DATE: 29 April 2014

REPORT FOR: Trust Board of Directors – Public

REPORT FROM: Karen Griffiths, Chief Operating Officer

CONTACT OFFICER: Antony Fitzgerald, General Manager, Surgery & Critical Care

SUBJECT: 7 day Working

BACKGROUND DOCUMENT (IF ANY): None

REPORT PREVIOUSLY CONSIDERED BY & DATE(S):
- Reports to the Trust Board: August 2013 – NLG(13)283
- November 2013 – NLG(13)419

EXECUTIVE COMMENT (INCLUDING KEY ISSUES OF NOTE OR, WHERE RELEVANT, CONCERN AND / OR NED CHALLENGE THAT THE BOARD NEED TO BE MADE AWARE OF):

The report provides an update on the Trust’s 7 day working project and makes recommendations for the Trust Board to consider.

HAVE THE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?: Yes where required

HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?: No

ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?: Yes to be agreed

IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?: See above

ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?: No

WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?: N/A

WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO SUSTAINABILITY IMPLICATIONS (QUALITY & FINANCIAL) & CLIMATE CHANGE?: N/A

THE PROPOSAL OR ARRANGEMENTS OUTLINED IN THIS PAPER SUPPORT THE ACHIEVEMENT OF THE TRUST OBJECTIVE(S) AND COMPLIANCE WITH THE REGULATORY STANDARDS LISTED:

Trust Objective(s) – Trust Keogh Action Plan 2013: Trust Objective for 7 day working

Links to regulatory standards – N/A

- To note the December 2013 “standards for healthcare organisations” issued by the NHS Medical Director
- To note the Trust participation in the East Midlands collaborative work will provide us with a local gap analysis against the national standards
- To note the likely impact to future contract implications
- To note the on-going participation in NEL project work supported by NHSIQ
- To acknowledge support to the internal and external work being undertaken on the 7 day access agenda.

ACTION REQUIRED BY THE BOARD:

• To note the December 2013 “standards for healthcare organisations” issued by the NHS Medical Director
• To note the Trust participation in the East Midlands collaborative work will provide us with a local gap analysis against the national standards
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Report to the Trust Board – 29 April 2014

7 Day Working

1. Background

This paper updates the Trust Board on the work that has been undertaken regarding 7 day working and access to services since outlined in the Board paper in November 2013.

In December 2013, Sir Bruce Keogh, NHS Medical Director released new clinical standards for healthcare organisations that defined what care and standards should be available to patients 7 days a week. The intention of the standards is to make “healthcare services more accessible seven days a week to avoid compromising safety and patient experience.”¹ As a result of this publication the Trust has adapted its established project structure and work plan to focus upon achievement of these standards. This paper describes the:

- Revised Project Structure
- Baseline Assessment against the clinical standards
- Project work currently being undertaken with North East Lincolnshire (NEL) Community and NHS Improving Quality (NHS IQ)
- Collaborative work being undertaken with East Midland Acute Providers and NHS England
- Future work programme and priorities

2. Revised Programme Structure

The 7 day access programme continues to be led by the Operations Directorate, and managed by the General Manager for Surgery & Critical Care. The 7 Day Access Programme Board is represented by all Operational Groups, Organisational Development and Workforce, Finance, Planning and the Facilities departments. Clinical input is provided by representation from the Associate Medical Directors.

The work plan of the programme concentrates upon urgent care access and specific work streams of:

- Timely access to senior clinical decision maker
- 7 day a week discharging of patients from clinical areas
- Safe development and sustainability of rotas
- Availability of adequate speciality beds over 7 days.

These work streams mirror the clinical standards released in December 2013. The project work described later in this paper is reported back into the Programme Board.

3. Baseline Assessment against the clinical standards

Appendix 1 shows the 10 clinical standards for 7 day a week services. As well as acute provision the standards also ensure there are recommendations for Community and Primary Care access as well as Mental Health Services.

The contractual intentions for the standards are shown below²

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¹ Keogh, Sir Bruce (December 2013). NHS Englands Sir Bruce Keogh sets out plan to drive seven day services across the NHS (online - http://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/)
• Year 1 (2014/15) - local contracts should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section.
• 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.

Through the programme board all operational groups are undertaking a gap assessment against these standards. Primary Care and Mental Health services have also been asked to do the same. The collated gap assessment will be presented at the programme board in May 2014. The intention is then to prioritise work streams, identifying redesign requirements and funding priorities.

4. Project Work with NEL and NHS IQ

NEL are one of the 12 Pilot sites for 7 day access and the only one that is concentrated upon community access. The Trust is working closely with NEL on the following established groups including

- Intermediate Care,
- Discharge,
- Equipment and dementia care
- Frail elderly including nursing and care home support
- Front Ending A&E
- Frequent Service User
- Single Point of Access
- End of Life Pathway

The groups have been meeting and have established their terms of reference and assumptions around provision. The groups are working through current services in place to identify gaps and duplications. Over the coming months it is anticipated that proposals will become evident from the analysis and recognition of drivers for change.

The 7 Day Access Committee members have been asked by the NHSIQ to work with them on developing the 'community clinical standards' for other areas nationally to undertake a gap analysis. NEL have been nationally recognised by Dr Ann Driver, NHSIQ lead for the level of integrated working to develop 7 day access in the area.

Winter incentives monies secured by the providers at NEL has been used to extend the current 7 day access pilots which includes; A&E Unplanned Care MDT which includes A&E GP, Community Nurse, MSK Physio and Focus Social Worker; Community Equipment Store open 7 days; Community driver and minibus to support patient transport and equipment delivery. These initiatives have contributed to improved patient flow throughout the whole system and achievement of the A&E 4 hour target throughout the usually unpredictable winter months of January, February and March.

5. Collaborative work being undertaken with East Midland Acute Providers and NHS England

NLAG have entered into an arrangement with 9 other acute providers within the East Midland region to work collaboratively around understanding the guidance and implementation of the clinical standards.
There have been a number of meetings with the other providers, NHS England and ATOS consultancy who are providing the management and analytical support to the programme. The work so far has included:

- Interpretation of the standards and recommendations for further clarification
- Comparisons across the organisations across the urgent care pathway

ATOS consultancy is meeting with representatives from the Trust in April to help with analytical support of the baseline assessment against the standards.

The intention is for a final report to be published in August 2014. This report will give an assessment of the NLAG and the regions ability to deliver the standards and recommendations on how this may be done.

6. Future Work Programme and Priorities

A significant amount of work is already underway within the Trust regarding 7 day access. This has included

- Extended diagnostic availability
- Extended Operational Matron hours and Operational Centre Support
- Extended availability of Acute Care Physicians
- Work to sustain a 24/7 GI Bleed Rota
- Extra Surgical doctor presence after 5pm across the Trust

The next work streams will fit with the requirements of clinical standards mentioned previously, informed by the gap analysis. It is also the intention to undertake a full audit of clinical activity out of hours across the organisation. This work will inform future staffing models and support required out of hours and weekends to provide safe and quality care for patients.

7. Recommendation

The Board are asked to

- Note the position statement and new programme arrangements
- Note the 10 7 day access standards and future contract implications
- Support the internal and external work being undertaken on the 7 day access agenda.

Anthony Fitzgerald
General Manager, Surgery & Critical Care
## NHS Services, Seven Days a Week: Clinical Standards

<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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</table>
| 1 | **Standard:** Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.  
**Supporting information:**  
• Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times.  
• The format of information provided must be appropriate to the patient’s needs and include acute conditions.  
• With the increasing collection of real-time feedback, it is expected that hospitals are able to compare feedback from weekday and weekend admissions and display publically in ward areas. | 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 of arrival at hospital.  
**Supporting information:**  
• All patients to 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. | 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* |
<table>
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<tr>
<th>Multi-disciplinary Team (MDT) review</th>
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<td><strong>3</strong></td>
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</table>

**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 (2012): Delivering a 12-hour, 7-day consultant presence on the acute medical unit

RCP (2007): Acute medical care: The right person, in the right setting – first time

RCS (2011): Emergency Surgery, Standards for unscheduled surgical care


Operations Directorate, April 2014
### Shift handovers

| 4 | **Standard:**  
Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.  
**Supporting information:**  
- Shift handovers should be kept to a minimum (recommended twice daily) and take place in or adjacent to the ward or unit.  
- Clinical data should be recorded electronically, according to national standards for structure and content and include the NHS number. | RCP (2011): *Acute care toolkit 1: Handover*  
RCP (2013): *Future Hospital Commission* |

### Diagnostics

| 5 | **Standard:**  
Hospital inpatients must have scheduled seven-day access to diagnostic services 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. | 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* |
• 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.

<table>
<thead>
<tr>
<th>Intervention / key services</th>
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<tr>
<td>6 Standard:</td>
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<tr>
<td>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:</td>
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<tr>
<td>• Critical care</td>
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<tr>
<td>• Interventional radiology</td>
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<tr>
<td>• Interventional endoscopy</td>
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<tr>
<td>• Emergency general surgery</td>
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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:
  o Renal replacement therapy
  o Urgent radiotherapy
  o Thrombolysis
  o PCI
  o Cardiac pacing

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
<table>
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<tr>
<th>Mental health</th>
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<tr>
<td><strong>7</strong> Standard:</td>
<td>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:</td>
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<tr>
<td></td>
<td>• Within 1 hour for emergency* care needs</td>
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<td>• Within 14 hours for urgent** care needs</td>
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<tr>
<td>Supporting information:</td>
<td>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.)</td>
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<td>An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.</td>
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<tr>
<td></td>
<td>** 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.</td>
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<td><strong>RCPsych PLAN (2011): Quality Standards for Liaison Psychiatry Services</strong></td>
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<tr>
<td>On-going review</td>
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<tr>
<td><strong>8</strong> Standard:</td>
<td>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.</td>
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<td></td>
<td>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.</td>
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<tr>
<td>Supporting information:</td>
<td>Patients, and where appropriate carers and families, must be made aware of</td>
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<tr>
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<td><strong>RCP (2007): Acute medical care: The right person, in the right setting – first time</strong></td>
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<td><strong>RCP (2013): Future Hospital Commission</strong></td>
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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.

### Transfer to community, primary and social care

<table>
<thead>
<tr>
<th>9</th>
<th>Standard:</th>
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<tr>
<td>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. <strong>Supporting information:</strong></td>
<td></td>
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</table>

- Primary and community care services should have access to appropriate senior AOMRC (2012): *Seven day consultant present care*
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.

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<th>Quality improvement</th>
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<td>10</td>
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<td><strong>Standard:</strong></td>
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<td>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>
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**Supporting information:**

- The review of patient outcomes should focus on the three pillars of quality care: patient experience, patient safety and clinical effectiveness.
- Attention should be paid to ensure the delivery of seven day services supports training that is consistent with General Medical Council and Health Education England recommendations and that trainees learn how to assess, treat and care for patients in emergency as well as elective settings.
- All clinicians should be involved in the review of outcomes to facilitate learning and drive quality improvements.

GMC (2010): Generic standards for specialty including GP training