Top-quality, coordinated clinical care seven days a week: an affordable vision?

An aspect of the report of the Future Hospital Commission (FHC) that was considered controversial when it was published 2 years ago was the perception that medical generalism was favoured over the trend towards increased specialisation. This notion was an oversimplification of a complex problem. A compelling component of the evidence gathered by the FHC came from patients and carers, who were engaged at all levels of the exercise. It became clear that they found the tendency for multiple specialists, often with extremely focused areas of expertise limited to a single organ (or indeed a part of that organ), to come to their bedside, pronounce on that specific aspect of their care and then depart to be frustrating, notwithstanding the undoubted improvements in clinical outcomes such specialisation has achieved.

In response, a central recommendation of the FHC was that a trained clinician would assume overall responsibility for managing and coordinating each patient's care. This role could be fulfilled by generalists, or delivered by specialists for part of their job plan. All those involved in producing the FHC report were adamant that maintaining and augmenting the access of patients to specialist care could not be compromised in the future hospital; the issue was merely that the coordination of these efforts and their delivery as part of a comprehensive care plan was often lacking. Robert Francis also emphasised this point in his report into the Mid-Staffordshire case, asserting that the responsibility for the delivery of a basic level of care to all patients needed to be assumed by a senior clinician. The publication of this issue of the journal comes at a time when there is increased emphasis on seven-day working, which could arguably fit very neatly into this theme of 'ongoing responsibility'. The weekend effect, in which the patients who are most unwell are admitted to hospital at the time of the week when the fewest staff are on duty, has been heavily publicised.[1,2] Whether or not consultants working seven days a week would actually save lives remains to be seen, especially as many already do, but the principle of senior involvement in the coordination and delivery of care, whether or not it directly affects outcome, was central to the message of the FHC.

How then can we afford this? The RCP has openly stated that the current system, with which your editor is extremely familiar, of consultants starting a 12-day stretch of work incorporating a weekend (and often including night calls) is not sustainable without compensatory rest. That would mean more consultants in the rota and a resulting increase in costs. Where will additional funding come from in this age of austerity? It's pretty clear that the orthodoxy of the NHS being free at the point of delivery is at least being questioned in England, if not by the devolved administrations of Wales and Scotland. In other jurisdictions (such as the Netherlands), reconciling this need to contain public cost with the drive for improvements in quality has also been addressed, albeit in a manner unfamiliar to the UK. In 2006, the Dutch introduced a compulsory deductible premium, with a maximum quantum of around $400 per year, which is levied upon patients who need to be admitted to hospital – a principle seemingly similar to the excess payable in association with car insurance.[3] A range of agents are permitted to oversee and deliver the processes and care packages.

The totemic tie of healthcare provision solely to the NHS also seems to be loosening in the eyes of the UK general public. The latest edition of the British Social Attitudes Survey contained a question about the delivery (as supposed to the funding) of healthcare. People were asked whether they would prefer to be treated by an NHS provider, or through private for-profit or non-profit companies. 43% of respondents said they had no general preference for any sector, and another 18% expressed an active preference for private providers. Finally, some authorities have suggested that patients should be given a free choice not only of healthcare provider but also of commissioner. Clinical commissioning groups fulfil a role similar to that of health insurers in more market-orientated systems, but are in effect local monopolies. Some argue that they should not be.[4] Addressing and broadening the issue of who pays (and when), and who commissions and provides clinical services, preferably in an integrated fashion, might help to close the funding gap.

In addition to thinking the unthinkable and raising extra money for the health service through raising funds from those who can afford to pay, demand management is moving centre stage. The hypothesis that an avalanche of unnecessary medical care is harming patients physically and financially is achieving

some traction. Atul Gawande, a surgeon, writer and 2014 BBC Reith lecturer, has argued that clinicians increasingly perform tests 'unnecessarily, to review problems that are not quite problems, to then be fixed unnecessarily at a great expense and no little risk',[5] while avoiding or inadequately addressing the public health epidemics of diabetes, hypertension and obesity. In the UK, the chief medical officer has expressed the concern that 'doctors over-medicate so it is difficult to trust them, and that clinical scientists are all beset by conflicts of interest from industry funding and are therefore untrustworthy too'. She has asked the Academy of Medical Sciences to produce an independent report looking at how society should judge the safety and efficacy of drugs as an intervention.[6]

Changing the funding systems and reducing unnecessary interventions are two possible approaches; a third involves looking at the operational productivity of providers. Lord Carter published, in June 2015, his report highlighting what he has called the NHS efficiency challenge.[7] Thus, in NHS England's *Five year forward view*, 2% net savings need to be achieved for the rest of the decade to fill a funding gap estimated at £22 billion. Doing so is clearly going to be challenging.

A large proportion (63%) of NHS provider expenditure in 2014 was accounted for by pay. Workforce management and increased productivity therefore have moved to the fore in the financial wars, against which all other areas of opportunity for cost containment, including inventory and procurement, pale. Carter used a cohort of 22 organisations and developed a metric termed the Adjusted Treatment Index to show variations in the four key areas of workforce management; hospital, pharmacy and medicine optimisation; estates management and procurement. Increased productivity and the management of hospital workflows fall very much within the remit of the FHC in your editor's eyes, although extension beyond Carter's focus on secondary care will be needed if admissions are to be avoided when possible and subacute services will need to be developed to facilitate the seamless and effective transfer of responsibility for delivery to community-based clinical and social care teams.

These are conflicting and enormous challenges. We need to provide seven-day, compassionate and integrated care, while closing a £22 billion funding gap during the next decade. Reconciliation might involve more innovative ways of raising funds, such as those introduced by the Netherlands, cost containment, increased productivity, or a combination of all three approaches. Your editor wishes to be part of this process and is moving on to precisely these pastures new. After launching and delivering the first six issues of the *Future Hospital Journal*, he hopes to leave the publication in good heart. The journal is attracting increasing numbers of excellent submissions, managed by an outstanding editorial team and occupying an academic niche that is of great relevance to the work of the RCP, that of its members and fellows, and, above all, our patients.■

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