FSSA
Federation of Surgical Specialty Associations

FSSA Position Paper: 7 day working

Summary:

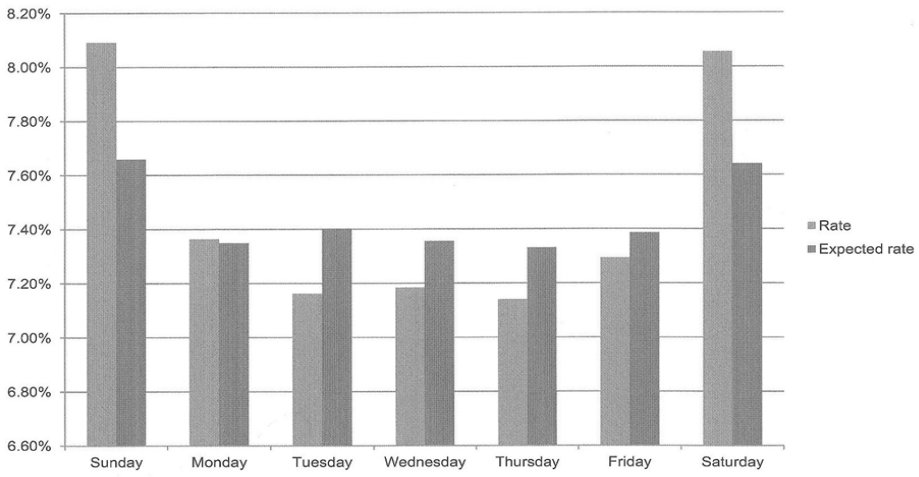
- The FSSA is aware of data which suggests increased mortality in hospitals at weekends and applauds government initiatives designed to reverse this trend.
- The FSSA advises caution in the interpretation of data that suggests that increased mortality in hospitals at weekends can be attributed to fewer senior staff available. There is no evidence to corroborate this in any of the surgical disciplines.
- The FSSA considers that increased priority should be given to enhancing recruitment into the specialities of Accident and Emergency Medicine and Acute Medicine. The impact of staff shortages in these "Cinderella" specialities has major knock on effects throughout the hospital service.
- The FSSA strongly believes that the priority in the implementation of 7 day working must be to the emergency patient. In particular, there is a need to enhance diagnostic and support services at weekends to facilitate safe and speedy discharge. We consider that this would be cost effective.
- The FSSA has reservations about 7 – day working as it applies to elective services.

1. Background

The clamour for seven day working is now overwhelming. It has become a stated commitment of the new Conservative administration and is enthusiastically backed by the Secretary of State for Health, Jeremy Hunt, and by Simon Stevens, Chief Executive of the NHS.

The rationale is based upon two broad premises: firstly, clinical data (see Fig 1). These suggest that mortality rates for patients admitted to hospitals is higher at weekends combined with some evidence that suggests that our junior doctors feel clinically exposed and unsupported at weekends, and that hospital chief executives are worried about weekend clinical cover.

Figure 1:



dr foster intelligence

And, secondly, logistical. It 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.

In 2013 NHS England published a document entitled "Everyone Counts: Planning for Patients 2013/14"[1]. In this, NHS England stated that the NHS will move towards routine services being available seven days a week. Subsequently, Bruce Keogh, Medical Director of the NHS 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[2].

The *Forum* produced its' first report in December 2013 concluding amongst other things that " *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, is affected by the day of the week*".

2. **Mortality data**

2.1 Clearly, any initiative associated with improved patient outcomes is to be welcomed. However, FSSA advises caution in the interpretation of mortality data for weekend work.

2.2 The mortality rates calculated from Dr Foster data and based on HES data suggested that increased mortality at weekends could be, at least, partially accounted for by the fact that there is significantly fewer senior staff in hospitals at weekends. For surgeons this is not supported by independently collated data from NCEPOD and NELA (National Emergency Laparotomy Audit), both of which clearly show that consultants are present (both surgeon and anaesthetist) for over 90% of out of hours operating at weekends[3,4].

2.3 Any correlation between senior medical input and weekend mortality oversimplifies a complicated and multifactorial system.

2.4 There is data available which suggest that there is no increase in mortality at weekends. For example, the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) reported results comparing mortality for cardiac surgery on week days compared to weekends[5]. Between 1st April 2008 and 31st March 2011, 93,463 patients underwent cardiac surgery on a week day with in-hospital mortality of 3.1%, compared to 3234 patients at weekends with mortality of 5.3%. No day of the week was associated with increased mortality. SCTS suggest that their results demonstrate that a speciality with an established clinical governance and quality improvement programme which is primarily a consultant based service, that there is no evidence to support the contention that weekends are associated with increased mortality. Similar data exists for patients admitted with fractured neck of femur[5].

2.5 In contrast, aside from Dr Foster data (upon which the Government relies and bases its arguments), there are some compelling data from other independent sources. For example, a Wellcome project analysed emergency admissions from national databases for all public hospitals in England and Wales from January 2004 to December 2012 [6]. They did find increased mortality at weekends for certain defined conditions such as abdominal aortic aneurysm, sub arachnoid haemorrhage and stroke. In contrast little or no effect was identified for pulmonary disease, pneumonia, hip fracture, acute pancreatitis and inflammatory bowel disease.

2.6 Mortality data can be skewed for reasons other than the quality of care available in hospitals at weekends. For example, patients with certain conditions are more likely to be admitted at weekends. These include patients with trauma, alcohol associated conditions and self harm. All of these conditions are associated with significant mortality. Further, in some areas a lack of hospice beds often means patients with terminal disease are admitted to acute hospitals when community services are inadequate to provide weekend cover.

Conclusion: *the FSSA takes the view that there is no evidence to support the contention that an absence of senior surgical staff contributes to an apparent increase in hospital mortality at weekends. Any correlation between senior medical input and weekend mortality oversimplifies a complicated and multifactorial system. Case mix and inadequacies in the community are more likely explanations for any apparent increases in weekend mortality.*

3. Integration with primary and community care

3.1 a major impediment to efficient provision of elective surgical services relates to "bed blocking" by emergency admissions (usually medical) which often result in cancellation of elective cases. Optimisation of elective surgical care and a move to seven day working is doomed to failure if the increasing problem of emergency admissions is not addressed. In our view this necessitates a radical reappraisal of Accident and Emergency services and the gate keeper role of the General Practitioner.

3.2 a major reason patients are admitted at weekends is variation in referral practice. Out of hours healthcare has changed dramatically in the past decade with increasing reliance on emergency services as compared to a patients' own general practitioner. A better understanding of medical staffing in the community would be useful in considering variations in mortality.

Conclusion: *the FSSA considers that increased priority should be given to optimising community and Accident and Emergency services. Acute medicine in particular is a Cinderella speciality. Failure to recruit to these posts has important knock on effects in all hospitals which adversely affect surgical provision. We believe the time has come for a reappraisal of remuneration packages for those involved in acute care. We need to do more to incentivise doctors to work in the acute sector.*

4. Bed Occupancy

4.1 a potential hazard of seven day working is increased pressure on beds. It is relevant that the NHS has lost 16% of acute beds in last 10 years.

4.2 Bed occupancy is now recognised as a reliable marker of the risk of HCAIs. Bed occupancy rates above 82% are a clear predictor of an increased risk of infection after an operation. National Audit office on HCAIs recommend < 82%.

4.3 Recent evidence cited by the CQC reports bed occupancy in acute Trusts in England and Wales as being >102%. The DH reported 87% for general and acute beds in 2012.

4.4 The RCS England has publically stated that it is committed to seeing bed occupancy rates fall, as this will significantly improve patient safety.

Conclusion: *the FSSA considers that caution is advised with implementation of seven day working if this results in significant increases in bed occupancy as these may jeopardise patient safety.*

5. Staffing / costs

5.1 Centre for work force intelligence estimate a 60% per cent increase in the consultant salary costs if the NHS adopted a "consultant-present" service.

5.2 Equivalent to £2.2 billion a year in consultants' wages, up from £3.8 billion in 2010, it is estimated.

5.3 The Secretary of State and CEO of the NHS have both stated that there will be considerable cost savings through efficiencies of practice, facilitated discharge of inpatients and more efficient referral from primary care. The evidence for this is not compelling.

5.4 The planned cost of implementing 7 – day services based on current evidence greatly exceeds the maximum amount that the NHS should spend on eradicating the weekend effect based on current evidence [7].

Conclusion: *The FSSA considers that the priority must be to ensure adequate provision of care for emergencies 7 days a week. Only after this has been achieved should the focus move to elective services.*

6. Other considerations

The FSSA welcomes in principle any measures designed to optimise care. However, there are a number of service constraints that need to be considered:

- 16% acute beds lost in 10 years
- 30% rise in emergency admissions
- A & E services are overwhelmed
- Ineffective primary care for acutely ill
- Hospital medicine is unpopular
- Numbers of trainees are falling
- EWTR
- Rota management
- Availability of transport
- Support from other directorates
- Absence of social services at weekend
- Reluctance of staff to change working patterns
- Social and domestic disruption
- Availability of transport
- Crèche facilities

Conclusion: *the FSSA welcomes the announcement by the Prime Minister of an additional £8b a year to fund the transformation to seven day working as part of the NHS' 5 year plan. We also note the additional monies allocated under the Better Care Fund (BCF). The FSSA welcomes these additional resources. Nonetheless, the ideal of 7 day working is likely to remain an aspiration rather than a reality without more innovative approaches to care.*

References:

1. Everyone Counts : Planning for Patients 2013/14 (www.england.nhs.uk/everyonecounts/)
2. NHS England: NHS services, seven days a week.(www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week)
3. NCEPOD report: knowing the risk 2011. www.ncepod.org.uk
4. NELA: www.networks.nhs.uk/laparotomy
5. "Higher senior staffing levels at weekends and reduced mortality". BMJ 2012 344 e67. See on line rapid responses
6. "Weekend emergency admissions and mortality England and Wales". Roberts et al, Lancet, published on line June 2015. http://dx.doi.org/10.1016/S0140-6736(15)60580-3
7. Meacock et al. "What are the costs and benefits of providing comprehensive seven day services for emergency hospital admissions". Health economics 2015 DOI 10 1002/hec.3207

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