Seven-day services in hospitals: clarification of priority clinical standards

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A series of clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. Ten standards were agreed and are now being rolled out across the NHS in England in acute hospitals. With the support of the AoMRC, four of these were identified as priority clinical standards on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.

The purposes of the standards are to deliver safer patient care, to improve patient flow through the acute system, to enhance patients’ experience of acute care, to reduce the variation in appropriate clinical supervision at weekends and, potentially, to mitigate the excess mortality that has been shown in large studies to be associated with weekend admission to hospital.

All acute trusts in England have undertaken self-assessment surveys to measure their compliance with the four priority standards for seven-day services in hospitals.
NHS England’s Sustainable Improvement Team invited feedback from acute trusts, which asked for clarification on some specific points about the standards.

NHS England and NHS Improvement formed a clinical group including frontline consultants and medical directors to develop this clarification, which has been discussed with the Academy of Medical Royal Colleges (AoMRC) and agreed by the 7 Day Services Delivery Group.

**Standard 2 – Time to first consultant review**

**Time to first consultant review:** This should be measured from the time of admission to hospital rather than the time of arrival at hospital. This reflects the original source document for this standard (Royal College of Physicians acute care toolkit number 4, referenced in the AoMRC 2012 paper, ‘Seven day consultant present care’), and aligns better with the usual daily pattern of emergency patient admissions and associated consultant staffing rosters. For this standard, the definition of ‘consultant’ remains a doctor who has completed all their specialist training and been placed on the General Medical Council’s specialist register.

**Pathways that are not consultant-led:** Patients with a clear diagnosis on a well-defined pathway (eg midwife-led maternity, simple superficial abscess management) may have their clinical care delegated from a consultant to another clinician under these circumstances:

- there is a clear written local protocol for the pathway, agreed within the trust clinical governance system and supported by the commissioners

- the protocol must describe actions to take in the event of clinical concern, including robust and rapid escalation to a consultant where appropriate: eg a maternity patient who develops the need for an emergency Caesarean section, or a patient with a superficial abscess who appears to be developing sepsis

- the patient’s care is still recorded as being under a named consultant for the purpose of clinical governance (excluding patients specifically on midwife-led care pathways).

**Further guidance on Standard 2**

Taking into account that the standard is now based on 14 hours from admission to hospital, potential actions to improve performance could include the following:

- Ensure a consultant on acute take (especially for high volume specialties such as medicine) is scheduled to be on site until 8pm every night, and from 8am every morning.
• Write into policy the expectation that patients admitted before 8pm will be seen by the evening-take consultant before the consultant goes home.

• Where an acute-take consultant assesses a patient in the emergency department (ED) before their admission to hospital, include this in the measurement of Clinical Standard 2 (and ensure your audit provides for measurement of this; in some cases where the first specialty consultant’s assessment is recorded in the ED notes, this might not be picked up by clerical staff doing retrospective case note audits).

• Ensure that the handover lists (ideally electronic) used for the take ward rounds include the time each patient arrived at hospital and the time they were admitted, as well as which ward they were admitted to. This will help the on-take consultant decide the order in which they see patients on the ward rounds.

• Ask on-take consultants to ensure that whoever is writing the entry in the medical notes makes it clear that the consultant is assessing the patient and the time this occurs.

• On high volume units, such as most acute medical units, use rolling ward rounds through the day to keep up with the new patients arriving.

• Make sure all team members, particularly junior doctors and senior ward nurses, know the importance of a prompt consultant assessment for new and undifferentiated patients (and effective recording of this).

Standard 5 – Timely access to diagnostics

Which diagnostic tests should be included? Acute trusts should use their clinical governance processes and discussions with their commissioners to judge which diagnostic tests their patients require access to seven days a week, and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances.

Data from the self-assessment surveys suggest that CT scans, ultrasound, endoscopy, microbiology and echocardiography are commonly required urgently to manage acutely ill inpatients. The quality surveillance group should confirm that these diagnostic tests are available seven days a week to patients in the trust. Histopathology is rarely needed urgently at weekends except in renal and transplant patients, and we no longer plan to record it in regular trust surveys. MRI is rarely needed urgently, but is specifically indicated for patients with suspected acute spinal cord compression and for some stroke patients.
**Standard 6 – Access to consultant-delivered interventions**

**Timeliness of interventions:** The principle is that patients should receive urgent interventions within a timeframe that does not reduce the quality of their care (safety, experience and efficacy). Where there is evidence-based national clinical guidance regarding time to urgent treatment (eg thrombolysis for stroke, emergency laparotomy for peritonitis), trusts should implement systems to deliver to these standards and monitor their performance.

Acute trusts should use their clinical governance processes and discussions with their commissioners to judge which of the agreed list of clinical interventions their patients may require access to seven days a week and whether these are delivered on site or via a networked arrangement. For example, some hospital sites are planning to provide emergency general surgery via a networked arrangement. Where this is agreed a written protocol should describe the arrangements, including a robust and transparent process for timely clinical assessment and patient transfer between sites.

Such processes should be regularly audited to ensure that transferred patients receive timely, high quality care. The quality surveillance group should confirm that these urgent interventions are available seven days a week to patients in the trust, either locally or via a timely networked arrangement. Trusts and their commissioners should have policies for managing a patient already in hospital who develops another acute condition: eg a general medical inpatient who has a STEMI heart attack requiring primary PCI.

**Standard 8 – Ongoing consultant-directed review**

**Daily ward rounds and delegation:** The principle remains that the default option is that every patient in an acute inpatient bed should be seen face to face by a consultant every day (and twice daily in high-dependency areas), since we believe that this will improve patient safety, patient experience, flow through the hospital and the supervision of junior clinical staff. Ideally every inpatient should be on a clearly defined pathway leading to an estimated discharge date. If a patient deviates from this pathway, it needs to be recognised promptly and addressed to ensure they are kept safe and avoid inappropriately prolonging their inpatient stay.

There should be consultant-led board rounds on every acute inpatient ward every day, and every patient should have a highly visible care plan (based on written protocols for individual conditions) that is updated daily at the board round. At the board round the consultant decides which, if any, of the patients’ reviews that day can be delegated to another competent clinician, such as a specialist nurse, consultant pharmacist or senior medical trainee.

The purpose of the consultant review is to see any patient who is not on a pathway, to address patient deterioration, to provide urgent important communication with
patients and carers, to speed flow and remove blockages in the care pathway. There should be clear escalation protocols, so that if a patient deteriorates between daily ward rounds there is appropriate timely clinical escalation (‘seeing the sickest quickest’). The default is always that a patient is seen by a consultant every day unless there is a recorded reason for delegation. Where a daily review is delegated, the reviewer should feed back promptly to the consultant any concerns they have about a patient.

Several trusts have segmented their inpatient population to facilitate the appropriate level of daily review. Typically the groups are described as ‘medically active’, ‘medically optimised’ and ‘medically fit for discharge’.

The medically active group **must** be seen daily by a consultant and not delegated. This includes all patients causing nursing concern, all patients on end-of-life care pathways, all new admissions to a ward in the previous 24 hours and all patients who require a potential same-day discharge decision.

The medically optimised group needs daily consultant input via the board round to ensure the multidisciplinary team (MDT) discusses progress on therapy and social assessments. Then, for some in this group, the consultant may choose to delegate that day’s face-to-face review to another MDT member.

The medically-fit-for-discharge group (including people who are delayed transfers of care) may be excluded from daily consultant face-to-face review, and instead be reviewed by a senior nurse or equivalent. There still needs to be a safety netting process in place so that if such a patient deteriorates unexpectedly a system ensures that a consultant assesses them promptly.

**Monitoring:** Electronic patient records, handover systems and automatic recording of vital signs can make these processes more efficient and effective, and more trusts are using them. Automatic track-and-trigger systems for vital signs can help prompt identification of deteriorating patients.

**Outliers:** There are concerns that a focus on board rounds could disadvantage patients who are ‘outliers’. Trusts should agree with their commissioners explicit strategies to mitigate this risk. Effective management of flow and bed occupancy should reduce the numbers of outlying patients. We know that outliers are often disadvantaged – typically by missing out on daily consultant reviews, but also due to having less access to specialist nurses and allied health professionals. The default position for outlying patients is that they should be seen face to face by a consultant every day.

**High dependency patients:** New emergency admissions in high dependency areas should be seen twice daily by a consultant until they are established on a clear pathway of care. This usually takes place in a medical assessment unit or
equivalent, and then patients are transferred to acute wards to continue their pathway. For the purposes of this standard, ‘high dependency’ refers to the patient rather than the clinical area in which they are situated.

**Definition of a ‘consultant’ for daily ward rounds:** Consultants in this context are those on the specialist register, those who hold certificates of completion of training and those the relevant Royal College recognises as being equivalently qualified. These senior decision-makers have a crucial role, not just in identifying and dealing with clinical issues but in communicating with patients and relatives, in taking active and appropriate decisions about discharge from hospital, and in providing support, supervision and education to junior clinical colleagues.

**Rehabilitation and intermediate care:** A trust may agree with its commissioner to designate certain wards as non-acute rehab or intermediate care wards that do not require the level of daily consultant intervention described above. There would still need to be a clear escalation protocol for any patient in a rehab or intermediate care bed who deteriorates unexpectedly.