Urgent Network Specialist Services and 7 Day Services – Frequently Asked Questions

What exactly are the services being measured?
These services are:

- Hyperacute stroke – acute stroke patients who have a critical need for thrombolysis.
- Paediatric intensive care – children who require level 3 Paediatric Critical Care.
- STEMI heart attacks – patients who require primary percutaneous coronary intervention for ST elevated myocardial infarction.
- Major trauma – patients treated for injuries at a major trauma centre.
- Emergency vascular services – emergency interventions (specifically abdominal aortic aneurism and lower limb ischemia, but also other vascular treatments for patients with critical needs) provided at a specified vascular centre.

How many case notes does each trust need to collect and over what period?
This template requests data from 10 patient case notes for each of these services provided by each trust. If a trust provides all five of these services, then five separate templates with data from 10 patients each need to be completed – one for each service. Ideally these would be collected over a single week, but as four of these cases must be from patients admitted at the weekend some low volume services may need to extend this time period to capture the appropriate number of weekend patients.

Are the 7 day services standards replacements for existing standards for these services?
No. The 7DS standards should not be seen in any way as replacing existing guidance for any of the urgent network specialist services. The specialised commissioning service specifications go into specific detail for 4 of the 5 services (STEMI heart attack, major trauma, emergency vascular and PIC) and for stroke the guidance produced by the RCP is the standard that all services should be delivering. Through supporting these services to meet the 7DS standards, we are helping to ensure that these services meet existing specification and guidance.

What do you mean by review by a specialist consultant within 14 hours for standard 2?
The definition of consultant for this standard is a consultant on the GMC's specialist register who is a specialist in the relevant area of care. The exact timescale for consultant involvement would vary dependent on best clinical practice and individual patient needs. For example, in many cases the appropriate clinical guidance may state that a senior registrar or other may make immediate treatment decisions. In these cases we would expect the speciality consultant to review the patient within the 14 hour 7DS guidance. In other cases, it will be the speciality consultant who makes the decision on whether to treat. In these cases, this involvement would count as the patient's initial consultant review.

How should the frequency of consultant reviews for standard 8 be determined?
Clinical judgement should be used to determine frequency of consultant review required, but as a guide patients with Intensive Care Society levels of care of 2 (level 3 for Paediatric Intensive Care Society standards) and above may require twice daily review, and patients with care needs of below level 2 (3 for paediatrics) may only require once daily review.

How long does ongoing consultant review (standard 8) need to be measured for these specialised services?
For these services, ongoing consultant review should only be measured for patients for the period that they are continuing to be treated by the service in question, up to a maximum of five days. Once a patient is no longer being treated within the service (i.e. if the patient has been treated and they have been moved to an

intermediate care setting or been discharged) then the frequency of ongoing review does not need to be captured in this exercise. The wider 7DS survey of all acute trusts' emergency admissions would measure this level of ongoing care.

How will these data be used and how do they relate to other data collected locally and the national baseline work?

The data collected through these case note reviews will be used to provide a nationally consistent 'snapshot' of performance for each of these services against the 7DS standards. This information should be brought together with other local information and data from the national baseline to provide an assessment of performance for each service. This assessment will then form the basis of each region's action plan for the delivery of the 7DS standards in these services by November.

How does this work relate to the wider 7DS in hospitals work and the survey for all acute trusts?

This work to deliver 7DS in urgent network specialist services is following the same principles as the wider 7DS in hospitals priority, but it is a distinct strand of this work. The 'snapshot' of 10 case note reviews is to help providers of these specialist services tackle any gaps in meeting the 7 day clinical standards by November 2017; to meet this timescale we have asked for this 10 case note survey to be completed as soon as possible. Therefore this exercise should be treated as a separate piece of work from the next biannual 7DS survey of trusts, which is due to take place in late March-April, with trusts reporting their results before 24 May. The wider 7DS work is focused on measuring the performance of an entire trust against the four priority standards, using a typical emergency inpatient caseload, rather than being specifically focused on certain specialities.

What about centres that do not operate on a 24/7 basis but alternative arrangements are in place for their patients on weekends?

This work is about ensuring that all patients have access to services which meet the 7DS standards. It is for each region to decide whether such service models can provide services for patients which not only meet the 7DS standards but also the specialised commissioning service specifications which outline in detail how each of these services should be delivered.