London Clinical Senate

Clinical Senate Forum

Delivering seven day services

Summary report

7 July 2016 at The King's Fund, London.

Delivering seven day services

Ensuring patients receive consistent, high standards of care, seven days a week, is a priority for the NHS. Early work towards this goal and baseline surveys of hospital services have highlighted the scale and complexities of the task. It involves making some far reaching changes in the way care is delivered across the health and care system, including hospital care, general practice and community based services including urgent care, local authority and mental health services.

The Seven Days a Week Forum, chaired by Professor Sir Bruce Keogh, developed 10 clinical standards which describe the minimum level of service that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

The seven day services initiative focuses on three elements:

- Provision of access to pre-bookable appointments to GP services in the evenings and at weekends on both Saturdays and Sunday.
- Urgent care; access to healthcare advice 24/7 via NHS 111.
- High quality hospital care that will provide 100% of the population with access to the same level of consultant assessment and review, diagnostic tests and consultant-led interventions every day of the week by 2020.

For hospital services, the Government's Mandate to NHS England for 2016/17 sets a priority deliverable that NHS England will work with others to:

'Rollout 4 priority clinical standards in all relevant specialties to 25% of the population in 2016/17; by 2020 roll out 7 day hospital services to 100% of the population (with progress also made on the other six standards identified by the NHS Services, Seven Days a Week Forum), so that patients receive the same standards of care in hospitals, seven days a week.'

The Clinical Senate felt this is an important topic to debate. As clinicians working across the health and care system, we will be expected to deliver patient focused, effective and sustainable 7 day services and therefore have a key role in how we develop our services in order to do so, tackling challenges in current ways of working across our health and care systems, especially where patients' pathways cross different care settings, to improve the outcomes and experiences that Londoners have.

The London Quality Standards, endorsed by the Clinical Senate in 2013, represent the minimum quality of care that patients attending an emergency department or who are admitted as an emergency should expect to receive in every acute hospital in London, at whatever time of day or day of the week they attend, and have informed both the national work and London approaches to 7 day services.

The early focus on seven day services programme across London has been through the '*North West London Early Implementers'* and the approach being taken to deliver 4 priority clinical standards, ensuring patients admitted to hospital in an emergency will receive the same quality of assessment, diagnosis, treatment and review on any day of the week.

This meeting aimed to set the scene for wider development of 7 day services across London, understanding the size of the task ahead, listening to what is important to patients, carers and clinicians and discussing key issues with those already involved and those soon to be involved in the 7 day services programme rollout. It provided an important opportunity to consider how we can collectively deliver improvements in 7 day services for Londoners. During this half-day meeting we heard:

- From **patients** who **shared their experiences of healthcare services throughout the week**, the challenges they have faced and what made, or would have made, a positive difference in their experiences, demonstrating the importance and value of involving patients and the public in developing 7 day services.

- How **networks for urgent and emergency care services** are contributing to delivery of the 7 days services, including work taking place to **significantly improve care for people experiencing mental health crisis**, involving development of centres of excellence and a culture of treating mental health crisis with the same urgency as physical health to achieve parity of esteem, 7 days a week.

- How **technology** is being used to support a system wider approach to integrated urgent care through development of innovative cloud-based technology designed to improve patients' experience, **supporting patients to receive personalised care and advice**, by enabling sharing of patient data with clinicians in across local health economies.

- How clinical teams from the ***North West London Early Implementers*** are implementing the four priority standards, responding to some of the challenges identified, and achieving a greater impact by **taking a sector wide approach.** This is driven by strong clinical leadership, drawing on innovation and involving system partners, trusts, GPs and local authorities, to develop solutions such as (i) **improving discharge** from hospital across all boroughs), (ii) improving access to **radiology services at weekends** and (iii) **engaging clinicians** using Clinical Implementation Groups.

- About national work to develop **outcome measures** for seven day services, noting some of the challenges of measuring achievement against the 10 national standards, methods being used to understand how the system was progressing towards the standards and findings from the most recent survey.

Informed by a series of presentations and some plenary debate, we considered how these approaches could be developed for wider rollout across London, in particular:

1. What do we need to focus on to deliver 7 day services as a whole system
2. How can metrics currently in development be enhanced to provide measures meaningful to patients and providers?

This report shares the key points from the Forum's discussions. We would like to extend our thanks to everyone who contributed.

Further information

I. The programme and presentation slides from the Forum are available on the Clinical Senate website.
II. This is a link to a useful synopsis of the evidence base for the weekend effect and efficacy of 7 day services which was referred to during the meeting
III. The following links provide useful sources of information and support for 7DS related work carried out in London
    a. Healthier North West London 7DS early adopter webpage https://www.healthiernorthwestlondon.nhs.uk/bettercare/sevendayservice

b. Healthy London Partnership urgent and emergency care 7DS programme https://www.myhealth.london.nhs.uk/healthy-london/urgent-emergency
c. NHS England, Urgent and Emergency Care Programme summary https://www.england.nhs.uk/london/2015/11/17/uec-coordinated-consistent/
d. NHS England, NHS Improving Quality archived webpage of 7DS quality improvement resources, including baseline standard survey information http://www.nhsiq.nhs.uk/improvement-programmes/acute-care/seven-day-services/seven-day-service-self-assessment-tool/march-2016-survey.aspx
e. NHS Improvement 7DS programme background summary and resources https://improvement.nhs.uk/resources/how-seven-day-services-can-benefit-patients/
f. NHS England 7DS webpage and resources https://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/

Views from the Forum's discussions

What do we need to focus on to deliver 7 day services as a whole system?

Participants discussed this question in groups. Group were asked to record key points from the discussions that they felt important to feedback. These are summarised below, arranged under common themes. They are not presented in any order of priority.

There needs to be a partnership approach and strong leadership

- The provision of high quality 7 day services which meets the standards set by the NHS needs a multi-professional and partnership approach including social care. This is not just an NHS issue. Sustainability and transformation plans (STPs) were seen as a key vehicle for this.
- Patients and the public want to hear about how the whole system links together – Urgent & Emergency Care, Mental Health, Primary Care, Social Care, and Community Services. There is a perception that secondary care seems to be leading the initiative, rather than primary care, community or social care teams; whereas the approach needs to involve the whole system.
- Patients need to know what they can expect and a set of publically available measures with metrics will facilitate this and be even stronger of patients and carers are involved in their development. Involving patients and the public will strengthen plans in several ways:
    - Patients and carers have powerful stories from their experiences of care during the week and at weekends which can be more convincing of the need to change
    - Involvement in the design of services (co-design) helps ensure appropriateness
    - A system will be designed in a way that people understand and are willing to access
- There needs to be a change of attitude at all levels of provision so that 7 day services is seen as the norm where required and appropriate; this should enable a whole system approach that encompasses all local partner's e.g. the role of pharmacies was a specific example highlighted
- Plans to develop seven day services should be built around whole system care pathways rather than beds (inpatient stays); learn from what has worked already (we need ways of sharing good practice) and make sure goals are clear; there needs to be a strong group of clinical leaders who will drive change and be prepared to take difficult decisions to overcome barriers; innovation should be encouraged; risk (with mitigation) should be accepted; it should be acknowledge that there may be no perfect solution and mistakes will be made along the way so we need to allow for experimentation and also for failure of some schemes
- There is value in focusing where different points in the system interact e.g. the interface between general practice and hospitals/urgent and emergency care services, models that are/could be put in place e.g. primary care hubs out of hours v. extended hours at all practices and evaluating the impact of change at these interfaces e.g. on flows to emergency departments
- Sector networking solutions were highlighted for diagnostics i.e. radiology, enabling consultant radiology cover at weekends and quality of reporting
- Where relevant, new developments should encompass 7 day services from the outset and not simply flag this as an aspiration to be addressed at a later stage.

Communication needs to improve

- More clarity is needed about what 7 day services actually means i.e. that it relates to urgent and emergency care, not elective care. It would be helpful to communicate specific examples to demonstrate how any changes introduced to achieve 7 day services benefit patients, carers and families. This is an important point for communication as the initiative is rolled out across London

- Local communities need better, clearer and consistent information to help them understand what services are available/offered locally and how to access them to reduce the extent to which emergency departments are the default point of access e.g. if people are directed (supportively) into primary care they are more likely to use it again; health and care staff also need to be kept informed so they can advise local people
- Communication and protocols should be developed across teams and organisations within a local health economy to signpost people appropriately to different parts of the system rather than encouraging attendance at A&E. Some participants identified the breadth of community teams and a lack of understanding about respective roles - what is different about them? who knows about them? e.g. consultant-led community /outreach services for admission avoidance.
- Our health and care systems are complex and are often perceived to be designed more for people who work in them rather than service users; the language we use – e.g. often using different terms for the same services or describing a service in a way that is not clear to people who use services e.g. GP surgery v primary care hub
- Professionals do not always talk in a coordinated way about the overall health and care system which reduces patients' confidence in parts of the system.

Improve information transfer and sharing, system integration and make better use of technology

- Ensuring information to support patient care transfers smoothly across the system at the time required is essential. Lack of availability of information often causes a delay in patients progressing along a pathways and impacts on care continuity. Information transfer must be improved to facilitate 7 day services and give confidence in changes made
- Patients do not want to be treated as strangers at each point of contact; timely information capture and transfer along the pathway would address this
- Electronic data transfer and shared access to information across the system were identified as key enablers for more responsive, personalised care through access to current clinical information. Key issues discussed were:
    - The need for the LAS to have electronic rather than paper based records, which would require investment, to enable interactions with individual patients to be joined up and support individualised care; it was noted that this is incorporated within the interoperability work underway (as presented)
    - Learning about integration of information from examples such as *Coordinate my Care*, work being done within STPs and vanguards (again mechanisms for sharing are needed)
    - In relation to interoperability, problems with linking different systems were recognised; we need to work with what already exists and where developments take place partners should give a commitment at the outset to implement what is developed.
- Telemedicine should be developed and there should be investment in community diagnostics – it was suggested that establishing what already exists and how effectively this works, would be useful and helpful to share.

Workforce

- Arrangements/rotas that span organisations enable staff resources and skills to be shared and can be more efficient where workload is variable/less predictable; sustaining 7 day rotas at every site may not be achievable. Consistency in policies and protocols is important to facilitate this. There was a lot of interest in the solutions being developed in NWL (area radiographer and sonographer bank). Rotas need to be seen as fair to staff and there should be equal access to development opportunities (including training and experience)
- In the absence of additional funding, resource needs to be shared. Rotations across a larger geography can also offer better training opportunities; sectors (which match the sustainability and transformation plan footprints) seemed to be considered a good footprint for developing solutions.

- Several suggestions were made about utilising and developing skills, for example:
    - Enhancing the contribution of pharmacists through broader access and increasing linkage within the overall system
    - We need a clearer idea of what MDT needs to exist especially in primary care; the need for an MDT approach in urgent and emergency care services was also raised
    - There is a skills gap (training and development) in mental health and physiotherapy
    - Deploying paramedics in GP practices and urgent care centres
    - There is a need for more generalists
- Education and training must include patients and carers as well a staff, particularly to support self-care and increasing knowledge and confidence to manage or seek support when a condition deteriorates or in a crisis so that emergency departments are not seen as the default
- Practical enablers need to be considered for example, incentives to work at weekends, opportunities linked to career pathways, availability of crèche facilities at weekends
- Some suggestions were made for developing specific roles to better match needs and resources across seven days e.g. expanding advance practice roles; exploring the potential contribution of practitioner assistants; retraining staff in existing roles to address resource gaps (a general point, specific examples were not identified); maximising skills and minimising overlap between different staff e.g. it was noted that practitioner assistant roles overlap with nursing roles.
- A general point was made about improving career pathways and training programmes to ensure they are relevant and fit for purpose, to facilitate staff development, flexibility and retention in a changing environment.

Learn from previous experience in London where change has been successfully introduced

- Models of care introduced in London for heart attack, stroke, trauma and vascular services, consolidating expertise, have led to improved outcomes and consistent, high quality services 24/7. There remain a number of other services/ conditions that would benefit from a similar clinically led approach to develop a model of care, define desired outcomes, agree core standards, and then commission services to meet these. Suggested areas are gastrointestinal bleeds; frailty; mental health. It was noted that some work is underway e.g. a Health Based Place of Safety specification and a section 136 care pathway for London which are being developed by the London Urgent and Emergency Care programme within the Healthy London Partnership, however work on other areas was advocated.
- More broadly, we should identify and build on good practice e.g. consider what we already have that is working well and how these teams could be developed so that we are not creating something new, but building upon existing expertise/workforce.

Mental health

- There was a very strong view from the Forum about the need for a general increase in availability of mental health expertise to achieve a comprehensive 7 day service which enables crises to be managed as early as possible. Work currently underway was acknowledged (see above). A model involving a single point of access and rapid response by a home treatment team available seven days a week was highlighted as a good example. There was a call for the S136 work to progress and report as quickly as possible.
- Specific issues that need to be addressed were highlighted:
    - Better systems to access/communicate information about bed availability
    - A better understanding of capacity
    - More awareness of (communicating) available services for appropriate psychiatric input
    - Use of service specifications to set standards and guide change/development
    - Capacity of consultant psychiatrists (for urgent and crisis care) and whether this is spread too thinly in current service model

How can metrics currently in development be enhanced to provide measures meaningful to patients and providers?

Metrics being use nationally currently, many acknowledged to be about process, are:

- Length of stay by day of week of admission
- Readmissions by day of discharge (helps monitor the risk of patients being discharged too early especially at weekends)
- Weekend v weekday mortality (noted to work well as a national statistic, more caution to be applied at trust, particularly speciality, level)
- GMC trainee survey
- Serious incidents by day of week are being explored as an indicator
- Seeking ideas for better ways of capturing patient experience, especially at weekends – it is recognised that the national inpatient survey is not robust enough

Participants were again asked discussed this question in groups and record key points, which ae summarised below, arranged under common themes. They are not presented in any order of priority.

General points

- The purpose of using any measure needs to be clear and a balance needs to be struck e.g. is the aim to measure patient-centred outcomes (quality of care), process driven outcome metrics i.e. LOS, readmissions, mortality etc., progress against national standards.
- There needs to be greater emphasis on improving coding and joining up clinical information gathering across pathways.
- Patients look at the whole system more than the NHS does and it is valuable to involve patient and the public in this work at all levels of the system. Organisations/programmes should engage their local patient groups.
- The overall process of capturing, reporting and using data needs to be more robust. Three main elements were suggestion once metrics are defined:
    1. Collection
    2. Effective analysis
    3. A systematic feedback loop (to service users/the public, providers and commissioners)
- The overall process needs to measure system wide experience as well as encompass measures relating to individualised care to help clinicians and commissioners identify what is working well and having a positive impact and to identify gaps and develop improvement plans.
- The overall burden and duplication of capturing, recording and reporting metrics should be minimised; several related points were made:
    - Capability in understanding data and how to use it (value and limitations) needs to be improved
    - A substantial amount of data is already collected and reported across the health and care system e.g. (not exhaustive) through the Health & Social Care Information Centre (HSCIC); Intensive Care National Audit & Research Centre (ICNARC); National HIP Fracture Data Base (NHFD); Trauma Audit & Research Network (TARN) /SitReps.
    - Metrics should start with what we have (though should only be selected if value in collection and reporting can be demonstrated) and awareness of what data sets are already available probably needs to be increased; suggestions for new metrics need to consider any added burden against potential value derived.
    - Measures relating to digital aspects of care should be considered and included.
    - There needs to be consistency in terminology used for metrics e.g. definition of a clinical decision maker (?consultant)

    - The recent 7 day services self-assessment exercise was reported to require significant resources to complete and whilst the Forum was briefed about changes proposed in the next survey (in response to feedback from clinicians/trusts) concerns remained.
    - Consideration should be given to measuring fewer standards instead of adding more
    - Information requests should be coordinated better across the system to reduce burden
- Thought should be given to how CCGs/specialised commissioning data sets could be considered together (for example to get a broader pathway view from selected standards);

Suggestions about where specific outcome measures could focus

- This work presents an **opportunity to consider patient experience metrics in a more meaningful way** that is individualised to the patient.
- **Patients need to know what they can expect** first in order to be able to make a decision as to whether they receive a good service at the weekend or not. 999/111 expectations are set on the telephone call. Patient reports of their experience might include: *Who did I see*? *How did they help me*? *Could I get home when I wanted*? Questions suggested included "*were you confident you were being looked after well*?" "*Did you get consistent messages around what your plan of care was going to be*?"
- Empirical evidence can be difficult at national level/comparable data – could 7 day services patient experience metrics consider how LOS **impacts on activities of daily living/long-term outcomes**? Clinically do patients get back to the same functional measure prior to admission?
- Trauma and orthopaedics currently measure **functional outcome metrics** i.e. Oxford hip/knee scores based on patient reported outcome measures. One group wondered if this could this be related to acute/medical services
- Measures relating to early warning signs of **deterioration**, to mitigate the risk of late detection of deterioration at weekends
- **Disease specific** metrics (examples not provided though availability of existing data through stroke, cardiac, major trauma networks was highlighted by one group)
- There was **support for the concept of never event metrics** (reiterating the Forum's support for the idea when initially discussed in July 2015)
- Development of **self-management strategies** –information/signposting
- Several areas where measures could be used to **show whether variation has reduced between weekdays and weekends** were suggested:
    - Medically fit patients remaining as inpatients
    - Delayed transfers of care (DTOC)
    - Criteria led discharge - measures aligned to criteria, suggestions included functional measures that follow a patient into primary or community care; patient held metrics; were services available on discharge as expected?
    - Care homes refusing Saturday/Sunday transfers
    - GP access to support patients over the weekend
    - Analysis of prescribing data - data for clinical action team decisions weekday v weekend
    - Availability of equipment
    - Ease of navigating the system to get the help required
- The creation of **outcome-based care plans** offers an opportunity to aggregate individuals' and services' needs and use that to design and develop services from a patient centred perspective.