What next for hospital services?

Emerging themes from the Future Hospital Commission

Briefing, 25 October 2012

1. Introduction

At the start of 2012, the RCP launched a new Commission to review the organisation of hospital care for adult inpatients with medical illness. The Commission, chaired by Sir Michael Rawlins, will report to the RCP president and Council in spring 2013.

In September 2012, the RCP released Hospitals on the edge? The time for action. Although not part of the Future Hospital Commission, the report sets the scene for why we must radically review the way we design and deliver acute services for patients. It sets out in stark terms the scale of the challenge facing acute hospitals.

Find out more:
- Future Hospital Commission – [www.rcplondon.ac.uk/futurehospital](http://www.rcplondon.ac.uk/futurehospital)
- Hospitals on the edge? The time for action - [http://www.rcplondon.ac.uk/projects/hospitals-edge-time-action](http://www.rcplondon.ac.uk/projects/hospitals-edge-time-action)

2. What are the Future Hospital Commission’s aims?

Hospital services must be designed around the needs of patients. The Future Hospital Commission aims to identify a system in which safe, effective, respectful and compassionate medical care can be delivered to all who need it as hospital inpatients, seven days a week. The focus of the Commission is the acute medical patient in a hospital setting, wherever they are cared for in hospital (eg whether they are in a bed on a medical, surgical or obstetric ward).

People's needs are often complex and this must be reflected in the organisation, structure and delivery of care, treatment and support. People admitted to hospitals with acute medical illness must receive holistic care. This means acute services must be designed to respond to, not just acute medical illness, but also:

- all aspects of physical health, including multiple acute and chronic conditions
- mental health and wellbeing
- social needs
In recognising that people often have specific and complex needs, the Commission also acknowledges that care, treatment and support services will need to be delivered in a range of ways, across a range of settings and by a range of professionals, all working in collaboration.

Therefore, although the Commission's focus is the hospital and medical teams, the interface and interaction with other parts of the health and social care economy is a fundamental aspect of its work. This will include consideration of: primary care, social care and mental health services.

3. **What is the Future Hospital Commission looking at?**

The work of the Future Hospital Commission will be structured around five key workstreams, each focusing on different factors in the effective design and delivery of inpatient hospital care:

- **Patients and compassion**
  This workstream is the driving force for the Commission’s work. It will look at issues relating to patient experience and how we can ensure that staff are empowered and equipped to deliver a high quality, effective and compassionate service designed around the needs to patients.

- **Place and process**
  This workstream will address the *place*, which broadly equates with hospital site or other sites as specified in the community, and *process*, looking at the elements of care delivery as they relate to the acutely unwell medical patient. It will consider issues around: the patient pathways into, through and out of hospital; the organisation of care and wards; the balance of generalist and specialist care; and how medical teams are deployed and interact with other teams in the hospital.

- **People – the workforce**
  This workstream will address the workforce issues related to delivering care to the acutely unwell medical patient. It will consider current and future national workforce policy; the changing demographic of the medical workforce; bed capacity in acute hospitals.

- **Data for improvement**
  This workstream will describe data requirements for the future hospital from the perspective of the physician and the physician leader. This will include standards for data recording, collection, review and feedback, and look at how we can turn data into knowledge. It will consider data at three levels: patient-level; clinician and team-level, and; hospital and service-level.

- **Planning and infrastructure**
  This workstream will looks at the diagnostic and supportive services that need to work with medical teams in the delivery of 24/7 care for patients. It will also look at issues around the physical environment, technological innovations, green environmental and human resource issues.
For each of these areas, the Commission will:

- develop proposals that are clinically-driven, but economically viable, widely applicable and sustainable
- take a long-term view and be prepared to make radical recommendations where these are necessary to achieve the aim of safe, high quality, sustainable care
- identify practical steps to work towards longer term recommendations, utilising existing examples of good and innovative practice
- take account of:
  - the future demographic of the general population and the healthcare workforce
  - the future design, delivery and operation of hospital services within the wider health economy, including the interaction with primary and social care; and
  - other issues likely to impact significantly on the delivery of hospital services, such as new technologies and other innovations.

4. Are there any themes emerging?

The Commission does not report until spring 2013, and its recommendations need to be approved by the high-level, multi-professional board of commissioners before they are presented to the RCP president and Council. However, a number of key areas of discussion have begun to emerge.

Principles for discussion:
These principles do not currently constitute recommendations, but they are areas around which we are particularly keen to receive feedback.

A. Seven-day health service
Patients and populations must have access to effective, coordinated services for diagnosis, treatment and care seven days a week. There must be consistent standards in safety, patient experience and clinical outcomes across the week. The day of the week should not be a barrier to patients receiving initial assessment and care, or moving along their care pathway into, within or out of hospital. This means services, facilities and staff, including senior clinical staff, must be organised and deployed to deliver seven day care across the health service.

B. Fewer moves
After an initial assessment, patients should not move again unless there are exceptional circumstances. Such a principle could be supported by a commitment from NHS staff to patients, such as:

- We will only move you on the basis of your needs.
- We will explain to you where you are moving to and why. Where possible, we will tell you how long you are moving for.
- We will not move you at night unless your needs immediately and urgently require it.
- We will make sure you know who to speak to about your needs, treatment and care.
• We will make sure your family know where you are and, where appropriate, why you are there.

C. Single consultant-led team
i. A single consultant-led team should be responsible for a patient’s care throughout their stay in hospital. The consultant-led team involved in care on day of admission, should deliver care the following day. Rotas for medical teams should be designed so that ‘on-call’ days are followed by scheduled days for follow up.
ii. Each ward should have a named consultant responsible for liaising with the ward manager on basic standards of care for all patients.
iii. Patients with multiple conditions on non-medical wards (eg surgical wards) should be cared for by a single medical team on an ongoing basis.

D. Expert general physicians and the interaction with specialised care
i. Physicians with specialist expertise in general medicine (including acute, general internal medicine (GIM) and elderly care physicians) should provide continuing care to patients, unless specialised care in a designated specialist ward is required.
ii. Advances in treatment and care brought about by increased specialism in medicine should be protected. The advances and benefits brought about by increased specialisation must be harnessed across system, including for patients with multiple conditions and treatment delivered in general and acute care wards.
iii. We must ensure general medicine is an attractive option for doctors at all career stages.
iv. Training in general medicine should be the norm for trainee doctors.

E. Designing care for patients with dementia
The hospital environment, standards and systems should be designed around the needs of acutely ill patients with dementia. Providing high quality care for patients with cognitive impairment is likely to provide a benchmark for the care of all patients. The needs of other groups of patients (eg young people) will, of course, also need to be considered.

F. Transferring care
i. Consultants should be involved in decision-making about the organisation of care once patients leave hospital. Patients and their families should be involved in discharge planning.
ii. Advanced care planning for people with end-stage disease should be done before hospital admission.
iii. Integration of services for vulnerable patients in the community, including care home residents, should be the focus of new ways of delivering services across primary, secondary and social care.
5. **A new model of care?**

Delivering integrated care for patients seven days a week is likely to require internal structural change within hospitals, and changes to working patterns. Over the next few months, the Commission will explore what this will mean in practice, but we are keen to receive your feedback on options we should explore.

**A. Acute care directorate**

*Should acute and urgent care functions within the hospital be brought together into one managed ‘directorate’?*

Such a directorate could include the emergency departments, acute medical unit, intensive care and general medical beds. The directorate could be supported by specialty beds where necessary, with rapid admission to specialty beds for patients where this is assessed as best option and (multiple) specialists providing a ‘consultation’ service to those based in general beds.

**B. ‘Front door’ assessment team**

*How can we ensure effective patient assessment and referral from the hospital ‘front door’?*

Assessment by experienced physicians and multidisciplinary teams on arrival in secondary care has been shown to improve care, reduce admission rates and help ensure appropriate referral. Examples from geriatric medicine suggest this model may work well for patients with multiple comorbidities. Rapid access to specialist services is linked to improved outcomes in important areas such as stroke and myocardial infarction. Strengthening initial assessment, organisational structures and physician-led community services can help ensure all patients, including those with multiple comorbidities and complex needs, have access to the specialist attention when and where they need it.

**C. Enhanced care beds**

*Do we need more enhanced care medical beds (level 1 or 1.5)?*

Patients admitted to hospital now have a greater acuity and complexity of illness than previously. The RCP 2007 report, *Acute medical care: the right person in the right setting first time (2007)*, recommends level 1 beds located on the acute medical unit (AMU), but few AMUs have implemented this.

Enhanced care beds (level 1 or 1.5), with greater nurse to patients ratios, could be located within the acute care directorate’s AMU and operated in conjunction with the high dependency unit (HDU) and intensive care unit (ITU). Enhanced care beds would provide an intermediate level of care for acutely ill medical patients. These patients currently have to compete for a very limited stock of high dependency (level 2) and intensive care (level 3) beds with patients on other clinical pathways, including patients following elective and emergency surgery.
Get involved

The emerging themes presented at today’s Future Hospital Commission stakeholder event are intended to generate discussion, further suggestions and improvements. To develop an effective and comprehensive set of recommendations, we need your suggestions and ideas.

Focus of discussions:

• How could we improve the emerging principles and proposed models?
• How else could we address the challenges outlined in Hospitals on the edge? and achieve the Commission’s principle aims of:
  i. continuity of care
  ii. seven day health service
  iii. effective, expert and high quality care for all patients, including those with complex multiple conditions
• Are there existing examples of good and innovative practice that we should explore?
• What should be our next steps?

Find out more:
www.rcplondon.ac.uk/futurehospital

Further resources will be available online soon, including:
• Discussion and briefing papers
• Online discussion forums

Get engaged in the debate:

We are keen to receive suggestion, comments, evidence and examples of good and innovative practice to:

futurehospital@rcplondon.ac.uk

We are also keen to receive feedback from other groups and meetings. Briefing papers and handouts can be provided on request. We may also be able to provide speakers, presentations and written content for magazines and bulletins – please contact the RCP External Affairs Team to discuss.

Contact:
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Annex

Questions being addressed by Future Hospital Commission workstreams

Patients and compassion

This workstream is the driving force for the Commission’s work. It will look at issues relating to patient experience and how we can ensure that staff are empowered and equipped to deliver a high quality, effective and compassionate service designed around the needs to patients.

Key questions:

1. **Professionalism - leadership, accountability and responsibility**: How do we embed professionalism in the hospital culture, emphasising team working, to ensure high standards of care for patients and better staff morale?
2. **Responding to patient needs**: How do we ensure personalised care recognising individual patient needs, e.g., the young, the older person, black and minority ethnic individuals, those with sensory impairment etc?
3. **Communicating with patients and carers**: How do we enhance good communication with patients and their families/carers, particularly at the interface of care?
4. **Shared decision-making and self care**: How can we promote shared decision making and self-management taking into account patient preferences?
5. **Advance care planning**: How do we improve recognition of the dying patient and ensure appropriate care planning, including decisions about ceiling of care, preferred place of care, and resuscitation decisions?
6. **Developing a caring and cared for workforce**: How can we support staff to provide compassionate and dignified care?
7. **Care for patients with dementia and delirium**: How do we ensure that healthcare staff working with patients with dementia are not only compassionate but also adequately skilled?
8. **Measurement**: How do we measure and feedback what patients experience?

Place and Process

This workstream will address the place (broadly equates with hospital site, or other sites as specified in the community) and process (elements of care delivery) relating to the acutely unwell medical patient.

Key questions:

1. **Interface with primary and community care**: How do we ensure that patients at all times receive care promptly in the setting (community or hospital) that matches their clinical needs?
2. **Clinical decision-making**: How do we ensure that the initial clinical assessment is accurate and prompt and that all subsequent clinical contacts with the patient are organised to enhance their clinical care?

3. **Medical patient at risk**: What are the best processes to ensure that the clinical team identifies deteriorating patients early leading to prompt delivery of the right care, in right acute care setting?

4. **Continuity of care**: How do we maximise continuity of care in hospital - what new models of care, team working, and working practices are required?

5. **Safe patient care**: What processes should we utilise to ensure patient care is as safe as possible?

**People – the workforce**

This workstream will address the workforce issues related to delivering care to the acutely unwell medical patient in the future.

**Key questions:**

1. What is the ideal team size and make-up to deliver care to acutely unwell medical patients?
2. How should consultants work in the next 10 years?
3. What new types of medical staff should we develop?
4. Career planning: How do we make the best use of the current non-consultant medical workforce?
5. How do we ensure the workforce remains healthy and equipped to deliver compassionate care?

**Data for improvement**

This workstream will describe data requirements for the Future Hospital from the perspective of the physician and the physician leader in a system designed around the patient and aiming to drive continuous improvement. This will include standards for data recording, collection, review and feedback.

The key questions will focus on how we can build a system in which health information and data can be used to:

1. facilitate care for individual patients
2. help clinicians to understand their own practice and that of their teams
3. tell us about how the system works.

**Planning and infrastructure**

This workstream will address the physical environment, technological innovations, green environmental and human resource issues related to the delivery of the relevant infrastructure to
support the provision of integrated healthcare across the entire patient pathway, in the proposed model(s) of the *Future Hospital*.

Key questions:

1. **Availability:** How should ‘support’ services be provided: which disciplines/services need to be available within hospitals 24/7, which should be ‘on call’ and which should work a ‘routine’ 9-5/6 or later pattern?
2. **Professional roles:** Who does/should do what (eg procedures) and what are the implications for service planning, availability and education/training?
3. **Service improvement:** How do other professions (nursing/ pathology, etc) consider that they could better support the clinical medical service, and what is the number of procedures/patients ratios for each profession/setting?
4. **Design and innovation:** How can building design facilitate access and high quality patient care and what will be the impact of new technologies and innovation on the infrastructure for service design and delivery?
5. **Integration:** How can the physical environment and human resource infrastructure ensure improved integration of the care pathway and patient experience, including primary and social care?