Delivering the new Government’s health agenda

Sarb Basi, Dr Penny Dash, Professor Steve Field CBE, Andy Goldney, Rt Hon Jeremy Hunt MP, Claire Murdoch, Dr Chris Roseveare, Dr David Rosser, Chris Walters, Dr Justin Whatling, Ian Williamson, Baroness Barbara Young

Chartered Accountants’ Hall
Moorgate Place
London
EC2R 6EA

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12.00 – 17.00

@reformthinktank
#reformhealth
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## Programme

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| 12.30 – 13.30 | Panel session on “Out of hospital care”                                | Integrating health and care depends on high quality, high value out of hospital care. On his reappointment as Health Secretary, Jeremy Hunt said his “biggest priority now is to transform care outside hospitals”. The Five Year Forward View has set out templates for new care models to help realise this long held ambition of joining up care around the patient and building capacity outside of acute hospitals. Yet while there is consensus on the direction of travel, there is debate on how to create the incentives and the system to realise these changes at the pace and scale required. This session will explore the system levers that can enable change on the front line.  
**Ian Williamson, Chief Officer, Greater Manchester Health and Social Care Devolution**  
**Chris Walters, Chief Economist, Monitor**  
**Dr Justin Whatling, Senior Director Strategic Consulting, Population Health, Cerner**  
**Andy Goldney, General Manager for UK, Ireland and Nordics, Baxter** |
| 13.30 – 14.30 | Panel session on “Making the NHS a learning organisation”             | In recent years transparency on outcomes and data has risen to the top of the health agenda. While in the past policymakers sought to ensure high standards and better access through national targets and command and control, this approach is not sustainable. Successful and continuous improvement requires local solutions to the actual needs of patients. This panel will consider how transparency and data can drive a more patient-centred, high quality and cost-effective NHS. It will consider from a provider and national perspective how transparency on outcomes and a culture of continuous learning can shine a light on poor performance and drive up standards across the board. It will consider the future role of targets in managing performance.  
**Professor Steve Field CBE, Chief Inspector of General Practice, Care Quality Commission**  
**Baroness Barbara Young, Chief Executive, Diabetes UK**  
**Dr David Rosser, Executive Medical Director, University Hospitals Birmingham NHS Foundation Trust** |
| 14.30 – 15.00 | Coffee                                                                 |                                                                                                    |
| 15.00 – 15.45 | Keynote speech on “The new health agenda”                              | The Secretary of State for Health, Rt Hon Jeremy Hunt MP, will deliver a keynote speech on the new Government’s vision for better health and social care. This will be followed by questions and answers from the audience, chaired by Andrew Haldenby, Director, Reform.  
**Claire Murdoch, Chief Executive, Central and North West London NHS Foundation Trust**  
**Sarb Basi, Managing Director, Vitality Partnership**  
**Dr Penny Dash, Senior Partner, McKinsey & Company**  
**Dr Chris Roseveare, Immediate Past President, Society for Acute Medicine** |
| 15.45 – 16.45 | Panel session on “Seven day services”                                 | Under the heading of seven day services, the new Government has pledged to give patients access to high quality hospital care and GPs every day of the week. The largest number of critically ill patients turn up to hospitals at the weekend when services are least able to handle them. Patients are increasingly frustrated with inconvenient opening hours and lengthy waits to see their GP. However many have raised concerns, warning that seven day care would mean additional costs for hospitals already in financial distress and further increasing the workload of GPs. The NHS will, therefore, need to use staff and services in very different ways. This panel will consider how the NHS can deliver better quality and access for patients whilst improving efficiency.  
**Claire Murdoch, Chief Executive, Central and North West London NHS Foundation Trust**  
**Sarb Basi, Managing Director, Vitality Partnership**  
**Dr Penny Dash, Senior Partner, McKinsey & Company**  
**Dr Chris Roseveare, Immediate Past President, Society for Acute Medicine** |
| 16.45 – 17.00 | Closing remarks                                                       | Andrew Haldenby, Director, Reform                                                                  |
The NHS has entered a new era of change defined by the Five Year Forward View. Arguably the most important health service report since the Wanless Review, it’s an unequivocal statement of reform. Recognising the mismatch between modern healthcare demand and the NHS’s traditional model of delivery, it recommends a radical course of action. It demands the health service integrate across boundaries, via a programme of New Models of Care, achieve a “radical upgrade” in prevention, and transform provider efficiency. Failure to deliver, it says, will leave the NHS facing a funding gap of more than £20 billion by the end of the Parliament.

The outcome of the general election confirmed this is the way forward for the NHS. The Government has endorsed and funded the Forward View. Moreover, since taking office, the Government has adopted an ambitious reforming tone and announced a series of initiatives of their own. Jeremy Hunt, the Health Secretary, recently outlined a 25-year vision for the health service based on harnessing the power of technology. A new deal for primary care, including 5,000 new GPs, has been announced. The Prime Minister has made delivering a seven day NHS a personal priority.

This is the Government’s new health agenda. Reform is delighted to hold this conference in partnership with Cerner, Baxter Healthcare Ltd. and McKinsey & Company to consider how to take this programme forward.

Our first session will address a recurring theme in health reform – integration. On his reappointment as Health Secretary, Jeremy Hunt said his “biggest priority... is to transform care outside hospitals”. Integration must now bear fruit. The Government’s devolution agenda, designed to facilitate service integration, will be vital. Policymakers around the country will be watching the progress of “Devo-Manc”.

Competition and centrally set targets used to be the levers of NHS reform. Now it is transparency and data. Our second session will explore how shining a light on poor performance will drive a more patient-centred, high quality and cost-effective NHS. History suggests this will be a significant challenge for the health service. For the NHS to “plagiarise” at scale, the spread of new learning will not come from centre. Successful and continuous improvement will most likely be driven from local solutions based on the actual needs of patients.

Our final panel will explore how the NHS can deliver better access for patients and quality of care through a seven day service. The largest number of critically ill patients turn up to hospitals at the weekend when services are least able to handle them. The Government is right to want to address these variations in care. However many have raised concerns, warning that seven day care would mean additional costs for hospitals already in financial distress and further increasing the workload of GPs. Workforce reform will be critical. The consultant contract allows doctors to opt out of non-emergency weekend work.

The Government, and NHS leaders, are right to be radical. The healthcare status quo is no longer sustainable. Due to its historically rising budget the NHS has, to some extent, been insulated from the need to deliver real efficiency. The task now is to rectify this by delivering a step change in productivity, while simultaneously expanding and improving services.
Out of hospital care

Andy Goldney
General Manager, Baxter Healthcare Limited, UK, Ireland and Nordic

The NHS is at a critical stage in reform. In order to achieve the £22 billion efficiency savings of the NHS Five Year Forward View by 2020, the momentum to drive New Models of Care needs to gain pace. With NHS costs growing by 3 per cent every year and annual funding growth averaging 1 per cent over the past 6 years, NHS organisations are under ever increasing pressure to reduce costs. With an ageing demographic and a rising trend in prevalence of co-morbidities, these costs will increase even further.

The challenges facing the NHS can only be overcome if we (industry, government, the NHS and patients) can shift our thinking and work collaboratively. Transformational innovation is key but let us not overlook incremental innovation; doing things differently, using our existing resources in a better way and redesigning treatment pathways is a central part of the solution to the problem.

We can only make the radical changes required to ensure the NHS is a first-class, world-leading organisation at the forefront of innovation if the right set of levers are put into place within the system. A clear road map which sets out a single systematic approach is essential for the nurturing and dissemination of successful innovation. Commissioning of new technologies should be accompanied with de-commissioning of services that are no longer fit for purpose in order to free up capacity.

In addition, budgetary silos between different NHS organisations which often act as a barrier to innovation, preventing new approaches in one place from being implemented elsewhere, need to be addressed. A joined-up, system-wide budgeting model must permit long term settlements for new innovations whose benefits may be realised sometime in the future but require an initial investment. This can only be achieved through payment system reform and alignment between commissioning and provider incentives.

It is vital that whilst working towards our shared goal of making the NHS a world-leading organisation, we leverage opportunities to build partnerships in order to accelerate pace and ensure alignment of our progress. We are only at the start of a difficult journey, but there is no obstacle that cannot be overcome if we can adopt a fresh approach to working collaboratively.

Baxter Healthcare is a leading supplier of products and services to the NHS, supporting patients at all stages from hospital admission to managing a long term condition at home. At Baxter we see ourselves as an integral partner to the NHS. We work with clinicians and patients to share our expertise on how to integrate and change patient pathways which can drive efficiencies as well as improving quality outcomes. As an incremental innovation, out of hospital care can empower patients to take control of their own treatment, drawing on clinical and other support to assist their choices.

There are evident examples of how Baxter can help the NHS deliver its out of hospital care agenda set out in the Five Year Forward View. An outpatient parenteral antimicrobial therapy (OPAT) service we set up in partnership with St. George’s NHS Healthcare Trust to enable a carefully selected group of patients to receive intravenous antibiotics at home has saved the hospital up to 2,700 bed days. OPAT reduces the length of hospital stays as it allows patients to continue their treatment at home and avoid unnecessary trips to the hospital. In some cases, it can completely eliminate the need for hospitalisation. Baxter provides the home delivery of medication as well as the nurses to infuse the drug as often as required.

Home dialysis is another incremental innovation that offers patients better clinical outcomes and improved quality of life. Baxter’s newly launched cloud-based communication platform that connects home dialysis devices to Renal Units enables clinicians to monitor their patients daily. This simple technology is a step change innovation and has the potential to increase both patients’ and clinicians’ confidence to opt for home dialysis, as well as enable Renal Units to make efficiency savings.

Andy Goldney, General Manager, Baxter Healthcare Limited, UK, Ireland and Nordic
@baxter_intl
There are a limited number of strategies to address the future sustainability of care systems around the world.

There is and will continue to be a need to improve the quality and efficiency of care providers, but whilst necessary, this is not enough. We know from clinical utilisation audits that 20-25 per cent of patient admissions and 50-60 per cent of patient bed stays are not due to the clinical acuity of care they need to receive. From our recent work on predictive models we also know that some 30 per cent of patients are sent to a sub-optimal venue of care post-acute care. So we have to optimise where care gets delivered.

A number of the hospitals we are working with across Europe are committing to bed reduction programmes, but they know this cannot be achieved unless a whole care system approach is adopted. So we have to integrate care networks in such a way that care standards can be assured across the system.

Lastly, but most importantly, we need to move to a wellness and prevention approach. I was most taken by a recent trip to Sweden where they chose not to put the citizen in the centre but put them around the ring with the other care professionals, making the very strong point that we need the citizen to be an activated and engaged member of the care team. The explosion in consumer apps and technologies is consumer apps and technologies is

The move to accountable care with total control of budget and quality in the USA is accelerating delivery of these strategies, and we expect to see the same here with New Models of Care. Care systems forming new clinically-integrated networks taking on outcomes-based contracts are successfully addressing variation in practice. Language such as “discharge” is being replaced by “transitions” of care as there is no longer a deposition of responsibility. Focus is shifting from the most expensive, high-risk patients to managing wellness, as this addresses future demand and cost. This shift to population health management is not possible without data and IT. To change the health of a population requires we need change one person at a time. For this we require a single source of truth for a citizen’s population record and need to be able – in real-time – to engage and actively manage the citizen in their care.

Care systems such as Advocate Physician Partners, the largest accountable care organisation in the USA, and Nuka Southcentral Foundation are taking population health management approaches and leveraging data and IT. They are driving up satisfaction, delivering on improving the patient experience of care, as well as improving the health of populations and being a good steward of the per capita cost of care – this is the Triple Aim of healthcare. It is the opportunity we have in the UK with New Models of Care. With our focus on the whole health and social care system, with our strengths in primary care, public health and research we are well positioned to lead the world in the delivery of population health systems.

Dr Justin Whatling, Senior Director Strategic Consulting, Population Health, Cerner
@JustinWhatling

Ian Williamson
Chief Officer, Greater Manchester Health and Social Care Devolution

Devolution in Greater Manchester presents us with the greatest opportunity to rethink how we provide health and social care services since the founding of the NHS in 1948 at Greater Manchester’s own Park (now Trafford) Hospital. But the opportunities stretch even wider. We have a vision to work across our city region to influence wider determinants of health, prosperity and service demand – education, employment, housing and so on.

Greater Manchester has a long history of close collaboration across both our ten local authorities and our range of NHS organisations. And following last November’s wider devolution deal, we in health and social care responded to the challenge to deliver improved health, prosperity and life opportunities for current and future generations of Greater Manchester’s people. In February of this year, a landmark deal was signed to devolve decision making powers over the entire £6 billion health and social care budget for Greater Manchester.

We believe that the people of Greater Manchester know what’s best for our public services, and already we have begun to demonstrate, in tangible terms, exactly what is possible when we in Greater Manchester are at the helm of planning and delivering our own public services across the city region.

In June we reaffirmed an ambitious commitment to delivering seven day access to primary care for all of our 2.8 million people by the end of the year. We
have signed a groundbreaking agreement with Public Health England and NHS England to bring together public health leadership across Greater Manchester to transform the health of our population by linking to employment, education, training, housing and much more. In July we confirmed the decision to establish “single service” networks of linked hospitals working in partnership. This means care will be provided by a team of medical staff who will work together across a number of hospital sites within the single service. All hospitals will improve to ensure they meet the quality and safety standards which are projected to save 300 additional lives per year.

Our directors of adult and children’s social care have given a commitment to boosting levels of access to social care to help with hospital discharge and avoidable admissions. And this work is taking real shape in the development of borough level plans to transform integrated community-based care and support.

We recognise that strong relationships with stakeholders, staff and members of the public need to underpin all of our endeavours and are working hard to keep people informed with briefings, presentations, bulletins and by attending and speaking at key local and national conferences. This month, we began a conversation across Greater Manchester by asking people for their views through an online public survey. We have also been hitting the streets to ask the general public their thoughts on devolution and what it means to them. Building on the results of this research we are working across Greater Manchester, alongside colleagues from HealthWatch and the voluntary sector, to design a detailed engagement programme.

These examples show what is possible through devolution, and we want and need to go further and faster.

In this build-up year before taking full control of the reins in April 2016, we are working hard to produce a comprehensive plan to set out how we will achieve clinical and financial sustainability. As part of the Comprehensive Spending Review, we are working with NHS England and the Government on a specific agreement for health and social care in Greater Manchester to support our strategic plan.

Each of our ten localities are producing detailed integrated plans for the delivery of joined-up health and social care services on a place-based footprint. Our localities not only have to deliver in their own areas, they have to deliver collaboratively across Greater Manchester. This requires compromise and collective responsibility. It means backing decisions that are sometimes difficult to sell back at the ranch. But a willingness to trust and to see things on both a locality and Greater Manchester-wide basis is delivering dynamic and heartening collaborative working relationships.

This is a once in a lifetime opportunity for our people and our city region and we won’t let it go by. My family were born in Greater Manchester, and go to school locally. I have received brilliant health care two miles from where I live, so this is personal for me and for so many others. Devolution is for Greater Manchester, by the people of Greater Manchester.

Ian Williamson, Chief Officer, Greater Manchester Health and Social Care Devolution

Chris Walters
Chief Economist, Monitor

Demand for acute care is set to increase.

To meet this challenge, national policy encourages care to be delivered out of hospitals and closer to home. The imperative now is to make practical progress on a wide scale. Monitor has developed four resources (available on our website) to help providers and commissioners understand the range of options available and assess the clinical quality and financial impact of each.

The first is a review of material on the clinical impact of care-in-community schemes. It finds that many lower acuity patients in hospitals could be treated elsewhere; that if patients don’t need acute care then being in hospital can be bad for them; and that well-delivered community care can benefit patients (though there can be risks).

The second is a set of insights from financial modelling of four established schemes. These say that the long-run cost of delivering care in the community can be lower than in acute settings but, if not well designed, short term challenges can prevent schemes delivering even long-term savings. This will be supplemented by guidance to providers and commissioners on developing business cases for comparable schemes, and by simulation models of activity and costs.

The third are the findings from interviews of 30 providers on the challenges and solutions to implementing schemes. Providers told us about five key challenges: targeting the right patients; meeting the needs of high severity patients; getting the right staff; building credibility and scale;
and getting data to evaluate effectiveness and set fair prices. Providers’ solutions to some of these were varied and innovative.

The fourth is a dozen case studies developed from interviews with providers about moving care to community settings. These span avoiding hospital admissions, improving pathways within hospitals and improving discharge from hospital.

These resources fit into Monitor’s wider work to meet its statutory duty to enable better integration of services. There are five strands to this:

Our new Provider Sustainability directorate has a remit to support financial and operational improvement, including by helping change patient pathways.

We have developed other resources to help frame and diagnose the challenge and generate options to meet it.

We have made changes that allow for greater flexibility in payment. This includes supporting local areas to link patient datasets so that payment can be more accurately calculated under new payment designs, such as capitation.

Our assessment process can accommodate new organisational forms that deliver care out of hospitals, provided they are well led, sustainable and use more than half their income for NHS purposes.

Patient choice is an important driver of improvement in the NHS. Organisational forms that integrate care in and out of hospitals do not generally bring together services that are in competition. They bring together services that are complementary, not substitutable. So there is no inherent contradiction between patient choice and competition, on the one hand, and integration to move care to community settings, on the other.

Chris Walters, Chief Economist, Monitor
@MonitorUpdate
Making the NHS a learning organisation

Baroness Barbara Young
Chief Executive, Diabetes UK

An American colleague once remarked that the NHS should be a significant opportunity to systematise the spreading of good practice in health care, a boon that the fragmented US system (or lack of it) was incapable of. Yet we increasingly see the N in NHS becoming Neighbourhood rather than National, with more local decision making and less top down requirements being laid on the system from the centre.

The Secretary of State believes firmly that transparency of performance data will mean that providers and the public will compare services and thereby drive up quality. There are few signs of that so far. The back marker practices in terms of Quality and Outcomes Framework (QOF) delivery continue year after year to be the back markers – those who commission primary care don’t use the few levers they have to remedy that other than in flagrant cases.

Good regulators ought to be constantly seeking to help poorer performing providers to adopt the good practices of the best, as opposed to simply bearing witness to how they are failing. The Care Quality Commission may yet pull that off. But even though the failure regime has been renamed to be more positive and supportive, we still see the culture of punishing failure by sacking chief executives.

If the NHS is to become a learning organisation, we need as much focus on plagiarism as on innovation. Awards for stealing others’ ideas and implementing them with pride should be the order of the day. There is a huge body of published work on what works for health outcomes and patients, and the drivers of efficiency savings. The accountability framework and policy levers need to ask serious questions about why wheels are re-invented and nationally acknowledged good practice not simply implemented.

Managers need to be allowed to stick around and learn from their successes and failures. And both providers and commissioners need effective and focussed improvement bodies, like the late lamented NHS Diabetes, to marshal and promulgate the good practice and help those less competent organisations to make the needed and no brainer, frankly, changes. And we need to foster a culture of questioning, fossicking to find the good practice and rapid implementation of wheels already invented. All to be done in close concert with patients and their families, who are a huge resource for learners.

Baroness Barbara Young
Chief Executive, Diabetes UK
@youngb48

Dr David Rosser
Executive Medical Director,
University Hospitals Birmingham

I am afraid that I do not accept the accusation that my NHS, the NHS of providers, those organisations that actually treat patients, is not a learning organisation.

My NHS does learn, it learns from the top, from its leadership. Over many years, it has learnt never to challenge dogma, but has learnt to avoid hard decisions, to rename, restructure and centralise power in the face of adversity, to overreact to problems and create another body to avoid making a decision.

The fruits of this learning can be seen in the failure to progress the overdue consolidation of the provider sector, the convoluted governance and committee structures of most Trusts, mirroring the bewildering number of bodies “advising”, “supporting” or instructing the providers. By the lack of challenge to the continuing nonsense that we can further decrease the number of hospital beds and still offer the same range of services and accessibility as we currently do.

My NHS has learnt that policies, strategies and targets should be nonsensical, ever changing, confusing and if possible contradictory. It has learnt to be pragmatic about this while dealing with the contradictions to the duty of candour, the transparency agenda, and the requirement to share data between providers created by the information governance agenda to name but one example.

More importantly my NHS has learnt that bullying is not just acceptable but is the way to manage organisations. It is
enshrined in contracts, regulatory approaches and is central to any good inspection regime. Staff are not defended when attacked by the press, and joining in the vilification is all too common. How well this has been learnt is demonstrated by the average tenure of ‘overpaid’ hospital CEOs at almost 30 months, compared to around 6 years for a FTSE 100 CEO.

My NHS learnt that quality of care is more important than money after the fall out from a number of scandals. These lessons were learnt so well the NHS was named the best health service in the world by the commonwealth fund in 2014, on the second lowest cost per capita. I don’t remember the praise from the top.

Now my NHS is quickly learning again that when the chips are down money trumps quality. It is learning again that rationing must be imposed to balance the books but the word must never be spoken. It is learning that the mature debate with the public about the type and amount of care they wish to fund will not happen. These are easy lessons for my NHS because they were never really forgotten.

The question should be how we teach my NHS the right lessons. The answer, inevitably, comes down to leadership across the system. A leadership which is honest with my NHS, the public and politicians, a leadership which does not ask my NHS to "do what I say not what I do". A leadership I have not known in my 28 years in my NHS.

Dr David Rosser, Executive Medical Director, University Hospitals Birmingham

Professor Steve Field CBE
Chief Inspector of General Practice, Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England, making sure health and social care services provide people with safe, effective, compassionate, and high-quality care. We encourage care services to improve. We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. And we publish what we find, including performance ratings, to help people choose care.

Since October 2014, the CQC has been inspecting GP practices under a new model. We have found fantastic examples of outstanding care that demonstrates where providers have gone above and beyond the regulations to deliver safe, compassionate, high quality care that is responsive to the needs of patients.

One of the key aspects of an outstanding practice is that it is well led and creates a learning culture where the leaders champion the care of the people who live in their area. These outstanding practices have a clear vision and great team working. They have a strong focus on continual quality improvement, learning from mistakes and significant events, encouraging improvement from the regular use of clinical audit and work in collaboration with neighbouring practices, hospitals and social care providers to improve care for their patients.

Examples from outstanding practices include supporting colleagues through strong mentorship, organising a practice apprenticeship scheme which has led to full employment for apprentices in local practices, and working with neighbouring practices to improve the care of people with learning disabilities. Another key theme that pervades an outstanding practice is working with patients and carers, which leads to improved clinical care, better integrated around the needs of the patient, and happier more fulfilled staff.

Professor Steve Field CBE, Chief Inspector of General Practice, Care Quality Commission
@ProfSteveField
Delivering the new Government’s health agenda

Dr Penny Dash  
Senior Partner, McKinsey & Company

The benefits to patients of having senior and experienced staff available on a 24/7 basis in emergency and complex care have been clearly laid out in the work carried out by Sir Bruce Keogh and colleagues.

But the best ways of implementing this are causing considerable discussion and debate. Covering 24 hours a day, 365 days a year requires 7-8 WTE (whole time equivalent) staff (assuming around 40 weeks work a year and 30 hours of patient facing time per week) but this presents (at least) three key challenges:

1. First, patient activity is not uniformly distributed across the day meaning that more staff are needed at peak times than at other times resulting in a need for more like 10-12 WTEs per specialty.
2. Second, many doctors are resistant to adjusting their staffing model away from a core Monday-Friday working week with on-call on top despite this being an inefficient way of providing care.
3. Third, for many hospitals, volumes of activity are too low to provide sufficient experience for these numbers staff to maintain their skills and expertise – and to enable specialist equipment to operate efficiently on a 24/7 basis.

Our work suggests that proactive planning is required across populations of around 750,000 to a million to determine the optimal configuration and staffing of services based on sound clinical and economic analysis. Along with IT/digital solutions, such as e-ICU, to maintain acute services in more geographically challenged parts of the country. Combined, we believe that 24/7 care can be delivered with no significant increase in resources.

Outside of emergency and complex services, the clinical case for 24/7 is less clear but there is a strong economic case for increasing operating hours. Longer operating hours help to reduce length of stay - itself one of the most significant drivers of cost in the NHS. Further, most buildings and equipment in the NHS are used for less than 40 hours a week, despite an annual running cost of the system of at least £5 billion and a considerable capital outlay. Increasing standard operating hours for all services (elective surgery, diagnostics, outpatients, therapies, community and primary care) will reduce the capital required and the ongoing operating costs of keeping the NHS estate and infrastructure. This can be achieved through better management of rotas without extending contracted hours but requires accurate planning of the economics of different facilities and catchment populations, e.g. for out of hospital hubs. We estimate this could save the NHS around £1-2 billion a year while maintaining services and improving access to care.

Dr Penny Dash, Senior Partner, McKinsey & Company
@McKinsey

Claire Murdoch  
Chief Executive, Central and North West London NHS Foundation Trust

It seems as though most people, be they staff, the public, patients, or political commentators, believe that seven day working in the NHS is desirable if not essential. If it saves lives and you can buy a Big Mac seven days a week, the view seems to be that we should get on with it.

The heat of the current debate on seven day working has taken many by surprise. Doctors have been outraged at the suggestion that they don’t already work seven days a week; managers have been asked where they are on a Saturday and Sunday; it has been pointed out that diagnostics, insufficient workforce and diminishing social care all mean that there simply isn’t the capacity to deliver services seven days a week even if it’s desirable. It has been posited that the biggest constraint on seven day services is financial pressure.

As a student nurse in 1983 I went to work on Christmas morning and have worked most Christmas days since. I have done this out of respect for the fact that the NHS is a seven day a week service and good staff do not hesitate to come to work at evenings, weekends and on high days and holidays. However, we must face up to the fact that seven day coverage is patchy. Of course we should ensure that the right number of staff are working in the right places at the right time, delivering care that improves outcomes and saves lives. Barriers to this should be understood and removed. It should not be a question of ‘if’, but ‘when’. In implementing the improvements there must be intelligent,
evidenced-based approaches to addressing the issues listed above. It could be argued that tackling these issues is the easy part of the equation in relation to seven day services. What about the role of community based services? Are they not essential in making the NHS effective around the clock? What about mental health care? Always something which will be tackled next, never now. The impact of spending reductions on social care are immense and will further impact what resource is available to support vulnerable people. Too often the answer to the over reliance on hospitals is to focus even more on hospitals.

The main driver for seven day working is better, safer healthcare. What is provided in the community is an essential part of delivering this and must be as much the focus of attention as hospital care. We must also continue to emphasise the need for people to be more responsible for their own health and to appreciate the cost of not using services wisely. The Five Year Forward View sets out a road map to help inform the thinking, ranging from personal responsibility for lifestyle, all the way through to emergency care. In the main they are not unrelated and we must become more sophisticated in how we understand the optimum health system. Without wanting to oversimplify an undeniably complex issue, our health system should be more independent of the political sphere of life; more invested in facts and intelligent information and more open to public debate and decision-making with regards to what is affordable and what our priorities are. The NHS and professionals should be the servant of these decisions as made by the public.

Seven day working should be seen in this context.

Claire Murdoch, Chief Executive, Central and North West London NHS Foundation Trust @ClaireCNWL

Dr Chris Roseveare
Immediate Past President, Society for Acute Medicine

Much has been said about the importance of providing a seven day service for patients with urgent care needs, both in hospital and in the community. The past decade has seen publication of a plethora of guidance documents and standards from Royal Colleges, Specialist Societies, the Department of Health and NHS England. The momentum for change increased further, following publication of data by Doctor Foster indicating that patients admitted to hospital at a weekend have a higher mortality than those admitted to hospital on a weekday. Although the precise reason for this difference is unclear, and may relate partly to illness severity, a similar pattern has been demonstrated in data from the USA, Australia and New Zealand.

Many NHS organisations have made considerable progress in delivering changes, but the speed of this change often feels frustratingly slow. In addition, messages from Government often appear confused, with statements about weekend services in primary care being focused on ‘convenience’ of access, rather than the specific needs of patients who are acutely unwell.

There is no question that real progress will require a multi-disciplinary approach, with a key component being access to allied healthcare professionals including social care, support services and specialist investigations. However the importance of a consultant presence in every clinical area at weekends should not be understated. In January 2012 the Academy of Medical Royal Colleges (AoMRC) published ‘The Benefits of Consultant Delivered Care’, which highlighted a number of key areas in which consultant care benefits hospital patients: improved outcomes, rapid decision making, more efficient use of resources and better trainee supervision. The document concluded that such benefits should be available for patients every day of the week. At the end of 2012 the AoMRC defined three key seven day standards, including the need for daily consultant review of patients whose care pathway may change as a result of this.

Although it is recognised that most consultants already work at weekends, the basis on which the consultant cover is provided usually differs to that during weekdays. While patients who are acutely unwell or deteriorating, those who require intensive care or emergency surgery will usually see a consultant, more stable patients frequently wait for review from Friday until Monday. Delivery of a daily consultant review will require job planning, and the implications of this were outlined in a further document published by the AoMRC in November 2013. Most specialties will require a considerable increase in the number of consultant hours provided at weekends: this will either require the appointment of more consultants or a substantial movement of work from weekdays into weekends, with consequent impact on weekday services.

While the delivery of a seven day consultant presence is likely to produce some long-term efficiency savings, it would be naive to suggest that this could be delivered on a ‘cost neutral’ basis. Development of sustainable rotas and engagement of the workforce in delivering the necessary changes will require investment and prioritisation of those aspects of urgent care which are likely to deliver the greatest benefit.

Dr Chris Roseveare, Immediate Past President, Society for Acute Medicine @CRoseveare
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