University Hospitals Coventry and Warwickshire NHS Trust

Internal Professional Standards

July 2025

Putting the Patient First



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NHS Trust

Safer faster hospital: internal professional standards

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Clinical Charter



1. We will focus at all times on the patient's care; ensuring patient safety and the best quality care
2. As colleagues we will treat one another professionally and in line with UHCW Trust values at all times.
3. As specialty consultants we will take over the care of patients who have a condition requiring our expertise when not on our specialty's base ward. We commit to provide a daily ward round 7 days a week of these patients and place a clear plan in the patient notes. We will move these patients to the specialty's base ward as soon as practicable.



4. Twice daily board rounds, to ensure timely and agile decision making, will be conducted on ALL wards Monday - Friday (daily at weekends).
5. An expected date of discharge (EDD) will be set within 24 hours of admission be reviewed daily and clearly visible to teams, alongside reason to reside and medically fit for discharge status. We aim to ensure only those patients who need to remain in the hospital do so.



6. The focus of the afternoon board round is twofold: completing today's tasks and identifying tomorrow's discharges and tasks to ensure we plan ahead for the benefit of our patients.
7. As clinical teams we will plan ahead for the weekend and Mondays. A "focused Friday" afternoon board round identifies discharges for Saturday, Sunday and Monday; these will be relayed to site management teams by group's duty managers. As clinical teams we will ensure patients' notes and ward boards/ward view clearly indentify potential weekend discharges that require review to confirm.



8. Supported discharges and more complex patients will be identified early (48 hours prior to being medically optimised).
9. As teams we recognise the need for 7 day services and will resource through appropriate rosters and cover arrangements the requirement to achieve the adequate weekend workforce.



10. Patients attending our ED with GP letters, even without a prior call from the GP, will be accepted directly (after triage to ensure patient safety) by specialist teams for review either in their assessment area (capacity allowing) or by the specialty in ED. ED will identify the most appropriate specialty.

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In the Emergency Department (ED), Medical Decisions Unit (MDU) and Surgical Assessment Unit (SAU)



1 All ED/MDU/SAU referrals to admitting specialty teams will be made to a registrar grade or equivalent. This doctor will triage referrals for urgency and clinical need.



2 A decision-making doctor should see new patients in the ED/MDU/SAU so that a management plan is documented within 60 minutes of a specialty referral by the ED/MDU/SAU team.



3 Tests requested in the ED/MDU/SAU will be completed and the results available within one hour (critical tests), 12 hours (urgent tests) and 24 hours (non-urgent tests).



4 If another specialty would provide more appropriate care, it is the responsibility of the first specialty, not the ED/MDU/SAU, to make the second referral and arrange transfer of care.



5 Patient care and admission will not be delayed by inter-specialty dispute over clinical ownership. ED/MDU/SAU consultants have the authority to allocate immediate clinical ownership to ensure timely care and admission.

Site management teams will endeavor to ensure patients are moved to the right ward first time.



6 The Trust does not admit patients who are likely to be able to go home from the ED to avoid a breach of the emergency care quality indicators.



7 Patients will not be transferred from outpatient areas to the ED unless they require immediate emergency medical care.



8 Specialties will manage the entire emergency pathway, this includes e-acknowledgment of all investigation results related to the admission.



9 A telephone call from primary care to specialty will not be a prerequisite for ED to stream patients directly to an admitting specialty team.



10 Accepting referrals from primary care (after triage) means that specialties take responsibility for evaluating the patient in the ED or elsewhere, or for directing the patient to an agreed alternative pathway for the condition.

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In the Emergency Department (ED), Medical Decisions Unit (MDU) and Surgical Assessment Unit (SAU)



1 Specialties must have a decision-maker to assess emergency or accepted patients referred from primary care within 60 minutes of arrival in ED/MDU/SAU. Breaches will be escalated to the appropriate consultant and group clinical director by the ED/MDU/SAU senior clinical decision-maker.



2 No admitting team can refuse a request to assess a patient in the ED/MDU/SAU. Seeing the referred patient is not dependent on diagnostic results being available.



3 If admission or transfer is obvious, specialties must not insist on tests that do not contribute to the decision to admit or transfer, or to the immediate management of the patient. Once a decision to admit or transfer is made, stable patients will not be kept in the ED/MDU/SAU for further review or assessment.



4 Patients requiring admissions from outpatients under the acute physicians should be referred by registrar or equivalent, to the on-call acute medical registrar or equivalent, who will triage the patient to the appropriate location.

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In the Acute Medical Unit (AMU)

1 All new medical admissions will be admitted to the AMU, unless advised by the acute physician.

2 Patients will have a consultant review within 14 hours of admission unless earlier assessment is necessary to progress care. Expected date of discharge and location of discharge/transfer will be predicted within 24 hours of admission.

3 AMU staff will compile a daily list by 8.30am of those patients requiring specialty in-reach review. Reviews should occur by 11am the same day to maximise discharge planning at the consultant-led board round.

4 There will be no delay in taking over accepted patients from the AMU due to specialty bed capacity issues.

5 The patient must be taken over immediately by the specialty team on the AMU once the transfer has been accepted. If necessary, the patient will be an outlier on the AMU under the specialty team

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In all wards

1 Morning board rounds will be performed by 9.30am, Monday to Friday, led by a consultant or senior doctor. Expected discharge dates and diagnostics required before discharge will be identified as will referrals to therapies/social services.

2 TTOs will be written (where possible) the day before discharge and flagged during board rounds. Discharges should be made before 11am. Transport arrangements should be well-timed to avoid discharge delays.

3 Delays in referrals and diagnostics will be escalated to consultants for action. Deteriorating patients should be identified for consultant review directly after the board round, and critical care outreach/ ITU review considered.

4 All patients to have a documented expected discharge date (EDD) within 24 hours of admission, set and changed by a consultant. If this standard is breached the ward manager should escalate to the group manager and clinical lead. A multi-professional assessment for complex needs will be performed within 14 hours of all admissions.

5 Patients within acute medical and surgical units should be seen and reviewed by a consultant during twice-daily ward rounds. The aim is for continuity of care from the same consultant.

6 Cross-cover of consultant absence will be transparent and all planned annual, study or professional leave will be arranged and documented at least six weeks prior to the absence. Leave with less notice should be approved by the Group Clinical Director

7 Referrals for specialist opinion will be seen by specialties within 24 hours. Specialties cannot refuse to see a patient based on incomplete diagnostics.

8 Documentation will be made according to current standards, in particular date, time, name, grade, GMC number and contact details for medical staff.

9 All patients must have a clear management plan documented in the medical notes. If this is not present, the ward manager should escalate to ward registrar and consultant.

10 All patients with a length of stay over seven days should have their clinical plan reviewed weekly by the consultant and ward manager, informing the relevant clinical lead and modern matron. All patients with a LOS>21 days will be escalated to the site management team, CNO and CMO and the responsible consultant should expect to update the CMO on progress.

11 Consultants should be freed of other daytime clinical or other duties whilst on clinical service. Senior decision-making and leadership should be available on medical and surgical units seven days a week.

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