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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Seven day service standards in NHS hospitals: thorny problem or blooming success?

David Oliver *consultant in geriatrics and acute general medicine*

Berkshire

Abraham Lincoln is often quoted as having said, "We can complain because rose bushes have thorns, or rejoice because thorn bushes have roses."[1]

This often seems pertinent to the quality and scope of NHS care. An important example is NHS England's recent summary on acute hospitals' performance against four of 10 key national indicators for delivering seven day services.

The 10 standards were drawn up by Bruce Keogh, national medical director, and his colleagues at NHS England in 2013, informed by an Academy of Medical Royal Colleges report from 2012. They were subsequently included in the Department of Health's mandate to the NHS and then adopted by NHS England. The four most exigent standards were selected for implementation by 2020—hence the progress monitoring.

Recently, NHS England invited 153 hospital trusts to submit their performance data through an online self assessment tool: 148 responded, and the results were published in November.[2] The *Health Service Journal*'s news headline (majoring on the thorns) was "Quarter of patients denied rapid review—even on weekdays."[3] This was unduly pessimistic, I reckon.

So, what were the standards and the performance against them? The first was "Patients who had an initial consultant review within 14 hours of admission," a target 73% of trusts met on weekdays and 70.3% at weekends. Second was "Patients who received daily ongoing consultant reviews" (90.9% of trusts on weekdays, 69.7% on weekends).

"Patients with same day access to diagnostic tests" was third (99.7% weekdays, 92.1% weekends), and fourth was "Consultant directed interventions available to patients" (95.2% weekdays, 91.9% weekends).

The "consultant directed interventions" included emergency surgery, stroke thrombolysis, urgent dialysis, interventional cardiology, and pacing. Performance on these measures was well over 90% over all seven days. Only in interventional radiology and urgent radiotherapy did performance fall well below this. I'd suggest that, given the crisis in the radiology and gastroenterology workforces, maintaining the reported performance levels is extraordinary.[4,5] Credit is due.

For "daily consultant review," of course we want patients seen frequently by senior doctors, and this happens at weekends far more than it used to, partly because of this seven day focus. But with no workforce expansion and many unfilled consultant and training posts, especially in high volume acute inpatient specialties,[6] having more consultants on inpatient wards at weekends will inevitably hamper weekday service provision.

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We must also surely allow some professional judgment and flexibility to let consultants prioritise patients who are most unwell, unstable, or unable to get home. Or perhaps we should let consultants speak to concerned families while junior doctors continue the round.

With the rapid rise in delayed care transfers, many patients stuck in hospital are medically stable and awaiting step-down care.[7] I'm not sure how much value is added by ensuring that a consultant sees a patient every day, just to tick a box. We might add greater value by seeing some three times a day and others three times a week.

Finally, for "consultant review within 14 hours," weekend performance matches that on weekdays. Dig deeper and, even in an acute admitting unit where consultants are present until 9 or 10 pm, it's quite possible that patients who arrived at, say, 7 pm wouldn't be clerked, investigated, and ready for senior review until the consultants had gone home. Yet they'll be seen by a consultant the next morning even if, given the workload, this isn't until 11 am—16 rather than 14 hours after admission, and prompt nonetheless.

In many specialties we don't have enough consultants for 24 hour resident cover, and we don't want to encourage "gaming" of the target where consultants review the care plan and put something in the notes before they've seen the patient.

davidoliver372@googlemail.com

I won't argue that trying to deliver such standards isn't a good ambition for patients or hospitals: they're probably what we'd want for ourselves or our families. It's also worth exploring the variation in datasets between hospitals and the causes of higher or lower performance against the standards, as well as how to improve. But, in a service under extreme pressure and with fewer medics and less kit than many countries, let us rejoice in what we're delivering—not all roses, but certainly not all thorns.

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