ITEM 8

Seven Day Services Improvement Programme Update

Committee:	Health and Wellbeing Board
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Date:	14 March 2014
Status:	For Information

Purpose

This report advises Southend Health and Wellbeing Board of progress with the Seven Day Service Improvement Programme.

Background

In November 2013, South East Essex was accepted as one of 13 early adopter sites within the national programme. The programme team from NHS Improving Quality visited the local team on February 3rd 2014.

We agreed that the key actions we need to work on as soon as possible are:

- How will we manage the programme alongside other improvement projects, e.g. Integration pioneers? We need to map these together as soon as possible.
- What is the overarching ambition for seven day services in South East Essex? What is our vision? We need a collective one that stretches across all of our pilots, initiatives and programmes.
- What is our plan for implementing change and improvement?

Programme Management

It is proposed that the Joint Executive Group (JEG) will be responsible for governance and direction of the work ensuring coordination with other change projects.

Southend is also one of 14 localities working in the Integrated Pioneer Programme. The aim of this is to improve the links between health and social care and provide better support at home and earlier treatment in the community. It is important that we avoid duplication of effort and therefore, Dominic Hall Senior Change Manager at Southend Hospital, will act as the link between these two programmes.

A separate group will be formed to direct and monitor the implementation plan for delivering the improvements. This will be known as the Seven Day Services Implementation Board, ideally will be made up senior clinical leaders and report quarterly to JEG.

Vision and Ambition

When we asked to become an early adopter, we said, that we have a vision where all health, social, community and third sector services are fully integrated, within and across organisations. We will provide the best care in the most appropriate setting, regardless of time of day or day of the week.

We want to refashion our services to our patients, their carers and families, so that they always feel supported and cared for, no matter where they are in the system or what day of the week it is.

If this is our vision, how do we communicate it to the wider community and members of our organisations?

Implementation Plan

The initial ambition was to focus on improving care for the 'deteriorating patient' and the 'frail elderly'. In December 2013, Sir Bruce Keogh reported back to the NHS England board on the outcomes of the Seven Day Services Forum. His report proposed 10 new clinical standards that describe seven day services, appendix 1. These have been approved by NHS England and will become part of contractual arrangements over the next 3 years.

Therefore, the implementation plan is now focused on achieving these standards and the 5 proposed workstreams are shown below:

Patient involvement	Consultants' working patterns	Psychiatric services	Discharge support	Patient outcomes
Better information to patients 7 days a week Publish patient feedback and measures	Consultant led assessments MDT assessments Consultant led diagnostics and interventions Consultant ward rounds	Available in < 1 hour for high risk patients and in < 14 hours for urgent patients	Available 7 days a week primary care, pharmacy, physiotherapy, occupational therapy, social services, equipment service, district	Review of patient outcomes to drive care quality improvement. Duties, working hours and supervision of trainees to be safe and effective

In the hospital, Mr. Neil Rothnie, Medical Director, is leading a team of senior clinicians to take the work forward. An initial plan has been drafted and will be reviewed by this team.
Each workstream, led by a senior clinician, will complete the details of their plans and report back to the senior clinical team on a monthly basis. The Programme Management Office at Southend Hospital is supporting this work.

There will be a report to the Seven Day Services Implementation group on a quarterly basis. As a minimum, each workstream will have finalised the details of their plans by 6th June. We need to report progress to NHSIQ on Friday 20th June.
The initial focus will be on mapping what we currently provide across the health economy, using a self-assessment tool developed by NHSIQ. This assessment will inform the workstream plans for improving and developing services.

Indicators for Success

All the clinical standards below apply seven days a week and 24 hours a day.

1	Patient involvement and information	Shared decision making with clear information	Patient feedback on weekday/weekend service displayed in public (Audit)
2	Emergency admissions assessed < 14 hours	Consultant led. High risk patients in < 1 hour. Early Warning Scores for all patients.	% of emergency admissions assessed in < 14 hours. % of patients with EWS (Record on PAS *)
3	MDT assessment in < 14 hours for emergency inpatients	Integrated management plan with estimated discharge date	% of emergency inpatients with MDT assessment in < 14 hours (record on PAS)
4	Standardised shift handovers	Multi-professional, twice a day, electronic, governed by policy	% of shift changes compliant with policy (Audit)
5	Inpatient access to consultant-directed diagnostic services	< 1 hour for critical < 12 hours for urgent < 24 hours for routine	Quarterly audit of provision by each service
6	Inpatient 24 hour access to consultant-directed interventions	e.g. Critical care, Radiology, Endoscopy, Surgery, etc	Quarterly audit of provision by each service
7	Psychiatric assessment for acute admissions	In < 1 hour for emergency patients and in < 14 hours for urgent	% of assessments within timescales (record on PAS)
8	Consultant led ward rounds	Twice daily for acute wards and once daily for other wards	Quarterly audit of provision by each service
9	Support for discharge	All support services available 7 days a week, social services, equipment, transport etc	Quarterly audit of provision by each service
10	Patient outcome reviews and training	All involved to participate in reviews. Hours, duties and supervision of trainees to be safe.	Number of outcomes per months completed. Quarterly audit of arrangements for trainees.
* Patient Administration System used at Southend Hospital			

The measurement and reporting process for these standards will be agreed within the relevant organisations and used to inform the baseline, and progress with the improvement work.

There are other factors in place that will influence the likelihood of success:

- Senior Consultant involvement – reflecting involvement of medical colleges
- Good senior leadership :
    - Neil Rothnie
    - Sunil Gupta
    - Katharine Marks
- Widespread recognition amongst health and social care staff that our services, out of hours and at weekends, need to be improved. We cannot continue with the current ways of working.
- Financial support is available. One of the six national conditions for access to the Better Care Fund requires improvements to seven day health and social care services to support patients being discharged and preventing unnecessary admissions at weekends. Also, a substantial part of the fund has been set aside for reward payments in April 2015 which will partly depend on improvements to seven day health and social care services.

Recommendations

Southend Health and Wellbeing Board is asked to review this update on progress with the Seven Day Services Improvement Programme and approve the recommendations below:

- The Joint Executive Group will be responsible for the governance and direction of this programme of work.
- A separate group, to be known as the Seven Day Services Implementation Board, will be formed to direct and monitor the implementation plan for delivering the improvements.
- The vision described above is communicated as widely as possible to the general public, our staff, patients and their carers.

Appendix 1

Standard 1:
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.

Standard 2:
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital. Supporting information:

- All patients 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.
- 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.
- Standards are not sequential; clinical assessment may require the results of diagnostic investigation.
- 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.
- 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.

Standard 3:
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.

Standard 4:
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.

Standard 5:
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.

Standard 6:
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

Standard 8:
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.

Standard 9:
Support services, both in the hospital and in primary ,community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken. Supporting information:

- Primary and community care services should have access to appropriate senior clinical expertise (e.g. via phone call), and where available, an integrated care record, to mitigate the risk of emergency readmission.
- Services include pharmacy, physiotherapy, occupational therapy, social services, equipment provision, district nursing and timely and effective communication of on-going care plan from hospital to primary, community and social care.
- Transport services must be available to transfer, seven days a week.
- There should be effective relationships between medical and other health and social care teams.

Standard 10:
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. 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.