*From the Rt Hon Jeremy Hunt MP*
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Dr Sarah Wollaston MP
Chair of the Committee
Health Committee
House of Commons
London SW1A 0AA

Dear Sarah,

You will have seen the recent media coverage on the evidence base for our commitment to ensure that people with urgent and emergency hospital care needs receive the same quality of care seven days a week. I wanted to write to you, in your role as Chair of the Health Committee, to set out some of this evidence.

I will begin by explaining what we are trying to achieve and how we plan to achieve it.

There is convincing evidence demonstrating the association between weekend hospital admissions and poorer outcomes, including higher rates of mortality. Our objective therefore is to tackle this excess mortality but also to improve patient experience and improve flow through the hospital at weekends.

To achieve this, by the end of this Parliament we expect the NHS to ensure that anyone with urgent and emergency care hospital needs has access to the same level of consultant assessment and review, diagnostic tests and consultant-led interventions, whatever day of the week it is.

In 2013 NHS England's Seven Day Services Forum, established and led by Professor Sir Bruce Keogh, identified ten clinical standards that describe the standard of urgent and emergency care that patients should expect to receive seven days a week. This spans action across health and social care, including supporting primary, community and mental health services. Analysis commissioned by NHS England, in consultation with the Academy of Medical Royal Colleges, led them to advise that there are four standards that are essential to reduce weekend mortality: consultants being present to assess and regularly review patients and access to diagnostic tests and consultant-led

interventions. A copy of all ten clinical standards is attached. While priority is being given to the first four standards, the NHS is expected to embed all of them in due course.

There have been some claims that we are expecting elective services to be run seven days a week. I must emphasise that the focus of this commitment is on urgent and emergency care hospital care. However some trusts may well find that this results in extra capacity at weekends, which enables them to also carry out some elective work on Saturdays and Sundays if they wish.

I add that we are not expecting all hospitals to meet the priority four standards seven days week. Some services may be provided through networking arrangements between hospitals. The key objective is that services are available to everyone across the country.

**The evidence base for the "weekend effect"**

There have been at least 15 studies investigating this "weekend effect" since 2010 (listed in an annex to this letter). I would like to draw your attention to a couple of these in particular and I can provide more information on any of the others

In 2013, the NHS England Seven Day Services Forum examined these sources and the wider evidence base for seven day services and said that the "weekend effect" is likely to be a consequence of:

- variable staffing levels at weekend;
- the absence of senior decision makers (consultants);
- a lack of consistent specialist services (eg diagnostic) at weekends; and
- a lack of availability of specialist community and primary care services.

More recently, analysis published in the BMJ in September 2015, which looked at hospital admissions in 2013-14, found that patients admitted to hospital at the weekend have an increased risk of mortality of 15% on a Sunday compared to a Wednesday and 10% on a Saturday compared to a Wednesday. It also found that 11,000 more people die each year within 30 days of admission to hospital on Friday, Saturday, Sunday, or Monday compared with other days of the week. The authors say that "it is not possible to ascertain the extent to which these deaths may be preventable" but that "from an epidemiological perspective [...] this statistic is 'not otherwise ignorable' as a source of information on risk of death and it raises challenging questions about reduced service provision at weekends".

The same study demonstrated that patients admitted at weekends are sicker. The analysis however, accounted for a number of markers of patient severity, including

diagnosis category, age, time of year, trust, deprivation, number of previous emergency admissions, number of previous complex admissions, admission source, admission urgency, sex, ethnicity and comorbidities. This enabled the researchers to control for a number of proxies for severity of illness.

In December 2012, the Academy of Medical Royal Colleges published its report, "Seven Day Consultant Present Care". It said the following about the weekend effect:

- "Most hospitals and specialties already provide a non-resident consultant-led on-call rota, which should ensure that an acutely unwell or deteriorating patient has access to a consultant, and timely intervention… However, in the absence of a daily 'planned' consultant review the remainder of the patient's care pathway is often put into hibernation particularly over weekends, resulting in delays in diagnosis, investigation, treatment and discharge from hospital."

- "…following discharge from acute areas to general wards the frequency of consultant review falls significantly. The result is that departures from the care pathway are not uncommon, and are not detected in a timely manner."

- "it is not uncommon for patients whose condition is not deteriorating to wait until the next scheduled weekday review before being seen by a consultant. For example, a patient who is admitted on a Thursday night will usually be seen by a consultant on Friday morning, but may then wait until Monday for their next scheduled consultant review."

- "The weekend effect is very likely attributable to deficiencies in care processes linked to the absence of skilled and empowered senior staff in a system which is not configured to provide full diagnostic and support services seven days a week."

- "The most effective way to improve outcomes for patients admitted to hospital at weekends is to ensure that care is delivered by adequately supported consultants and monitored using care pathways."

Other research suggests that a weekend effect is not unique to the English NHS. Poorer outcomes for elective and emergency admissions have been demonstrated in US, Australia and other European countries. However we are leading the world in trying to measure its extent and tackle its impact on clinical outcomes.

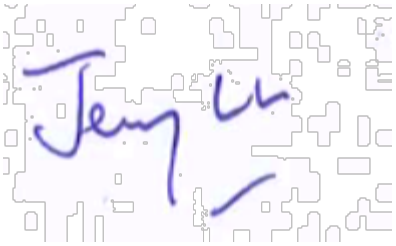
Finally, there has been some public discussion about statements I made recently about a 20% increased risk of death if you have a stroke at a weekend. This statistic was taken from the Seven Day Services Forum Evidence Base published in 2013. This evidence base is the most recent summary of all the published research on the

need for seven day care and includes references from over 120 academic and clinical studies up to 2013.

As part of this evidence base there was a case study of a specialist care pathway for stroke. The case study states: “National evidence suggests that across NHS hospitals stroke patients have approaching a 20% greater risk of dying if admitted on a weekend in contrast to a weekday”. The case study goes on to report that specialised units that are staffed 24 hours a day by stroke experts and have arrangements in place with ambulance services to take suspected stroke patients straight to their nearest Hyper Acute Stroke Units rather than the local hospital have significantly reduced this higher mortality rate for stroke patients admitted at weekends.

The roll out of Hyper Acute Stroke Units may well mean the situation has improved since the most recent mortality figures were collected and if this is the case it clearly demonstrates the correlation between seven day services and reduced mortality rates.

I hope you find this letter helpful.



**JEREMY HUNT**

## Annex A – 10 Clinical Standards

| No. | Standard | Adapted from source |
|---|---|---|
| | **Patient Experience** | |
| 1 | **Standard:**<br>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.<br><br>**Supporting information:**<br>• Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times.<br><br>• The format of information provided must be appropriate to the patient's needs and include acute conditions.<br><br>• 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)<br><br>RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* |
| | **Time to first consultant review** | |
| 2 | **Standard:**<br>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.<br><br>**Supporting information:**<br>• All patients to have a National Early Warning Score (NEWS) established at the time of admission.<br><br>• Consultant involvement for patients considered 'high risk' (defined as where the | NCEPOD (2007): *Emergency Admissions: A journey in the right direction?*<br><br>RCP (2007): *Acute medical care: The right person, in the right setting – first time*<br><br>RCS (2011): *Emergency Surgery, Standards for* |

| No. | Standard | Adapted from source |
|---|---|---|
| | 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.<br>• 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.<br>• Standards are not sequential; clinical assessment may require the results of diagnostic investigation.<br>• 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.<br>• The standard applies to emergency admissions via any route, not just the Emergency Department.<br>• For emergency care settings without consultant leadership, review is undertaken by appropriate senior clinician e.g. GP-led inpatient units. | *unscheduled surgical care*<br>RCP (2012): *Delivering a 12-hour, 7-day consultant presence on the acute medical unit* |
| | **Multi-disciplinary Team (MDT) review** | |
| 3 | **Standard:**<br>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*<br>RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*<br>NICE (2007): *Technical patient safety solutions for* |

| No. | Standard | Adapted from source |
|---|---|---|
| | **Supporting information:**<br>• The MDT will vary by specialty but as a minimum will include Nursing, Medicine, Pharmacy, Physiotherapy and for medical patients, Occupational Therapy.<br>• 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.<br>• Reviews should be informed by patients existing primary and community care records.<br>• Appropriate staff must be available for the treatment/management plan to be carried out. | *medicines reconciliation on admission of adults to hospital* |
| | **Shift handovers** | |
| 4 | **Standard:**<br>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.<br>**Supporting information:**<br>• Shift handovers should be kept to a minimum (recommended twice daily) and take place in or adjacent to the ward or unit.<br>• 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*<br>RCP (2013): *Future Hospital Commission* |
| | **Diagnostics** | |

| No. | Standard | Adapted from source |
|---|---|---|
| 5 | **Standard:**<br><br>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:<br><br>• Within 1 hour for critical patients<br>• Within 12 hours for urgent patients<br>• Within 24 hours for non-urgent patients<br><br>**Supporting information:**<br><br>• It is expected that all hospitals have access to radiology, haematology, biochemistry, microbiology and histopathology<br>• 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.<br>• Standards are not sequential; if critical diagnostics are required they may precede the thorough clinical assessment by a suitable consultant in standard 2.<br>• Investigation of diagnostic results should be seen and acted on promptly by the MDT, led by a competent decision maker.<br>• Where a service is not available on-site (e.g. interventional radiology/endoscopy or MRI), clear patient pathways must be in place between providers. | RCP (2007): *Acute medical care: The right person, in the right setting – first time*<br><br>RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*<br><br>AOMRC (2012): *Seven day consultant present care*<br><br>RCR (2009): *Standards for providing a 24-hour radiology diagnostic service*<br><br>NICE (2008): *Metastatic spinal cord compression* |

| No. | Standard | Adapted from source |
|---|---|---|
| | • Seven-day consultant presence in the radiology department is envisaged.<br>• Non-ionizing procedures may be undertaken by independent practitioners and not under consultant direction. | |
| | **Intervention / key services** | |
| 6 | **Standard:**<br>Hospital inpatients must have 24 hour access, seven days a week, to consultant-directed interventions either on-site or through formally agreed networked arrangements with clear protocols, such as:<br>• Critical care<br>• Interventional radiology<br>• Interventional endoscopy<br>• Emergency general surgery<br>**Supporting information:**<br>• Standards are not sequential; if an intervention is required it may precede the thorough clinical assessment by a suitable consultant in standard 2.<br>• Other interventions may also be required. For example, this may include:<br>o Renal replacement therapy<br>o Urgent radiotherapy<br>o Thrombolysis<br>o PCI<br>o Cardiac pacing | NCEPOD (1997): *Who operates when?*<br>NCEPOD (2007): *Emergency admissions: A journey in the right direction?*<br>RCP (2007): *Acute medical care: The right person, in the right setting – first time*<br>RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*<br>British Society of Gastroenterology<br>AoMRC (2008): *Managing urgent mental health needs in the acute trust* |
| | **Mental health** | |
| 7 | **Standard:**<br>People with mental health needs must be assessed within the appropriate timescales 24 hours a day, | RCPsych PLAN (2011): *Quality Standards for Liaison Psychiatry* |

| No. | Standard | Adapted from source |
|---|---|---|
| | seven days a week:<br>• Within 1 hour for emergency* care needs<br>• Within the same day for urgent** care needs<br>**Supporting information:**<br>• 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.)<br>* An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.<br>** 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. | *Services* |
| | **On-going review** | |
| 8 | **Standard:**<br>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.<br>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.<br>**Supporting information:**<br>• 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 | RCP (2007): *Acute medical care: The right person, in the right setting – first time*<br>RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*<br>AOMRC (2012): *Seven day consultant present care*<br>RCP (2013): *Future Hospital Commission* |

| No. | Standard | Adapted from source |
|---|---|---|
| | written, information.<br>• 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).<br>• Consultants 'multiple day blocks' should be between two and four continuous days.<br>• 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.<br>• Once admitted to hospital, patients should not be transferred between wards unless their clinical needs demand it.<br>• The number of handovers between teams should be kept to a minimum to maximise patient continuity of care.<br>• 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.<br>• 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** | |

| No. | Standard | Adapted from source |
|---|---|---|
| 9 | **Standard:**<br><br>Support services, both in the hospital and primary and community setting 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.<br><br>**Supporting information:**<br><br>• 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.<br><br>• 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.<br><br>• Transport services must be available to transfer, seven days a week.<br><br>• 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:**<br>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. | GMC (2010): Generic standards for specialty including GP training |

| No. | Standard | Adapted from source |
|---|---|---|
| | **Supporting information:**<br>• The review of patient outcomes should focus on the three pillars of quality care: patient experience, patient safety and clinical effectiveness.<br>• 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.<br>• All clinicians should be involved in the review of outcomes to facilitate learning and drive quality improvements. | |

**ANNEX B - Research into 'the weekend effect' on patient outcomes and mortality**


1. Ozdemir et al (2015). Mortality of emergency general surgical patients and associations with hospital structures and processes. British Journal of Anaesthesia

2. Palmer, Bottle & Aylin (2015). Association between day of delivery and obstetric outcomes: observational study. BMJ

3. Ruiz et al (2015). Exploring the impact of consultants' experience on hospital mortality by day of the week: a retrospective analysis of hospital episode statistics. BMJ Quality and Safety

4. Freemantle et al (2015). Increased mortality associated with weekend hospital admission: a case for expanded 7 day services? BMJ

5. Ruiz et al (2015). The Global Comparators Project: international comparison of 30 day in-hospital mortality by day of the week. BMJ Quality and Safety

6. Aiken et al (2014). Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. Lancet

7. East Midlands Clinical Senate (2014). 7 Day Services Project: Acute Collaborative Report.

8. Aylin et al (2013). Day of week of procedure and 30-day mortality for elective surgery: retrospective analysis of Hospital Episodes Statistics. BMJ

9. NHS services, 7 days a week. NHS services, 7 days a week forum (2013).

10. Palmer et al (2012). Dying for the weekend: a retrospective cohort study on the association between day of hospital presentation and the quality and safety of stroke care. Archives of Neurology

11. Freemantle et al (2012). Weekend hospitalisation and additional risk of death: an analysis of inpatient data. J R Soc Med

12. AoMRC (2012). 7 day consultant present care.

13. Mickulich et al (2011). The increased mortality associated with a weekend emergency admission is due to increased illness severity and altered case mix. Acute Medicine

14. Aylin et al (2010). Weekend mortality for emergency admissions: a large multicentre study. BMJ Quality and Safety

15. Professor Sir John Temple (2010). Time for training.