



To:
Medical Directors of Acute NHS Trusts
Medical Directors of Acute NHS Foundation Trusts

cc:
CCG Clinical Leaders
CCG Accountable Officers
NHS England Regional Medical Directors
Monitor Regional Directors
NHS TDA Directors of Delivery and Development

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Dear Colleague

Establishing a baseline of the seven day services clinical standards in acute care

The clinical case for seven day services includes reducing variation in the mortality risk for patients admitted on weekdays and weekends, and ensuring that doctors in training are safely supervised on every day of the week.

Analysis of hospital admissions in 2009/10 showed that the risk of 30 day mortality for people admitted on a Saturday was 11% higher and 16% higher on a Sunday, when compared with admissions on a Wednesday¹.

In 2013 the NHS Services, Seven Days a Week Forum developed ten clinical standards describing the minimum level of service that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week. We know that local organisations have been working over the last year to make

¹ <http://jrs.sagepub.com/content/105/2/74.short>

progress on these standards in line with Technical Guidance on the NHS Standard Contract 2015/16.

During 2014/15, commissioners and providers ensured that contracts with acute providers contained an initial action plan, set out in a Service Development and Improvement Plan (SDIP), to deliver the ten clinical standards for seven day services. We asked that during 2015/16, commissioners should agree updated SDIPs, building on steps taken in 2014/15 and making further progress towards implementation of at least five standards which will have the greatest impact locally, within the resources available. In future the seven day service clinical standards will be embedded in plans to deliver Urgent and Emergency Care Networks across England.

Following discussions with the Academy of Medical Royal Colleges the following four standards have been identified as having the most impact on reducing weekend mortality and will therefore become our immediate focus. These are:

Standard 2: Time to Consultant Review

Standard 5: Access to Diagnostics

Standard 6: Access to Consultant-directed Interventions

Standard 8: On-going Review

We are writing to ask you to support the establishment of a robust baseline showing the extent to which these standards are being met nationally, by completing the sections of the NHS Improving Quality Seven Day Service Self-Assessment Tool which address these four priority standards, by Friday 4th September 2015. Once established, this baseline will be used to track progress against the roll-out of the standards nationally.

Over 90% of NHS trusts are registered to use the Self-Assessment Tool, and we are now requesting that you take the following actions:

- Identify a lead in your trust who will be responsible for collecting and inputting the data onto the NHS Improving Quality Self-Assessment Tool (see guidance on completing the tool in appendix 1).
- Act as (or identify) the executive director in your trust who will quality assure the data prior to submission and subsequently report your baseline position against the standards to your board of directors.
- Approve data for your trust by 5p.m. on the final submission date Friday 4th September 2015.

We appreciate that we are entering a difficult time of year for data collection and sharing, and that we are asking for a very quick response. For this reason, NHS Improving Quality colleagues will provide support and advice on how to gather, input and assure data (see Appendix 1). Once established in September, the baseline will

help local and national teams to identify the main areas for quality improvement. Results of the survey will be published nationally and will provide a baseline against which the progress of implementation can be measured on a quarterly basis.

Thank you for your cooperation on this important issue.

Yours sincerely



Professor Hugo Mascie-Taylor

Dr Kathy Mclean

Professor Sir Bruce Keogh

Medical Director

Medical Director

National Medical Director

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NHS Trust Development
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Appendices

Appendix 1: NHS Improving Quality Seven Day Services Self-Assessment Tool

The Self-Assessment Tool can be accessed via:

<http://www.7daysat.nhs.uk>

A detailed user guide for the self-assessment tool is available at:

<http://www.7daysat.nhs.uk/7dsatuserguide.ppt>

NHS Improving Quality staff will provide telephone advice on registering for and using the Self-Assessment Tool, as well as on how to assure the data through, for example, case note audits.

The NHS Improving Quality website will also signpost you to additional improvement resources, tools and case study examples to support 7 day services analysis and implementation:

<http://www.nhs.uk/improvement-programmes/acute-care/seven-day-services.aspx>

Acute trusts can contact the team through a single email address 7dssupport@nhs.uk and a member of the team will make contact with you to discuss your requirements.

Appendix 2: Seven Day Services Clinical Standards

No.	Standard	Adapted from source
	Patient Experience	
1	<p>Standard:</p> <p>Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.</p> <p>Supporting information:</p> <ul style="list-style-type: none"> • Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times. • The format of information provided must be appropriate to the patient’s needs and include acute conditions. • With the increasing collection of real-time feedback, it is expected that hospitals are able to compare feedback from weekday and weekend admissions and display publicly in ward areas. 	<p>NICE (2012): Quality standard for patient experience in adult NHS services (QS15)</p> <p>RCS (2011): <i>Emergency Surgery, Standards for unscheduled surgical care</i></p>
	Time to first consultant review	
2	<p>Standard:</p> <p>All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.</p> <p>Supporting information:</p> <ul style="list-style-type: none"> • All patients to have a National Early Warning Score (NEWS) established at the time of admission. • Consultant involvement for patients considered ‘high risk’ (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected) should be 	<p>NCEPOD (2007): <i>Emergency Admissions: A journey in the right direction?</i></p> <p>RCP (2007): <i>Acute medical care: The right person, in the right setting – first time</i></p> <p>RCS (2011): <i>Emergency Surgery, Standards for unscheduled surgical care</i></p> <p>RCP (2012): <i>Delivering a 12-hour, 7-day consultant presence on the acute medical</i></p>

No.	Standard	Adapted from source
	<p>within one hour.</p> <ul style="list-style-type: none"> • All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor, or advanced non-medical practitioner with a similar level of skill promptly, and seen and assessed by a consultant within six hours. • Standards are not sequential; clinical assessment may require the results of diagnostic investigation. • A 'suitable' consultant is one who is familiar with the type of emergency presentations in the relevant specialty and is able to initiate a diagnostic and treatment plan. • The standard applies to emergency admissions via any route, not just the Emergency Department. • For emergency care settings without consultant leadership, review is undertaken by appropriate senior clinician e.g. GP-led inpatient units. 	<p><i>unit</i></p>
Multi-disciplinary Team (MDT) review		
3	<p>Standard:</p> <p>All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.</p> <p>Supporting information:</p> <ul style="list-style-type: none"> • The MDT will vary by specialty but as a minimum will include Nursing, Medicine, Pharmacy, Physiotherapy and for medical patients, Occupational Therapy. • Other professionals that may be required include but are not limited to: dieticians, podiatrists, speech and language therapy and psychologists and consultants in other specialist areas such as geriatrics. • Reviews should be informed by patients existing primary and community care records. • Appropriate staff must be available for the treatment/management plan to be carried out. 	<p>RCP (2007): <i>Acute medical care: The right person, in the right setting – first time</i></p> <p>RCS (2011): <i>Emergency Surgery, Standards for unscheduled surgical care</i></p> <p>NICE (2007): <i>Technical patient safety solutions for medicines reconciliation on admission of adults to hospital</i></p>

No.	Standard	Adapted from source
	Shift handovers	
4	<p>Standard:</p> <p>Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.</p> <p>Supporting information:</p> <ul style="list-style-type: none"> • Shift handovers should be kept to a minimum (recommended twice daily) and take place in or adjacent to the ward or unit. • Clinical data should be recorded electronically, according to national standards for structure and content and include the NHS number. 	<p>RCP (2011): <i>Acute care toolkit 1: Handover</i></p> <p>RCP (2013): <i>Future Hospital Commission</i></p>
	Diagnostics	
5	<p>Standard:</p> <p>Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:</p> <ul style="list-style-type: none"> • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients <p>Supporting information:</p> <ul style="list-style-type: none"> • It is expected that all hospitals have access to radiology, haematology, biochemistry, microbiology and histopathology • Critical patients are considered those for whom the test will alter their management at the time; urgent patients are considered those for whom the test will alter their management but not necessarily that day. • Standards are not sequential; if critical diagnostics are required they may precede the thorough clinical assessment by a suitable consultant in standard 2. • Investigation of diagnostic results should be seen and acted on promptly by the MDT, led by a competent decision maker. 	<p>RCP (2007): <i>Acute medical care: The right person, in the right setting – first time</i></p> <p>RCS (2011): <i>Emergency Surgery, Standards for unscheduled surgical care</i></p> <p>AOMRC (2012): <i>Seven day consultant present care</i></p> <p>RCR (2009): <i>Standards for providing a 24-hour radiology diagnostic service</i></p> <p>NICE (2008): <i>Metastatic spinal cord compression</i></p>

No.	Standard	Adapted from source
	<ul style="list-style-type: none"> • Where a service is not available on-site (e.g. interventional radiology/endoscopy or MRI), clear patient pathways must be in place between providers. • Seven-day consultant presence in the radiology department is envisaged. • Non-ionizing procedures may be undertaken by independent practitioners and not under consultant direction. 	
Intervention / key services		
6	<p>Standard:</p> <p>Hospital inpatients must have 24 hour access, seven days a week, to consultant-directed interventions either on-site or through formally agreed networked arrangements with clear protocols, such as:</p> <ul style="list-style-type: none"> • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery <p>Supporting information:</p> <ul style="list-style-type: none"> • Standards are not sequential; if an intervention is required it may precede the thorough clinical assessment by a suitable consultant in standard 2. • Other interventions may also be required. For example, this may include: <ul style="list-style-type: none"> ○ Renal replacement therapy ○ Urgent radiotherapy ○ Thrombolysis ○ PCI ○ Cardiac pacing 	<p>NCEPOD (1997): <i>Who operates when?</i></p> <p>NCEPOD (2007): <i>Emergency admissions: A journey in the right direction?</i></p> <p>RCP (2007): <i>Acute medical care: The right person, in the right setting – first time</i></p> <p>RCS (2011): <i>Emergency Surgery, Standards for unscheduled surgical care</i></p> <p>British Society of Gastroenterology</p> <p>AoMRC (2008): <i>Managing urgent mental health needs in the acute trust</i></p>
Mental health		
7	<p>Standard:</p> <p>People with mental health needs must be assessed within the appropriate timescales 24 hours a day, seven days a week:</p> <ul style="list-style-type: none"> • Within 1 hour for emergency* care needs • Within the same day for urgent** care needs 	<p>RCPsych PLAN (2011): <i>Quality Standards for Liaison Psychiatry Services</i></p>

No.	Standard	Adapted from source
	<ul style="list-style-type: none"> • Supporting information: <ul style="list-style-type: none"> • Unless the liaison team provides 24 hour cover, there must be effective collaboration between the liaison team and out-of-hours services (e.g. Crisis Resolution Home Treatment Teams, on-call staff, etc.) <p>* An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.</p> <p>** A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.</p>	
	On-going review	
8	<p>Standard:</p> <p>All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.</p> <p>Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.</p> <p>Supporting information:</p> <ul style="list-style-type: none"> • Patients, and where appropriate carers and families, must be made aware of reviews. Where a review results in a change to the patient's management plan, they should be made aware of the outcome and provided with relevant verbal, and where appropriate written, information. • Inpatient specialist referral should be made on the same day as the decision to refer and patients should be seen by the specialist within 24 hours or one hour for high risk patients (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected). • Consultants 'multiple day blocks' should be between 	<p>RCP (2007): <i>Acute medical care: The right person, in the right setting – first time</i></p> <p>RCS (2011): <i>Emergency Surgery, Standards for unscheduled surgical care</i></p> <p>AOMRC (2012): <i>Seven day consultant present care</i></p> <p>RCP (2013): <i>Future Hospital Commission</i></p>

No.	Standard	Adapted from source
	<p>two and four continuous days.</p> <ul style="list-style-type: none"> • Ward rounds are defined as a face-to-face review of all patients and include members of the nursing team to ensure proactive management and transfer of information. • Once admitted to hospital, patients should not be transferred between wards unless their clinical needs demand it. • The number of handovers between teams should be kept to a minimum to maximise patient continuity of care. • Where patients are required to transfer between wards or teams, this is prioritised by staff and supported by an electronic record of the patient's clinical and care needs. • Inpatients not in high dependency areas must still have daily review by a competent decision-maker. This can be delegated by consultants on a named patient basis. The responsible consultant should be made aware of any decision and available for support if required. 	
Transfer to community, primary and social care		
9	<p>Standard: Support services, both in the hospital and primary and community setting must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.</p> <p>Supporting information:</p> <ul style="list-style-type: none"> • Primary and community care services should have access to appropriate senior clinical expertise (e.g. via phone call), and where available, an integrated care record, to mitigate the risk of emergency readmission. • Services include pharmacy, physiotherapy, occupational therapy, social services, equipment provision, district nursing and timely and effective communication of on-going care plan from hospital to primary, community and social care. • Transport services must be available to transfer, seven days a week. • There should be effective relationships between medical and other health and social care teams. 	AOMRC (2012): <i>Seven day consultant present care</i>

No.	Standard	Adapted from source
	Quality improvement	
10	<p>Standard: 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.</p> <p>Supporting information:</p> <ul style="list-style-type: none"> • The review of patient outcomes should focus on the three pillars of quality care: patient experience, patient safety and clinical effectiveness. • Attention should be paid to ensure the delivery of seven day services supports training that is consistent with General Medical Council and Health Education England recommendations and that trainees learn how to assess, treat and care for patients in emergency as well as elective settings. • All clinicians should be involved in the review of outcomes to facilitate learning and drive quality improvements. 	GMC (2010): Generic standards for specialty including GP training