NHS England

Paper NHS121315

BOARD PAPER - NHS ENGLAND

Title: NHS Services, Seven Days a Week

Clearance: Professor Sir Bruce Keogh, National Medical Director

Purpose of paper:

- To outline the insight and evidence gathered to date by the NHS Services, Seven Days a Week Forum.
- To ask the Board to endorse recommendations put forward by the Forum, which are intended to ensure all patients receive a consistent, high quality urgent and emergency care service across the seven day week.
- To ask the Board to endorse the proposed next stage of the Forum's review.

Key issues and recommendations:

The NHS Services, Seven Days a Week Forum, chaired by the National Medical Director, was established in February 2013 to consider how NHS services can be improved to provide a more responsive and patient centred service across the seven day week. The Forum was asked by NHS England to focus, as a first stage, on urgent and emergency care services and their supporting diagnostic services

The Forum's review points to significant variation in outcomes for patients admitted to our hospitals at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates.

Based on the insight and evidence gathered, the Forum is making recommendations to NHS England for supporting the NHS to improve clinical outcomes and patient experience at weekends by the end of 2016/17.

It is also recommended that the Forum's remit going forward be broadened to include setting out proposals for the creation of a fully integrated service delivering high quality treatment and care seven days a week.

Actions required by Board Members:

- To agree that the Forum's clinical standards should be adopted to support the NHS to drive up clinical outcomes and improve patient experience at weekends.
- To commit to driving full implementation of the clinical standards within the next 3 years using the range of commissioning tools and levers at its disposal.
- To agree recommendations for incentives, rewards and sanctions and, where appropriate, reflect them in the 2014/15 NHS planning guidance.
- To note recommendations for incentives, rewards and sanctions in relation to other organisations.
- To consider whether the proposed plans for supporting commissioners and providers to introduce seven day services look sufficient.
- To agree that the remit of the Forum should now be broadened and that it should be asked to report again in Autumn 2014 setting out proposals for the creation of a fully integrated service delivering high quality treatment and care seven days a week.

NHS Services, Seven Days a Week

Introduction

1. *Everyone Counts: Planning for Patients 2013/14* signalled that the NHS will move towards routine services being available seven days a week – a development which is essential to delivering a much more patient-focused service and one which offers the opportunity to improve clinical outcomes.
2. The NHS Services, Seven Days a Week Forum ("the Forum"), Chaired by the National Medical Director, was established in February 2013 to consider how NHS services can be improved to provide a more responsive and patient centred service across the seven day week.
3. The accompanying Summary Report presents the findings of the first stage of the Forum's review.

"Primum non nocere" - first do no harm

4. Considerable evidence has emerged in recent years linking poorer outcomes for patients admitted to hospital as an emergency and the reduced level of service provision at the weekend. So, on advice from the medical Royal Colleges and the BMA, the Forum was asked by NHS England to focus, as a first stage, on urgent and emergency care services and their supporting diagnostic services. The proposals in this paper are complementary to NHS England's recent Urgent and Emergency Care review.

What the evidence tells us

5. The Forum's review points to significant variation in outcomes for patients admitted to our hospitals at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates.
6. There is increasing evidence that mortality rates for patients admitted to hospitals on both sides of the Atlantic is higher at weekends, our junior doctors feel clinically exposed and unsupported at weekends, and that hospital chief executives are worried about weekend clinical cover.
7. It is also clear that the lack of many seven day services has an adverse effect on measurable outcomes in each of the five domains of the NHS Outcomes Framework: mortality amenable to healthcare, treatment of long term conditions, outcomes from acute episodes of care, patient experience, and patient safety.
8. This evidence has led to calls for greater consultant presence in hospitals at the weekend from Health Education England, the Academy of Medical Royal Colleges, the Royal College of Physicians, and the Royal College of Surgeons,

with the aim of not only improving patient outcomes but also to enhance the training of the next generation of NHS doctors.

9. The cause of the weekday - weekend variation in outcomes is multifactorial and is likely to be a consequence of:

   - variable staffing levels in hospitals at the weekend;
   - fewer senior decision makers of consultant level skill and experience on site at the weekend;
   - a lack of consistent support services, such as diagnostic and scientific services at weekends; and
   - a lack of community and primary care services which could prevent some unnecessary admissions and support timely discharge.

10. This is not just about hospitals; it is about the whole system. One part cannot function efficiently at the weekend if other parts don't. Progress will be contingent on improving primary and social care services at weekends if we are not to dilute the efficiencies of the standard working week in secondary care.

The role of NHS England

11. The link between poorer outcomes and reduced levels of service provision at the weekend is a problem facing most healthcare systems around the world. It is NOT unique to the NHS. In fact, as the largest and most comprehensive health service in the world, the NHS is well positioned to solve the issue. There are encouraging examples of NHS organisations that have moved to making healthcare services more accessible seven days a week to avoid compromising safety and patient experience. These moves have been strongly supported by the main professional bodies and the media.

12. As the custodians of £97 billion of taxpayers' money it is ultimately the responsibility of commissioners, including NHS England, to buy the health services patients deserve. NHS England must help accelerate the pace and spread of these changes. In doing so, we can ensure the NHS leads the world in providing equality of access to consistent, high quality healthcare, seven days a week.

13. The following paragraphs set out an approach, with recommendations for action, to support the achievement of this ambition.

Setting clear clinical standards

14. There is no 'one size fits all' answer to introducing seven day urgent and emergency care services - local solutions will need to be found. The Forum has developed a set of clinical standards describing the standard of urgent and

emergency care that all patients should expect to receive seven days a week. For example, the standards describe how quickly admissions should be seen and assessed by a suitable consultant; that diagnostic and scientific services should be available seven days a week; and the process for safe handovers between clinical teams. **The full set of clinical standards is attached at Annex A**.

15. Although fairly technical in nature, these standards are, nevertheless, radical and will undo more than fifty years of accumulated custom and practice which have failed to put the interests of patients first.

16. The standards have been developed through extensive engagement with stakeholders, and include a comprehensive supporting evidence base. The Academy of Medical Royal Colleges has been a key partner in this work and there has been an explicit effort to align the standards with the Academy's own work on *Seven Day Consultant Present Care*.

17. NHS England has commenced work in London to develop a complementary set of clinical standards for primary care. These are at an early stage and will be developed in conjunction with the Care Quality Commission's (CQC's) Chief Inspector of Primary Care within the next year.

Recommendation: ***The Forum's clinical standards should be adopted to support the NHS to drive up clinical outcomes and improve patient experience at weekends.***

18. The Forum has provided an assessment of the challenges some health economies will face in meeting the clinical standards in a way that is clinically and financially sustainable. This points to the need for providers and commissioners to explore new ways of working, in networks, collaboratives or federations, and to consider the distribution of different services between trusts.

19. Taking into account these challenges, the Forum has proposed that NHS England's ambition should be for all the clinical standards to be adopted in every community in England by the end of 2016/17.

Recommendation: ***The Board should support full implementation of the clinical standards within the next 3 years using the range of commissioning tools and levers at its disposal.***

NHS Planning process

20. Progression towards improved seven day services will be challenging. If the NHS continues to deliver services in the same way as it has in the past, it will be unaffordable in some health economies. It is therefore vital that the ambition to move towards seven day services is linked into the broader strategic plans for the NHS. This means that local five year strategic and seven year operational plans, flowing from the "Call to Action", need to set out the steps local health economies will take to deliver this ambition within three years.

21. Further work is required to understand the full financial impact of service change. This analysis will need to be undertaken in the first half of 2014 in order to inform discussions with Monitor on the 2015/16 tariff.

Incentives, rewards and sanctions

22. The Forum is recommending that NHS England, and a number of our key strategic partners, should take strong action through the use of a range of incentives, rewards and sanctions to support the scale of change required. These recommendations include the following:

Contracts

- Year 1 (2014/15) - local contracts should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section.
- Use of local CQUIN schemes should be encouraged, based on the clinical standard for time from arrival to initial consultant assessment.
- Year 2 (2015/16) - those clinical standards which will have the greatest impact should move into the national quality requirements section of the NHS Standard Contract.
- Year 3 (2016/17) - all clinical standards should be incorporated into the national quality requirements section of the NHS Standard Contract with appropriate contractual sanctions in place for non-compliance, as is the case with other high priority service requirements.

Measurement and transparency

- That data and information on the extent to which the clinical standards are being delivered, and the provision of seven day services, should be published in an accessible format that lends itself to comparisons. Consideration should be given to including this information in Quality Accounts.

Better Care Fund

- The Forum has identified the Better Care Fund (BCF) as a key enabler for change. As part of the process for accessing BCF funding, CCGs and local authorities will have to demonstrate, as part of agreed local plans, that they are addressing a number of national conditions. These include seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends. This will require close monitoring.

Recommendation: ***the Board should accept these recommendations and incorporate them in the 2014/15 NHS planning guidance.***

Inspection and assurance

- That the CQC and the Chief Inspector of Hospitals should be asked to consider how implementation of the clinical standards could best be assessed by the CQC and how this might be reflected in judgements/ratings.

  Note: Preliminary discussions with the Chief Inspector of Hospitals suggest that the CQC is likely to agree to routinely assess the availability of seven day services as part of the assessment of safety within a hospital. For acute services to be judged safe they have to be safe 24/7.

Education commissioning

- That Health Education England (HEE) should be asked to ensure that education contracts include consultant availability to provide adequate supervision of doctors in training seven days a week in line with the clinical standards.

  Note: HEE has confirmed that this recommendation will be accepted.

The Board is asked to note the Forum's recommendations in relation to other organisations.

Reform of consultants' contractual pay and terms and conditions

23. Removing barriers within the consultant contract to developing seven day services is an essential purpose of current discussions aimed at reforming the contract. Ending the absolute right of consultants to refuse non-emergency out of hours work and changing the balance between plain time and premium time payment to ensure that extending access to services does not impose unnecessary costs are key enablers to the introduction of seven day services.

Supporting commissioners and providers

24. NHS Improving Quality (NHS IQ) is proposing to introduce a new, large-scale transformation change programme to support the spread of seven day services. The proposed programme will start by engaging and supporting every commissioner and provider to support them to deliver services that meet the clinical standards. This work will be overseen by regional and area team directors to ensure it is mainstreamed. NHS IQ has also selected 13 'early adopter' health economies to help develop new models for seven day services which will push the boundaries and start to shape a new direction for the future.
25. NHS IQ (in collaboration with the National Clinical Analysis and Specialised Applications Team) are also developing a self-assessment / diagnostic tool that

will be made available to all health and care organisations early next year. The tool will support the assessment of current and future provision of seven day services, indicate progress against the delivery of the clinical standards and support the development of local Action Plans.

26. The proposed change programme will be a key part of NHS IQ's core business over the next 3 years and, as such, will be a significant investment in service improvement.

27. As commissioners and providers start to develop their Action Plans for delivering the clinical standards it is proposed that NHS England should review whether any additional support or national guidance is required.

The Board is asked to consider whether the proposed plans for supporting commissioners and providers to introduce seven day services look sufficient?

***"Deinde adjuvare"* - next do some good**

28. For the reasons described above, the first stage of the Forum's review was limited in its scope. It takes a range of agencies and services to create a seamless, integrated pathway to prevent admissions and readmission and support safe hospital discharge. We know that their absence is most acutely felt at weekends, therefore, if patients and the public are to experience genuine seven day treatment and care, we must look beyond emergency services and beyond the services offered to hospital inpatients. We need to make similar improvements across primary and community health services and social care, and remove the barriers between organisations.

29. NHS England will:

- Commission pilots across England during 2014/15 to set up improved access to general practice for at least 500,000 people; and

- Evaluate these pilots to identify the most effective ways to improve access to routine primary care - and support a more a integrated approach to urgent care services - in 2015/16.

30. The NHS should be there for people when they need it and provide equally good care every day of the week. We should consider whether, in the 21st century, it is still acceptable for the NHS to expect hard working people to always take time off work to access healthcare or to support a relative or friend to do the same? This inevitably has an economic impact as well as an impact on patient and family experience.

31. NHS England has set out a vision for the NHS which is of a service more closely organised around the lives of the public it serves. Starting the move towards non-emergency and planned care being available seven days a week would be

another important step to achieving a service that is truly responsive to our patients' needs.

Recommendation: ***The remit of the Forum should be broadened and it should report again in Autumn 2014 setting out proposals for the creation of a fully integrated service delivering high quality treatment and care seven days a week.***

Professor Sir Bruce Keogh

National Medical Director

December 2013

Annex A

NHS Services, Seven Days a Week: Clinical Standards

No.	Standard	Adapted from source
	Patient Experience	
1	**Standard:** 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, seven 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.	NICE (2012): Quality standard for patient experience in adult NHS services (QS15) RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*
	Time to first consultant review	
2	**Standard:** 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 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	NCEPOD (2007): *Emergency Admissions: A journey in the right direction?* RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* RCP (2012): *Delivering a 12-hour, 7-day consultant presence on the acute medical unit*

No.	Standard	Adapted from source
	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 inpatient units	
	Multi-disciplinary Team (MDT) review	
3	**Standard:** All emergency inpatients 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	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* NICE (2007): *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital*

No.	Standard	Adapted from source
	care records. • Appropriate staff must be available for the treatment/management plan to be carried out.	
	Shift handovers	
4	**Standard:** 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 seven 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.	RCP (2011): *Acute care toolkit 1: Handover* RCP (2013): *Future Hospital Commission*
	Diagnostics	
5	**Standard:** 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 **Supporting information:** • It is expected that all hospitals have access to radiology, haematology, biochemistry, microbiology and histopathology	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* AOMRC (2012): *Seven day consultant present care* RCR (2009): *Standards for providing a 24-hour radiology diagnostic service* NICE (2008): *Metastatic spinal cord compression*

No.	Standard	Adapted from source
	• 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. • Seven-day consultant presence in the radiology department is envisaged. • Non-ionizing procedures may be undertaken by independent practitioners and not under consultant direction.	
	Intervention / key services	
6	**Standard:** 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 **Supporting information:** • Standards are not sequential; if an intervention is required it may	NCEPOD (1997): *Who operates when?* NCEPOD (2007): *Emergency admissions: A journey in the right direction?* RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* British Society of Gastroenterology AoMRC (2008): *Managing urgent mental health needs in the acute trust*

No.	Standard	Adapted from source
	precede the thorough clinical assessment by a suitable consultant in standard 2. • Other interventions may also be required. For example, this may include: o Renal replacement therapy o Urgent radiotherapy o Thrombolysis o PCI o Cardiac pacing	
	Mental health	
7	**Standard:** 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, seven 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, etc.) * 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.	RCPsych PLAN (2011): *Quality Standards for Liaison Psychiatry Services*
	On-going review	
8	**Standard:** All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients	RCP (2007): *Acute medical care: The right person, in the right setting – first time*

No.	Standard	Adapted from source
	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, seven 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. • Inpatient 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.	RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* AOMRC (2012): *Seven day consultant present care* RCP (2013): *Future Hospital Commission*

No.	Standard	Adapted from source
	• Inpatients 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.	
	Transfer to community, primary and social care	
9	**Standard:** Support services, both in the hospital and in primary, community and mental health settings must be available seven 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 plan from hospital to primary, community and social care. • Transport services must be available to transfer, seven days a week. • There should be effective relationships between medical and other health and social care teams.	AOMRC (2012): *Seven day consultant present care*
	Quality improvement	
10	**Standard:** 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	GMC (2010): Generic standards for specialty including GP training

No.	Standard	Adapted from source
	and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven 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 the delivery of seven 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.	

NHS

NHS Services, Seven Days a Week Forum

Summary of Initial Findings

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The Challenge

It would be useful if our traumas and crises limited themselves to **office hours.** Life would be simpler and safer if we *only* suffered strokes or multiple traumas, if we *only* found lumps or pee'd bloody urine, or if we *only* had heart attacks, mental health crises and babies from Mon 9am-Friday 5pm. But our illnesses and conditions don't limit themselves to office hours. **So why does the NHS?**

And the thing that keeps coming up is that **if we were starting** this thing from scratch – this jewel, this precious, marvelous NHS – we **wouldn't design a part-time**, system.

Clearly, the five day system creates **inconvenience** we have become used to: taking time off work to see a GP or Consultant, or to accompany a relative or neighbour; hospitals spending half of Monday 'warming up' systems and machines, and dealing with the backlogs and crises that built over the weekend.

But it creates **distress** too. What *are* we to do out of hours? With a lump, a failed insulin pump, a teenager self-harming?

And everyone 'knows' that if you're in hospital over the weekend **everything goes quiet**: tests can't be authorised because there aren't any Consultants; they can't be carried out because the machines are turned off, or the labs aren't staffed; nothing is signed off, and you can't be discharged because no-one can contact GPs, District Nurses or social care agencies. And that's before we get into the 'poor experience' of **feeling neglected** or unsafe because of low staffing and the absence of experienced staff.

But much worse, much more frightening, is the increasingly compelling, evidence that **five-day working costs lives**. That your **chances of dying** are increased *significantly* because of the simple fact that you *arrived* there on a Saturday (an 11% increased risk of dying) or, even worse, on a Sunday (a 16% increased risk).

And measuring the dead is only one aspect. What of the many who've survived but who've had **worse outcomes** than if they had been admitted on a weekday: delayed diagnoses and treatment, more complications, longer stays and more re-admissions?

So, what to do?
We need to find a way of doing something sensible and obvious, but fantastically difficult. This begs two questions:

Question 1: How can we take on the **extraordinary challenge of integrating services** into a seamless, consistent, high-quality seven-day service?

Question 2: Actually, how can we *not*?

Fiona Carey,
Cancer Patient and Patient Representative

Foreword: Professor Sir Bruce Keogh

Initially conceived in 1940s America to respect Christian and Jewish practices, the weekend has been universally adopted in Western countries as protected personal time. In the UK, challenges from high street retailers resulted in a change to the Sunday trading law in 1994. Since then social behaviour has changed profoundly. Public expectation of services designed for customer convenience has resulted in routine seven day services in many industries – but not healthcare.

This is a missed opportunity, because extending the service would improve clinical outcomes, with the added benefit of providing a much more patient focussed service.

We have evidence that mortality rates for patients admitted to hospitals on both sides of the Atlantic is higher at weekends, that our junior doctors feel clinically exposed and unsupported at weekends, and that hospital chief executives are worried about weekend clinical cover.

It is also clear that the lack of many seven day services has an adverse effect on measurable outcomes in each of the five domains of the NHS Outcomes Framework: mortality amenable to healthcare, treatment of long term conditions, outcomes from acute episodes of care, patient experience, and patient safety.

It also seems inefficient that in many hospitals expensive diagnostic machines, laboratory equipment and pathology laboratories are underused, operating theatres lie fallow and clinics remain empty, while access to specialist care is dogged by waiting lists and general practitioners and patients wait for diagnostic results.

These concerns have led to calls for better service models in hospitals at the weekend from Health Education England, the Academy of Medical Royal Colleges, the Royal College of Physicians, and the Royal College of Surgeons with the aim of not only improving patient outcomes but also to enrich the training of the next generation of NHS doctors.

The problem of diluted services and poorer outcomes at the weekend is NOT unique to the NHS. In fact, as the largest and most comprehensive health service in the world, the NHS is well positioned to solve the issue. There are encouraging examples of NHS organisations that have moved to making healthcare services more accessible seven days a week to avoid compromising safety and patient experience. These moves have been strongly supported by the main professional bodies and the media.

As the custodians of £97 billion of taxpayers' money it is ultimately the responsibility of commissioners, including NHS England, to buy the health services patients deserve. NHS England must help accelerate the pace and spread of these changes. In doing so, we can ensure the NHS leads the world in providing equality of access to consistent, high quality healthcare seven days a week.

So, a year ago, in Everyone Counts : Planning for Patients 2013/14, NHS England stated that the NHS will move towards routine services being available seven days a week.

In response, I established the NHS Services, Seven Days a Week Forum to give all NHS commissioners the evidence, insight and tools they need to move the NHS towards routine services being available seven days a week. This report is a summary of the findings from the first stage of the Forum's review, which has focused on urgent and emergency care services.

We know that across the country, more hospitals, primary and community care organisations and social care services are working together to break the link between poorer outcomes for patients and the reduced level of service provision at the weekend. We also know that patients and the public want us to act now to make seven day services a reality in all parts of our NHS.

The scope of the Forum's review will quickly widen to include consideration of a fully integrated service delivering high quality treatment and care seven days a week.

I would like to thank all the members of the Forum, professional and patient organisations who have helped us - they have issued a challenge to NHS England to use all means at their disposal to create an unstoppable movement.

This change will be difficult - but it is the right thing to do.

Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP
Medical Director, NHS England

The Forum's ambition for service improvement

The Forum's review took place in the context of a growing social movement for seven day services in the NHS. This was reflected in the 'conversation' with patients and the public that took place at NHS England's recent Annual General Meeting on 12 September 2013 - and is articulated clearly by Fiona Carey in her foreword to this report.

It is also reflected in recent campaigns in the national media and in many reviews supporting the development of seven day service models, including the Academy of Medical Royal Colleges' recent report on *Seven Day Consultant Present Care*[1] and the report from the *Future Hospital Commission* to the Royal College of Physicians[2], as well as NHS England's own Call to Action and Urgent and Emergency Care Review.

Our ambition

The Forum believes that patients in every community in England should be able to access urgent and emergency care services, and their supporting diagnostic services, delivered in a way that meets the clinical standards we have developed, seven days a week. Meeting the standards in a clinically and financially sustainable way will require transformational change and collaboration between providers of services and different sectors of the health and social care system. This aligns with NHS England's *A Call to Action*, which urges a united approach to fundamentally changing how we deliver and use health and care services.

Through the NHS Planning Guidance, NHS England should require NHS commissioners and providers to work together with clinicians, patients and service users to ensure appropriate services are available by the end of the next NHS commissioning cycle. Where specific action can be taken to widen access to services in a shorter timeframe, this should happen as quickly as possible.

[1] Academy of Medical Royal Colleges (2013) *Seven Day Consultant Present Care. Implementation considerations*

[2] Future Hospital Commission (2013) *Future Hospital: Caring for Medical Patients – A report from the Future Hospital Commission to the Royal College of Physicians*

1. Introduction

1.1 Over the last ten years a growing body of national and international evidence has emerged, that links poor outcomes, including a higher risk of death, for patients admitted to hospital at the weekend, around the world.

1.2 The historical five day service model offered in many NHS hospitals no longer meets justifiable patient and public expectations of a safe, efficient, effective and responsive service.

1.3 In December 2012 NHS England published *Everyone Counts: Planning for patients 2013/14*[3]. It included a number of offers to NHS commissioners, to give them the insights and evidence they need to produce better local health outcomes. It stated, for the first time, that the NHS will move towards routine services being available seven days a week.

1.4 To deliver NHS England's offer, the National Medical Director, Professor Sir Bruce Keogh, established the *NHS Services, Seven Days a Week Forum* ("the Forum") to consider the consequences of the non-availability of clinical services across the seven day week, and provide proposals for improvements to any shortcomings. Details of the Forum's terms of reference and membership can be found in *Appendix A*.

1.5 The Forum believes that patients' experiences of care are particularly affected at weekends by a lack of integration across all health settings and with social care services. However, given the immediate need to reduce the higher mortality risk for patients admitted at weekends, the Forum focused, as a first stage, on the part played by the acute hospital's weekend service, and specifically on urgent and emergency care and supporting diagnostics.

1.6 The Forum met for the first time in February 2013 and established thematic workstreams to explore some of the issues that are critical to the successful delivery of seven day services in acute settings, and to create opportunities for a wider group of stakeholders to contribute. The workstreams, each of which was led by a member of the Forum, were:

- Clinical standards;
- Workforce and organisational development;
- Finance and costing;
- Incentives, rewards and sanctions.
- Service models

1.7 Patients, members of the public and carers have played an important role in the Forum's review. As well as contributing directly to a number of the workstreams, NHS Improving Quality brought together representatives from 30 patient bodies to participate in a 'learning exchange' event to inform the Forum's findings. They raised a wide range of issues, including:

- the need for co-ordination across primary, secondary, community and social care;

[3] NHS Commissioning Board (2012) *Everyone Counts: Planning for Patients 2013/14*

- improving the primary care offer, and flexible approaches to accessing services using new technologies;
- educating patients about the service and intervention options available, to make more appropriate use of the right service, at the right time and in the right place;
- greater support across seven days for self-care, to reduce the impact of people using emergency facilities when they might otherwise self-manage;
- introducing minimum standards for seven day services in a range of settings and disciplines to maximise consistency, parity and continuity of care and minimise variation across the country.

1.8 The transformation from a five day model to the delivery of a consistent, high quality service, seven days a week, will take place in the context of the broader challenges facing the NHS, and with the benefit of learning from other reviews. These include :

- the Call to Action[4], which, as part of NHS England's 10 year strategy to transform the NHS, makes clear that doing nothing is not an option - the NHS cannot meet future challenges without change;
- the finding from the recent review into the quality of care and treatment provided by 14 hospital trusts in England[5], that hospitals with high mortality rates also offer sub-optimal emergency care, particularly at the weekend and at night;
- a review of the way the NHS responds to and receives emergency patients, announced by Professor Sir Bruce Keogh in January 2013[6].The emerging principles for urgent and emergency care describe a system that provides high quality, safe care, seven days a week. The ten clinical standards, developed by the Forum during the first stage of its work, and described in section 3, set out what that means for the care and onward transfer of acute inpatients;
- NHS England is currently developing a strategic framework for Commissioning Primary Care to describe the national direction of travel, based on a vision of what primary care could contribute to the overarching strategy for health and care in England for the next ten years. It will set out how NHS England, as commissioner of primary care services, will encourage local action to improve the quality of primary care and more integrated out-of-hospital services;
- as part of this Strategic Framework, *Improving general practice - a call to action* was launched in August 2013. This identifies the potential contribution of general practice to ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances. It is expected that further information about the strategic framework will be published early in 2014;
- alongside this work, the Prime Minister recently announced a new £50m Challenge Fund to encourage GP practices to offer wider access for patients. Nine pioneers will be established in different parts of the country. Together they are expected to cover up to

[4] NHS England (July 2013) : *The NHS Belongs to the People – A Call to Action* .
[5] Keogh, B. (2013) : *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*
[6] NHS England : *Transforming urgent and emergency care services in England. Urgent and Emergency Care Review .*

half a million patients and offer seven days a week access and evening opening hours. Following a “Challenge Fund competition” the first wave of these pioneers will be established in 2014/15.

1.9 This report to NHS England sets out the Forum’s ambition. A summary of the initial findings of each of the Forum’s workstreams, and next steps in relation to the first stage of the review.

1.10 This summary should be read alongside more detailed reports and related documents published by NHS England and NHS Improving Quality. A number of them are included as appendices. All documents can be accessed by following links on NHS England’s website.

2. The case for change - setting out the evidence

2.1 Considerable evidence has emerged over the last ten years linking the reduced level of service provision at the weekend and poor outcomes for patients admitted to hospital as an emergency. Hospitals should meet patient and public expectations by providing a consistent service seven days a week. This will drive up clinical outcomes and improve patient experience by reducing the risk of morbidity and mortality following weekend admission in a range of specialties. This view is supported by a broad range of public and professional bodies.

2.2 **This section provides a high level overview of the variation in weekend outcomes identified by the Forum. Detail of the underpinning analysis and evidence is provided in the Forum's Evidence Base document.**

2.3 The Forum established a Clinical Reference Group (CRG) to provide clinical advice, opinion and direction. It drew together a clinical evidence base in support of seven day services in the NHS and developed ten clinical standards based on existing recommendations from relevant national and professional bodies. The clinical standards themselves are covered in further detail in *Section 3*.

2.4 The Evidence Base draws from a significant body of research, as well as a national survey of acute hospital services. It highlights the link between poorer outcomes, and the workforce, systems and processes in place to manage emergency hospital admissions at weekends.

2.5 The CRG's review points to significant variation in outcomes for patients admitted as an emergency at the weekend, across the NHS in England. This variation is seen in mortality rates, length of hospital stay, re-admission rates and the patient's experience of care.

Mortality rates

2.6 Evidence drawn from national research by influential bodies such as the medical Royal Colleges and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), has highlighted deficiencies of care in many areas and demonstrated that patients admitted at the weekend have a significantly greater risk of dying within 30 days of admission than those admitted on a weekday; the increased risk of mortality could be as high as 16%.

2.7 The explanation of the higher mortality rate is multifactorial and is likely to be a consequence of:

- variable staffing levels in hospitals at the weekend;
- the absence of senior decision makers of consultant level skill and experience;
- a lack of consistent specialist services, such as diagnostic and scientific services at weekends; and
- a lack of availability of specialist community and primary care services, which might otherwise support patients on an end-of-life care pathway to die at home.

Length of hospital stay

2.8 Minimising a patient's length of stay can improve their experience of care, and reduces their risk of acquiring a hospital based infection and the degree of lost mobility from time spent in bed. Several of the factors which contribute to unnecessarily prolonged lengths of stay are

more pronounced at weekends. These include the non-availability of community-based resources such as primary care and social care, hospital factors such as lack of senior clinical review and timely access to therapies, and reduced co-ordination between services.

2.9 Analysis has found that when patients have to wait for senior assessment, they have a longer length of hospital stay.

2.10 Length of stay can also indicate whether relationships across the wider health and social care system are organised effectively - matching capacity to demand and supporting the flow of patients along their pathway, benefiting both patient care and system efficiency. These systems are less robust at weekends.

Re-admission rates

2.11 If a patient’s health deteriorates once they have been discharged from hospital, they may need to be re-admitted for further care. In some cases this is an avoidable result of shortcomings in their care and as such is another important indicator of care quality, both in hospital and in the community. At weekends, important collaboration and multi disciplinary planning between the hospital, community health services and social care becomes increasingly difficult, and may impact negatively on re-admission rates.

Patient experience

2.12 The quality of care people receive, as opposed to the quality of their treatment, is also hugely important. Admitted patients are often elderly and vulnerable, making it even more important that they are cared for with compassion and respect.

2.13 The Royal College of Physicians’ *Future Hospital Commission* states that in the hospital of the future, patient experience will be valued as much as clinical effectiveness, and that good communication with and about patients will be the norm. It believes that “patients can be empowered to prevent and recover from ill health through effective communication, shared decision-making and self-management”.

2.14 The quality of care and communication for patients, their families and carers can be woefully inadequate without the right levels of expertise, staffing and attention to individual patients’ needs. When too few senior decision makers are present, communication with patients, their families and carers is hindered. This is a problem at weekends.

3. Clinical standards

3.1 There is no ‘one size fits all’ answer to introducing seven day urgent and emergency care services. Local solutions need to be found.

3.2 The Forum recommends the adoption of ten clinical standards that describe the standard of urgent and emergency care that patients should expect to receive, seven days a week. The Forum believes the standards will support the NHS to improve clinical outcomes and patient experience. Delivery of these standards should reduce the risk of morbidity and mortality following weekend admission in a range of specialties and provide consistent NHS services, across all seven days of the week.

3.3 The standards include Diagnostic Services. Both hospital clinicians and GPs require access to diagnostic and scientific services to support their decision making and interventions. Results can dramatically affect plans for admission, treatment or discharge. Without timely access to diagnostic and scientific services, results and reports, treatment can’t begin. From a patient’s perspective, timely, accurate support contributes to a better overall experience by reducing lengths of stay, avoiding unnecessary admissions and improving clinical outcomes.

3.4 The Forum’s Clinical Reference Group (CRG) reviewed the available evidence, along with standards of care published by recognised and respected clinical bodies, and collated them into ten key areas.

3.5 The Academy of Medical Royal Colleges (“the Academy”) has been a key partner in the Forum’s review. Its own work on seven day services has made a significant contribution to the Forum’s report and there has been an explicit effort to align the recommendations made with the Academy’s work. Professor Terence Stephenson, Chair of the Academy, is a member of the Forum and Dr Chris Roseveare, clinical project lead for the Academy’s seven day work is a member of the Clinical Reference Group.

3.6 The ten clinical standards developed by the Forum are as follows:

1. Patient Experience
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, seven days a week.

2. Time to first consultant review
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 of arrival at hospital.

3. Multi-disciplinary Team (MDT) review
All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, unless deemed unnecessary by the responsible consultant. The multi-disciplinary assessment should be overseen by a competent decision-maker, be undertaken within 14 hours and an integrated management plan

with estimated discharge date to be in place along with completed medicines reconciliation within 24 hours.

4. Shift handovers

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 seven days of the week.

5. 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 their reporting will be available seven days a week:

- within 1 hour for critical patients;
- within 12 hours for urgent patients; and
- within 24 hours for non-urgent patients

6. Intervention / key services

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; and
- emergency general surgery.

7. Mental health

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, seven days a week:

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

8. On-going review

All patients on the AMU, SAU, 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, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

9. Transfer to community, primary and social care
Support services, both in the hospital and in primary ,community and mental health settings must be available seven 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.

10. Quality improvement
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, seven days a week.

3.7 *Appendix B* contains supporting information on each of the Forum's clinical standards, along with information on their sources. As part of its next phase, the Forum will be taking forward further work to develop metrics for each of the standards, to track both delivery of the standards and achievement of the intended benefits for patients.

4. Workforce and organisational development

Approach

4.1 The Forum's Workforce and Organisational Development (OD) workstream was tasked with designing a high-level workforce model and OD framework and making a preliminary analysis of its related risks.

4.2 The workstream convened a steering group drawn from senior representation in a geographically and functionally diverse range of organisations and professional perspectives who offered case studies, personal views and guidance. The workstream also conducted a literature review, and further good practice and recommendations were sought from senior clinicians and other professionals.

Background and context

4.3 Many professionals are themselves making the case for change to system-wide provision of seven day services and it is important to recognise that in 2013 many organisations already deliver some degree of seven day services within their current workforce establishment, not only in urgent and emergency care but also elective and ambulatory care and discharge planning.

4.4 The provision of seven day services by organisations does not require seven day working by individuals. Indeed, in many cases seven day services have reportedly had a positive impact on individuals' work-life balance, offering greater certainty in planning ahead and flexibility in time off.

Local workforce considerations

4.5 No one-size model of seven day service provision will fit all local conditions. Although different communities of practice will wish to adopt different solutions, there may be some common local workforce issues pertaining to provision of seven day services, such as:

- Rota and shift planning for senior as well as junior doctors;
- Ensuring the right balance between training and service provision;
- Staff pay and terms & conditions;
- Staff deployment and skill-mix;
- Leadership development, particularly for clinicians; and
- Network service models, particularly in rural areas.

4.6 **Rota and shift planning** is an essential component of effective seven day service delivery. Software packages are available which can greatly assist with complex rota and shift planning and also deliver efficiency benefits[7]

[7] NHS Employers, *e-Rostering good practice case studies, 2012*

4.7 **Service - training balance.** As noted by Professor Sir John Temple in his 2010 review *Time for Training*[8], "Training is patient safety for the next thirty years". Health Education England's (HEE) *Better Training Better Care*[9] review has shown that increased consultant presence can reduce the number of serious untoward incidents involving doctors in training and Professor Greenaway's conclusions in *Shape of training: securing the future of excellent patient care*[10] confirm that patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings.

4.8 Reform of consultants' contractual **pay and terms & conditions** is a key enabler of seven day services, and the British Medical Association's commitment to support the same high quality NHS care across seven days of the week[11] is welcomed.

4.9 Trusts looking to adopt provision of high quality care seven days a week will wish to consider developing their **skill mix** to create more generalist, cross-covering medical roles such as the physician's associate. As medical services move to seven day delivery, so too will demand for Allied Health Professionals' (AHP) services, diagnostic services and services in areas such as pharmacy."

4.10 The well-being of clinicians and other staff must be considered and their **leadership development** needs met, so as to support them to deliver a seven day service from the front.

4.11 To deliver services to the clinical standards set out by the Forum across the board it is likely that transformational change will be required. **Network roles and rotas** which adapt to seven day services, for example, by sharing roles with other Trusts or creating joint rotas across primary and secondary care, will likely be required.

National workforce considerations

4.12 **Future workforce demand:** To model the future workforce demand it is necessary to start with a projection of future activity. Although the workstream's remit was initially limited to acute care services, in consultation with its steering group this was subsequently expanded, to include emergency, urgent and acute admissions care, community care to prevent admissions and readmissions and primary care.

4.13 To develop sustained and robust local seven day services, particular consideration should be given to building up comprehensive community based care services to improve and maintain patient flows in acute services.

4.14 The workstream described this service development space, which stands between the acute and home-based services, as "the Place in the Middle", which includes preventative services/self-care, and assessment/triage, through to residential care, re-ablement, rapid

[8] Professor Sir John Temple, *Time for Training, 2010*
[9] Health Education England, *Better Training Better Care, 2013*
[10] Professor David Greenaway, *Shape of training: securing the future of excellent patient care, 2013*
[11] BMA Position Paper, *7-day services, 2013*

response and intermediate care, community based care and palliative/end of life care, acute admission and discharge, and urgent & emergency care.

4.15 The workstream built a service model to assess if there are sufficient trained staff available to achieve this. In particular, the model sought to address the need to focus on maintaining flows in the acute sector by developing community services; to develop comprehensive mental health services; to incorporate maternity services; and, critically, to include enabling community services such as pharmacy, therapy and diagnostic and scientific services.

4.16 As a next phase the Forum recommends that further research is undertaken to collate activity and workforce data on weekdays and weekends. To avoid duplication of effort, this should be aligned as closely as possible with the analysis needs of the Urgent and Emergency Care Review.

Organisational Development

4.17 The Forum's proposed Organisational Development framework is presented as a high level change programme based around three key areas of work, mirroring the design principles for "the Place in the Middle", namely; to improve patient flows, develop community services, and to underpin the system.

4.18 It is recommended that NHS England should work with the Department of Health, Health Education England and the Centre for Workforce Intelligence to facilitate further strategic workforce modelling and analysis by drawing together demand and supply side workforce planning requirements.

4.19 The workstream identified the appropriate change agency to drive forward the change programme as Clinical Commissioning Groups (CCGs).CCGs would need to work with a range of strategic partners, including Local Education and Training Boards. The Forum recommends that NHS England give consideration to how CCGs are supported and developed with this function in mind.

5. Finance and costing

5.1 NHS England's *A Call to Action* states that: ' In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30 billion between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21).' In this context, NHS providers and their commissioners face difficult choices when deciding where to invest their resources in order to deliver the best outcomes for patients and value for taxpayers.

5.2 There is a growing body of evidence showing the clinical benefits and service quality improvements from providing NHS services seven days a week. However, the move to deliver services seven days a week should not be looked at in isolation of the other changes taking place in the NHS. The scale of the financial and quality challenge in the NHS is unprecedented and moving towards the provision of services seven days a week is only one of a number of financial pressures facing the NHS. Providing services seven days a week should therefore be factored into policy making considerations and strategic change programmes.

Approach

5.3 The Healthcare Financial Management Association (HFMA), on behalf of the Forum, has looked into the financial implications of introducing seven day services for urgent and emergency care and supporting diagnostics in the NHS. The HFMA's research was informed by a combination of methods including a literature review of business plans and other evidence, and working with a sample of eight acute providers to establish the cost of meeting the Forum's clinical standards.

5.4 NHS organisations need a clinically and financially sustainable strategic plan, which should include how they will work towards seven day services without increasing the overall costs of healthcare. HFMA's research provides a helpful indication of the costs that some providers and commissioners have faced, or expect to face, when considering how to shape their emergency and urgent care services to provide comprehensive services over seven days. It is difficult to calculate potential costs for the NHS in England as a whole from this work due to the sample size and the inconsistent starting positions of the trusts, which result from the varying levels of prior investment across the country. Further work on this will be taken forward by the Urgent and Emergency Care review.

Findings

5.5 Under the present configuration of services, delivering the clinical standards for urgent and emergency in-patients at weekends appears likely to add to overall hospital costs, despite some potential savings from reducing lengths of stay. Reconfiguration of services may substantially reduce these costs.

5.6 There is evidence that, in some trusts, seven day services at the front-end (accident and emergency departments, and admissions units with supporting diagnostics) can pay for themselves, by reducing admissions and lengths of stay. However, usual Payment by Results (PbR) rules have to be flexed locally to enable providers to share the financial benefit of reducing admissions so that both the hospital and its commissioners gain from a reduced 'net cost' to the local NHS. Levers and incentives are discussed in section 6.

5.7 Most of the additional costs reported by the trusts in the study are driven by the need to recruit additional medical staff. Other costs may vary widely depending on local service models; for example some trusts would want to recruit extra specialist nurses to support doctors and speed up hospital discharges, while other trusts did not anticipate making any changes to the nursing workforce. A change to weekend pay premiums would make seven day services more affordable, but not cost-neutral under the current configuration of services, as most of the cost comes from employing more, highly paid, medical staff.

5.8 The trusts in the study did not expect any material change in non-pay costs (except where services such as radiology or pathology were outsourced) or any significant one-off costs to introduce seven day services. When looking at buildings and equipment it makes financial sense to 'sweat the assets' by using expensive equipment more at weekends where the total workload is growing or it is consolidated across fewer providers.

5.9 All trusts in the HFMA's study commented on the anomaly of expanding hospital services at weekends while leaving primary and social care unchanged. If primary and social care provided a weekend service, hospital admissions could be reduced and hospital discharge speeded up. Healthcare commissioners and providers will need to work across the whole health and social care system to optimise the value to be gained from all local resources. Considering the wider system changes and the varying starting positions it is likely that seven day services will progress best by local negotiation and a locally agreed speed.

5.10 It is reasonable to conclude from this small study that the move to seven day services does appear achievable, but it may be unsustainable for all existing hospitals to move all their current range of services to a seven day basis. The Forum believes that patients in every community in England should be able to access urgent and emergency care services, and their supporting diagnostic services seven days a week. This recommendation can be achieved without every hospital delivering a full range of services on a seven day basis. Trusts are therefore encouraged to explore with commissioners new ways of working in networks, collaboratives or federations and some trusts may have to stop providing some services. The scope for consolidation is obviously greater in the large conurbations whereas rural areas may face greater challenges.

5.11 NHS finance staff have a role in making this happen. This includes modelling the options, managing financial risks and working with commissioners to resolve funding issues. If the clinical case for seven day services is strong, internal NHS obstacles should not be allowed to prevent it.

6. Incentives, rewards and sanctions

6.1 A Workstream considered the incentives, rewards and sanctions that are available to commissioners and others to encourage the delivery of the clinical standards, seven days a week.

Approach

6.2 The views of experienced commissioners, clinicians and other opinion-leaders on specific health service commissioning levers, or less formal levers that could nonetheless encourage seven day services were sought.

6.3 Following initial exploration of the levers a working group determined their priority, potential effectiveness and the feasibility of objective measurement, and made recommendations. The Clinical Reference Group established by the Forum (see *Section 3*) also considered the ongoing measurement and assurance of the clinical standards.

Findings

6.4 To drive change, levers beyond pure commissioning are needed. This means that a mix of formal contractual levers and informal levers are required and there is also a need to work across these levers at different levels - national, local, organisational, team and individual to bring about the large scale change required. Moving to the delivery of a consistent high quality service every day of the week requires a significant cultural shift as well as practical and logistical changes. To succeed, widespread support for the clinical standards and the introduction of seven day services is needed.

6.5 The message that patient outcomes and experience are improved when high quality, consistent seven day services are provided needs to be communicated widely to the public, patients and carers. Transparency about the current level of service provision and distance from the clinical standards is also required to highlight areas of good practice and expose variation. This should support informed choice, encourage competition between services and providers and drive quality improvements.

6.6 The report from the Forum's Incentives, Rewards and Sanctions Workstream recommends the following formal and informal levers to encourage the delivery of the clinical standards for seven day services:

Contracts

- Year 1 (2014/15) - local contracts should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section.
- Use of local CQUIN schemes should be encouraged, based on the clinical standard for time from arrival to initial consultant assessment.
- Year 2 (2015/16) - those clinical standards which will have the greatest impact should move into the national quality requirements section of the NHS Standard Contract.
- Year 3 (2016/17) - all clinical standards should be incorporated into the national quality requirements section of the NHS Standard Contract with appropriate contractual

sanctions in place for non-compliance, as is the case with other high priority service requirements.

Payment System

- NHS England and Monitor should ensure that the new payment system reflects the extent to which clinical standards are being delivered on every day of the week.

Inspection and Assurance

- That the CQC and the Chief Inspector of Hospitals should be asked to consider how implementation of the clinical standards could best be assessed by the CQC and how this might be reflected in judgments/ratings.

Measurement and Transparency

- Future revisions of the CCG outcomes indicator set by NHS England, supported by NICE, should include indicators relating to delivery of the clinical standards.

- NHS England should refer the clinical standards to NICE for accrediting as an evidence-based resource. If accredited, the standards should then be used to inform any future quality standard produced by NICE on seven day services.

- Data and information on the extent to which the standards are being achieved, and the provision of seven day services, should be published in an accessible format that lends itself to comparisons. Consideration should be given to including this information in Quality Accounts.

Education commissioning and revalidation

- Education contracts with Health Education England and the developing failure regime should include Consultant availability to provide adequate supervision of doctors in training seven days a week in line with the clinical standards.

- Consultant revalidation and appraisals should reflect delivery of the clinical standards, seven days a week, as appropriate to the specialty and setting.

Engagement

- The evidence base for the clinical standards, quality and outcome benefits, and the working life implications of the delivery of the clinical standards should be widely shared through comprehensive engagement with a wide range of stakeholders - patients and carers, clinicians, commissioners and providers.

6.7 Further information on each of the levers, including the rationale for each recommendation, is included in the Workstream's report.

7. Implications for service models

7.1 The historical model in the NHS is a five day a week service. This has largely been driven by tradition, and inevitably leads to variations in outcomes for patients.

7.2 As the views of patients and the public are increasingly heard, it is clear that people are outraged when they understand the extent of the withdrawal of their services at weekends and the associated risks. They, and most clinical leaders, believe the variation is unacceptable.

7.3 The debate should focus on the best configuration of primary, community and hospital health and social services, to meet the population's needs. This is not about 'bricks and mortar' provision but about people receiving the right care at the right time and by the right person in the right place. Leaders should consider whether their messaging around seven day services promotes the concepts of improved outcomes and patient experience, and challenges thinking which is focused only on centralisation.

7.4 Where analysis shows that sites cannot meet the Forum's clinical standards, commissioners and providers of services should consider whether their population's needs can be met through collaboration, networking and redesign across a health and care economy, in line with Call to Action principles. The issue is not the "amount" of service on offer, but the extent to which all patients have access to a high quality service at weekends. A useful analogy is access to community pharmacists, which is delivered by a well-signposted selection of pharmacies providing weekend services, without detriment to those which only open on Monday to Friday.

7.5 Teams that have made changes, whether small or large scale, towards provision of seven day services, achieved benefits for patients. These arose mainly from the presence of a senior decision maker of consultant level skill and experience, and included:

- the speed of assessment diagnosis and treatment;
- intervention to spot and prevent deterioration;
- safer and more timely supported discharge; and
- reduced risk of emergency readmission.

7.6 These teams also found that there were organisational benefits to moving toward provision of seven day services, such as:

- avoidance of waste and repetition;
- fewer complications;
- admission to the right place, first time;
- better supervision of the work of doctors in training;
- more efficient use of expensive plant and equipment;
- shorter length of stay; and
- reduced bed pressure Monday to Friday.

7.7 These patient and organisational benefits of seven day services are demonstrated in greater detail in NHS IQ's publication *Seven Day Services – open seven days a week: every day counts.*

7.8 Some teams, specialties and whole organisations have improved their weekend offer despite financial pressures and with current system levers that do not incentivise the change.

7.9 Those that already offer some seven day services have done so regardless of the potential for additional cost. The drivers were varied but most often the prime motivation was to improve the quality of services and to meet patient needs. This was sometimes supplemented by the need to respond to local circumstances, including the desire to manage demand by flexing capacity of services over seven days.

7.10 Some providers and commissioners have agreed locally to aim for standards already developed by medical Royal Colleges and professional bodies. They have set local goals, and share the inherent risk by flexing national frameworks to suit local circumstances, so that, for example, diverting admissions to more appropriate services does not benefit commissioners alone, while causing a loss of income for the trust.

7.11 Models must be adaptable and appropriate to the locality of the area and the services adopting them. Changes need not always be wholesale or large scale; incremental changes can be made as services begin to identify their particular opportunities to modify their offer. The clinical standards developed by the forum reflect standards of care already being delivered by some innovating organisations across England.

The shape of the service

7.12 The hospital at weekends needs to resemble the weekday service in many more respects than having consultants on site. The Academy of Medical Royal Colleges' report on implementation of consultant-present care has identified the services that consultants report are needed to support their own decision making at weekends. Pharmacy services, therapists, and diagnostic and scientific services are crucial to make sure that care can progress without delay.

7.13 Hospitals have always recognised the need to provide round the clock, seven day nursing. Administrative and clerical, facilities and ancillary services will also need to adapt according to local circumstances.

7.14 There is a risk that attention to day to day operational quality decreases at weekends, for example on breaches of single sex accommodation. Some trust executive management teams are now rostered to ensure a management presence at weekends, improving continuity and focus on these issues.

7.15 When additional resources are put in place to improve urgent care, some senior staff capacity might also be used to supply services for patients whose care can be scheduled. Trusts might find that there is capacity for more active treatment of in-patients, additional out-patient clinics and routine post-operative care, in line with commissioning agreements.

7.16 Some NHS providers will find seven day services challenging to deliver. NHS Improving Quality plans to support them through its Seven Day Services Improvement Programme, which will offer practical support to every commissioner and provider in England (see Section 9 for further information).

7.17 The Urgent and Emergency Review is working on the design of an initial system of care, components for service delivery and ways of working in relation to access to emergency units. This will form the basis for future change, and facilitate the development of standards for specific areas across urgent and emergency care. It is envisaged that areas such as telephone access, general practice and primary care, accident and emergency and acute care could all

benefit from revisions to existing clinical standards to ensure high quality and safe services that are provided consistently across all seven days of the week.

Leadership

7.18 Early changes have generally been driven by individuals, for example heads of Allied Health Professions, rather than by the organisational strategy. The drive for new seven day models should be systematic, and therefore needs to be positioned and driven through the executive boards of organisations, working collectively across whole health and care communities.

7.19 Many of the organisations already moving toward seven day services have observed that this commitment requires real grit and leadership to deliver, accepting that organisational cultures differ and that a pragmatic, long-term view may be required.

Innovation and Technology

7.20 Searching for and applying innovative approaches to delivering healthcare must become an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and services for patients. It will deliver the productivity savings we need to meet the growing demand for services, and it will also support our role as a major investor and wealth creator in the UK.

7.21 Seeking efficiency savings alone will not deliver the required changes. The Forum endorses the work of NHS England's 3 Million Lives Programme, a unique collaboration between Government, industry, NHS, social care and others, to improve the lives of three million people with long term conditions through the better use of telehealth and telecare, telemedicine and telecoaching.

7.22 Integrated care records are a pre-requisite for integrated care. Ensuring that all NHS urgent care staff have access to relevant medical records right across the system would mean that every healthcare professional has access to up-to-date information, and be better placed to work with patients and carers in making the best decisions and giving advice on every day of the week.

Integration and Partnerships

7.23 Experience shows us that to deliver seven day services that meet patients' needs, models must include both health and local government services, covering a shared population. Primary care and other non-hospital health settings, secondary care, community health services and social care, housing and the voluntary sector all provide vital inputs into care packages and are brought together within Health and Well Being Partnerships.

7.24 Improved integration between health and social services is being supported by the recently announced Better Care Fund. (Formerly known as the Integration Transformation Fund) The Better Care Fund is a single pooled budget for health and social care services to work more closely together in local areas. NHS England and the Local Government Association's aim is for a seamless health and social care system so that people receive the right care at the right time in the right place.

7.25 NHS England and the Local Government Association will be seeking evidence in bids to the fund of a strategic commitment at a joint leadership level to prevent unnecessary admission and support timely discharge from hospital at the same level on every day of the week.

7.26 Local government and the wider health and well-being agenda may hold the key to many of the out-of-hospital issues that are sometimes cited as reasons for not widening access to services seven days a week. For example, the reduction in weekend public transport is a barrier in some places, particularly if increased consultant presence means that out-patient services could be offered. Housing may also be integral to discharge planning and should be represented where appropriate at multi-disciplinary team meetings.

7.27 Fourteen Integrated Care and Support Pioneers 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 seven day models of integrated care.

8. NHS Diagnostic and Scientific Services, Seven Days a Week

8.1 Diagnostic, and scientific services are fundamental to improving the prevention, identification and diagnosis of disease. They are also central to monitoring and assessing changes in an individual's health status as part of an urgent or emergency episode, or ongoing chronic disease management, and to ensuring treatments and other interventions are safe and effective.

8.2 Despite this crucial importance in all elements of patient care and impact on all five domains of the NHS Outcomes Framework (2012),[12] access to, and provision of diagnostics in imaging, endoscopy, pathology and physiology is variable across the country and especially at weekends.

8.3 This variation was highlighted in a recent survey of scientific services (including pathology, physiology and some imaging), which indicated that:

- Pathology, physiology and especially cardiac physiology, and medical physics to support imaging and radiotherapy, are key priority areas to deliver services seven days a week
- Less than half of organisations reported that they provide services across seven days of the week
- A further third of organisations provide limited services at weekend with the remainder with no service
- Less than half of services have asked what services are required seven days a week.
- The majority of health care scientists believed seven day services were right for patients

8.4 The importance of getting it right now cannot be underestimated in terms of the benefits to patients and those looking after their care.

"The effect of delays in diagnostic tests or procedures means that I cannot move on to the next part of my treatment or indeed be discharged" : Patient story

8.5 It is therefore essential that services organise themselves to deliver an efficient and effective service on every day of the week, balancing the safety and quality of their support for emergency specialties with the existing demand for elective procedures, especially where the size of the appropriately skilled workforce may be the constraint.

8.6 Examples of seven day diagnostic and scientific service delivery models, including an excellent example in embryology which demonstrates how a small, highly technical services can offer patient centred provision, can be found in Equality for All.[13]

8.7 It may be a challenge for all diagnostic and scientific services to deliver appropriate, high quality and cost effective provision seven days a week for primary and secondary care users. Some systematic approaches to delivering seven day diagnostic and scientific services are evident across England but have not spread. Services need to be ambitious and introduce transformational solutions, particularly when resources are under pressure. For example:

[12] Department of Health (2012) *NHS Outcomes Framework 2013 to 2014*
[13] NHS Improvement: *Equality for All. Delivering safe care seven days a week.*

- managing the demand for emergency and inpatient investigations alongside outpatients over seven days ensures tests are not delayed over the weekend, cancellations are minimised and the highly skilled and qualified workforce are used effectively and efficiently;
- introducing improved staff rostering and compliant rotas are both better for staff and more cost effective for organisations;
- working across seven days enables more rapid turnaround of diagnostic tests and their reports, shortening the time to clinical decision making and treatment; and
- if all days of the week are the same for diagnostic and scientific services, waiting times can be managed and reduced in a controlled and systematic way and the overall experience of patients and their carers improved.

8.8 To achieve the level of transformational change required, commissioners need a better understanding of how to commission diagnostic and scientific services. There is a need for a clearer specification of a seven day offer in contracts. We should require providers to demonstrate to commissioners how their diagnostic services currently support seven day service provision and emergency and urgent care.

8.9 A key emerging theme arising from the survey of scientific services mentioned above, is the importance of developing strong and resilient clinical leaders in all diagnostic and scientific services, who understand the impact their services have on patient outcomes and experience.

8.10 The critical importance of diagnostics to improving outcomes, especially in relation to mortality, is recognised in the NHS England prevention, early identification and diagnosis work programme. Introducing a NICE quality standard for diagnostics would also be a key lever for ensuring high quality and safe provision and NHS England is exploring the possibility of this with NICE.

8.11 The formation of local networks is a potential solution to ensure seven day access to a range of diagnostic and scientific services. The design of the networks involves all stakeholders with responsibility for delivering services across a geographical area. Healthcare Science Networks, working across local geographies, with lead scientists representing provider organisations, are working in partnerships to develop a strategy to spread sustainable seven day delivery models.

8.12 Diagnostic and scientific workforce issues have been identified as a key limiting factor for provision of seven days services across England. The main challenges include recruitment and retention of skilled staff, skill mix issues, compliant staff rosters, the need for changes to current terms and conditions and contracts, and matching supply of appropriately skilled workers with demand.

8.13 All diagnostic services would benefit from working together within provider organisations to share learning and to develop solutions to common problems and issues. This may also facilitate discussions about flexible working across the diagnostic services and the sharing of skills and expertise. NHS Improving Quality's *Seven Day Services Improvement Programme*, described in Section 10, will identify best practice and case studies, and encourage systematic adoption across the NHS.

9. Conclusion, actions and next steps

Conclusion

9.1 Demand for urgent and emergency care does not follow a pattern consistent with the traditional working week of Monday to Friday, nine to five. If a profession, intervention or service is important to the care of patients, the NHS cannot justify its absence based solely on the fact that it is the weekend. The Forum has identified a strong body of evidence suggesting that the standard of care a patient receives, their experience of it and the outcome as a result, are affected by the day of the week.

9.2 There is no 'one size fits all' answer to this challenging problem, which is why the Forum's approach is to recommend the adoption of clinical standards that describe the standard of urgent and emergency care that all patients should expect to receive, seven days a week. There are, however, excellent examples of how organisations and teams have overcome challenges to widen access to services in a sustainable way. Accepting the limitations of NHS resources, the Forum believes that every effort should be made by all healthcare commissioners and providers to address this issue.

9.3 The Forum also proposes that NHS England should ensure that the presumption of a full time, seven day service is built into its own current and strategic initiatives, especially the reviews of urgent and emergency and primary care, and in all efforts to establish joint working across the health and care system.

9.4 The Forum has been helped and informed by a broad range of opinion, and we have been encouraged by advice that NHS England should actively promote the case for seven day services, by sharing what the Forum has learned so far, and involving patients, the public and clinicians much more intensively in the next steps.

Action - NHS Planning Guidance

9.5 NHS England should ensure that NHS Planning Guidance for 2014/15 includes a requirement that, from 2014/15, local contracts should incorporate, within the Service Development and Improvement Plan, an Action Plan to deliver the clinical standards.

Action - incentives, rewards and sanctions

9.6 Working with key partners and stakeholders, NHS England should ensure that the national levers and incentives described in Section 6 of this report are used to support achievement of the Forum's ambition. NHS England has recently undertaken a review of the incentives, rewards and sanctions used within the NHS. Steps have been taken to ensure that the recommendations contained in this report are aligned with this wider review.

Action - NHS Improving Quality: *Seven Day Services Improvement Programme*

9.7 NHS Improving Quality, in partnership with NHS England, is supporting the Forum and will continue to do so. The specific role of NHS Improving Quality is to:

- support the adoption into practice of evidence based seven day services at pace and scale across England;

- work with providers and commissioners to ensure that they have the improvement expertise, capability, knowledge and tools to implement sustainable change;
- create a vibrant network of seven day services learning across England that connects clinical teams, services, organisations and communities;
- ensure patients, carers and users across the health system are actively engaged in designing and influencing the right solutions to meet local health needs; and
- challenge the NHS to think radically, push the boundaries and look for new and innovative ways of providing leading edge, sustainable seven day services.

9.8 NHS Improving Quality will introduce a new, large scale transformation change programme across England - the *Seven Day Services Improvement Programme*,(SDSIP)- which will be set up in collaboration with all healthcare commissioners and providers. It will support the spread of what we already know, the development of emerging and new practices and models, and provide dedicated support, available locally to the NHS to enable change to happen in practice. SDSIP will commence in January 2014.

9.9 The priorities for the programme in year one are to:

- signpost evidence from the diagnostic service reviews of 24/7 provision across England in Interventional Radiology, Endoscopy and scientific services to ensure providers and networks have plans in place to implement evidence-based seven day diagnostics services and models;
- start the drive for spread: engaging every commissioner and provider in moving towards the provision of services that are delivered in a way that meets the Forum's clinical standards. This work will be overseen by NHS England's Regional and Area Teams. The expectation is that organisations will understand their starting or baseline position, examine local data, review local practice and compare against the leaders in the field and start to identify and adopt the top interventions which will make the biggest difference to supporting delivery of a local seven day service. The focus in year one will be on the urgent and emergency and enhanced recovery pathways, and diagnostic and support services such as pharmacy and professions allied to medicine; and
- identify and work with 13 Early Adopter providers/health economies who will start to develop new models for seven day services which push the boundaries and start to shape a new direction for the future. These are listed at *Appendix C.* The SDSIP will create a 'learning community' which includes all organisations who expressed an interest in becoming an Early Adopter, to ensure concurrent learning.

9.10 Further information on the *Seven Day Services Improvement Programme,* and information on how communities, organisations and teams can join the learning network, can be found on NHS Improving Quality's website

Action – the Better Care Fund

9.11 In 2014/15 £1.1 billion is being made available to Local Authorities to support health and social care services to work more closely together in local areas. By 2015/16 the Better Care Fund (BCF) will be a single pooled budget of £3.8 billion. NHS England and the Local Government Association's aim is for a health and social care system that is truly seamless so that people receive the right care, at the right time in the right place.

9.12 The Forum considers the BCF to be a significant catalyst for change. As part of the process for accessing BCF funding, CCGs and local authorities will have to demonstrate that they are meeting a number of national conditions. These include seven day health and social care services to support patients being discharged and to prevent unnecessary admissions at weekends. The Forum therefore urges CCGs to work with local authorities to agree local plans for accessing the BCF, and to ensure these are aligned with their wider plans for delivering seven day services.

Action - stakeholder engagement

9.13 The Forum believes that publication of its initial findings should mark the start of a comprehensive engagement strategy on the move to seven day services in the NHS.

9.14 The use of formal levers and mechanisms alone will not secure the high quality care described by the Forum's clinical standards. NHS staff, clinicians, patients, the public, politicians, the media, commissioners, providers, regulators and all the other stakeholders in the health and care system will play important roles.

9.15 NHS England and NHS Improving Quality have developed a draft stakeholder engagement strategy to support the Forum's work. This will ensure that we clearly and consistently articulate the benefits of seven day services, listen to the views and experiences of others and form effective alliances to work through tricky issues together. The draft stakeholder engagement plan is included at *Appendix D* .

Action - further workforce and financial analysis

9.16 The Forum recommends that further research is undertaken to collate activity, workforce and costing data on weekdays and weekends. To avoid duplication of effort, this should be aligned as far as possible with the analysis needs of the Urgent and Emergency Care Review.

Action – how will we know what is changing?

9.17 Different types of organisations and teams have already succeeded in widening access to services across the seven day week. It is clear from case studies published by NHS Improving Quality[14] that organisations often follow a series of incremental steps as they reconfigure the five day offer. NHS Improving Quality has devised a model focusing on access which sets out four levels of service provision and can be used to explain and support local moves towards a wider offer of appropriate services at weekends.

9.18 NHS Improving Quality will commission an evaluation which captures the changes, experience and learning across organisations and teams among the 13 Early Adopters who are testing and developing new models of seven day services and care. The Forum believes that rapid dissemination of this learning should be a priority to encourage further action.

9.19 The Academy of Medical Royal Colleges, and Professor Julian Bion from the University of Birmingham will be undertaking an evaluation of the impact of high intensity specialist led acute care (HiSLAC). The research, due to begin in January 2014, will compare the quality of acute care in hospitals that have higher levels of specialist doctor presence at weekends with those that have lower levels, and develop a model to estimate the costs and health outcomes associated with increased intensity of specialist cover. The Forum welcomes the opportunity to

[14] NHS IQ *Seven Day Services – open seven days a week: every day counts.*

work together with this evaluation to further understand the benefits of seven day service provision.

Forum next steps - clinical standards

9.20 The Forum has been asked by NHS England to take forward further work to develop metrics for each of the clinical standards, to track both delivery of the standards and achievement of the intended benefits for patients. Details of the metrics will be made available on the NHS England website when this work is completed.

Forum next steps - whole system approach

9.21 Finally, the scope of the first stage of the Forum's work has been largely limited to services patients receive whilst inpatients in hospital. However, all of these patients begin their episode of care either in primary care or the emergency department before being admitted, and for a great many it continues in the community after being discharged. If patients and the public are to experience genuine seven day care from the NHS this work will need to be accompanied by similar improvements across primary, community and social care.

9.22 The recent announcement by the Prime Minister of funding to support the piloting of seven day working by GP practices, and the establishment of the Health and Social Care Better Care Fund provide valuable opportunities to improve system-wide access to services across the seven day week.

9.23 NHS England has asked members of the Forum to continue their review and to widen the scope of their work to include considering how the interface between organisations can be improved and streamlined to improve both patient safety and efficiency.

9.24 In order for the Forum to consider the interface between organisations, its membership will be expanded to include appropriate representation from local government and social care organisations.

9.25 NHS England has asked the Forum to report again in Autumn 2014.

Appendix A: NHS Services, Seven Days a Week Forum: terms of reference and membership

Introduction

1. The NHS Commissioning Board's vision for Seven Day Services is set out in *Everyone Counts: Planning for Patients 2013/14*, which flags the intention that the NHS will move to providing seven days a week access to routine services.

2. The National Medical Director has established the NHS Services, Seven Days a Week Forum to identify how there might be better access to routine services seven days a week and report in the autumn of 2013.

3. In this first stage, the review will focus on improving diagnostics and urgent and emergency care. It will include the consequences of the non-availability of clinical services across the seven day week and provide proposals for improvements to any shortcomings.

Definitions

For the purposes of this project "Urgent and Emergency Care" covers:

The management of urgent and emergency episodes of ill-health, including mental ill-health, through self-care, and in primary and community settings, and referrals to a community or hospital urgent or emergency care receiving facility, for stabilisation.

Once stabilised, the care and services provided from the time of the decision to admit as an in-patient, for treatment, investigation or further observation, to the patient's discharge or transfer to another care setting. These services include non-hospital services which facilitate the timely end of an urgent or emergency in-patient episode.

"Diagnostics" is defined as diagnostic services in support of urgent and emergency care, investigation, treatment and discharge or transfer.[15]

Membership

Dr Andrew Stein	Consultant in Acute and Renal Medicine , Clinical Commissioning Director (Secondary Care), Coventry and Rugby CCGs
Ann Macintyre	Director of Workforce, Guy's and St Thomas's NHSFT
Celia Ingham-Clark	National Clinical Director: Enhanced Recovery & Acute Surgery
Chris Hopson	Chief Executive, Foundation Trust Network
Chris Welsh	Director of Education and Quality, HEE
David Dalton	Chief Executive, Salford Royal NHS FT
Gavin Larner	Director, Department of Health
John Stewart	Director, Quality Framework, NHS England
Julian Hartley	Chief Executive, NHS Improving Quality
Professor Keith	Director Domain 3: Urgent and Emergency Review Lead

[15] *Implementing 7 Day working in imaging departments: Good Practice Guidance. A report from the National Imaging Clinical Advisory Group*

Willett	
Professor Mark Baker	NICE
Dr Mark Hackett	Chief Executive University Hospitals North Staffordshire NHS FT
Dr Mark Spencer	Senior GP Partner, Ealing CCG; MD Quality and Service Design, NHS England: London
Dr Mike Durkin	Director Domain 5: Director of Patient Safety
Pia Clinton-Tarestad	Head of Commissioning Policy & Resources; NHS England
Raj Bhamber	Director of Organisational Development & Communications, Medway NHS Foundation Trust
Sam Higginson	Director of Strategic Finance, NHS England
Simon Pleydell	Associate Director, NHS Confederation
Professor Sue Hill	Chief Scientific Officer, NHS England
Sue Jacques	Chief Executive, Co. Durham and Darlington NHS FT
Professor Terence Stephenson	Chair, Academy of Medical Royal Colleges
Tony Whitfield	Director of Finance, Deputy CE Salford NHS FT: President HFMA

Workstreams

The Forum established workstreams which were led by the Forum member indicated below:

- Clinical standards (Celia Ingham-Clark)
- Workforce and organisational development (Raj Bamber)
- Finance and costing (Tony Whitfield)
- Incentives, rewards and sanctions (Dr Mark Spencer)
- Service Models (Dr Mark Hackett)

NHS Services, Seven Days a Week Forum: Clinical Standards

No.	Standard	Adapted from source
	Patient Experience	
1	**Standard:** 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, seven 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 publicly in ward areas.	NICE (2012): Quality standard for patient experience in adult NHS services (QS15) RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*
	Time to first consultant review	
2	**Standard:** 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 of arrival at hospital. **Supporting information:** • All patients to have a National Early Warning Score (NEWS) established	NCEPOD (2007): *Emergency Admissions: A journey in the right direction?* RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* RCP (2012): *Delivering a 12-hour, 7-day*

No.	Standard	Adapted from source
	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 inpatient units.	*consultant presence on the acute medical unit*
	Multi-disciplinary Team (MDT) review	
3	**Standard:** All emergency inpatients 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.	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* NICE (2007): *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital*

No.	Standard	Adapted from source
	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.	
	Shift handovers	
4	**Standard:** 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 seven 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.	RCP (2011): *Acute care toolkit 1: Handover* RCP (2013): *Future Hospital Commission*
	Diagnostics	
5	**Standard:**	RCP (2007): *Acute medical care: The right*

No.	Standard	Adapted from source
	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 **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. • Seven-day consultant presence in the radiology department is envisaged. • Non-ionizing procedures may be undertaken by independent practitioners and not under consultant direction.	*person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* AOMRC (2012): *Seven day consultant present care* RCR (2009): *Standards for providing a 24-hour radiology diagnostic service* NICE (2008): *Metastatic spinal cord compression*
	Intervention / key services	
6	**Standard:** Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines,	NCEPOD (1997): *Who operates when?* NCEPOD (2007): *Emergency admissions: A journey in the right direction?*

No.	Standard	Adapted from source

	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. For example, this may include:
	  o Renal replacement therapy
	  o Urgent radiotherapy
	  o Thrombolysis
	  o PCI
	  o Cardiac pacing
		RCP (2007): *Acute medical care: The right person, in the right setting – first time*
		
		RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*
		British Society of Gastroenterology
		AoMRC (2008): *Managing urgent mental health needs in the acute trust*

	Mental health	
7	**Standard:** 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, seven days a week: • Within 1 hour for emergency* care needs • Within 14 hours for urgent** care needs	RCPsych PLAN (2011): *Quality Standards for Liaison Psychiatry Services*

No.	Standard	Adapted from source
	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, etc.) * 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.	
	On-going review	
8	**Standard:** All patients on the AMU, SAU, 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, seven 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,	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* AOMRC (2012): *Seven day consultant present care* RCP (2013): *Future Hospital Commission*

No.	Standard	Adapted from source
	information. • Inpatient 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. • Inpatients 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.	
	Transfer to community, primary and social care	
9	**Standard:** Support services, both in the hospital and in primary ,community and mental health settings must be available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily consultant-led	AOMRC (2012): *Seven day consultant present care*

No.	Standard	Adapted from source
	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 plan from hospital to primary, community and social care. • Transport services must be available to transfer, seven days a week. • There should be effective relationships between medical and other health and social care teams.	
	Quality improvement	
10	**Standard:** 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, seven 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 the delivery of seven day services supports training that is consistent with General Medical Council and Health Education England recommendations and that trainees learn how	GMC (2010): Generic standards for specialty including GP training

No.	Standard	Adapted from source
	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.	

Appendix C : NHSIQ Seven Day Services, Early Adopters

NHS Services, Seven Days a Week

NHSIQ Seven Day Services, Early Adopters

Name of Organisation	Selection panel Comments
South East Essex and Social Care	Enthusiastic and committed to integrated team approach.
Wrightington, Wigan and Leigh NHS Foundation Trust	Strong potential to provide lessons to others from finance.
Medway Foundation Trusts, and NHS Medway CCG	Engaging and honest, know they have a lot to do and good grasp of the issues.
North East Lincolnshire Out of Hospital Providers	Interesting community focus, social enterprise and integrated commissioning.
NHS Chorley, South Ribble and Greater Preston CCGs	Impressive knowledge and understanding of their services and issues and good integration of partnerships and planning.
Dorset County Hospital NHS Foundation Trust	Understanding of the rural community and issues, clearly committed and good local partnerships.
Dudley CCG and Health & Wellbeing Board	Good strategic perspective and also bold.
County Durham and Darlington Local Health Economy	Good patient and carer focus and some interesting and ambitious aspects
Birmingham Collaborative	Impressive frontline detail backing up over-arching objectives, good knowledge and interesting integration plans.
Chesterfield Royal Hospital NHS Foundation Trust	Winning the hearts and minds of consultant physicians to change. Strong links with other providers, Urgent Care Village model opportunity to share the learning wider
James Paget Foundation Trust and Great Yarmouth and Waveney CCG	Strong patient involvement, very clear vision, strategy and engagement, single organisations, single system approach and valuable new learning
Sheffield Health and Social Care NHS Foundation Trust	Right first time partnership programme, driven by quality not cash. City wide approach.
North West London CCG Collaborative	CCG Collaborative approach, alignment to Shaping Healthier Future and tackling the whole system.

Appendix D: NHS Services, Seven Days a Week Stakeholder Engagement Strategy

NHS Services, Seven Days a Week

Stakeholder Engagement Strategy

Introduction

NHS Improving Quality will support the adoption of seven day services by means of 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.

The Seven Day Services Improvement Programme (SDSIP) will support delivery by 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 seven day services for whole system change.

These priorities will be underpinned by capability building, rapid knowledge transfer and practical support for commissioners and providers.

In order to ensure that seven day services are prioritised and the Forum's clinical standards are adopted, highly effective engagement across multiple stakeholder groups will be required. Previous large-scale change programmes in the NHS have shown the value of significant, on-going stakeholder participation. The use of formal levers and mechanisms alone will not ensure the achievement of the high quality care described by the Forum's clinical standards. NHS staff, clinicians, patients, the public, politicians, the media, commissioners, providers, regulators and all of the other stakeholders in the health and care system will play an important role.

Effectively capturing a broad range of views and experiences at a local and national level will enable the promotion of solutions and removal of barriers to change. An inclusive engagement process will also facilitate a collective agreement of the issues and the co-design of solutions, in line with NHS England's *Call to Action.*

This document outlines the seven day services engagement strategy that commenced in November 2013. The strategy has two overarching aims, which apply to both the local and national context:

- To ensure that the views and experiences of as many relevant stakeholder groups as possible are shared and shape the agenda
- To ensure that support for the seven day services offer - as defined by the NHS Services, Seven Days a Week Forum's clinical standards - is mobilised.

NHS Improving Quality's SDSIP, with its national coordination role and regional focus is an ideal vehicle for much of the engagement work required. NHS Improving

Quality teams will be 'on the ground' working alongside providers and communities in their day to day work – engagement with those communities will be routine and high impact. This work will link to NHS England's regional and local structures and networks.

The focus of this strategy is the engagement of patients, carers and the public as well as clinicians, providers and commissioners. In addition, there are a number of national organisations with whom strong engagement and partnership work is essential, due to their topic expertise and influence in the system.

This strategy is the start of a roadmap of engagement which will undoubtedly evolve. A detailed engagement plan to support the principals outlined in this strategy has also been formulated.

Ultimately, we anticipate the most powerful and sustainable engagement work will be done not by NHS England or NHS Improving Quality, but by a growing cohort of people and organisations who are convinced that equal access to care seven days a week is the only way forward.

Stakeholder analysis

The following table depicts the initial stakeholder analysis and will form the basis of our engagement plan. Asterisks denote engagement that will be carried out at a local area level by NHS Improving Quality's SDSIP team and NHS England's regional and local area teams. This local engagement will both reflect and feed into the national programme, overseen by NHS England and NHS Improving Quality (SDSIP).

Engagement approach	Stakeholders

Partnership	• NHS Improving Quality SDSIP*
	• NHS England
	    o National clinical directors
	    o Nursing directorate
	    o Chief professional officers
	    o All national directorates
	    o Regional and local area teams*
	    o Specialised & direct commissioning
	• NHS Services, Seven Days a Week Forum
	• National Patient/Public/Carer Steering Group

Participation	• Healthwatch* • SDSIP Early Adopters* • NHS Employers • NHS Confederation • CQC • Monitor • National Trust Development Agency • Foundation Trust Network • HFMA • NICE • Health Education England

	• Health & Social Care Information Centre

Consultation	• Providers*
	  o Acute Trusts
	  o Mental Health Trusts
	  o Health & Care Trusts
	  o Ambulance Trusts
	  o Community Providers
	  o GP & Out of Hours Providers
	  o Voluntary sector
	• NHS staff
	• Patients & public
	• Academy of Medical Royal Colleges, Specialist Royal Colleges and their patient groups
	• BMA
	• Clinical networks
	• Clinical senates
	• Academic Health Science Networks
	• Revalidation networks
	• Local Education Training Boards*
	• Deaneries
	• Specialty / area based networks*
	• Quality Surveillance Groups*
	• Clinical Commissioning Groups*
	• Commissioning Support Units*
	• Commissioning Assembly
	• Regional Commissioning Councils*
	• Public Health England
	• Local Authorities*
	• Health & Wellbeing Boards*
	• Regional Government Health Boards*
	• Local Government Association
	• Industry & commerce

Targeted communications	• Government ministers • Internal stakeholders • Interested parties that raise issues/queries • All stakeholders identified in the 'consultation' category above
General communications	• General public • Press/broadcast/television/social media professionals

Engagement in action

NHS Improving Quality's dedicated seven day services improvement team will consist of regional resource and a central support function. Regional teams will ensure that organisations, early adopter sites and communities of best practice

across the country are well supported with a range of practical, specialist inputs. This will encompass local engagement with key players, such as CCGs, Health & Wellbeing Boards, social care providers, primary care and a range of other key local change agents. The regional team members will regularly meet to share knowledge and best practice.

Seven day services champions in NHS England's regional and area teams will maintain knowledge and awareness of the local developments, helping to link stakeholders through existing forums, e.g. clinical senates, reference groups and CSUs.

The national support functions will have a strategic focus, engaging with the major national partners (see *Key national stakeholders*, page 12). NHS England and NHS Improving Quality have established strong working relationships, with robust processes for decision making, delegation of tasks and information sharing. This will be used to ensure smooth delivery of strategic engagement activity.

They will ensure that seven day services remains on the national agenda via attendance at high profile events / conferences, media engagement, ministerial engagement and appropriate linkage against national initiatives, such as the Urgent & Emergency Care Review. They will ensure that the information received from the regions flows outwards, disseminating the learning from regional teams to the rest of the country across multiple channels. The central support teams will work closely alongside the NHS Services, Seven Days a Week Forum, providing programme oversight and ensuring consistency of approach.

On 16th November 2013, NHS Improving Quality hosted a high profile national event, with keynote speeches from David Nicholson, Chief Executive of NHS England and Professor Sir Bruce Keogh, National Medical Director. The event, held on a Saturday (in the spirit of seven days) marked the start of the SDSIP and was a final listening opportunity for Sir Bruce as he finalised his report . The event brought together key stakeholders from the following invited groups:

- Acute providers (Chief Executives & Directors of Nursing)
- Local area team
- Regional area teams
- CSUs
- Royal colleges
- Health & Wellbeing Boards
- Clinical networks
- CCGs (Clinical Leads & accountable officers)
- Representatives of patients, carers & public

This important event was the first of a number of significant engagement exercises. This diverse list of invitees reflects the fact that the achievement of seven day services will require the removal of boundaries – functional, professional and geographical.

In 2014, a series of four regional conversation events will take place to bring together commissioners, clinicians, patients, carers and the public to raise awareness, learn from each other and develop a rich picture of issues and considerations.

Principles for engagement

- Openness and transparency to build trust and confidence in the 7DS improvement programme;
- Commitment to active, relevant and proportionate engagement;
- Learning, sharing and providing feedback;
- Listening to views and taking these into consideration in shaping and redesign of services;
- Acknowledging that responsibility must be shared – patients, professionals and the public are partners in making high quality care, seven days a week a reality.

Framework for sharing knowledge and information

NHS Improving Quality will support communities of practice to ensure that organisations are brought together in learning and networking forums that support transformation. The framework for knowledge share will include:

- **Comparison:** How does the information and the learning gathered from individual sites/areas on seven day services compare with others?
- **Consequences:** Are there any positive or negative implications arising from the information gathered? What are the consequences for broader decision making?
- **Connections**: How does the information and knowledge gathered relate to other stakeholders such as clinicians and other NHS staff, other providers, commissioners, patients, carers, public etc. and how can it best be shared?
- **Conversations:** Not only sharing information, but gaining the feedback of others based on their experiences and facilitating linkage between individuals and groups.

A range of knowledge sharing and knowledge-creating activities and tools will be used as an investment in learning to support the wider engagement, spread and adoption of seven day service models.

Articulating the benefits

Recent engagement, particularly with patients and the public, indicates that the messaging around the benefits of implementing seven day services is not articulated clearly enough. Feedback received has been that the debate around providing equal access to care, seven days a week too often results in a polarised debate around centralisation v. localism or reasons for and against consultants and GPs working out of hours. Instead, the focus needs to be on appropriate **integration** of services and local solutions. This will mean promoting a new way of thinking that is less about beds and buildings and more about right care, right time, right person. Feedback at the NHS England AGM from patients and clinicians suggested

that this was the only way to improve outcomes and patient experience, by looking at their entire treatment/care journey.

Central to our engagement plan is the intention to articulate the debate around seven day services in such a way that promotes the concept of integration as a way of driving improvement. This is so important, as we know that the areas in England that are successfully adopting seven day provision are often the areas with a multi-agency approach. Key structures and initiatives such as Health and Wellbeing Boards, Integration Pioneers and the Better Care Fund are ensuring that one of the key enablers for seven day services remains high on the agenda.

Key objectives

- To communicate and publish timely and relevant information about 7DS to ensure stakeholders are aware of and kept informed about current thinking;
- To capture views, insight and ideas about 7DS to ensure that the improvement programme is informed by and reflects the needs, beliefs and aspirations of stakeholders;
- To actively invite comments, ideas and experiences from stakeholders, including those who may be considered ‘hard to reach’ to shape the agenda;
- To identify and maintain strong relationships with 7DS champions, including early adopters, encouraging them to promote and support the improvement programme and 7DS transformation agenda;
- To work closely with partners and networks to maximise the opportunity for collaboration to build momentum, spread and stimulate the development of a social movement.

Patient, carer and public engagement

There is a clear need for meaningful engagement with patients, the public and carers to help us to develop patient focused solutions and understand how people really feel about their NHS.

Participants have expressed a strong desire to be involved in the shaping the next phase of the NHS Services, Seven Days a Week programme. They have told us that this should include frank discussions about the issues involved and a fully transparent approach. Public and patients want to be involved in the tricky issues and understand the opportunities and challenges.

NHS Improving Quality will work with NHS England to test out ideas to best involve patients and the public, such as a dedicated patient, public and carer steering group at a national level. This engagement will be carried out in collaboration with Healthwatch nationally and locally. It will reach out to individuals and patients’ networks, such as National Voices and condition focused patient forums.t

Central to our strategy is our intention to proactively involve young people in decision making. Young people have a unique perspective on the world, which can bring new ideas and innovation to some of the complex challenges we face. It is the right of young people to have a say in the future of the NHS they will inherit.

Targeted engagement will be undertaken through outreach activity, aimed at gaining the views of specific groups within their own communities. This will enable greater insight and perspective to be obtained, particularly from groups known to have health inequalities, and will enable the voice of patients, public and carers from 'hard to reach' communities to be heard in the discussions affecting future service delivery.

Clinical engagement

Experience has shown the value of clinical engagement across all professional groups, including GPs, hospital doctors, nurses and allied health professionals. In order for the seven day services clinical standards to be adopted, the benefits for organisations, practitioners and patients must be clear.

A good example is the London Quality Standards. A clear articulation of the evidence base and extensive clinical engagement led to the standards being endorsed by the local Clinical Senate and CCGs with a collective agreement to commission them.

It is important to open up a broad collective dialogue and gain insight from all clinical professions. The process will be a mixture of direct engagement with professionals and initiatives with their representative bodies. It will also take into account the nuances of clinical structures and representation. For example, we must ensure we communicate with GPs directly as opposed to relying on a CCG perspective alone. We must consult with specialist colleges as well as the Academy of Medical Royal Colleges. We must understand the nursing, therapy and other professionals as well as the medical perspective.

Forums for clinical engagement	• National clinical directors, chief professional officers & nursing directorate • Academy of Medical Royal Colleges, Specialist Royal Colleges • BMA • Clinical networks • Clinical senates • Academic Health Science Networks • Revalidation networks • Quality Surveillance Groups
Messages	• Impact on patients / outcomes – including reduced mortality, patient experience • Case studies of seven day services in practice – how others have done it • Workforce benefits – removal of Monday backlog, childcare flexibility, intelligent rostering
Sample Methods	• NHS England clinical leadership structures, including specialised commissioning and CRGs • Engaging via Foundation Trust Network and Trust Development Agency meetings and events • Clinical case studies • Website & blogs i.e. IQ, NHS England, early adopter

	sites • Presence at key clinical events i.e. Acute General Medicine, Best Practice (NAPC) • Articles in peer review journals, newsletters and trade press • Focused NHS IQ event to share and promote early adopter work • Local/regional events - listening exercises and coproduction • Targeted social media with clinical groups, e.g. nurses, doctors • Online knowledge hub and collaboration platform • Engage and collaborate with partner organisations e.g. professional bodies

Provider engagement

As part of the SDSIP, NHS Improving Quality have invited expressions of interest from across the health and social care system to become seven day services 'early adopters'. Submissions from local partnership of providers, commissioners and local authorities were welcomed – in recognition of the importance of integration as a key enabler. The response has been very positive.

The successful organisations, announced on 16th November 2013, will be at the frontline of stakeholder engagement with us – sharing knowledge and learning and helping other providers, commissioners and communities to understand the benefits. NHS improving Quality will also maintain contact with all unsuccessful applicants, as an important cohort for future dialogue.

An annual event will be staged to showcase the work of the SDSIP early adopters, highlighting progress made in areas such as finance, workforce and organisational development and implementation of the clinical standards.

A high proportion of NHS Improving Quality's activity will be carried out with the early adopters, constituting intensive 'provider' engagement work. They will each receive a bespoke package of support, developed from a baseline assessment of where they currently stand in relation to the delivery of services seven days a week. Support offered by NHS Improving Quality's change and transformation experts will include such aspects as developing a business case for 7 day services, engaging with commissioners for support, understanding workforce implications, engaging with community partners, gaining support for and implementing the clinical standards, selecting high impact interventions and measuring success. This support will also include working with patients and carers within the provider organisations.

Local areas will be supported to engage effectively, through activity which may include:

- Working with early adopter sites on planned local events

- Providing a communications and engagement strategy template for local areas to adapt and use
- Press release templates and draft articles on key milestones for local tailoring
- Posters and leaflets explaining to patients and the public the work the site is involved in and why it is important
- Regular updates on emerging issues, evidence and priorities.

The work carried out with the early adopters will provide ample material to communicate to other providers across the country, via a range of channels.

Commissioner engagement

Clinical commissioners must understand the reasons for configuring services around a seven day service model. They must also be supported on engaging with member GPs on the issue. We are already seeing positive signs of this through our work – with a high proportion of bids for NHS Improving Quality's early adopter programme being co-signed by CCGs who already have seven day services as a priority and an enabler in their drive for integrated local services.

Engagement must be convenient – e.g. through existing channels such as the quarterly cluster meetings. The NHS England local teams will also be an effective channel based on their existing remit. It will be the role of the SDSIP team to monitor and support CCG involvement. CCGs will also be a key focus in our communications strategy, ensuring they get pertinent information for example via the NHS England CCG bulletin and that we stay updated on their agenda – e.g. following blogs from the CCG community.

The NHS Commissioning Assembly is the community of leaders for NHS commissioning, the 'one team' that will deliver better outcomes for patients. It is set up to create shared leadership nationally and locally and co-produce national strategy and direction. It comprises of the clinical leaders from all CCGs and NHS England and therefore will be a powerful forum for promoting the values of seven day services.

It is important that the regional SDSIP teams engage with Commissioning Support Units. They provide bespoke, targeted support to commissioners to help them to deliver key priorities and it is likely that they will be invested in projects that directly or indirectly facilitate seven day services.

The central support team of NHS England will lead the engagement with commissioning development colleagues who are responsible for setting the direction of specialised services, primary care and offender health, in order to maximise on opportunities for seven day service provision.

Key national stakeholders: case studies

As well as engagement with providers, commissioners, patient and public and clinicians, it is imperative that we work in partnership with some key national organisations that will assist that the spread of seven day services is at scale and

pace. There are many organisations that fall into this category – however, we highlight a few key examples here:

Health Education England is responsible for the education, training and personal development of every member of staff, and recruiting for values. HEE and its Local Education Training Boards have the flexibility to invest in education and training to support innovation and the development of the wider health system. They ensure that training funding follows students/trainees on the basis of quality. If seven day services are to take hold in the system, LETBs will be instrumental in ensuring the system responds to evidence based, clinically accepted recommendations.

NICE develop clinical guidelines, quality standards and elements of the CCG Outcome Indicator Set (CCG OIS). In addition, NICE have an accreditation programme for external guidance which assesses the processes used in development. As the NHS Services, Seven Days a Week Forum's clinical standards are based on a robust evidence base, there may be a potential for NICE to accredit the standards. This could facilitate the development of a Quality Standard for seven day services, which in turn will increase the likelihood of the inclusion of seven day services related quality measures in the CCG OIS.

NHS Employers is the voice of employers in the NHS, supporting them to put patients first and negotiating fairly to get the best deal for patients. Seven day services will require reorganisation and development of the workforce and our engagement of NHS Employers will ensure we are tapping in to their expertise and experience in relation to pay and contracts, recruitment and retention, employment policy, employee wellbeing and shared learning