SEPTEMBER 2016
SEVEN DAY SERVICES SURVEY:
SUPPORTING INFORMATION
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INTRODUCTION

This supporting information has been developed to provide guidance on the questions in the seven day services survey. Further information and guidance is available throughout the document to enable more detail to be accessed about each question if required.

Useful links
These documents, hosted on the 7DSAT supporting information page at www.7daysat.nhs.uk provide further useful information to help you to undertake this survey. They can be accessed by clicking on the ‘Resources and FAQs’ tab at the bottom of the log-in page.

- What can I do in preparation for the September 2016 survey?
- 7DSAT user guide: registering and approving
- Letter sent to trust medical directors in July 2016
- Rationale for changes to the September 2016 seven day services survey
- September 2016 seven day services survey questions
- Seven day self-assessment survey letter from NHS Improvement to trusts 5 August 2016
- NHS Data Dictionary.

When new information is added to the resources page, you will be alerted by a pop-up box when you log in the date each document was updated will also be displayed on the resources screen.
## IMPORTANT DATES

### A. Survey Timescales

<table>
<thead>
<tr>
<th>DATE</th>
<th>EVENT</th>
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<tbody>
<tr>
<td>6 July to 28 September 2016</td>
<td>Case notes to be undertaken on a consecutive seven day period between these two dates, avoiding the 29 August Bank Holiday</td>
</tr>
<tr>
<td>16 August 2016</td>
<td>The link to the local diagnostics and interventions survey available</td>
</tr>
<tr>
<td>7 September 2016</td>
<td>The 7DSAT opens to allow data to be entered</td>
</tr>
<tr>
<td>23 September 2016</td>
<td>The deadline for the local diagnostics and interventions survey to be completed</td>
</tr>
<tr>
<td>30 September 2016</td>
<td>Data from the local consultant survey is added to the 7DSAT for local validation</td>
</tr>
<tr>
<td>19 October 2016</td>
<td>The deadline for submission and approval of data</td>
</tr>
<tr>
<td>28 October 2016</td>
<td>Initial analysis of the data is made available to NHS England and NHS Improvement</td>
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### B. ‘How to’ Support Webinars

A number of ‘how to’ support webinars are being run by the Sustainable Improvement team, to answer any questions that trusts may have with regards to the September 2016 survey.

The dates and times are below, with each planned to run for approximately 90 minutes.

- **2 September 2016** (15:00) Q&A session 1
- **6 September 2016** (13:00) Q&A session 2
- **16 September 2016** (10:30) Q&A session 3

To register for one of these webinars, please send an email with your name and date preference to: england.si-7ds-support@nhs.net
CHANGES TO THE SURVEY SINCE MARCH 2016

- Pro-rata sampling based on the number of eligible emergency admissions, excluding some specific groups of patients (LINK: Sampling and Methodology)
- Randomisation of sample and selection methodology using a sample size calculator
- Flexible data collection period; user defined consecutive seven day period between 6 July and 28 September, excluding the 29 August Bank Holiday
- The data collection method now allows for analysis by individual day of the week rather than by weekdays and weekends
- A new subset of questions on the deteriorating patient has been added to the clinical standard 8 section. This is to better understand weekend variation in the management of this patient group.
- A retrospective rather than prospective survey focus
- Provision of a telephone helpline to answer survey questions queries and to expedite requests for assistance. This is in addition to the technical telephone support previously provided.

- Patient level data entered directly into the seven day self-assessment tool, minimising data handling stages and duplication.
- Strengthening of the seven day services diagnostics and interventions data (Standard 5: diagnostics)
- Obtaining specialist opinions; a question has been added to identify how specialist opinion is obtained where hospitals do not have inpatient beds for a particular specialty.
- The level of need for the group of patients who need daily and twice daily reviews will be based on the Intensive Care Society definitions of levels of illness, and the Paediatric Intensive Care Society standards for the care of critically ill children. In the previous survey, frequency of patient review was based on the patient’s geographical location in hospital for example a high dependency unit.

More information on the rationale for these changes can be found HERE.
CALCULATING YOUR SAMPLE SIZE

The number of case notes each trust should review is based on trust-specific weekly emergency admission rates.

Trusts will need to sample fewer patients in this survey to demonstrate that standards are being met, than in the previous one.

**How do we access the calculator to work out our sample size and sampling methodology?**

The sample size can be calculated using the sample size calculator, embedded within the 7DSAT. To access this calculator follow the steps below:

- Log in to the 7DSAT at [www.7daysat.nhs.uk](http://www.7daysat.nhs.uk)
- Click on the ‘Enter Data’ button (top left)
- Click on the ‘trust data and sample size calculator’ button (far left).
How do we use the calculator to work out our sample size and sampling methodology?

Two fields need to be populated to calculate the sample size and sampling methodology

- Number of emergency admissions in your selected consecutive seven day period
- Number of emergency admissions in your selected consecutive seven day period to be excluded from survey.

Information about calculating sample size, including details of emergency admissions that should be excluded from your number can be found HERE.
PROVISION FOR CONSULTANT REVIEW

A number of questions have been included to determine the provision for consultant review within your trust. These questions are as below:

- For patients admitted as an emergency, are there formal arrangements to obtain advice from specialties for which your own trust makes no acute provision?
- Does consultant job planning in the trust make provision for a consultant-led ward round on every ward every day of the week?

Further details relating to the format of these questions and the possible responses can be found HERE.

Frequently Asked Questions
- What is a ‘formal arrangement’?
- What is an ‘informal arrangement’?
- When is it appropriate to obtain specialist advice via the telephone?
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.

Data in this section is now collected at a patient level, with fields such as ‘time and date of arrival’, ‘time and date of first assessment’, ‘specialty’ and ‘time and date of admission’ being required for each patient. Further details of the data fields requested for this standard can be found in the questions document available here.

Further information on this standard can be found HERE.

Frequently Asked Questions
• Who should carry out the first consultant review?
• What is considered to be a suitable consultant for clinical standard 2?
• Which patients should be included in this section?
• Specific advice for inclusion of obstetric patients?
CLINICAL STANDARD 5
ACCESS TO CONSULTANT DIRECTED DIAGNOSTICS

Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology.

Consultant-directed diagnostic tests and completed reporting will be available seven days a week:
- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients.

Questions about access to colonoscopy, and bronchoscopy have been removed as the low volumes of patients mean reliable conclusions cannot be drawn from the small sample size.

Diagnostics and Interventions Local Survey of Consultants
A local survey has been developed in conjunction with stakeholders, the link and further information can be found HERE. This survey covers access to both diagnostics and interventions.

Frequently Asked Questions
- Who should carry out the local diagnostic and interventions survey?
- How do we access the local diagnostic and interventions survey for consultants?
- How is the diagnostic and interventions survey completed by consultants?
- What sort of questions does the survey cover?
- How do we access the results of the survey?
- How is the aggregate consultant response calculated?
- Is this element of the survey compulsory?

Diagnostic Imaging Data Set (DID)
The DID will be interrogated and data extracted centrally for each trust on the length of time between request, test and report, by day of the week.

For more information on clinical standard 5, please click HERE.
CLINICAL STANDARD 6
INTERVENTIONS

Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery.

This standard gathers information in two ways:

Diagnostics and Interventions Local Survey of Consultants
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Frequently Asked Questions
- How do we access the local diagnostic and interventions survey for consultants?
- How is the diagnostic and interventions survey completed by consultants?
- What sort of questions does the survey cover?
- How do we access the results of the survey?
- How is the aggregate consultant response calculated?
- Is this element of the survey compulsory?

Self-Assessment of Local or Networked Provision for Interventions
This is the same method of collecting data that was used in the March 2016 survey. The details of this question can be found HERE.

Frequently Asked Questions
- What is the definition of a formal network arrangement?
CLINICAL STANDARD 8
ONGOING REVIEW

The level of need for the group of patients who need daily and twice daily reviews are based on the [Intensive Care Society definitions of levels of illness](#), and the [Paediatric Intensive Care Society standards](#) for the care of critically ill children.

**Frequently Asked Questions**
- Who should be reviewed by an on-site consultant twice a day?
- What are the Intensive Care Society definitions of levels of illness?
- Which patients should receive a daily review?
- What are the Paediatric Intensive Care Society standards for the care of critically ill children?
- How long after admission should reviews be recorded for the purposes of the survey?
- When is it considered appropriate to obtain specialist advice via a telephone call?
- Why have the additional questions on the deteriorating patient been included?
- What is the definition of a consultant for clinical standard 8?

More information on clinical standard 8 can be found [HERE](#).
FREQUENTLY ASKED QUESTIONS

Provision for Consultant Review

What is a ‘formal arrangement’?
Access for inpatients may be on-site or via a formal network arrangement with another site. Formal networks are those:

- Established with protocols formally agreed between the relevant organisations
- Which operate a published rota populated with consultant names and contact details
- Which are available as part of the assurance process.

What is an ‘informal arrangement’?
Arrangements where patients are transferred for the intervention on an ad-hoc basis would be considered to be an informal arrangement.

When is it appropriate to obtain specialist advice via the telephone?
Where a specialty has an inpatient service it is expected that a consultant will attend the hospital every day to review the inpatients (with delegation permitted as described above) and see any urgent new referrals. Most sites will have all or most of the ten key specialties which will include the majority of patients.

Where a specialty has no inpatient service at a hospital there should be an established system for clinicians to obtain urgent specialist advice by telephone every day of the week, for example where an urgent neurology opinion is needed for a medical patient in a district general hospital with no inpatient neurology service.
FREQUENTLY ASKED QUESTIONS

Clinical Standard 2: First Consultant Review

Who should carry out the first consultant review?
The first consultant review should be carried out by a consultant of the appropriate specialty for the patient’s condition on arrival at hospital and within 14 hours of arrival to align with clinical standard 2:

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

Who is considered to be a suitable consultant for clinical standard 2?
A suitable consultant is one who is trained and competent in dealing with emergency and acute presentations in the specialty concerned and is able to initiate a diagnostic and treatment plan.

The standard applies to emergency hospital admissions via any route, not just the Emergency Department. For emergency care settings without consultant leadership, review can be undertaken by appropriate senior clinician e.g. GP-led inpatient units.

Consultants need adequate support seven days a week from an appropriate team of healthcare professionals to ensure patients receive good quality care. Junior doctors involved in providing urgent and emergency care should have prompt access to consultant support and advice including a consultant presence on site every day to optimise opportunities for training and clinical supervision.
FREQUENTLY ASKED QUESTIONS

Which patients should be included in this section?
Include all patients who are admitted to hospital as an emergency. Do not include patients who are not formally admitted but who are seen in the emergency departments or acute assessment units and discharged. Please follow the National Institute of Health and Care Excellence (NICE) recommended pathways, so if the guidance doesn’t include a consultant review then the 14 hour consultant assessment standard does not apply.

Patients admitted as an emergency should all be assessed using a validated early warning score e.g. the National Early Warning Score (NEWS).

Exclude patients in the categories below:
- Patients who are admitted as an emergency but who stay in hospital for fewer than 14 hours from arrival.
- Patients on an inpatient pathway on which care for the entire patient group is, by design, routinely delivered by non consultants e.g. midwife led care on a maternity unit.
- Patients admitted to a short stay ambulatory care unit who typically stay for only a few hours before transfer to community-based care e.g. most patients with DVT
- Exclude neonates unless they are admitted to hospital as an emergency.

Please see the section on ‘sampling and methodology’, available HERE for more detail on how the sample is calculated.
FREQUENTLY ASKED QUESTIONS

Clinical Standard 2: Obstetrics Patient Guidance

As detailed in the section on ‘sampling and sample size’, patients on maternity units who wouldn’t for clinical reasons usually require consultant involvement in their care, and are receiving midwife led care only can be excluded.

This would apply to:

- Women who are expected to have routine labours with no complications
- Women with a medical condition in whom there has been a prior agreement that midwife led care is clinically appropriate e.g. spontaneous labour at term with a known medical complication but clear plan for labour already made.

Where it is identified that consultant involvement is needed in the woman’s care¹, they should be included in the requirement for first consultant assessment within 14 hours and for daily consultant review until they are transferred back to midwifery care.

Situations where consultants must attend in person whatever the level of the trainee:

- Eclampsia
- Maternal collapse (such as massive abruption, septic shock)
- Caesarean section for major placenta praevia
- Postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated
- Return to theatre – laparotomy
- When requested.

FREQUENTLY ASKED QUESTIONS

Procedures where the consultant should attend in person or should be immediately available if the trainee on duty has not been assessed and signed-off as competent for the procedure in question:

- Vaginal breech delivery
- Trial of instrumental delivery in theatre
- Twin delivery
- Caesarean section at full dilatation
- Caesarean section in women with body mass index greater than 40
- Caesarean section for transverse lie
- Caesarean section at less than 32 weeks of gestation.
FREQUENTLY ASKED QUESTIONS

Clinical Standard 5: Diagnostic and Interventions Local Survey of Consultants

Who should carry out the local diagnostic and interventions survey?
This survey is aimed at consultants in your trust who take emergency admissions. You may circulate the link to other consultants for your own local information, but only data from consultants who tick the box in the survey to say they take emergency admissions will be analysed centrally.

How do we access the local diagnostic and interventions survey for consultants?
There are two ways to access the link for the local diagnostic survey for consultants:
1. The survey can be accessed using the following link. To enable your consultants to respond to this survey, you will just need to send them the link. They can then click on this link to access the survey directly, complete their answers, and press submit.
2. The survey can also be accessed directly within the 7DSAT. To access it via this route, please follow the steps below:
   a. Go to the 7DSAT log-in page: www.7daysat.nhs.uk
   b. Enter your log-in details
   c. Click on ‘Enter Data’
   d. Click on ‘Consultant Directed Diagnostics’ or ‘Consultant Directed Interventions’ (both pages will provide a link to the same survey)
   e. The link is in the box at the top of the screen. This can either be copy and pasted or you can click the ‘copy link to clipboard’ button.

How is the diagnostic and interventions survey completed by consultants?
Once they have the link, via one of the routes detailed above, consultants will just need to click on the link to access the survey. The survey consists of a series of multiple choice questions using drop downs, and some free text boxes to enter further information where relevant.
FREQUENTLY ASKED QUESTIONS

What sort of questions does the diagnostics and interventions survey cover?
The questions within the survey can be viewed by following the instructions on page 18 of this guidance.

How do we access the results of the survey?
After 30 September, trusts will have access to an excel file containing the individual responses entered by their consultants within the survey.

Each respondent will be on a separate row, with the columns representing the questions asked and the responses to these questions. In addition to the data on the excel file, the relevant fields within the 7DSAT automatically completed for each trust with the aggregated answers from their individual consultant responses.

Trusts will then be asked to approve their diagnostics/interventions survey data as part of the standard approval process as outlined in the user guide, available HERE.

A question in the survey will ask for an outline of any actions that the trust plans to take in response to the results of this survey. If you have any queries regarding the data in this section or identify any anomalies, you will be able to do so by contacting the helpdesk on: 0870 840 8033 or via the email helpdesk within the 7DSAT.

How is the aggregate consultant response calculated?
The aggregate response for the diagnostics and interventions survey will be calculated by using the average (mode) response i.e. the most prevalent response given by your respondents.

Is this element of the survey compulsory, are we able to provide our own responses to these questions using our local systems / local reports or another survey that is able to answer the same questions?
To ensure consistency and comparability between responses, the survey provided should be used to provide the answers to the questions within the 7DSAT. You are able to amend any answers that you think do not reflect the situation locally by contacting the helpdesk on 0870 840 8033 or via the email helpdesk within the 7DSAT.
How do we access the diagnostics and interventions local survey for consultants?

There are two ways to access the link for the local survey for consultants:

1. The survey can be accessed using the following link. To enable your consultants to respond to this survey, you will just need to send them the link. They can then click on this link to access the survey directly, complete their answers, and press submit.

2. The survey can also be accessed directly within the 7DSAT. To access it via this route, please follow the steps below:
   a. Go to the 7DSAT log-in page: [www.7daysat.nhs.uk](http://www.7daysat.nhs.uk)
   b. Enter your log-in details
   c. Click on ‘Enter Data’
   d. Click on ‘Consultant Directed Diagnostics’ or ‘Consultant Directed Interventions’
   e. The link is in the box at the top of the screen. This can either be copy and pasted or you can click the ‘copy link to clipboard’ button.

How is the diagnostics and interventions survey completed by consultants?

Once they have the link, via one of the routes detailed above, consultants will just need to click on the link to access the survey. The survey consists of a series of multiple choice questions using drop downs, and some free text boxes to enter further information where relevant. An example of one of the multiple choice fields is provided below:

> 5. Approximately for what proportion of your emergency admissions are you able to access the interventions below as quickly as the clinical need of the patient requires?

Please select ‘Not Applicable’ if you don’t have a need for a particular intervention for your patients.
FREQUENTLY ASKED QUESTIONS

What sort of questions does the diagnostics and interventions survey cover?
The questions within the survey can be viewed by following the instructions on page 18 of this guidance.

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FREQUENTLY ASKED QUESTIONS

Is this element of the survey compulsory, are we able to provide our own responses to these questions using our local systems / local reports or another survey that is able to answer the same questions?

To ensure consistency and comparability between responses, the completed survey should be used to provide the answers to the questions within the 7DSAT. You are able to amend any answers that you think do not reflect the situation locally by contacting the helpdesk on 0870 840 8033 or via the email helpdesk within the 7DSAT.

What is the definition of a formal network arrangement?
Access for inpatients may be on-site or via a formal network arrangement with another site. Formal networks are those:

- Established with protocols formally agreed between the relevant organisations
- Which operate a published rota populated with consultant names and contact details
- Which are available as part of the assurance process

Arrangements where patients are transferred for the intervention on an ad-hoc basis would be considered to be an informal arrangement.
FREQUENTLY ASKED QUESTIONS

Clinical Standard 8: Ongoing Review

**Who should be reviewed by an on-site consultant twice daily?**
Clinical judgement should be used to determine frequency of consultant review required, but as a guide patients with Intensive Care Society levels of need of 2 (3 for paediatrics) and above may require twice daily review, and patients with needs of below level 2 (3 for paediatrics) may only require once daily review.

The group of patients who need twice daily reviews should be based on the Intensive Care Society definitions of levels of illness and the Paediatric Intensive Care Society standards for the care of critically ill children rather than their geographical ward location in the hospital.

**What are the Intensive Care Society definitions of levels of illness?**
These can be accessed by clicking the hyperlink above, an abridged version is given below:

**Intensive Care Society Levels of Critical Care for Adult Patients (ICS 2009)**

**Level 0** Patients whose needs can be met through normal ward care in an acute hospital.

**Level 1** Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.

**Level 2** Patients requiring more detailed observation or intervention including support for a single failing organ, post-operative care and those ‘stepping down’ form higher levels of care.

**Level 3** Patients requiring advanced respiratory support alone or basic respiratory support together with support for at least two organ systems. This level includes all complex patients requiring support for multi organ failure.

**Which patients should receive a daily review?**
The principles in the AoMRC paper ‘Seven Day Consultant Present Care: Implementation Considerations’ along with clinical judgement should be used to determine when an individual patient review can be delegated to an appropriate other at the weekend, and the types of patients who will not require daily consultant review.
Case notes, or other sources of clinical documentation will need to record that the consultant has delegated the daily review for a specific patient. For example, during a joint board round, the consultant might decide which patients to delegate to another member of the team for example a trainee. The consultant and trainee would each see their allocated patients on that ward, then confer again in case the trainee would like the consultant to review any patients causing concerns, prior to moving on to the next ward.

**What are the Paediatric Intensive Care Society standards for the care of critically ill children?**

These can be accessed by clicking the hyperlink above, an abridged version is given below:

**Level 1** High Dependency Care requiring nurse to patient Ratio of 0.5:1 (1:1 if in a cubicle). Close monitoring and observation required but not requiring acute mechanical ventilation.

**Level 2** Intensive Care requiring a nurse to patient ratio of 1:1. A child requiring continuous nursing supervision who is usually receiving advanced respiratory support, i.e. intubated and ventilated or receiving BiPAP. Also the unstable non-intubated child, for example some cases with acute upper airway obstruction who may be receiving nebulised adrenaline. The dependency of a level 2 patient increases to level 3 if nursed in a cubicle.

**Level 3** Intensive Care requiring nurse to patient ratio of 1.5:1. The child requiring intensive supervision at all times who needs additional complex therapeutic procedures and nursing. For example, unstable ventilated children on vasoactive drugs and inotropic support or with multiple organ failure. The dependency of a Level 3 patient increases to Level 4 if nursed in a cubicle.

**Level 4** Intensive care requiring a nurse to patient ratio of 2:1. Children requiring the most intensive interventions such as particularly unstable patients, Level 3 patients managed in a cubicle, those on ECMO, and children undergoing renal replacement therapy.
FREQUENTLY ASKED QUESTIONS

How long after admission should reviews be recorded for the purposes of the survey?  
Reviews undertaken for up to five days following the patient’s admission should be recorded for the survey. This five day period is solely to ensure data can be collected for this standard within a defined timescale, and should not be taken as guidance for the period twice daily reviews should be carried out in practice. Clinical judgement should be the only deciding factor for the period of time twice daily reviews are required.

The survey will ask you to enter the discharge date for each patient, if this results in a stay of fewer than five days, then only the relevant number of days of responses will be available for you to complete.

When is it considered appropriate to obtain specialist advice via a telephone call?  
Where a specialty has an inpatient service it is expected that a consultant will attend the hospital every day to review the inpatients (with delegation permitted as described above) and see any urgent new referrals.

Most sites have all or most of the ten key specialties which include the majority of patients.

Where a specialty has no in-patient service at a hospital there should be an established system for clinicians to obtain urgent specialist advice by telephone every day of the week, for example where an urgent neurology opinion is needed on a medical patient in a district general hospital with no inpatient neurology service.

Why have the additional questions on the deteriorating patient been included?  
There was a strong view from senior clinicians, that ‘failure to rescue’ is a very important part of the assurance of consistent acute care. An additional subset of questions aimed at understanding the weekend variation in identifying and managing the deteriorating patient have been included to assess progress on seven day services implementation.
What is the definition of a consultant for clinical standard 8?
The AoMRC refers to a consultant as a hospital doctor who have either a Certificate of Completion of Training (CCT) or Certificate of Eligibility for Specialist Registration (CESR) and are thus eligible to be on the General Medical Council (GMC) Specialist Register, or certain senior doctors with appropriate competencies, to include those in Staff, Associate Specialist and Senior Specialty Doctor (SAS) grade posts. The term ‘consultant’ is maintained because it is believed that this is a term broadly understood by doctors and the public. This description of the consultant is included in this supporting information, to align the standard with professional opinion, and provide clarity on which senior doctors could provide ongoing review without compromising patient safety. In units which are non-medical consultant led e.g. GP or midwife / therapist led units, it is acceptable for this consultant leadership to be provided by the GP, therapist, midwife or senior nurse.
### Glossary of Terms and Definitions

<table>
<thead>
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<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Emergency admission</td>
<td>Emergency admission, when admission is unpredictable and at short notice because of clinical need: Coding examples as detailed on the data dictionary 21 Accident and emergency or dental casualty department of the Health Care Provider 22 GENERAL PRACTITIONER: after a request for immediate admission has been made direct to a Hospital Provider, i.e. not through a bed bureau, by a GENERAL PRACTITIONER or deputy 23 Bed bureau 24 Consultant clinic, of this or another Health Care Provider 25 Admission via Mental Health Crisis Resolution Team 2A Accident and Emergency Department of another provider where the PATIENT had not been admitted * 2B Transfer of an admitted PATIENT from another Hospital Provider in an emergency * 2C Baby born at home as intended * 2D Other emergency admission * 28 Other means, examples are: **  • admitted from the Accident and Emergency Department of another provider where they had not been admitted  • transfer of an admitted PATIENT from another Hospital Provider in an emergency  • baby born at home as intended</td>
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### GLOSSARY OF TERMS AND DEFINITIONS

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<td>Consultant definition for Clinical Standard 2 (1st assessment)</td>
<td>A suitable consultant is one who is trained and competent in dealing with emergency and acute presentations in the specialty concerned and is able to initiate a diagnostic and treatment plan.</td>
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<td>Consultant definition for Clinical Standard 8 (ongoing review)</td>
<td>This definition uses that of the <a href="https://www.aomrc.org.uk">Academy of Medical Royal Colleges (AOMRC)</a> “In using the term ‘consultant’ the Academy is referring to the level of expertise and skill required of the individual, not their contract of employment...the appropriate level of expertise and skill may be found in those not on a consultant contract, or in a formal consultant grade, but with a Certificate of Completion of Training (CCT) or Certificate of Eligibility for Specialist Registration (CESR) or certain senior doctors with appropriate competencies, to include those in Staff and Associate Specialist and Senior Specialty Doctor (SAS) grade posts. The term ‘consultant’ is maintained because it is believed that this is a term broadly understood by doctors and the public. In units which are non-medical consultant led e.g. GP or midwife/therapist led units, it is acceptable for consultant leadership to be provided by the GP, therapist, midwife or senior nurse.</td>
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<td>• Established with protocols formally agreed between the relevant organisations</td>
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<td>• Which operate a published rota populated with consultant names and contact details</td>
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<td>• Which are available as part of the assurance process.</td>
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<td></td>
<td>Arrangements where patients are transferred for the intervention on an ad-hoc basis would be considered to be an informal arrangement.</td>
</tr>
</tbody>
</table>