from referral to that team. When the decision is taken to admit a patient to a ward/ unit, actual admission to a ward/ unit to take place within one hour of the decision to admit. If admission is to an alternative facility the decision maker is to ensure the transfer takes place within timeframes specified.	CEM (2011) Emergency Medicine The Way Ahead London standards for inter-hospital transfers
5	An area for mental health assessments, where continuous observation is possible, should be in place in every emergency department. This are should reflect the needs of people experiencing a mental health crisis and be compliant with Royal College of Psychiatry standards.	Royal College of Psychiatry standards
6	A designated nursing shift leader (Band 7) to be present in the emergency department 24 hours a day, seven days a week with provision of nursing and clinical support staff in emergency departments to be based on emergency department-specific skill mix tool and mapped to clinical activity.	CEM (2011) Emergency Medicine The Way Ahead Emergency Nurse Consultant Association (2009) Royal College of Nursing & Faculty of Emergency Nursing

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Ref	Indicator	
8	Triage to be provided by a qualified healthcare and registration is not to delay triage.	LQS Clinical expert panel consensus
9	Emergency departments to have a policy in place to access support services seven days a week including: - Alcohol liaison - Mental health - Older people's care - Safeguarding - Social services	HM Government (2012) Alcohol Strategy LQS Clinical expert panel consensus
10	Timely access seven days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital.	CEM (2011) Emergency Medicine The Way Ahead
11	Timely access seven days a week to, and support from, Social Services/Social Worker, physiotherapy and occupational therapy teams to support discharge from hospital.	
12	Emergency departments to have an IT system for tracking patients, integrated with order communications. A reception facility with trained administrative capability to accurately record patients into the emergency department to be available 24 hours a day, seven days a week. Patient emergency department attendance record and discharge summaries to be immediately available in case of re-attendance and monitored for data quality.	CEM (2011) Emergency Medicine The Way Ahead
13	All emergency departments should have access to on-site liaison psychiatry within 1 hour of referral, 24 hours a day, seven days a week	
14	All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high- quality, safe patient care, seven days a week.	CEM (2011) Emergency Medicine The Way Ahead
15	Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear consultant-led communication and information including the provision of patient information leaflets to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them.	London Health Programmes (2011) Adult emergency services standards
16	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.	London Health Programmes (2011) Adult emergency services standards
17	Facilities allow audio-visual separation of children from adults	RCPCH (2012) Standards for Children and Young People in Emergency Care Settings [supersedes Services for Children in Emergency departments 2007]
18	Recommendations for number of nursing staff on duty as a whole and specific paediatric emergency nursing staff which is currently work in progress for NHS England	Evidence available from NHS England

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Ref	Indicator	
	Urgent Care Centre Standards – to be checked	
	Trauma Standards - to be checked	
	Paediatric emergency services	
P1	All emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital. Where children are admitted with surgical problems they should be jointly managed by teams with competencies in both surgical and paediatric care.	NCEPOD (2007) Emergency admissions: A journey in the right direction? RCP (2007) The right person in the right setting – first time RCS (2011) Emergency Surgery Standards for unscheduled care RCPCH (2011) Facing the future
P2	All emergency departments which see children to have a named paediatric consultant with designated responsibility for paediatric care in the emergency department. All emergency departments are to appoint a consultant with sub-specialty training in paediatric emergency medicine. Emergency departments to have in place clear protocols for the involvement of an on-site paediatric team.	Intercollegiate Committee (2012) Services for children in emergency departments
P3	All children admitted as an emergency to be seen and reviewed by a consultant during twice daily ward rounds.	RCPCH (2011) Facing the future
P4	A consultant paediatrician is to be present and readily available in the hospital during times of peak emergency attendance and activity. Consultant decision making and leadership to be available to cover extended day working (up until 10pm), seven days a week.	RCPCH (2011) Facing the future
P6	All hospital based settings seeing paediatric emergencies including emergency departments and short-stay paediatric units to have a policy to identify and manage an acutely unwell child. Trusts are to have local policies for recognition and escalation of the critical child and to be supported by a resuscitation team. All hospitals dealing with acutely unwell children to be able to provide stabilisation for acutely unwell children with short term level 2 HDU.	DH (2006) The acutely or critically sick or injured child in the DGH NHSLA
P7	When functioning as the admitting consultant for emergency admissions, a consultant and their team are to be completely free from any other clinical duties or elective commitments.	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

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Ref	Indicator	
P8	Hospital based settings seeing paediatric emergencies, emergency departments and short stay units to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be band 6 or above) with appropriate skills and competencies for the emergency area.	Intercollegiate Committee (2012) Services for children in emergency departments RCN (2010) Maximising nursing skills in caring for children in emergency departments HMSO (1994) Report of the Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven Hospital during the period February to April 1991
P10	All hospitals admitting medical and surgical paediatric emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: · Critical – imaging and reporting within 1 hour · Urgent – imaging and reporting within 12 hours · All non-urgent – within 24 hours	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
P11	Hospitals providing paediatric emergency surgery services to be effectively co-ordinated within a formal network arrangement, with shared protocols and workforce planning.	DH (2006) The acutely or critically sick or injured child in the DGH Healthcare Commission (2007), Improving services for children in hospital RCS (2010) Ensuring the provision of general paediatrics surgery in the DGH NCEPOD (2011) Are we there yet?

BHP care standards – Acute Medicine

Ref	Indicator
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.
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**.
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.
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical/surgical unit to cover extended day working, seven days a week. **CAG amended to:** 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.
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.**
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 12hours of request**
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

BHP care standards – Acute Medicine

Ref	Indicator
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 retain responsibility for a single patient on the acute medical/surgical unit. Subsequent transfer or discharge must be based on clinical need.
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.
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,** critical care environment.
12	Patients to be discharged to their named GP with a complete discharge summary sent within 24 hours.
13	All referrals to intensive care to be made with the involvement of a consultant both in the referring and receiving teams.
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.
15	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.
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.

BHP care standards – Acute Medicine

Ref	Indicator
17	Patients should always be admitted or transferred to the most appropriate ward for their clinical needs.
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).
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.
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.
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.
22	All hospitals dealing with complex acute medicine to have onsite access level 1, 2 and 3 critical care services.
23	Training to be delivered in a supportive environment with appropriate consultant supervision

BHP care standards – Acute general surgery

Ref	Indicator
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% .
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.
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.
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.
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.
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.
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
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
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.

BHP care standards – Acute general surgery

Ref	Indicator
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.
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.
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.
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.
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.
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%.
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.
17	The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.
18	All referrals to intensive care to be made from a consultant to consultant.

BHP care standards – Acute general surgery

Ref	Indicator
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.
20	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.
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.
22	All acute medical and surgical units to have provision for ambulatory emergency care.
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.
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.
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.
26	Training to be delivered in a supportive environment with appropriate, graded consultant supervision,
27	There should be a minimum 8 person rota for all acute sites.

BHP care standards - Acute Paediatrics

Ref	Indicator
1	All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open, 7 day service.
2	A paediatric consultant (or equivalent) is present in the hospital during times of peak activity. 7 day service
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.
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 14 hours of admission
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.
6	All general acute paediatric rotas are made up of at least ten WTEs, all of whom are WTD compliant.
7	At least -two medical handover in every 24 hours is led by a paediatric consultant (or equivalent).
8	Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

BHP care standards - Acute Paediatrics

Ref	Indicator
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.
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.
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.
12	No individual consultant paediatrician or anaesthetist practicing PIC should do so for less than 2 DCC PAs per week.
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.
14	All nurses who provide care to children and young people should have a specific qualification in the nursing of children and young people
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
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.

BHP care standards - Acute Paediatrics

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator
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. **[clarification is required on the statement about the change or ratio of nurse to patient]** **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.
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.
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
20	PICU nurses should be trained in retrieval **[clarification training neonatal nurses to do transfers as well as PICU nurses?? – clarify with neonatal network plans for transport for transport system]**
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.
22	Paediatric anaesthetist groups should undertake at least 100, ideally greater than 200, paediatric anaesthetic procedures per year.
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.
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.

BHP Clinical care standards - Acute Paediatrics

Ref	Indicator
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.
26	It was agreed that a minimum number of lists per week should be set for paediatric anaesthetists
27	It was agreed that a minimum number of cases per annum should be set for 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.
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.
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.
31	PICU must have 24-hr access to radiology, including CT and MRI scanners, with 24-hr reporting available by consultant radiologists and neuro-radiologists.
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.
33	All short stay paediatric assessment facilities to have access to a paediatric consultant throughout all the hours they are open, with on site consultant presence during times of peak attendance.

BHP Clinical care standards
Updated Maternity/Obstetrics standards

Better health programme

NHS
The NHS in Darlington, Durham and Tees

Ref	Indicator
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.
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.
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.
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 appts; uncomplicated parous women: 7 appts.
5	Women should be able to access promptly adequately equipped Early Pregnancy Assessment Units.
6	Larger obstetrics units (>3500) should provide 23hr EPAUs on weekdays and extended hours at weekends that provide scanning and assessment.
7	Commissioners and providers must develop maternity and neonatal care networks.
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.

BHP Clinical care standards
Updated Maternity/Obstetrics standards

The NHS in Darlington, Durham and Tees

Ref	Indicator
9	All new-born infants should have a complete clinical examination within 72 hours of birth.
10	No less than 2500 births per year for a consultant led unit.
11	Every consultant led unit should have on site haematology, blood transfusion and ITU
12	Access to second theatre must be available within 20 minutes 24/7.
13	MLU's should maintain skills by rotating workforce via larger units.
14	Free-standing Midwifery Units must have robust admission criteria and transfer protocols; obstetric units should have Alongside Midwifery Units co-located with them.
15	Establish prospective consultant obstetrician presence on each labour ward: 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.

BHP Clinical care standards
Updated Maternity/Obstetrics standards

Better health programme

NHS
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Ref	Indicator
17	A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.
18	Patients on the labour ward should have four board/team reviews between 8am and 10pm – amended to: Patients on the labour ward should have a minimum of four consultant board/team reviews every 24 hours. This was amended as 10pm to 8am was felt to be a long stretch of time without a board review
19	There should be a minimum of 10 WTE on medical staff rotas at each level.
20	There should be consultant attendance at vaginal breech, vaginal twins, C-section at fully dilated, trials, return to theatre, placenta previa, PdH ongoing of 1.5litres. There was debate around this list being longer.
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.
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 The group discussed removing the ratios within this standard as there is a move towards staffing based on case mix. It was agreed to keep the ratios as a minimum standard with a view to revising this standard once further guidance is issued.
23	There should be an identified supernumery midwifery team leader on every shift located on the labour ward
24	Consultant obstetric units require a 24-hour anaesthesia and analgesia service 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.
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.

BHP Clinical care standards
Updated Maternity/Obstetrics standards

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator
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).
27	For any obstetric unit there should be a separate consultant anaesthetist for each formal elective caesarean section list.
28	Labour wards should be able to care for Critical care Level 2 (non-ventilated) patients.
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.
30	24 hour paediatric middle grade cover should be available 24/7 to be present at vaginal breech, vaginal twins, C-section at fully dilated.
31	Foetal medicine review should happen within 72 hours from when indicated
32	Obs-med patients deemed to be of increased risk should be seen in a joint obs-med clinic with an appropriate physician
33	Pre term babies should be delivered in a unit with appropriate neonatal facilities
34	Women in pre term labour (less than 30 weeks should be offered magnesium sulphate and appropriate diagnostic testing
35	Women should have the choice of delivery location offered in an unbiased manner to include where appropriate home birth, MLU (stand alone and co-located) or consultant led care
36	All women should be offered the opportunity to develop with their midwife and if required obstetrician an individual care plan that takes into account their individual needs.

BHP Clinical care standards - Neonatology

Better health programme

The NHS in Darlington, Durham and Tees

Standard					Source
Medical staffing		**SCBU**	**NHDU / Local Neonatal Unit**	**NICU**	
Tier 1	**1**	At least 8 wte on rota	At least 8 wte on rota	At least 8 wte on rota	Toolkit for High Quality Nenonatal Services (2009)
ANNPs GP Trainees Foundation Year Doctors Trust doctors ST1-3 trainees**		24/7	24/7	24/7	
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	**2**	At least 8 wte on rota	At least 8 wte on rota	At least 8 wte on rota	Toolkit for High Quality Nenonatal Services (2009)
ANNPs Trust doctors ST trainees - ST 3* and above SSASG Consultants		24/7	24/7	24/7	
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	**3**	At least 8 wte on rota	At least 8 wte on rota	At least 8 wte on rota	Toolkit for High Quality Nenonatal Services (2009)
Consultants		14-16/7	14-16/7	14-16/7	
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*			

BHP Clinical care standards –Acute Gynaecology standards

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As Gynaecology standards were not agreed within phases 1 & 2 of BHP, the subgroup drafted the following new set of standards in December 2014:

Ref	Indicator
1	All inpatients should be reviewed by a consultant on a daily basis.
2	All inpatients should have a clearly documented management plan and a predicted date of discharge.
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.
4	There should be a clearly identified consultant on call for gynaecology, 24 hours a day.
5	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner seven days a week to support clinical decision making:
6	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.
7	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.
8	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.
9	A policy is to be in place to access social services seven days per week.

BHP Clinical care standards –Acute Gynaecology standards

As Gynaecology standards were not agreed within phases 1 & 2 of SeQiHS, the subgroup drafted the following new set of standards in December 2014:

Ref	Indicator
10	All hospitals admitting emergency gynaecology 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.
11	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.
12	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.
13	The majority of emergency gynaecological surgery to be done on scheduled emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications. and the decision to operate made by the consultant Gynaecologist.
14	All referrals to intensive care to be made from a consultant to consultant..
15	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.
16	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.
17	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.
18	All acute medical and surgical units to have provision for ambulatory emergency care.

BHP Clinical care standards –Acute Gynaecology standards

As Gynaecology standards were not agreed within phases 1 & 2 of SeQIHS, the subgroup drafted the following new set of standards in December 2014:

Ref	Indicator
19	Training to be delivered in a supportive environment with appropriate, graded consultant supervision.
20	There should be a minimum 8 person rota for all acute sites.
21	The principles of enhanced recovery should be adopted.
22	Recommendations from NICE should be implemented.

BHP Clinical care standards – Critical Care

Ref	Indicator
1	All Trusts must participate in ICNARC and achieve good clinical outcomes as compared to comparable units.
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 (4 hour) <10% [For discussion is this achievable?] Early readmissions < 3% Post ITU deaths <10% [Keep this in?]
3	Non clinical transfers out of hospital should be a rare event and out of network an SUI.
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).
5	All consultants participating the Critical Care rota must do daytime sessions in Critical Care, 2 is considered minimum.
6	New consultant appointments to critical care rotas should have CCT in Critical Care and FFICM exam.
7	All critical care units should have consultant sessions and ward rounds in evenings and weekends. Standard 15 PAs for each 8 (or part) level 3 beds as national recommendation.
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.

BHP Clinical care standards – Critical Care

Ref	Indicator
9	Each admission to critical care should be reviewed by a consultant within 12 hours of admission.
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.
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 .
12	All referrals to critical care should involve discussion with the referring and receiving parent consultant
13	Level 3 Units should deliver renal support in dialysis or CVVH.
14	Every patient in an Critical Care must have immediate access to a registered nurse with a post registration qualification in this specific speciality.
15	Level 3 (ventilated or CVVH) patients should have a minimum of one nurse to one patient.
16	Level 2 patients should have a minimum of one nurse to two patients.

BHP Clinical care standards – Critical Care

Ref	Indicator
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.
18	Intensive Care Units should maintain mean occupancy levels of <70% for units of 8 beds or fewer and <80% for larger units.
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.
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.
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.
22	All Critical Care Units should perform a RCA on unplanned readmissions or early discharges from critical Care areas within a 48 hour period.
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.

BHP Clinical care standards – Critical Care

Ref	Indicator
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.
25	All Trusts should implement the NICE Rehabilitation after Critical Illness (NICE 2009) guidelines, including follow up clinics and 7 day rehab.
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.
27	The structure of Intensive Care Units should follow HBN 57 and CCUs V4 for all new builds or refurbishment.
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.
29	All units should have a mandatory clinical educator
30	All larger centres should have a research nurse

Interventional Radiology Clinical Standards

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Situations where urgent or emergency interventional radiology is indicated

- Stopping haemorrhage (eg, trauma, gastrointestinal (GI) bleeding, post-partum haemorrhage)
- Thoracic aortic aneurysm, traumatic dissection and the complications of Type B dissection, ruptured peripheral aneurysms
- Acute peripheral and visceral ischaemia
- Managing sepsis secondary to upper urinary tract and biliary obstruction (often urgent though rarely an emergency)
- Draining intra-abdominal and intra-thoracic abscess (often urgent, though rarely an emergency)
- Colonic stenting (often urgent, though rarely an emergency)
- Image-guided intervention in subarachnoid haemorrhage

Situations where emergency interventional radiology might be indicated in future

- Emergency management of abdominal aortic aneurysm
- Stroke

Ref	Indicator
	Recommendations for individual departments and trusts
1	Recognition that in the absence of provision of IR services patients will be placed at risk
2	There should be clarity within the trust and among referring clinicians and service commissioners about what interventional radiology services are available and when they are available
3	Clear pathways should be in place for treating patients appropriately when the interventional radiology service is not available
4	Out-of-hours service provision must be subject to a formal rota
5	There should be recognition of the resource implication of supporting a 24-hour interventional service in terms of diagnostic imaging and manpower
6	Onward referral pathways must be clear
	Recommendations for individual radiologists
7	All doctors are bound to adhere to General Medical Council (GMC) guidance and must comply with the principles and values set out in GMC Good Medical Practice
8	Radiologists should not normally carry out procedures with which they are unfamiliar
9	Radiologists should recognise that ad-hoc on call rotas are not in the best interest of patients
10	It is the duty of the radiologists to report any risk management concerns to the trust's clinical governance committee

Radiology Clinical Standards

Ref	Indicator
	Implementation of standards **Departmental leads should ensure the following:**
1	Local agreement is reached amongst radiologists in clinical departments about what services are provided on call. Discussion about maintenance of and definition of what constitutes "core" radiological skills among local radiologists and how these may be maintained should take place. Attendance at relevant continuing medical education (CME) courses such as those provided by the British Society of Interventional Radiology and the RCR is advisable and it may be necessary to update practical skills by spending time in larger departments
2	There is agreement with clinicians on treatment /alternative imaging pathways when a particular aspect of the imaging/interventional service is not available
3	There is mechanism for information to be available to clinicians on a daily/weekly basis about when services are/are not available
4	Formal contracts exist with other trusts to which patients are transferred for imaging or intervention
5	Locally agreed protocols and/or guidelines for referral for emergency imaging/intervention have the potential to reduce confusion and/or disagreement in individual cases. These protocols should be evidence-based and have been agreed with the local clinical governance committee and the relevant clinical teams
6	Individual radiologists, in conjunction with clinical leads or their appraiser, should keep their range of skills and routine practice under review, with the aim of balancing subspecialty expertise with the maintenance of core skills needed to provide a trust-wide emergency radiology service (see 1 above)

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