WM QRS West Midlands Quality Review Service

NHS

Review of Care of Critically Ill & Critically Injured Children, Urgent Care and Critical Care

Walsall Healthcare NHS Trust

Visit Date: 2nd October 2013 Report Date: December 2013

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INTRODUCTION

This report presents the findings of the review of services for critically ill and critically injured children, critical care, urgent care and acute medicine at Walsall Healthcare NHS Trust which took place on 2nd October 2013. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of Critically Ill & Injured Children in the West Midlands, Version 4, March 2013
- Critical Care Services, Version 3, Draft 17, September 2013
- Urgent Care, Version 2, Draft 4 September 2013
- Acute Medical Units (AMUs), Version 2, June 2012

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team which reviewed the services at Walsall Healthcare NHS Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

WALSALL HEALTH ECONOMY

This report describes services provided or commissioned by the following organisations:

- Walsall Healthcare NHS Trust
- NHS Walsall Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Walsall Clinical Commissioning Group

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGEMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Walsall Healthcare NHS Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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TRUST-WIDE

General Comments and Achievements

Trust-wide progress had been made on several aspects of the care of critically ill and critically injured children, including shared use of a Paediatric Early Warning Score across the Emergency Department and paediatric services and a shared white-board summarising patient details. Good working relationships between paediatric, anaesthetic, surgical and Emergency Department staff were evident. One example of this was that Emergency Department staff received information about critical incidents involving children.

Good Practice

1 The Trust-wide dispensing system was easily accessible and had finger-print recognition. This resulted in quick dispensing and no delays for patients waiting for drugs.

2 Children's attendances at the Emergency Department and paediatric services were reviewed daily (5/7) by a paediatric liaison nurse.

Immediate Risks: No immediate risks were identified

Concerns

1 **Policies and Procedures**

Some of the expected policies and procedures were not yet documented. For children those relating to paediatric escalation, staff working outside their area of competence and financial support for children were not yet in place. Policies on surgery on children and transfer of the most critically ill children were in draft form. Several adult policies in the Emergency Department were out of date and some were too large to be easily used. A new document control system had been introduced for Trust-wide policies and the Trust was working through existing policies and so some were not yet in this format. Individual departmental policies were not covered by the Trust-wide system and the process of document control of these policies was not clearly defined.

2 **Medical Staff Resuscitation Training**

Evidence that consultant and middle grade doctors had appropriate training in resuscitation and stabilisation of critically ill children was not available. Evidence of consultant and middle grade doctors training for adults (ATLS and ALS) was also not available.

Further Consideration

1 Walsall Healthcare NHS Trust and NHS Walsall Clinical Commissioning Group (CCG) both had plans for how to improve the urgent care system for adults but these plans did not appear to be coordinated and agreed. The 'STAR' Group for adults provided an appropriate forum for discussion but had not yet achieved integration of the different approaches. Reviewers were concerned that CCG plans to increase community bed capacity may result in these becoming blocked, rather than achieving improved flow through the urgent care system.

2 Reviewers saw little information for children and families in languages other than English.

3 The Trust resuscitation policy was not clear on accessing ENT services for airway emergencies or the action to take at times when ENT staff were not available on site.

4 The Trust used *Partners in Paediatrics* (PiP) guidelines which were not easily searchable. The Trust may wish to suggest to PiP that this be addressed. Also, PiP guidelines did not cover 'inhaled foreign bodies' which would be a useful addition.

5 Reviewers were told of difficulty in accessing child and adolescent mental health services, especially at weekends. This was leading to delays in discharging some young people, some of whom could be

emotionally disturbed. This affected the individual child or young person and also impacted on other children in the ward at the time and on staff. Reviewers suggested that the Trust should ensure that commissioners are aware of the full impact of this issue.

6 Establishing rotation of children's trained nurses between the paediatric services and Emergency Department may be helpful, especially in improving the level of children's trained nurses in the Emergency Department

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CRITICALLY ILL AND CRITICALLY INJURED CHILDREN

EMERGENCY DEPARTMENT (CHILDREN AND YOUNG PEOPLE)

The Emergency Department was reviewed for its care of critically ill and critically injured children and for the care of adults. These two sections are separate but should be read together for reviewers' views of the Department as a whole.

'Trust-wide' comments on the care of critically ill and critically injured children also apply to the Emergency Department.

General Comments and Achievements

Staff in the Emergency Department were dedicated and working hard despite the constraints with which they had to cope.

Good Practice

1 The Emergency Department had electronic links to Local Authority safeguarding team, resulting in 'real-time' updates of children's child protection records being available to Emergency Department staff.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Initial Assessment of Children and Links with the Urgent Care Centre**

Reviewers were concerned about the initial assessment and 'streaming' of children and young people attending the Emergency Department. Initial assessment was undertaken by Emergency Department nurses from 8am to 10pm. If a streaming nurse was not available then patients were 'triaged' by an Emergency Department nurse and then referred to the 'Badger' Urgent Care Centre, if appropriate. Approximately 24% of Emergency Department attendances were 'streamed' or triaged to the Urgent Care Centre with children making up approximately 35% of these patients. Children aged under five who were 'streamed' to the Urgent Care Centre were sent with a set of nursing observations. This review did not cover the Urgent Care Centre and so reviewers were not aware of a) the level of 'Badger' nurses' training in the recognition of ill children and b) whether this service had the same access to up to date child protection information as the Emergency Department. The Paediatric Liaison Nurse did not review attendances at the Urgent Care Centre. Reviewers were concerned about the governance of the initial assessment process, including identification of safeguarding issues, as this process was undertaken by different staff depending on staff availability and the arrangements when either service was particularly busy were not clearly defined.

Arrangements for liaison between the Emergency Department, paediatric service and Urgent Care Centre were not clear. Reviewers were told both that there were no arrangements for liaison and that quarterly meetings were held. Reviewers were told of some inappropriate referrals to paediatric services but the 'feedback loop' or system whereby these could be raised did not appear to be clearly defined.

This issue is included in the Emergency Department section of this report because it relates to the care of children and young people who present at the door of the Emergency Department. Addressing this concern is not wholly within the power of the Emergency Department or Walsall Healthcare NHS Trust and will need the involvement and commitment of 'Badger' and NHS Walsall Clinical Commissioning Group.

2 **Facilities:** See adult Emergency Department section of this report.

3 **Policies and Procedures:** See Trust-wide section of this report.

4 **Medical Staff Resuscitation Training:** See Trust-wide section of this report.

Further Consideration

1 Little age-appropriate information for children and families was available.

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PAEDIATRIC SERVICE:

IN-PATIENT PAEDIATRIC WARD, PAEDIATRIC ASSESSMENT UNIT AND DAY SURGERY UNIT

'Trust-wide' comments on the care of critically ill and critically injured children also apply to paediatric services.

General Comments and Achievements

Medical and nursing teams were working well together. Expected competences had been clearly defined and a high proportion of staff achieved these, including high levels of nurse resuscitation training. A play specialist was available for one shift each day, including at weekends.

Good Practice

1 The facilities and environment were excellent and child-friendly, including an adolescent area.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Medical Staff Resuscitation Training:** See Trust-wide section of this report.

Further Consideration

1 The 'grab bag' for in-hospital transfers was not routinely checked after use.

2 Arrangements for counting activity on the Paediatric Assessment Unit were not clear. This unit seemed to be used for a variety of purposes and it was not clear that these were being counted and coded appropriately.

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Paediatric Anaesthesia

Most 'Trust-wide' comments on the care of critically ill and critically injured children also apply to paediatric anaesthesia services.

General Comments and Achievements

Anaesthetic areas were spacious and well-equipped with good displays and charts relating to children. Anaesthetic staff were clearly committed to contributing to the care of children.

Immediate Risks: No immediate risks were identified.

Concerns

1 For five consultants who were part of the emergency on-call rota there was no evidence of up to date competences in advanced paediatric life support / resuscitation and stabilisation of critically ill children.

Further Consideration

1 Reviewers suggested that appropriate in-house continuing professional development for on call consultants may be partially achieved through involvement in paediatric lists.

2 Paediatric training for Operating Department Practitioners was being addressed through rotation through paediatric lists. This will need to be an ongoing process for these competences to be maintained.

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Urgent Care (Adults)

Emergency Department – Adults

At the time of the review, the Emergency Department at Walsall Healthcare NHS Trust delivered emergency care to approximately 80,000 patients per year. The service operated 24 hours per day, seven days a week in partnership with a primary care provider of an Emergency and Urgent Care Centre. The Emergency Department was also a designated Trauma Unit within the West Midlands Trauma Network, linked with University Hospitals Birmingham NHS Foundation Trust.

The Emergency Department was built in 1989 and was designed for approximately 45,000 attendances per annum. The department had been modified on two occasions. A paediatric 'see and treat' area was created in 2000. In 2009 the number of cubicles increased from 12 to 15 and a fourth resuscitation bay was provided. Further developments were planned for November 2013 when the number of cubicles will be increased. Work with NHS Walsall on an integrated Emergency and Urgent Care model was anticipated to lead, by March 2014, to a reduction in Emergency Department attendances by people with minor illnesses and injuries.

The Emergency Department was reviewed for its care of critically ill and critically injured children and for the care of adults. These two sections are separate but should be read together for reviewers' views of the Department as a whole.

General Comments and Achievements

This was a department where staff worked very hard in an environment that was not conducive to the delivery high quality care. Reviewers considered that the staff were working well together and good working relationships between the Emergency Department and Acute Medical Admissions Unit were evident. Reviewers commented particularly on the change in the approach taken by consultant medical staff since the last visit (2011) with increased clinical presence in the Department and greater multi-disciplinary working.

Good Practice

1 The service for frail older people was well integrated with the Emergency Department. This service could mobilise the Integrated Care Team and was working hard to maintain flow out of the hospital. Approximately 40 patients per day were being referred directly to the Intermediate Care Team. This service also supported the care of people with COPD and the district nursing team at nights and weekends and support for district nursing teams. The frail older people service took referrals from a GPs, ambulances and social services.

2 The Emergency Department had good access to imaging, in particular, CT was available within the same timescale as other imaging investigations for the department.

3 Training records were comprehensive with a good competence framework and good evidence of training in 'Point of Care' testing, undertaken by the Medical Devices Team.

4 Information on the achievement of Key Performance Indicators was clearly displayed to the public.

5 The antimicrobial prescribing policy included colour-coding for those patients with penicillin allergies.

6 A UECIP project team had enabled a behavioural shift across the organisation, including developing a CQUIN relating to discharges by lunchtime.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Environment and Facilities**

The environment and facilities in the Emergency Department were too small for the number of patients being seen. Reviewers were particularly concerned about:

a. Resuscitation Area

This was cramped and cluttered with insufficient space for staff to move around.

b. Bereavement Room

This room had several doors with no signs on the doors. It would be possible for other patients or relatives to walk into the room unintentionally. There was no way of seeing if the room was in use. A curtain rail was available but no curtain to screen families from a deceased relative. No facilities for families were available in the room. The room was also used for mental health assessments despite not meeting expected standards, including a panic button.

c. Four patients were sometimes being placed in one cubicle while waiting admission or the results of investigations. This had happened at least twice in the previous month. This issue had been identified previously and the risk assessments, criteria and decision-making before placing multiple patients in one cubicle had become clearer. Reviewers considered that this was unacceptable but was, in practice, the least risky of the options available to Emergency Department staff.

The Department was generally cluttered and reviewers identified some potential for improvements within the facilities available, especially by de-cluttering. Reviewers were concerned that staff may have become de-sensitised to the conditions under which they were working and to their impact on privacy and dignity of patients.

2 **Consultant Staffing Levels**

Consultant numbers had increased to six but one post was vacant. Reviewers advised that this staffing was insufficient for the sort of service being provided. Nationally recommended levels would be 10 consultants for the size of department and type of care being offered.

3 **Initial Assessment of Adults and Links with the Urgent Care Centre**

Concerns relating to initial assessment and links with the Urgent Care Centre are described in detail in the Emergency Department – Children section of this report. The situation was the same for adults, although reviewers considered that the potential risk to patients was less in adults. Reviewers were, however, told of patients being 'streamed' to the Urgent Care Centre and then being referred back to the Emergency Department because they needed to be admitted.

4 **Medical Staff Resuscitation Training:** See Trust-wide section of this report.

5 **Policies and Procedures:** See Trust-wide section of this report.

6 **Multi-Disciplinary Review and Learning**

Consultant job plans did not include enough 'SPA' time for consultants to attend governance meeting. As a result, governance meetings had no input from consultant medical staff. Mortality meetings were held and information from these meetings was distributed to staff. Multi-disciplinary review and learning from complaints, positive feedback, incidents and 'near misses' was not yet in place.

Further Consideration

1 Reviewers found it remarkable that the Urgent Care Centre had a great deal of physical space and good facilities but there were no arrangements for sharing of these facilities or joint working, even at times when the Emergency Department was stretched well beyond its capacity and, for example, having to put four patients in a cubicle.

2 Many of the timescales expected by the Quality Standards for Urgent Care were not reflected in the Department 'Standard Operating Procedure'. Data were also not being collected to show whether expected Standards were being achieved. It was therefore not possible to audit achievement of the expected timescales. Data collection and clear timescales may help the Department to understand the blocks in flow through the service.

3 An in-depth medication review for frail older people did not appear to be part of the pathway of care. It was noted that in the future these may be completed by practice pharmacists in the community.

4 The plasma screen was not working on the day of the visit. Reviewers also commented on the long time which patients had to wait before the 'front of the queue' information became visible.

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Acute Medical Unit

At the time of the review the Acute Medical Unit comprised a 45 bedded unit, one trolley, a GP waiting area, a triage and assessment cubicle and an acute review clinic. Adult medical patients were referred mainly from the Emergency Department and GPs, with some referrals from outpatients. Imaging and community-based clinical teams also referred patients to the Unit.

General Comments and Achievements

This was a consultant-delivered service with good input to clinical care from consultants working on the unit. The environment was good and ambulatory care pathways were well organised. Acute medical follow-up clinics had been established with the aim of facilitating early discharge although, at the time of the review, these were only operating for three days each week. Good working relationships between the Acute Medical Unit and Emergency Department were apparent. Patients had been involved in the re-design of information leaflets.

Good Practice

1 Rolling review of patients had been established and was working well.

2 All nurses on the Acute Medical Unit were trained in non-invasive ventilation and were able to initiate this when required.

3 Good work on workforce and competence planning for the nursing establishment had been undertaken. Roles and responsibilities for Band 6 nurses were clearly defined. A competency framework for nursing assistants was also in use.

4 The nursing documentation was comprehensive and included all the admission assessments within this record.

Immediate Risks: No immediate risks were identified.

Concerns

1 Many patients who may benefit from Acute Medical Admissions Unit (AMU) care were not being admitted. Acute medical consultants were spending a considerable proportion of their time in the Emergency Department and reported difficulties in being able to admit patients to the AMU. This will be contributing to the difficulties in the Emergency Department (see above). The length of stay on the AMU was reported as one day (although see concern 2 below) which suggests that patients were staying longer than necessary on AMU which, in turn, may contribute to the difficulty in admitting appropriate patients. Occupancy on AMU was reported as always 100%, leaving little capacity to respond quickly to admissions. Two short stay wards had been established, originally as escalation beds. These wards were staffed separately from AMU and length of stay for these patients was not clear.

2 Performance data for the AMU were not being systematically captured. Time for admission from the Emergency Department and time to consultant review were not collected and staff appeared unaware of established acute medicine national performance targets. These data were therefore not being used to manage flow through the urgent care pathway.

3 The AMU did not have 'hot' access to specialty clinics and reviewers were told that consultant to consultant referral was not allowed without referral back to the GP. Specialty in-reach to AMU was patchy with no in-reach by respiratory and gastroenterology services.

4 Laboratory response times were routinely longer than the expected standard of one hour and the AMU was treated as a general medical ward, rather than as requiring the same speed of response as the Emergency Department.

5 Imaging was not reported urgently for the AMU (as it was for the Emergency Department).

6 Middle grade medical cover was insufficient. Outside normal working hours, one middle grade doctor covered the AMU, Emergency Department and ward referrals. This meant that there was no consistent middle grade medical cover on the AMU.

Further Consideration

1 At the time of the review, daily AMU visits for mental health assessments took place. Consideration should be given to ensuring the mental health liaison team meet the expected response times.

2 Acute physician staffing levels had improved since the last visit (2011) but were insufficient to provide appropriate cover for the AMU at weekends. A consultant was present on the Unit from 8am to 8pm Monday to Friday and from 9am to 5pm on Saturdays and Sundays and this would not ensure consultant review of all admissions within 14 hours.

3 AMU follow-up clinics were held on three days a week in order to facilitate early discharge. These clinics were mainly for follow-up and did not accept urgent referrals of patients with the aim of avoiding

admission. Reviewers suggested that the frequency of these clinics should be increased to at least five days per week with clear protocols to identify the patients who should be referred.

4 This report identifies several issues which, if implemented, should quickly reduce pressure on the Emergency Department and Acute Medical Unit:

a. Data collection, particularly to monitor achievement of national acute medicine performance targets.

b. Increased middle grade medical cover outside normal working hours.

c. Imaging and laboratory services responding to AMU in the same way as to the Emergency Department.

d. Mental health liaison team responding within expected timescales.

e. 'Hot' access, including consultant to consultant referral, to specialty clinics.

f. Specialty in-reach to the AMU at least daily, including at weekends.

g. Increasing the frequency of follow-up clinics to at least five days per week, clarifying the criteria for referral to these clinics and including referrals for acute medical assessments from GPs, GP out of hours services and the Emergency Department.

h. Reviewers suggested that the Trust may wish to give consideration to expanding the acute medicine bed base by running one of the current 'short stay' wards as a performance managed 48-72 hours admission area under the control and leadership of the acute medicine team. This may improve the patient flow into the AMU without medical patients being held in the Emergency Department waiting admission.

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CRITICAL CARE

LEVEL 2 AND 3 IN CRITICAL CARE UNITS

General Comments and Achievements

Staff were clearly enthusiastic and motivated by the prospect of a new unit, although at the time of the review this had not yet been ratified by the Trust Board. Reviewers were told that the unit was due for completion in 2015. Staff were trying to maintain and improve standards of care but were hindered by the environment in which they were working.

Since the last review good progress had been made towards the achievement of expected Standards. In particular, there was evidence of multi-disciplinary team working and liaison which had led to demonstrable improvements in mortality rates. This progress had been achieved by strong divisional leadership and good support from staff and from senior management within the Trust.

A good Doctors' Handbook, incorporating specific guidance on the roles and responsibilities of doctors in the Critical Care Unit, was in use.

Good Practice

1 Patient representatives were involved in the Critical Care Steering Group.

2 Volunteer hostesses from the league of friends were utilised on the unit on a daily basis to help support visiting relatives of patients and to make refreshments for them as required.

Immediate Risks: No immediate risks were identified.

Concerns

1 Facilities on the critical care unit were inadequate. Isolation facilities were insufficient for the number of patients, bed spaces were cramped and bathroom facilities were inadequate for patients' privacy and dignity. There was a long distance between the Intensive Therapy Unit and High Dependency Unit. All of these issues will be addressed by the new unit if this is approved and built.

2 There was not always immediate availability of syringe drivers or infusion pumps from the hospital equipment bank which sometimes led to shortages and delays in commencing some treatments whilst the appropriate pump was located and obtained.

3 Average occupancy of the critical care unit was running at over 100%. This may lead to delays in admission and increased infection rates if not addressed.

Further Consideration

1 Purchase of ITU-specific pumps may be helpful which could therefore have superior functionality suitable for infusions in the Critical Care setting only.

2 Expanding the Operational Policy could relatively easily ensure that several of the Standards with which the Unit was not compliant are met.

3 NICE guidance on follow-up clinics and rehabilitation had not yet been implemented.

4 There was no evidence of provision of medical discharge summaries. Rehabilitation prescriptions were not used extensively in Critical Care Unit. The Unit may want to undertake further work in this area.

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Care Outside the Critical Care Unit

Concerns

1 Reviewers were seriously concerned at the time of the review about a lack of formalised handover from the Outreach Team to Critical Care Unit staff at 5pm and a lack of clarity over responsibility for the 'outreach bleep' between 5pm and 9pm. Arrangements to address this issue were implemented immediately after the review. These arrangements should be kept under regular review to ensure the newly implemented systems are working effectively.

2 Effective arrangements for liaison between the Outreach Team and critical care were not apparent. In particular, there was no evidence of multi-disciplinary review and learning involving both services.

3 It was not clear that members of the Outreach Team had appropriate competences for their work with critically ill patients.

4 No outreach operational policy was in place at the time of the review and the role of the team and its future development was unclear. There was a confusing use of different team titles on colour-coded observation chart and on the clinical escalation policy. The mechanism for triggering referrals to the Outreach Team was not clear.

Further Consideration

1 It is usual for Outreach Teams to be an integral part of critical care services. In Walsall, the Outreach Team was in a separate management division to critical care. Reviewers considered that the concerns identified above were directly related to the separate of outreach from critical care. Reviewers strongly suggested that management arrangements for the service should be reviewed with the aim of bringing the Outreach Team within the management and clinical responsibility of Critical Care.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr John Alexander	Clinical Director, PICU	University Hospital of North Staffordshire NHS Trust
Dr Jana Bellin	Consultant in Anaesthesia & Critical Care	Sandwell & West Birmingham Hospitals NHS Trust
David Coles	Commissioner	NHS Birmingham South Central CCG
Dr James Davidson	Clinical Director, Emergency Medicine	University Hospitals Coventry and Warwickshire NHS Trust
Andrea Dodds	Senior Nurse, Emergency Department	University Hospitals Coventry and Warwickshire NHS Trust
Suzanne Findler	Commissioning & Service Redesign Manager	NHS Stoke on Trent CCG
Nick Flint	User Representative	
Lesley Galvin	Admissions/Discharge Pharmacist	University Hospitals Coventry and Warwickshire NHS Trust
Angela Himsworth	Network Lead Nurse	Midlands Critical Care & Trauma Networks
Dr Tracey Leach	Consultant Anaesthetist	Worcestershire Acute Hospitals NHS Trust
Dr Frank Leahy	Consultant Radiologist	Sandwell & West Birmingham Hospitals NHS Trust
Sue Lear	Acute Associate, Service Redesign & Innovation	NHS Arden Commissioning Support
Dr Sven Lehm	Consultant in Acute and Respiratory Medicine & Clinical Lead for Acute Medicine	University Hospital of North Staffordshire NHS Trust
Phil Lephalala	Acting Matron, Acute Paediatrics	Sandwell & West Birmingham Hospitals NHS Trust
Christine McGuire	Clinical Sister	South Warwickshire NHS Foundation Trust
Dr Colin Melville	Consultant Paediatrician	Mid Staffordshire NHS Foundation Trust
Kaye Sheppard	Matron, Critical Care & Respiratory Services	The Dudley Group NHS Foundation Trust
Dr Chris Turner	Consultant Emergency Medicine	University Hospitals Coventry and Warwickshire NHS Trust
Andrea Vigrass	Senior Sister, Acute Medical Unit	University Hospital of North Staffordshire NHS Trust
Denise Wixey	Sister & Lead Paediatric Nurse, Emergency Department	University Hospitals Birmingham NHS Foundation Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Care of Critically Ill and Critically Injured Children			
Trust-Wide	9	8	89
Emergency Department	46	23	50
Paediatric Services	90	62	69
In-patient and PAU	(53)	(37)	(70)
Day Surgery	(37)	(25)	(68)
Paediatric Anaesthesia	17	14	82
Total	**162**	**107**	**66**
Urgent Care			
Acute Trust-wide	12	9	75
Emergency Department	76	51	67
Acute Medical Unit	61	37	61
Total	**149**	**97**	**65**
Critical Care			
Acute Trust-wide	10	8	80
Level 2 and 2 in Critical Care Units	53	42	79
Care Outside the Critical Care Unit	6	0	0
Total	**69**	**50**	**72**

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