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Board Assurance Framework for Seven Day Hospital Services

Guidance for Providers of Acute Services

Version 2, 8 February 2022

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Contents

Introduction

This updated Board Assurance Framework reduces internal data collection burden for Trust Boards, compared with the previous BAF that was more extensive and detailed, and had to be uploaded twice yearly to a national portal.

1.1 The Seven Day Hospital Services Clinical Standards

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services 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:

NHS England » Seven Day Services Clinical Standards

The importance of ensuring that patients receive the same level of high quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. Delivery of the 7DS clinical standards should also support better patient flow through acute hospitals. The standards have been reviewed in 2021 by a clinical reference group that confirmed they remain relevant and important in the NHS today.

Measuring Delivery

2.1 Measuring 7DS delivery

Provider Boards should assess at least once a year whether their acute services are meeting the four priority 7DS clinical standards by using the Board Assurance Framework described below. Providers should be ready to demonstrate their performance against the four priority 7DS clinical standards to their commissioners and to their regulators.

2.2 Principles and process of board assurance of 7DS delivery

A 7 Day Services report signed off by the Executive Medical Director should be presented to the provider Board at least once a year. A proposed framework for this report is included at Appendix 1. The content for this report can be drawn from the following sources.

A) Sitrep. The primary source of data regarding acute patient flow through the hospital is the daily sitrep. If your sitrep shows that LOS and number of discharges do not vary significantly between weekdays and weekends, then it's likely that you are running your acute services efficiently. In contrast, if LOS is longer for admissions on Thursdays and Fridays, and number of daily discharges drops on Saturdays and Sundays, then it's likely that your services have a lower level of consultant cover at weekends, lower multi-professional team provision at weekends, and/or that community and social care services are less able to take transfers of patients at weekends. You should consider a deep dive to understand this variation better and mitigate it.

B) Consultant job plans. For each acute specialty consultant job plans should be reviewed to ensure that there is sufficient timetabled consultant time to meet the anticipated demand from emergency admissions. The term consultant in this context includes all doctors on the GMC Specialist Register, those who have achieved a Certificate of Completion of Training (CCT), and for the purpose of providing 7 day services, has been broadened to also include doctors in the new specialist grade (but not Specialty Doctors or other SAS grades). The precise level of consultant presence required to deliver these standards is for the provider to assess locally rather than being specified centrally, as each organisation has its own requirements.

- Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

- Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.

- Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.
- Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) 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.

In addition to the requisite level of consultant presence to deliver standard 8, 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 (NEWS2)
3. A clear process to decide which patients do not need a daily consultant review and the proportion of admitted patients in this category.

There will be some trusts where there are insufficient consultants in a specialty to meet Standard 8. In this case while the standard remains as an aspiration, the Executive Medical Director may grant a derogation to allow the inclusion of Specialty Doctors and doctors in higher specialist training at ST4 and above to provide some of the daily ward rounds. Nevertheless there should be consultant ward rounds on at least 4 days a week including at least 1 weekend day. Such derogations should be specialty-specific and be reviewed at least annually. They are at the discretion of the Executive Medical Director, should be reported to the Board, and should be reconsidered if patient safety issues cause concern in that specialty.

C) Deep dives. Where the daily sitrep suggests significant variation by day of the week or where the Executive Medical Director has granted a derogation from clinical standard 8, the Board should consider authorising a deep dive into any area of concern regarding 7 day services. Deep dives should typically be in the form of

an audit and should report to the Board the percentage of patients within the audit for whom the relevant standard was met. For standards 2 and 8 where an electronic patient record is in place this may enable such an audit. Without an EPR an audit is likely to need case note reviews to ascertain which doctor saw each patient at what time. Using a snapshot or a sampling approach may enable such an audit to be done without excessive administrative burden. 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 such audits must examine whether consistent levels of service are being provided seven days a week.

D) Wider performance and experience measures. Wider sources of qualitative information that may reflect delivery of the 7DS clinical standards could be used. These include:

- 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
- Audits of staffing levels and activity related to 7DS as recommended by the Royal College of Physicians' *Guidance on safe medical staffing*[1]

2.3 7DS Standards for Continuous Improvement

All 10 7DS clinical standards contribute to the delivery of consistently high quality care and patient experience. Providers have the option to review their performance against the other six 7DS clinical standards and report on this in a narrative format in their 7DS Board report. Integrated Care Boards may wish to consider Clinical Standard 9 as a means to evaluate the system-level implementation of 7 day services.

Below is a guide to the type of evidence providers could use for each of the remaining Clinical Standards if they wish to reflect these in their Board report.

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.

[1] *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

Clinical Standard	Evidence to support assurance of progress
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.
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.

2.4 External assurance

The Care Quality Commission's (CQC) current hospital inspection regime features 7DS under the effective key question. 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. As its new regulatory model is developed, CQC will consider how a trust's performance against the 7DS CQC will be incorporated going forward.

Clinical commissioning groups (and where relevant Specialised Services commissioners) also play a role in providing external assurance of 7DS delivery. Completion of the 7DS board assurance process is a requirement of the NHS Standard Contract. Delivery of the four priority standards features in the contract under 'Service Condition 3'.

Integrated care systems will have a particular interest in the delivery of 7 day services to improve emergency patient flow. There is an opportunity for system-wide transformation, especially using Clinical Standard 9 to deliver 7 day services across a local system, not just in hospitals.

Appendix: Suggested framework for Board report on 7 Day Services

Please use these prompts to frame your Board report on 7 Day Services and to discuss with regulators when asked.

1) The daily hospital sitrep shows significant variation in LOS associated with the day of the week patients are admitted. Yes/No
2) The daily hospital sitrep shows significant variation in the number of discharges by day of the week. Yes/No
3) Job plans for consultants in all acute specialties provide scheduled on-site consultant cover every day that reflects the likely demand for that specialty. Yes/No
4) The template below shows the level of compliance with Standard 5 regarding 24/7 access to these emergency diagnostic tests:

Emergency diagnostic test	Available on site at weekends	Available via network at weekends	Not available
USS			
CT			
MRI			
endoscopy			
echocardiography			
microbiology			

5) The template below shows the level of compliance with Standard 6 regarding 24/7 access to these emergency consultant-led interventions:

Emergency intervention	Available on site at weekends	Available via network at weekends	Not available
Intensive care			
Interventional radiology			
Interventional endoscopy			
Surgery			

Renal replacement therapy			
Radiotherapy			
Stroke thrombolysis			
Stroke thrombectomy			
PCI for MI			
Cardiac pacing			

6) If the answers to questions 1,2 or 3 above are 'No' please provide evidence here from suitable deep dive audits on relevant specialties to demonstrate the level of compliance with Standard 2 and Standard 8.
7) The Executive Medical Director has approved derogation regarding Standard 8 for the following specialties.

   List the specialties and the details of the derogation here. Note such derogations should be reviewed at least annually and examined in relation to any relevant patient safety issues.
8) Narrative section to include any other aspects of 7 day services to draw to the Board's attention
9) Action plan section to describe the key actions being undertaken to address issues identified in sections 1-8.

Supporting Information

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

- NHS England website (NHS England » Seven Day Hospital Services)
- Case studies (NHS England » Resources)