NHS Improvement

Seven day hospital services: challenges and solutions

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Introduction

The seven day hospital services programme aims to ensure that patients requiring emergency treatment receive high quality, consistent care every day of the week. The programme centres on delivering the 10 clinical standards,[1] with four standards identified as priorities.[2]

Trusts from across the country shared successes and challenges at five regional events organised by NHS Improvement and NHS England. These events showcased solutions to the challenges of implementing seven day hospital services from several trusts of varying sizes. Delegates also had the opportunity to share their experiences, in small group sessions. Key learning themes emerged, some common to all regions. This document describes key challenges and practical solutions that trusts identified. For more information about seven day hospital services and the support available, please email: nhsi.medicaldirectorate@nhs.net

[1] https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/
[2] https://improvement.nhs.uk/resources/seven-day-services/

Challenge 1: implementing Clinical Standard 2 – time to first consultant review

For many trusts, delivering Standard 2 has proved particularly challenging. Several regional events dedicated entire discussions to this standard – to the specific barriers to implementation and how trusts might overcome them.

Challenges

- Many trusts believe they comply with Standard 2 in practice but that inaccurate documentation lets them down. This includes failure to accurately record the time of review and/or sign clinical entries so that consultant review is identified.
- Barriers to achieving good documentation include time pressures on clinical staff and a wider cultural view that directly delivering patient care takes precedence over recording its details.
- Timely consultant reviews of patients who arrive late in the afternoon or early evening are particularly challenging.
- Many trusts reported that live **activity and compliance** data would help them identify patterns of non-compliance and enable them to undertake locally driven improvement solutions.
- Several trusts reported problems with recruiting to consultant and middle-grade rotas, particularly in care-of-the-elderly departments. This, and problems with effective frailty management of elderly patients in emergency departments (EDs), can lead to bottlenecks of medically fit patients and reduced patient flow.
- Some trusts highlighted the conflicting challenge of prioritising those with the most pressing and immediate clinical need, against time elapsed since

hospital admission when deciding which patients to review first on a post-take ward round.

Solutions

- Data on patient flow and meeting seven day hospital services standards must be shared with local teams. This can encourage them to take responsibility for solutions, and help responsive and innovative improvement.

- Organisations need to consider how they can free staff to complete documentation, or provide support (eg using physicians' associates) to maintain documentation standards.

- Several trusts provided free stamps to staff, electronic record systems and standardised ward round templates. These all improved the clarity of patient documentation, and enabled the lead clinician to be easily identified.

- Some trusts reorganised their local consultant workforce to meet Clinical Standard 2, as well as Clinical Standard 8. Suggestions included:

  - a single structured post-take ward round combined with ward rounds from 8am to 7pm and daily teaching board rounds
  - multiple post-take ward rounds

Salisbury NHS Foundation Trust has an older people's assessment liaison (OPAL) team in ED and the short-stay unit**.**

Great Western Hospitals NHS Foundation Trust employs a dedicated consultant for outlier patients.

The Royal Wolverhampton NHS Trust has consultants present until 10pm seven days a week, and has evening ward rounds to complement morning rounds in surgery, cardiothoracics, cardiology and gynaecology**.**

Salisbury NHS Foundation Trust removed subspecialties from the general medical rota and provides distinct specialty presence on wards seven days a week, integrated into consultant job plans.

Royal United Hospitals Bath NHS Foundation Trust deploys geriatricians at the front door to enable rapid discharge and facilitate admission avoidance. **Portsmouth Hospitals NHS Trust** is trialling this in Q3 and Q4 2017/18**.**

Calderdale and Huddersfield NHS Foundation Trust modified its surgical consultant rota to provide twice-daily ward rounds and night-time cover. This improved surgical outcomes and mortality.

for medicine – known as ‘continuous rounding’
  - separate takes and rotas for adult medicine and care of the elderly
  - using a ‘consultant of the week’ model for general surgery.

- Sometimes effective community and primary care management of patients can reduce unnecessary admissions.

- Trust policies can enable on-call consultants who have clerked or reviewed newly admitted patients to recommend when the parent team needs to conduct the patient’s next review, and contact them immediately if this is within 24 hours. This prevents unnecessary duplication of clinical time and enables trusts to put more resources into the on-call take.

- Several trusts use risk stratification and prioritisation tools. These enable clinicians to decide which patients need to be seen first based on a combination of time elapsed since admission and immediate clinical need.

- Trusts need to emphasise the added clinical value of prompt consultant reviews, including facilitating discharge and rationing investigations.

- Electronic solutions include real-time dashboards and virtual whiteboards to track patients throughout their stay and make it easier for clinicians to identify help in meeting the standards.

- System-level approaches include:
  - arrangements between neighbouring trusts and the local ambulance service to monitor accident and emergency (A&E) pressures and direct new admissions to sites with greatest capacity
  - amending the timings of GP home visits so that referred patients arrive at hospital earlier in the afternoon

The Newcastle upon Tyne Hospitals NHS Foundation Trust uses an electronic review system to identify patients needing to be reviewed, based on length of time in hospital and clinical need identified by a consultant**.**

Homerton University Hospital NHS Foundation Trust introduced electronic whiteboards with early warning scores, live patient locations and information on nursing and therapy needs.

– a consultant connect service in many trusts, to give GPs telephone advice on appropriate management and investigations, avoiding unnecessary acute admissions.

Guildford and Waverly Clinical Commissioning Group (CCG) focuses on care homes and high intensity users to reduce admissions.

Challenge 2: understanding Clinical Standard 2 – time to first consultant review

Challenges

- Some trusts felt it was unclear whether the standard applied to all patients, for example:
  - medically fit patients awaiting a package of care
  - patients who had been reviewed and placed on a management plan by a senior registrar
  - patients on well-defined clinical pathways that do not normally require a consultant review.
- Many trusts were not confident whether the 14-hour window should begin at the point of arrival at ED, at the decision to admit, or on arrival at an inpatient ward.
- Some trusts were unsure whether the standard required a specialist consultant to review all patients, or if an initial generalist review would be sufficient.

Solutions

- Where a consultant reviews a patient and then decides to admit – for example, during an outpatient clinic – this automatically meets the standard.
- Patients with a clear diagnosis, on a well-defined pathway, may have their clinical care delegated from a consultant to another clinician (not necessarily another doctor) in these circumstances:

  - the pathway follows a clear written local protocol agreed within the trust clinical governance system and supported by commissioners
  - this protocol describes actions in the event of clinical concern, including robust and rapid escalation to a consultant where appropriate
  - the patient's care is still recorded as being under a named consultant for the purpose of clinical governance (NB this specifically excludes patients on midwife-led care pathways).

- Trust should refer to the latest *Seven day services clinical standards*,[3] updated September 2017, which include comprehensive guidance that states:

  - the review must take place within 14 hours of admission.
  - all emergency admissions should be considered, irrespective of route; this includes admissions via radiology, consultant clinic or a direct admission to the acute medical unit (AMU).

- A suitable consultant is a doctor who has completed all their specialist training and has a certificate of completion of training or equivalent. They should be trained and competent in dealing with the emergency and acute presentations concerned, and be able to initiate a diagnostic and management plan.

- Trusts must make local decisions that conform with this guidance. This may include increasing the number of formal protocol pathways in operation, enabling consultants to concentrate on, and dedicate more time to, complex patient cases.

- Where a dedicated specialty team looks after patients, consider whether a generalist could review them initially, with specialist input as required.

[3] https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/

Challenge 3: job planning

Deploying consultants effectively to provide good quality, safe services at a team or departmental level relies on rigorous job planning. Job plans should include clear objectives as well as adequate time to undertake clinical and non-clinical responsibilities – for example, one trust department's initial review of job plans identified that no programmed activities (PAs) were allocated for consultant ward rounds. Job plans should be available in a form which facilitates review, ie electronically.

Many organisations highlighted that job planning could become a continuous year-round process and not simply an annual event. Trusts can refer to the latest NHS Improvement consultant job planning guidance.[4]

Challenges

- A workforce with many subspecialties but few generalists can find it difficult to provide a seven day service. Trusts must consider the consultant workforce's skill mix, as well as any additional training required.
- Trusts with significant consultant vacancies may find job planning particularly challenging. Those with a significant proportion of older consultants expressed concern that reconfiguring work patterns risked staff attrition.
- Some trusts were unsure how to train clinical managers to undertake effective job planning and how best to reconfigure job plans mid-year.
- Trusts should use reconfigured consultant work plans as an opportunity to maintain and improve a good educational experience for their trainees.
- Trusts will need to balance acute cover needs with impact on elective care referral to treatment times.

[4] https://improvement.nhs.uk/resources/best-practice-guide-consultant-job-planning/

- Many trusts felt traditional professional barriers prevented them releasing senior clinical time by transferring workload from consultants to other colleagues.
- Trusts had specific concerns about how to recruit to roles with many PAs.
- Trusts must consider the implication of future contract changes on the cost and feasibility of new working patterns.

Solutions

- Job planning should occur at departmental level. Increasing numbers of trust mergers and network working may result in more job plans which cross trust boundaries. In each instance job plans should reflect shared objectives and the job planning process should align with the trust's business planning process.
- Staff should feel they own new ways of working. Accountable and transparent systems promote greater engagement and trust from the consultant body.
- Recommended measures include medical job plan consistency committees, and sharing job plan policies and templates at sustainability and transformation partnership (STP) level.
- Job planning should be supported by data (eg patient-level costing (PLICS) or Model Hospital data) and ideally by software systems.
- Emergency and acute work should be prioritised when reforming job plans.

University Hospital of Leicester NHS Trust uses department-level job planning.

East and North Hertfordshire NHS Trust introduced a new job planning policy after reviewing policies across its local region.

Northumbria Healthcare NHS Foundation Trust increased directed teaching through a stronger consultant presence and integrated this into job plans.

Imperial College Healthcare NHS Trust employed an additional pharmacy technician to free senior pharmacists to address complex issues, resolve reconciliations and improve on-ward dispensing to 95%.

- Some trusts cap job plans at 12 PAs alongside an exception/approval system overseen by senior managers.

- Junior and middle-grade roles can be made more attractive through clinical fellowship, research and leadership opportunities.
- Multi-site organisations need to reduce barriers to staff moving between sites. This may include reducing discrepancies in IT access, equipment availability or log-ins and badges.
- Several organisations use a clinical director, business manager and nurse when devising job plans. Involving other health professionals in discussions on approach and strategy may help identify tasks that other members of the multidisciplinary team (MDT) can do.
- Several trusts created clearly defined job roles to free clinical time of senior staff. This includes:
  - medical support workers
  - therapy assistants, to improve the capacity of physiotherapists/occupational therapists
  - apprenticeships for clinical support workers.
- Some organisations modified existing job roles to help deliver seven day hospital services. Strategies include:
  - pooling ED and AMU consultants to share rotas across emergency care
  - integrating weekend discharge team responsibilities into consultant job plans
  - explicitly outlining ward round responsibilities and providing protected time in consultants' job plans.

Northern Devon Healthcare NHS Trust used intelligent data analysis to predict health demands. This led to a review of consultant job plans to identify gaps and solutions to delivering a seven day acute medicine service.

Derby Teaching Hospitals NHS Foundation Trust used job planning to recognise that senior decision-makers need an MDT to enact management plans. This includes junior doctors, advanced care practitioners, therapists and pharmacists.

Surrey and Sussex Healthcare NHS Trust uses therapy assistants as part of its seven day therapy ED model. It is now piloting this approach on acute medical wards.

University Hospital Southampton NHS Foundation Trust ensures all new consultants have one PA designated for out-of-hours (OOH) care.

Challenge 4: winning hearts and minds

Delivering seven day hospital services requires a flexible culture focused on patient outcomes. Organisations should consider novel clinical roles and new working patterns – inter-organisational network working as well as innovations – to further the work of their staff.

Walsall Healthcare NHS Trust allocates dedicated time in the clinical director's job plan to liaise with the operations team and understand the interdependencies of individual staff job plans.

Ensuring the clinical workforce's commitment is essential. All staff, not just consultants, should be included in this engagement process, but it is likely that different staff groups will need to be engaged in different ways. Across several events, many delegates suggested framing seven day hospital services as a patient care priority and operating from a principle of continuous service improvement. When suggesting how to engage trusts to make seven day hospital services an organisational priority, many delegates discussed how such services benefited patient flow and the use of hospital resources, as well as how they can help achieve other organisational targets (eg the four-hour A&E target).

Challenges

- A major barrier to engaging nurses and junior doctors is a continuing lack of awareness of the four priority clinical standards.
- Some trusts reported that consultants are still not convinced the priority clinical standards affect their patient care.

Torbay and South Devon NHS Foundation Trust moved staff meetings to day time and offered staff a chance to vote on rota options as well as method of reimbursement.

- Specialty consultants often feel the standards do not apply to them, and the nature of their clinical caseload means patients sometimes do not require daily review.

- Several trusts found it difficult to motivate staff who were already heavily stretched.
- Many organisations felt there was a lack of broader engagement at STP level.
- Failure to win hearts and minds can lead to poor quality documentation, limited clinical input into audit, and consequently weak seven day hospital services survey performance.

Solutions

- Organisations, locally and centrally, need to present the standards' benefits and emphasise patient experience and hospital flow.
- Trusts must translate national messages into a local vision that reflects staff values.
- Positive examples from individual trusts include starting this process with an initial engagement meeting or appointing senior individuals as seven day hospital services champions.
- Seven day hospital services can be integrated with existing trust programmes: for example, patient safety groups. This should minimise bureaucratic burden, and ensure consistency of leadership.

Salisbury NHS Foundation Trust ran two workshops to engage consultants, focusing on seven day hospital services as quality measures, not operational measures.

Torbay and South Devon NHS Foundation Trust's deputy medical director and clinical director for medicine are involved in seven day hospital services work as trust champions.

Maidstone and Tunbridge Wells NHS Trust has a designated clinical lead and project management support for seven day hospital services following leadership support and direction from its medical director.

North Tees and Hartlepool NHS Foundation Trust is developing a communication strategy and planning raising awareness roadshows targeted at all staff groups, supported by its communications team.

- Organisations should share and promote positive stories where networking and new working patterns have been successfully implemented. These can be showcased on the online Improvement Hub.[5]

- Cultural barriers to clear, legible documentation may be addressed by reviewing clinicians' documentation during appraisals.

Homerton University Hospital NHS Foundation Trust improved documentation standards through dedicated engagement sessions with clinical staff.

[5] https://improvement.nhs.uk/improvement-hub/

Challenge 5: clinical handover

The four priority standards are among 10 national clinical standards for seven day hospital services. Effective clinical handover is essential to achieve the four priority standards and is also the focus of Clinical Standard 4.

Challenges

- Many felt there was no objective method to define an effective handover and this is a challenge to making evidence-based improvements.
- Clinical teams often disagree on patient diagnosis. Even when they do agree, the most appropriate patient care pathway may be debateable.
- Patient journeys can include multiple assessments that may overlap or duplicate.
- Handover may not clarify which patients require consultant review. This leads to discrepancies between documented and delivered clinical plans.
- Different specialties and different grades within the same specialty often undertake handover at different times. This undermines consistency of clinical care between teams.
- Planning the weekend clinical management of every patient on Friday can be challenging.

Oxford University Hospitals NHS Trust hosts information on OOH services and referral pathways on the intranet.

North West London CCGs implemented a single agreed assessment-for-discharge process.

University Hospital Southampton NHS Foundation Trust developed in-house an IT solution that includes electronic prescribing, activity dashboard and an electronic SBAR (situation, background, assessment, recommendation) handover tool.

Solutions

- Several trusts used standardised formats, proformas and checklists for safe handover.
- Electronic systems can identify the sickest patients and enable automatic escalation of clinical care. This should reflect the services and resources available at the trust.
- Trusts should empower departments to work collaboratively to define referral processes and criteria.
- Some trusts suggested using networks to manage specialist patient take lists. This would mean specialist clinicians covering multiple sites.
- Measureable data, particularly mortality data, can support business cases for technology and other resource investments.

Ashford and St Peter's Hospitals NHS Foundation Trust introduced Friday handover sheets for patient case notes. These include the weekend plan, required investigations and expected review requirements for the weekend.

Challenge 6: workforce constraints

NHS staff are key to achieving seven day hospital services, and organisations should empower them to set their own rotas and have more control over local delivery. The push for specialist input should not solely focus on consultants but include other staff groups – for example, clinical nurse specialists – that add much of the value of specialist care. Additional consultant posts have to be balanced with using resources in alternative ways.

For example, several trusts felt investing in additional consultant posts would not improve clinical outcomes. In these instances, patients were already well-served by specialist multidisciplinary teams supplemented by daily consultant cover via ward rounds or on-call arrangements.

Challenges

- Working preferences across all staff groups have changed in recent years. This adds greater complexity to job planning.
- If traditional roles are broken down, a clear system of assuring competencies will be needed.
- Extended services such as seven-day therapies will take significant time to implement.
- Wider healthcare training factors (eg reducing nursing bursaries) will affect recruitment and staff numbers.

Northumbria Healthcare NHS Foundation Trust puts frontline prescribing pharmacists in A&E as well as outpatients.

Imperial College Healthcare NHS Trust recently increased therapists and senior nurses at weekends to drive discharges, as well as adding a pharmaceutical technician in AMU to speed up discharge medication.

London North West Healthcare NHS Trust employs pharmacists to prepare discharge medications. This reduced dispensing errors, improved staff satisfaction and reduced patient length of stay.

The Leeds Teaching Hospitals NHS Trust uses 'Kaizen'-based service improvement methodology designed to enhance productivity and efficiency. It has established a specific value stream to improve access to senior decision-makers in acute medicine, reduce interruptions during medical clerking and trial a multidisciplinary clerking team.

Solutions

- Enabling staff to retain some control over reconfiguring their working patterns helps engagement, retention and future recruitment.
- Organisations must understand the gaps in their service, how alternative care models can address these, and the training required for the workforce to gain the necessary skills.
- NHS England has produced case studies[6] on how seven day pharmacy services can help achieve the standards.
- Several new care models were showcased and well received. These included nurse-trained social workers.
- Ambulatory care can help achieve the standards and improve hospital flow and patient experience.
- Several trusts would value access to off-the-shelf business cases that other organisations had used successfully. These should include:
  - a summary of the proposed intervention
  - the resources this could free
  - how these newly available resources could improve patient care.

Manchester University NHS Foundation Trust's Wythenshawe Hospital site has a surgical ambulatory care receiving unit, which reduces GP referrals to ED, fast-tracks self-presenting patients, reduces unnecessary admissions and facilitates discharges.

University Hospital Southampton NHS Foundation Trust introduced a lead consultant for OOH care and a branded OOH team rostered from 4pm to 8am.

Salisbury NHS Foundation Trust focused heavily on ambulatory care pathways, with 30% of medical patients and 50% of surgical patients managed in this way. Pathways also exist for venous thromboembolism (VTE) clinics and gynaecology emergencies as well as plastics and trauma.

[6] https://www.england.nhs.uk/wp-content/uploads/2016/09/7ds-clinical-pharmacy-acute-hosp.pdf

Challenge 7: reconfiguring and networking services

Economy, efficiency and effectiveness of services can be improved by implementing networks across neighbouring trusts, STP patches or possibly a larger scale if appropriate. Many networks already exist for historical reasons, while most trusts have informal arrangements for specialty referrals and advice.

Challenges

- It is often unclear which specific service 'gaps' are best solved through networks.
- Trusts felt confident about creating networks within their own multi-site organisations but often felt they had insufficient knowledge or resources to set up networks across multiple trusts.
- Specific network arrangements bring significant resource challenges. For example, limited staff numbers are a barrier to effective network working in ultrasonography and echocardiography, while both staff numbers and equipment availability are key concerns in establishing effective interventional radiology networks.
- Different policies and unfamiliar equipment can impede integrated networks and result in services that feel fragmented.
- Networks need to consider patients' or carers'/relatives' travel arrangements, particularly in rural areas.

Colchester Hospital University NHS Foundation Trust and **The Ipswich Hospital NHS Trust** are considering a merger, and have a combined clinical board delivering their network services. Senior visibility and clinical leadership play a valuable role in reducing uncertainty about what the merger between the trusts means.

Bedford Hospital NHS Trust and **Luton and Dunstable University Hospital NHS Foundation Trust** work closely in various clinical services. In September 2017 the boards agreed to pursue a strategic alliance bringing both Trusts into a single organisation delivering a full range of services in 2018. The move has the STP's support and aligns with regional strategic objectives.

Solutions

- Successful clinical networks require effective clinical leadership, dedicated manager time, administrative resources and clearly defined incentives for individual providers.
- Some networks exist informally. Many trusts could formalise these simply through published protocols, with regional support.
- Many trusts suggested an STP-level forum, where specialty clinical leads can agree network configurations, have honest system-level discussions and disseminate best practice between providers.
- Getting It Right First Time[7] is an important initiative to reduce variation in trusts' policies and remove it as a barrier to network working.
- The Emergency Care Improvement Programme[8] is effective at sharing practical support among organisations. Many trusts would value a similar forum for seven day hospital services best practice.
- Electronic systems, data sharing and integrated IT across a region can promote effective collaboration. They are already used in telestroke and out-of-hours CT reporting.
- Clearly agreed protocols for efficiently 'repatriating' patients between acute providers are needed.
- Trusts should take account of patient perspectives when planning their networks. Some trusts have patient representatives in their working groups.
- CCG-level gap analysis of providers would give trusts system-level insight into how to structure services differently to improve patient flow.

Working Together is an innovative partnership between seven hospital trusts in **Yorkshire and Derbyshire** and is piloting managed networks in several clinical areas. Benefits include reduced variance in quality and safety and development of workforce solutions.

The Royal Wolverhampton NHS Trust uses transfer protocols with the Black Country STP with great success.

NHS Somerset CCG meets quarterly with acute providers to agree gap analysis and understand progress towards delivery plans. The A&E delivery board oversees delivery across the CCG.

[7] http://gettingitrightfirsttime.co.uk/
[8] https://improvement.nhs.uk/improvement-offers/ecip/

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