Public Health England

Protecting and improving the nation's health

East of England Clinical Senate

Review of the readiness of NHS Acute Trusts to deliver Standard Eight of the National Seven Day Services Clinical Standards in the East of England

Jessica Stokes, Public Health Registrar
Dr Robert Lindfield, Consultant in Healthcare Public Health, Public Health England

Acknowledgements

Papworth Hospital NHS Foundation Trust
Southend University Hospital NHS Foundation Trust
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
East of England Clinical Senate

1. Background

This project was delivered by the East of England Clinical Senate and Public Health England working in collaboration with NHS Acute Trusts. The focus was on Standard Eight, which by definition is more relevant to secondary care. The most significant improvements in patient care will require enhanced delivery against all ten standards with primary care, community services, mental health services and ambulance service working in collaboration.

1.1 Evidence base

A body of evidence has emerged linking hospital admissions at the weekend with increased mortality.[1] For example; analysis of NHS inpatient records found an increased risk of death within 30 days of weekend admissions, with an 11% increased risk when admitted on a Saturday and 16% when admitted on a Sunday when compared to a Wednesday. [2] A raised mortality risk was also established for emergency and elective surgery when the operation was performed on, or just before, the weekend. Additionally patient re-admission rates were higher if they had initially been admitted at the weekend. [3]

The explanation for these higher mortality rates is thought to be multifactorial and there is limited evidence of a causal relationship. However, there are some widely accepted views that may explain the increased mortality rates:[4]

- Variable staffing levels in hospitals at the weekend
- A lack of consistent specialist services, such as diagnostics, at weekends
- A lack of availability of specialist community and primary care services, resulting in more patients on an end of life care pathway dying in hospital.

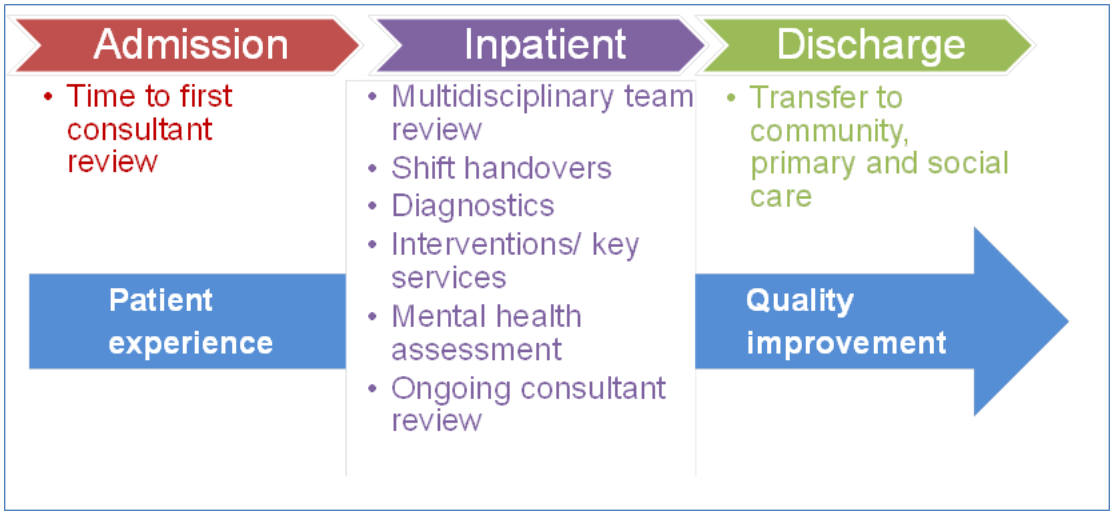
1.2 National framework

The provision of routine NHS services seven days a week is a key national priority. The NHS Five Year Forward View, in outlining a new model for urgent and emergency care networks, stated that there is a need to ensure that hospital patients have access to seven day services where this makes a difference to clinical outcomes.[5] The NHS England planning guidance for 2014/15 to 2018/19 had seven day services as a key element in ensuring high quality care for all.[6]

The 'Seven Days a Week Forum' was established by the NHS England Medical Director in 2013 to provide evidence and tools to take this work forward. The initial focus has been on urgent and emergency care services and 10 clinical standards have been published that patients should expect to receive seven days a week.[1] The themes of the standards are illustrated in figure 1 below.

The NHS operational planning guidance for 2015/16 set out the expectation that providers of acute care should implement at least five of the ten clinical standards in 2015/16[7] with full compliance expected in 2016/17.[6] It is noted that this should be achieved within the resources available, recognising that the tariff for 2015/16 does not include specific additional resources for seven day working.

Figure 1. National seven day service clinical standard themes



1.3 East of England Approach

The East of England Clinical Senate were keen to support health economies across the region in assessing their readiness for seven day services and this was raised with the Medical Directors of Acute Hospital Trusts in January 2015. The Medical Directors voiced concerns about the 'on going consultant review' standard (standard 8) as this seemed one of the more difficult standards to measure and achieve. The Senate Council agreed to undertake a project to review this in more detail. It was recognised from the outset that improvements against all the standards are required to achieve the best outcomes for patients – this project aimed at being a first step in a broader piece of work across the East of England.

The Senate in conjunction with Public Health England established a working group to take forward a project focusing on this standard. The working group included the Clinical Senate Chair and Manager, Public Health England Consultant and Registrar, NHS England Lead for seven day services, GP/CCG representative, patient representative, consultant from a local Acute Hospital Trust and a representative from the East of England Ambulance Service.

The aims of this work were to:

- Develop an approach to help improve the definition and measurement of standard 8
- Determine the feasibility of carrying out a more detailed baseline assessment of standard 8
- Identify barriers to achievement and factors that have helped achieve standard
- Identify areas where further support to implement 7 day services is needed

1.4 Standard 8 – on-going consultant review

The details of this standard and supporting information are shown in Table 1 below. This standard is partly adapted from guidance published by the Academy of Medical Royal Colleges (AMRC) in 2012 on seven day consultant present care.[8] This guidance recognises that the availability of consultants varies greatly by specialty and hospital in the evenings and at weekends and that some specialties already provide a seven day consultant presence. The AMRC surveyed 36 specialties with regards to seven day consultant present care and

published 'Implementation considerations.'[9] The issues for consideration relating to on-going consultant review are summarised in Appendix 1.

Table 1. Standard 8 definition and supporting information[1]

Standard 8 - On-going review

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.

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.

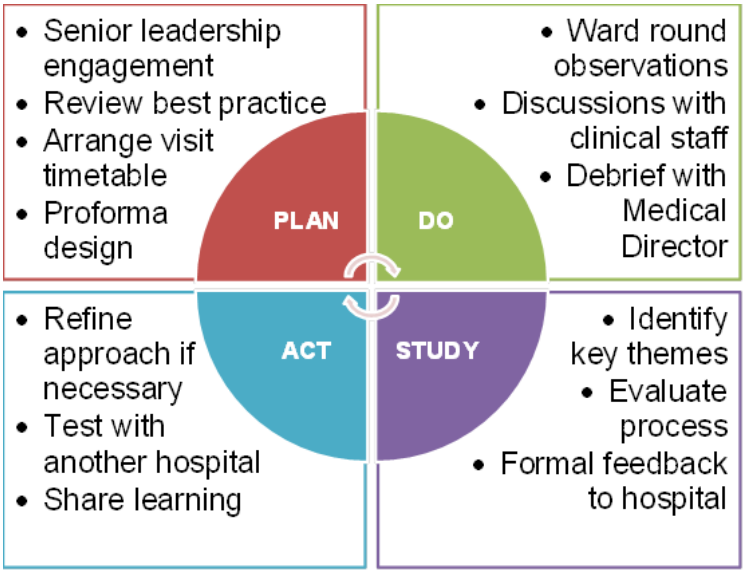
Supporting information

- 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 two and four continuous days.
- 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.

2. Method

Following an initial scoping exercise, it was apparent that the information required for standard 8 was not routinely collected by hospitals. Therefore, in order to measure this standard and discover how hospitals are addressing these issues, it was agreed to pilot an approach with three different hospitals within the East of England clinical senate area. This involved visiting the hospitals to observe ward rounds conducted by different specialties and discussing the issues relating to consultant-led reviews with staff. The approach taken is illustrated in the Plan Do Study Act (PDSA) cycle below (Figure 2).

Figure 2. PDSA cycle for assessing on going consultant review practice.



2.1 Hospitals visited

During the five month period from March 2015 to August 2015, three hospitals in the East of England were visited. Two of these hospitals volunteered and the third was approached to be a pilot site. The hospitals involved were:

- Papworth Hospital NHS Foundation Trust (PFT)– a specialist cardiothoracic hospital
- Southend University Hospital NHS Foundation Trust (SUFT) – a district general hospital
- The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust (QEFT) – a district general hospital

It was important to get engagement from hospital senior leadership for the visit and approval was sought from the Medical Directors and Directors of Nursing.

2.2 Format of visit

A visit team was formed for each visit, consisting of between 4 and 5 members of the seven day services working group.

The format of the visit was arranged in conjunction with the hospitals in advance and consisted of ward round observations in the morning, followed by an opportunity to obtain more information from staff and a debrief session with the Medical Director and others where available. Table 2 shows the range of wards visited at each hospital.

Following the first visit, it was decided that it would be useful to have a patient representative on the visit team to ensure that the patient perspective was considered. A member of staff from the first hospital visited was also invited to visit the other two hospitals to help share learning.

Table 2. Wards visited at each hospital.

PFT	SUFT	QEFT
• Cardiothoracic surgery • Thoracic surgery • Cardiology • Transplant • Respiratory medicine (Respiratory Support and Sleep Centre (RSSC) and Pulmonary Vascular Disease Unit (PVDU)) • Critical care	• Critical care • Surgical Assessment Unit • Acute Medicine Unit • Acute Respiratory Unit • Coronary Care Unit • Medicine for the Elderly • Cardiology • Wound management unit	• Critical care • Urology • Cardiology • Respiratory • Palliative care

Consent

Verbal consent was obtained from every patient involved by the consultant leading the ward round following an explanation of the purpose of the visit and an overview of who was visiting.

2.3 Information collected

A proforma was developed for collecting information on each ward, based on standard 8 and the Royal College of Physicians and Royal College of Nursing best practice guidance for ward rounds.[10] While this was not used by every team member, it acted as a key line of enquiry and helped focus the discussion. The team were also encouraged to complete reflective notes at the end of the session to capture their main thoughts.

2.4 Sharing the information

A debrief meeting was held at the end of the observations with key members of nursing and medical staff to discuss the findings and share reflections. Following the visit a report was drafted sharing the learning from the visit with the hospital. Information specific to the hospital was shared with the Medical Director and Director of Nursing in a separate letter where any specific concerns raised by the visit team were also detailed.

3. Results

3.1 Measuring on-going consultant review

There are significant issues with measuring this standard as information on this is not routinely collected. Each aspect of the standard was measured during the visit by talking to staff on the wards, observing ward rounds and patient/carer involvement in them and observing handovers.

There are not robust systems in place to identify and report data on:

- the frequency and type of consultant reviews carried out
- those who did not require a consultant review
- the timeliness of specialist review.
- The number of transfers/handovers between wards and teams

Some mechanisms for measuring standard 8 could include:

- Use of Early Warning Scores or other such systems to identify and document those not needing a daily consultant review.
- Asking for patients views on whether they were aware of reviews and whether they feel they were provided with relevant information both during the week and at weekends.
- Using a formal referral process for inpatient specialist referral (providing local hospital policy allows this) with a referral form. The date and time of referral and when the patient was seen by the specialist would need to be recorded. An electronic referral system would be ideal.
- Use of a ward round checklist which may help with documenting outcomes and actions from the ward round and facilitate audit.
- A ward round policy may help clarify what practice is expected on each ward regarding ward rounds.

SUFT reported that they had robust systems in place to capture data regarding transfers between wards.

SUFT participated in the 'High-intensity Specialist Led Acute Care (HiSLAC)' project. This project evaluates the impact of HiSLAC on emergency admissions to NHS hospitals at the weekend. It is an annual point prevalence survey comparing specialist involvement in emergency admissions on a named weekday and weekend day.

QEFT had agreed a CQUIN* with their commissioner to improve seven day services linked to standard 8, which required defined progress each quarter.

Definitions

Further clarity is needed on the following aspects of the standard:

- The definition of a 'ward-round' and whether face-to-face reviews are always necessary or other methods can be employed.
- The appropriateness of staff other than consultants carrying out ward rounds, for example Specialist Nurses who run their own services including admitting and discharging patients with limited or no consultant input required. There needs to be clarity about how this fits into the definitions used in the 7 day services standards.
- What does 'kept to a minimum' mean with regards to *handovers between teams?* When is it appropriate to handover between teams?

* Commissioning for Quality and Innovation (CQUIN) is a national framework which enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.

3.2 Findings relating to on-going consultant review

Consultant led ward rounds at weekends

- In all three Trusts, there appeared to be a high level of compliance with twice daily consultant reviews of patients in high dependency areas.
- The degree to which patients on general wards were reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week varied between specialties and hospitals.

At PFT all patients were reviewed on a daily basis, seven days a week, as part of a ward round and in most cases this was consultant led. A consistent theme at PFT was that 'Sunday is different' with other models of patient assessment employed (e.g. registrar-led ward rounds and communication with the consultant over the phone).

At SUFT, consultants were present from each of the medical specialties at weekends and on bank holidays through participation in relatively high intensity rotas.

At QEFT the ability to carry out reviews at the weekend varied between specialties. Some specialties had specialty-specific cover at the weekend, whereas others had cover from consultants in a different specialty. A list was left on Friday for the specialty providing cover over the weekend of the patients requiring review.

- Where ward rounds were not consultant led, reasons for this included:
    - Lack of consultant capacity to review all patients, particularly in specialties where there were few or no consultants available at the weekend. The reviews in these specialties tended to be targeted towards the sicker patients, those that have been specifically handed over and those that required a senior review prior to discharge. However there were questions about how this was documented.
    - Reduced staffing levels of junior and support staff at weekends, often to a greater degree than the reduced presence of senior doctors. This is highly likely to decrease the efficiency and effectiveness of consultant level input (it was recognised that the consultants could probably only review half as many patients in the same time frame without the additional support and that other elements of care could not be progressed as effectively).
    - Ward rounds being carried out by specialist nurses who then liaised with the consultant.

SUFT and QEFT were exploring the use of Physician's Assistants to enable more efficient consultant working.

- Having ward rounds in the consultant's job plan and allocated time in their diary facilitated consultant led ward rounds. Providing adequate time off in lieu for weekend cover should also be considered.

Patient/carer awareness of reviews

- In all three Trusts, patients were observed to be involved in conversations with clinicians in most face-to-face ward rounds where they were able. All information was provided verbally and patients were generally given the opportunity to ask questions.
- Excellent examples of communication with patients were witnessed across all three Trusts.
- It was difficult to determine the extent to which carers and families were made aware of reviews.
- Where the review is not face to face, consideration should be given to how patients are communicated with regarding the outcome and plan.

On one ward in PFT, patient-held exercise books were used and patients/carers were encouraged to record relevant information from the ward round (e.g. changes in drug dosage).

Inpatient specialist referrals

- There appeared to be both formal and informal referral mechanisms used. Formal, with written referrals, particularly to allied health professionals, and informal, where medical staff discussed patient care with different teams verbally, including at board rounds.
- Specialist reviews did not appear to routinely take place at weekends. The addition of specialist reviews at weekends would clearly add to current workloads unless this is offset by measures taken to make more efficient use of senior doctor time.

In SUFT all specialist referrals were made through a referral process and a copy of the referral kept in the patient's medical notes.

In QEFT a 'green card' system was used for inpatient specialist referrals.

Consultants multiple day blocks

- There appeared to be variation in the use of multiple day blocks of consultant care between specialties. Some specialties appeared less likely to have multiple day blocks partly from a desire to follow up individual patients that they had managed.
- The 'consultant of the week' model was used in some specialties, but in some cases not every patient was seen every day.
- The number of patients in each specialty would clearly impact on the ability of a consultant of the week to review each patient on a daily basis.

In PFT, some of the medical specialities had adopted an 'Interventional Cardiologist (or Interventionalist) of the week' model allowing the same consultant to have oversight of patient care for seven days.

In SUFT, the Gastroenterology and Cardiology specialties had introduced a 'consultant of the week' model, but not every patient is seen every day. The general

surgeons/critical care tended to cover acute admissions in blocks of two or three days.

In QEFT consultants did not appear to work multiple day blocks. Consultant cover, particularly for smaller specialities or sub-specialities, at the weekends was found to be complex, particularly where jobs are shared between different Trusts.

Ward rounds

Across all three Trusts:

- Different models of ward round were observed ranging from full multi-disciplinary face-to-face ward rounds to table top reviews and 'board rounds'[†] by the medical team away from the patient. The models varied further at weekends when the ward-round often took place over the phone or where a board round was more likely to take place.
- Ward rounds did not always involve members of the nursing team and where they did, their level of participation varied significantly between specialties. Problems arose when nurses provided care to patients with different consultants whose ward rounds took place at the same time, and when ward rounds took place at a time when nurses were busy with other duties, such as drug rounds or caring for other patients. Consideration should be given as to how to empower nurses to become more actively involved in ward rounds across all specialties to ensure their knowledge about patients and their treatment is included.
- The multidisciplinary nature of the ward round varied between specialties.
- Information was usually recorded in the patient's notes by a junior doctor but it was not always clear how transfer of information took place with those not present on the ward round.
- Ward round checklists were not routinely used.

SUFT have allocated specific time to ward managers to participate in ward rounds and the named nurse for the patient is encouraged to attend. Good practice was observed with the inclusion of physiotherapists, occupational therapists and social workers on some ward rounds. However, the levels of such staff are greatly reduced at weekends. The inclusion of social workers on wards has contributed towards a decrease in delayed transfers of care. The need for mental health and pharmacist input to ward rounds was highlighted.

In SUFT, ward round checklists were used by critical care and wound management units, where a consultant signature was required. There were examples of consultants recording the information in medical notes themselves which may enhance reliability but could also impact on the efficiency of consultant time.

In QEFT, an exemplary board round took place each day on Monday to Friday on one ward, which followed face to face ward rounds by the consultants. The board round was led by the Senior Nurse and included an occupational therapist, discharge planning co-ordinator and nurses. Each patient was discussed and their care plan, actions and estimated discharge date documented on the board. This approach could be adopted by other wards.

[†] A 'board round' is usually a review of patients by a multi-disciplinary team held next to an 'at-a-glance' white board, away from the bedside.

Transfers between wards

- This aspect of the standard is likely to be a challenge for many Trusts and will require optimisation of patient flow and reliable capacity planning.

Due to the status of PFT as a specialist hospital, with relatively few beds and a high acuity of patients, this was difficult to assess. It was obvious in PFT that there were limited options for patient transfers between wards.

At SUFT, it was noted that not all transfers were for clinical reasons and there were recurrent issues with bed capacity.

Handovers and continuity of care

- A variety of handovers were observed or described and these varied between specialties. However, it was not always clear how this was documented.

At PFT, there was an example of a multi-disciplinary hand over where all staff including those on nights met on a Monday morning when the new 'Consultant/Interventional Cardiologist of the week' took over. In PFT, it appeared that, particularly for surgical patients, the same team managed their care throughout their stay which limited the number of handovers.

At SUFT, handovers varied between specialties. A brief safety handover had been introduced, which takes place at 9.00-9.30am and 9.00-9.30pm, with exception reporting in terms of issues that have arisen overnight

Transfer between wards and teams supported by an electronic record

- The importance of electronic records was acknowledged and Trusts have plans to introduce them.
- Paper records were largely used with some information being accessed electronically on different systems such as letters, radiological investigations and blood tests.
- The introduction of electronic records could potentially enable audit and tracking of timeliness of patient reviews, etc.
- Where electronic patient records are not used, it might be useful to audit information transfer between wards and teams.

PFT had two systems of patient records; electronic on intensive care and paper-based on other wards. It was reported that there are plans to introduce an electronic patient record throughout the Trust.

QEFT also had electronic records in critical care but paper-based records were used in the rest of the hospital.

SUFT used paper records to record patient's needs. Information was also accessed electronically on different systems such as letters, radiological investigations and blood tests.

It was reported that SUFT are introducing a 'nerve centre' for electronic handover for all patients in the hospital. All nurses and junior doctors will have hand held devices to record observations and handover information. Workstations on wheels are also being introduced to be able to access blood results and radiological investigations which will not be on the hand held devices.

Other issues

- A recurrent theme was the difficulty in engaging junior medical staff as members of a team due to the working hours directive. The numbers of junior medical staff available at the weekend was less than during the week, requiring more wards and many more patients to be covered.
- A particular issue was raised that patient transport services were not available at weekends.

4. Discussion

It is clear that implementing the approach prescribed for seven day services by NHS England in Acute Trusts is complicated and potentially costly and that meeting all of the standards will be difficult. This review has established some key findings about standard 8 which are pertinent not only to Acute Trusts but also to the National Seven Day Services Team.

4.1 Key findings concerning standard 8

Variation in implementing standard 8 between and within hospitals.

It was clear that there was significant variation between the hospitals in implementing standard 8. There were various examples of good practice and different approaches to changing the way of working to achieve better quality of care and the seven day service objective (e.g. implementing electronic patient records).

There was also variation within hospitals, with clinical areas such as ITU already providing 7 day services aside from the ability to access some specialist diagnostic services or reviews and, occasionally, issues with delayed transfers of care. This compared with other areas which provided limited or no weekend cover. Hospitals need to be able to justify this internal variation and ensure that systems are in place to share best practice and ensure that optimal care is delivered at weekends.

Issues with the interpretation and application of standard 8 locally

There were lots of issues with the interpretation and application of standard 8 locally. For example in specialities without on-site consultant-led services at weekends when cover was provided by another consultant team (e.g. oncology patients being covered by the acute medical team) – was this adequate? Also where a nurse-specialist led a ward-round then was this adequate? Is a board round adequate? Is a telephone 'check-in' with junior medical staff where each patient is discussed adequate?

Issues documenting and reporting adherence with standard 8

Despite a lot of discussion we have not seen any evidence of a set of robust metrics that Acute Trusts can use to measure implementation of standard 8. It is, therefore, unclear what is expected and how it should be reported.

Issues with availability of staff/resources/services at the weekend (links with other standards)

An issue that made consistent care throughout the week more difficult was the variability in availability of staff (junior medical staff, laboratory or diagnostic staff, ancillary staff), resources (e.g, beds in the community), or services (e.g. diagnostic services). Whilst these relate to the other standards it is clear that they are all interconnected and the ability to implement standard 8 is affected by the ability to deliver the other standards.

4.2 Key findings about the assessment process

This project was solely concerned with the on-going consultant review standard (standard 8) and the approach was to review how each aspect of the standard could be measured. It was identified that much of this information is not routinely recorded and available and therefore it is difficult to measure and will be even more difficult to measure improvement. There is a question whether the aspects of the standard should be focussed on in this way or whether outcome measures such as mortality, length of stay, delayed transfers of care and readmission rates should be used to measure improvement across all standards.

Each hospital visit included the observation of different wards and specialities. This was felt to be important as it enabled the team to understand how the particular requirements varied according to speciality.

It is important to ensure that patient representatives are included at an early stage in assessing readiness for 7 day services. Having a patient representative on the visit team was very helpful and ensured there was an appropriate focus on what is in the best interests of patients.

Including a member of the team from PFT on the visit team to SUFT and QEFT enabled sharing of good practice and ideas between the hospitals (see box below). This peer to peer review approach worked well.

Reflections on being a pilot site and visiting other sites

"It was not like an inspection. Yes they asked questions and yes they wrote notes but it was obvious that the team were keen to learn, see how we managed our services and identify areas of good practices and yes areas where we could improve.

Your natural instinct is often to defend why something is like it is but you gain far more by being open and receptive. Often we are so busy with the day job that we do not make time to see things how others would see, how can we improve rather than just survive. That is why my perception of this type of visit has changed, and that is why having been through the process I jumped at the opportunity to join the team with their next visit.

With my 27 years of NHS experience I hoped I had something to offer but as of equal importance what could I learn from other hospitals that I could bring back.

It is definitely different doing the visit rather than being visited. I could sympathise with

others perhaps apprehension of what to expect, hopefully put them at ease and explain that I have been in their position.

Visiting other hospitals as a manager has huge value, looking at their workforce set up, new roles, new ways of working, delivery of care, monitoring, paperwork, IT, governance the list goes on.

Obviously in one half day you can only get a glimpse of a day in the life of X hospital, just a flavour of what it is like. We need to revert back to the feeling of working as one NHS, one seamless provider of patient care, one employer. The personal interaction rather than through an IT link is of equal importance. Once you have met someone in person, exchanged details you are far more likely to pick up the phone to them, ask for assistance, offer support, and discuss new products, services, ways in which you can mutually benefit.

Since getting our report from the visit we are still not perfect, we have still got areas where we have our challenges, but we have also fed back where teams are performing well and where they have worked hard to implement standard 8. Governance is often associated with where things have not gone well, where we have had to risk assess and develop actions plans to calculate the risk, we often forget it's also about looking at what we do well, showing the positives and celebrating successes."

The visits were intended to be non-threatening. As they were carried out by a team which was not from a regulator or a performance management organisation it possibly resulted in a more accurate picture of the areas of strength and areas for development and perhaps led to more honest discussions than would be the case if the hospital was "showing its best face".

"We welcomed the visit from the Clinical Senate and the opportunity to discuss our standards with the team. It is always good to debate matters which affect Trusts across the board and share the learning derived. There is a frustration that things are put into place without consideration for funding, but of course, we continue to drive this initiative forward in the interests of improving patient care. The team were very friendly and professional and it was a pleasure to interact with you all on the day."

Individual members of the visit team have noted that they benefitted from being part of the visit team, for example

"As a GP and a member of a CCG, it enabled me to get a better understanding of the difficulties and pressures faced by hospitals."

4.3 Limitations of the approach

The limitations of the approach that was developed to assess standard 8 were:

- It was only possible to observe a specific, time-limited period which may not have been 'usual'. This was also during the week and not at the weekend.
- It was possible that people changed their behaviour due to being observed, but it is difficult to assess the impact of this.
- This only focused on one standard of the 7 day working programme and did not touch in detail on any other issues that might be of concern for the trust.

- The approach was resource intensive in terms of visit team members and currently only a limited number of people have experience of this observation process. It will not be possible to conduct the same exercise in several different Trusts unless more people can be involved.

4.4 Implementing 7 day services

Through carrying out this project a number of issues have arisen about the wider implementation of 7 day services across the healthcare system.

There is a need for a clear definition of what is meant by '7 day services.' The 10 clinical standards that have been developed are largely focussed on secondary care acute services, with one standard relating to transfer to community, primary and social care which states that:

"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.

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."

Current support services are not provided seven days a week and significant changes would need to be made across all systems to achieve this, which would have considerable resource implications. There is a need for a whole system approach and discussions need to include all organisations involved in providing health and social care to patients. There would also need to be changes in current working practices and contracts, which would need to be agreed with the workforce.

It also needs to be acknowledged that fully implementing 7 day services will have significant financial implications. The NHS Seven Days a Week Forum estimated the costs of seven day services in acute emergency and urgent services and supporting diagnostics using eight successful foundation trusts with an interest in seven day services. It was concluded that the costs of implementing 7 day services vary, but are typically 1.5% to 2% of total income or, a 5% to 6% addition to the cost of emergency admissions.[11] Given the current financial situation in the NHS, finding additional finance for this would be difficult.

It should also be noted that 7 day services is not an isolated stream of work and should be considered as part of the wider urgent and emergency care review.

5 Conclusion and recommendations

This work has been useful in terms of assessing the readiness for seven day services across the East of England and has in particular identified issues regarding the definition and measurement of the on-going consultant review standard (standard 8). It has

identified areas of good practice across the three hospitals visited and barriers to achieving this standard and 7 day services as a whole. In order to achieve all elements of standard 8 a significant amount of further work will be required. Feedback from several other Trusts suggests that this will be a significant challenge in most if not all Trusts and Health Care systems across the East of England.

The project involved visits to three hospitals in the East of England and clearly there may be further good practice and learning to be identified from other Trusts across the region.

The following recommendations are therefore made:

- This report should be shared with Medical Directors in the East of England to determine how the learning can be shared across the region. For example through an event or by setting up a 7 day services forum/network.
- The report should be shared with other clinical senates to enable learning to be shared outside of the East of England.
- The report should be shared with the national seven-day services team as issues have been raised that need clarification in terms of implementing 7 day services.
- All Trusts must develop a robust clinical approach to determine which patients do and do not require daily consultant review
    - Utilising the National Early Warning Score or equivalent should be considered as part of this approach to ensure stable patients who become unstable are reviewed.
    - The approach should also detail when a review by a junior doctor or specialist nurse would be appropriate.
- Data collection for all elements of standard 8 needs to be improved.
    - Ideally electronic systems including those used for handover, recording electronic health records or monitoring patient flow should be utilised.
    - This should include a method for sending, receiving and monitoring requests for specialist review.
- Clinical documentation in either paper-based or electronic form must be improved to ensure that the timing of all clinical reviews including board rounds is accurately recorded.
- Structured board rounds support many elements of patient care and could be utilised to assist with monitoring and delivering elements of standard 8.
- Taking part in peer review visits is recommended to assist Trusts and Healthcare systems in gaining knowledge of good practice on other clinical settings.
- Sharing information with patients and relatives should be improved. The utility of communications books should be considered.
- To facilitate the required increase in consultant reviews Trusts must consider ways to support consultants to deliver an efficient and effective service.. – This could include:
    - using physician's assistants (e.g. to accompany consultants on ward rounds)
    - utilising nursing staff to support ward rounds,
    - or specialist nurses to review specific patients
- Trusts must ensure that appropriate job planning and timetabling is developed to ensure that their consultant workforce achieve an acceptable work-life balance. This should include appropriate mid-week breaks if required and restrictions on the number of consecutive days worked. This is vital to ensure recruitment and retention.

6 References

[1] NHS Services, Seven Days a Week Forum. Summary of initial findings. December 2013.

[2] Freemantle, N. et al. (2012). Weekend hospitalization and additional risk of death: An analysis of inpatient data. Journal of the Royal Society of Medicine (105(2):74-84.

[3] Dr Foster Dr Foster Intelligence. (2013). Dr Foster Hospital Guide 2013

[4] NHS Services, Seven Days a Week Forum. Evidence base and clinical standards for the care and onward transfer of acute patients.

[5] NHS Five Year Forward View. October 2014.

[6] NHS England. Everyone counts planning for patients 2014/15 to 2018/19. December 2013.

[7] NHS The Forward View into Action: Planning for 2015/16. December 2014.

[8] Academy of Medical Royal Colleges. Seven day consultant present care. December 2012.

[9] Academy of Medical Royal Colleges. Seven day consultant present care implementation considerations. November 2013.

[10] Royal College of Physicians and Royal College of Nursing. Ward rounds in medicines: Principles for best practice. October 2012

[11] NHS Services, Seven Days a Week Forum. Costing seven day services
The financial implications of seven day services for acute emergency and urgent services and supporting diagnostics

Appendix 1

Areas for consideration for on-going consultant review from Academy of Medical Royal Colleges[8,9]

- Which patients need a daily review?
    - The AMRC propose an 'opt-out' system where daily consultant review is the default position unless it is specified that this is not required.
    - Some patients may not benefit from a daily consultant review, such as those whose clinical condition is stable or where there anticipated discharge date is not imminent.
    - Ten specialties indicated that all inpatients would require a daily consultant-led review (obstetrics and gynaecology, intensive care medicine, respiratory medicine, paediatrics, emergency medicine, infectious diseases, acute internal medicine, surgery-renal transplantation, surgery-vascular, surgery-colorectal).
    - Other specialties indicated that patients would not require daily review if some or all of the following factors were present:
        - Patient is physiologically stable
        - Patient has a diagnosis either confirmed or appropriate tests underway
        - Patient is on the correct care pathway and is progressing on schedule
        - There are no specific communication tasks or care strategy questions outstanding

- How are patients needing a daily review identified?
    - There is a need to develop robust mechanisms to identify those patients where a consultant led daily review will not influence their care pathway and to reinstate consultant-led review if the patient's condition changes.
    - The consistent use of Early Warning Scores can trigger a consultant-led review or traffic light systems scan be used to identify those patients not needing a daily consultant review.
    - The skills and experience of the multidisciplinary team should be used effectively, for example introducing nurse led discharge or ceilings of care.

- Are there any acceptable alternatives to a face-to-face bedside review by a consultant?
    - The AMRC guidance states that there may be other appropriate methods of consultant-led review than the formal bedside ward round, such as:
        - Ward round undertaken by a doctor in training followed by discussion with the consultant
        - A multi-disciplinary team 'board-based' round.
    - The physical presence of the consultant, however, is key to ensure issues arising from the review are identified and there is no delay in actions being instigated.
    - There is a need for adequate support for consultants carrying out reviews from a wide range of health professionals at weekends, as on weekdays.