Seven Day Services Clinical Standards

September 2017

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Gateway reference: 06408

No.	Standard	Adapted from source
Patient Experience		
1.	**Standard:** 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. **Supporting information:** • 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.	NICE (2012): Quality standard for patient experience in adult NHS services (QS15) RCS (2011): Emergency Surgery, Standards for unscheduled surgical care
Time to first consultant review		
2.	**Standard:** 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 from the time of admission to hospital. **Supporting information:** • A suitable consultant is a doctor who has completed all of their specialist training and has their CCT or equivalent and is therefore trained and competent in dealing with emergency and acute presentations in the specialty	NCEPOD (2007): Emergency Admissions: A journey in the right direction? RCP (2007): Acute medical care: The right person, in the right setting – first time RCS (2011): Emergency Surgery, Standards for unscheduled surgical

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	concerned 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 example admissions via radiology, consultant clinic and direct admission to AMU. NOTE: if a patient is admitted from clinic, this consultation amounts to a first consultant review and meets this standard. • All patients should have a National Early Warning Score (NEWS) established at the time of admission. • 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 promptly, and seen and assessed by a consultant within six hours. • 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 within one hour. • For emergency care settings without consultant leadership, review can be undertaken by appropriate senior clinician e.g. GP-led inpatient units. • Standards are not sequential; clinical assessment may require the results of diagnostic investigation. • Patients with a clear diagnosis on a well-defined pathway (e.g. midwife-led maternity, simple superficial abscess management) may have their clinical care delegated from a consultant to another clinician under the following circumstances: o there is a clear written local protocol for the pathway that has been agreed within the Trust clinical governance system and that is supported by the commissioners; o the protocol must describe actions to take in the event of clinical concern and that includes robust and rapid escalation to a consultant where	care RCP (2012): Delivering a 12-hour, 7-day consultant presence on the acute medical unit

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	appropriate e.g. a maternity patient who develops the need for an emergency Caesarean section or a patient with a superficial abscess who appears to be developing sepsis; and, ○ the patient's care is still recorded as being under a named consultant for the purpose of clinical governance (excluding patients specifically on midwife-led care pathways).	
MDT review		
3.	**Standard:** 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. **Supporting information:** • The multi-professional team 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.	RCP (2007): Acute medical care: The right person, in the right setting – first time RCS (2011): Emergency Surgery, Standards for unscheduled surgical care NICE (2007): Technical patient safety solutions for medicines reconciliation on admission of adults to hospital

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Shift handovers		
4.	**Standard:** 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. **Supporting information:** • 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.	RCP (2011): Acute care toolkit 1: Handover RCP (2013): Future Hospital Commission
Diagnostics		
5.	**Standard:** Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients **Supporting information:**	RCP (2007): Acute medical care: The right person, in the right setting – first time RCS (2011): Emergency Surgery, Standards for unscheduled surgical care AOMRC (2012): Seven day consultant present care RCR (2009): Standards for providing a 24-hour radiology diagnostic service

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	• Acute trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances. • The intention of the standard is to ensure that diagnostic tests are done within a specified period of time after the clinician in charge of the patient has requested them. • The standard requires that diagnostic services are made available for patients to access; it does not set an expectation that clinicians should order tests inappropriately early in the care pathway. There is a very important role for watchful waiting to see how a patient's condition progresses. • Unless it is clinically indicated, patients should not remain in hospital solely for the purpose of receiving the diagnostic test they require. • 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. • Seven-day consultant presence in the radiology department is envisaged.	NICE (2008): Metastatic spinal cord compression

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Intervention / key services		
6.	**Standard:** Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be: • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery • Emergency renal replacement therapy • Urgent radiotherapy • Stroke thrombolysis • Percutaneous Coronary Intervention • Cardiac pacing (either temporary via internal wire or permanent) **Supporting information:** • Standards are not sequential; if an intervention is required it may precede the thorough clinical assessment by a suitable consultant in standard 2. • The principle is that patients should receive urgent interventions within a timeframe that does not reduce the quality of their care (safety, experience and efficacy). Where there is evidence-based national clinical guidance regarding time to urgent treatment (e.g. thrombolysis for stroke, emergency laparotomy for peritonitis), trusts should implement systems to deliver to these standards and should monitor their performance. • Acute trusts should make a judgment through their clinical governance	NCEPOD (1997): Who operates when? NCEPOD (2007): Emergency admissions: A journey in the right direction? RCP (2007): Acute medical care: The right person, in the right setting – first time RCS (2011): Emergency Surgery, Standards for unscheduled surgical care British Society of Gastroenterology AoMRC (2008): Managing urgent mental health needs in the acute trust

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	processes and in discussion with their commissioners regarding which interventions their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. • Clear written protocols should describe any networked service arrangements, including a robust and transparent process for timely clinical assessment and patient transfer between sites. • Such processes should be regularly audited to ensure that transferred patients receive timely high quality care. • Trusts and their commissioners should have policies for managing a patient who is already in hospital and who develops another acute condition e.g. a general medical in-patient who then has a STEMI heart attack requiring primary PCI.	
Mental Health		
7.	**Standard:** Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week. Where an emergency* mental health need is identified in the Emergency Department or on an acute general hospital ward, a liaison mental health service should respond to the referral within one hour. Emergency referrals should be made at the earliest opportunity after a patient arrives in the ED. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment. Within four hours of arriving in an ED or being referred from a ward, the patient	NHS England, NICE, NCCMH (2016): Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults

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	should: • have received a full biopsychosocial assessment, and • have an urgent and emergency mental health care plan in place, and • at a minimum, be en route to their next location if geographically different, or • have been accepted and scheduled for follow-up care by a responding service, or • have been discharged because the crisis has resolved OR • have started a Mental Health Act assessment. Where an urgent** mental health need is identified on acute general hospital ward, a liaison mental health service should respond to the referrer within one hour of receiving a referral to ascertain its urgency, the type of assessment needed and resources required for the assessment. The urgent and emergency liaison mental health assessment should start within 24 hours of receiving a referral. Within 24 hours of presenting with a suspected urgent mental health problem on a general hospital ward it is recommended that a person should: • have received a full biopsychosocial assessment, and • have an urgent and emergency mental health care plan in place, and • at a minimum, be en route to their next location if geographically different, or • have been accepted and scheduled for a follow-up appointment by a responding service, or • have been provided with advice or signposted, where appropriate.	

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	Supporting information: • In line with the commitment made by NHS England in response to the *Five Year Forward View for Mental Health*, all acute hospitals with 24/7 EDs should be working towards providing an all-age service and achieving as a minimum the core 24 liaison mental health service standard for adults and older adults. Where services are not currently operating on a 24/7 basis, outside the liaison services' hours of operation there may need to be effective collaboration between the liaison team and out-of-hours services (e.g. Crisis Resolution Home Treatment Teams, on-call mental health staff, out-of-hours mental health services for children and young people etc). * An emergency is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response. ** An urgent situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening.	
Ongoing review		
8.	**Standard:** All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant 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. **Supporting information**	RCP (2007): Acute medical care: The right person, in the right setting – first time RCP (2012): Delivering a 12-hour, 7-day consultant presence on the acute medical unit RCS (2011): Emergency Surgery, Standards for unscheduled surgical

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	<u>Definition of a consultant for this standard</u> • Consultants in this context are defined as doctors on the Specialist Register, CCT-holders and those recognised as being equivalent in the view of the relevant Royal College. These senior decision-makers have a crucial role, not just in identifying and dealing with clinical issues but also in communication with patients and relatives, in taking active and appropriate decisions about discharge from hospital, and in providing support and supervision and education to junior clinical colleagues. • The term 'consultant' is maintained because it is believed that this is a term broadly understood by doctors and the public. This description of the consultant is included in this supporting information, to align the standard with professional opinion, and provide clarity on which senior doctors could provide ongoing review without compromising patient safety. <u>Purpose of consultant review</u> • The purpose of the consultant review is to see any patient who is not on a pathway, to address patient deterioration, to provide urgent important communication with patients and carers where appropriate, to speed flow and remove blockages in the care pathway. There should be clear escalation protocols so that if a patient deteriorates in-between daily ward rounds there is appropriate timely clinical escalation. ("Seeing the sickest quickest"). <u>Frequency of consultant reviews</u>	care AOMRC (2012): Seven day consultant present care AOMRC (2013): Implementing 7 day consultant-present care Intensive Care Society (2009) Levels of Critical Care for Adult Patients. Paediatric Intensive Care Society (2015) Quality Standards for the Care of Critically Ill Children

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	• Clinical judgement should be used to determine frequency of consultant review required, but as a guide patients with Intensive Care Society levels of need of 2 (3 for paediatrics) and above may require twice daily review, and patients with needs of below level 2 (3 for paediatrics) may only require once daily review. The group of patients who need twice daily reviews should be based on the Intensive Care Society definitions of levels of illness and the Paediatric Intensive Care Society standards for the care of critically ill children rather than their geographical ward location in the hospital. <u>Use of Board rounds and delegation</u> • There should be consultant-led Board rounds on every acute inpatient ward every day, and every patient should have a highly visible care plan (based on written protocols for individual conditions) that is updated daily at the Board round. At the Board round the consultant decides which, if any of the patients' reviews that day can be delegated to another competent clinician, such as a specialist nurse or senior medical trainee. The following are considerations that may be used to exclude individual patients from requirement for daily consultant review: • The patient's physiological safety (low early warning score (EWS)). • The patient's level of need for further investigations and revision of diagnosis.. • The patient's level of need for therapeutic intervention. • The level of need for communication with patient, carers, clinical colleagues. • Their likelihood of imminent discharge. For example patients who are	

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	medically fit for discharge and awaiting a social care placement (delayed transfers of care) may not need daily consultant review unless there are signs of clinical deterioration. The effective use of the skills and experience of a multidisciplinary team should be preserved, and this group will still need daily review with access to same day consultant advice. • The decision that the patient does not need a daily consultant review should be documented, along with the plan for how the patient will be reviewed each day by the multi-disciplinary team (MDT) to ensure any signs of clinical deterioration are acted upon.. Where a daily review is delegated the reviewer should feed back promptly to the consultant any concerns they have about a patient. Several examples exist of trusts that have segmented their inpatient population to facilitate the appropriate level of daily review. Typically the groups are described as 'medically active', 'medically optimised' and 'medically fit for discharge'. o The medically active group MUST be seen daily by a consultant and not delegated. This includes all patients causing nursing concern, all patients on end-of-life care pathways, all new admissions to a ward in the previous 24 hours and all patients in whom a potential same day discharge decision is required. o The medically optimised group need daily consultant input via the Board Round, to ensure there is an MDT discussion around progress on therapy and social assessments, then for some in this group the consultant may choose to delegate that day's face to face review to another member of the multidisciplinary team.	

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	○ The medically fit for discharge group (including people who are Delayed Transfers of Care) may be excluded from daily consultant face to face review, and instead reviewed by a senior nurse or equivalent. There would still need to be a safety netting process in place so that if such a patient experiences unexpected deterioration there is a system that ensures that a consultant assesses them promptly. • There are concerns that a focus on Board rounds could disadvantage patients who are "outliers" and trusts should agree with their commissioners explicit strategies to mitigate this risk. Effective management of flow and bed occupancy should reduce the numbers of outlying patients. We know that outliers are often disadvantaged by typically not only missing out on daily consultant reviews, but also due to having less access to specialist nurses and allied health professionals. *The default position for outlying patients is that they should be seen face to face by a consultant every day.* <u>Role of the multidisciplinary team to support daily consultant reviews</u> • In units which are non-medical consultant led e.g. GP or midwife / therapist led units, it is acceptable for this consultant leadership to be provided by the GP, therapist, midwife or senior nurse. • Consultants need adequate support seven days a week from an appropriate team of healthcare professionals to ensure patients receive good quality care. Junior doctors involved in providing urgent and emergency care should have prompt access to consultant support and advice including a consultant presence on site every day to optimise opportunities for training and clinical supervision.	

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	• Consultant ward rounds should be optimised for efficiency and effectiveness e.g. using specialist and senior nurses, pharmacists or physiotherapists to work with consultants and review specific patients. Appropriate administrative support is also needed every day and can be provided by other staff groups such as physician associates, doctors' assistants and ward clerks. The use of a standardised checklist on ward rounds can also improve efficiency. • A trust may agree with its commissioner to designate certain wards as non-acute rehab or intermediate care wards that don't require the level of daily consultant intervention described above. There would still need to be a clear escalation protocol for any patient in a rehab or intermediate care bed who deteriorates unexpectedly. <u>Optimising effective 7 day reviews</u> • Rota patterns which optimise continuity of care, such as consultants working multiple day blocks, should be designed; consultant review is likely to take less time if a patient is already known to the consultant. • A greater proportion of generalists (consultants with the skills to manage patients across different specialty areas) will increase the flexibility of the consultant workforce delivering daily reviews at weekends. • 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. For high risk patients defined as where the risk of mortality is greater than 10%, or	

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	where a patient is unstable and not responding to treatment as expected, consultant involvement should be within one hour. <u>Patient and family involvement</u> • 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.	
Transfer to community, primary and social care		
9.	**Standard:** Support services, both in the hospital and in primary, community and mental health settings 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. **Supporting information:** • 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	AOMRC (2012): Seven day consultant present care

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	social care teams.	
Quality Improvement		
10.	**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. **Supporting information:** • 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