Board assurance framework for Seven Day Hospital Services: guidance for providers of acute services

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1. Introduction

1.1 The Seven Day Hospital Services Programme

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services ('providers') to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week. Full details of all the clinical standards are available at:

https://improvement.nhs.uk/resources/seven-day-services-clarification-four-priority-clinical-standards/

The importance of ensuring that patients receive the same level of high quality care every day is reflected in the prominence given to the delivery of this programme in the government's mandate to the NHS and the NHS planning guidance.

1.2 Measuring 7DS delivery

To enable providers to track their progress in achieving the four priority 7DS clinical standards, we developed a self-assessment survey. This is an online tool that allows providers to input data taken from patient case notes to measure achievement of standards 2 and 8, alongside an assessment of the availability of key diagnostics for Standard 5 and interventions for Standard 6.

To achieve each standard, a provider must be able to meet this level of care for at least 90% of its patients.

Providers have measured their delivery of 7DS using this tool since 2016. But unfortunately, the significant changes and considerable improvements have not always been reflected in the survey results due to the quality of source data and validation issues. The survey also places a significant administrative burden on providers as it involves reviewing many patient case notes.

To resolve these issues and enable provider boards to directly oversee reporting on this work, we are replacing the survey tool with this board assurance framework for measuring 7DS delivery.

1.3 Principles and process of board assurance of 7DS delivery

A clinical reference group of senior provider clinicians advised on developing a robust board assurance process.[1] Its work was based on agreed design principles for the board assurance model, to ensure that the new measurement system is:

- consistent, both in terms of the product (a single template for all providers) and its contents (assessments of delivery based on evidence aligned with the organisation's planned improvement trajectory)
- robust and accurate, containing independently verifiable information relating to 7DS, allowing for appropriate external scrutiny
- less of an administrative burden than the existing 7DS survey
- linked to developments in urgent and emergency care (UEC) and joint structures that enable network solutions such as sustainability and transformation partnerships (STPs)
- aligned with national-level measurement and reporting against the mandate and planning guidance ambitions for 7DS.

Building on these principles and following the clinical reference group's advice, we developed a single template for providers to record their self-assessments of 7DS delivery. The template is available at:

https://improvement.nhs.uk/resources/board-assurance-framework-seven-day-hospital-services

This template enables providers to record their assessments of 7DS delivery in each of the four priority standards for both weekdays and weekends. They can also record progress against the remaining six standards (the 7DS Clinical Standards for Continuous Improvement) and the four priority 7DS clinical standards in five urgent network specialised services (where applicable).

[1] Providers represented on the 7DS clinical reference group: The Newcastle upon Tyne Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, The Leeds Teaching Hospitals NHS Trust, Calderdale and Huddersfield NHS Foundation Trust, Liverpool Heart and Chest Hospital NHS Foundation Trust, Bolton NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust, Royal Surrey County Hospital NHS Foundation Trust, University Hospitals Plymouth NHS Trust, The Royal Wolverhampton NHS Trust, University Hospitals of Leicester NHS Trust, Nottingham University Hospitals NHS Trust, Epsom and St Helier University Hospitals NHS Trust, St George's University Hospitals NHS Foundation Trust, Chelsea and Westminster Hospital NHS Foundation Trust.

2. Guidance for completing the 7DS board assurance framework template

2.1 Overview

The purpose of the self-assessment template is to ensure providers can produce a single, consistent report of their 7DS delivery, for the dual purpose of assurance from their own boards and national reporting.

To match consistent presentation with consistent self-assessment, this guidance offers specific advice for each section of the template to be completed.

2.2 Clinical Standard 2

Clinical Standard 2 specifies that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

Assurance of delivery of this standard for 90% of all patients admitted in an emergency should be based on three sources of evidence that in combination give a complete view of delivery of Clinical Standard 2.

Evidence source 1 – consultant job plans

To deliver this standard, a provider should confirm that consultant job plans in all specialties that receive emergency admissions provide sufficient daily consultant presence to support the delivery of 7DS Clinical Standard 2 within the organisation.

The precise level of consultant presence required to deliver this standard is for the provider to assess locally rather than being specified centrally, as each organisation has its own requirements. Providers must also consider the availability of wider clinical services, such as pharmacy and therapy, over seven days in the delivery of this standard.

Evidence source 2 – local clinical audit

If a provider believes it has sufficient consultant presence to deliver the standard in theory, this should be evidenced by data from audits of delivery taken from patient case notes or data taken from electronic patient records if these are able to provide this information.

Once again, the exact type and level of clinical audit is for local determination as it must be based on whatever is required for the provider's board to give assurance of delivery. However, given the nature of this programme, whatever audit is used must be able to demonstrate consistent delivery 24/7.

One option is to focus these audits on areas or specialties where the provider feels it may not meet the standards, for the purposes of improvement and measuring any gaps. In doing this, a provider should give statistical assurance that areas not being audited are meeting the standard.

Another option is to conduct an audit that is representative of the provider's normal emergency admission patient profile. If a provider does this, an example of the minimum statistically significant sample size would be 70 case notes out of 500 relevant admissions in a given period. At least 90% (63) of these case notes would need to confirm compliance with the clinical standard to support delivery. In doing this, an organisation may need to provide further assurance that smaller specialties that may not be covered in this sample have arrangements to deliver the clinical standard.

Providers with electronic patient records from which relevant information can be extracted and analysed may wish to use a larger sample size to give assurance to their boards.

Evidence source 3 – wider performance and experience measures

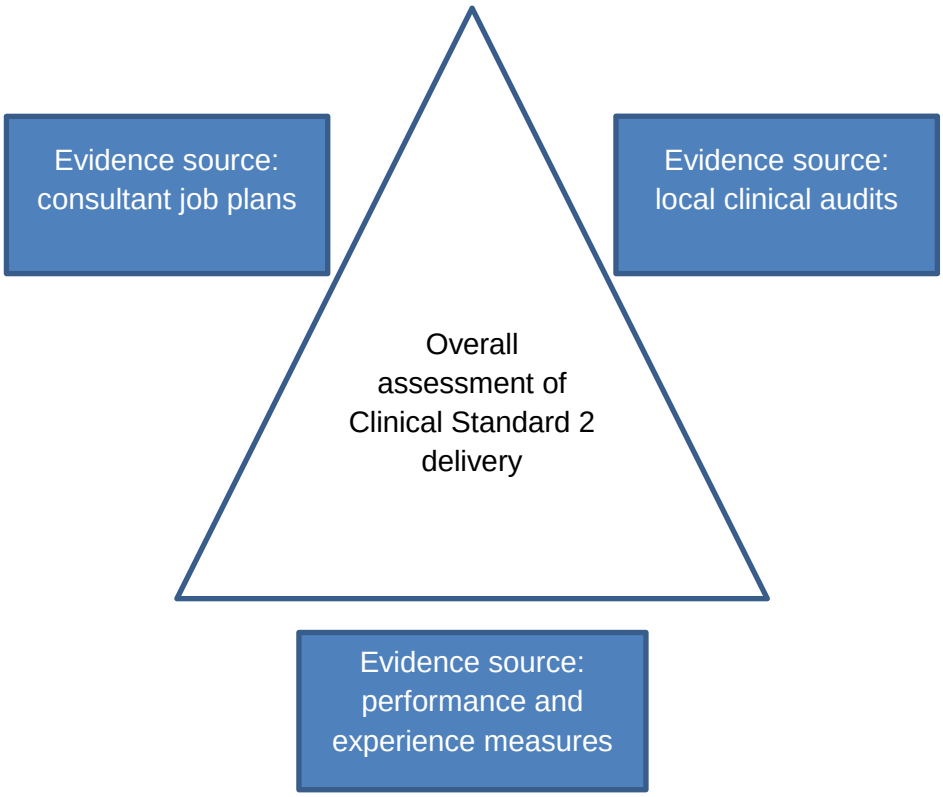
Alongside an assessment of job plans and supporting clinical audit evidence of delivery, wider sources of information with potential links to delivering this standard could indicate whether it is being achieved. These include:

- weekday and weekend ratio data in mortality, length of stay, readmissions
- patient experience data from weekdays versus weekends covering consultant presence/availability
- General Medical Council (GMC) trainee doctor survey data on the support offered by consultants
- wider, related patient flow and urgent and emergency care improvement programmes and metrics (for example, SAFER/number of red-green days and accident and emergency performance)
- audits of staffing levels and activity related to 7DS as recommended by the Royal College of Physicians' *Guidance on safe medical staffing*[2]
- separate targeted ongoing audits of performance in specific specialties or locations as part of provider continuous improvement activity.

[2] *Guidance on safe medical staffing: report of a working party*, Royal College of Physicians, July 2018. https://www.rcplondon.ac.uk/projects/outputs/safe-medical-staffing

Providers should assess their progress in these and other areas related to delivering this clinical standard to support their assessment. For example, providers should explore relatively weak performance in any of these areas to see if there is a direct link to not delivering Clinical Standard 2 on every day of the week.

Figure 1: Evidence for delivery of 7DS Clinical Standard 2



Providers should base their self-assessment ratings for weekdays and weekends for this standard on the above criteria, offering a short commentary in the template to evidence their assessments, with areas for improvement noted in the cases where the standard is not met.

Overall compliance with this standard is achieved if a provider assesses itself as meeting the standard on both weekdays and weekends.

2.3 Clinical Standard 5

Clinical Standard 5 covers the availability of six consultant-directed diagnostic tests for patients to clinically appropriate timescales, which is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.

Self-assessment of delivery of this standard should be based on a response to the following question for each of the diagnostic tests:

Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?

- *Computerised tomography (CT)*
- *Ultrasound (USS)*
- *Echocardiography*
- *Upper GI endoscopy*
- *Magnetic resonance imaging (MRI)*
- *Microbiology*

For this assessment, there are several potential responses:

Response	**Compliance with 7DS standard**
Yes, available on site	Yes
Yes, available off site via formal arrangement	Yes
Yes, mix of on-site and off-site by formal arrangement	Yes
No, the intervention is only available on or off site via informal arrangement	No
No, the intervention is not available	No
Not applicable to patients in this trust	N/A

The self-assessment template requires each provider to assess the availability of each of the six diagnostic tests for weekdays and weekends. This is done by selecting one of the above answers from the drop-down menu in the yellow cells for each diagnostic test for weekdays and weekends.

Overall compliance (ie achievement of the 90% threshold) is based on a combination of these weekday and weekend assessments, with 50% weighting given to each.

The diagnostic tests themselves are also weighted on the frequency of use for patients admitted in an emergency. The weighted score given to each test is:

Test	**% of diagnostic test requests**
Microbiology	33.4%
Computerised tomography (CT)	32.4%
Ultrasound	14.4%
Echocardiography	12.6%
Magnetic resonance imaging (MRI)	5.2%
Upper GI endoscopy	2.2%

The self-assessment template is designed to automatically calculate an overall compliance score for each provider based on the above weighting from the responses inputted for each diagnostic test.

2.4 Clinical Standard 6

Clinical Standard 6 covers timely 24-hour access seven days a week to nine consultant-directed interventions.

Self-assessment of delivery of this standard should be based on a response to the following question for each of the interventions:

Q: Do inpatients have 24-hour access to the following consultant-directed interventions seven days a week, either on site or via formal network arrangements?

- *Critical care*
- *Interventional radiology*
- *Interventional endoscopy*
- *Emergency surgery*
- *Emergency renal replacement therapy*
- *Urgent radiotherapy*
- *Stroke thrombolysis*
- *Percutaneous coronary intervention*
- *Cardiac pacing*

As with Clinical Standard 5, for this assessment, there are several potential responses:

Response	**Compliance with 7DS standard**
Yes, available on site	Yes
Yes, available off site via formal arrangement	Yes
Yes, mix of on-site and off-site by formal arrangement	Yes
No, the intervention is only available on or off site via informal arrangement	No
No, the intervention is not available	No
Not applicable to patients in this trust	N/A

The self-assessment template requires each provider to assess the availability of each of the nine interventions for weekdays and weekends. This is done by selecting one of the above answers from the drop-down menu in the yellow cells for each diagnostic test for weekdays and weekends.

Overall compliance (ie achievement of the 90% threshold) is based on a combination of these weekday and weekend assessments. This overall score is based on a 50%

weighting for weekday and weekend availability, but unlike Clinical Standard 5 for diagnostics, there is no different weighting of scores for the individual interventions based on frequency of use.
Therefore, a provider can only comply with this standard if all these interventions are available both on weekdays and at weekends, with only one exception (ie there are nine interventions, so 18 potential responses (weekday and weekend scores), of which 17 must comply with the standard to achieve overall compliance).

The self-assessment template is designed to automatically calculate an overall compliance score for each provider based on the responses inputted for each intervention.

2.5 Clinical Standard 8

Clinical Standard 8 relates to the ongoing consultant-directed reviews received by patients admitted in an emergency once they have had their initial consultant assessment. The standard aims to ensure that all patient cohorts receive an appropriate number and level of reviews from consultants depending on the severity of their condition.

In practice this means that patients with high dependency needs,[3] usually but not always sited in AMU, SAU and ITU, should be reviewed by a consultant twice daily. All other patients admitted in an emergency should be reviewed by a consultant once daily unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

Assurance of delivery of this standard for 90% of all patients admitted in an emergency should be based on four sources of evidence that in combination give a complete view of delivery of Clinical Standard 8.

<u>Evidence source 1 – consultant job plans</u>

To deliver this standard, a provider must confirm that consultant job plans in all specialties that cover emergency admissions provide sufficient daily consultant presence to support the delivery of twice-daily ward rounds for high dependency patients and once-daily ward rounds for all other patients.

[3] Definition of high dependency needs for Clinical Standard 8: Clinical judgement should be used to determine frequency of consultant review required, but as a guide, patients with Intensive Care Society levels of need of 2 (3 for paediatrics) and above may require twice-daily review, and patients with needs below level 2 (3 for paediatrics) may only require once-daily review. The group of patients who need twice daily reviews should be based on the Intensive Care Society definitions of levels of illness and the Paediatric Intensive Care Society standards for the care of critically ill children rather than their geographical ward location in the hospital.

The precise level of consultant presence required to deliver this standard is for the provider to assess locally rather than being specified centrally, as each organisation has its own requirements. Providers must also consider the availability of wider clinical services, such as pharmacy and therapy, over seven days in the delivery of this standard.

Evidence source 2 – systems to support ongoing review

In addition to the requisite level of consultant presence to deliver the standard, providers should have systems to support seamless and appropriate ongoing review, specifically:

1. a board round system that enables the responsible consultant to delegate reviews appropriately based on clinical need and the presence of agreed written protocols
2. a system of escalation for deteriorating patients based on agreed protocols, ideally built around monitoring each patient's National Early Warning Score (NEWS)
3. a clear process to decide which patients do not need a daily consultant review and the proportion of admitted patients in this category.

Evidence source 3 – local clinical audit

As with Clinical Standard 2, if a provider believes it has sufficient consultant presence to deliver Clinical Standard 8 in theory, this should be evidenced by data from clinical audits of patient case notes or data taken from electronic patient records if these are able to provide this information.

Once again, the exact type and level of clinical audit is for local determination as it must be based on whatever is required for the provider's board to give assurance of delivery. However, given the nature of this programme, whatever audit is used must be able to demonstrate consistent delivery 24/7.

One option is to focus these audits on areas or specialties where a provider feels they may not meet the standards, for the purposes of improvement and measuring any gaps. In doing this, a provider should give statistical assurance that areas not being audited are meeting the standard.

Another option is to conduct an audit that is representative of the provider's normal emergency admission patient profile. If a provider does this, once again an example of the minimum statistically significant sample size would be 70 case notes out of 500 relevant admissions in a given period. At least 90% (63) of these case notes would need to confirm compliance with the clinical standard to support delivery. In doing this, an organisation may need to provide further assurance that smaller

specialties that may not be covered in this sample have arrangements to deliver the clinical standard.

Providers with electronic patient records from which relevant information can be extracted and analysed may wish to use a larger sample size to give assurance to their boards.

Evidence source 4 – wider performance and experience measures

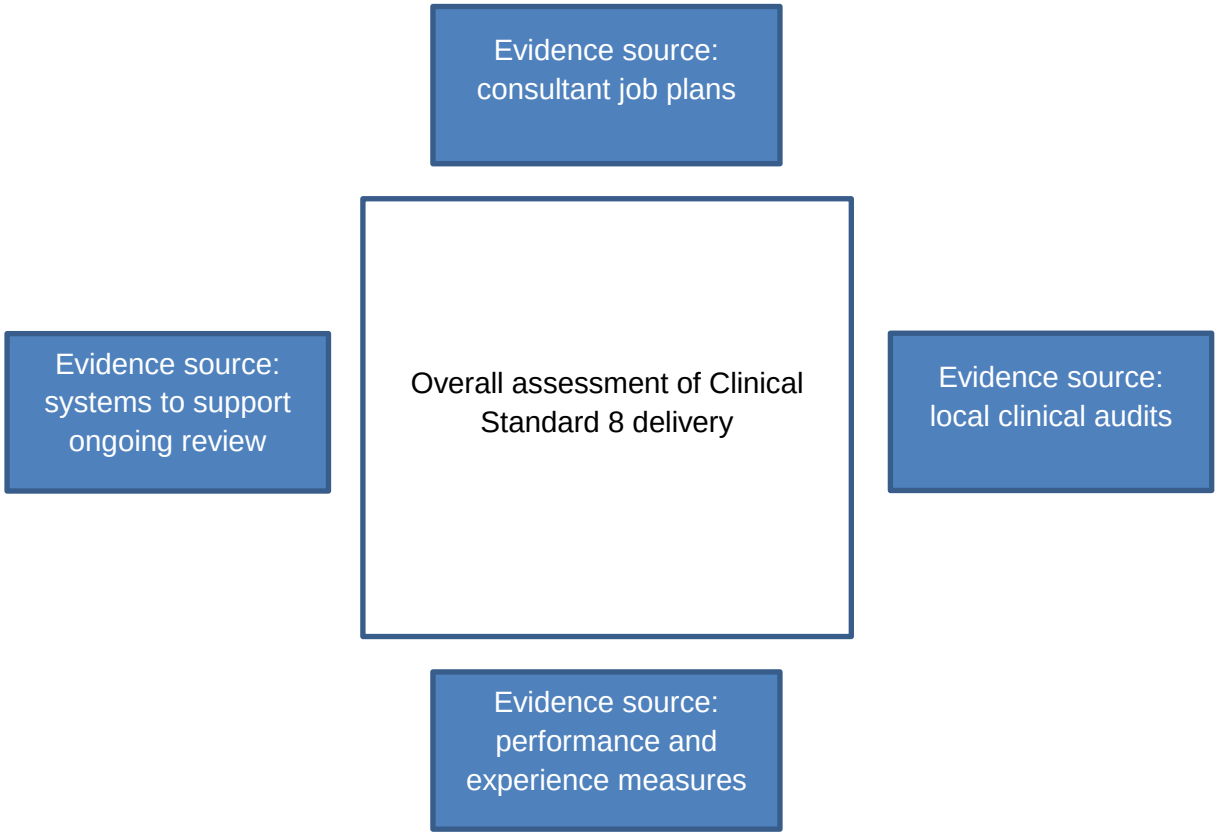
Alongside an assessment of job plans and supporting clinical audit evidence of delivery, wider sources of information with potential links to delivering this standard could indicate whether it is being achieved. These include:

- weekday and weekend ratio data in mortality, length of stay, readmissions
- patient experience data from weekdays versus weekends covering consultant presence/availability
- GMC trainee doctor survey data on the support offered by consultants
- wider, related patient flow and urgent and emergency care improvement programmes and metrics (for example SAFER/number of red-green days and A&E performance)
- audits of staffing levels and activity related to 7DS as recommended by the Royal College of Physicians' *Guidance on safe medical staffing*[4]
- separate targeted ongoing audits of performance in specific specialties or locations as part of provider continuous improvement activity.

Providers should assess their progress in these and other areas related to delivering this clinical standard to support their assessment. For example, providers should explore relatively weak performance in any of these areas to see if there is a direct link to not delivering Clinical Standard 8 on every day of the week.

[4] *Guidance on safe medical staffing: report of a working party*, Royal College of Physicians, July 2018. https://www.rcplondon.ac.uk/projects/outputs/safe-medical-staffing

Figure 2: Evidence for delivery of 7DS Clinical Standard 8



Providers should base their self-assessment ratings for this standard, covering both patients requiring once-daily and twice-daily reviews on weekdays and at weekends, on the above criteria. Providers should offer a short commentary in the template as evidence of their assessments, with areas for improvement noted where the standard is not met.

Overall compliance with this standard is achieved if a provider assesses itself as meeting the standard both on weekdays and at weekends for patients requiring once-daily and twice-daily reviews.

2.6 7DS Standards for Continuous Improvement

All 10 7DS clinical standards are vital to consistently high quality care, and taken as a whole, impact positively on the quality of care and patient experience.

As well as the four priority 7DS clinical standards, the 7DS programme supports providers to deliver the remaining six 7DS standards, referred to as the 7DS Standards for Continuous Improvement.

To assess progress against these standards, providers must draft a commentary on work done relating to their delivery in the board assurance template. We do not require an assessment of whether a provider is meeting the standards, just evidence of overall improvement.

The full set of all clinical standards is available at:

https://improvement.nhs.uk/resources/seven-day-services-clarification-four-priority-clinical-standards/

Below is a guide to the type of evidence providers should use for each of the Standards for Continuous Improvement to form their self-assessment.

Clinical Standard	**Evidence to support assurance of progress**
1 – Patient experience	Information from local patient experience surveys on quality of care/consultant presence on weekdays versus weekends. Feedback from wider sources of patient experience, such as levels of complaints and local Healthwatch feedback directly related to quality of care on weekdays and at weekends.
3 – Multidisciplinary team review	Assurance of written policies for MDT processes in all specialties with emergency admissions, with appropriate members (medical, nursing, physiotherapy, pharmacy and any others) to enable assessment for ongoing/complex needs and integrated management plan covering discharge planning and medicines reconciliation within 24 hours.
4 – Shift handovers	Assurance of handovers led by a competent senior decision-maker taking place at a designated time and place, with multiprofessional participation from the relevant incoming and outgoing shifts. Assurance that these handover processes, including communication and documentation, are reflected in hospital policy and standardised across seven days of the week.
7 – Mental health	Assurance that liaison mental health services are available to respond to referrals and provide urgent and emergency mental healthcare in acute hospitals with 24/7 emergency departments 24 hours a day, seven days a week.

Clinical Standard	Evidence to support assurance of progress
9 – Transfer to community, primary and social care	Assurance that the hospital services to enable the next steps in the patient's care pathway, as determined by the daily consultant-led review, are available every day of the week. These services should include: • discharge co-ordinators. • pharmacy services to facilitate discharge (eg provision of TTAs within same timescales on weekdays and at weekends) • physiotherapy and other therapies • access to social and community care providers to start packages of care • access to transport services.
10 – Quality improvement	Assurance that provider board-level reviews of patient outcomes cover elements of care and quality that relate to the delivery of high quality care seven days a week – such as weekday and weekend mortality, length of stay and readmission ratios – and that 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.

2.7 7DS in urgent network specialist services

Alongside delivery of the 7DS clinical standards for all patients admitted to hospital in an emergency, the 7DS programme has worked with providers to measure delivery of the four priority clinical standards in five urgent network clinical services. These services and the specific patients covered by this element of the programme are:

- hyperacute stroke (specialist care provided for hyperacute stroke patients, covering the first 72 hours)
- paediatric intensive care (patients admitted to be cared for at a centre providing Level 3 paediatric critical care).
- STEMI heart attacks (patients treated for ST elevation myocardial infarction at specialist centres)
- major trauma (major trauma patients with an ISS>8 treated in a major trauma centre)
- emergency vascular services (patients receiving emergency vascular surgery and interventions in designated specialist centres).

This part of the 7DS programme is to ensure that patients treated in these urgent settings/high dependency areas receive care that meets the 7DS standards. Once

these patients have either had their emergency episode treated, been stabilised or moved to another setting within the hospital, the quality of their care would be covered by the wider 7DS programme.

Organisations that provide one or more of these services have been providing assessments of their delivery of the four priority clinical standards separately, using the same criteria for measuring assessment of the four priority standards as detailed above for all emergency admissions, which in turn mirror the specialised commissioning service specifications for these services (or national guidance in the case of hyperacute stroke).

The new board assurance process for 7DS will incorporate this work on specialist services to provide a single reporting process for all 7DS work. To ensure consistency, the template for board assurance of 7DS to be sent to providers will include individually tailored information for each provider's specialist services, including their previous assessment of performance. This will allow the board to provide assurance of these assessments alongside the assurance of 7DS delivery for all emergency admissions.

3. Reporting, support and assurance of 7DS delivery

3.1 Process for 7DS board assurance

The process of 7DS board assurance emphasises provider boards giving evidence-based assurance of their organisation's delivery of 7DS, rather than relying on a national recording tool.

To ensure progress in the 7DS programme can continue to be measured to existing timescales, provider boards must self-assess performance twice a year, once in spring and once in autumn.

3.2 Format of 7DS board assurance reporting

The 7DS board assurance framework template provides a single, consistent way of recording provider self-assessments of 7DS delivery. The template requires providers to complete all yellow cells either:

- with a free text commentary of performance, covering any gaps to be addressed or
- by selecting a response to questions of compliance from a drop-down list.

This template should be used to summarise the headline issues relating to delivery of the 7DS clinical standards as well as providing self-assessment information. It is not meant to provide a comprehensive picture of the provider's work on 7DS nor capture the full details of the audit data gathered to support any self-assessments.

Providers may wish to provide this depth of information separately to their boards to enable them to confirm their assurance of the assessments of delivery. It could be a bi-annual paper for boards, with the template used as an appendix to this board paper.

3.3 Central reporting of 7DS performance

As noted above, provider boards should assess their delivery of the 7DS clinical standards twice a year. To measure progress in the delivery of 7DS nationally, as outlined in the mandate ambitions and NHS shared planning guidance, these assessments, in the form of completed board assurance framework templates, should be shared with regional 7DS teams to allow for their collation and national analysis.

The headline data of compliance against each of the four priority clinical standards will be used to calculate delivery against national 7DS programme ambitions.

To ensure transparency, these headline data will continue to be published on the NHS Improvement and NHS England websites.

3.4 Regional support

The 7DS programme is supported by national organisations' regional teams, reporting to regional medical directors, which help providers achieve the 7DS clinical standards by sharing best practice and learning, and by advising on improvement strategies.

Regional teams worked with providers in detail when necessary, to support the evidence base and audit process. We expect the board assurance process will not require intensive support from regional teams as it will be for provider boards to assure themselves of progress from locally collected data. Therefore, regional teams will focus on supporting providers with improvement strategies and processes to fill any identified gaps.

Regional 7DS teams will support providers to ensure that 7DS is embedded into a business-as-usual model of delivery and performance measures.

3.5 External assurance

The Care Quality Commission's (CQC) hospital inspection regime features 7DS as one of its key lines of enquiry under the quality of care theme. CQC uses results from the national 7DS survey to help focus its inspections. We envisage the evidence supporting the assessments in the board assurance process would be made available to CQC during any inspection to enable it to assess the quality of 7DS.

Clinical commissioning groups (CCGs) will also play a role in providing external assurance of 7DS delivery. Completion of the bi-annual 7DS board assurance process will be a requirement of the NHS Standard Contract. Delivery of the four priority standards features in the contract under the 'service development and improvement plans' section. A metric based on the delivery of 7DS will feature in the next CCG improvement and assessment framework.

Sustainability and transformation partnerships and integrated care systems are an opportunity for system-wide transformation, particularly where greater co-operation between local providers is required to meet the 7DS clinical standards. Where appropriate, these systems should play a role in ensuring providers can be compliant and could be involved in wider assurance beyond individual providers when required.

3.6 Supporting Information

Further information on the 7DS programme and practical examples to support improvement and transformation can be found at the following links:

- NHS Improvement website (https://improvement.nhs.uk/resources/seven-day-services/)
- NHS England website (https://www.england.nhs.uk/seven-day-hospital-services/)
- Case studies (https://improvement.nhs.uk/resources/implementing-seven-day-hospital-services/)
- Challenges and solutions (https://improvement.nhs.uk/resources/seven-day-hospital-services-challenges-and-solutions/)