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East Midlands Clinical Senate

East Midlands

7 Day Services project

Acute Collaborative Report

November 2014

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The moral case is clear and unquestionable: all patients (and their carers) deserve consistent, high-quality care 7 days a week. Whether – and how quickly – we recover from a period of ill health may be influenced by many things, but should not be due to the time of day or day of the week that we need care. This is about ensuring patient safety, but it is more than that: it is about delivering the care that we would like our mother, or anyone dear to us, to have. The question for those of us responsible for delivering health care is how we, and our partners across the health and care system, can respond to and meet the challenge of 7 day services at a time of increasing demand, financial austerity and pressures on our workforce. The national clinical standards for urgent and emergency care and supporting diagnostics provide a really useful, evidence-based foundation from which to start. There are many things that we can do within our own organisations, but the real challenges will require a system response underpinned by cultural change and ongoing clinical leadership. This project has helped each of the acute trusts within the East Midlands understand where we are now, where the real challenges lie and where we can work together. We need to work together to make 7 day services a reality. It will not be achieved over night, but it will be achieved faster and be more sustainable if we work together to identify solutions, learn from each other and keep our people at the heart of our decisions.

Gavin Boyle
Chief Executive, Chesterfield Royal Hospital NHS Foundation Trust

Clinical Senates have been established to provide clinical leadership and to be the clinical conscience and guiding intelligence for complex clinical issues. The East Midlands Clinical Senate have been involved in a number of strategic reviews and it is clear that projects could have progressed further and faster if there had been a clearer, more collaborative approach between provider organisations. It was with this in mind, the Clinical Senate has been pleased to support this proactive project and development of a community of practice within the East Midlands. Each of the participating organisations has a separate more detailed report, which we hope will underpin local plans and individual health community discussions. This report is intended to highlight the overall scale of the challenge, the opportunities for resolution and learnings for others. Although this project was acute focused we hope that it usefully informs local planning and commissioning decisions. We recognise that this is that start of a journey to ensure delivery of high quality, sustainable services for all 7 days a week. East Midlands Clinical Senate is committed to continuing to support commissioners to make the best decisions about health care for the populations they serve.

Dave Rowbotham
Nigel Beasley
East Midlands Clinical Senate co-chairs

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Acknowledgements

A significant number of stakeholders from across the region have been involved in this initial phase of the project. Drawn from a wide range of professions and grades, everyone approached has provided valuable challenge and input into the development of the baseline assessment, the gap analysis against the 7 day services clinical standards and the preliminary recommendations.

The list of key stakeholders who have contributed to this report are included at Appendix A.

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1 Executive summary

Patients need the NHS every day and as such the delivery of consistently high-quality care 7 days a week is one of the biggest challenges facing the NHS. Commissioners and providers are committed to making 7 day services a reality within a challenging national timeframe.

The 7 days services agenda is clear: to end unacceptable clinical variations for patients admitted to hospital regardless of time or day of admission. Data analysis on this project has highlighted the link between day of admission and outcome for patients in the East Midlands.

While consistent 7 day service provision is a huge challenge, it can be an important lever to address deep-rooted, common and prevailing issues in service delivery. It can also be a driver for realising the long-term vision for more integrated, patient-focused care.

In early 2014, the ten East Midlands acute trusts (the Collaborative) embarked on an unprecedented data-gathering exercise to look at current provision against the ten 7 day services clinical standards for urgent and emergency care and supporting diagnostics, assess the gaps, and identify opportunities for filling those gaps in the short and longer term. Significant time was spent engaging broad range of clinical and non-clinical staff to develop a shared understanding of the ten clinical standards and their implications.

While each trust has produced its own report into gaps in service and how to fill these, this report highlights the strategic and operational opportunities and areas of current good practice. It is intended to inform further discussion between commissioners and providers to identify solutions, and deliver robust, consistent care to patients every day of the week.

Delivering 7 day services is a system-wide issue. This collaborative report is intended to inform wider planning to improve access to NHS services. Making 7 day services work in the acute trusts will be highly dependent on corresponding improvements across the community, primary, mental health and social care services.

1.1 Measuring clinical outcomes

Evidence shows that the limited availability of some hospital services at weekends has a detrimental impact on outcomes for patients, including raising the risk of mortality, re-admission and the length of stay. The Keogh Review, NHS Services 7 days a week Forum, December 2013, crystallised this by identifying an 11% increased risk of mortality for emergency admissions on a Saturday and a 16% increased risk for emergency admissions on a Sunday. This project has taken account of clinical outcomes data provided by each organisation during the baseline assessment of current provision against the requirements of the ten standards. However, this cannot be directly compared with the overall mortality indicators used nationally in relation to urgent care standards.

The national comparator available is from the published Summary Hospital-level Mortality Indicator (SHMI) data from NHS England. The latest version is for April 2013 to March 2014 (published on 23 October 2014). This indicates a mortality rate of 1.9% above expected rates across the East Midlands collaborative. Within the region however, there is significant variation ranging from 9% below the expected rate to 9% above the expected rate, with three acute trusts within the Collaborative at 5% or higher than the national expected rate. The data is not separated between weekdays and weekends and is therefore of limited value when trying to compare these rates with the 11% and 16% challenge set out in the Keogh review. Critical differences to note between the SHMI data and the data available at East Midlands regional level through Hospital Episode Statistics (HES) is that the national rate excludes specific urgent admissions (for example patients admitted on a palliative care pathway). In addition, it looks at mortality rates up to 30 days after acute discharge. More detail on clinical outcomes is in Section 6.5.

1.2 Closing the gaps to 7 day services

Closing the gaps between current provision and consistent 7 day services requires organisations to be innovative, cooperative, and bold in their thinking. There is a need constantly to challenge the status quo – particularly where workforce and funding issues are concerned.

Each individual trust report incorporates the site-specific data, examines local challenges and opportunities to close the gaps between current provision and the requirements of each clinical standard (CS). The consolidated dashboard below paints a common picture across East Midlands with key shortfalls primarily against those standards that are more reliant on the wider health and social care system. It also points to significant variation in availability and operational constrains of support services.

The detail behind this dashboard (and outlined in this report) takes account of the data capture and analysis by the ten trusts within the timeframe available. It also illustrates the collective challenge, together with three broad levels of options and opportunities to close the gaps:

- **Operational** opportunities to close the gaps at trust and site level
- **Tactical** opportunities for trusts to work together to close gaps at a regional level
- **Strategic** partnerships and collaborative relationships with commissioners and providers in the economy, and other health and social care partners within and outside of the region.

These are intended to inform further discussion between commissioners and providers to help identify solutions for delivery of robust and consistent care to patients every day of the week.

Figure 1: Current baseline position of each clinical standard (CS)

	Chesterfield Royal	Derby Hospitals	Kettering General	University Hospitals Leicester	North Lincs & Goole	Northampton General	Nottingham University	Peterborough & Stamford	Sherwood Forest	United Lincs Hospitals	**Average across Trusts**
Clinical Standard 01 **Patient Experience**	67.4%	75.3%	65.6%	64.6%	76.5%	76.3%	64.9%	78.5%	57.7%	75.3%	69.4%
Clinical Standard 02 **Time to 1st Consultant review**	50.1%	44.6%	73.8%	43.4%	59.0%	53.9%	66.9%	53.0%	64.1%	71.5%	57.4%
Clinical Standard 03 **Multi-disciplinary Team Review**	42.0%	47.6%	51.7%	51.5%	49.7%	48.3%	53.7%	53.1%	35.5%	57.3%	49.3%
Clinical Standard 04 **Shift Handover**	68.6%	74.2%	71.8%	75.2%	86.6%	74.6%	75.3%	71.4%	60.4%	76.6%	73.3%
Clinical Standard 05 **Diagnostics**	67.8%	65.1%	61.9%	51.9%	67.8%	73.4%	55.9%	55.6%	67.5%	52.8%	61.3%
Clinical Standard 06 **Interventions/Key Services**	44.0%	61.7%	42.5%	70.9%	37.8%	58.2%	48.9%	38.2%	39.8%	56.8%	52.4%
Clinical Standard 07 **Mental Health**	48.8%	58.4%	34.1%	28.2%	46.6%	44.9%	26.7%	21.7%	54.3%	53.0%	42.4%
Clinical Standard 08 **On-going Review**	35.9%	44.8%	52.8%	50.1%	41.4%	47.2%	61.1%	47.3%	54.9%	61.9%	49.8%
Clinical Standard 09 **Transfer to Primary, Community and Social Care**	39.2%	47.2%	49.2%	64.0%	46.9%	37.5%	44.2%	52.7%	42.3%	45.1%	47.3%
Clinical Standard 10 **Quality Improvement**	35.8%	45.5%	65.5%	62.6%	18.4%	53.4%	72.3%	63.2%	54.7%	74.6%	55.6%
Average across Standards	50.2%	55.4%	57.9%	56.9%	53.9%	56.9%	60.3%	54.0%	53.5%	63.7%	56.4%

Definition of RAG: Red= <50% across 7 days; Amber= between 50%-70% across 7 days; Green= > 70% across 7 days

denotes clinical standards that have dependencies on key support services

denotes clinical standards that have dependencies on the wider system

Note: A detailed description of each standard is given in Section 6.4.

1.3 Targeting specialties and services

As part of the baseline assessment, the project included a detailed assessment at specialty and service levels which identifies the need to prioritise improvement activities in eight key specialties. These are: Ear, Nose and Throat/Head and Neck; General Medicine; General Surgery; Geriatric Medicine; Oncology; Ophthalmology; Trauma and Orthopaedics; and Urology. This would contribute to achieving the requirements of CS2 (Time to 1st Consultant Review), CS3 (MDT Review) and CS8 (On-going Review).

Clinical support services present some of the largest challenges for workforce availability across 7 days. Pharmacy and Therapies are highlighted as having recurring gaps.

1.4 Operational opportunities: tackling challenges at trust level

Making operational improvements will improve productivity, enhance patient care, and support achievement against the ten clinical standards. This report identifies short- and longer-term opportunities in the areas of process, workforce and Information Technology improvements. These can be integrated into trusts' individual planning processes and transformation programmes.

This report provides insight into where to target resources.

- The standards most achievable now at trust level are: CS1 (Patient Experience), CS2 (Time to 1st Consultant Review), CS3 (MDT Review), CS4 (Shift Handover), CS5 (Diagnostics) and CS8 (On-going Review) and CS10 (Quality Improvement).
- Medical specialties and support services such as Therapies and Pharmacy are not currently provided across all days or times required, resulting in significant impacts on operational services and patient outcomes.
- Specific examples of operational improvements include: achieving a better balance between demand and capacity across 7 days; reducing variation in how CS2 (Time to 1st Consultant Review) is measured; and ensuring that CS3 (MDT Review) is systematically and consistently documented across 7 days a week.

Other opportunities are:

- Developing a common solution for recording and reporting against the ten clinical standards which may include introduction of new systems or better integration of existing ones

- Improving recording against requirements of CS2 (Time to 1st Consultant Review) (e.g. consistency in recording NEWS score and the time of first review)
- Electronic recording of clinical handover and Multi-Disciplinary Teams
- Aligning demand and capacity for services such as mental health and social care where the majority of patients are seen but the timing is mis-aligned with the rest of the care pathway.

There are areas of good practice within each organisation (referenced in Section 6.4 of this report). Trusts need to build on and replicate these where appropriate as part of the operational improvements.

1.5 Tactical opportunities: working with other trusts and partner organisations

Even if all operational improvements listed in this and in trust-level reports were made, resources will be limited and trusts will need to decide if and how working with other trusts or partners could help close the gaps in service delivery long term.

It is likely to be unsustainable and potentially unnecessary for all trusts to deliver all services 7 days a week. Commissioners and providers need seriously to consider alternative models of service provision (for example in interventional radiology and endoscopy). This study shows that opportunities such as service and site rationalisation will have to be considered to help provide more consistent services across 7 days a week. This project has identified examples to evidence this point, such as lack of consistency in delivering Trauma services in some of the multi-site organisations.

Alternatively, this report highlights the need for network arrangements between trusts (where geographically feasible) to ensure sustainable access to high-quality care. This could be done by developing a larger pool of clinicians in specific specialties and/or services in order to deliver patient services with less variation across 7 days. Specialties with fewer than five consultants or suitable decision-makers, as per the clinical standards definition on a rota (particularly surgical specialties due to theatre commitments) could find it particularly challenging to achieve the requirements of CS2 (Time to 1st Consultant Review), CS3 (MDT Review) and CS8 (On-going Review). This project has highlighted specialties and services which have already started working on this approach.

Other tactical opportunities include:

- Creating the infrastructure for improving clinical teleconferencing and telemedicine capability to support redesign of decision-making processes (for example multi-disciplinary team (MDT) input, virtual first consultant review in appropriate specialties or conducting multi-disciplinary handover)
- Introducing new IT and information sharing systems, such as a shared clinical portal, to access primary and community care records to inform MDT review across 7 days consistently
- Developing an integrated health and social care MDT approach clustered around patient pathway and not constrained by organisational boundaries. This concept has proved effective, for example in specialties such as stroke and care of elderly (e.g. Adult Reablement Unit).

1.6 Strategic opportunities system-wide: delivering integrated systems

The baseline assessment has revealed that a number of specialties and supporting services would be at a point of failure in the context of 7 day services standards. Examples include interventional services for gastroenterology and radiology, diagnostics reporting within 24 hours, or urgent ultrasound provision within the suggested timeline of the standard. The root causes are availability of workforce either to manage the overall volume of demand and/or the ability to attend patient bedside within the required timelines.

Strategic solutions will need to be identified in the context of local transformation programmes and take into account the implications of the national Urgent and Emergency Care Review with its recommendations on service provision outside of hospitals, the designation of major emergency centres and the establishment of urgent and emergency care strategic networks.

A common set of solutions that should be considered to address these challenges in the medium to long term include:

- Working in partnership with Health Education East Midlands (HEEM) to better understand the overall, regional capacity requirements and to develop workable solutions to resolve these challenges

  This project has shown that there are significant capacity gaps, which prevents the achievement of CS2 (Time to 1st Consultant Review), CS3 (MDT Review) and CS8 (On-going Review) and which will require a radical approach to create alternative roles to deliver additional parts of the patient pathway. This will allow the limited Consultant time to be targeted where it is most needed to

maximise impact. For example, the balance of outpatient service delivery could move away from a Consultant-led model without compromising patients' care and in accordance with Royal Colleges guidelines

- Further progressing a networked approach to imaging.

1.7 Addressing workforce challenges: building the flexible workforce of the future

While services will need to be redesigned at operational, tactical and strategic levels to ensure the availability of workforce, a more fundamental culture shift is also needed to embrace the necessity to work across 7 days.

This project has identified three key areas in which to address workforce challenges:

- **Culture** – investing in clinical leadership to own and drive the fundamental changes to workforce models
- **Capacity** – particularly for small- to medium-sized DGHs, creating the right balance of specialisation and a more generalist workforce
- **Capability** – finding alternative ways to develop a more flexible and mobile workforce; for example, to be able to work across different organisations in sub-regional teams.

Working with HEEM, the 7 Day Services HR Directors Group and engaging with the Health Education England Emergency Medicine Workforce Implementation Group and supporting programmes, there are further opportunities to address common challenges. These include:

- Workforce planning process and clarity around roles, responsibilities and interfaces
- Influencing the overall training numbers in specific areas and contractual arrangements
- Collaborating on the common workforce actions across the East Midlands
- Agreeing 'East Midlands' workforce roles that work across acute organisation boundaries facilitating more East Midlands clinical pathways
- Developing and rolling out alternative workforce models such as provision of sonographers, reporting radiographers, consultant nurse endoscopists and advanced clinical practitioners. Timing of the implementation of these schemes will have to be aligned with the 7 day service year 2 and

3 commissioning intentions. Time needed for training will mean that new roles or increased numbers will take some years to appear in the workforce.

- Exploring the use of a common HR system (e.g. ESR) to better understand the skill mix and manage the workforce across the East Midlands.

This report shows that addressing existing workforce challenges will have the biggest impact on achieving CS2 (Time to 1st Consultant Review), CS3 (MDT Review), CS5 (Diagnostics), CS6 (Interventions/Key Services) and CS8 (On-going Review).

1.8 Finding alternative funding and commissioning models: facilitating innovation

The extra costs of fully achieving the 7 day service clinical standards are largely driven by workforce and the impact of a limited number of clinical standards. These are CS2 (Time to 1st Consultant Review), CS3 (MDT Review), CS5 (Diagnostics), CS6 (Interventions/Key Services) and CS8 (On-going Review). Even without the detailed cost/benefit analysis of short-term improvements, it is clear that alternative funding sources must be found.

Based on the indicative costs submitted by five of the trusts, the total estimated investment is between £16.5m–£89.6m representing 0.8%–4.4% of turnover. This compares to Healthcare Financial Management Association (HFMA) findings of 1.5%–2% which would equate to £30.3m–£40.3m. These figures are indicative, based on current approaches to service delivery.

Extrapolating these figures across East Midlands provides an indicative view of total investment ranging from £33.0– £179.2m based on the revenues of the ten trusts. This is in contrast to HFMA findings of 1.5%–2% which would equate to £60.5m–£80.7m. (note: the range of costs identified by the Trusts are broad and require further detailed review and assessment prior to implementation of any proposed actions).

Acknowledging finance and resource constraints facing the NHS, health communities will need to exploit opportunities presented through the new payment system for the NHS to underpin new delivery models.

1.9 Risks to the 7 Day Services delivery

There are a number of key risks which will need mitigation:

- If the momentum developed within the acute trusts is not maintained, then achieving consistency of care delivery across 7 days a week by June 2016 will rapidly become unachievable
- The need to focus resources on current operational pressures may mean that addressing more complex and wider system challenges will not get the same focus due to the level of difficulty and the longer lead times involved
- If workforce challenges which fall outside of the control of the acute trusts are not addressed at the pace needed to support the fundamental service redesign then achieving new models of care and their benefits to patient care will become increasingly difficult
- Delivery of collaborative opportunities will require partnership arrangements and higher degree of trust within and across health economies. This way of working will require a cultural shift which will take time to develop. Without applying significant time and effort to develop this way of working, 7 day service provision will seriously be undermined
- Timescales for local health and care system transformation programmes may not be aligned to the 7 day service requirements.

The implementation of 7 day services requires focus and resources to deliver; it is important for it not to become 'yet another initiative' and it will have to be integrated into the strategic clinical and delivery agendas of each health economy.

1.10 Next steps

Acute Trusts now have a baseline assessment of the implications of the clinical standards for operations, workforce, IT and cost.

Section 9 *Organising for delivery* lists key conclusions from this report together with practical considerations for taking the project to the next stage.

Some trusts have already embarked on their own transformation programmes. Next steps recommended to Chief Executives for consideration are as follows:

- Agree how to continue this project across East Midlands to maintain the momentum gained through this initial phase of work, with a particular focus on clinical engagement
- Define the role of the Acute Trust Chief Executives Collaborative in supporting future phases of work – to drive and deliver the change and/or to facilitate the sharing of best practice
- Identify the approach to engaging the wider system partners in future phases
- Work with CCGs, NHS England and NHS IQ to confirm the priority clinical standards for 15/16 to help prioritise gap closure actions. Latest information available at the time of finalising this report indicates it is possible that trusts will be required to implement 5 of the 10 clinical standards which will make the greatest impact by march 2016 and achieve the remaining 5 by march 2017. Trusts need to review this as a matter of priority and escalate any issues which require a national steer or national solutions directly to NHS IQ
- Trust teams to undertake a stocktake of all existing and planned trust improvement programmes to test alignment with the 7 day services clinical standard requirements and identify if projects need to be accelerated, stopped or re-scoped
- Agree how this project can be used to engage the wider health and social care system in the challenge. It is proposed that a workshop is run with the CEOs, commissioning representatives and Trust 7 Day Services leads to agree priorities and how to take them forward
- Current IT and information systems are a barrier to progress; Trusts need to review them as a matter of priority
- Agree how the information in this report, and the detail within individual trust reports, can be used to engage the wider health and social care system in the challenge.

While the challenges of 7 day service provision are significant, this project presents major opportunities. Lessons learned so far will be of interest to others in the health system. By sharing thinking and introducing more innovative models and approaches, the East Midlands Collaborative has the prospect now of helping shape to the landscape of the NHS at a national level for the next five years.

Using this report: key audiences

Key information for providers

The scale and pace of change needed to deliver consistent, robust, high-quality services is huge. There are major implications for every aspect of service delivery, and for clinical and non-clinical workforces. Consistent 7 day services need to be integral to clinical and operational strategy, but the scale of the challenge and resource constraints mean that some options will require a whole system response.

- While service availability must be based on demand, there is a need to understand which services are the most critical to patients' pathways to ensure they are delivered to high standards across the 7 days. *Sections 6.3 and 6.5 contain overviews of provision across the 7 days, and by specialty.*
- Opportunities exist at three different levels: operational (within the acute trust), tactical (between acute trusts and partners), and strategic (with other providers and partners system-wide and beyond East Midlands). *Section 6.4 sets out common challenges and opportunities for closing gaps through processes, workforce and IT.*
- There are opportunities to work across other acute providers to develop common solutions and share best practice. Trusts will need to find a balance for implementing quick wins whilst working on longer term solutions to close the gaps. *Section 6.4 identifies best practices that have been found at each of the ten acute trusts.*
- Organisations need to be proactive in engaging with other service providers in the local economy, such as mental health services. *Section 6.5 looks at those services where there are most challenges for meeting the requirements of the standards*.
- Improving and diversifying the skills mix can be done by introducing new roles and different requirements, internally and on a networked basis. 7 day service requirements need to be part of staff objectives aligned with trust strategic vision/objectives. Job plans must be coordinated with overall workforce planning, recognising the potential for different solutions in short, medium and longer term as organisations move from transactional to transformational change. A shift in culture is needed by challenging the status quo and moving to the mind-set of a 7 day services provider. *Section 7 addresses strategies for building capability, capacity and culture.*

Key information for commissioners

A major cultural shift is needed towards a system that delivers high-quality, robust services irrespective of time or day of the week. This project highlights options and recommendations which aim to provide additional thought for commissioners, who can be influential in driving the collaboration agenda.

- The baseline assessment provides specialty and service level insights to identify the services which will potentially require system-wide changes to bring more effective care models across the health and social care systems. *Section 6.5 provides insights into some of these challenges.*
- Recommendations are based on principles of commissioning for outcomes which will incorporate the ten clinical standards. It acknowledges that current activity-based commissioning models and payment systems will require further consideration.
- Contractual vehicles will be needed to ensure 7 day services incentives and consequences are core to commissioning, with robust and transparent measuring and monitoring processes. 7 day service provision should be confirmed as a core criterion across all services within local transformation programmes.
- Collaboration with health education commissioners and providers will be needed to provide a medium- and long-term view of demand and its impact on workforce availability, and to commission for effective training and development programmes. *Section 7 outlines some of the key strategic workforce challenges.*
- There is a need to drive funding for the whole system to deliver 7 day services, recognising there may be a potential for a balance of upfront investment to achieve the standards. This has been reinforced in a recent publication from Monitor and NHS England 'Reforming the Payment System For NHS Services: supporting the five year forward view' (October 2014). The investment profile associated with 7 day services needs to be considered against commissioning intentions and the opportunities associated with the local transformation programme. *Section 8 gives more detail of potential alternative funding and commissioning options.*

Key information for policy-makers

More resources need to be targeted (locally and nationally) to support the improvement agenda and evaluate the impact of service reconfiguration, with comparative analysis of different models of care – and particularly their impact on quality and cost. Proposals need to emerge based on strong engagement from clinicians, the public and politicians.

- Joined-up thinking across health economies will be key to delivering consistent 7 days services. Strategic and system changes must be driven by policy-makers in close collaboration with regulators and local systems to break down barriers and ensure sustainability and greater buy-in. This project has identified recommendations which will require major system reconfiguration and collaborative working. However, there are many examples of trusts and commissioners who are making good progress towards improving clinical outcomes by reducing variation in service levels.
- Analysis has highlighted variations in outcomes at weekends that are due to reduced service levels that need to be addressed. National data (e.g. standardised hospital mortality rates,) should be available to enable transparent consideration of access to services 7 days a week. *Section 6.5 gives more details on clinical outcomes data.*
- Workforce and financial constraints will need to be resolved through innovative solutions and alternative care models to provide the required step change to bridge the gap.
- Innovation is enabled through co-commissioning, with a review of the value of Payment by Results (PbR). *Section 8 gives an overview of alternative funding and commissioning options.*
- Clarity is needed on the order in which clinical standards will be implemented, how requirements of the standards will be communicated and measured, including by regulatory bodies, and how Out of Hospital Hours standards will be integrated into the ten clinical standards for acute providers. More clarification is needed on some of the definitions of the ten clinical standards. *More details are in Appendix C.*
- Agreeing flexible national contracts for health professionals (or a mandate 5/7 working as the national contract for all NHS employees) will help to address workforce and training shortages. Section *7 looks at the strategic workforce challenges.*
- 7 day services delivery will be closely linked with the NHS Five Year Forward View and the scientific and digital revolution across the NHS.

East Midlands Clinical Senate

Section 2

Introduction

This report was jointly sponsored by the East Midlands Clinical Senate and the Chief Executives of the ten East Midlands acute trusts.

The national 7 Day Services programme has set a challenging timeframe in which to make consistent 7 day services a reality. East Midlands has started the process of collaboration to address major system-wide challenges. The detailed analysis and recommendations contained in this report are intended to help acute providers, commissioners and policy-makers make decisions and focus resources for the next stage of the East Midlands 7 Day Services Collaborative project.

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2 Introduction

This report summarises the output from the East Midlands acute Collaborative Project for 7 Day Services. It was jointly sponsored by the East Midlands Clinical Senate and the Chief Executives of East Midlands acute trusts including:

- Chesterfield Royal Hospital NHS Foundation Trust
- Derby Hospitals NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- Northampton General Hospital NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Nottingham University Hospitals NHS Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- University Hospitals of Leicester NHS Trust.

2.1 Structure and purpose of this report

This report is intended for use by providers, commissioners and policy-makers.

It complements the ten individual trust reports produced as part of this project which each contain the trust baseline position against the ten clinical standards, areas of best practice, key themes and issues, agreed options to close the gaps, considerations for their wider health economy, conclusions and recommended next steps.

This report provides a consolidated view across the ten trusts and highlights additional cross-organisational opportunities to address the challenges of delivering consistent 7 day services. Its structure is as follows:

- **Introduction** sets out the national context and timeframes for the project
- **Urgent and emergency care in the East Midlands** summarises the scale of service demand across the region to inform decision-making on the actions needed to close the gaps for 7 day services
- **East Midlands 7 Day Services Collaborative project** sets out the objectives and principles of the project
- **Project methodology** provides an overview of the methods used for data assessment and engaging stakeholders
- **Findings and recommendations for closing the gaps** outlines key findings from the baseline assessment, gives a consolidation of common themes, and identifies operational and strategic opportunities to address common challenges with processes, workforce and IT
- **Addressing strategic workforce challenges** presents recommendations to build capacity, capability and the culture needed to make consistent, robust 7 day services a reality long term
- **Funding and contracting considerations** explores options and recommendations for next steps for the organisations in finding alternative sources of funding and commissioning models
- **Organising for delivery** presents the conclusions from this report, with a series of practical considerations and recommended next steps for the next phase of the East Midlands Collaborative 7 Days Services project.

Appendices to this report are as follows:

- Appendix A: List of contributors to this report
- Appendix B: Regional dashboard with site details
- Appendix C: More detail on the methodology for the project
- Appendix D: Summary by trust of specialties/support services with greatest challenge to meet the clinical standards
- Appendix E: Whole Time Equivalent (WTE) requirements split by specialty and staff group
- Appendix F: Detailed case studies/best practice
- Appendix G: References.

Annex to this report: see separate document entitled Urgent and Emergency Care Pathway Flow Maps

2.2 National context for 7 Day Services

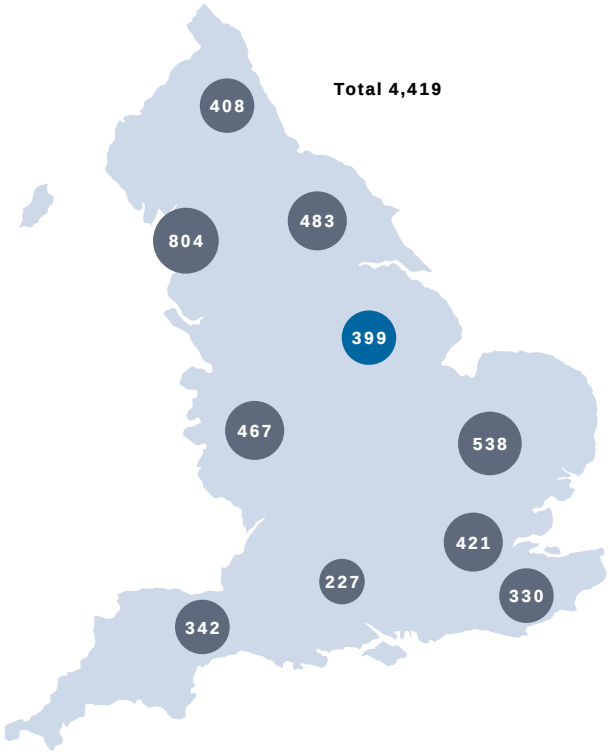
Everyone Counts: Planning for patients 2013/14 committed the NHS to move towards making routine services available 7 days a week. A national 7 Day Services Forum was established by Professor Sir Bruce Keogh in 2013 and asked to concentrate its first stage review on urgent and emergency care services and their supporting diagnostic services.

The Forum established a Clinical Reference Group (CRG) to provide clinical advice, opinion and direction. A review by the CRG highlighted significant variation in outcomes across the NHS in England for patients admitted as an emergency at the weekend in relation to: mortality rates; length of hospital stay; re-admission rates and the patient's experience of care.

The National 7 Day Standards Forum initiated a first stage review of urgent and emergency care services and their supporting diagnostic services

In England, patients admitted to hospital as an emergency at the weekend have a significantly increased risk of dying compared to those admitted on a weekday. The baseline assessment of services across East Midlands that is summarised in this report confirms a correlation between day of admission (weekday versus weekend) and outcome for the patient (as detailed in each of the trust level reports). Data shows that around 4,400 lives in England could be saved every year if the mortality rate for patients admitted at the weekend was the same as for those admitted on a weekday. Figure 2 demonstrates the number of lives that could be saved in the different regions in England if there was no difference in weekend and weekday mortality rates. The national Keogh review undertook analysis of Hospital Episode Statistics from 1 April 2008 to 31 March 2011 which indicates that for the East Midlands there were 399 deaths per year which could be attributed to the lack of consistent care across 7 days.

Figure 2: Number of lives that could be saved with no difference in weekend and weekday mortality rates



Source: Based on analysis of Hospital Episode Statistics from 1 April 2008 to 31 March 2011

For East Midlands, there were 399 deaths per year which could be attributed to the lack of consistent care across 7 days

The 7 Day Services Forum's *Summary of Initial Findings* was presented to the Board of NHS England in December 2013. One of its recommendations was that by 2016/17 the NHS should adopt ten evidence-based clinical standards for urgent and emergency care and supporting diagnostics to end current variations in outcomes for patients admitted to hospital at the weekend. NHS England's Board agreed to all of the Forum's recommendations, including full implementation of the clinical standards. The Five Year Forward View reaffirms a commitment to developing a framework for how 7 day services can be implemented affordably and sustainably as part of NHS England's core ambitions on quality.

2.2.1 7 Day Services clinical standards

There is no 'one size fits all' answer to introducing 7 day urgent and emergency care services and supporting diagnostics. Local solutions need to be found.

The ten key standards specify the minimum quality of service that patients should expect to receive, 7 days a week. Delivering these standards will:

- Support the NHS to improve clinical outcomes and patient experience
- Reduce the risk of morbidity and mortality following weekend admission in a range of specialties.

The standards include diagnostic and scientific services that are needed by hospital clinicians and GPs to support their decision-making and interventions. These results and reports are essential for prevention and early diagnosis as they can dramatically affect plans for admission, treatment or discharge and without them, treatment can be delayed. For patients, timely accurate support contributes to a better overall experience by reducing lengths of stay, avoiding unnecessary admissions and improving clinical outcomes.

*The ten standards specify the **minimum** quality of service that patients should expect to receive, 7 days a week*

The ten 7 Day Services clinical standards are as follows:

Figure 3: 7 day services clinical standards for urgent and emergency care and supporting diagnostics

During the project a number of ambiguities around the clinical standard definitions have been identified. For some of the standards more clarity is needed on definitions to reduce the risk of variation in local interpretation and/or evidencing achievement against standards. Clarification has been sought through this project at a national level. A summary of these ambiguities and recommendations on the way forward can be found in Appendix C of this report.

A more detailed definition of each clinical standard be found in Section 6.4 of this report.

2.3 How the rollout of 7 day services can be seen in 2014/15

'Early adopters' have been engaged to accelerate implementation by developing communities of practice and learning networks

Sir Bruce Keogh, National Medical Director, NHS England announced the first cohort of 13 'early adopters' as part of the Seven Day Services Improvement Programme in November 2013.

'Early adopters' have been engaged to accelerate implementation by developing communities of practice and learning networks across the country as a means of driving forward 7 day services at scale and pace.

The early adopter trusts within the East Midlands Collaborative are Chesterfield Royal and Northern Lincolnshire and Goole Hospitals NHS Foundation Trusts.

NHS Improving Quality is working in collaboration with NHS England, Royal Colleges, communities of practices and the first cohort of early adopters to spread 7 day service models. The work will help to evidence whole system models of delivery as part of the three- to five-year transformational 7 Day Service Improvement Programme.

A number of Trusts have agreed Commissioning for Quality and Innovation arrangements (CQUINs) in 14/15

Alongside the early adopters, a number of trusts have agreed Commissioning for Quality and Innovation arrangements (CQUINs) in 14/15 with their commissioners. These are particularly associated with both the development of their implementation plans and/or achievement of clinical standards (e.g. Time to 1st Consultant Review):

- Kettering General Hospital NHS Foundation Trust
- Northampton General Hospital NHS Trust
- United Lincolnshire Hospitals NHS Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- University Hospitals of Leicester NHS Trust.

This project has supported the achievement of those CQUINs associated with plan development. It has also identified a need for greater communication and ownership of CQUINs at an operational level if these are to be maximised as drivers for quality improvement in practice.

East Midlands Clinical Senate

Section 3

Urgent and emergency care across East Midlands

An overview of the scale of demand for services across the region will help inform organisations' decision-making on the actions needed to close the gaps for 7 day services.

When services are provided more consistently across 7 days, analysis indicates that a number of operational pressures will be relieved by improvements in demand management, earlier senior decision-making and availability in key specialty and support services.

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Services are under significant pressure as demand on acute provision continues to rise

3 Urgent and emergency care in the East Midlands

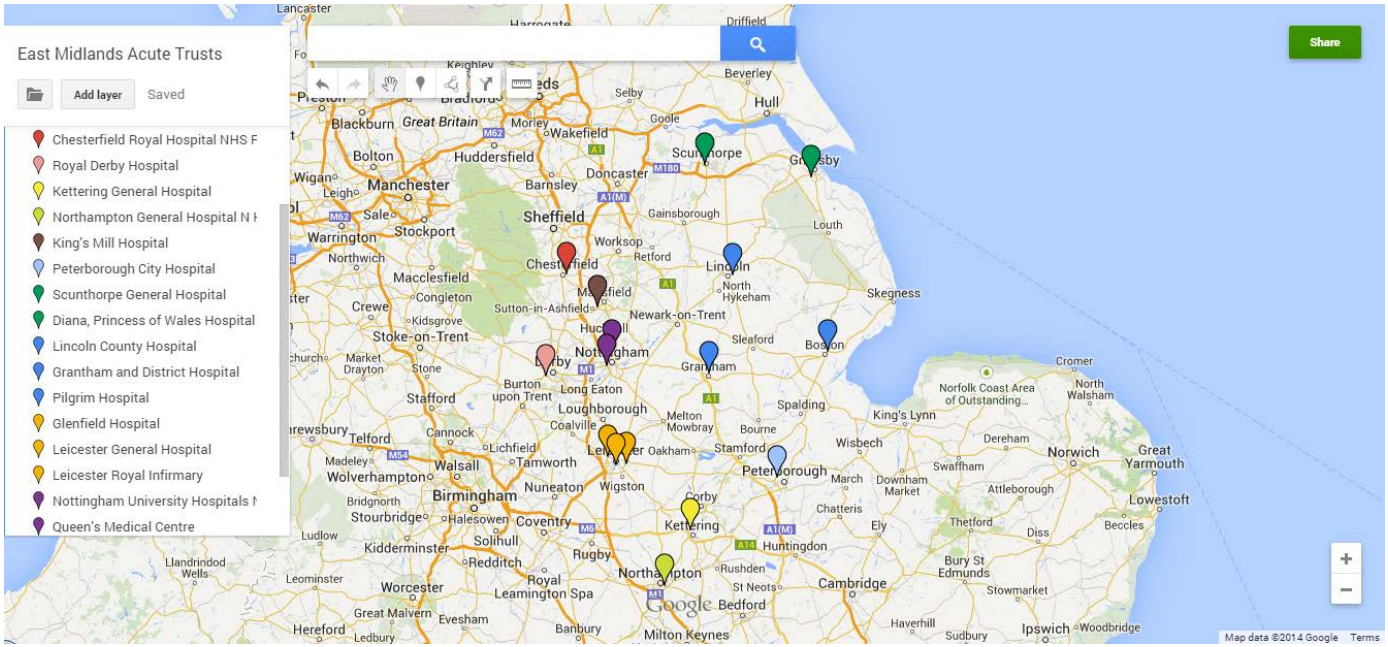
For the purposes of this report, it is useful to summarise the scale of service demand across the region. This information will help inform the decision-making on the actions needed to close the gaps for 7 day services.

Key findings from this analysis

- There is a consistent and predictable pattern of attendance across 7 days across all trusts.
- Variations exist across the ten acute trusts in the conversion rates of attendances to admission/discharge levels.
- Services are under significant pressure, with nine out of the ten trusts having bed occupancy levels for the period over 85%.
- Demand on acute services continues to increase, whilst bed capacity is being reduced to meet ongoing cost pressures.
- During quarter two of 14/15, only four of the ten trusts achieved the 95% target for A&E waits.
- There is consensus from the clinical teams involved in this project that consistent service provision across 7 days will reduce operational pressures.

Ten acute trusts provide urgent and emergency care services from 16 sites across the East Midlands.

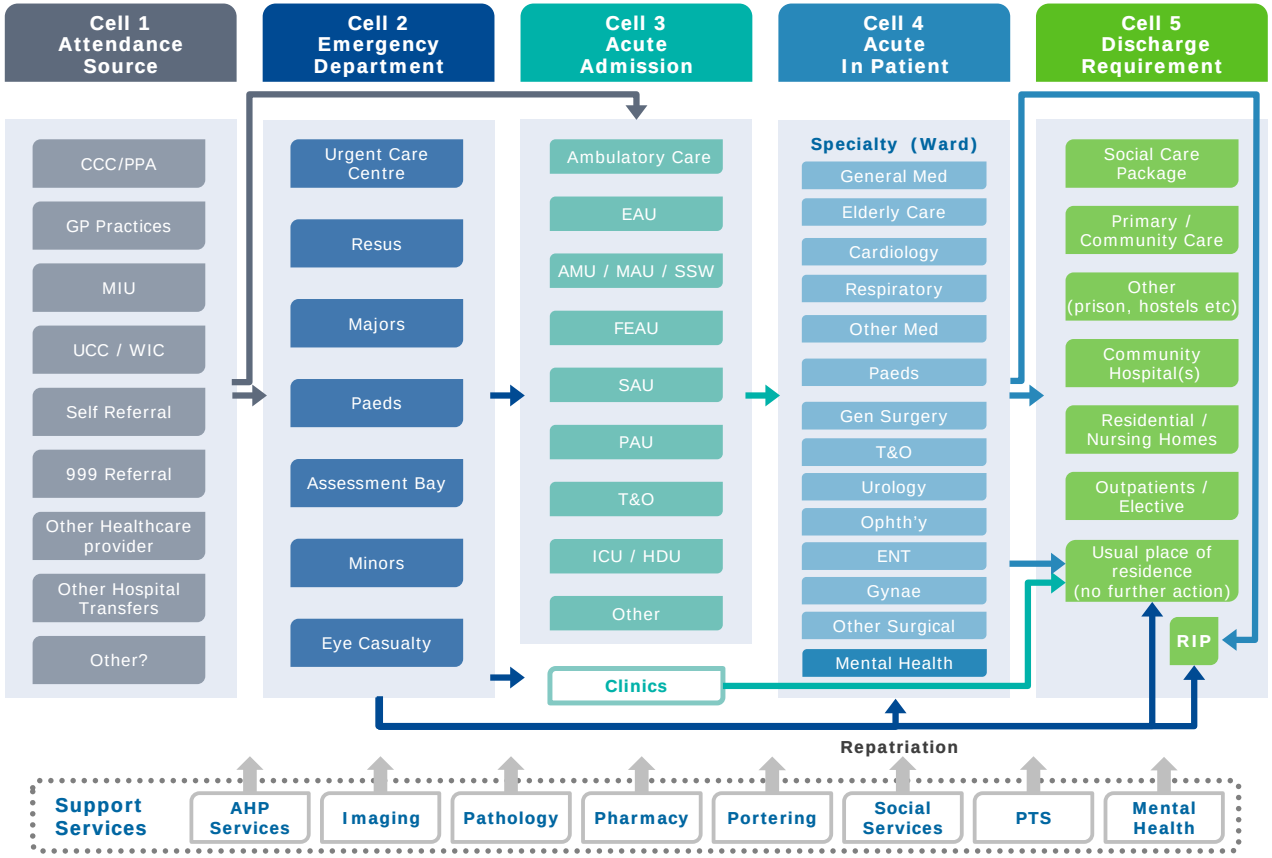
Figure 4: Acute hospital locations for urgent and emergency care services across East Midlands



The baseline assessment identified the interfaces between specialties and services involved in supporting the urgent and emergency care pathway in each Trust

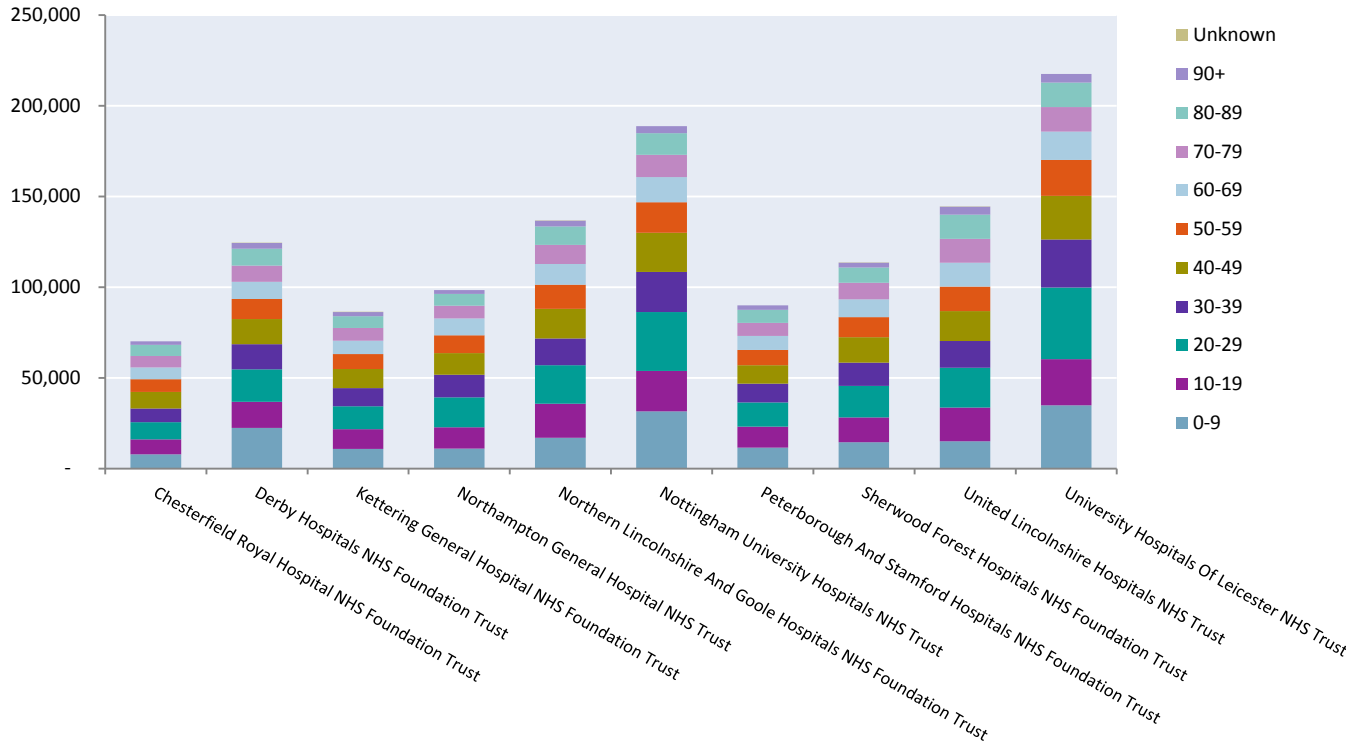
As part of the initial scoping work undertaken by the project team, local flow maps were produced to visualise the flow of patients through the acute system and to identify the specific range of specialties and services involved in supporting the pathway within each trust. An example flow map is shown in Figure 5 below.

Figure 5: Example urgent and emergency care flow map for an acute trust



Across the region, 1.27 million patients accessed the urgent and emergency care system during 2012/13 and this had increased to 1.31 million in 2013/14 (an increase of 5.4%). The breakdown of these demand volumes are shown by trust in Figure 6.

Figure 6: Number of A&E attendances at each provider by age group, 2012-13

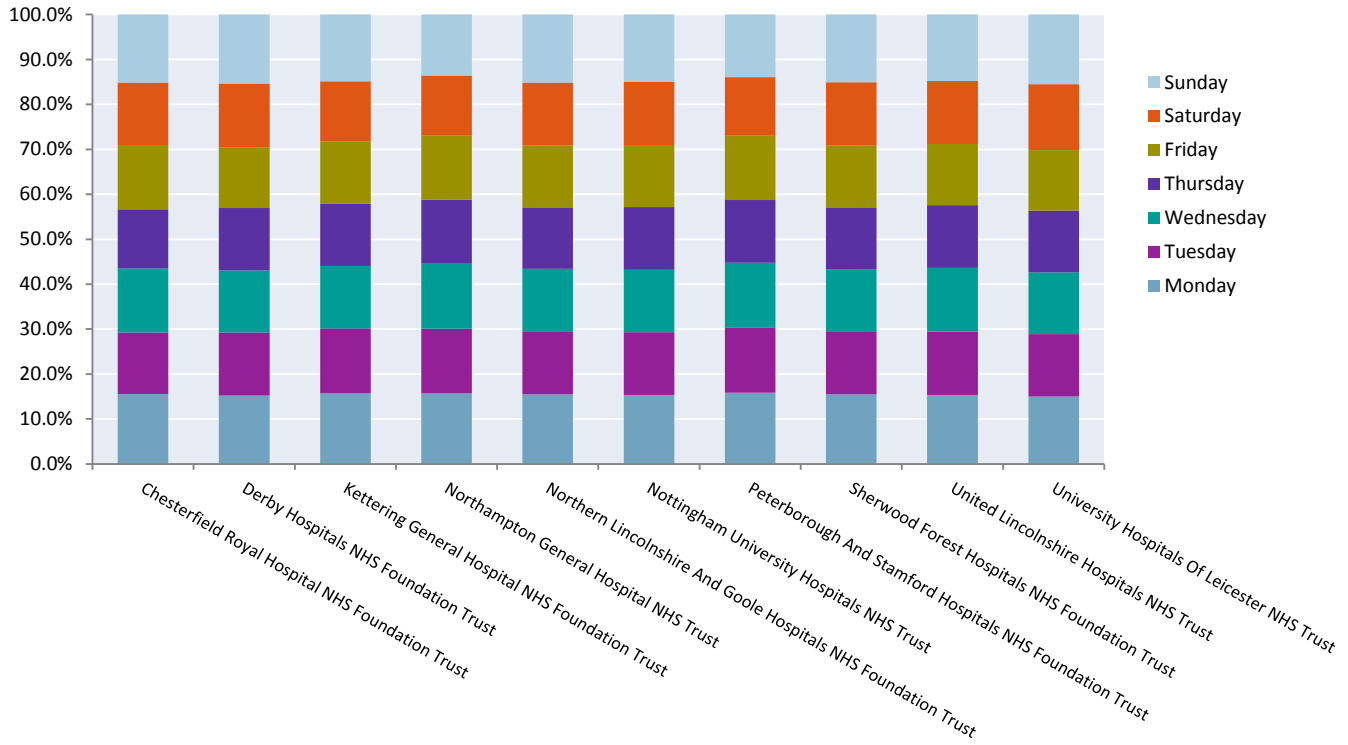


Source: HSCIC Provider level analysis for HES Accident and Emergency Attendances 2011-12 and 2012-13

Demand volumes are fairly consistent across 7 days, which provides a reasonable indicator of levels of service availability needed to meet the requirements of the standards

Analysing this data further identifies that demand volumes are fairly consistent across 7 days and across all East Midlands trusts as indicated in Figure 7.

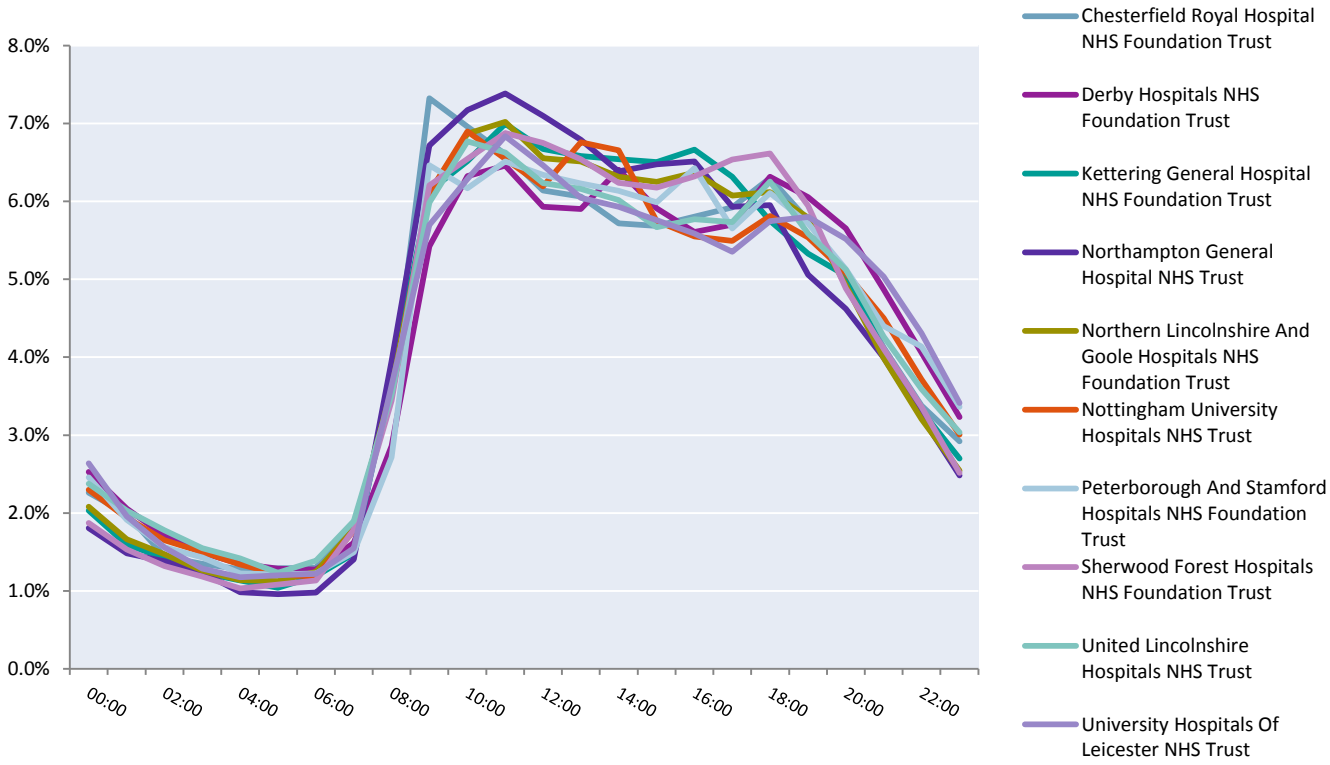
Figure 7: % of A&E attendances in each provider by day of arrival, 2012-13



Source: HSCIC Provider level analysis for HES Accident and Emergency Attendances 2011-12 and 2012-13

The demand profiles also identify a consistent and predictable pattern of attendance across 7 days, as shown in Figure 8.

Figure 8: % of A&E attendances by hour of arrival for each provider, 2012-13

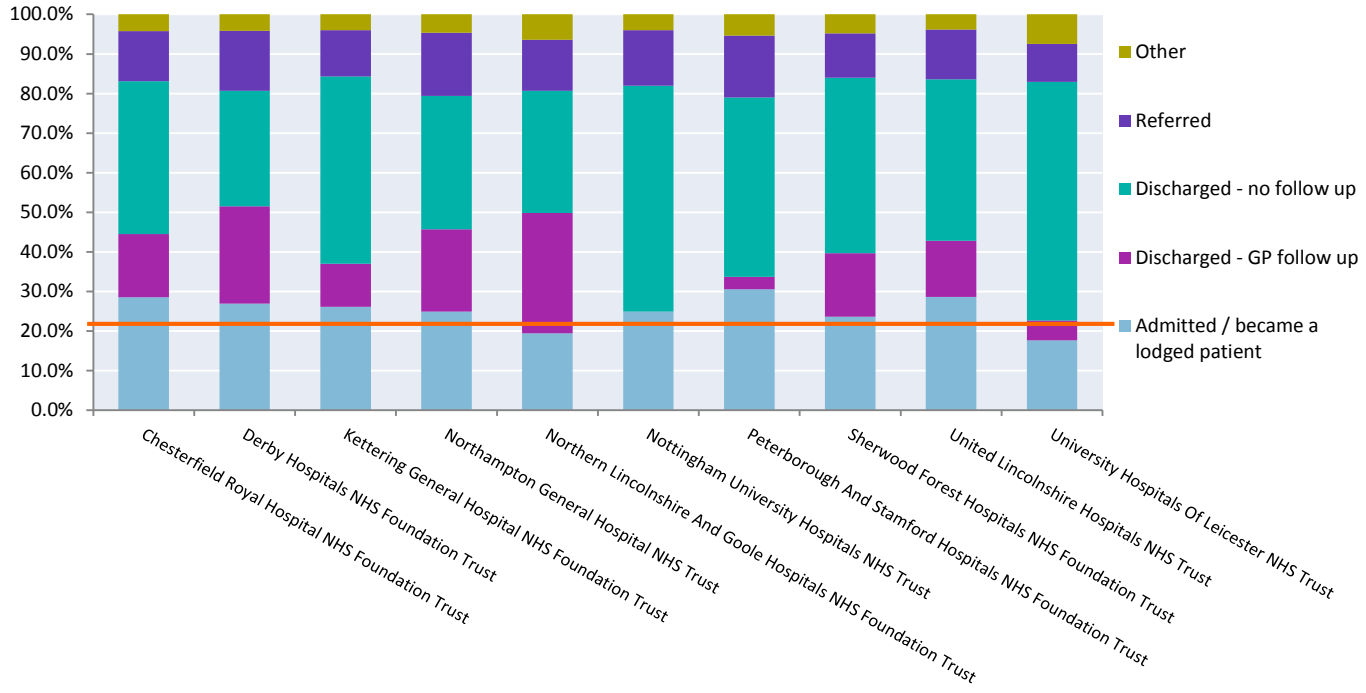


Source: HSCIC Provider level analysis for HES Accident and Emergency Attendances 2011-12 and 2012-13

Levels of admission above circa 22% typically indicate that there may be a deficiency in the level of senior decision-making in the emergency portals of an acute trust

Patterns start to become more varied across the trusts when analyses of outcomes from those attendances are reviewed. Figure 9 identifies a fairly high level of variation in the conversion rates of attendances to admission/discharge levels. Based on experience of urgent care turnaround both within the trusts and through work in other economies, as a general rule of thumb, levels of admission above circa 22% typically indicates that there may be a deficiency in the level of senior decision-making in the emergency portals of an acute trust, although a further more detailed assessment would need to be undertaken before any firm conclusions could be made.

Figure 9: % of A&E attendances by method of discharge by provider, 2012-13 (excluding planned attendances)

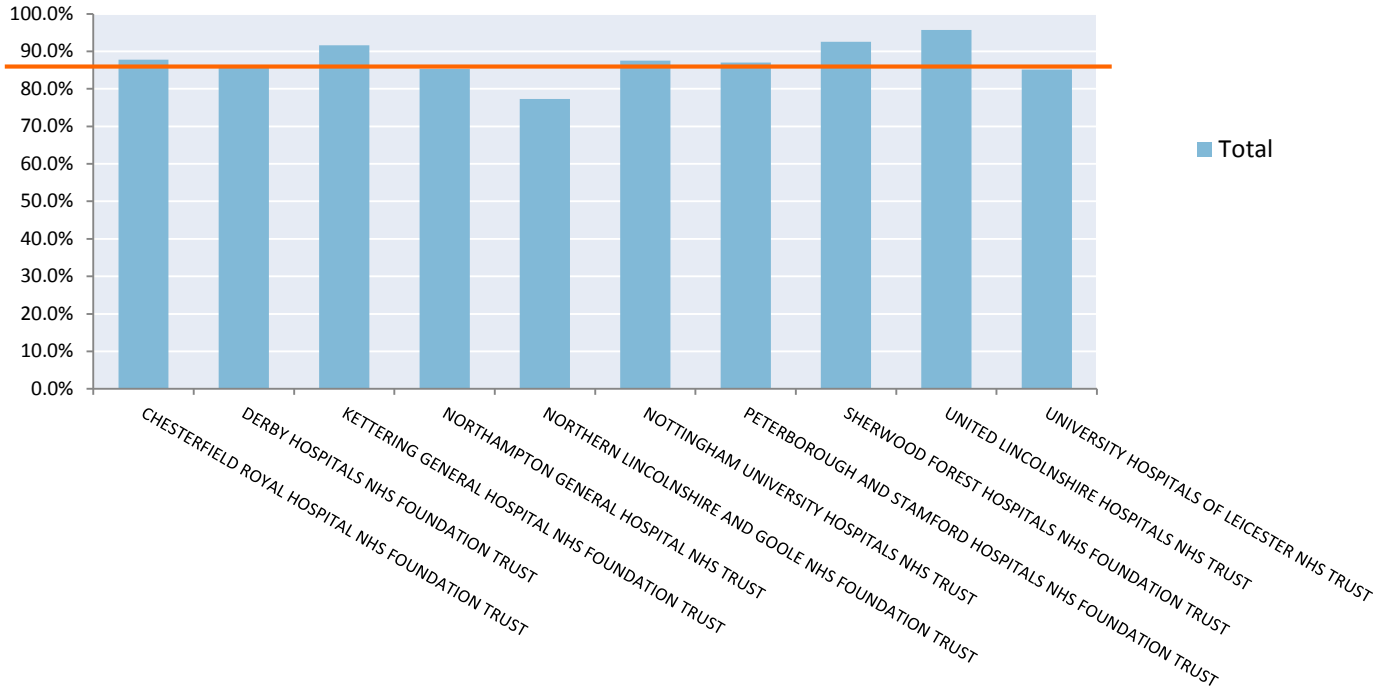


Source: HSCIC Provider level analysis for HES Accident and Emergency Attendances 2011-12 and 2012-13

The system does not require much in the way of increased activity volumes to create a critical capacity issue in the acute setting

It is also possible to see that some trusts typically run 'hotter' (i.e. higher levels of bed occupancy), with nine out of the ten having bed occupancy levels for the period over 85%. This typically indicates that the system does not require much in the way of increased activity volumes to create a critical capacity issue in the acute setting. Average daily percentage of available and occupied beds open overnight are shown by trust in Figure 10.

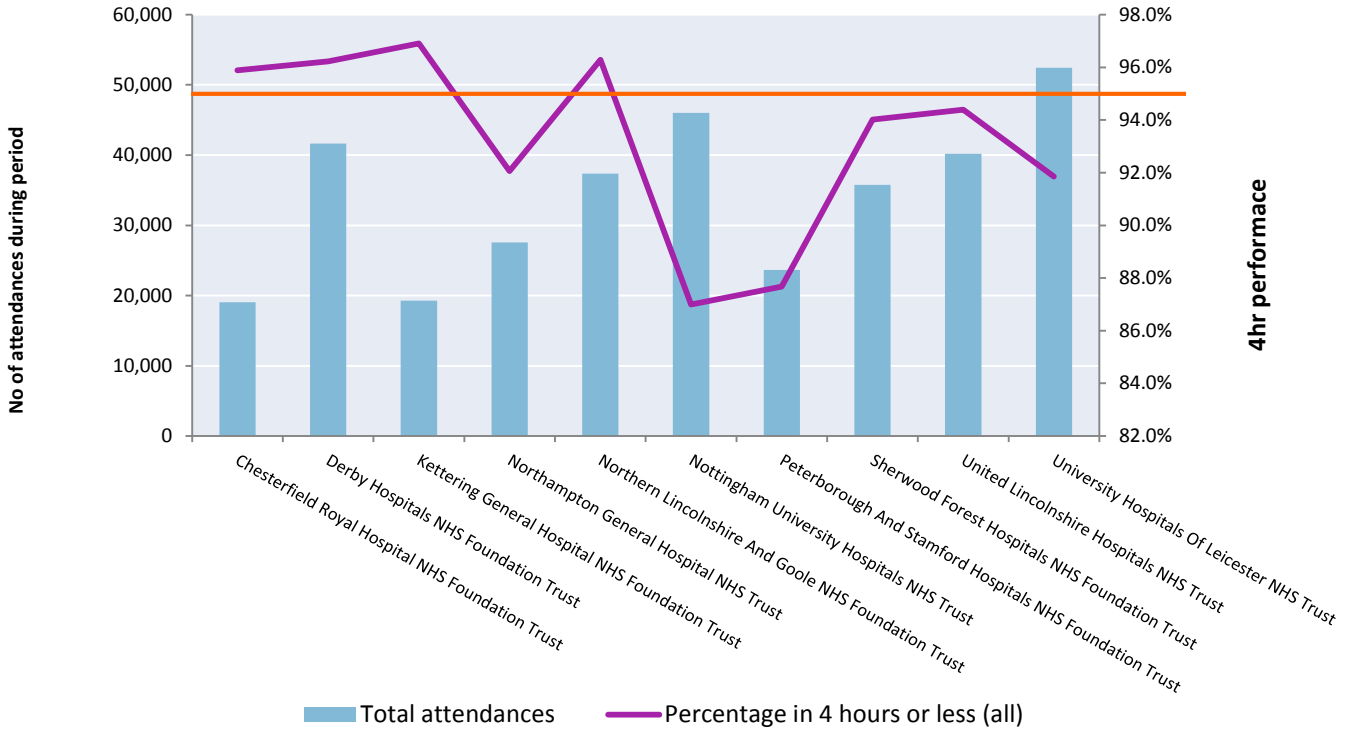
Figure 10: Average daily percentage of available and occupied beds open overnight by provider



Source: NHS England: Unify2 data collection - KH03 - Average daily number of available and occupied beds open overnight by sector - April to June 2014

With demand on acute services continuing to increase, and with bed capacity being reduced to meet ongoing cost pressures, one of the common effects is for A&E performance to be affected. During quarter 2 of 14/15, only four of the ten trusts achieved the 95% target (see Figure 11 for details).

Figure 11: A&E performance and activity - 2014-15 Quarter 2



Source: Unify2 data collection – WsitAE - A&E quarterly activity statistics, NHS and independent sector organisations in England - 2014-15 Quarter 2 (includes w/e 06/07/2014 to w/e 28/09/2014)

There was a strong consensus from the clinical teams involved in this project that when services are provided more consistently across 7 days, a number of the operational pressures highlighted from the analysis above will be improved, through improvements in:

- Demand management
- Earlier senior decision-making
- Availability in key specialty and support services.

East Midlands Clinical Senate

Section 4

East Midlands 7 Day Services Collaborative project

The collaborative approach taken by East Midlands is unique. The ten acute trust Chief Executives have agreed principles for collaborative working and undertaken an unprecedented data assessment exercise to gain an evidence-based view of current service provision at site, trust and regional level. Working collaboratively is enabling trusts to identify common experiences and opportunities to implement strategic change at a pan-regional level to meet the ten clinical standards.

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4 East Midlands 7 Day Services Collaborative project

The aim of the initial stage of the project was to undertake a rapid review and identify gaps in 7 day hospital service provision across the East Midlands

The East Midlands Acute Trust Chief Executives agreed a set of principles for collaborative working

The East Midlands 7 Day Services Collaborative project was initiated by the East Midlands Acute Chief Executive Forum and the East Midlands Clinical Senate to develop sustainable (clinical, workforce, operational and financial sustainable) 7 day hospital services, in accordance with the national standards, for the benefit of the East Midlands' patients and population served.

The aim of the initial stage of the project was to undertake a rapid review and identify gaps in 7 day hospital service provision across the East Midlands. The objectives set for this phase of the project were to:

- Achieve both organisational and East Midlands-wide understanding of the implications (costs and benefits) of delivering the national 7 day services standards
- Inform implementation plans and associated decision-making for the move to 7 day service provision, in accordance with the national standards, at both organisational and East Midlands level.

When considering how best to understand and address the challenges of 7 day service provision, the East Midlands Chief Executives agreed a set of principles for collaborative working. These were then used by the project team to:

- Co-produce the approach and methodology for the ten trusts to work together
- Undertake and agree a baseline assessment of current service provision against the clinical standards, underpinned by data through use of analytics and significant clinical engagement
- Work with trust teams and through engagement events to build consensus around gaps in service and options to address those gaps
- Develop a series of preliminary recommendations to close gaps between the standards and baseline.

The collaborative approach taken by East Midlands trusts to this phase of work is unique; in other areas of the country, acute trusts are, in general, completing their baseline assessments in isolation of other local acute trusts and wider partner organisations.

There are major strategic benefits of working collaboratively across the ten acute trusts

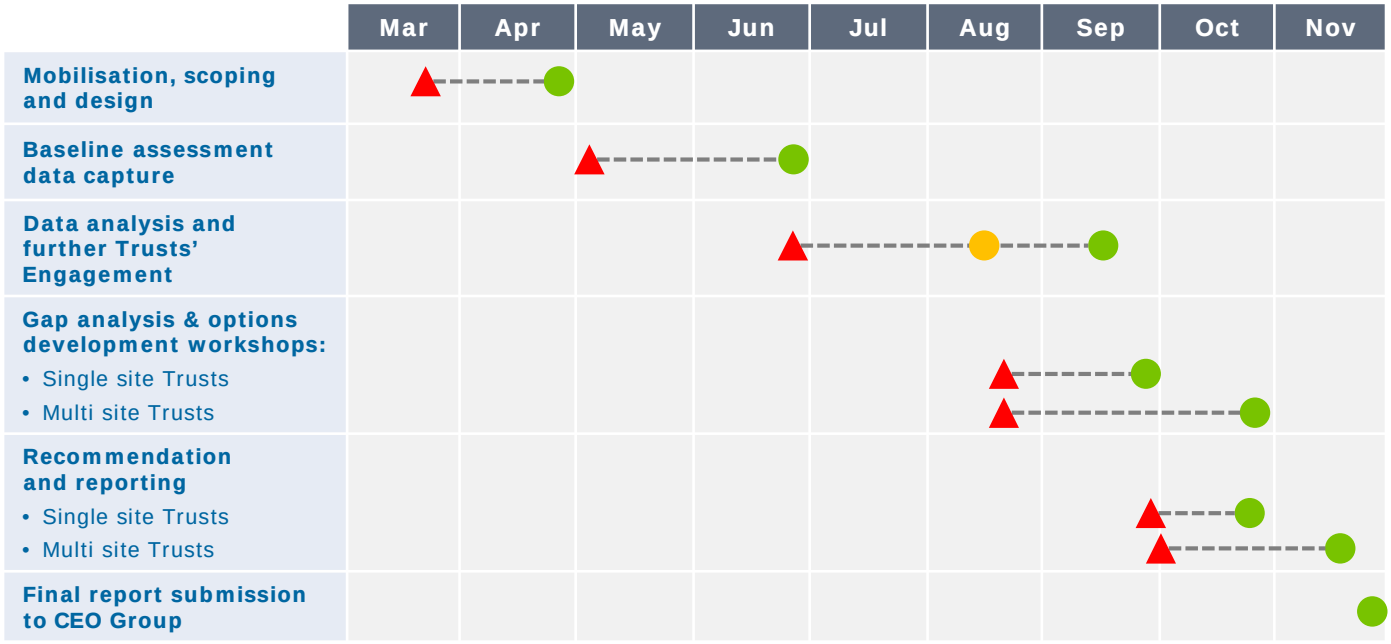
The strategic benefits of working collaboratively include:

- Gaining and sharing a collective view of the challenges of meeting the clinical standards
- Creating a framework for collaboration which can be continued, including a learning network comprising organisational 7 Day Services Project leads
- Identifying potential areas for service reconfiguration and collaborative working to address gaps in current service delivery against the clinical standards
- Taking a data-driven, evidence-based approach across the region rather than relying on anecdotal evidence.

Supported by the East Midlands Clinical Senate and Strategic Clinical Networks, Atos Consulting was engaged to provide analytical and project management support to the East Midlands 7 Day Services Collaborative project.

The high-level programme plan for the East Midlands 7 Day Services Collaborative project is shown in Figure 12.

Figure 12: High-level plan for the 7 Day Services Collaborative project



4.1 Schedule for implementing the 7 day services clinical standards nationally

NHS England has identified that the ten clinical standards will be the minimum standards for delivery, will be mandatory and will apply on a 24x7 basis.

The following implementation timetable for meeting the standards is outlined:

- Year 1 (2014/15) – local contracts should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan section
- Year 2 (2015/16) – those clinical standards which will have the greatest impact should move into the national requirements section of the NHS Standard Contract

It is still to be confirmed which priorities will be defined at a national level for implementation during 2015/16

- Year 3 (2016/17) – all clinical standards should be incorporated into the national requirements section of the NHS Standard Contract with appropriate contractual sanctions for non-compliance.

At the time of writing this report, it is still to be confirmed which priorities will be defined at a national level for implementation during 2015/16. Feedback from national forums indicates that latest thinking is for local commissioning teams to agree the prioritisation of clinical standard implementation over the next 2 years with their provider organisations. However, little evidence exists of these priorities being clarified at a local level at this time.

4.1.1 Definitions and scope

For the purposes of this project 'urgent and emergency care' covers:

- The management of urgent and emergency episodes of ill-health and referrals to a hospital urgent or emergency care receiving facility, for stabilisation
- Once the patient is stabilised, the care and services provided from the time of the decision to admit as an inpatient, for treatment, investigation or further observation, to the patient's discharge or transfer to another care setting. This includes non-hospital services which facilitate the timely end of an urgent or emergency in-patient episode.

'Diagnostics' covers diagnostic services that support urgent and emergency care, investigation, treatment and discharge or transfer.

The following services are out of scope of this report:

- Primary care, community care, social care, mental health (except those elements reflected in the 7 day services clinical standards)
- Non-urgent and elective services (in accordance with Stage 1 of the National project)
- Diagnostics not covered by the definition above
- Support services to which the 7 Day Services clinical standards do not directly apply (e.g. Estates and Facilities, HR, Finance, Outpatient Services).

East Midlands Clinical Senate

Section 5

Project methodology

The methodology for gathering, processing and analysing data from across the region was co-created by the participating trusts and engaged a wide range of contributors. It is generic enough for region-wide analysis and adaptable enough for detailed analysis by individual trusts. While challenges exist for future data collection, there is now a repeatable methodology for re-assessment against the ten clinical standards.

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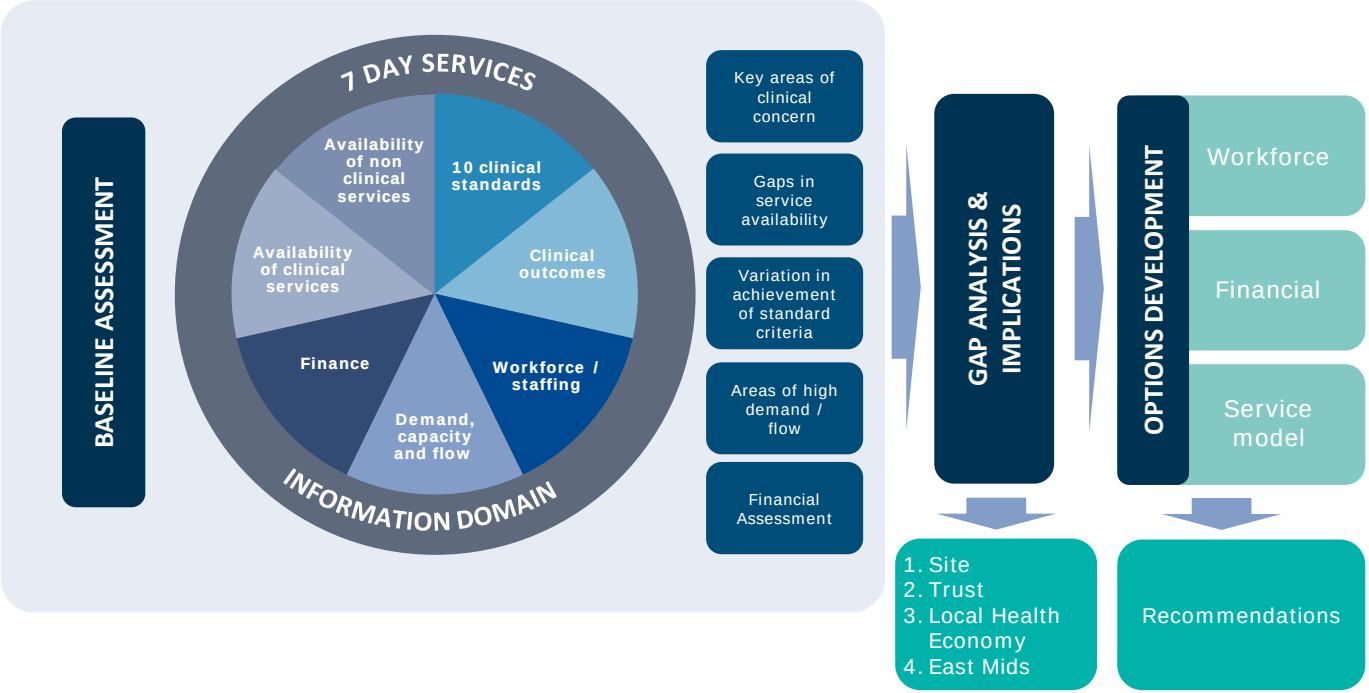
5 Project methodology

The ten acute trusts collectively developed the overall approach to phase one of the 7 Day Services project, as illustrated in Figure 13 below.

Figure 13: Overall project approach



The consistency in approach has enabled trusts to understand the current position and agree on common priorities

The consistency in approach and data collection across trusts has enabled each organisation to understand its current position against the ten clinical standards and to agree on key priorities for closing the gaps.

The level of engagement and co-working is a defining characteristic of the project. The team held over 80 engagement workshops during the project

Working collaboratively has provided trusts with an opportunity to highlight and share good practice, identify key themes and issues at regional level and enabled discussions around potential areas for future partnership and collaboration across trusts.

The level of engagement and co-working to collect and analyse the data is a defining characteristic of the project. Engaging a large number of clinical and non-clinical staff, co-producing outputs and maintaining ongoing communication have all helped build the necessary consensus and ownership in each organisation.

The project has developed a repeatable methodology for collecting and analysing detailed data on the ten clinical standards to monitor on-going progress on gap closure.

5.1 Collecting and analysing the data

Data collection involved multiple quantitative and qualitative data sources. Quantitative data captured 18 months of data covering two winter periods; qualitative data came from 2000 patient notes, over 180 interviews and over 2500 survey responses

The first phase of the 7 Day Services project comprised four key stages.

1. **Performing a data-driven, evidenced baseline assessment against the ten clinical standards:**

- Understanding the definition of the clinical standards and their applicability in the urgent and emergency care pathway
- Agreeing the data collection methods and the time-blocks to be used to compare clinical standards achievement and clinical outcomes across the 7 days of the week. The four time-blocks are:
  - weekday core hours (Monday-Friday 0800-2000)
  - weekday out of hours (Monday-Friday 2000-0800)
  - Saturday
  - Sunday.
- Agreeing the data collection methods and volumetric for the different data types required and analysing the data to provide baseline assessment position of each clinical standards and clinical outcomes by trust as illustrated in the next table:

Data type	Data source	Data capture method	Clinical standards / clinical outcomes assessed	Scale of data collected across East Midlands
Qualitative	NHSIQ / NHSIQ Other	Self-assessment survey	1-10	2526
Qualitative	Structured interviews	Face-to-face interview	1, 4, 7 and 9	183
Qualitative	Patient notes	Audit	2, 3, 5, 8 and 10	2000
Quantitative	Clinical outcome data	IT system extract	1 and clinical outcomes	18 months' worth of data covering two winters

The team faced a number of challenges, predominantly centred around data collection and data quality

2. Using an analytical tool to inform a gap analysis against the clinical standards:

- Participation of clinicians, managerial and support services staff in workshops to review baseline assessment output at trust, divisional and specialty levels (approximately 80 engagement sessions/workshops were carried out across the region)
- Identifying and prioritising the issues contributing to the gaps in meeting the clinical standards.

3. Developing and assessing options to close the gaps:

- Prioritising options to form part of each trust's 7 Day Services implementation plan based on impact of implementation and effort to implement
- Assessing the workforce and financial implications of implementing the prioritised options.

4. Creating recommendations and reporting:

- Developing individual trust level reports to include the baseline assessment, areas of best practice identified, key themes and issues, options and recommendations for closing the gaps
- Developing the East Midlands Collaborative report showing the regional position against the baseline assessment, areas of best practice, common themes and issues across the region, operational and strategic options and recommendations for closing the gaps.

5.2 Acknowledging the challenges

Recognising inconsistency in service/specialty naming conventions within trusts and across the region, the project agreed a single approach to provide the aggregate view of the baseline assessment at site, trust and regional level.

Delivering to the milestones within the timescale of the project, the team faced a number of challenges which are listed below.

- Complex data mining and significant data quality and linkage issues resulted in changes to project timelines and added resource pressures.
- Trusts had limited resources available to both collect data (manually and extraction from IT systems) and fully implement the approach developed. The level of data collected is variable and is detailed in each of the individual Trusts reports.
- The resulting compressed timescale for the gap analysis and options development phase reduced the opportunity to gain the greatest benefit from the engagement sessions.

Key learning: Significant time taken dealing with data quality, complex data miming and specialty naming challenges

Tableau, the analytics reporting tool used to display the baseline assessment outputs, is not routinely available on NHS systems. The issue was partially mitigated through the use of a mobile tablet which was made available for the trusts affected; however this impacted on the time available for key staff to review the results and identify options. Further access to Tableau remains an issue for future data access.

The team has done a lessons learnt exercise that also highlighted that the impact of data challenges could have been minimised by earlier engagement of trusts analytics and informatics leads.

A more detailed description of the project methodology and data analytics architecture is in Appendix C.

5.3 Clarifying clinical standard ambiguities

The project has identified a number of ambiguities within some of the clinical standard definitions. On advice from NHS England and with input from clinicians across East Midlands, the project agreed a region-wide set of assumptions to address these ambiguities. These have been the basis for the baseline assessment, gap analysis and opportunities developed through this project. The ambiguities and assumptions are tabled in Appendix C.

East Midlands Clinical Senate

Section 6

Findings and recommendations for closing gaps

The baseline assessment identified common challenges, themes and opportunities and revealed gaps that were broadly consistent across all ten acute trusts. Achievability of the clinical standards is a significant challenge during core hours, and even more so out of hours and at weekends. Operational and strategic opportunities exist to improve processes, re-organise workforces and make more effective use of IT. Specific specialty and support services across the whole health economy need targeting if clinical standard requirements are to be met. Networking arrangements and collaboration will be needed to close the gaps for 7 day services region-wide.

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6 Findings and recommendations for closing the gaps

This section presents findings from the baseline assessment as:

- Key themes emerging across East Midlands
- An overview of the dashboard for achievement against each clinical standard by acute trust, including the themes that have emerged across the region
- A more detailed assessment of East Midlands current provision against each standard, gaps between current provision and the standards, examples of good practice, and opportunities (operational and strategic) to close those gaps through changes to processes, workforce and IT
- A review of service provision across the regional against key specialties/support services
- A summary of current clinical outcomes (morbidity and mortality, length of stay, and re-admission rates).

Any Out of Hospital Care standards should be fully integrated with the acute provider standards

6.1 Themes emerging across East Midlands

So far, the project has revealed that more clarity is needed nationally on:

- Implementation phasing of the clinical standards into acute provider contracts
- Some of the terminology used in the clinical standard definitions.

It has also been widely acknowledged that any Out of Hospital Care standards should be fully integrated with the acute provider standards and not separate to them.

Neither the size of the trusts nor whether they are single or multi-site was a defining factor in their ability to meet the requirements of the standards

Notwithstanding this, the regional baseline assessment reveals consistent results across all trusts, with each facing similar challenges to meeting the requirements of the standards across 7 days. Neither the size of the trusts nor whether they are single or multi-site was a defining factor in their ability to meet the requirements of the standards.

This project has identified that achievability of the clinical standards is a significant challenge during core hours on a Monday to Friday. This challenge is increased out of hours Monday to Friday, and increased even further when assessed for Saturday and Sunday.

There is a high dependency on the wider system and key non-acute services if clinical standards are to be achieved. For example, CS7 (Mental Health) and CS9 (Transfer to Primary, Community and Social Care) are impossible to achieve without significant changes to ways of working across partnership organisations.

6.2 Regional clinical standard dashboard

Teams can drill down through the results of their baseline assessment data at overall trust, site, division and specialty levels

The results of the baseline assessment for the ten acute trusts have been consolidated. Each trust has access to its own Tableau reports, providing teams with the ability to drill down through the results of their baseline assessment data at overall trust, site, division and specialty levels. Variation in ability to meet the standards exists across 7 days, not just at weekends. Reporting was therefore developed so that the achievability of each standard could be compared across the following four time-blocks:

- Weekday core hours (Monday-Friday 0800-2000)
- Weekday out of hours (Monday-Friday 2000-0800)
- Saturday
- Sunday.

Findings at these levels have been included in each of the individual trust reports and presented to each of their Executive boards.

The regional position across the ten trusts is shown in Figure 14. It presents an aggregated score of the current baseline against each clinical standard across 7 days, for each trust.

Figure 14: East Midlands regional dashboard

	Chesterfield Royal	Derby Hospitals	Kettering General	University Hospitals Leicester	North Lincs & Goole	Northampton General	Nottingham University	Peterborough & Stamford	Sherwood Forest	United Lincs Hospitals	**Average across Trusts**
Clinical Standard 01 **Patient Experience**	67.4%	75.3%	65.6%	64.6%	76.5%	76.3%	64.9%	78.5%	57.7%	75.3%	69.4%
Clinical Standard 02 **Time to 1st Consultant review**	50.1%	44.6%	73.8%	43.4%	59.0%	53.9%	66.9%	53.0%	64.1%	71.5%	57.4%
Clinical Standard 03 **Multi-disciplinary Team Review**	42.0%	47.6%	51.7%	51.5%	49.7%	48.3%	53.7%	53.1%	35.5%	57.3%	49.3%
Clinical Standard 04 **Shift Handover**	68.6%	74.2%	71.8%	75.2%	86.6%	74.6%	75.3%	71.4%	60.4%	76.6%	73.3%
Clinical Standard 05 **Diagnostics**	67.8%	65.1%	61.9%	51.9%	67.8%	73.4%	55.9%	55.6%	67.5%	52.8%	61.3%
Clinical Standard 06 **Interventions/Key Services**	44.0%	61.7%	42.5%	70.9%	37.8%	58.2%	48.9%	38.2%	39.8%	56.8%	52.4%
Clinical Standard 07 **Mental Health**	48.8%	58.4%	34.1%	28.2%	46.6%	44.9%	26.7%	21.7%	54.3%	53.0%	42.4%
Clinical Standard 08 **On-going Review**	35.9%	44.8%	52.8%	50.1%	41.4%	47.2%	61.1%	47.3%	54.9%	61.9%	49.8%
Clinical Standard 09 **Transfer to Primary, Community and Social Care**	39.2%	47.2%	49.2%	64.0%	46.9%	37.5%	44.2%	52.7%	42.3%	45.1%	47.3%
Clinical Standard 10 **Quality Improvement**	35.8%	45.5%	65.5%	62.6%	18.4%	53.4%	72.3%	63.2%	54.7%	74.6%	55.6%
Average across Standards	50.2%	55.4%	57.9%	56.9%	53.9%	56.9%	60.3%	54.0%	53.5%	63.7%	56.4%

Definition of RAG: Red= <50% across 7 days; Amber= between 50%-70% across 7 days; Green= > 70% across 7 days

denotes clinical standards that have dependencies on key support services; denotes clinical standards that have dependencies on the wider system

Note: University Hospitals of Leicester NHS Trust applied different RAG thresholds within its own report. For the purpose of this report, its RAG thresholds are aligned with the other trusts as stated above.

This analysis provides an initial view of the impact of shortfalls in acute service provision. Teams have started to determine which services are critical

Shortfalls in provision of some services and an imbalance of service availability across 7 days have a high impact on achievability of clinical standards and quality of service

6.3 Review of 7 day service provision across East Midlands

This analysis provides an initial view of the impact of shortfalls in acute service provision. Teams have started to determine which services are critical to delivery of the core urgent and emergency care pathway and supporting diagnostics.

Recommendation

A detailed view of current and future demand and capacity at a whole-system level is now needed.

Where services are currently not provided by an individual trust, there are a number of options to explore. Firstly, there may be local operational solutions to increase capacity through productivity and efficiency measures. Secondly where it is not possible to increase capacity within an acute trust, then potential collaboration opportunities could be explored. These may be local networks with other acute trusts and provider organisations or more widely, such as an East Midlands regional solution.

The following table summarises the services which from the analysis have either no or most limited service provision outside of core hours Monday to Friday across the trusts, e.g. from the data it has been highlighted that speech and language services are not available 86% of the time across all trusts either out of hours Monday to Friday or on a Saturday or Sunday.

The project teams have identified that the shortfalls in provision of these services across 7 days reported in this table have a potentially high impact on achievability of the clinical standards and/or clinical outcomes for patients on the urgent and emergency care pathway. To further inform decision-making, the project teams have also undertaken an initial assessment as to whether solutions to improve the provision of these services should be driven at an acute trust, local economy or regional level.

Figure 15: Analysis of key specialties/services with limited 7 day provision across all trusts

Specialty / Service	% of Trusts with no / partial provision across OOH, Sat or Sun	Critical issue for U&E pathway? (Y/N)	Impact on standards / outcomes (L / M /H)	Potential route to address
Social Care	86%	Yes	H	Local Economy
Speech and Language Therapy	86%	Yes	H	Local Economy
Rehabilitation Medicine	83%	Yes	H	Local Economy
Radiotherapy	78%	Yes	H	Regional
Discharge Liaison services	71%	Yes	H	Local Economy
Occupational Therapy	67%	Yes	H	Local Economy
Equipment and Adaptations	63%	Yes	H	Local Economy
Obstetric Ultrasound– Fetal medicine	62%	Yes	H	Trust
Early Supported Discharge	57%	Yes	H	Local Economy
Intermediate Care Teams	57%	Yes	H	Local Economy
Geriatric Medicine	54%	Yes	H	Regional
MRI	52%	Yes	H	Regional
Interventional Radiology	50%	Yes	H	Regional
Physiotherapy	50%	Yes	H	Regional
Pharmacy	46%	Yes	H	Regional
Rapid Response Team	44%	Yes	H	Local Economy
Echocardiogram	43%	Yes	H	Regional
Bronchoscopy	43%	Yes	H	Regional
Transport Support	42%	Yes	H	Regional
Early Pregnancy Assessment Unit	38%	Yes	H	Local Economy
End of Life Care /Palliative Care	33%	Yes	H	Local Economy
Haematology	33%	Yes	H	Regional

Trusts have already been looking at their own plans and details of proposed local actions are included in the individual trust reports. 7 Day Services Trust leads have been focusing on their organisations' gap analysis and service provision challenges. They have begun to discuss innovative solutions and the potential for collaboration to address the gaps.

Recommendation

More detailed discussions are needed with all relevant stakeholders to establish a suitable sustainable model for service provision at the required capacity level.

6.4 Regional assessment against each clinical standard

Project teams have engaged large groups of operational staff (clinicians, managers, support services) to discuss the gaps in achievability, use the data to build consensus, and agree how to close the gaps

This section outlines the common findings and recommendations against each of the ten clinical standards across all ten acute trusts. For each clinical standard it presents:

- The national definition of the standard
- An overview of the baseline assessment of the achievability of each standard for each trust, presented as RAG (red, amber, green) values
- There are examples of good and best practice to evidence achievement against the clinical standard across the region (with one example Trust referenced for each)
- Common challenges to achieving the standard (i.e. gaps)
- Opportunities for closing the gaps
- Signposting to relevant case studies as examples of good practice across East Midlands (a full list of case studies is in Appendix F).

6.4.1 Assessing opportunities for closing the gaps

The trust project teams have engaged large groups of operational staff (clinicians, managers, support services) to discuss the gaps in achievability and to identify opportunities for closing the gaps.

Detailed action plans are included in each of the trust-level reports being reported to Trust Chief Executives via the Trust Project lead. This project has also identified a number of common opportunities for closing gaps in ability to achieve the standards. These opportunities are summarised in this section and fall into three categories:

- **Process**-based opportunities
- **Technology**-based opportunities
- **Workforce**-based opportunities.

Within each of these three categories, opportunities are further identified as:

- **Operational** opportunities – shorter-term actions for individual trusts to consider as part of their planning process
- **Strategic** opportunities – longer-term actions to consider in collaboration at a regional level.

It is important to note that the challenges this project has revealed in relation to the ten clinical standards are being felt across 7 days. The baseline assessment shows that gaps need to be addressed during core hours Monday to Friday in addition to out of hours and at weekends.

Clinical standard 1
Patient Experience

Standard definition

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, 7 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.

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Patient Experience across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 01 **Patient Experience**	67.4%	75.3%	65.6%	64.6%	76.5%	76.3%	64.9%	78.5%	57.7%	75.3%	69.4%

Key findings from the baseline assessment

- There is a key opportunity to develop a consistent set of principles for patient feedback across trusts to provide comparability and learning between organisations.
- The current ad-hoc nature (and often manual process) of collecting this information means it is currently of limited use in influencing patient care. Exploitation of IT offers significant opportunities to provide real-time feedback and analysis of the patient experience for incorporation into ward handover and MDT discussions where appropriate, together with wider learning opportunities.
- The variances in structures for managing this process are appropriate to each trust. However, a single 'owner' or 'champion' for patient experience is often difficult to identify (other than at Board level), or is fulfilled by multiple people from different teams. Without clear ownership, opportunities are difficult to maximise.

Good / best practice within East Midlands

The following areas of good practice have been highlighted:

- Early pathway engagement with patients, friends and families (Northampton General Hospital NHS Trust)
- Dedicated Patient Experience lead working on data capture enhancements (University Hospitals of Leicester NHS Trust)
- 'Your Views Matter' feedback displayed in ward areas (Derby Hospitals NHS Foundation Trust).

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	▶ Variable quality/discipline of capturing patient/family feedback in patient notes ▶ Variability in quality /granularity of patient feedback ▶ Frequently the feedback obtained does not enable whole pathway learning	▶ Improve consistency of how patient experience feedback is collected and reported across 7 days ▶ Create a common set of principles and approach across all trusts	▶ Seek a national solution to enhanced friends and family test based on 7DS requirements
Technology	▶ No real-time data capture or 7 day monitoring across the region	▶ Introduce day of feedback field on existing systems	▶ Work collectively to develop a real-time patient experience data capture and feedback solution
Workforce	▶ Different teams own different parts of the process at present	▶ Train staff in new patient experience process and supporting technology ▶ Explore the option of deploying Patient Experience teams across clinical areas	

Applicable case studies

▶ United Hospital of North Staffordshire NHS Trust

Clinical standard 2

Time to 1st Consultant Review

Standard definition

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 in-patient units).

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Time to 1st Consultant Review across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 02 **Time to 1st Consultant review**	50.1%	44.6%	73.8%	43.4%	59.0%	53.9%	66.9%	53.0%	64.1%	71.5%	57.4%

Key findings from the baseline assessment

- Clearly defined patient pathways are required for high-risk patient groups. These should be shared with all admitting teams to ensure that patients on a 1-hour pathway are clearly visible and can be managed effectively.
- Surgical specialties have greater challenges in meeting the requirements of the standards and have larger gaps than medical specialties. More robust senior cover of Surgical Assessment Units or equivalent is needed.
- This standard relies significantly on pure physical capacity as well as effective rota arrangements. Overall workforce shortfalls are therefore likely to become a key driver for service redesign and/or wider system options such as site rationalisation or collaboration. In addition to operational improvements, partnership approaches and enhanced use of technology will become key enablers to achieve this standard.

Good / best practice within East Midlands

The following areas of good practice have been highlighted:

- Rollout of IT systems to improve future data capture (University Hospitals of Leicester NHS Trust)
- Consultant rota changes have improved the level of achievement against standards. This has been achieved locally through specialty and service level dialogue (Chesterfield Royal Hospital NHS Foundation Trust)

- Collaboration with out-of-area providers in smaller specialties (United Lincolnshire Hospitals NHS Trust)
- Introduction of improved MAU (Medical Assessment Unit) and SAU (Surgical Assessment Unit) models (Northern Lincolnshire and Goole Hospitals NHS Foundation Trust).

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Inconsistencies in recording date/time of events in patient notes ► Not all trusts robustly using NEWS, some in transition ► Cross-site transfers can impact achievement of this standard ► Lack of pathway to identify and manage high-risk patients	► Reduce variation in availability of senior clinical cover in key admissions areas (e.g. MAU/SAU) ► Develop common pathway and triggers for high-risk patient groups	► Shortages of senior clinical staff require fundamental service redesign to deliver a sustainable solution, predominantly in the core admission areas ► Need to link HEEM planning to new process requirements
Technology	► No IT provision to record this event	► Identify options to capture time and date stamp in existing systems	► Introduction of workflow management solution to trigger and record necessary actions e.g. NerveCentre

Category	Common challenges	Operational opportunities	Strategic opportunities
Workforce	► Lack of consultant cover to achieve time-based assessment target (with bigger gaps at the weekend) ► Variability of consultant presence in assessment / admission areas ► Heavy reliance on on-call rotas which is not sustainable for a seven day service	► Review and amend consultant rotas and job plans to introduce 5/7 days working ► Review local on-call and out of hours arrangements including payments to provide a sustainable mechanism to deliver services across 7 days	► Invest in increase in consultant workforce alongside fundamental re-design of front door to reduce acute ward bed days ► Collaborate across East Midlands to establish consultant-led major emergency centres ► Introduce practitioner-led services in other areas to release consultant time to review urgent and emergency patients

Applicable case studies

► Salford Royal NHS Foundation Trust – Emergency Village

Clinical standard 3

Multi-Disciplinary Teams (MDTs)

Standard definition

All emergency in-patients 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.

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Multi-Disciplinary Teams across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 03 **Multi-disciplinary Team Review**	42.0%	47.6%	51.7%	51.5%	49.7%	48.3%	53.7%	53.1%	35.5%	57.3%	49.3%

Atos Consulting

Key findings from the baseline assessment

- Clinical support services present some of the largest challenges for workforce availability across 7 days for MDT reviews. Pharmacy and Therapies are highlighted as having recurring gaps.
- In most of the trusts reviewed, access to primary and community care records is not currently feasible; health communities will rapidly need to come together to agree and implement accelerated approaches to accessing records electronically to meet this standard and support the MDT process.
- A significant number of teams identified MDT input as an area with potential for innovation, e.g. Virtual MDTs enabled by technological solutions either within organisations or between organisations where networked solutions are needed.

Good / best practice within East Midlands

The following areas of good practice have been highlighted:

- 'Consultant of the week' model has been successfully introduced in some trusts providing improved clinical coverage (Kettering General Hospital NHS Foundation Trust)
- Pharmacy business cases developed to improve 7 day cover (United Lincolnshire Hospitals NHS Trust)
- Introduction of front door MDT models to enable senior decision-making at the point where it is most beneficial to patient care and most likely to reduce length of stay (University Hospitals of Leicester NHS Trust)
- Allocated Allied Health Professionals (AHPs) and Social Care workers taking part in structured MDTs in areas such as Adult Reablement Unit (Chesterfield Royal Hospital NHS Foundation Trust).

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Variable completion of medicines reconciliation when compared to standard requirements ► Fixed scheduling of MDTs across wards difficult due to other role requirements	► Agreement of definition for what constitutes an MDT and what input is required from all team members ► Redefine MDT processes to be efficient ► Establish an operation schedule for MDTs across key inpatient areas	► True networked approach to MDTs ► Virtual MDTs
Technology	► Trusts unable to consistently evidence MDT working due to lack of IT/note-recording solution ► Trusts unable to access Primary Care Records	► Develop simple e-whiteboard solutions ► Develop a health community approach to a clinical portal	► Use of mobile/video technologies to enable virtual MDTs ► Ensure imaging transmission sufficient quality; ► Immediate voice dictation
Workforce	► Inability to run daily MDTs both in and out of core hours due to shortage in key staff groups (e.g. AHPs, Pharmacy, specialist services	► Introduce local contract changes to enable wider 5/7 or rota based MDT working to better allocate current resource over 7 days inclusive of support services ► Train and develop existing staff to improve the skill mix to deliver MDT reviews e.g. Pharmacy Prescribers, AHP	► Develop an MDT workforce model enabling full assessment of emergency admissions within 14 hours across 7 days ► Work across East Midlands to establish 'virtual MDT review teams' enabled by new collaborative tools and technologies and pooled resources

Category	Common challenges	Operational opportunities	Strategic opportunities
		prescribers ► Introduce Advanced Clinical Practitioner and other new roles to release senior clinical decision-makers for MDT reviews ► Review job plans to ensure MDT is included. Define workforce gap (full scope) and agree credible workforce plan	► Agree East Midlands definition of 'competent decision-maker' to lead MDT reviews

Applicable case studies

- University Hospitals of Leicester NHS Trust - Leicester Fertility Centre
- Gloucester Hospitals NHS Trust
- South Tees Hospitals NHS Foundation Trust

Clinical standard 4
Shift Handover

Standard definition

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 7 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.

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Shift Handover across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 04 **Shift Handover**	68.6%	74.2%	71.8%	75.2%	86.6%	74.6%	75.3%	71.4%	60.4%	76.6%	73.3%

Atos Consulting

Key findings from the baseline assessment

- Interviews and process observations show that although shift handovers take place between specific staff groups, multi-disciplinary handover or sharing of handover issues between disciplines is rare or non-existent.
- Trust policy is often poorly defined and applied either variably within teams or not at all. There was little evidence of links from trust policy to national best practice guidance. A consistent, well defined approach within organisations is a relatively low-cost priority that can deliver improvements relatively quickly.
- Electronic handover processes offer significant opportunity to create flexible ways of supporting wider sharing of handover information between disciplines and would support creative solutions based around a virtual multi-disciplinary handover where required.

Good / best practice within East Midlands

The following areas of good practice have been highlighted:

- Rollout of electronic handover solutions in some trusts (University Hospitals of Leicester NHS Trust)
- Rota arrangements have been reviewed in some trusts to enable a multi-disciplinary shift handover (Sherwood Forest Hospitals NHS Foundation Trust).

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Lack of trust-wide operating procedures and policy ► Lack of central handover between teams (i.e. doctors to nurses), usually only held within staff groups	► Work collectively to develop a common policy/ standard process for MDT shift handover	► Develop process for virtual multi-disciplinary handover

Category	Common challenges	Operational opportunities	Strategic opportunities
Technology	► Handover information not typically recorded electronically	► Cross-regional review of e-Handover solutions	► Work collectively (sharing existing best practice) to develop an electronic solution for multi-professional shift handover ► Enable virtual multi-disciplinary handover through mobile technologies and wider roll out of e-Handover solutions
Workforce	► Variability around medical shift handover process and occurrence ► Availability of AHP workforce to engage in multi-professional shift handover	► Engage medical workforce in importance of standardised, electronic shift handover – cultural shift required ► Review AHP rotas to include presence at multi-professional shift handover ► Share nursing good practice more widely	► Training in new systems, virtual working

Applicable case studies

- Doncaster Metropolitan Borough Council, Rotherham, Doncaster South Humber NHS Foundation Trust
- Doncaster and Bassetlaw NHS Foundation Trust

Clinical standard 5
Diagnostics

Standard definition

Hospital in-patients must have scheduled 7-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 7 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.
- 7-day consultant presence in the radiology department is envisaged.
- Non-ionising procedures may be undertaken by independent practitioners and not under consultant direction.

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Diagnostics across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 05 **Diagnostics**	67.8%	65.1%	61.9%	51.9%	67.8%	73.4%	55.9%	55.6%	67.5%	52.8%	61.3%

Key findings from the baseline assessment

- There remains an opportunity to carry out a detailed diagnostics demand and capacity planning review to better understand service demands. This is in the process of being commissioned in the context of cancer waiting times; however the analysis is expected to have a broader application. This is for inclusion in actual delivery of scans but also in their reporting. As this is initially within control of each organisation and informs wider requirements this should be seen as a priority.
- Reporting offers a significant opportunity for wider network arrangements, as recognised through EMPATH (pathology services), EMRAD (East Midlands Radiology)/RADISH (Radiology Integrated Service Hub) and other related emerging programmes. Delivering all reports within 24 hours recurs as a key challenge and a number of organisations already use some form of outsourcing arrangement. Better joint planning and commissioning of collective reporting capacity offers a significant area for collaboration on both procurement and delivery.
- Diagnostics recurs as an area of significant challenge for workforce. In a number of areas (particularly Ultrasound and Interventional radiology – see CS6) significant national shortages mean some form of network arrangement is likely to offer a viable way forward for a number of organisations. Given the hands-on nature of these services however, these are unlikely to be in the form of workload transfer and will require more creative forms of network, together with developing and extending other staff roles to support the service.
- There needs to be an assessment of the implications of technological advance, particularly in relation to advances in healthcare science.

Good / best practice within East Midlands

The following areas of good practice have been highlighted:

- Availability of technology to process, view and share test results including remote access (Derby Hospitals NHS Foundations Trust)
- Some network arrangements in place (Northern Lincolnshire and Goole Hospitals NHS Foundation Trust).

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Increasing volume of requests – how many are appropriate? ► Challenge to achieve access and reporting targets as specified in standards (particularly 24 hours for all non-urgent patients) ► Variation of service availability in relation to specialty requirements ► Need to determine ways of getting clinicians to put patients on an East Midlands Pathway (i.e. across the network)	► Demand and capacity planning ► Reduce variation in service availability through better alignment of capacity driven by a detailed demand analysis ► Outsourcing, e.g. interventional radiologists in Durham ► Identify key diagnostics that, when provided over 7 days, would have an impact in terms of improved patient outcomes ► Improve wider system understanding of current reporting standards	► Integrated outsourcing across all trusts ► Collaboration across services and trusts to provide scientific and diagnostic services over 7 days ► Improve effectiveness of the outsourcing; have good service level agreements in place; use consortia buying powers

Category	Common challenges	Operational opportunities	Strategic opportunities
	► Impacts on supplier costs as turnaround timescales are much tighter than current arrangements	► Create a network that agrees tests of limited clinical value ► Identifying/agreeing triggers for alerting to process blockages and rectification action	
Technology	► Diagnostic Ca Reporting	► Provide IT support across 7 days for diagnostic technology ► Enable access to remote reading	► Image Exchange Portal (IEP) – national solution to enable digital image sharing and streamlined radiology reporting ► Interoperability standards for cross-enterprise imaging informatics ► Use tele-reporting nationally and internationally ► Introduce regional 'horizon scanning' network to consider the introduction of new technology (e.g. proton beam therapy, hand-held devices, patient INR monitoring, molecular imaging) ► EMRAD (procurement consortium organisation and radiology networked services)

Category	Common challenges	Operational opportunities	Strategic opportunities
Workforce	► Recruitment challenges for diagnostic roles ► Recruitment challenges for healthcare scientists e.g. neurophysiology is on the national shortage list ► Existing healthcare scientist workforce is small and spread across 52 diverse specialisms ► East Midlands not 'joined-up' with regard to workforce planning ► Staffing problem not just Radiologists - radiographers, sonographers also ► Need to explore 'role extension' to allow greater flexibility and overlap of roles ► East Midlands workforce slightly worse than other areas - in lowest quartile ► >30 clinical vacancies – unsustainable	► Effective use of appropriately trained non-medical staff to ease pressure on radiologists ► Specialist advanced practitioner and consultant radiographic grades ► Radiographers extending their role to support patients referred from the accident and emergency department for imaging of minor injuries ► Review rotas and on-call arrangements to optimise service availability ► Invest in training and developing existing staff to provide the necessary skills mix to deliver a wider range of services within a more flexible workforce model ► Staff education on 'appropriate testing' to reduce unnecessary diagnostic workload ► Staff engagement and education programme to understand what diagnostic tests are available when and how to access them.	► Continue to work across the East Midlands to address the shortages of key staff (including radiologists, sonographers, report writers); requires fundamental service redesign to deliver a sustainable network solution ► Pooling of skills across a wide area network ► Consider commissioning more consultant HCS roles (HSST) who can lead the delivery of specialist diagnostic and rehabilitation services and support medical practitioner ► Introduce regional HCS training consortia to balance training capacity between larger and smaller services ► Introduce a pool of resources that can deliver diagnostic services across different organisations e.g. within the acute setting,

Category	Common challenges	Operational opportunities	Strategic opportunities
		► Extend the roles of scientists to include for example the reporting of results in cardiac physiology	multi-specialty community providers and in patients' homes ► Extend role to include plain film reading for radiographers

Applicable case studies

- South London Collaborative Working Pilot
- Royal Free Hampstead NHS Trust

Clinical standard 6
Interventions / Key Services

Standard definition

Hospital in-patients must have timely 24 hour access, 7 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, including:

- renal replacement therapy
  urgent radiotherapy
  thrombolysis
  percutaneous coronary intervention (PCI)
  cardiac pacing.

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Interventions/Key Services across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 06 **Interventions and Key Services**	44.0%	61.7%	42.5%	70.9%	37.8%	58.2%	48.9%	38.2%	39.8%	56.8%	52.4%

Key findings from the baseline assessment

- A balanced approach combining operational improvements and strategic opportunities will be needed to close the gaps in service level variation. Similarly to CS5 (Diagnostics), detailed demand and capacity planning linked to predictable service demands could help in a number of areas by realigning existing capacity. This is unlikely to resolve the entire gap but offers an opportunity to make significant improvements as, currently, most patients will receive their intervention but not at the optimum point in the pathway.
- This is an area of key national shortfalls in staff availability. Currently, for example, around 50% of interventional radiology vacancies are unfilled. This suggests that further networking or other innovative arrangements are likely to be the only viable way forward. The fact that patients may ultimately have to be moved to receive appropriate interventions in some cases means this is likely to have a more significant impact on patient pathways and overall models of care for those requiring interventions.
- To minimise the requirement for patient moves and wider impacts on patient pathways, ongoing development of extended roles, in partnership with HEEM and supported through enhanced network relationships and technology for video-conference support, need strategic consideration across trusts – at least at a sub-regional level.

Good / best practice within East Midlands

The following area of good practice has been highlighted:

- Some service areas already collaborating and networking e.g. IR, PCI and thrombolysis

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Lack of staff awareness of availability of 24 hr services ► Common challenges in availability of certain services (e.g. interventional radiology)	► Demand and capacity planning ► Improve communication of key interventions /service availability - plus better performance management of existing contracts/SLAs with external providers ► Realign diagnostic rota ► Local specialist IR MDT ► Medical staff/nurses joint working ► Formal cross-site MDT working ► Links with vascular surgery ► Active waiting list management	► Work across East Midlands and with neighbouring economies/external providers to develop sustainable network solutions (e.g. interventional radiology/endoscopy) ► Networked on-call IR ► Equipment/procurement merger ► IR on-call manual ► Monthly Interventional forum ► Regional on-call collaboration
Technology		► Use video-conferencing	► IT enabled transformation of service provision

Category	Common challenges	Operational opportunities	Strategic opportunities
Workforce	▶ Challenges for recruitment into key roles	▶ Train and develop existing staff to expand roles and diversify the skills mix ▶ Explore the introduction of Advanced Clinical Practitioner roles to release senior clinicians' time. ▶ Recruitment and retention premiums - 'pay more to attract' ▶ Joint contracts/ appointments ▶ Appointments from abroad	▶ Further commissioning review of East Midlands acute service redesign options e.g. clinical hubs/centres of excellence for key interventions/services – pooling resources to deliver this

Applicable case studies

- Cumbria and Lancashire Telestroke network
- University Hospitals Coventry and Warwickshire and George Eliot Nuneaton NHS Trusts
- Newcastle Upon Tyne NHS Trust
- South Devon and Royal Exeter and Devon NHS Trusts
- NHS Greater Glasgow and Clyde
- West Yorkshire Cardiovascular Network
- Newton Abbot Hospital, Torbay and Southern Devon Care Trust

Clinical standard 7
Mental Health

Standard definition

Where a mental health need is identified following an acute admission, the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, 7 days a week:

- Within 1 hour for emergency* care needs
- Within 14 hours for urgent** care needs.

Supporting information

Unless the liaison team provides 24-hour cover, there must be effective collaboration between the liaison team and out-of-hours services (e.g. Crisis Resolution Home Treatment Teams, on-call staff).

*An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others

**A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Mental Health across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 07 **Mental Health**	48.8%	58.4%	34.1%	28.2%	46.6%	44.9%	26.7%	21.7%	54.3%	53.0%	42.4%

Atos Consulting

Key findings from the baseline assessment

- The gaps in mental health are primarily driven by a lack of service integration and a mis-alignment of demand and capacity for both Adult and Children services.
- This is compounded by a lack of consistent operational information and understanding about the availability and means to access mental health services, even where they are available.
- Integrating services at local levels and developing partnership arrangements at local health system level will contribute significantly to closing the gaps against the required standard
- There is evidence that the provision of better use of IT is required to improve cross-organisational information flow to make timely decisions. In addition, there is a strong case to explore and find alternative working models to improve communication amongst the staff groups. This could be achieved by co-locating of services around specific parts of patient pathways and specialties.

Good / best practice within East Midlands

The following areas of good practice have been highlighted:

- Some trusts working closely with partnership organisations to develop improved service models (Northern Lincolnshire and Goole Hospitals NHS Foundation Trust)

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Lack of integration of mental and physical health services across the pathways of care ► Mis-alignment between wards and mental health liaison service about definition and requirements for	► Work with the wider health system to improve understanding of both adult and children's mental health requirements and service availability ► Develop and communicate a clear directory of	► Acute trusts work collaboratively with partnership providers to develop radical economy wide service redesign options e.g. RAID (see list of applicable case studies) ► Single point of access to mental health trust

Category	Common challenges	Operational opportunities	Strategic opportunities
	seeing emergency and acute patients ► Lack of staff awareness about the services available	services	
Technology	► No/limited access to mental health care records on wards	► Improve access to mental health care records within acute providers ► Enable input via Virtual working	► Introduce integrated care records
Workforce	► Limited mental health awareness with acute provider teams	► Co-locate community mental health staff at the front door to address issues early and within community-based services including ambulance ► Educate staff about what mental health services are available and how to access them	► Improve mental health training across acute provider teams

Applicable case studies

- Northumberland, Tyne and Wear NHS Foundation Trust
- Birmingham – Rapid Assessment Interface Discharge (RAID)

Clinical standard 8

On-going Review

Standard definition

All patients on the AMU, SAU, Intensive Care Unit (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, 7 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.
- In-patient 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.
- In-patients 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.

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for On-going Review across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 08 **On-going Review**	35.9%	44.8%	52.8%	50.1%	41.4%	47.2%	61.1%	47.3%	54.9%	61.9%	49.8%

Key findings from the baseline assessment

- Variation in the availability of senior clinicians across 7 days has significant impact on achieving this standard. Trusts have embarked on many operational improvements schemes to address the availability gaps by introducing changes to rotas and shift coverage to get a better balance across 7 days.
- New workforce models driven by service redesign will be required to improve staff availability and reduce service variation.

Good / best practice within East Midlands

The following areas of good practice have been highlighted:

- Twice-daily reviews in some trusts for acute/high-dependency wards (Kettering General Hospital NHS Foundation Trust)
- Consultant rota changes have improved standard achievement in some trusts (Chesterfield Royal Hospital NHS Foundation Trust)
- Introduction of electronic whiteboard systems in some trusts (Northampton General Hospital NHS Trust).

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Challenges in meeting requirements for daily consultant-led ward rounds across all in-patient areas ► No core criteria for 'not required'	► Reduce variation in availability of senior clinical cover ► Wider introduction of consultant of the week models	► Work collectively across East Midlands to develop acute service redesign options (e.g. clinical hubs/centres of excellence for key specialties). ► 'Hot' centre for acute care
Technology	► Lack of workflow management across teams meaning	► Review e-whiteboard solutions ► Other areas of best practice across East Midlands	► Enable virtual ward rounds ► Pursue opportunities for more cross-site working

Category	Common challenges	Operational opportunities	Strategic opportunities
Workforce	► Job plans and staff rotas will require significant change to achieve the standard	► Protect time in job plans to reduce variation of daily consultant led ward rounds. ► Better align capacity to demand ► Review rotas and on-call arrangements to optimise consultant availability to deliver daily ward rounds	► Introduce new roles into the workforce model such as Physician Associates to release consultant time for daily ward rounds ► Introduce practitioner-led services in other areas to release consultant time to review urgent and emergency patients e.g. Outpatient redesign

Applicable case studies

► Northumbria Healthcare NHS Foundation Trust

Clinical standard 9

Transfer to Primary, Community and Social Care

Standard definition

Support services (both in the hospital and in primary, community and mental health settings) must be available 7 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 plans from hospital to primary, community and social care.
- Transport services must be available to transfer, 7 days a week.
- Effective relationships should exist between medical and other health and social care teams.

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Transfer to Primary, Community and Social Care across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 09 **Transfer to Primary, Community and Social Care**	39.2%	47.2%	49.2%	64.0%	46.9%	37.5%	44.2%	52.7%	42.3%	45.1%	47.3%

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Key findings from the baseline assessment

- Variation in service provision is driven by availability of workforce and also major gaps in working as an integrated health and social care team which goes across the boundaries of the acute, community, primary and social care. This concept has proved effective, for example in specialties such as stroke and care of elderly.
- Local health economies will need to work in partnership to better understand or jointly develop patient pathways and the required interventions at different stages of patient journey.
- Working in integrated teams will also depend on seamless information flows and access to/availability of integrated care records. Implementation of these options will have a significant impact on achieving this standard and providing a consistent service.

Good / best practice within East Midlands

The following areas of good practice have been highlighted:

- 24/7 access to community Emergency Care Practitioners (ECPs) to aid admission avoidance (United Lincolnshire Hospitals NHS Trust)
- Working closely with partnership organisations to develop improved service models (Northern Lincolnshire and Goole Hospitals NHS Foundation Trust).

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Misalignment of process and definition between trust discharge criteria and community	► Establish joint improvement plans with partnership organisations to eliminate discharge /transfer delays	► Acute trusts work collaboratively with partnership providers to develop radical economy-wide integrated care solutions; for example:

Category	Common challenges	Operational opportunities	Strategic opportunities
	admission criteria resulting in delayed transfers of care ► Lack of step up/down facilities in community ► Transportation contracts not aligned to demand requirements	► Develop and communicate a clear directory of services	► Integrated care model ► Multi-disciplinary rapid assessment programme team ► Computerised 'i-tracker' system e.g. workflow management ► Discharge nurse specialist case managers ► Hospital at Home ► Co-location of social care in AMU ► Multi-disciplinary Joint Emergency Team (JET team) ► Joint governance board ► More structured approach to problem solving ► Out-of-hours/weekend audits ► Systematic testing of changes ► Long-term conditions (LTC) management ► Attendance/admission avoidance models ► Early supported discharge models
Technology	► Lack of integrated ways of working (e.g. demand and capacity planning, sharing of data and information)	► Improve access to Primary Care summaries within acute providers	► Introduce Integrated Care Records

Category	Common challenges	Operational opportunities	Strategic opportunities
Workforce	► Lack of understanding about ways of working, pressures and processes between acute, primary, community and social care workforces	► Rotate resources across the different organisations within the whole system ► Establish pooled resources (e.g. Occupational Therapists) to work across the whole system ► Identify key resources to co-locate within the Acute site e.g. social workers in AMU ► Identify key acute resources to provide outreach services ► Use of estates fleet to provide out of hours (OOH) support	► Explore the inclusion of flexibility clauses in existing contracts and the alignment, where possible, of key policies and processes to allow key resources to work more flexibly across the whole system

Applicable case studies

- Doncaster Council and local NHS Trusts
- Epsom and St Helier University Hospitals NHS Trust and Surrey County Council Adult Social Care
- Oxleas NHS Foundation Trust and Greenwich Local Authority
- Bristol, North Somerset and South Gloucestershire Urgent Care Board
- Aneurin Bevan Health Board – Wales
- Birmingham Community Healthcare NHS Trust
- South Devon Healthcare NHS Foundation Trust – Torbay Hospital
- Great Yarmouth and Waveney

Clinical standard 10
Quality Improvement

Standard definition

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, 7 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 that delivery of 7 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.

Baseline assessment

The following table summarises the outcome of the baseline assessment phase. The RAG values indicate the level of compliance of each trust's operational processes when tested against the clinical standard requirements for Quality Improvement across 7 days.

Red Amber Green Compliance Score by Trust and Clinical Standard

	Chesterfield	Derby	Kettering	Leicester	North Lincs & Goole	Northampton	Nottingham	Peterborough	Sherwood Forest	United Lincs	**Average across Trusts**
Clinical Standard 10 **Quality Improvement**	35.8%	45.5%	65.5%	62.6%	18.4%	53.4%	72.3%	63.2%	54.7%	74.6%	55.6%

Key findings from the baseline assessment

- The achievability of this standard will partly require an introduction of better knowledge sharing and networking processes.
- Developing a culture of continuous improvement will be key where clinical and non-clinical staff place a greater emphasis on quality improvement as part of their daily operations.
- Redesign of existing business intelligence processes and provision of IT enablers will be needed to provide a stronger platform for measuring and taking timely actions to address quality and outcome challenges. This will require a robust service management regime to enable timely decisions to be made.

Good / best practice within East Midlands

The following area of good practice has been highlighted:

- Clinical governance meetings scheduled to share lessons learned and improve service provision (Northampton General Hospital NHS Trust).

Common challenges and opportunities for achieving the standard

Category	Common challenges	Operational opportunities	Strategic opportunities
Process	► Inconsistent process to review outcomes and embed lessons learned/training ► Reviews tend to be staff group specific, rather than MDT based	► Improve current processes for sharing knowledge and best practices across trusts and the wider economy ► Ensure the availability and use of the right data to drive patient outcome reviews	► Implementation of a cross-regional collaboration and knowledge-sharing solution

Category	Common challenges	Operational opportunities	Strategic opportunities
	► Data is sometimes unavailable or inappropriate to drive effective review conversations		
Technology	► Variable business intelligence data available to clinical teams	► Improve availability of key outcome data across services	► Outcome reports automatically generated by integrated business intelligence systems
Workforce		► Offer training in continuous improvement methodologies and approaches as part of development plans for clinical leaders	► Alteration of junior doctor contracts to support OOH training requirements ► Foster a culture of continuous improvement where clinicians, non-medics and managers accept this as part of everyday operations not just at formal audits ► Review the 'positioning' of urgent and emergency care within junior doctor training

Applicable case studies

► Bristol, North Somerset and South Gloucestershire Urgent Care Board

6.5 Measuring clinical outcomes

This project has taken account of clinical outcomes data provided by each organisation during the baseline assessment of current provision. It indicates some variation in clinical outcomes of mortality and length of stay between weekdays and weekends

Evidence shows that the limited availability of some hospital services at weekends has a detrimental impact on outcomes for patients, including raising the risk of mortality, re-admission and the length of stay. The Keogh Review in November 2013 crystallised this by identifying an 11% increased risk of mortality for emergency admissions on a Saturday and a 16% increased risk for emergency admissions on a Sunday. This project has taken account of clinical outcomes data provided by each East Midlands acute trust during the baseline assessment of current provision against the requirements of the ten standards. However, this cannot be directly compared with the overall mortality indicators used nationally in relation to urgent care standards. Detailed analysis of the clinical outcomes data provided by each trust is included in their individual trust Tableau dashboard.

The national comparator available is from the published Summary Hospital-level Mortality Indicator (SHMI) data from NHS England. The latest version is for April 2013 to March 2014 (published on 23 October 2014). This indicates a mortality rate of 1.9% above expected rates across the East Midlands collaborative. Within the region however, there is significant variation ranging from 9% below the expected rate to 9% above the expected rate, with three acute trusts within the Collaborative at 5% or higher than the national expected rate.

Trust	Mortality rate in relation to national expected rate	
Derby Hospitals NHS Foundation Trust	+9%	above national expected rate
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	+8%	
University of Leicester Hospitals NHS Trust	+5%	
Sherwood Forest Hospitals NHS Foundation Trust	+4%	
United Lincolnshire Hospital NHS Trust	+4%	
Kettering General Hospital NHS Foundation Trust	+1%	
Northampton General Hospital NHS Trust	+1%	
Peterborough and Stamford Hospital NHS Foundation Trust	0%	at expected national rate
Chesterfield Royal Hospital NHS Foundation Trust	-1%	below national expected rate
Nottingham University Hospital NHS Trust	-9%	

Source: Summary Hospital-level Mortality Indicator- Death associated with hospitalisation, April 2013- March 2014 Quarterly report (HSCIC publication 23rd October 2014)

The data is not separated between weekdays and weekends and is therefore of limited value when trying to compare these rates with the 11% and 16% challenge set out in the Keogh review. Critical differences to note between the SHMI data and the data available at East Midlands regional level through Hospital Episode Statistics (HES) is that the national rate excludes specific urgent admissions (for example patients admitted on a palliative care pathway). In addition, it looks at mortality rates up to 30 days after acute discharge.

Based on the HES data submitted by a number of trusts, clinical outcomes indicate that the:

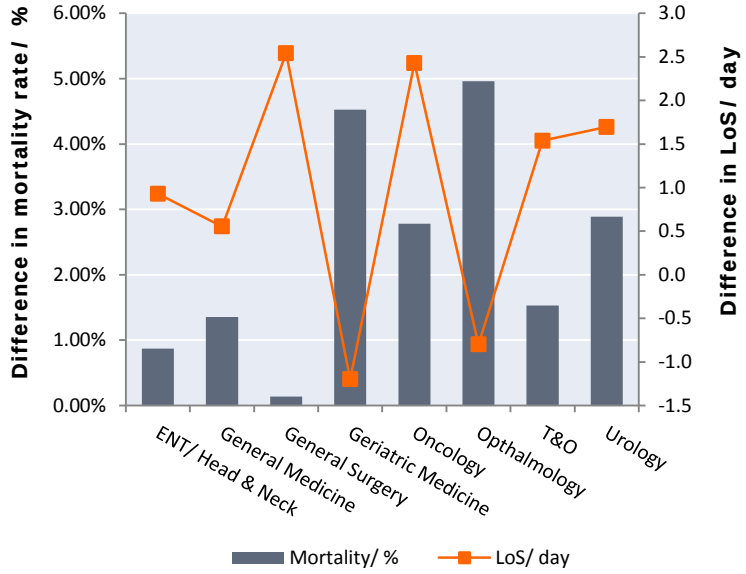
- Mortality rate across all specialties is:
  - 1.23% higher on Saturdays than on weekdays
  - 1.33% higher on Sundays than on weekdays.
- Length of stay rate across all specialties is:
  - The same on Saturdays as on weekdays
  - 0.4% higher on Sundays than on weekdays.

The approach to the baseline assessment across the trusts has driven a bottom-up assessment at specialty and service levels.

Analysis of the data submitted shows that the greatest impact for closing gaps in clinical standards achievability across the region would result from prioritising improvement activities in eight key specialties. These are: Ear, Nose and Throat/Head and Neck; General Medicine; General Surgery; Geriatric Medicine; Oncology; Ophthalmology; Trauma and Orthopaedics; and Urology. Within these specialties, CS2 (Time to 1st Consultant Review), CS3 (MDT Review), and CS8 (On-going Review) present the biggest challenges. Appendix D contains more detailed information on clinical standards achievability by specialty.

By addressing the root causes of these challenges, trusts will achieve a positive impact on the clinical outcomes of these specialties. Figure 16 shows the difference in clinical outcomes between these eight specialties.

Figure 16: Difference in clinical outcomes between admissions at weekend compared to weekday

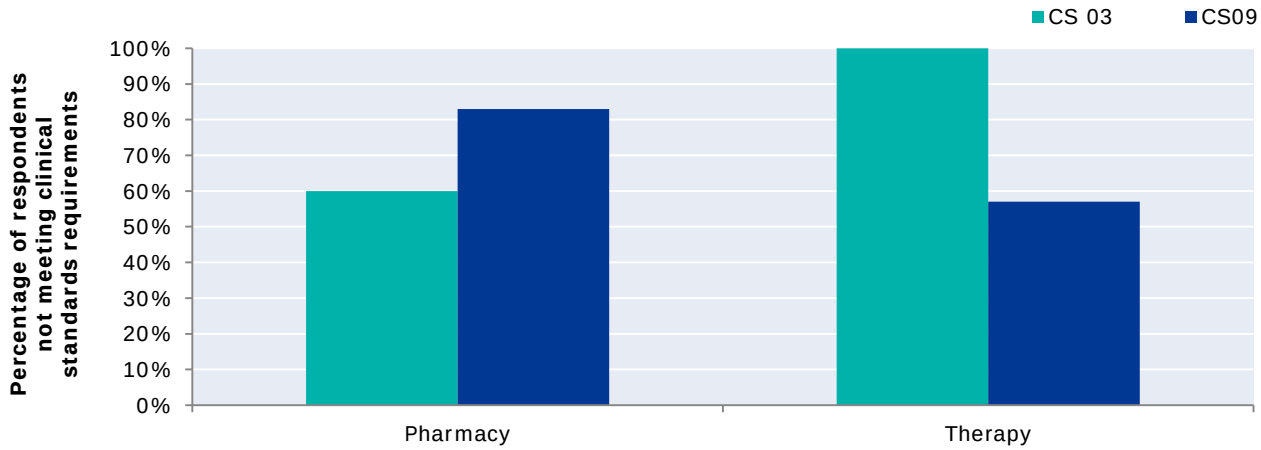


Specialty	Mortality/ %	LoS/ day
ENT/ Head & Neck	0.87%	0.93
General Medicine	1.36%	0.55
General Surgery	0.14%	2.54
Geriatric Medicine	4.53%	-1.20
Oncology	2.78%	2.43
Opthalmology	4.96%	-0.80
T&O	1.53%	1.54
Urology	2.89%	1.70

The analysis shows that all of those specialties with the exception of Geriatric Medicine and Ophthalmology have a higher length of stay for patients admitted over the weekend and all eight have a higher mortality rate for patients admitted at weekend. Trusts' teams have acknowledged that further analysis of clinical outcomes data is needed to ascertain the key differences in clinical outcomes between weekends and weekdays.

Clinical support services present some of the largest challenges for workforce availability across 7 days. Pharmacy and Therapies are highlighted as having recurring gaps.

Figure 17: Support services with greatest challenges to meet the clinical standards



The analysis above indicates that support services which have the greatest gap to achieving the standards are in:

- CS3 (MDT Review)
- CS9 (Transfer to Primary, Community and Social Care).

A trust-level consolidation of this information is included in Appendix D to help senior decision-making on prioritisation at a trust level.

It is unlikely that all trusts will be able to deliver all services 7 days a week within the national timeframe given financial and resource constraints

6.5.1 Looking to the future

It is unlikely that all trusts will be able to deliver all services 7 days a week within the national timeframe given financial and resource constraints. This opens up the requirement for serious consideration as to future models of service provision, in terms of:

- Introducing new delivery models
- Service rationalisation/centralisation
- Site rationalisation

- Partnerships/joint ventures.

For those services which are required across 7 days but are not being provided either wholly or partially, further detailed demand and capacity analysis should be completed within key areas to identify whether:

- Each trust can address the gap individually
- Organisations need to work together
- One organisation can scale up its service to provide the required capacity across a local area or across the region.

This analysis seems to present a scenario where the likely solution to ensure provision of sustainable service models will be to centralise, reconfigure or network (see list of case studies in Appendix F).

East Midlands Clinical Senate

Section 7

Addressing strategic workforce challenges

Put simply, consistent and robust 7 day services are dependent on having the right people in the right place at the right time doing the right things. Each of the ten clinical standards will have an impact on the workforce, some more than others. Meeting the standards will require a blend of traditional and innovative workforce solutions that address current capacity and capability constraints. Services will need to be redesigned at an operational and strategic level, supported by a fundamental culture shift which accepts the need to work across 7 days. Clinical leaders are pivotal to shaping and driving the level of change necessary to meet these challenges.

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7 Addressing strategic workforce challenges

It will not be possible to meet the standards through recruitment alone; NHS budgets are sorely stretched and there are national shortages for some professions

This section provides high-level recommendations in three areas:

- Addressing capacity constraints
- Maintaining and building capability
- Creating a 7 day services culture.

7.1 Workforce as a key enabler

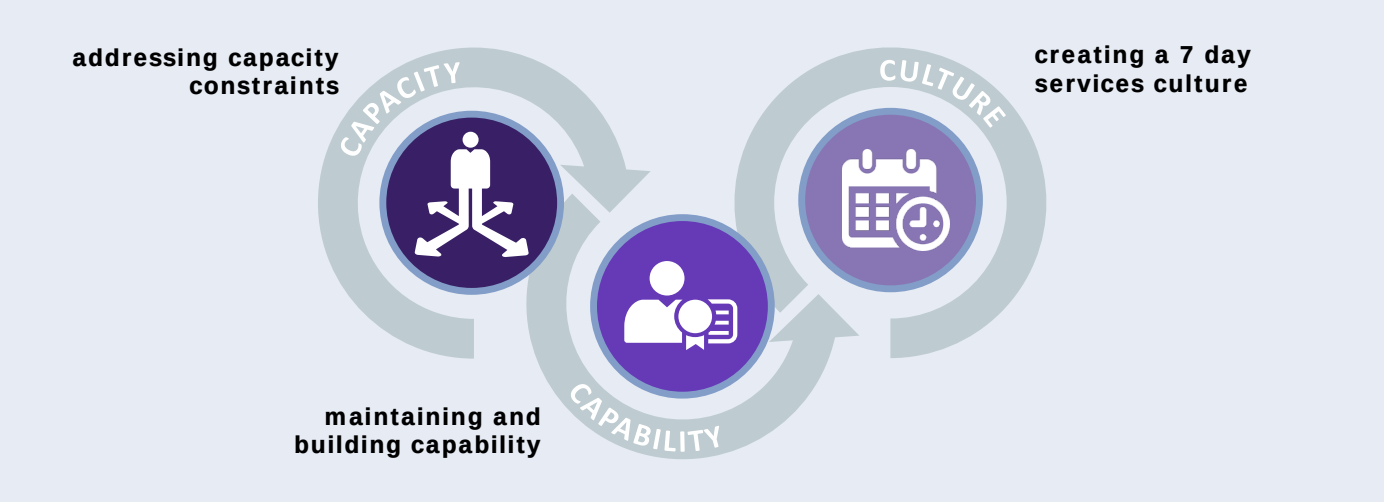
Each of the ten clinical standards will have an impact on the workforce, some more than others. It will not be possible to meet the standards through recruitment alone; NHS budgets are sorely stretched and there are national shortages for some professions. Meeting the standards will require a blend of traditional and innovative workforce solutions. Services will need to be redesigned at an operational and strategic level, supported by a fundamental culture shift which accepts the need to work across 7 days to provide consistently safe patient care.

The regional process needs to better integrate Trust business planning with commissioner intentions and HEEM workforce planning in order to match future supply with trusts' workforce demands

Workforce planning processes will need to be reviewed across East Midlands to provide real clarity on the roles, responsibilities and interfaces between organisations such as trusts, Health Education East Midlands (HEEM), including Local Education and Training Council, and potential clinical advice from the Clinical Senate and clinical networks. The regional process needs to better integrate trust business planning with commissioner intentions and HEEM workforce planning in order to match future supply with trusts' workforce demands.

The Collaborative, East Midlands Clinical Senate and Strategic Clinical Networks, HEEM and the Deputy Chief Scientific Officer for NHS England worked closely to analyse the implications of the 7 Day Services clinical standards for the East Midlands acute workforce over the next two years. The detailed findings of common challenges and opportunities can be found in Section 6.4.

Figure 18: The three key areas to address strategic workforce challenges



7.1.1 Focuses for workforce challenges

This section makes particular reference to CS2 (Time to First Consultant Review), CS3 (MDT Review), CS5 (Diagnostics), CS6 (Interventions/Key Services) and CS8 (On-going Review). This is because these four clinical standards present the most significant workforce challenges internally to each trust.

Workforce challenges for CS7 (Mental Health) and CS9 (Transfer to Primary, Community and Social Care) are equally significant, but require whole-system solutions.

7.2 Addressing capacity constraints

There are clear recruitment challenges within the East Midlands

There are clear recruitment challenges within the East Midlands with each of the ten trusts highlighting vacant funded establishments across a wide range of professions. HEEM is working across all acute trusts within the East Midlands to understand the extent of current workforce challenges. There are particular issues within diagnostics, interventional services, the healthcare scientist profession and nursing (e.g. advanced nurse practitioners (ANPs)). The current position is unsustainable, evidenced for example by the year-on-year increases in the number of CT and MRI examinations together with

Addressing capacity constraints requires a broader response than just recruitment

12% of radiology posts within East Midlands remaining unfilled, with particular challenges in the recruitment and retention of interventional radiologists. HEEM and East Midlands Strategic Clinical Networks and Clinical Senate are working closely to address these challenges, for example to model radiographer/radiologist demand and supply and to facilitate discussions on new service and workforce solutions such as the Radiology Integrated Service Hub (RADISH).

Addressing capacity constraints therefore requires a broader response than recruitment. It is about organising the workforce effectively across 7 days, growing capacity from within and having the right retention strategies in place to prevent that investment walking out of the door.

7.2.1 Organising the workforce effectively

Traditional HR enablers such as local changes to contracts, job plans and rotas, on call and out of hour's arrangements will go some way to facilitate the effective organisation of staff across an acute organisation over 7 days. Rota changes have improved the level of achievement against standards in some trusts in East Midlands. This has been achieved locally at specialty and service level through dialogue with HR, consultants, AHPs and service managers.

Recommendation

The 7 Day Services HR Group could capture and share practice and learning around using rotas across acute trusts. In addition, clinicians who are now working with different rotas should engage their peers.

Advertising more roles as 'East Midlands' roles that work regionally across organisations would help share resources and facilitate East Midlands clinical pathways

There is, however, a clear opportunity to address these challenges collaboratively to provide a level workforce playing field across East Midlands. This will enable existing staff to work more easily across acute organisation boundaries when needed, facilitating more 'East Midlands clinical pathways' that share resources (as well as technology and standard processes). This could be supported with the introduction of more roles being advertised as 'East Midlands' roles that work regionally across organisations.

Recommendation

The 7 Day Services HR Directors Group is well positioned to agree East Midlands-wide HR levers that enable the workforce changes required to deliver 7 day services across the region. There should be clear engagement of the HR Directors Group to transformational programmes and connections to clinical network activities in order that HR levers are considered explicitly within improvement plans.

7.2.2 Growing capacity from within

There are opportunities to pool resources across organisational boundaries to provide the necessary roles and skills mix to deliver networked services

This is dependent on knowing the present workforce in terms of roles, skills and knowledge, and having robust service demand and capacity analysis so that workforce requirements are clear. Whilst this can be done locally there is clearly the opportunity to join-up workforce planning across East Midlands. This would highlight opportunities to pool resources across organisational boundaries providing the necessary roles and skills mix to deliver networked services for those that individual trusts would otherwise struggle to deliver.

Recommendation

Workforce planning could be joined up across East Midlands to pool resources to provide the mix of roles and skills needed for 7 day services.

Growing capacity from within also requires leadership commitment to invest in people and make the time and space available for training and education. There are good practice examples of improving diagnostic and interventional services provision across 7 days by developing existing staff to improve the skills mix to deliver a wider range of services. HEEM's Advanced Clinical Practice Framework supports the training and development of specialist advanced practitioner and consultant radiographic grades. It also supports appropriate training for non-medical staff to ease the pressure on, for example, radiologists. HEEM is working closely with organisations across East Midlands to embed the Advanced Clinical Practice Framework providing common understanding and definition of the functions, knowledge, skills and competences of healthcare professionals working in advanced clinical practice roles. The typical training time for an Advanced Practitioner with existing professional registration and experience is 12 months.

Recommendation

Advanced Practitioner roles should continue to feature within each trust's workforce strategy to ensure sufficient senior clinical decision-makers for front door MDT and on-going daily reviews. It is important that clinicians have the opportunity to engage effectively in workforce planning and are made aware of developments such as HEEM's Advanced Clinical Practice Framework.

7.3 Maintaining and building capability

A flexible workforce will be needed to deliver improved services using the latest tools, techniques and research

Trusts will need a clear workforce strategy that blends the introduction of new roles within the organisation with the enhancement of existing ones

This is very much linked to growing capacity from within. The requirements to maintain and build capability will be driven by the trusts' strategic 7 day services objectives and business plans. They will also be influenced by the transformational programmes of partners within the local care system. A flexible workforce will be needed to deliver improved services using the latest tools, techniques and research. Although there is a national timescale for the provision of consistent 7 day services by 2016/17, a significant number of scientific developments are currently being anticipated, which will materially impact on technology and the roles that need to be developed in terms of medium to longer term workforce strategies. While these do not relate specifically to 7 day services, they represent challenges and opportunities that may impact on strategic investment decisions.

Recommendation

Trusts will need a clear workforce strategy that blends the introduction of new roles within the organisation with the enhancement of existing ones. Trusts will need to be clear about how they will equip the workforce with the skills to work more flexibly.

Maintaining and building capability is about:

- Prioritising mandatory training to maintain competence, service quality and safety
- Ensuring the existing workforce has the opportunity to 'learn beyond registration'
- Enabling staff to collaborate through learning networks to share best practice about 7 day services.

Investing in existing staff to address workforce challenges will need new ways of working that take into account new roles and responsibilities. Innovative workforce solutions alongside service redesign will be needed to deliver 7 day services; for example:

- The introduction of practitioner-led services in other areas to release consultants
- Alternative roles, such as Physician Associate, that would also release Consultant capacity
- Clinical hubs for key specialties with pooled Consultant resource
- Appropriate training for non-medical staff to ease the pressure on, for example, radiologists.

- Development of new skills within key areas that will enable transformational opportunities associated with anticipated developments in healthcare science (e.g. for CS5 (Diagnostics) – Clinical Engineers and Computer Technologists to support intensivists).

HEEM's Advanced Practitioner Framework is a key enabler to building capability within East Midland's workforce. So too is the Learning Beyond Registration Fund that provides the opportunity for post registration healthcare professionals (excluding doctors and dentists) to access a wide range of educational activity to develop further competences in line with trusts' strategic 7 day services objectives.

The Learning Beyond Registration Fund provides the opportunity for post registration healthcare professionals to access a wide range of educational activity to further develop competences

Recommendations

HEEM's Local Workforce Teams and clinical managers within the trusts could engage more directly with the workforce to promote the Learning Beyond Registration fund particularly for the AHP and Healthcare Scientist workforce.

In addition to building clinical and professional capability, training is needed in service improvement methodology and the management of change. These are not innate skills but need to be learnt if trusts are to successfully transition to 7 day services.

There should be a transparent planning environment for the development and introduction of new roles in support of urgent and emergency care pathway across primary, community, mental health and ambulance services and social care with the acute trusts. Opportunities to use secondary care expertise to upskill others within the health system should also be encouraged.

Trusts will have to make better use of workforce IT solutions to capture staff training records detailing skills, competences and role suitability. These should be used to inform workforce planning and the flexible deployment of staff.

Recommendation

There is a clear opportunity to work collaboratively to explore the use of ESR or other IT solutions to improve workforce planning.

Strong clinical leadership will be needed that commits to investing in people and drives the adoption of new ways of working

Clinical leaders will also need to recognise the importance of their role in workforce planning and development

The introduction of new roles and competences to deliver 7 day services will require strong clinical leadership that commits to investing in people and drives the adoption of new ways of working.

7.4 Creating a 7 day services culture

The moral case for change is clear. Irrefutable evidence has been provided that proves the NHS needs to move to a 7 day services model. What is not so clear is what that model is

Delivering consistently safe patient care across 7 days a week requires a fundamental culture shift. It is about:

- Accepting and adopting a whole system move towards delivering 7 day services for the benefit of patient safety and care
- Thinking flexibly about addressing current workforce challenges and having the courage to shift the status quo
- Changing mind-sets to recognise that working in the NHS is no longer about Monday to Friday.

The moral case for change is clear. Irrefutable evidence has been provided that proves the NHS needs to move to a 7 day services model. What is not so clear is what that model is. The engagement of health professionals through this project has started to shape conversations about how 7 day services can be achieved. It is the beginning of the acceptance that things need to change.

Mobilising and engaging clinical leadership will be critical to the successful delivery of 7 day services. Collaborative/network approaches can support them by empowering clinical leaders, providing them with data, training them in improvement methodologies and giving them the space and time in which to think things through. This will require investment and the provision of adequate time to dedicate to clinical leadership activity; such is the case at Salford Royal NHS Foundation Trust where full-time clinical leaders drive improvement and transformational change.

Recommendation

Trusts need to agree their strategic vision of 7 day services and identify and support clinical leaders who can engage their peers in the workforce models needed to deliver this transformational change at specialty and service levels.

Clinical leaders need to recognise the importance of their role in workforce planning and development and need their organisations to provide them with the training and time to engage in these activities.

7.5 Workforce requirements to deliver 7 day services across East Midlands

The project has identified high-priority opportunities (detailed in each individual trust report) to close the gaps between the baseline assessment position and the requirements of the ten clinical standards. The workforce implications of these opportunities have mainly focused on core clinical roles such as consultants, nurses, AHPs and clinical support staff.

The indicative workforce requirement submitted as part of this project by five of the ten trusts (and not wholly included in any previous workforce planning activity) to support their high-priority opportunities is 679.4 whole-time equivalents (WTEs). The table below provides a summary of WTE requirements split by staff group.

Staff group	WTE
Consultant	167.57
Other medical	41
Nursing	54.14
AHP	182.83
Administrative	44.56
Pharmacist	32
Other	157.3
Total	**679.4**

The three specialties/services that require the largest increase in WTEs to deliver services across 7 days are Therapies, General Surgery and Diagnostics

The three specialties/services that require the largest increase in WTEs to deliver services across 7 days are Therapies, General Surgery and Diagnostics. Appendix E shows the breakdown of this WTE requirement split by specialty and staff group. In the face of workforce shortages and affordability challenges, innovative new solutions are needed to fill the gaps.

It is important to note these WTE figures provide a 'rough order of magnitude' view and need refinement as the priority opportunities are further developed. They have not yet gone through any rigorous challenge (e.g. Local Education and Training Council (LETC) scrutiny) or been included in the HEEM workforce planning exercise earlier this year.

Workforce requirements identified to support the high-priority opportunities need to be included in future workforce planning rounds and business development activities within each of the trusts

The workforce requirements identified to support the high-priority opportunities need to be included in future workforce planning rounds and business development activities within each trust.

Recommendations

Clinical Leads need to be empowered to engage more directly with their trust and HEEM's workforce planning process to influence this activity in line with future service changes to achieve the 7 day services clinical standards.

Service Managers, General Managers and Clinical leads need training to better understand and articulate workforce requirements.

Any future workforce planning activity should include a 7 day services principle test and should facilitate regional level workforce planning for some professional groups.

7.6 Cost implications for high-priority opportunities

The high-priority opportunities identified by trusts are at varying levels of maturity and this is reflected in the workforce costings below. High-level indicative costs have been provided for Chesterfield Royal Hospitals NHS Foundation Trust, Derby Hospitals NHS Foundation NHS Trust, Kettering General Hospital NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, and University Hospitals of Leicester NHS Trust. The remaining trusts are continuing to work costs through – including the cost of additional WTE to close the gaps as prepared by the specialty teams against the clinical standards.

The costings are based on the views of the specialty teams in terms of the level of resources required to close the gap between their current position and the requirements of the clinical standards. They do not include any increased or alternative service provision of services that are out of scope of this report (i.e. Facilities and Estates).

The costings have not been evaluated in terms of associated levels of benefits. It is expected that further work on the prioritised options will elicit financial benefits, for example, through reduction in length of stay and reduced re-admission levels in certain specialties and that finance teams will work with divisions locally to further refine these costings.

Trust	Indicative costs (£k)	Cost as % of turnover	Cost as % workforce cost
	Standard rates		
Chesterfield Royal Hospital NHS Foundation Trust	9284	4.4%	6.9%
Derby Hospitals NHS Foundation Trust	16517	3.5%	6.5%
Kettering General Hospital NHS Foundation Trust	4175	2.3%	2.8%
United Lincolnshire Hospitals NHS Trust	8249	2.1%	2.8%
University Hospitals of Leicester NHS Trust	6303	0.8%	1.3%

Based on the indicative costs submitted by the five trusts, the total estimated investment is between £16.5m–£89.6m, representing 0.8%–4.4% of turnover

Based on the indicative costs submitted by the five trusts, the total estimated investment is between £16.5m–£89.6m representing 0.8%–4.4% of turnover. This compares to Healthcare Financial Management Association (HFMA) findings of 1.5%–2% which would equate to £30.3m–£40.3m. These figures are indicative, based on current approaches to service delivery.

Extrapolating these figures across East Midlands provides an indicative view of total investment ranging from £33.0– £179.2m based on the revenues of the ten trusts. This is in contrast to HFMA findings of 1.5%–2% which would equate to £60.5m–£80.7m.

The indicative ratios have been calculated based on trust turnover and the estimated investment as shown in the table above.

The five key specialties that drive over 50% of the total indicative costs are: General Surgery, Therapies, General Medicine, Paediatrics and Trauma and Orthopaedics

Acknowledging the financial challenges facing the ten trusts, this level of investment will not be feasible without wider support and finding innovative service models to close the gaps. Finding alternative commissioning models and approaches to funding will be central to making 7 day services a reality. New funding approaches will have to satisfy two requirements. These are short to medium term spend to save investments and recurrent investment in overall capacity shortfall.

Specific examples to support this area are outcome based commissioning which focuses on clinical outcomes delivered consistently across 7 days rather than just focusing on activity driven PbR arrangements. In addition, the use of better care funds and the extension of similar approaches will be necessary to achieve the level of integration needed to share risks and benefits across the health economy.

High level analysis has shown that there are five key specialties which drive over 50% of the total indicative costs. These are General Surgery (15.1%), Therapies (12.75%), General Medicine (7.4%), Paediatrics (7.3%) and Trauma and Orthopaedics (6.3%). In addition, the key clinical standards with the largest contribution towards the additional costs are CS2 (Time to First Consultant Review), CS3 (MDT Review), CS5 (Diagnostics), CS6 (Interventions/Key Services) and CS8 (On-going Review).

Recommendations

Further trust scrutiny is needed to ensure that costs against the high-priority opportunities are robust.

Cost and benefit assessment needs to be done at a whole-system level to accurately identify where investments need to be made and savings can be found.

East Midlands Clinical Senate

Section 8

Funding and commissioning considerations

To deliver consistent and sustainable 7 day services, commissioners and providers need to find alternative funding sources, and explore new ways of contracting to share risks and financial benefits across the whole healthcare system. There must be local flexibility to enable the innovation needed to coordinate delivery of high-quality care to patients every day of the week.

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8 Funding and commissioning considerations

Most trusts recognise that to meet the costs of 7 day provision and the funding shortfall, more collaboration and risk-sharing will be needed between providers, commissioners and other parties, and alternative funding sources will need to be found.

8.1 Innovative service provision and contracting solutions

Commissioners and providers will need to negotiate and agree spend locally in order to prioritise for the wider local health economy.

A pilot study at Chesterfield Royal Hospital NHS Foundation Trust (see below) found that a focus on the hospital front-end can be effective in minimising costs and that 7 day services can be self-financing

A pilot study at Chesterfield Royal Hospital NHS Foundation Trust (see below) found that a focus on the hospital front-end can be effective in minimising costs and that 7 day services can be self-financing by reducing admissions and lengths of stay.

The HFMA study found that Payment by Results (PbR) provides little incentive to reduce admissions

The HFMA study found that Payment by Results (PbR) provides little incentive to reduce admissions. National tariff rules and contractual arrangements may therefore have to be flexed to enable providers to share the financial benefits and risks of reducing admissions to gain from a reduced 'net cost' to the local NHS. The Chesterfield pilot study led to an alternative National tariff arrangement and the 'emergency village' at Salford Royal NHS Foundation Trust (below) is an example of innovative contracting enabling major savings through risk share.

Best practice – Self-financing 7 day working by front-loading, reducing admissions and length of stay

Chesterfield Royal Hospital NHS Foundation Trust has run a successful pilot project to provide 7 day services at the front-end of the hospital.

The main driver was a need to reduce length of stay to create capacity for increasing referrals.

The Trust invested in additional consultants in A&E and medicine, plus improved diagnostics, therapies and pharmacy. Staff who had to change their patterns of working were involved in the project from the outset.

The project has paid for itself by reducing unnecessary admissions and lengths of stay (by about half a day on average for all medical admissions).

If activity had remained static, the Trust would have been able to close a ward with about £1m of savings. However, as in many hospitals, emergency activity has been growing. Instead of closing beds, the Trust achieved efficiencies that enabled it to cope with growing activity at little extra cost.

Best practice – Innovative contracting – major savings through risk share

Salford Royal NHS Foundation Trust had an opportunity as part of a new PFI build to re-design its emergency village (incorporating traditional A&E and Assessment Unit services). Discussions and negotiations with local commissioners explored the likely impact on GP services and how the existing standard PBR contract would have to change.

The Trust agreed a new risk share contract which has an infrastructure payment for the fixed costs associated with the availability of the entire emergency village. This payment does not vary for normal small changes in activity levels. There are then ‘stripes’ of agreed activity steps. If activity increases or decreases significantly above or below an existing step, the value of the contract increases or decreases by an agreed infrastructure payment (based on the step change in the hospital’s costs).

The introduction of the emergency village saved significant acute ward bed days by preventing admissions beyond the front door into acute ward beds.

The savings largely paid for the additional investment in clinical and other staff in the emergency village.

Recommendation

With commissioners, trusts need to explore new ways of contracting to share risks and financial benefits between providers across the whole healthcare system. Next steps could include modelling the options, managing financial risks and working with commissioners to resolve funding issues.

There must be flexibility locally in the way payment rules, regulatory requirements and other mechanisms are applied.

8.2 Funding and commissioning options for integrated care

Considering the commissioning landscape, the teams have identified examples of arrangements and initiatives that will support more effective service delivery. Many of these are through networks and collaborative working and are currently available to trusts.

In October 2014, the national organisations responsible for delivering NHS services in England set out their joint vision for the NHS in the 'Five Year Forward View'. Several payment approaches, have been identified, with potential to help realise this vision. To support the development of urgent and emergency care networks, the proposal is to develop a three- part payment approach comprising payments for capacity, activity, and quality, which shares risk between providers and commissioners across the networks to ensure patients receive the care they need in the right setting at the right time.

The table below provides a brief summary of some of the initiatives available, together with their relevant factors and links to the clinical standards.

Name	Description	Relevant factors and links to clinical standards
Better Care Fund (BCF)	Now set up as a pooled budget used to drive integration of health and social care services to deliver better services and improve outcomes and keep people out of hospitals. Due to 'Go live' April 2015 with a budget of £3.8 billion for 2015/16	CCGs, local authorities and providers need to be considering governance and operational issues now to establish pooled budgets. Current funding in social care, disabilities and mental health link particularly to CS7 (Mental Health) and CS9 (Transfer to Community, Primary and Social Care)

Name	Description	Relevant factors and links to clinical standards
Co-commissioning and partnership working	Two or more commissioning organisations/local authorities align their services, systems and priorities for the purpose of achieving shared outcomes while retaining separate responsibility for managing their own resources	These arrangements could support cross-regional collaborative initiatives taking advantage of pooled funds, e.g. BCF (above)
Marginal rate of emergency tariff (MRET)	In 2014/15, NHSE East Midlands made available over £4 million for investment in demand management, preventative, community rehabilitation and enablement services with the aim of reducing emergency admissions to specialised services pathways	Trusts and collaboratives are invited to submit bids for MRET funding emphasising a clear impact on specialised services pathways. There are many examples of successful bids available with links to CS1 (Patient Experience), CS2 (Time to 1st Consultant Review), CS8 (On-going Review), CS9 (Transfer to Community, Primary and Social Care) and CS10 (Quality Improvement)
Reform of Urgent and Emergency Care (UEC) payments	Promoting the UEC vision, the proposal sets out a new payment approach (potentially replacing MRET above) to enable individual providers to share in the benefits (or costs) of their actions to the system as a whole based on a proportion of fixed core, volume-based funding and system-wide funding.	Removing the conflict between activity-based and fixed cost funding across care providers could influence more appropriate care and integration across UEC pathway impacting across all the clinical standards
Monitor and NHS England payment system	Monitor and NHS England will propose a system that will aim to improve services for patients and encourage the development of new service models and providing greater financial incentives	Trusts have the opportunity, together with commissioners to shape and influence the payment system for 2015/16 in line with a more integrated approach which recognises activity across the whole system and 7 day services

Name	Description	Relevant factors and links to clinical standards
NHS England – Five Year Forward View	As above, the vision promotes alternative funding and pricing regimes to transition to new care models. This could ultimately involve unlocking assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation	As new sources of funding become available, NHS locally will need national bodies jointly to exercise flexibility in the application of their payment rules, regulatory approaches, staffing models and other policies
Integrated care funding models	There are three contractual vehicles currently being used by commissioners reflecting relative shifts in integration and accountability	Case studies from Cambridgeshire and Salford demonstrate integration of acute activities within contracts valued at c£700-800m across three to five years
Integrated Digital Care (Technology) Fund	An example of funding available to promote the use of technology. This fund's priority is to enable information flows across care settings	Overall value of the fund is now over £500m. Could impact CS1 (Patient Experience), CS2 (Time to 1st Consultant Review) and CS4 (Shift Handover) in particular
Personal Care Budgets	Assigned to an individual by CCG to support care and support plans primarily aimed at people with long-term conditions and disabilities.	Latest evaluation suggests reduced use of hospital services and reduction in hospital costs which may impact future funding. Likely to be extended further in April 2015
Prime Ministers Challenge Fund	Primary care fund to help improve access to general practice and stimulate innovative ways of providing primary care services. Initial fund of £50m now supplemented by further £100m for 2015/16	Some impact on acute trusts as initiatives include reducing hospital admissions, particularly in Nottinghamshire and Derbyshire

Name	Description	Relevant factors and links to clinical standards
Patient level information and costing system (PLICS)	A research project discusses how an 'open-book NHS' using PLICS could influence future funding models and lead to more transparent and collaborative working across the health economy	Example of how open-book costing could facilitate more collaborative and integrated working. Many examples of this exist in other geographies and sectors

If innovative solutions for integrated care are to be possible, alternative financial arrangements must be found

Recommendation

If innovative solutions for integrated care are to be possible, alternative financial arrangements must be found. Commissioners and providers should provide further consideration to how funding and commissioning options can be used to support 7 day services, in the process of further development and/or operational in other healthcare economies/sectors.

East Midlands Clinical Senate

Section 9

Organising for delivery

Some operational solutions can be implemented quickly while more strategic and collaborative opportunities are developed. More work is now needed to shape decision-making by acute providers, commissioners and policy-makers. While fundamental change is imperative, there are existing network arrangements and collaborative partnership that can be scaled up to meet the challenges. 7 Day Services need to be integrated with other transformations and overall strategic direction. This gives East Midlands the opportunity to be at the forefront of helping to shape the national NHS landscape for the next five years.

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9 Organising for delivery across the region

9.1 Key conclusions

This section presents key conclusions from the baseline assessment. These have informed the recommendations identified throughout this report.

Pressures on the acute setting are intense.

- During 2012/13, 1.27 million patients accessed the acute urgent and emergency care system across the East Midlands.
- With high levels of bed occupancy, not much is needed in the way of increased activity volumes to create a critical capacity issue in the acute setting, with some trusts already not achieving national waiting times within A&E.

The scale and pace of change needed across the system to deliver 7 day services is substantial.

- To meet the national timetable for implementing the clinical standards, changes need to be coordinated from now between providers, commissioners and policy-makers. Organisations are going to have to be innovative, cooperative and bold in their thinking.
- Based on initial estimates from five of the ten trusts, the impact of the clinical standards indicate that, without radical whole-system thinking across the region, increases in the workforce of those trusts will need to be in the region of 679 WTEs (whole time equivalents). Scaling this up for all ten acute trusts creates an increased cost pressure ranging from £33.0m-£179.2m.
- While cross-system approaches could have benefit in multiple areas, two of the ten standards (CS7 (Mental Health) and CS9 (Transfer to Community, Primary and Social Care)) can only be met by improvements across the whole system.

The current baseline position is similar across all ten acute trusts.

- Common issues and challenges have emerged in relation to workforce availability, variations in service, and limited use of technology. These commonalities underline the value of collaborating further to exchange thinking and experience.

- Existing good/best practice (such as use of IT and local rota and job planning changes) can be shared across the region through collaborative planning.

Trusts can implement operational solutions in the short term while developing more strategic and collaborative opportunities.

- Opportunities for closing gaps can be evaluated on a sliding scale from short-term operational improvements under the control of individual trusts, through to tactical options involving collaboration between trusts and partners, to strategic partnerships and collaborative relationships with commissioners and providers, and other health and social care partners within and outside the East Midlands.
- Operational opportunities lie in areas such as process improvement, technology and business intelligence (such as collaborative IT solutions to enable flexible, virtual teams), and workforce IT solutions (such as Electronic Staff Record to support more flexible staff deployment).
- There are different levels of collaboration potential amongst trusts ranging from strategic regional service reconfiguration, to local economy system redesign, to the trusts working together to develop common changes, for example to policy, processes and data collection.
- There is major potential to scale-up the number of existing network arrangements and collaborative service models.
- A lack of detailed whole-system demand and capacity modelling leaves decision-makers without the necessary information in areas such as cross-provider activity shift scenarios, and alternative workforce modelling.
- Workforce planning processes are fragmented across the region. Reviewing these will help clarify roles, responsibilities and ensure future supply is better aligned with trust workforce demand.
- Equipping clinicians and service managers with the skills to understand and articulate workforce requirements, transform services and manage change.

Practical implementation issues need to be addressed to help trusts meet the challenge.

- There needs to be clear and consistent information for operational staff about the scope and availability of services available within the organisation and from other providers 7 days a week, potentially through an up-to-date Directory of Services.

- The introduction of CQUINs has exposed some lack of detailed knowledge among stakeholders of the exact requirements of the clinical standards, and there is lack of clarity around the phasing of their introduction.
- There is a need for clear and transparent definitions of the measures that commissioners and regulators will use to assess delivery of consistent high-quality care, 7 days a week.
- There are significant data-gathering challenges for trusts to provide the necessary evidence for re-assessment of future achievement against the standard.
- Clear and robust governance is needed to support organisations to plan and work together to implement change.

The collaborative project has created some firm foundations for moving forward.

- While the timescales are challenging, the 7 day services early adopter programme and use of CQUINs are helping to accelerate the pace of engagement and delivery planning across the region.
- There are a number of existing trust 'transformation' activities which can be realigned to support the shift towards 7 day services, for example the use of NerveCentre as an IT workflow solution and existing projects relating to the Better Care Fund.
- The level of engagement produced through this project has created momentum for driving the next phase forward – and needs to be focused on meeting the demands of the national rollout programme over the next two years.
- New integrated care and delivery models will be supported by NHS England over the next five years. The East Midlands trusts have the opportunity to be at the forefront by exploring and progressing strategic opportunities in collaboration with their wider system partners.

9.2 Aligning with the future of the wider healthcare landscape

Future plans must take into account the direction of the healthcare landscape as a whole and the strategic direction of the NHS.

The NHS 5 Year Forward View describes a landscape that includes 'networks' of care across organisations, with more out-of-hospital and integrated care built around patients' needs

The NHS 5 Year Forward View sets out its view of future care models. It describes a landscape that includes 'networks' of care across organisations, with more out-of-hospital and integrated care built around patients' needs. Already, isolated examples of these care models are emerging across the country.

NHS England will promote a number of additional care models over the next five years which will either directly or indirectly impact acute care including Multi-specialty Community Providers (MCPs), Primary and acute Care Systems (PACS) and urgent and emergency care networks. NHS England is planning to work with local communities and leaders to identify what changes are needed for national and local organisations to work together to jointly develop these new integrated care models.

A fundamental shift is underway to encourage more collaboration and partnership across the wider healthcare system. The community of practice established for this project has an important opportunity to help shape the future landscape by taking a proactive approach to cross-party working, including shared risk and funding arrangements with local economy partners.

This section sets out practical next steps for organising the future collaborative activities and individual trusts to undertake the next phase of the 7 Day Services project.

9.3 Priority considerations for the East Midlands

The community of practice established for this project has an important opportunity to help shape the future landscape by taking a proactive approach to cross-party working, including shared risk and funding arrangements with local economy partners

For note, the conclusions and recommendations within this report should be considered in conjunction with other key reviews and work-streams underway nationally, regionally and locally. Nationally these include the national review of urgent and emergency care with its focus on service provision outside of hospitals, prevention and the designation of major emergency centres and the establishment of urgent and emergency care strategic networks. Currently local system resilience groups have an overview of what is happening in urgent and emergency care. The NHS England Five Year Forward Plan proposed different care models including multi-specialty community provider and primary and acute care systems. The Prime Ministers Challenge Fund has been established to improve access to general practice and stimulate innovative ways of providing primary care services. Priority is being given to practices where they propose to open longer in the week and at the weekend.

Locally, health and social care economies have developed proposals for the use of the Better Care Fund with many schemes having a focus on admission avoidance. The provision of 7 day services need to run through these as a common thread

Locally, health and social care economies have each developed proposals for the use of the Better Care Fund with many schemes having a focus on admission avoidance. Alongside this are the South Nottinghamshire Transformation schemes across the East Midlands; Better Together Mid Nottinghamshire, Lincolnshire Health and Care, 21st Century Health and Care in North Derbyshire, Healthier Northamptonshire, the South Derbyshire transformation programme and Better Care Together in Leicester, Leicestershire and Rutland. The focus of these is on improving productivity, increasing efficiency and raising the quality of services. The provision of seven day services need to run through these as a common thread.

An example of a problem being tackled on an East Midlands basis is Radiology. The Strategic Clinical Networks and Clinical Senate have brought together leads from across the region to confirm the key challenges; Diagnostic test reporting, MDT attendance and input into decision-making and lack of workforce, capacity and skill mix, building on provider-led proposals for a new networked solution. The group is working towards short, medium and long term solutions for these challenges. Seven of the acute trusts have already procured a shared radiology information and image archiving system.

Most of the gap closure opportunities identified through the project need more development and scrutiny, together with robust challenges to the workforce and cost projections. To ensure robustness of planning decisions the following recommendations are made:

- It is proposed that a workshop is run with the CEOs, commissioning representatives and trust 7 Day Services leads to agree priorities and how they will take them forward
- Each trust should review the resource requirements outlined in this report before doing more detailed cost/benefit analyses
- Policy-makers should be encouraged to resolve any ambiguities in clinical standard definitions
- Trusts should take stock of their current delivery models and transformation programmes and integrate into them the recommendations contained within this report. Achievements against the ten clinical standards should be aligned with the overall strategic direction of the trusts
- Trusts should decide which options to implement as operational quick wins while continuing to develop more strategic solutions
- Commissioners and providers should agree which initiatives and solutions it is better / easier to develop in collaboration (e.g. handover policies, data collection activities)

- It is well understood that current IT and information systems are a barrier to progress; Trusts need to review them as a matter of priority.

9.4 How will the Collaborative work?

- To support the shift in emphasis from the current phase of work (baseline assessment and gap analysis) to implementation, a governance framework should be agreed, potentially with the Clinical Senate acting as coordinator, including:
  - agreeing roles, responsibilities and ways of working together (it is recommended that each trust should have a clinical and non-clinical lead to manage delivery)
  - setting, prioritising and communicating shared goals and objectives
  - providing opportunities for trusts to collaborate and share best practice
  - maintaining momentum and driving change
  - reporting performance and monitoring progress
  - resolving and/or escalating issues
  - providing links to/engagement with external organisations for those areas requiring involvement of the wider system.
- The role of the Chief Executive Group should be defined to include:
  - promoting the strategic recommendations, including commencing dialogue with national and local partners on new care models and alternative funding mechanisms
  - providing system-wide executive leadership, perhaps sponsoring specific streams of work moving forward
  - approving resources and funding – initiatives need to be properly resourced and funded to ensure successful implementation
  - approving project outputs
  - agreeing communication for their organisations and external stakeholders
  - ensuring alignment with other related activities.

The Acute Chief Executives Group is well placed to promote the strategic recommendations in this report to enhance dialogue with national and local partners on new care models and alternative funding mechanisms

9.5 Widening the focus: engaging local health economies

It has been widely acknowledged that many weaknesses in meeting the ten clinical standards are whole-system-related

It has been widely acknowledged that although the first phase of the national 7 Day Services project has focused on the urgent and emergency care pathway in the acute setting, many weaknesses in meeting the ten clinical standards are whole-system-related.

The same level of baseline assessment and gap analysis will therefore be needed for out-of-hospital services such as primary and community health services and social care.

Throughout this project, discussions with trust leads and clinicians indicated the need for a set of integrated clinical standards. This will avoid confusion and help with better integration of services and associated resources to deliver the 7 day service aims.

NHS England Board is currently developing a set of complementary clinical standards for primary and community care services. This should work as an integrator to help deliver high-quality care, with fewer variations in service availability across 7 days a week. The timescale for this work is currently under review.

The same level of baseline assessment and gap analysis should be undertaken for out-of-hospital services

Leads from the trusts involved in this collaborative project have concluded that having now completed this exercise, they are now better placed to engage in the wider system level discussions required in a number of areas. As such, consideration should be given to:

- Current collaborations and local partnerships need to be recognised. For example, Kettering General Hospital and Northampton General Hospital have committed to working together to ensure that services can be provided for the people of Northamptonshire in accordance with the Healthier Northamptonshire programme. A set of guiding principles (see Kettering General Hospital Trust's report) are already in place for how the two trusts are planning to work together. Other similar arrangements are in place across East Midlands.
- Trusts need to understand that their vision and strategic direction will need to comply with that of their future partners and that of the wider system. Understanding the current status of collaboration and discussions with other local providers, commissioners and local authorities is a pre-requisite to furthering these relationships.

9.6 Risks / issues for the 7 Day Services Collaborative project

Key risks and issues that may impact the successful implementation and delivery include:

Risk / issue	Mitigation / resolution
No delivery models in place to manage and implement the 7 Day Services project, both at a trust and Collaborative level and across the wider health economy	Establish a local and Collaborative delivery model that oversees and coordinates implementation ensuring internal and external interdependencies are effectively managed. The model should include clarity on process steps for moving from recommendation to implementation and link to the wider health economy to ensure implementation plans are complementary
Lack of a formal governance agreement which carries tangible support from the trusts	Develop and agree with all partner organisations a robust governance and accountability framework including executive level Project Board group involving senior representatives from all trusts
Lack of buy-in across all trusts on aspects of sharing and driving n behaviours	Develop communications strategy highlighting benefits that compliance and collaboration can bring
Resources stretched to deliver current workload without additional scope and activities	Ensure provision of the necessary capability and capacity of resources for successful implementation
Engaging external community stakeholders and other key players	Effective communication strategy and strong partnership arrangements Explicit engagement with HEEM and Commissioning leads within the collaborative structure
Wider policy changes / general election may affect national implementation schedule	Continue to engage NHS IQ in ongoing Collaborative arrangements and engagement through the regional NHS England seven day services group to escalate policy issues and opportunities

East Midlands Clinical Senate

Appendices

Atos Consulting

Appendix A: List of contributors

We would like to thank the following key stakeholders responsible for delivering this first phase.

Role	Roleholder
Project SRO	Gavin Boyle
Programme Leads	Roz Lindridge and Stuart Ellis
Clinical Senate	Roz Lindridge and Sarah Hughes
Chesterfield Project team	Stuart Ellis, Steven Collis, Dr Gail Collins, John Williams, Nicky Hill, Claire Carson, Zoe Vaughan, Helen Shields
Derby Project team	Duncan Bedford, Roger McBroom, Dr Chris Whale, Lauren Townsend, Anna Stone, Amanda Batley, Scott Jarvis, Nicki Hoon, Lee Outhwaite
Kettering Project team	Simon Beesley, Mr S Al-Hamali, Dr Raja Reddy, Leanne Hackshall, Rachel Brown, Tracy Reid, Michelle Robinson, Fay Trodd, Andy Frost, Angela MacFarlaine
Northampton Project team	Suzanne Lee, Dr Amanda Bisset, Dawn Sharples, Yasmina Gainer
Northern Lincolnshire and Goole Project team	Claire Phillips , Simon Hearne, Jason Baker, Karen Jackson
Nottingham Project team	Zara Jones , Zoe Greatrex, Jim Hatton
Peterborough and Stamford Project team	Dr Callum Gardner, Helena Baxter, Alec Dearden
Sherwood Forest Project team	Yvonne Simpson, Claire Madon, Dr Benjamin Owens, Ian Lovett
United Lincolnshire Project team	Garry Marsh, Penn Anderson, Angela Ashcroft, Alex Afifi, Hayley Jackson, Lisa Vickers, Neil Ellis, Anita Cooper, Paul Hinchliffe
United Hospitals Leicester Project team	Vicki Hing, Mr Andrew Furlong, Julia Ball and John Roberts
NHS IQ	Marie Tarplee, Elizabeth Hindmarsh
HEEM	Jane Johnson
NHS England	Jane Blower

Appendix B: Regional dashboard with site details

				Leicester				North Lincs & Goole					Nottingham					United Lincs				
	Chester -field	Derby Hospitals	Kettering	Leicester General Hospital	Leicester General Hospital	Leicester Royal Infirmary	Pan Trust	Diana Princess of Wales	Goole and District Hospital	Scunthorpe General Hospital	Pan Trust	Northamp -ton	City Campus	Queen's Medical Centre	Pan Trust	Peter borough	Sherwood Forest	Grantham & District Hospital	Lincoln County	Pilgrim Hospital	Pan Trust	**Average across Trusts**
Clinical Standard 01 **Patient Experience**	67.4%	75.3%	65.6%	67.6%	82.4%	78.5%	38.3%	84.6%	N/A	90.6%	45.4%	76.3%	58.6%	69.8%	67.1%	78.5%	57.7%	89.3%	86.2%	76.1%	84.1%	69.4%
Clinical Standard 02 **Time to 1st Consultant review**	50.1%	44.6%	73.8%	40%	22.1%	47.9%	55.5%	48.2%	N/A	46.7%	94.4%	53.9%	78.3%	63.2%	58.5%	53.0%	64.1%	76%	70.6%	59.7%	54.2%	57.4%
Clinical Standard 03 **Multi-disciplinary Team Review**	42.0%	47.6%	51.7%	64.6%	58.2%	59.1%	32.6%	46.9%	N/A	55%	47.6%	48.3%	57.0%	51.1%	59.3%	53.1%	35.5%	68.1%	61.2%	50.4%	50.5%	49.3%
Clinical Standard 04 **Shift Handover**	68.6%	74.2%	71.8%	95.1%	72.8%	78.5%	58.7%	89.7%	N/A	89.9%	76.5%	74.6%	65%	75.4%	80%	71.4%	60.4%	80.5%	76.3%	73.4%	87.7%	73.3%
Clinical Standard 05 **Diagnostics**	67.8%	65.1%	61.9%	67.6%	39.8%	44.8%	74.5%	72.2%	77.4%	62.4%	38.7%	73.4%	74.2%	47.7%	58.1%	55.6%	67.5%	N/A	66.7%	55.4%	66.7%	61.3%
Clinical Standard 06 **Interventions and Key Services**	44.0%	61.7%	42.5%	75.9%	72.4%	69.8%	68.7%	70.2%	N/A	N/A	29.7%	58.2%	54%	48.9%	N/A	38.2%	39.8%	74.7%	49%	40.9%	37.8%	52.4%
Clinical Standard 07 **Mental Health**	48.8%	58.4%	34.1%	20%	55.4%	31%	13.2%	44.4%	N/A	41.6%	46.7%	44.9%	25%	16.7%	80%	21.7%	54.3%	47.3%	63.8%	40.1%	43.4%	42.4%
Clinical Standard 08 **On-going Review**	35.9%	44.8%	52.8%	49.5%	45.6%	48.4%	77.9%	35.8%	N/A	34.6%	62.4%	47.2%	61.1%	62.2%	63.9%	47.3%	54.9%	66.7%	58.4%	48.1%	39.1%	49.8%
Clinical Standard 09 **Transfer to Primary, Community and Social Care**	39.2%	47.2%	49.2%	92.3%	43.7%	60%	68.8%	37.9%	N/A	39.4%	67.9%	37.5%	37.5%	37.2%	53.2%	52.7%	42.3%	37.9%	46.9%	42.2%	42.1%	47.3%
Clinical Standard 10 **Quality Improvement**	35.8%	45.5%	65.5%	62%	72.6%	70.9%	43.7%	13.7%	73.1%	11.6%	44.2%	53.4%	59.6%	80.8%	71.4%	63.2%	54.7%	83.7%	68.2%	55.5%	19.1%	55.6%
Average across Standards	50.2%	55.4%	57.9%	62.3%	56.5%	58.8%	51.1%	53.1%	75.2%	51.7%	58.0%	56.9%	58.3%	59.3%	65.9%	54.0%	53.5%	68.9%	65.9%	55.8%	53.3%	56.4%

Definition of RAG:

- Red= <50% across 7 days
- Amber= between 50%-70% across 7 days
- Green= > 70% across 7 days
- NA Pink N/A: No usable data provided
- NA Grey N/A- Clinical standard not applicable

denotes clinical standards that have dependencies on key support services

denotes clinical standards that have dependencies on the wider system

Note: The columns indicated as Pan Trust above represent baseline assessment results for those specialties and services completed at an overall cross-trust level i.e. were not assessed on an individual site level.

Appendix C: More detail on the methodology for the project

This Appendix outlines the methods that were developed and used by the project team to deliver the project and carry out the baseline assessment. These were discussed and agreed by the Collaborative at every stage.

Key learnings for future projects are identified where possible.

Agreeing a standard approach

Working collaboratively with the 7 Day Services Project leads, the team agreed a standard approach to:

- Performing a data-driven, evidenced baseline assessment against the new clinical standards
- Using an analytical tool to identify the gaps between the current state and the requirements of the clinical standards
- Developing and agreeing options to close the gaps, with an understanding of the workforce and financial implications.

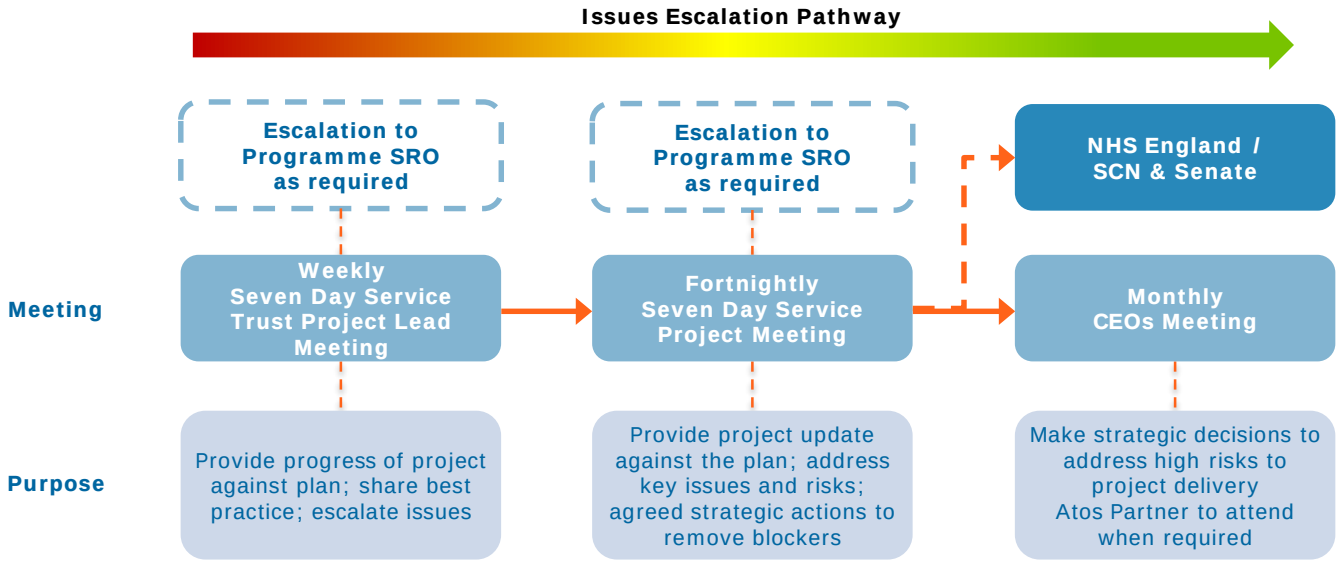
Establishing the Collaborative governance structure

The Collaborative agreed the governance structure for managing the 7 Day Services project and established three key project management forums:

- Weekly 7 Day Services project team meeting comprising Clinical lead, Finance lead, Workforce lead, Informatics lead and Nursing lead
- Fortnightly 7 Day Services project reviews via conference call involving all Trust Project leads and the overall Project leads
- Six-weekly East Midlands Programme meetings involving all Trust Project leads. These meetings were face to face, with optional participation from Trusts' Clinical leads, Workforce leads, Finance leads and Informatics leads.

Risks and issues identified at these meetings were escalated in a timely manner as illustrated in the diagram below:

Figure 19: Programme issues escalation pathway



Key learnings:

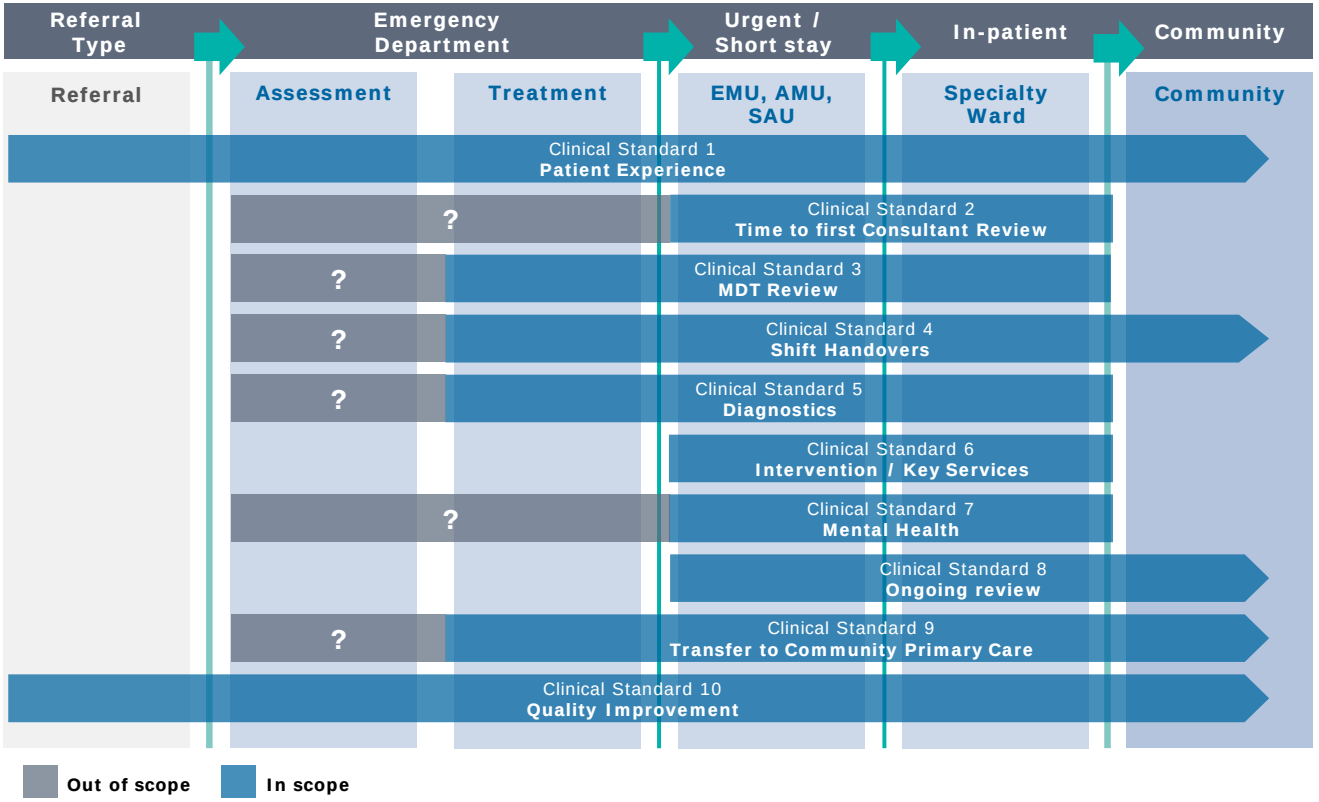
- The governance meetings enabled the ten acute trusts to come together as a Collaborative to raise concerns and issues, challenge each other, share best practice and agree a regional approach.
- It is imperative to have a dedicated project team with protected time to contribute to the project and deliver to agreed timeline. This should include the following members: Clinical lead, Informatics lead, HR lead, Finance lead, Diagnostics lead and IT lead.

Agreeing the scope of the baseline assessment

The project team, Trust Leads and clinicians agreed the scope of the assessment within the urgent and emergency care pathway and how it interfaces with the wider system. This did not include detailed assessment of services outside the scope of acute trusts, other than identifying the availability of interfaces with these other organisations across 7 days and evaluating the effectiveness of these.

The team assessed the applicability of the ten clinical standards across the whole system, as illustrated below:

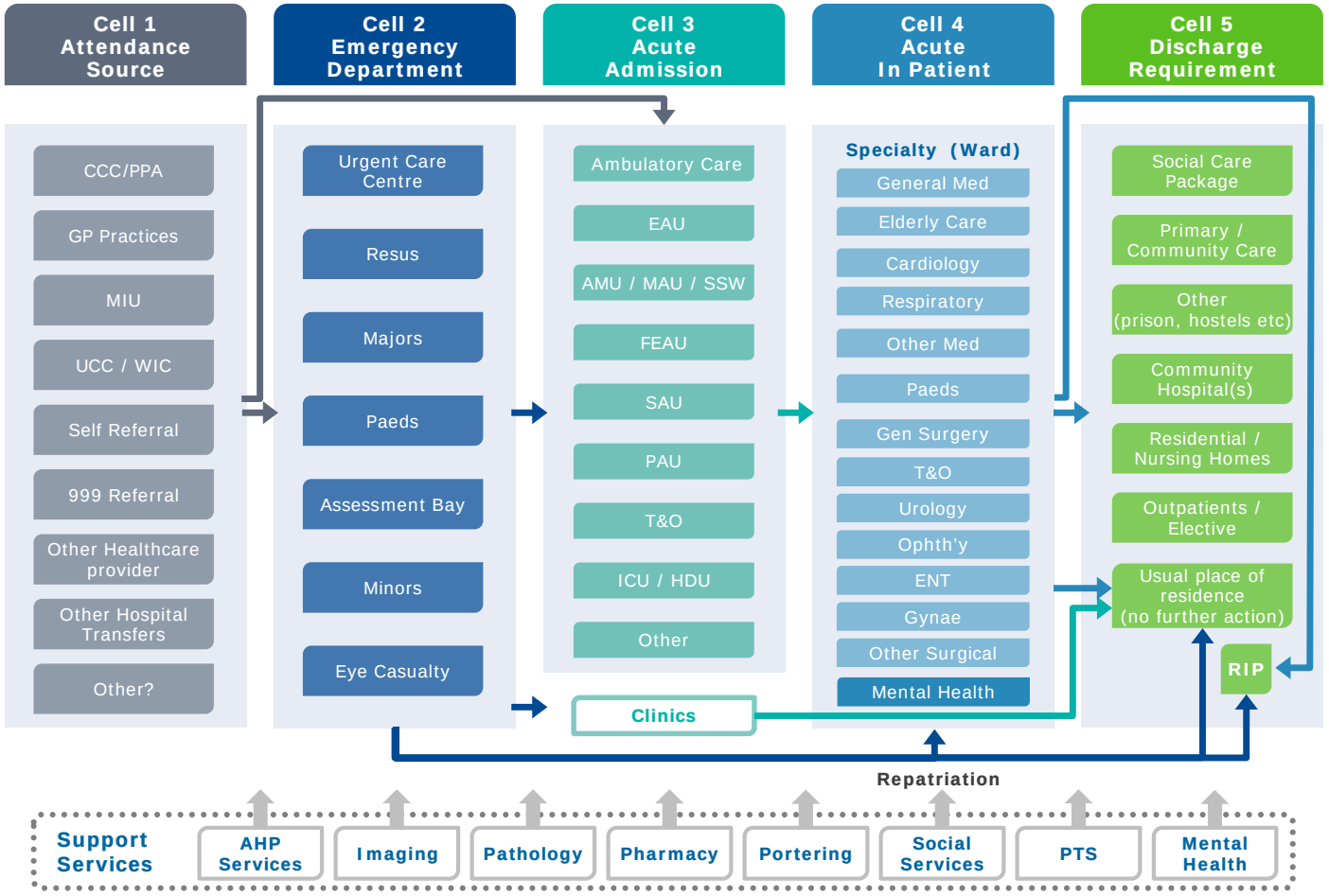
Figure 20: Applicability of the ten clinical standards across the whole system



A generic urgent and emergency care pathway scope map was generated (as shown below) illustrating the routes into the Emergency Department, the onward flow to assessment units, wards and ultimately to discharge, and the extent of the supporting services.

Each trust adapted this to fit their local urgent and emergency care pathway. The Collaborative agreed to undertake the baseline assessment at specialty level to provide a detailed picture of clinical standards achievement within the trust. This enabled a baseline position to be presented at specialty, divisional, site and trust levels, mitigating the risk of outliers skewing the overall trust position. On average 49 specialties were included within the baseline assessment per trust.

Figure 21: Generic urgent and emergency care pathway scope map



Key learnings:

- Early engagement with clinicians across the urgent and emergency care pathway increases awareness and understanding of the 7 day services agenda, creates the opportunity to discuss service implications and fosters clinical ownership for solutions.

Addressing ambiguities within clinical standards

The initial engagement workshop in March included the key representatives from across the ten trusts: Trust Project leads, clinicians, workforce, Informatics and Finance. Representatives from NHS Improving Quality and the East Midlands Senate were also present. Participants held a discussion to assess stakeholders' collective understanding of the ten clinical standards. Where possible, a common definition of each clinical standard was agreed. However, there were a number of concerns about ambiguities in terminology which could not be clarified on the day and were escalated to NHS England.

NHS England advised East Midlands Clinical Senate to agree on a region-wide set of assumptions until the ambiguities can be clarified nationally. With the approval of clinicians across the East Midlands some assumptions were made at an East Midlands regional level.

The table below summarises the ambiguities identified within the clinical standards, the further clarification required from NHS England, and assumptions made by East Midlands.

Clinical standard	Ambiguity	Clarity needed from NHS England on	East Midlands regional assumptions made
2. Time to 1st Consultant Review	Definition of a 'suitable consultant'	► Whether this includes a specialist consultant or can be an A&E Consultant in the Emergency Department	► Suitable consultant is specialist consultant
3. Multi-Disciplinary Team (MDT) Review	Definition of a 'competent decision-maker' for multi-disciplinary team reviews	► Who a 'competent decision-maker' can be	► Consultant level
4. Shift Handover	Attendance of staff level at multi-disciplinary team reviews	► Level of staff attending the MDT reviews from clinical support; for example, for attendance by Pharmacy:	► Pharmacist level staff to attend MDT

Clinical standard	Ambiguity	Clarity needed from NHS England on	East Midlands regional assumptions made
		does it need to be a pharmacist or is a technician role sufficient?	
		► Whether the MDT team has to come together physically to do a MDT or can they be done remotely using technology	► Physical presence of all MDT members required for reviews
	Definition of multi-professional participation at shift handovers	► Which staff group need to be present at shift handovers	► Same staff group level handover assessed
	Recording of clinical data electronically	► If trusts should be assessed as not-compliant if they do not record data electronically	► Trusts assessed as non-compliant for lack of electronic data
	Recording of clinical data according to national standards	► What national standards and policies are referred to for shift handover	► Assessed as non-compliant for lack of awareness of national standards
8. On-going Review	Transfer of patients between wards and teams supported by an electronic record	► If trusts should be assessed as not-compliant if transfer is not supported by electronic record	► Trust assessed as non-compliant for lack of electronic record
	Definition of a 'competent decision-maker' for in-patients not in high-dependency units	► Who a 'competent decision-maker' can be for on-going review of patients	► Consultant level

Engagement workshops have revealed that more clarity is needed within the guidelines published by the Royal Colleges. This will provide consistency and help to further clarify the clinical standards.

At the time of writing this report, it remains unclear which clinical standards will be applied during 15/16 and which will be implemented during 16/17. Confirmation through NHS England is vital to enable trusts to prioritise resources for closing gaps in compliance. Furthermore NHS England need to provide clarity on how the clinical standards will be measured, evaluated and monitored going forward.

Performing the baseline assessment

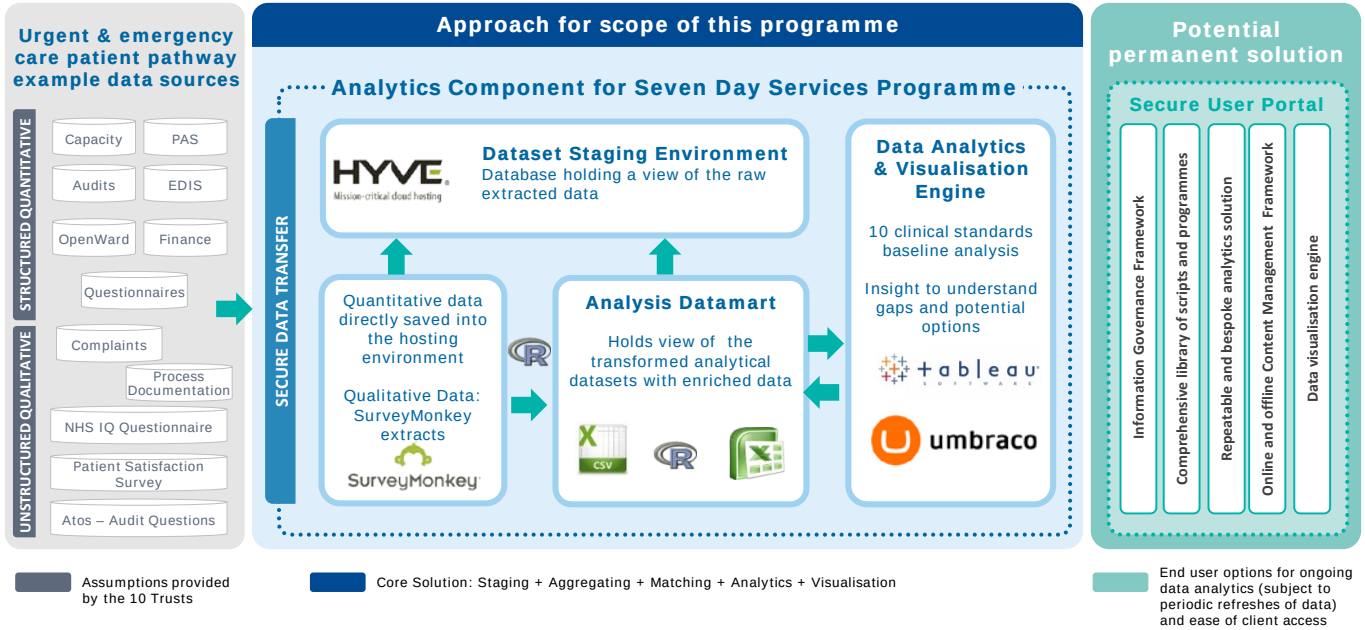
Acquiring and preparing the data

Working with the 7 Day Services Project leads the team agreed to analyse data from four sources:

Data type	Weighting	Data source	Data capture method	Clinical standards / clinical outcomes assessed
Qualitative	20%	NHSIQ / NHSIQ Other	Self-assessment survey	1-10
Qualitative	20%	Structured interviews	Face-to-face interview	1, 4, 7 and 9
Qualitative	20%	Patient notes	Audit	2, 3, 5, 8 and 10
Quantitative	40%	Clinical outcome data	IT system extract	1
			IT system extract	Length of stay
			IT system extract	Re-admissions
			IT system extract	Mortality

Trusts were provided with online surveys and data capture templates with clear guidance on data requirements including the format and fields needed. Trusts agreed the data they would be able to submit through their informatics and project leads, in some cases trusts decided not to take part in all aspects of data collection, as detailed within the individual Trust reports. Trusts used a web-based secure File Transfer Protocol (sFTP) to upload extracted quantitative data files into the staging environment of the secure hosting analytics platform. The diagram below gives a high level representation of the programme analytics approach and architecture.

Figure 22: Data analytics architecture



Key learnings:

- It is very important to engage trusts' Informatics leads at the data definition phase, to identify availability of datasets required in the current legacy systems and to identify alternatives where needed which will facilitate the data collection and analysis phase.

Analysing the data and presenting the baseline assessment

A data quality check was performed to assess completeness, relevance and accuracy of data received. As part of standard data cleansing and preparation exercise some of the data was excluded due to following reasons:

- Unknown data – quantitative
- Relevance – to the standard – both qualitative and quantitative

- Lack of basis for comparison – quantitative
- Prioritisation – quantitative
- Test responses – qualitative.

Developing the decision tree

The Collaborative collectively agreed the scoring criteria and assumptions which formed the decision tree that was applied to the data collected from the different data sources to derive the baseline assessment scores against each of the ten clinical standards.

The criteria and assumptions are detailed below:

Missing data assumptions

In cases where one or more data source(s) was not applicable and/or missing, the aggregated site/ trust level scores were calculated by re-assigning the available weighted scores. For example Nottingham did not complete Audit Patient Notes Questionnaires. Its site and trust level scores were calculated by re-assigning higher weightings to NHSIQ and NHSIQ other responses.

Criticality of questions

All qualitative data questions were assigned an importance rating, ranging from High to Medium to Low, based on their criticality to assess the clinical standards compliance. A weighting score was then applied as shown in the table below:

Importance	Weighting
High	1.5
Medium	1.25
Low	1

Nulls and not applicable responses

Questions left unanswered were not assigned any scores. 'Not Applicable' questions were assigned scores half way between a positive and a negative response. This was done to avoid an adverse impact of the 'Not Applicable' questions on the final score.

Weightings

All specialties and sites within each trust were weighted equally, irrespective of specialty size, patient volumes or other service-related metrics. Each data source was based on its relative importance to the overall score and output analysis. The table below shows the weighting applied for each data source:

Data Source	Weighting	Comments
NHSIQ	20%	
NHSIQ Other	20%	Mutually Exclusive - only one data source applicable
Audit Patient Notes	20%	
Audit - Process Observation and Structured Interview	20%	
Quantitative Data	40%	

Calculation

All responses were assessed based on a set of scores/weights agreed during the collaborative workshops to convert absolute responses into relative scores. This was done to calculate percentage compliance against a standard and was applicable to close-ended questions only.

Since the answer choices were representative of compliance to a standard, those that suggest a definitive compliance to 7 day services were scored more than the ones that did not. Unknowns and "not applicable" responses were scored in the middle. The table below shows the relative scores used for each answer choice, by clinical standard.

Figure 23: Relative weightings by clinical standard

Answer choice	Weighting	Answer choice	Weighting	Answer choice	Weighting
Generic weightings matrix applied across several questions / standards					
Yes	1.25	High Impact	1.5		
No	0	Medium Impact	1.25		
Don't Know	0.5	Low Impact	1		
Not applicable	0.75				

Clinical Standard 1 (Patient Experience)	
NHSIQ Clinical Standard 1 - Ques 4, 7	
5 days or less	1
6 days (with either Saturday or Sunday)	1.25
7 days	1.5

Clinical Standard 2 (Time For First Consultant Review)					
NHSIQ Clinical Standard 2 - Ques 3		**NHSIQ Clinical Standard 2 - Ques 7**		**Audit - Patient Notes - Ques 11**	
Yes – All within 14 Hours	1.5	Yes – within 1 hour	1.5	Daily	1
Yes – All but at varying times	1.25	Yes – at varying times	1.25	Weekdays only	0.75
Not applicable	0.75	Not applicable	0.75	Weekdays and Weekends	0.5
Don't know	0.5	Don't know	0.5	Weekend only	0.25
No	0	No	0		

Clinical Standard 3 (MDT Review)					
NHSIQ Clinical Standard 3 - Ques 3		**NHSIQ Clinical Standard 3 - Ques 4 , 6**		**Audit - Patient Notes - Ques 28, 29**	
Yes – within 14 hours of initial admission	1.5	Yes – within 24 hours of initial admission	1.5	Yes, at any time, including weekends	1.5
Yes – after 14 hours of initial admission	1.25	Yes – after 24 hours of initial admission	1.25	Yes at any time, except weekends	1.25
Not applicable	0.75	Not applicable	0.75	Yes only during office hours Monday to Friday	1
Don't know	0.5	Don't know	0.5	Not applicable	0.75
No	0	No	0	No	0

Clinical Standard 4 (Shift Handovers)			
Audit - Interview - Ques 11		**Audit - Interview - Ques 13**	
Yes for every handover whenever it is	1.75	Yes	1.25
Yes twice per day	1.5	Partially	1
Yes once per day	1.25	Don't Know	0.5
Sometimes	1	No	0
Don't know	0.5		

Clinical Standard 5 (Diagnostics)	
NHSIQ Clinical Standard 5 - Ques 9	
Yes – Seven days a week	1.5
Yes – But not seven days	1.25
Not applicable	0.75
Don't know	0.5
No	0

Generic weightings matrix applied across several questions / standards					
	1.25		1.5		
	0		1.25		
	0.5		1		
	0.75				

Clinical Standard 6 (Intervention Key Services)			
NHSIQ Clinical Standard 6 - Ques 3		**NHSIQ Clinical Standard 6 - Ques 5**	
	1		0.67
	1.25		0.33
	1.25		1

Clinical Standard 7 (Mental Health)					
Audit - Interview - Ques 18		**Audit - Interview - Ques 19**		**Audit - Interview - Ques 20**	
	0.75		1		1.5
	1		0.75		1.25
	1.25		0.5		0.75
	1.5				0.5
	1.75				0.25
	2				***No "Moderate" Rating hence drop from 1.25 to 0.75***

Assumes if service is provided over the weekend then service is also available during weekday (by default)

Clinical Standard 7 (Mental Health)			
Audit - Interview - Ques 21		**Audit - Interview - Ques 22**	
	1		1
-2 hours	0.75		0.75
-4 hours	0.5		0.5
	0.25		0.25

Clinical Standard 9 (Transfer to Community, Primary and Social Care)
Audit - Interview - Ques 23 / 24 / 26
1.5
1.25
0.75
0.5
0.25

Clinical Standard 10 (Quality Improvement)
Audit - Patient Notes - Ques 56
1.5
1.25
1
0.75
0.5

The scoring logic uses the decision tree criteria and applies aggregation rules to formulate a composite baseline score for each of the ten clinical standards.

Qualitative data calculation

NHSIQ

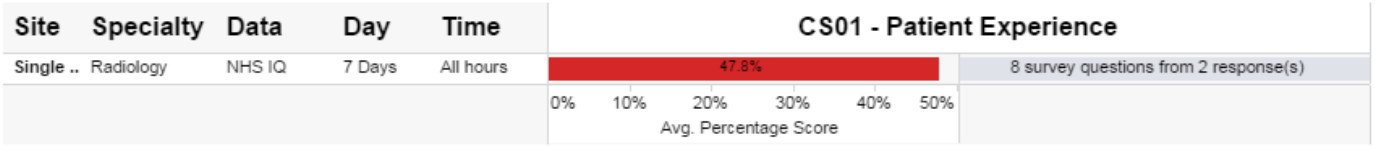
The overall percentage score for each clinical standard by specialty by site/trust was calculated by comparing the total score of the responses received with the maximum possible score attainable for that clinical standard. Where more than one clinical standard response was received for a specialty, survey response with the highest score was used for the baseline assessment.

As an example, the table below indicates two responses received for Radiology for CS1. The highest Overall Response Score was used to calculate the overall baseline percentage.

Extract from Raw Data File			
Site.Updated	**Specialty.Updated**	**Overall.Response.Score**	**Used.in.Dashboard**
Single Site	Radiology	5.25	No
Single Site	Radiology	6.75	Yes

Using the decision tree, the maximum possible NHSIQ score for that standard was 14.125. Therefore the percentage score for Radiology for CS1 was: **6.75/14.125*100 = 47.8%.**

Figure 23: Example of CS1 score for Radiology from Tableau



NHSIQ Other

The overall percentage score for each clinical standard by specialty by site/trust was calculated by comparing the total score of responses received with the maximum possible score attainable for that clinical standard. When more than one response per specialty per site was given then the median

score of all responses was used to compare with the highest score and then calculate the baseline percentage score.

As an example, the table below indicates two responses received for Ambulatory Care for clinical standard one. Median of the Overall Response Scores was calculated and compared against the overall maximum attainable score to formulate the baseline percentage.

Site Updated	Specialty Updated	Overall Response Score
Single Site	Ambulatory Care	12
Single Site	Ambulatory Care	4.9375
Median(12,4.9375) =	8.46875	

Using the decision tree, the maximum possible score for that standard was 19.375. Therefore the percentage score for Ambulatory Care for CS1 was: **8.46875/19.375* 100 = 43.7%.**

Figure 24: Example of CS1 score for Ambulatory Care from Tableau

Patient Notes

Patient notes audit responses were segregated into day and time combination (i.e. weekday/weekend/out of hours/in hours). A median score of all responses received for each time-block was compared against the maximum attainable score to calculate the baseline score per time-block.

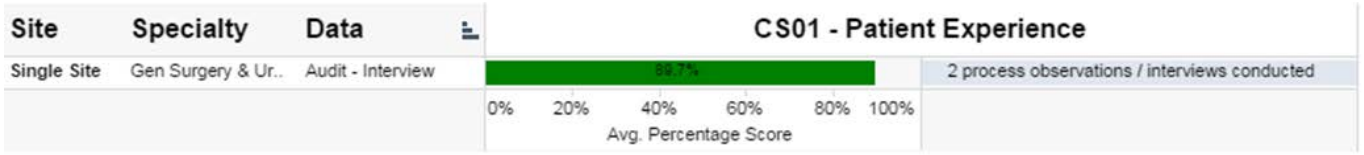
Figure 25: Example of CS2 score for Cardiology across different time-block from Tableau

Interview

For audit process interviews the overall percentage score for each clinical standard by specialty by site/trust was calculated by comparing the total score for that specialty/standard with the maximum possible score attainable for that clinical standard.

When more than one response per specialty per site was given then the median score of all Overall Responses Scores was used to compare with the maximum possible score attainable for that clinical standard to calculate the baseline percentage score.

Figure 26: Example of CS1 score for General Surgery from Tableau



Quantitative data calculation

Following an extensive exercise of mapping quantitative data extracts (predominantly for clinical outcomes) to clinical standards, only Patient Experience data was deemed relevant to be used in assessing compliance against CS1.

Patient feedback in the datasets provided was used and categorised as positive and negative feedback. Comments were then scored with polarity algorithm which utilised the sentiment dictionary built to

categorise product reviews (Hu and Liu, 2004) to tag polarised words. Words which amplify, attenuate or negate meaning were used to affect score. Total count of positive instances was then compared against total patient/spell counts to calculate percentage scores. This percentage denoted a total % of patients who had positive experience throughout the pathway as per clinical standard 1 criterion.

The team applied the decision tree scoring logic to the qualitative data using 'R' analytical software scripting to generate the baseline scores. Quantitative data was analysed separately.

Normalising the data

Elements of the data had to be normalised, particularly specialty names, to present a consolidated picture across the ten trusts. The specialty names were reconciled to the national specialty list used by Health and Social Care Information Centre (HSCIC) when publishing Hospital Episodes Statistics (HES) data. Where names could not be reconciled, the team used the most frequently used specialty name across the ten trusts.

As a result of standardising and reconciling the specialty names there is a slight difference between individual trusts' dashboards to the overall regional dashboard. This reconciliation has not impacted on the trusts' ability to perform an accurate gap analysis and options development at specialty level. Individuals' dashboards presents the local trusts' specialties names and the East Midlands regional dashboard presents the national naming convention to enable a like-for-like comparison across the ten trusts.

Key learnings:

There is an opportunity for the Collaborative to standardise their local specialty naming convention with the national naming convention. This will allow like-for-like specialty comparison across the Collaborative and nationally.

Data analysis was presented using a combination of Tableau and Excel workbooks.

The Tableau workbooks provided various views of the baseline assessment:

- Output 1: aggregated scores for a specialty and standard across all 7 days and both core and out of hours
- Output 2 and 4: scores by each data source for each site, specialty and standard combination

- Output 3 and 5: further breakdown of scores for each site, specialty, standard and data source combination broken down by day of the week and time.

Quantitative clinical outcomes data was presented in a series of graphs for ease of comparison across specialties.

Tailoring the data analysis

To support the trusts' gap analysis workshops, the team offered an 'on demand' analytics service over a two-week period to supplement the baseline assessment. This enabled trusts to request bespoke analysis of their own data.

Over the two weeks, 25 requests were made by trusts to further analyse their data. The analysis concentrated on:

- Sentiment analysis of complaints and incidents split across weekdays and weekends
- Comparison of complaints and incidents across specialties
- Merging of specialties in provision of additional tableau output
- Analysis of service provision data across the East Midlands.

The benefits of this 'on demand' analysis include:

- Identifying key complaints and incidents trends by specialty across the 7 days
- Understanding current gaps in the way trusts collect data and identify actions to address these
- Having a more detailed picture of service availability across the East Midlands to identify potential areas of collaboration.

Engaging key decision-makers

After the data analysis, trusts engaged clinical, managerial and support services staff to understand the gaps between their baseline position and the ten clinical standards and to develop options to close these gaps.

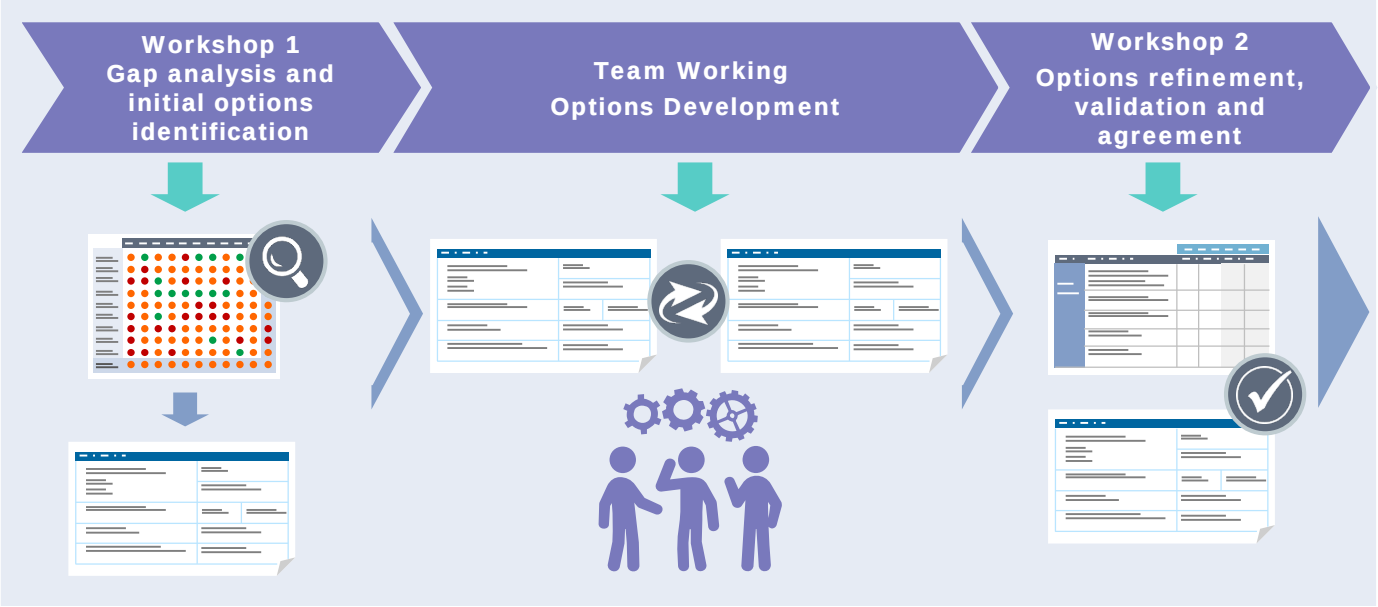
Working closely with the Trust Leads, the team developed the engagement approach shown below in Figure 27 (tailored if necessary for each trust). This gave trusts the opportunity to bring together key

decision-makers from across their divisions, support services (including Finance and HR), and in some cases external partners. Operational- and strategic-level discussions addressed the implications of moving to a 7 day services model. Many of the trusts took the opportunity to continue these discussions within divisional meetings, embedding the 7 day service agenda into existing operational conversations.

There was also a series of workshops with the trusts' 7 day services Finance and HR leads (where available). Finance leads agreed a standard approach to costing options for closing the gaps between current and 7 day service provision (see *Financial assessment* later in this section). HR leads agreed the key workforce metrics to inform the gap analysis.

The baseline assessment outputs were shared with wider stakeholders across the East Midlands region; for example, presentations to HR Directors at their monthly event, Health Education East Midlands, and to Finance Directors through the community chair.

Figure 27: Generic trust engagement approach



Analysing the gaps between the current state and the clinical standards

Gap analysis workshops with Trust leads were typically half- or full-day events designed to:

- Review the baseline assessment and the current position against the ten clinical standards at a division/specialty level
- Identify areas of best practice where the trust is already meeting the clinical standards
- Identify the key gaps and explore the causes of and issues relating to those gaps
- Categorise and prioritise the issues (e.g. organisation/people, process, IT, access to services, finance), identifying key themes across divisions/specialties.

The team provided templates to enable consistent data capture. Trusts then began to explore options to address the prioritised issues. Against each potential option trusts captured the probable effort to implement the option and the impact it would have on closing the gap. The output from the gap analysis workshops was a set of prioritised options which would be developed further by the clinical teams.

Developing and finalising the options to close the gaps

Following the gap analysis workshops, the divisional teams and their finance and HR colleagues developed the options in more detail. Workforce implications could then be costed. In addition, each option included the:

- Option level (specialty, division, trust, local health economy, Collaborative, pan-East Midlands)
- Delivery horizon (>3months, 3-6 months, 6-12 months, >12 months)
- Key risks and issues
- Defined priority (high, medium, low).

The options were taken to a workshop, or in some cases a project steering board, for further refinement, validation and agreement that they would form the basis of the trusts' 7 day services plans.

Key learnings:

- Clinical engagement is important in identifying innovative solutions to deliver 7 day services and taking the lead in driving 7DS within the organisation.

Reporting and recommendations

The Collaborative produced a standard report template for use across the region. The report template captures and presents the options and recommendations agreed during the trusts' workshops.

There are two levels of reporting.

- **Individual trust level report** (one for each of the ten trusts) provides the trust baseline position against the ten clinical standards, areas of best practice, key themes and issues, agreed options to close the gaps, considerations for their wider health economy, conclusions and recommended next steps.
- **East Midlands Chief Executives'** report (a consolidated report) provides a consolidated view across the ten trusts and highlights key opportunities for collaboration.

Finance assessment approach

The team agreed a common approach to assess the high-level financial impact of 7 day services during a series of collaborative workshops and meetings with members of the Finance community from all ten trusts.

Finance teams worked closely with clinicians and other non-clinical staff at workshops and divisional meetings at most trusts. This helped build the necessary understanding and consensus around the issues, service gaps and options and the financial implications of these.

Using a standard costing template and a set of associated assumptions (as detailed in individual trust reports), indicative costs were developed for each option to inform the action plans for each trust.

Some trust reports contain a full cost submission for developed options. However, given the level of detail needed to fully evaluate costs and benefits of each option, these costs, at this stage, should be considered as indicative.

Note. The template takes account of staff costs. Non-pay costs, income and one-off costs are excluded unless indicated otherwise. Staff costs are based on standard NHS rates and any additional

premium rates based on local experience. Therefore, two costs may be included reflecting standard and premium rates.

Acknowledging challenges along the way

The process of completing the baseline assessment across ten acute trusts has not been without challenge.

- Statistical relevance has been an issue when considering the evidence base for each clinical standard. Ideally, sample sizes would be significant, but given the timescales, and with little data automation in place across the ten trusts, it would have been resource-intensive and impractical to have acquired the sample sizes initially requested. Therefore the Trust leads, endorsed by the CEOs, decided to take a hybrid approach and allow each trust to source the required data pragmatically and taking into account operational constraints.
- Robust evidence simply does not exist for some of the clinical standards; for example, the time of first consultant review is rarely documented and when it is, the quality of the data is variable. Some evidence can only be found by auditing paper patient notes; the quality and structure of these notes is variable.
- Variability in service provision between core hours Monday to Friday, Out of Hours and weekends could not always be fully determined from the data made available during the collection phase.
- Inconsistent service/specialty naming conventions has caused significant challenge when providing an aggregate view across ten acute trusts.

Appendix D: Summary by trust of specialties/support services with greatest challenge to meet the clinical standards

Figure 28: Summary by Trust of specialties/support services with greatest challenge to meet the clinical standards

Trust	Specialty	CS 02	CS 03	CS 04	CS 05	CS 06	CS 07	CS 08	CS 09
Chesterfield Royal Hospital	A&E	■	■					■	■
	Ambulatory Care	■	■					■	■
	Anaesthetics, Critical Care & Theaters	■				■	■	■	■
	Clinical Pharmacology (Pharmacy)		■	■					■
	Dietetics		■						
	Ear Nose & Throat		■	■		■		■	
	Gastroenterology	■	■					■	■
	General Surgery					■	■	■	■
	Geriatric Medicine	■	■				■	■	■
	Opthalmology	■	■		■	■		■	■
	Respiratory Medicine					■	■	■	
	Stroke Medicine	■	■				■	■	
	Therapy		■						■
	Trauma & Orthopaedics	■	■					■	■
	Total non-compliance per CS by Specialty	**8**	**11**	**2**	**1**	**5**	**5**	**11**	**10**
Kettering General Hospital	Clinical Pharmacology (Pharmacy)					■			■
	General Medicine	■	■				■	■	■
	General Surgery		■			■	■	■	■
	Head & Neck	■	■	■			■	■	■
	Respiratory Medicine						■	■	
	Total non-compliance per CS by Specialty	**2**	**3**	**1**	**0**	**2**	**4**	**4**	**4**
University Hospitals of Leicester	A&E	■	■					■	
	Clinical Haematology		■		■		■	■	■
	Clinical Pharmacology (Pharmacy)		■	■					■
	Ear Nose & Throat	■		■	■	■	■	■	■
	Nephrology		■		■		■	■	■
	Therapy		■	■					
	Total non-compliance per CS by Specialty	**2**	**5**	**3**	**3**	**1**	**3**	**4**	**4**
Northampton General Hospital	Clinical Pharmacology (Pharmacy)					■			■
	Ear Nose & Throat	■	■					■	
	General Medicine		■				■	■	■
	Head & Neck	■	■					■	■
	Nephrology		■			■		■	
	Oncology	■	■						
	Respiratory Medicine		■				■		■
	Urology		■					■	
	Total non-compliance per CS by Specialty	**3**	**7**	**0**	**0**	**2**	**2**	**5**	**4**
North Lincolnshire and Goole Hospital	A&E	■	■					■	
	Ear Nose & Throat	■						■	
	Gastroenterology	■	■		■	■	■	■	■
	Geriatric Medicine							■	
	Gynaecology	■	■				■	■	■
	Opthalmology	■						■	
	Rheumatology	■						■	
	Total non-compliance per CS by Specialty	**6**	**3**	**0**	**1**	**1**	**2**	**7**	**2**

Trust	Specialty	CS 02	CS 03	CS 04	CS 05	CS 06	CS 07	CS 08	CS 09
Nottingham University Hospitals	General Surgery		■				■		
	Oncology	■							
	Therapy		■						
	Urology					■	■		■
	Total non-compliance per CS by Specialty	**1**	**2**	**0**	**0**	**1**	**2**	**0**	**1**
Peterborough and Stamford Hospital	Gastroenterology	■						■	
	General Medicine	■	■	■	■	■	■	■	
	General Surgery				■	■	■	■	■
	Stroke Medicine	■	■		■	■		■	
	Therapy		■						
	Trauma & Orthopaedics	■						■	
	Urology	■						■	
	Total non-compliance per CS by Specialty	**5**	**3**	**1**	**3**	**3**	**2**	**6**	**1**
Royal Derby Hospital	Anaesthetics, Critical Care & Theaters	■	■					■	
	Ear Nose & Throat	■	■				■	■	■
	General Surgery	■	■			■	■	■	■
	Geriatric Medicine	■	■					■	■
	Gynaecology	■	■					■	
	Hepathology	■	■				■	■	■
	MAU	■	■					■	
	Obstetrics & Gynae	■	■					■	
	Oncology	■	■					■	
	Opthalmology	■						■	
	Paediatrics	■	■					■	
	Total non-compliance per CS by Specialty	**11**	**10**	**0**	**0**	**1**	**3**	**11**	**4**
Sherwood Forest Hospital	A&E			■		■			■
	Cardiology		■			■			■
	Ear Nose & Throat		■						
	Neurology	■	■					■	■
	Obstetrics & Gynae	■	■						■
	Paediatrics	■	■			■			■
	Radiology								■
	Therapy		■						■
	Total non-compliance per CS by Specialty	**3**	**6**	**1**	**0**	**3**	**0**	**1**	**7**
United Lincolnshire Hospital	Ambulatory Care	■	■					■	
	Clinical Pharmacology (Pharmacy)								
	Dietetics		■						
	Radiology				■				
	Total non-compliance per CS by Specialty	**1**	**2**	**0**	**1**	**0**	**0**	**1**	**0**
Total non-compliance by clinical standard		**42**	**52**	**8**	**9**	**19**	**23**	**50**	**37**

■ Indicates specialty/support service not meeting clinical standard requirements

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Appendix E: Whole Time Equivalent (WTE) requirements split by specialty and staff group

Figure 29: WTE requirements split by specialty and staff group

	WTEs							
Specialties	**Consultant**	**Other medical**	**Nurses**	**AHP**	**Admin**	**Pharmacists**	**Others**	**Total**
Accident & Emergency	7	8	0	0	1.5	0	0	**16.5**
Acute Internal Medicine	3	0	0	0	0	0	0	**3**
Ambulatory Care	0	3	1.5	0	0.8	0	0	**5.3**
Anaesthetic, critical care & Theatres	0.5	0	1	0	0	0	0	**1.5**
Cardiology	5.5	2	5.79	0.54	0.4	0	1.5	**15.73**
Diabetics	0	1	0	0	0	0	0	**1**
Diagnostics	12.6	0	2	23	0	0	23.2	**60.8**
Dietetics	0	0	0	2.5	0	0	0	**2.5**
Endocrinology	2	0	0	0	0	0	0	**2**
ENT	1	0	0	0	0.43	0	0	**1.43**
Gastroenterology	4	3	1	0	0.4	0	0	**8.4**
General Medicine	22.69	0	4.64	4.8	12.9	0	0	**45.03**
General Surgery	23.1	5	0.5	0	1.24	0	51	**80.84**
Geriatric Medicine	14	0	0	0	0	0	0	**14**
Haematology	1	0	0	0	0	0	0	**1**
Medical Assessment Unit	4.7	0	0	0	2.35	0	2.1	**9.15**
Obstetrics & Gynaecology	9.7	2.5	12.99	0	10.24	0	0	**35.43**
Oncology	7.7	0.5	2.12	0	3.38	0	1.9	**15.6**
Ophthalmology	0	0	2	0	0	0	0	**2**
Paediatrics	20	0	13	0	5.24	1	0	**39.24**
Pathology	0.5	0	0	0	0	0	36	**36.5**
Pharmacy	0	0	0	0	1	31	40	**72**
Renal	1	1	0	1.52	0.4	0	0	**3.92**
Respiratory Medicine	5.6	2	0	0	0.4	0	0	**8**
Speech & Language Therapy	0	0	0	3.5	0	0	0	**3.5**
Stroke	3	2	0	1	0.4	0	0	**6.4**
Therapy	0	0	0	145.97	0	0	0	**145.97**
Trauma & Orthopaedics	14.48	4	7.6	0	2.24	0	1.6	**29.92**
Urology	4.5	2	0	0	1.24	0	0	**7.74**
Vascular	0	5	0	0	0	0	0	**5**
Grand Total	**167.57**	**41**	**54.14**	**182.83**	**44.56**	**32**	**157.3**	**679.4**

The WTE numbers included in the above table have been submitted by Chesterfield Royal Hospital NHS Foundation Trust, Derby Hospitals NHS Foundation Trust, Kettering General Hospital NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust and University Hospitals of Leicester NHS

Appendix F: Detailed case studies / best practice

To supplement the findings, the team carried out extensive research into areas of good and best practice within and outside the health sector many of which are directly referenced within this report. This section lists a number of case studies and further examples and, where possible, relates them to clinical standards, clinical areas and integrated care models.

Case studies by clinical standard

Many of the case studies in this section are examples of collaborative and partnership working within the NHS which can be linked to clinical standards. This table identifies the organisation(s), provision model, area of good/best practice, collaborative scope and source of the information.

Clinical standard	Organisation	Provision model	Areas of good / best practice	Collaborative scope	Source
CS1	United Hospital of North Staffordshire NHS Trust	Developing a 24/7 service on the acute Stroke Unit	Focus on the needs of the patient with family participation		NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS2	Salford Royal NHS Foundation Trust	Emergency care village	Front-end loading Service redesign Innovative contracting	Foundation Trust and commissioners	Seven Days a Week Forum, Costing seven day services - The financial implications of seven day services for acute Emergency and Urgent services and supporting Diagnostics.

Clinical standard	Organisation	Provision model	Areas of good / best practice	Collaborative scope	Source
CS3	University Hospitals of Leicester NHS Trust - Leicester Fertility Centre	Fertility Centre	MDT working Improved equipment use		NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS3	Gloucester Hospitals Foundation Trust	7 Day Consultant Radiology service	Time shifted contracts		NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS3	South Tees Hospital NHS Foundation Trust	7 Day Physiotherapy service in cardiac care	LOS reduction Flexible working structure Open communications between stakeholders		NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS4	Doncaster Council and local NHS Trusts	Health & social care in partnership	Multidisciplinary rapid assessment programme team Computerised 'i-tracker' system Discharge nurse specialist case managers	Metropolitan Borough Council and 2 NHS Trusts	NHSIQ
CS5	South London Collaborative Working Pilot	Initial discussion structured to capture broad areas of interest	Pooling resources & workflow Smoothing demand/capacity Hot reporting	All NHS acute trusts in South Thames	Implementing 7 Day Working in Imaging Departments: Good Practice Guidance

Clinical standard	Organisation	Provision model	Areas of good / best practice	Collaborative scope	Source
CS5	Royal Free Hampstead NHS Trust	7 Day microbiology service	Only 24 hour microbiology centre in England Flexible and self-rostering Changing workforce profiles and terms and conditions		NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS6	Cumbria & Lancashire Telestroke Network	Provision of thrombolysis for stroke patients using video-conferencing	Video-conferencing Collaboration inc private companies	6 acute trusts, 8 sites, 9 CCGs and 3 private companies	NHSIQ
CS6	UH Coventry & Warwick and George Eliot Nuneaton NHS Trusts	OOH IR service using consultants from neighbouring trust	Realignment of diagnostic rota Local specialist IR MDT	2 trusts	Towards best practice in IR
CS6	Newcastle Upon Tyne NHS Trust	Radiology nursing cross site rotation	Single nurse on-call rota Medical staff/nurses joint working	Multi sites	Towards best practice in IR
CS6	S Devon and Royal Exeter & Devon NHS Trusts	On-call interventional radiology across 2 sites	Networked on-call IR Formal cross-site MDT working Links with vascular surgery	2 trusts	Towards best practice in IR

Clinical standard	Organisation	Provision model	Areas of good/best practice	Collaborative scope	Source
CS6	NHS Gtr Glasgow & Clyde	24/7/365 interventional on-call services	Equipment/procurement merger IR on-call manual Monthly Interventional forum	9 sites	Towards best practice in IR
CS6	West Yorkshire Cardiovascular Network	Regional PPCI (Primary Percutaneous Coronary Intervention) on-call rota	Regional on-call collaboration	9 sites	NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS6	Newton Abbot Hospital, Torbay and Southern Devon Care Trust	Physiotherapy and occupational therapy 7 day service for the stroke unit	Demand & capacity planning	acute & Community	NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS7	Northumberland, Tyne and Wear NHS Foundation Trust	24/7 telephone service and single point of access for patients with mental health issues	24/7 Telephone referral line Risk monitoring and signposting Crisis management Digital dictation/3G tablets Single point of access to trust	Acute trusts, MH trusts, GPs	NHSIQ
CS7	Birmingham Community Healthcare NHS Trust/Birmingham & Solihull MH NHS Foundation Trust/ Sandwell & W Birm Hosps	Rapid Assessment Interface Discharge (RAID)	24 hour community based rapid response service prevents acute admissions Single point of access to discuss referrals directly with referrers and direct them to	acute & Community	NHS Improvement Equality for all - Delivering safe care – Seven Day Working, RAID case study pdf

Clinical standard	Organisation	Provision model	Areas of good / best practice	Collaborative scope	Source
	NHS Trust / Heart of Birm Teaching PCT		the appropriate place of care Integrated multidisciplinary teams (IMTs). Large scale patient and public involvement 'Virtual ward'		
CS8	**Northumbria Healthcare NHS Foundation Trust**	Consultant led and delivered 7 day working model	'Hot' centre for acute care Job plans changed On-call commitments were re-defined Alteration of junior doctors training Talk to public	10 sites	NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS9	**Doncaster Council and local NHS Trusts**	Health & social care in partnership	Multidisciplinary rapid assessment programme team Computerised 'i-tracker' system Discharge nurse specialist case managers	Metropolitan Borough Council and 2 NHS trusts	NHSIQ
CS9	**Epsom and St Helier University Hospitals NHS Trust and Surrey County Council Adult Social Care**	Social care presence on the acute medical unit	Co-location of social care in AMU MDT approach	NHS Trust and County Council Adult Social Care	NHSIQ

Clinical standard	Organisation	Provision model	Areas of good / best practice	Collaborative scope	Source
CS9	Oxleas NHS Foundation Trust and Greenwich Local Authority	Seven day integrated admission avoidance service	Multi-disciplined Joint Emergency Team (JET team) Joint governance board	NHS trust and Local Authority	NHSIQ
CS9	Bristol, North Somerset and South Glos Urgent Care Board	Systematic improvement approach to identify services required over 7 days	System-wide 7 Day Action team formed 'Plan, Do, Study, Act' approach OOH/weekend audits Systematic testing of changes	NHS trusts, Community Health, CCGs, City Council, Urgent Care Board	NHSIQ
CS9	Aneurin Bevan Health Board	Pan Gwent Frailty Programme: Supporting people at home through seven day rapid response and re-enablement	Hospital at home Single point of access for health and social care teams. GPs, district nurses, the -e services, social services and ambulance services working together The 'voice of the patient	Hospital trust, 5 local health boards (PCTs), 5 local authorities	NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS9	Birmingham Community Healthcare NHS Trust / Birmingham & Solihull MH NHS Foundation Trust / Sandwell & W Birm Hosps NHS Trust / Heart of Birm	Rapid Assessment Interface Discharge (RAID)	24 hour community based rapid response service prevents acute admissions Single point of access to discuss referrals directly with referrers and direct them to the appropriate place of care	Acute & Community	NHS Improvement Equality for all - Delivering safe care – Seven Day Working, RAID case study pdf

Clinical standard	Organisation	Provision model	Areas of good / best practice	Collaborative scope	Source
	Teaching PCT		Integrated multidisciplinary teams (IMTs). Large scale patient and public involvement 'Virtual ward'		
CS9	**South Devon Healthcare NHS Foundation trust**	Working Towards a Seven Day Hospital Service	Integrated community care organisation System wide approach to delivering 7 day services. Hospital@Night Practice Trauma and orthopaedics 7 day operating lists 364 days a year Surgical consultant of the week Elective/emergency radiology onsite weekend service Interventional radiology 7 day rota Discharge care co-ordinator role		NHS Improvement Equality for all - Delivering safe care – Seven Day Working
CS9	**NHS Great Yarmouth and Waveney Integrated Care**	Integration – empowering people to stay at home	Whole system approach Leaders commitment Clinical/professional	Out of Hospital Team, GPs, in and out of hours, Therapists and	NHS Great Yarmouth & Waveney case study.ppt

Clinical standard	Organisation	Provision model	Areas of good / best practice	Collaborative scope	Source
	System		steering/design Communication Detailed planning	Podiatrists, Community Nurses and Phlebotomists, Social Work Practitioners, Community Mental Health Practitioners, Paramedics, Pharmacists, Community Support Workers	
CS10	**Bristol, North Somerset and South Glos Urgent Care Board**	Systematic improvement approach to identify services required over 7 days	System-wide 7 Day Action team formed 'Plan, Do, Study, Act' approach OOH/weekend audits Systematic testing of changes	NHS trusts, Community Health, CCGs, City Council, Urgent Care Board	NHSIQ

Case studies by clinical area (source - NHS Improvement Equality for all - Delivering safe care – Seven Day Working)

The case studies in this section are examples of initiatives resulting from 7 day working within the NHS that can be directly linked to clinical areas identifying the organisation(s), provision model, staff group and area of good/best practice (where available).

Clinical area	Organisation(s)	Model	Staff groups	Areas of good/best practice
Cancer Care	Cambridge University Hospitals NHS Foundation Trust	Extended Radiotherapy Service	Radiographers	
Cancer Care	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Six Day Chemotherapy Service	Nursing Staff , Medical Staff, Pharmacy	
Cardiac Care	The Leeds Teaching Hospitals NHS Trust	A Regional PPCI Service	Cardiologists, Catheter Lab Staff	
Cardiac Care	Royal Berkshire NHS Foundation Trust	Seven Day acute Cardiology Service	Cardiologists	Development of a Chest Pain Assessment Unit (CPAU) Clinical engagement between cardiology, the emergency department and South Central Ambulance Service
Cardiac Care	South Tees Hospitals NHS Foundation Trust	Seven Day Physiotherapy Service for Cardiothoracic Patients	Physiotherapists	

Clinical area	Organisation(s)	Model	Staff groups	Areas of good/best practice
Diagnostics	Gloucester Hospitals NHS Foundation Trust	Seven Day Consultant Radiology Service	Consultant Radiologists, Radiographers and Clerical Staff	Time shifted contracts
Diagnostics	Royal Free Hampstead NHS Trust	Seven Day Microbiology Service	Health Care Scientists	The only 24 hour microbiology service in England Flexible and self - rostering systems Changing workforce profiles and terms and conditions
Diagnostics	Salisbury NHS Foundation Trust	Seven Day Radiology Service	Radiographers	
General Medicine	Heart of England NHS Foundation Trust	Seven Day Ward Rounds for General Medical Admissions	Consultant Physicians, Junior Doctors	
Integrated System	Northumbria Healthcare NHS Foundation Trust	A Consultant led and Delivered Seven Day Working Model Across a Geographically Challenged Trust	Consultant Staff , Junior Doctors, Nursing Staff, Administrative Staff	
Integrated System	South Devon Healthcare NHS Foundation Trust	Working Towards a Seven Day Hospital Service	All Major Staff Groups	Integrated community care organisation System wide approach to delivering 7 day services. Hospital@Night Practice Trauma and orthopaedics 7 day operating lists 364 days a year

Clinical area	Organisation(s)	Model	Staff groups	Areas of good/best practice
				Surgical consultant of the week Elective/emergency radiology onsite weekend service Interventional radiology 7 day rota Discharge care co-ordinator role
Women's Services	**The Ipswich Hospital NHS Trust**	Obstetric and Gynaecological Physiotherapy Services	Physiotherapist	
Women's Services	**University Hospitals of Leicester NHS Trust**	Leicester Fertility Centre	Healthcare Scientists, Clinicians, Nurses, Administrative Staff, Healthcare Assistant	Multi-disciplinary teamworking (MDT) Improved equipment usage
Women's Services	**Winchester & Eastleigh Healthcare NHS Trust**	Extending the Consultants Day in Breast and Gynaecological Services – including Theatres and Wards	Breast Surgeons, Gynaecologists, Pathologists, Anaesthetists, Theatre Staff, Ward Clerks, Nursing Staff, Admin Staff	
Pharmacy	**Oxford Radcliffe Hospitals NHS Trust**		Pharmacists	
Respiratory	**Guy's and St. Thomas NHS Foundation Trust**		Physiotherapists	

Clinical area	Organisation(s)	Model	Staff groups	Areas of good/best practice
Respiratory	**South Tees Hospitals NHS Foundation Trust**	Seven Day Respiratory Surgical Physiotherapy Service	Physiotherapists, Physiotherapy Assistant Practitioners	
Stroke	**Torbay and Southern Devon Care Trust - Newton Abbott Hospital**	Physiotherapy and Occupational Therapy Seven Day Service for the Stroke Unit and Community Team	Physiotherapists, Occupational Therapists, Nursing Staff	
Stroke	**University Hospitals Leicester NHS Trust**	Seven Day Service for the Assessment and Treatment of Transient Ischaemic Attack (TIA)	Healthcare Scientist - Vascular Technicians, Nursing Staff, Healthcare Assistants, Clinic Aids, Medical Consultant, Radiographers	
Stroke	**United Hospital of North Staffordshire NHS Trust**	Developing a 24/7 Service on the acute Stroke Unit	Nursing Staff, Allied Health Professionals	Streamlined and simplified management processes Focus on the needs of the patient with family participation
Telemedicine	**East Kent Stroke Network Salisbury NHS Foundation Trust Nottinghamshire Healthcare NHS Trust NHS Nottinghamshire**	Telemedicine Supporting Seven Day Working Across a Range of Clinical Specialties	All Major Staff Groups	

Clinical area	Organisation(s)	Model	Staff groups	Areas of good/best practice
	& Nottinghamshire County Council Adult Social Care, Health & Public Protection			
Therapy Services	Heart of England NHS Foundation Trust	Seven Day Therapy Service	Occupational Therapists. Physiotherapists, Speech and Language Therapists, Dieticians	
Therapy Services	South Tees Hospitals NHS Foundation Trust	Seven Day Physiotherapy Service across ICU, HDU and Surgery	Physiotherapist	Band 4, physiotherapy assistant practitioner role
Vascular	Thames Valley Vascular Centre	Hub and Spoke	Vascular staff	
Vascular	London Cardiovascular Project	Central units/hubs supported by local hospitals	Vascular staff	Central units that will provide arterial vascular surgery, each linked with several local units

Integrated care models

The case studies in this are examples of national and international integrated care initiatives, organisational, commissioning and contracting models within healthcare some which are linked to 7 day working and acute care.

Organisation	Initiative / model
Central Manchester's Clinical Integrated Care Board (CICB)	A partnership of Central Manchester CCG, Central Manchester Foundation Trust, Manchester City Council, Manchester Mental Health and Social Care Trust and the North West Ambulance Service working towards more integrated care
The North Lanarkshire Health and Care Partnership	Brings together the work of North Lanarkshire Council and NHS Lanarkshire to deliver better integrated services to four care groups: older people, and those with disabilities, addictions and mental health problems. ► multi-professional team-working between health and social care ► organisational development work to develop shared goals and values ► the creation of shared outcome measures ► care co-ordination targeted at the highest risk individuals with the most complex problems ► involvement of community teams and organisations in ongoing care and support
South Devon and Torbay Health & Care Cabinet	Incorporates clinicians, execs from all local healthcare trusts, GPs, social care, health & wellbeing boards, healthwatch and public watch
Bristol, North Somerset & South Glos Urgent Care Board	A '7 day action team' was formed with clinicians, managers and commissioners from both the hospital and community health and social care providers
South Essex Partnership University NHS Foundation Trust (SEPT)	Provides integrated care for more than 200 locations across Bedfordshire, Essex, Luton and Suffolk ► standardising clinical and quality standards across different sites ► patient and service-user involvement ► high-calibre local management groups ► locality sub-committee structure ► central corporate function

Organisation	Initiative / model
Cambridgeshire and Peterborough Clinical Commissioning Group	An example of a Prime provider contract worth £800m over 5 years with a single prime provider to control the budget for the whole patient pathway and relevant services for older people. The advantages of this model are: ▶ increased direct control over provision across a pathway ▶ demand risk shifts to provider(s) ▶ enables money to move within the pathway ▶ clear governance arrangements through contract/ subcontract mechanisms
Salford Integrated Care Programme (ICP)	Salford's ICP developed an Alliance contract or agreement between partners as a vehicle to bind commissioners and providers with shared strategic intent, decision-making, goals and improvement measures. A pooled health and social care budget for older people valued at c£800m over 6-7 years includes acute and community services provided by the local trusts, care services provided or sub-contracted by the local authority and further services provided by a Mental Health trust. The advantages of this model are: ▶ strong incentives to collaborate ▶ limits dominance of a single organisation ▶ strengthens relationship between commissioners and providers ▶ retains the active involvement of commissioners
Integrated Care and Support Pioneers	14 NHS organisations have been identified to work across the whole of their local health, public health and care and support systems, and alongside other local authority departments as necessary, to improve the consistency and quality of services and develop new 7 day models of integrated care
Academic Health Science Networks (AHSNs)	Established 'to deliver a step change in the way the NHS identifies, develops and adopts new technologies'. Their role is to promote effective collaboration between organisations across the whole healthcare sector – NHS, academia, social care, private sector – and drive them to innovate in the way they provide healthcare, speeding up the adoption of innovations and technologies resulting in better outcomes and patient care
Geriant (Netherlands)	A community-based service to people diagnosed with dementia. Case managers act as the focal point for the client and his or her informal caregivers, co-ordinating services from the team and from other network partners including GPs, hospitals, home care and welfare organisations.

Organisation	Initiative / model
Kaiser Permanente (USA)	The largest non-profit-making health maintenance organisation in the United States, serving 8.7 million people in eight regions – integrated delivery system and financing scheme – equal partners, separate entities, operates like mini NHS.
Canterbury District Heath Board, New Zealand	One system, one budget - the price/volume schedule (the equivalent of the NHS tariff) was scrapped and the budgets for hospital departments were re-built from the base up

Other case studies

Prime Ministers Challenge Fund - Workington Better Together – Developing Primary Care Communities in Cumbria (Cumbria, Northumberland, Tyne and Wear)	This pilot of five practices have come together to operate as a single organisation to provide modernised local services for the Workington population of 33,292 patients. The team have redesigned the minor injury service into a Primary Care Centre offering same day appointments to enable same-day access to primary care. This will be open 8-8, 7 days a week for minor ailments and injuries by the end of October 2014. They have also re-designed the management of same-day appointments releasing capacity within practices to focus on primary prevention and improve the management and care of frail elderly patients with long term conditions. Both aim to reduce the impact on A& E attendances. In addition, the team has implemented a specialist nurse practitioner post supported by GPs to support care homes provide one to one care, care planning and medicine reviews of those with complex long term conditions and developed specialist diabetes and COPD clinics in primary care to reduce admissions to acute hospitals by managing long term conditions within primary care. This pilot was awarded £511,000.

Appendix G: References

To supplement the findings, the team carried out research in many clinically-related areas. As a result, there are a number of useful and relevant references within this report and this section lists and provides links (where available).

The table below lists those references used within the report and links them to the section number of the report.

Section title	Reference
Executive summary	Keogh Review, NHS Services 7 days a week forum December 2013 Five year forward view October 2014
Introduction	Keogh Review, NHS Services 7 days a week forum December 2013 Five year forward view October 2014
Finding and recommendations for closing the gaps	► Chesterfield Royal Hospital NHS Foundation Trust 7 day services final report ► Derby Hospitals NHS Foundation Trust 7 day services final report ► Kettering General Hospital NHS Foundation Trust 7 day services final report ► Northampton General Hospital NHS Trust 7 day services final report ► Northern Lincolnshire and Goole Hospitals NHS Foundation Trust 7 day services final report ► United Lincolnshire Hospitals NHS Trust 7 day services final report ► Nottingham University Hospitals NHS Trust 7 day services final report ► Peterborough and Stamford Hospitals NHS Foundation Trust 7 day services final report ► Sherwood Forest Hospitals NHS Foundation Trust 7 day services final report ► University Hospitals of Leicester NHS Trust 7 day services final report
Addressing strategic workforce challenges	Workforce development plan (2014/17), Health Education East Midlands

Section title	Reference
Funding and commissioning considerations	Healthcare Financial Management Association (HFMA) study, on behalf of the Seven Days a Week Forum report 'Costing seven day services - The financial implications of seven day services for acute emergency and urgent services and supporting diagnostics' Monitor and NHS England publication 'Reimbursement of urgent and emergency care: discussion document on options for reform' Monitor and NHS England publication, October 2014 'Reforming the Payment System For NHS Services: supporting the five year forward view' Integrated care funding - Kings Fund. http://www.kingsfund.org.uk/projects/integrated-care-making-it-happen/integrated-care-map Personal health budgets - http://www.personalhealthbudgets.england.nhs.uk/About/faqs/ Patient level information and costing system (PLICS) - http://www.hsj.co.uk/home/innovation-and-efficiency/open-book-accounting-can-lead-to-a-more-honest-nhs/5071602.article
Organising for delivery	Keogh Review, November 2013, Five year forward view October 2014

In addition, there are a number of further references to 7 day working and associated subjects which are listed in the following table together with the source location and subject (where available):

Other information sources	Subject
Implementing 7 Day Working in Imaging Departments: Good Practice Guidance	Identifies issues, gives evidence and provides case studies for resolving these to ensure a patient focussed and consultant delivered service. Examples of best practice include: Pooling of skills across a wide area network Image Exchange Portal (IEP) – national solution to enable digital image sharing and streamlined radiology reporting Interoperability standards for cross enterprise imaging informatics Effective use of appropriately trained non-medical staff to ease

Other information sources	Subject
	pressure on radiologists Specialist advanced practitioner and consultant radiographic grades Radiographers extending their role to support patients referred from the accident and emergency department for imaging of minor injuries Outsourcing e.g. interventional radiologists in Durham
Towards best practice in Interventional Radiology http://www.slideshare.net/NHSImprovement/towards-best-practice-in-interventional-radiology	Findings from visits to interventional radiology (IR) services at proposed major trauma centres in England
NHS Improvement Equality for all - Delivering safe care – Seven Day Working	Examples of how teams have overcome the 7 Day challenge and what can be achieved to deliver extended services in a sustainable way
Seven Day Services Improvement Programme (SDSIP) - NHSIQ 7DS forum-summary-report Dec13	Includes: ► A dedicated transformational improvement programme which will provide the NHS with a delivery framework and national co-ordination over the next three to five years. ► Spreading and embedding existing and emerging practice, developing new models of delivery and supporting whole system change across the NHS in England ► Three improvement priorities form the basis of NHS Improving Quality's commitment to this programme: ► Bespoke targeted improvements: with a focus on diagnostics and spreading evidence-based models. ► Start the drive for spread: engaging all stakeholders to identify and adopt the top interventions which make a difference. ► Forward thinking improvement: designing new models of 7 day services for whole system change.

Other information sources	Subject
acute Upper Gastrointestinal Bleeding	An overview of out of hours service provision and equity of access
NHSIQ - Challenges and improvements in diagnostic services across 7 days	Summarises service improvement achievements and potential challenges in achieving 7 day services across diagnostic services
NHS Improvement - case studies http://webarchive.nationalarchives.gov.uk/20130221101407/http://www.improvement.nhs.uk/7DayServices/SevenDayWorkingCaseStudies/tabid/219/Default.aspx	These demonstrate where extended working days or weeks have been successfully implemented
NHSIQ - Providing access to interventional radiology services 7 days a week	Economic benefits, examples and emerging themes of networked solutions
Implementing 7 Day working in Imaging Departments: Good Practice Guidance - A Report from the National Imaging Clinical Advisory Group	Advice for commissioners and providers who wish to develop 7 day working in imaging departments.
Sustaining Universal Healthcare in the UK: Making Better Use of Information to Deliver Wellness Model - A Report by Volterra Partners for EMC	How data analytics have been effectively employed to deliver better quality of care
Kings Fund - Future organisational models for the NHS - Perspectives for the Dalton review	Examples of different types of healthcare organisational models including: ► Buddying ► Learning and clinical networks ► Partnerships/joint ventures ► Hospital franchises ► Mergers ► Hospital chains

East Midlands Clinical Senate

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