Report to Trust Board of Directors

<table>
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<tr>
<th>Date of Meeting:</th>
<th>24 March 2015</th>
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<tbody>
<tr>
<td>Enclosure Number:</td>
<td>12</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Moving to 7 Day Services</td>
</tr>
<tr>
<td>Author:</td>
<td>Kerry Gant, Head of Finance Change Team/Debbie Freake, Executive Director of Strategy</td>
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<td>Executive Lead:</td>
<td>Debbie Freake, Executive Director of Strategy</td>
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<tr>
<td>Responsible Sub-Committee (if appropriate):</td>
<td>N/a</td>
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**Executive Summary:**

This report updates the Board on progress against delivery of the national 7 day working clinical standards.

The Trust has started from a reasonable baseline position in 2014/15, having implemented improvements over recent years such as the move to an Acute Care Physician model. Progress has been made in 2014/15 against Standard 2 through a CQUIN (Commissioning for Quality and Innovation payment), and for other standards through a range of Trust improvement initiatives.

A refresh of the March 2014 baseline will be undertaken in early 2015/16, with subsequent development of a detailed costed action plan.

The Trust has identified 5 clinical standards for 2015/16 implementation (where funding allows), for discussion with the Clinical Commissioning Group as part of 2015/16 contracting discussions.

**Board Assurance Framework Reference:**

2.1, 3.1

**Risk Rating (high, medium, low risk) and any recommended changes to risk rating:**

High – progress on 7 day working will help reduce risks in these areas.

**Compliance, legal and national policy regulatory requirements:**

This report supports the Trust working towards delivering the 7 day working clinical standards.
<table>
<thead>
<tr>
<th><strong>Financial Implications:</strong></th>
<th>None identified to date; financial modelling is a key part of action planning.</th>
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</thead>
<tbody>
<tr>
<td><strong>Actions required by the Board:</strong></td>
<td><strong>To approve:</strong> Discussion and decision</td>
</tr>
<tr>
<td></td>
<td><strong>To note:</strong> Where the Board is made aware of key points but no decision required</td>
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<tr>
<td></td>
<td><strong>For information:</strong> For reading and consideration and for discussion by exception only</td>
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<td></td>
<td>The Board are requested to <strong>NOTE</strong> action being taken to address implementation of 7 day working requirements.</td>
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<tr>
<td><strong>Data quality:</strong></td>
<td><strong>Source:</strong> CQUIN audit data – manual audit by Medical &amp; Surgical BU clinical teams</td>
</tr>
<tr>
<td></td>
<td><strong>Validated by:</strong> Not validated</td>
</tr>
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<td></td>
<td><strong>Date:</strong> 12 March 2015</td>
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Context

Seven Day working concerns equitable access, care and treatment, regardless of the day of the week: there is a compelling case for change including addressing higher mortality rates and less favourable clinical outcomes associated with weekends. The level of service provided should ensure that the patient has a seamless pathway of care when accessing services no matter what day of the week.

The NHS Services Seven Days a Week Forum, chaired by the National Medical Director, Sir Bruce Keogh was established in February 2013 to provide an insight and evidence into how to improve access and outcomes, and consider how NHS services can be improved to provide a more responsive and patient centred service across the seven day week. The Forum was asked by NHS England to focus as a first stage on urgent and emergency care services and their supporting diagnostic services. The Forum’s review highlighted significant variation in outcomes for patients admitted to hospitals at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, and length of hospital stay and readmission rates. The introduction of 7 day services across the NHS is aimed at reducing this variation in outcomes for patients admitted to hospitals at weekends as displayed by these measures.

Sir Bruce Keogh and NHS England proposed to introduce a plan to roll out seven day services across the NHS by the end of 2016/17, and set out 10 clinical standards, with a supporting evidence base developed in partnership with the Academy of Medical Royal colleges (see Appendix).

Nationally proposed timescales for change were originally set as follows:

- Year 1 (2014/15) – local contracts should include an action plan to deliver the clinical standards within the service development and improvement plan section of the contract. Use of local CQUIN schemes encouraged, based on the clinical standard for time of arrival to initial consultant assessment
• Year 2 (2015/16) – those clinical standards which will have the greatest impact should move into the national quality requirements section of the NHS standard contract

• Year 3 (2016/17) – all clinical standards should be incorporated into the national quality requirements section of the NHS standard contract with appropriate contractual sanctions in place for non-compliance, as is the case with other high priority service requirements

• Basing access to the Better Care Fund for CCGs and local authorities on provision of demonstrable evidence of effort to address national conditions around seven day services

In 2014/15 Cumbria Clinical Commissioning Group (CCG) set a local CQUIN in relation to Standard 2 (initial consultant assessment), and additionally required development of an action plan for implementation of 7 day working in line as part of the Contract Service Development & Improvement Plan (SDIP).

Trust Development Authority (TDA) guidance for NHS Trust ‘refreshed’ Annual Plans in 2015/16 stipulates that NHS Trust Boards are expected to make further progress in implementing at least 5 of the 10 clinical standards when doing so is affordable within resources available. Updated SDIPs are expected to include reporting based on the NHSIQ self-assessment tool. (Note: NHSIQ, or NHS Improving Quality, is an improvement organisation hosted by NHS England)

2014/15 Progress

In 2014 the Trust completed a comprehensive speciality-level baseline review of services and identified areas where change was required to meet 7 day standards. This showed good progress in some key areas, (eg introduction of the 7 day Acute Care Physician model on both sites, additional posts in physiotherapy, radiology and pharmacy), but also highlighted gaps in provision.

A report to the Trust Board in March 2014 included an initial action plan for 7 day working in 2014. Further work to refine this was undertaken and an action plan was submitted to the CCG for Quarter 2 in line with the SDIP requirements. Due to changing system governance arrangements with the establishment of the System Resilience Group and work within the Together for a Healthier Future Programme for North Cumbria, original planned actions to ensure oversight of whole health economy working together to implement 7 day services have not been followed through. Other challenges throughout the year have also meant that this has not been a priority within the contract monitoring process for 2014/15.
However, the Trust has provided evidence to the CCG in relation to the CQUIN for Standard 2:

- *To ensure that all emergency admissions are seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of arrival at hospital.*

In Quarter 1, it was agreed to determine the baseline for 14 hour consultant assessment – internal audit identified this as 75% extrapolated across medicine and surgery. Targets were set for subsequent quarters at 80%, 85% and 90% respectively. In addition, it was agreed to start to audit NEWS (National Early Warning Scores) on admission and feedback the results.

Whilst no audit details were specified by the CCG, in Quarter 2 an audit tool was used on Pillar/Patterdale, Larch A/B and Beech C/D wards on both sites considering a total of 354 patients. Information was collected manually with a paper based system and consultant ward round checklist forming part of the admission document filed within the patient’s records. Data was incomplete in a significant proportion of patients (53%), but for those with complete data, 93.1% of patients were seen by a consultant within 14 hours.

In Quarter 3 teams have been provided by the Trust with more comprehensive audit instructions but results are as yet unavailable due to the systems used. The difficulties associated with manual audit are notable, and as a Trust we need to learn from this to ensure appropriate support is provided to enable successful CQUIN delivery in the future.

**Current Trust Position**

The Trust is committed to continued achievement of the 7 day working standards and sees this as a key improvement priority for the year ahead. The Medical Director monitors benchmarked weekend and weekday mortality rates which show the Trust to be in line with peers nationally. (HSMR [Hospital Standardised Mortality Rates] as provided by Dr Foster are currently 103.5 and 105.6 respectively.) However, there remain differences in overall mortality between the two sites: work through the Clinical Strategy programme, Business Unit Business Plan priorities and Trust-wide improvement projects seeks to address these in order to continue to improve on performance.

Specific Trust priority improvement initiatives currently underway are aimed at enabling movement towards 7 day working standard achievement:

- Trust-wide improvement initiative: NEWS on admission and identification of high-risk patients (Standard 2)
- An active transformation project looking at shift handovers to implement standard documentation and systems across the Trust (Standard 4)
- A priority improvement initiative on discharge planning and flow, including work with system partners (Standards 3 & 9)
- Additional capacity created in endoscopy to address current levels of demand plus GI bleed plans and developing business case for delivery of stroke care (Standards 5&6)
- New Trust Quality Strategy, OD Strategy implementation (Standard 10)

The Trust is completing the NHSIQ Seven Day Working Self Assessment Tool (due end March 2015), the results of which will assist the Trust in understanding how it is positioned against other similar organisations in the provision of 7 day services, and help to prioritise its forward plan.

No specific resource has been made available to date to support improvement work to achieve overall 7 day working standards, with available Resilience Funding largely used to support locum costs at West Cumberland Hospital. It is important to recognise the financial consequences of Standard implementation – for example, the Trauma Review has highlighted the need for resident CT radiographers.

**The Forward Plan & Governance**

Building on results from the NHSIQ tool and from the 2014/15 baseline, the Trust plans to refresh the existing 7 day service assessment by specialty in early 2015/16. From this, and in line with Business Unit Business plan priorities the Trust will develop a 2 year action plan to enable compliance with all ten clinical standards.

In line with 2015/16 contract requirements, early consideration has been given by the Medical Director and Director of Strategy to possible prioritisation of the standards to allow implementation of five of these within available resource by the end of 2015/16. These initial priority standards will need to be reviewed follow discussion with commissioners and in light of the refreshed baseline and benchmarking work:

1. Standard 1 – Patient Experience
2. Standard 4 – Shift handovers
3. Standard 7 – Mental Health
4. Standard 9 – Transfer to community, primary and social care setting
5. Standard 10 –Quality Improvement

Working within system wide improvement arrangements and in particular the work of the System Resilience Group, the Trust plan will be coordinated by the Trust Change Team. It will include estimated costs for implementation for discussion as appropriate.
with commissioners, and will be phased to enable the Trust to demonstrate how it will comply with contract requirements over the coming years.

7 day working action plans form an integral part of the Business Unit Business Plans which are managed through the EMT-approved annual planning process.

Progress against the Trust wide action plan will be reported 6 monthly to EMT.

Conclusion

Good progress towards 7 day working across the Trust has been made in a number of key areas, and local performance would appear to compare reasonably well to other Trust experiences so far as can be ascertained at present. Internal and external governance arrangements to systematically drive implementation of the clinical standards have not progressed as originally anticipated due to system changes, and prioritisation of arrangements to both implement Chief Inspector recommendations, and to manage operational pressures impacting on bed flows and constitutional targets. Increasing financial pressures (system-wide) make required investment in 7 day services difficult and acknowledgement of financial constraints within the Planning Guidance for 2015/16 is therefore welcomed.

However, the Trust is firmly of the opinion that delivery of the standards is not only intrinsically bound with necessary improvements against our own internal core strategic objectives, but also those required across the wider system; it remains fully committed to driving forward progress on this during 2014/15, necessarily in conjunction with both provider partners and commissioners.

Dr Debbie Freake

Executive Director of Strategy

13th March 2015
## Appendix

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Adapted from source</th>
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<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
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<tr>
<td>1</td>
<td><strong>Standard:</strong> 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.</td>
<td>NICE (2012): Quality standard for patient experience in adult NHS services (QS15)</td>
</tr>
<tr>
<td><strong>Supporting information:</strong></td>
<td></td>
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<tr>
<td>• Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times.</td>
<td>RCS (2011): Emergency Surgery, Standards for unscheduled surgical care</td>
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<tr>
<td>• The format of information provided must be appropriate to the patient’s needs and include acute conditions.</td>
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<tr>
<td>• 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 publically in ward areas.</td>
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<td><strong>Time to first consultant review</strong></td>
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<tr>
<td>2</td>
<td><strong>Standard:</strong> 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.</td>
<td>NCEPOD (2007): Emergency Admissions: A journey in the right direction?</td>
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<tr>
<td><strong>Supporting information:</strong></td>
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<tr>
<td>• All patients to have a National Early Warning Score (NEWS) established at the time of admission.</td>
<td>RCP (2007): Acute medical care: The right person, in the right setting – first time</td>
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<tr>
<td>• 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.</td>
<td>RCS (2011): Emergency Surgery, Standards for unscheduled surgical care</td>
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<tr>
<td>• 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.</td>
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<tr>
<td>• Standards are not sequential; clinical assessment may require the results of diagnostic investigation.</td>
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<tr>
<td>• A ‘suitable’ consultant is one who is familiar with the type of emergency presentations in the relevant specialty and is able to initiate a diagnostic and treatment plan.</td>
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<tr>
<td>• The standard applies to emergency admissions via any route, not just the Emergency Department. For emergency care settings without consultant leadership, review is undertaken by appropriate senior clinician e.g. GP-led inpatient units.</td>
<td>RCP (2012): Delivering a 12-hour, 7-day consultant presence on the acute medical unit</td>
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<tr>
<td><strong>Multi-disciplinary Team (MDT) review</strong></td>
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| 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 MDT will vary by specialty but as a minimum will include Nursing, Medicine, Pharmacy, Physiotherapy and for medical patients, Occupational Therapy.  
- Other professionals that may be required include but are not limited to: dieticians, podiatrists, speech and language therapy and psychologists and consultants in other specialist areas such as geriatrics.  
- Reviews should be informed by patients existing primary and community care records.  
- Appropriate staff must be available for the treatment/management plan to be carried out. | RCP (2007): Acute medical care: The right person, in the right setting – first time  
RCS (2011): Emergency Surgery, Standards for unscheduled surgical care  
|---|---|
| 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 |
### 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
- 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.
- Where a service is not available on-site (e.g. interventional radiology/endoscopy or MRI), clear patient pathways must be in place between providers.
- Seven-day consultant presence in the radiology department is envisaged.
- Non-ionizing procedures may be undertaken by independent practitioners and not under consultant direction.

### Intervention / key services
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
  - Urgent radiotherapy
  - Thrombolysis
  - PCI
  - Cardiac pacing

### Mental health

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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
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
| 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. |

| 8 | **Standard:**
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.
- Inpatients not in high dependency areas must still have daily review by a competent decision-maker. This can be delegated by consultants on a named patient basis. The responsible consultant should be made aware of any decision and available for support if required. |

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
RCP (2013): Future Hospital Commission
<table>
<thead>
<tr>
<th>Transfer to community, primary and social care</th>
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<tr>
<td><strong>9 Standard:</strong> 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.</td>
</tr>
<tr>
<td><strong>Supporting information:</strong></td>
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<tr>
<td>• 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.</td>
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<tr>
<td>• 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.</td>
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<tr>
<td>• Transport services must be available to transfer, seven days a week.</td>
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<tr>
<td>• There should be effective relationships between medical and other health and social care teams.</td>
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<tr>
<td><strong>AOMRC (2012): Seven day consultant present care</strong></td>
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<tr>
<th>Quality improvement</th>
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<tr>
<td><strong>10 Standard:</strong> 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.</td>
</tr>
<tr>
<td><strong>Supporting information:</strong></td>
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<tr>
<td>• The review of patient outcomes should focus on the three pillars of quality care: patient experience, patient safety and clinical effectiveness.</td>
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<tr>
<td>• 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.</td>
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<tr>
<td>• All clinicians should be involved in the review of outcomes to facilitate learning and drive quality improvements.</td>
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<tr>
<td><strong>GMC (2010): Generic standards for specialty including GP training</strong></td>
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