Implementing Clinical Quality Standards for NHS Services – 7 days a week

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Seven day service

- Definition
- Planned v unplanned
- 24/7
- Extended day
- Part day

- Not new but pressures
  - Hours of work
  - More we can do and more we know
Programme process

1. Review evidence base for change
2. Develop case for change
3. Develop standards
4. Commission standards
5. Audit acute hospitals against standards
6. Follow up with acute hospitals
7. One year on: provider self-assessment

Engagement with key stakeholders
London quality standards – development

• Over 90 clinical experts and patient panels reviewed the evidence base for best practice and where London is falling short, through:
  
  • Literature review
  • Hospital Episode Statistics data analysis
  • Survey of current arrangements at acute hospitals

• Clinical expert panels were multi-disciplinary and geographically representative.

• London quality standards were then developed to address the key issues found and were built on existing national standards.
## Stakeholder engagement snapshot

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians contributing to expert panels</td>
<td>90+</td>
</tr>
<tr>
<td>Patient and service user panel members</td>
<td>27</td>
</tr>
<tr>
<td>Attendees at stakeholder events</td>
<td>400+</td>
</tr>
<tr>
<td>Meetings with key stakeholder groups</td>
<td>80+</td>
</tr>
<tr>
<td>Clinical, patient, and GP commissioning group representatives participating in audit teams</td>
<td>60+</td>
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</tbody>
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Adult emergency services – case for change

- The Quality and Safety Programme built on the review of adult emergency services (AES, 2011) – acute medicine and emergency general surgery which found:
  - Variable and inadequate involvement of consultants
    - Consultant cover half at weekends compared to midweek
  - Patients admitted as an emergency at the weekend have an increased risk of dying
    - **Estimated 500 lives could be saved every year.**
  - Most literature excess mortality about 10%
  - Morbidity
  - Cost
    - Reduced overall service provision
  - Recommendations from clinical evidence were clear
    - early and consistent input by consultants improves patient outcomes.
London quality standards

• London quality standards developed to address variation in service provision and in working patterns between normal working hours and weekends.

• The standards represent the minimum quality of care patients should expect.

• Compliance will ensure acute emergency and maternity services are **consultant-delivered 7/7 and consistent across all providers**.

• The programme guided *Everyone Counts: Planning for Patients 2013/14* 7 days a week.
London quality standards – key themes

• Admissions seen by consultant <12 hours
• Twice daily ward consultant rounds for all patients
• MDT plan within 24 hours including EDD
• Timely access to diagnostics and reports
• Timely access to interventions including theatre
• All high risk operations to be undertaken under the direct supervision of a consultant surgeon and anaesthetist
• Good information for patients and their carers
• Timely transfer to next place of care

The standards were agreed and endorsed by the London Clinical Senate and Commissioning Council and:
• Commissioned from all providers from April 2012
• Providers were audited against the standards during 2012/13
2012/13 Acute emergency services audit – findings

• From May 2012 - January 2013 all acute hospitals in London were audited against the London quality standards for acute medicine and emergency general surgery. Reports published 28 February 2013.

• All hospitals recognised the value of meeting the standards and in:
  • Reinforcing the importance of meeting the clinical quality standards;
  • Focusing teams on prioritising efforts to address gaps identified; and
  • Developing approaches to monitoring delivery and ongoing achievement of the standards.

• Many hospitals have recognised that compliance with all of the standards may mean a significant change to the way services are provided at a local and at a network level.
2012/13 Acute emergency services audit – findings

- No one hospital met all standards.
- Every standard is met by at least one hospital.
- Hospitals had made significant efforts to change practice to and achieve the standards or most have robust plans in progress.
- Most hospitals had progress to make to ensure standards are consistent seven days of the week.
2012/13 Acute emergency services audit – findings

Percentage of standards met or not met

- Met: 51%
- Not met: 46%
- Plans in place: 3%

Acute medicine:
- Met: 49%
- Not met: 48%
- Plans in place: 3%

Emergency general surgery:
- Met: 53%
- Not met: 44%
- Plans in place: 3%
The biggest challenges are in consultant delivered care and multidisciplinary assessment, 7 days a week.
During November 2013 London’s acute hospitals self-assessed progress against meeting the London quality standards.

Results highlight progress for adult acute medicine and emergency general surgery.

- Commissioned from April 2012 and formally audited during 2012/13.

Improvements were seen across adult acute medicine and emergency general surgery.
Results from the 2013 self-assessment show there was no one standard not met by all hospitals during weekdays or weekends.

Key findings in 2013 v 2012:

- 55% v 35% of hospitals deliver consultant review within 12 hours.
- 35% v 7% of hospitals have twice daily ward rounds by a consultant.
- 72% v 28% of hospitals provide extended day working by consultants.
- 38% v 4% of hospitals provide multi-disciplinary team assessment within 12 hours.
- 45% v 21% of hospitals meet the standard for 24/7 timely access to diagnostics.
Improvements in adult acute medicine

Improvements were reported in:
- Consultant review within 12 hours;
- Extended day working;
- Twice daily ward rounds;
- Multidisciplinary team assessment.

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Adult emergency general surgery standards

There was no one standard not met by all hospitals during weekdays or weekends.

Key findings 2013 v 2012:

- 50% v 15% of hospitals deliver consultant review within 12 hours for emergency surgery.
- 38% v 7% of hospitals have twice daily ward rounds by a consultant.
- 69% v 22% of hospitals provide extended day working by consultants during the week.
- 23% v 0% of hospitals provide multi-disciplinary team assessment within 12 hours for emergency surgery.
- 46% v 22% of hospitals meet the standard for 24/7 timely access to diagnostics for emergency surgery.
Improvements in adult emergency general surgery

Improvements were reported in:
- Consultant review within 12 hours;
- Access to and provision of theatres; and
- Multi-disciplinary team assessment.
National seven day services clinical standards

• The national review is the first step in delivering NHS England’s goal to ensure routine services are available 7/7
  • same approach as London
  • Evidence based approach
  • Professional body support

• The review focussed on diagnostics and treatment of acute inpatients
  • the need for whole-system implementation.
  • aligned with the Urgent and Emergency Care Review.

•
National Seven Day Services: Key findings

• Inadequate involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients, particularly at the weekend.
• Limited access to diagnostic services and allied health professionals at weekends to establish management plans and facilitate discharge.
• Poor weekend emergency service provision is associated with an increased variation in outcomes such as:
  • Mortality rates
  • Patient experience
  • Length of stay
Seven day services: survey findings

Consultant review within 12/14 hrs

Weekday
- 100%
- 90-100%
- 75-90%
- 50-75%
- 25-50%
- 0-25%

Weekend
- 100%
- 90-100%
- 75-90%
- 50-75%
- 25-50%
- 0-25%

Only 16% of hospitals review all emergency medical admissions within 14 hours of arrival.

Rapid access to diagnostics

Nearly 80% have 5 or more MDT members during the week. This is just 30% at the weekend.

Availability of core MDT

MDT members include: Medical; Nursing; Physiotherapy; Occupational therapy; Pharmacy; Social Care

X-ray and CT availability is consistently high but other services vary considerably making informed decision making difficult.
Seven day services forum: clinical standards

1. **Patient Experience:** Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information.

2. **Time to first consultant review:** All emergency admissions must be seen and have a thorough clinical assessment at the latest within 14 hours of arrival at hospital.

3. **Multi-disciplinary Team review:** All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, within 14 hours.

4. **Shift handovers:** Handovers must be led by a competent senior decision maker and take place at a designated time and place.

5. **Diagnostics:** Hospital inpatients must have scheduled seven-day access to diagnostic services.
6. Intervention / key services: Hospital inpatients must have timely 24/7 access to consultant-directed interventions.

7. Mental health: Where a mental health need is identified the patient must be assessed by Liaison Psychiatry within the appropriate timescales 24/7

8. On-going review: All patients must be seen and reviewed by a consultant twice daily. Once transferred to a general ward patients should be reviewed by a consultant at least once every 24 hours.

9. Transfer to community, primary and social care: Support services must be available seven days a week.

10. Quality improvement: All those involved in the delivery of acute care must participate in the review of patient outcomes. The duties, working hours and supervision of trainees must be consistent with the delivery of high-quality, safe patient care, seven days a week.
The wider context

- The delivery of the standards is just one part of ensuring a high quality urgent and emergency care network.
- A whole-system approach to seven day working is required, both in terms of the acute hospital professions and services within scope, and the wider health and care system out of scope.
- Uncoordinated, piecemeal implementation will limit the beneficial impact both in terms of improved outcomes for patients and the clinical and financial viability of moving to seven day services.
Implementing the London quality standards

- London’s hospitals have shown commitment to implementing the standards and progress is being made.
- The challenge for many hospitals is ensuring that the standards are in place seven days a week.
- All standards are achievable and of value to improving patient care.
- London will continue with the London quality standards
  - To provide high quality and safe services consistently seven days/week.
- The London quality standards are included in the pan-London acute commissioning intentions (2014/15) and the local contract quality schedule of requirements.
Overview

• Better understanding of inter and intra departmental flow
  – 24/7 and 7/7
  – Elective flow, unplanned and unplanned to planned.

• Occupancy data poorly understood and often misrepresented
  – All understand overcrowding and boarding (outliers)

• Flow and capacity/demand management are not new to health
  – Often poorly applied

• Relate to outcomes including experience.

• Health care is complex
St E Action Effect Diagram

Outline of shared aim, contributing factors, actions and measures developed through staff dialogue and visit team feedback. Represents cause and effect relationships and intended to support conversations and planning in regards to improvement.

Embrace positivity and empower staff to deliver high quality care to patients: improving patient experience and outcomes and working with family and carers

* timely, patient centred care, safe, evidence-based, equitable, efficient

Efficient, effective and proactive flow within hospital: right care, right place, right time

Improve flow out of hospital

Positive working environment that supports staff to collaboratively manage flow

1. Health outcomes
2. Patient experience/ quality of life
3. Staff satisfaction
4. Readmissions
5. Compliance to 4 hour standard
6. Admission trend data
7. Boarding
8. Discharge trend data (day of week, time of day)

Publication in press: 
Reed J, McNicholas C, Woodcock T, Bell D Designing quality improvement initiatives: the action effect method, a structured approach to identifying and articulating programme theory BMJ Qual Saf.
Hospital X: ED attendances 4 hour access

Average daily attendances; weekly 4 hr Emergency Department (ED) time in department compliance, %

Sources: WSitAE Unity2-derived publications covering unscheduled activity for ED sites w/e 7th Nov 2011 and w/e 21st Sept 2014. Notes: (i) ED’ refers to EDs, MIUs and WICs; (ii) unadjusted, XmR-based process control limits with mR screening. Baseline to w/e 30th Dec 2012 (iii) results are intended for management information only and are subject to change.

Baseline (process limits) Operating Standard (95%) Average daily attendances for week 2011 2013 2014
Hospital Y : ED attendances
Average daily type-1 ED attendance, n; weekly 4 hr ED LoS compliance (type-1), %
Sources: WSitAE Unify2-derived publications covering unscheduled activity for ED’ sites w/e 7 Nov 2010 to w/e 14 Sep 2014
Notes: (i) ED’ refers to EDs, MIUs and WICs; (ii) **unadjusted, XmR-based process control limits recalculated against Wheeler rules 1,4 and 24-pt baseline; (iii) results are intended for management information only and are subject to change
Feeder systems

Interrelated
- Reservoirs
- Locks
- Vessels

Rapids v regular flow reduce unnecessary overnight moves
St E: AAU spell LoS distribution, 14 Apr to 8 Jun 2014*

Stays for all patients discharged from hospital 14 Apr to 8 Jun 2014, n; AAU spell LoS in 4 hr bins to 168 hr, ≥168 hr

Notes: (i) AAU spell LoS calculated in minutes and excludes transit areas; (ii) results are intended for management information only and are subject to change

Process map
Ethnography
St E: cumulative hourly hospital inpatient discharge profile, 14 Apr to 8 Jun 2014

Proportion of hospital discharges completed (excl. same-day non-emergency admissions and non-admitted ED' attendances), %, by hour of day,

Note: results are intended for management information only; transit areas considered out of hospital wrt discharge.
Proportion of hospital discharges completed (excl. same-day non-emergency admissions and non-admitted ED' attendances), %, by hour of day.

Note: results are intended for management information only; transit areas considered out of hospital wrt discharge.
St E: daily hospital inpatient arrival and discharge profile, 14 Apr to 8 Jun 2014

Avg daily hospital arrivals and discharges (excl. same-day non-emergency admissions and non-admitted ED’ attendances), by day of week, n

Note: results are intended for management information only; transit areas considered out of hospital wrt discharge.
St E A&E: weekly 4 hr emergency access performance, 1 Nov 2010 to 29 Dec 2013

Weekly overall 4 hr ED LoS compliance, by patient flow group, %

Notes: (i) excludes planned reviews, UCC attendances and ED ward stays; (ii) results are intended for management information only and are subject to change.
St E A&E: weekly Mon 4 hr emergency access performance, 1 Nov 2010 to 29 Dec 2013

Weekly Monday 4 hr ED LoS compliance, by patient flow group, %

Notes: (i) excludes planned reviews, UCC attendances and ED ward stays; (ii) results are intended for management information only and are subject to change.
St E Hospital
High level system overview and balance measures (8 weeks)

Ambulance
Ramping hours 7.5 (average per day)

Emergency Department
Re-pres 48h 5.2%
Re-pres 7d 10.4%
Avg LOS 03:27
4 h 78%
Outliers 22%
Mortality 0.2%

Medical Acute Unit
Re-pres 7d 3.0%
Re-pres 28d 9.5%
Avg LOS 1:05:43
4 h 69%
Outliers 33%
Mortality 0.9%

Surgical Acute Unit
Re-pres 7d 4.2%
Re-pres 28d 7.6%
Avg LOS 2:07:10
4 h 61%
Outliers 51%
Mortality 0.0%

Other Wards
<table>
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<tr>
<th>Ward</th>
<th>Re-Ad</th>
<th>Avg LOS</th>
<th>Outliers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Surgery</td>
<td>?</td>
<td>?</td>
<td>15%</td>
</tr>
<tr>
<td>Specialty Medicine</td>
<td>?</td>
<td>?</td>
<td>21%</td>
</tr>
<tr>
<td>Intensive/CCU</td>
<td>?</td>
<td>?</td>
<td>14%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>?</td>
<td>?</td>
<td>32%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>?</td>
<td>?</td>
<td>50%</td>
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<tr>
<td>Orthopaedics</td>
<td>?</td>
<td>?</td>
<td>9%</td>
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<tr>
<td>Geriatric Medicine</td>
<td>?</td>
<td>?</td>
<td>18%</td>
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<tr>
<td>Mental Health</td>
<td>?</td>
<td>?</td>
<td>2%</td>
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St E: emergency readmission within 7 days, w/e 8 Apr 2012 to 18 May 2014

Proportion of inpatient discharges\(^*\) readmitted as an emergency\%; avg daily inpatient discharges\(^*\), n

Notes: (i) ED\(^*\) refers to EDs, MIUs and WICs; (ii) \(^*\) excludes same-day non-emergency stays, in-hospital deaths and hospital transfers; (iii) **unadjusted. XmR-based process control limits recalculated against Wheeler rules 1, 4 and 24 pt baseline; (iii) changes in rates may be the result of a number of factors, incl. shifts in underlying case-mix and clinical practice; (iv) results are intended for management information only and are subject to change.
Schematic of Demand and capacity per day by clinical department

Most headroom needed – and when

Patient Numbers

ED

AMU

Specialty Wards

Rehabilitation

Optimal maximum occupancy

0.00%

10.00%

20.00%

30.00%

40.00%

50.00%

60.00%

70.00%

80.00%

90.00%

100.00%
Summary

• Improve patient flow – securing links in the chain
• Flow and capacity are dynamic
• Influenced by system and processes
  ➢ By hour by day by week
  ➢ In day capacity
  ➢ Weekend capacity
• Optimise admission and discharge pathways
• Improve continuity of patient care
• Optimise physical and staff capacity – doing today’s work today
• Move from TGIF – Happy Mondays
Structure simple – delivery is complex

Demand

- Unplanned
  - Urgent to emergency
  - Predictable

- Planned
  - Variable

- Convert unplanned
  - ? % gain

- Minor
  - Medical Surgical
  - Paediatric and Maternity

Workforce
  - Clinical and non-clinical
  - Competencies
  - Rota design
  - Diagnostics
  - Lab and imaging