Seven Day Services Clinical Standards

February 2016

Revisions to supporting information for seven day services clinical standards 2, 5, and 8

19 February 2016

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	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 arrival at hospital. **Supporting information:** • 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. • The standard applies to emergency admissions via any route, not just the Emergency Department.	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 RCP (2012): Delivering a 12-hour, 7-day consultant presence on the acute medical unit

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	• All patients should 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 within one hour.
	• Standards are not sequential; clinical assessment may require the results of diagnostic investigation.
	• A suitable consultant is one who is trained and competent in dealing with emergency and acute presentations in the specialty concerned and is able to initiate a diagnostic and treatment plan.
	• For emergency care settings without consultant leadership, review can be undertaken by appropriate senior clinician e.g. GP-led inpatient units.
	• Where women on maternity units wouldn't usually for clinical reasons require consultant involvement in their care, and would usually receive only midwife-led care can be excluded. This would apply to
	  ○ Women who are expected to have routine labours with no complications
	  ○ Women with a medical condition in whom there has been a prior agreement that midwife-led care is clinically appropriate e.g. spontaneous labour at term with known medical complication but clear plan for labour already made.
	Where it is identified that consultant involvement is needed in the woman's care, they should be included in the requirement for first consultant assessment within 14 hours and for daily consultant review, until they are transferred back to midwife-led care.	

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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 herapy. • 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
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.	RCP (2011): Acute care toolkit 1: Handover RCP (2013): Future Hospital Commission

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	• Clinical data should be recorded electronically, according to national standards for structure and content and include the NHS number.	
Diagnostics		
5.	**Standard:** 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: • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients **Supporting information:** • It is expected that all hospitals have access to radiology, haematology, biochemistry, microbiology and histopathology • 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	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 NICE (2008): Metastatic spinal cord compression

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	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. • Where a service is not available on-site (e.g. interventional or MRI), clear patient pathways using formal networks between providers must be in place between providers. • Seven-day consultant presence in the radiology department is envisaged.	
Intervention / key services		
6.	**Standard:** Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery **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. • Other interventions may also be required. For example, this may include: • Renal replacement therapy	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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	• Urgent radiotherapy • Thrombolysis • PCI • Cardiac pacing	
Mental Health		
7.	**Standard:** Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: • Within 1 hour for emergency* care needs • Within 14 hours for urgent** care needs **Supporting information:** • 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.) * An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others. ** 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.	RCPsych PLAN (2011): Quality Standards for Liaison Psychiatry Services
Ongoing review		
8.	**Standard:** **A)** All patients on the Acute Medical Unit (AMU), Acute Surgical Assessment Unit (ASU), and Intensive Therapy Unit (ITU) and other high dependency areas are seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate) **Supporting information** Hospital in-patients in high dependency areas should be reviewed by an	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

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	on-site consultant twice daily seven days a week unless it has been determined that this would not affect the patient's care pathway. To maximise continuity of care consultants should be working multiple day blocks. **Standard** **B)** 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:** • Acute area means those parts of the hospital identified in 8A. • Definition of a consultant. The AOMRC refers to a consultant as hospital doctors who have either a Certificate of Completion of Training (CCT) or Certificate of Eligibility for Specialist Registration (CESR) and are thus eligible to be on the General Medical Council (GMC) Specialist Register, or certain senior doctors with appropriate competencies, to include those in Staff, Associate Specialist and Senior Specialty Doctor (SAS) grade posts. 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. 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.	AOMRC (2013): Implementing 7 day consultant-present care

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	• 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. • The physical presence of the consultant in the clinical environment is a key and important component of this part of the clinical standard, so that issues arising from the daily review can be identified and appropriate actions instigated without delay. • Some inpatients care pathways are not likely to be influenced by a daily consultant-led review and specialties should develop robust mechanisms to monitor the status of inpatients every 24 hours in order to safely identify them. 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. The following are considerations, taken from the AoMRC, which may be used to exclude 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	

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	who are 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. • One model for non-acute wards is for a consultant and a senior trainee to do a board round together and the consultant to identify patients (according to the criteria above) that may be reviewed that day by the senior trainee rather than directly by the consultant • 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 • Rota patterns which optimise continuity of care 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	

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	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 where a patient is unstable and not responding to treatment as expected consultant involvement should be within one hour for high risk patients).	
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 social care teams.	AOMRC (2012): Seven day consultant present care
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	GMC (2010): Generic standards for specialty including GP training

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	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.	