

Future hospital: Caring for medical patients

A report from the Future Hospital Commission
to the Royal College of Physicians
September 2013

Future Hospital Commission

The Future Hospital Commission was established by the Royal College of Physicians in March 2012. The Commission is an independent group tasked with identifying how hospital services can adapt to meet the needs of patients, now and in the future. *Future hospital: caring for medical patients* is a report from the chair of the Future Hospital Commission, Professor Sir Michael Rawlins, to the RCP. The Future Hospital Commission's report is the first step in a longer programme of activity designed to achieve real change across hospitals and the wider health and social care economy in which they operate.

The Royal College of Physicians

The Royal College of Physicians plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in over 30 medical specialties with education, training and support throughout their careers. As an independent charity representing more than 28,500 fellows and members worldwide, we advise and work with government, patients, allied healthcare professionals and the public to improve health and healthcare.

Citation for this document: Future Hospital Commission. *Future hospital: caring for medical patients*. A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013.

Copyright

All rights reserved. No part of this publication may be reproduced in any form (including photocopying or storing it in any medium by electronic means and whether or not transiently or incidentally to some other use of this publication) without the written permission of the copyright owner. Applications for the copyright owner's written permission to reproduce any part of this publication should be addressed to the publisher.

Copyright © Royal College of Physicians 2013

ISBN 978 1 86016 518 4

eISBN 978 1 86016 519 1

Future Hospital Commission
Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

www.rcplondon.ac.uk

Registered Charity No 210508

Typeset by Cambrian Typesetters, Camberley, Surrey

Contents

Foreword	vii
Chairman's Preface	ix
Foreword: the patient perspective	xi
Future Hospital Commission	xiii
Operational Group	xv
List of case studies	xvii
Executive summary	xxi

Part A Background and drivers for the Future Hospital Commission: the principles of care

1 Introduction and purpose of the report	3
The needs of patients in the 21st century	4
The challenges faced by our hospitals	5
The Future Hospital Commission	7
Evolution to the future hospital – adapting to local circumstances	9
Engagement in designing the Future Hospital Commission's recommendations	10
2 Principles underpinning the care of medical patients	13
The hospital at the hub of a new system of care	13
Improving collaboration across health and social care	14
The hospital's public health role	15
The acutely ill: managed in the right place by the right team	15
An end to silo working: communication and continuity of care	16
Administration and management	17
Delivering patient-centred care: four principles	17
Embedding the principles of patient care in service design and delivery	19
The Commission's vision for patient care	21

Part B A new model of clinical care

Introduction	26
Our vision of the future hospital – a new model of clinical care	27
3 A new organisational approach: the Medical Division	29
What is the Medical Division?	29
Resources the Medical Division will need to function effectively	30

Physical areas of responsibility of the Medical Division	31
The Acute Care Hub	32
Medical (specialty and non-specialty) and surgical wards	34
The Clinical Coordination Centre	35
How the Medical Division is managed and led	35
Who will work in the Medical Division?	37
Recommendations	40
4 Staffing the Medical Division: an increased role for the generalist and specialist	41
An increasing need for general medical skills	41
The role of the specialist defined and extended	43
Recommendations	48
5 The hospital–community interface	49
Operational imperatives	49
At the front door: early, expert assessment	49
A focus on ambulatory (day-case) emergency care	51
Moving through the Acute Care Hub	54
Discharge no longer: planning the transition of care from hospital to the community	54
Enhanced recovery and rehabilitation	55
‘Early supported discharge’	55
Integrated acute and specialist care beyond the hospital walls	57
Teams delivering healthcare outside the hospital	58
Appropriate support to care home residents	59
Governance and organisational processes/infrastructure	60
Recommendations	61
6 Specific services: care for older people with frailty, people with mental health conditions, people who are homeless, and young people and adolescents	63
Care of the older patient with frailty: the extent and nature of the challenge	63
Care of the older patient with frailty: optimal assessment in hospital	65
Care of the older patient with frailty: alternatives to hospital admission	66
People with mental health conditions	66
Patients who are homeless	67
Young adults and adolescents	69
Recommendations	72
Part C Evolution to the future hospital model of care	
Introduction	74
Our vision of the future hospital – evolution to the future hospital vision of care	75
7 The changing workforce: meeting the needs of patients across the system	77
The medical workforce: current pressures and constraints	77
Achieving a balance of holistic and specialist care: the importance of team working and leadership	78
A new focus on general medicine in the hospital and community settings	78
What does this model mean for medical education and training?	79
Non-clinical core skills for medical professionals: clinical leadership	80

Information technology and education and training	81
Recommendations	82
8 Management: prioritising non-elective medical care and developing relevant tools	85
Costing, funding and payment	85
Clinical leadership in financial and operational management	86
Service-line management	86
Recommendations	88
9 Using information to support care and measure success	89
Clinical information and the delivery of compassionate, effective healthcare: the need for data	89
Clinical data collection and uses: the current situation	89
The clinical record: key principles	90
Technology to improve the patient experience	93
Access to knowledge	94
Use of the clinical record	95
Enhanced research capability	96
Recommendations	97
10 Research and development	99
The value of research	99
Supporting staff to carry out research	100
Measuring research performance	100
Patient involvement in research	102
Recommendations	103
11 Building a culture of compassion and respect	105
The national agenda	105
Valuing patient experience	106
Measuring patient experience – an overview of existing data sources	111
Healthcare delivery: team working, communication and continuity	111
Responding to the needs of specific groups of patients	113
Shared decision-making	113
Compassionate care: supporting staff	114
Health of the medical workforce	115
Recommendations	118
Appendices	
1 Future hospital principles, vision, recommendations and commitments to patients	123
2 Recommendations for the RCP	141
3 The future hospital described: overview of new models and roles	143
4 The future hospital explained	150
5 View from the chief of medicine	157
6 The medical workforce explained	161
7 Glossary	167
8 Members of work streams for the Future Hospital Commission	174
9 Contributors	180

Foreword

There has been a sea change in acute medical care over the past decade or so, as the Royal College of Physicians (RCP) described so vividly in its 2012 report, *Hospitals on the edge?** Slowly, almost imperceptibly, the numbers of patients coming through the doors have kept rising year on year, a cumulative rise of 37% over 10 years, and they are older and have more comorbidities. Physicians noticed, and struggled, and coped with these gradual increases in the number and complexity of emergency admissions by reducing the length of stay in hospital. But we can no longer do that. Our patients deserve better than the care we can now deliver under current pressures.

If this increase had happened all in one year, it would have been deemed a national disaster, given the immediate priority of a major disease outbreak, and a national plan and resources would have been marshalled to meet the challenges. But because it crept up in small increments, none of this happened. Every hospital is now feeling the strain, and financial resources have been cut. We have long run out of our yearly coping strategies and must take a more radical approach to solve the problem.

To do this, in 2012 the RCP set up the Future Hospital Commission, chaired by Sir Michael Rawlins, to review all aspects of the design and delivery of inpatient hospital care, and to make recommendations to provide patients with the safe, high-quality healthcare that they deserve. I am delighted to say that the Commission has exceeded that goal.

It sought the best of physicianly practice across the country, and brought together panels of experts from medical and other health disciplines to build a vision of what comprehensive care for medical patients could look like. But it has done much more. The first half of the report makes bold suggestions for a new model of clinical care for acute medical patients. The second part of the report looks at the supporting systems and culture change that will be necessary to support the reorganisation of acute care. In our post-Francis world, it focuses on the qualities needed for hospitals and professionals to build a patient-centred culture in which all are treated with compassion and respect.

There are caveats – acute care is only one part of a hospital, but vital nevertheless, and we need all parts of the health and social care system to work together to deliver sustainable change, whether working in surgery, obstetrics and gynaecology, general practice or social care. The way hospitals implement the proposals will depend on local circumstances, size and staffing. We know that

*Royal College of Physicians. *Hospitals on the edge? The time for action*. London: RCP, 2012.

delivering radical change – as has been proposed by the Commission – is not easy. It will mean evolution, difficult decisions and strong leadership.

However, these recommendations are only the start of our work on the future hospital to improve the care of medical patients. As I write this, the RCP has already begun work on its formal response, in which we shall explain how we shall respond to the Commission's recommendations and then continue to develop its themes across our work.

The RCP and the healthcare professions must now lead the way: through the delivery of the high clinical standards the public has come to expect from UK doctors; through the development of new models of care that drive improvements in both clinical outcomes and patient experience; through our daily interactions with patients, enabling and empowering them to lead healthier lives; and through the education and training of future generations of doctors. This report will not sit on a shelf; it will continue to be at the top of the RCP's agenda into 2014 and well beyond.

I would like to thank all who worked on this report, and in particular Professor Tim Evans and Gemma Cantelo, both for its radical content and the speed with which it was produced.

September 2013

Sir Richard Thompson
President, Royal College of Physicians

Chairman's Preface

Dear president

It has been both a privilege and a pleasure to chair the Future Hospital Commission. The privilege has been the knowledge that, if the Commission could develop an approach to shaping the future of hospital medicine that met the increasingly complex needs of patients, we would make a real difference to the landscape in which the Royal College of Physicians' (RCP) members and fellows carry out their day-to-day clinical practice. The pleasure has come from working with the members of the Commission itself; gathering together the wisdom of the members of the Commission's five work streams, and working with colleagues at the RCP, most especially Professor Tim Evans and Gemma Cantelo. The Commission is grateful to them all.

The Commission took, as its starting point, the RCP's salutary report, *Hospitals on the edge?*, published a year ago. In that report the RCP identified five major challenges facing the acute hospital medical services:

- > increasing clinical demands in the face of reduced facilities for acute medicine
- > the changing needs of patients, with those over 65 years of age, and with multiple conditions, requiring holistic care
- > poor continuity of care that too many patients receive when admitted to hospital
- > inadequate arrangements for out-of-hours care in hospitals
- > a looming workforce crisis amongst both consultants and trainees.

In designing solutions to resolve these problems the interests of patients have been paramount. And the Commission has benefited, hugely, from working with clinical leaders, frontline health and care professionals, and patients themselves, to identify innovative new ways of working that deliver the best possible care. Physicians, managers and other professionals – from Nottingham to Northumberland – have been driven by the desire to improve the services they provide for patients. The innovative approaches, already being delivered in the health service, have consistently impressed me. Many of the ideas the Commission is proposing have already been tried and tested. Our challenge, therefore, was not to invent good practice but to seek it out where it already existed.

It was clear to the Commission, at the outset, that the *status quo* was not an option. We needed to formulate a radical reinvention of the front end of the hospital so that patients receive early diagnosis and treatment, as well as all the other components of appropriate care, delivered in a location best suiting their needs. This meant making sure that patients will, in the future, be able to leave hospital as

soon as they no longer need acute medical care. For this, new ways of working within and between hospital teams, as well as with colleagues in primary and social care, will be needed.

The model is radical. Embedded within our recommendations is the need for a resurgence of general medicine. Specialists, of course, play an essential role in the acute hospital but we need to ensure that, in the future, specialists all possess expertise in general medicine as well as in their specialty; and that they are able to provide patients with the broad range of clinical skills that the majority of them so desperately need.

The Commission's report indicates the direction of travel. The pace of progress will inevitably vary from institution to institution. There are, moreover, very important implications for the training of future generations of consultant physicians in all specialties as well as in the research agenda. The Commission has not shied away from considering these as it developed its proposals.

The Commission is extremely grateful to all the patients, professionals and other experts who contributed to this report, developed its ideas and were brave enough to make radical suggestions. I am confident that the RCP, and the wider health community, will make improving care for acute medical patients their priority over the coming years. It is a duty we owe our patients.

With all good wishes

Professor Sir Michael Rawlins
Chairman, Future Hospital Commission

September 2013

Foreword: the patient perspective

Like many patients with a long-term medical condition who from time to time need to be admitted to hospital urgently, I have an ambivalent relationship with our hospitals. The high standard of medical care I have received, coupled with the compassion of many doctors and nurses, has shown me the very best our health service can offer. However, there have also been times when I have felt like a parcel, passed around the hospital from ward to ward, sometimes in the middle of the night. This has often been without explanation, and with no idea of who is actually responsible for my care or who I could talk to about the situation.

At times like these – and particularly when I have been admitted at the weekend – it can seem as though my care is organised for the convenience of the system and its staff, with very little to do with my needs. I believe doctors and nurses in our hospitals want to do the best for their patients. But I have seen at first hand the consequences of hospital wards being put under extreme stress by the number of patients and the complexity of the medical conditions to be treated. Stress can dehumanise, and staff learn to rely increasingly on systems and processes just to cope with the sheer number of patients under their care. It is often unthinking and unnoticed, with just no time for staff to pause and reflect. Frequently, the number of temporary staff from agencies outstrips the number of permanent staff familiar with the team, the ward, the hospital and individual patients. As patients, we can see what could be improved and often how to do it, yet are left thinking ‘Why did no-one ask us?’

So as an individual patient, and in my role in the RCP’s Patient and Carer Network, I was delighted when the RCP set up the Future Hospital Commission. There has been a real commitment to involving patients throughout the Commission’s work streams. Rather than feeling like the passenger in the juggernaut of system improvement, patients – and their *real* needs and experiences – have been the Commission’s driving force.

Patients must be treated with kindness, respect and dignity, and the way we experience care should be valued as much as how good our clinical treatment is and how quickly we get better. The 11 principles of patient care that underpin the Future Hospital Commission’s vision of care and are described in this report, will counteract many of the issues that are often so detrimental to patients’ experience of the NHS.

The report expects all involved in the provision of care to think in a new way – to take responsibility for each patient’s experience, to communicate appropriately and continually, and to make sure that patients are proactively involved in decisions about their care. Importantly, the report embeds a new philosophy – that care should come to the patient, not the other way around. Patients should not move beds unless

this is necessary for their clinical care, and time spent in hospital should be seen as just one small (but often crucial part) of a patient's journey. Embedding a new culture will take time, and present many challenges.

I would particularly like to thank Margaret Goose, patient representative on the Commission's strategic steering group, and all members of the RCP's Patient and Carer Network for shaping the Commission's proposals. As chair of the Patient and Carer Network, I now look forward to going through these proposals in more detail, working with the RCP and others to influence how their work can be developed and taken forward in our hospitals. Whatever changes lie ahead, one thing is clear: hospitals must never again lose sight of the needs of the patients they serve.

September 2013

Suzie Hughes
Chair, RCP Patient and Carer Network

Future Hospital Commission

The Future Hospital Commission is led by an independent chair, Sir Michael Rawlins. The chair was commissioned by the Royal College of Physicians (RCP) to undertake this review. This report was presented by the chair of the Future Hospital Commission to the RCP president and Council.

Chair of the Future Hospital Commission

Professor Sir Michael Rawlins MD FRCP FFPM FMedSci
President, Royal Society of Medicine

Ms Janet Davies FRCN
Director of Nursing Service Delivery, Royal College of Nursing

Dr Jennifer Dixon CBE FFPHM FRCP
Chief executive, The Nuffield Trust

Advisers to the chair

Sir Michael Rawlins received advice from a high-level Strategic Steering Group, comprised of representatives from across health and social care. The chair would like to thank the following members of the Strategic Steering Group for their advice.

Mr Mike Farrar CBE Hon FRCP
Chief executive, NHS Confederation

Professor Sir Ian Gilmore MD FRCP
Consultant physician and gastroenterologist, University of Liverpool; president, British Society of Gastroenterology; former president of the Royal College of Physicians

Professor Julian Bion FRCP FRCA FFICM MD
Dean of the UK Faculty of Intensive Care Medicine, and professor of intensive care medicine, University of Birmingham and Queen Elizabeth Hospital, Birmingham

Miss Margaret Goose OBE MA FHSM FRSA Hon MFPH Hon FRCP
RCP Patient and Carer Network

Dr Patrick Cadigan FRCP FRCP Edin
Registrar, Royal College of Physicians; consultant physician and cardiologist, Sandwell General Hospital, West Midlands

Professor David Haslam CBE FRCP FRCGP FFPH
Chair, National Institute for Health and Care Excellence

Mr Mike Clancy
Immediate past president, College of Emergency Medicine

Professor Peter Kopelman MD FRCP
Principal, St George's University of London

Mr Peter Lees FRCP
Founding director, Faculty of Medical Leadership and Management

Dr Clifford Mann FRCP FCEM
President, College of Emergency Medicine

Professor Finbarr Martin MD FRCP
Consultant geriatrician, Guy's and St Thomas' NHS Trust, London

Dr Steve Mowle FRCGP
Vice chair of Council, Royal College of General Practitioners

Dr Jonathan Myers MRCP(UK)
Chair, Trainees Committee, Royal College of Physicians

Dr Peter Nightingale FRCA FRCP FFICM
Immediate past president, Royal College of Anaesthetists

Dr Christopher Roseveare FRCP
President, Society for Acute Medicine;
acute medicine consultant, University Hospital Southampton NHS Foundation Trust

Mr Duncan Selbie
Chief executive, Public Health England

Professor Sir Patrick Sissons FRCP
Vice president, Academy of Medical Sciences

Mrs Andrea Sutcliffe
Chief executive, Social Care Institute for Excellence

Dr J-P van Besouw FRCA
President, Royal College of Anaesthetists

Professor Norman S Williams MS FMedSci FRCP FRCS
President, Royal College of Surgeons of England

Disclaimer: Members of the Strategic Steering Group provided advice as individuals with expertise in a particular field, not as representatives of their specific organisations. Although every effort was made to reach consensus decisions, the chair was the final arbiter of all decisions and final content. The Future Hospital Commission report is a report from the

chair of the Commission, acting on the advice of the Strategic Steering Group as appropriate.

Declarations of interest

Janet Davies: chair, Health Quality Improvement Partnership

Jennifer Dixon: chief executive, Nuffield Trust; chief executive (designate) of Health Foundation; Board member of the Care Quality Commission

David Haslam: chair, National Institute for Health and Care Excellence; columnist, *The Practitioner* (monthly, for GPs); member, Royal College of General Practitioners and Faculty of Public Health

Ian Gilmore: president, British Society of Gastroenterology and chair of Trustees of the charity; non-executive director, BMJ Publishing Group; chair, Commission on Health and Healthcare in Liverpool

Margaret Goose: governor, The Health Foundation; vice president (and former chief executive), The Stroke Association; member, Governance Board of Centre for Workforce Intelligence

Steve Mowle: vice chair, Royal College of General Practitioners; chair, London Catalyst Charitable Foundation

Jonathan Myers: deputy manager, Healthcare Services, Crisis; SpR in geriatric medicine and general medicine, London Deanery

Christopher Roseveare: editor, *Acute Medicine Journal*; director, Wessex Medical Communications Ltd.

Michael Rawlins: chairman, UK Biobank; president, Royal Society of Medicine

Andrea Sutcliffe: chief executive, Social Care Institute for Excellence

J-P van Besouw: president, Royal College of Anaesthetists

Operational Group

The chair of the Future Hospital Commission and his advisers were supported by an Operational Group. The Operational Group coordinated activities across the work streams and themes of the Future Hospital Commission, submitting evidence and recommendations for the approval of the Commission chair.

Operational group lead

Professor Timothy Evans MD FRCP
Consultant in thoracic and intensive care medicine, medical director and responsible officer, Royal Brompton and Harefield NHS Foundation Trust; professor of intensive care medicine, Imperial College London; lead fellow, future hospital, Royal College of Physicians

Project management and support across work streams

Ms Gemma Cantelo
Head of policy, Royal College of Physicians; project manager, Future Hospital Commission

Dr Georgina Russell MRCP(UK)
Clinical fellow, Royal College of Physicians

Ms Laura Brennan
Policy adviser, Royal College of Physicians

Ms Tracy Scollin
Administration lead, Future Hospital Commission; committee manager, Royal College of Physicians

Place and process work stream leads

Dr Mark Temple MD FRCP
Acute care fellow, Royal College of Physicians; consultant physician and nephrologist, Birmingham Heartlands Hospital

Dr Patrick Cadigan FRCP FRCP Edin
Registrar, Royal College of Physicians; consultant physician and cardiologist, Sandwell General Hospital, West Midlands

Data for improvement work stream leads

Dr Kevin Stewart FRCP
Clinical director, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians; consultant physician, Royal Hampshire County Hospital

Professor John Williams FRCP
Director, Health Informatics Unit, Royal College of Physicians; professor of health services research, College of Medicine, Swansea University

Additional support from:

Mrs Jan Hoogewerf
Programme manager, Health Informatics Unit, Royal College of Physicians

Patients and compassion work stream lead

Dr Linda Patterson OBE FRCP

Clinical vice-president, Royal College of Physicians; consultant physician in general and geriatric medicine, East Lancashire Primary Care Trust

Additional support from:

Dr Ian Bullock

Chief operating officer, National Clinical Guideline Centre

Planning and infrastructure work stream lead

Professor Linda Luxon CBE FRCP

Treasurer, Royal College of Physicians; consultant physician in neuro-otology, University College London Hospital NHS Foundation Trust; emeritus professor of audiovestibular medicine, University College London

People (workforce) work stream lead

Dr Andrew Goddard MD FRCP

Director, Medical Workforce Unit, Royal College of Physicians; consultant gastroenterologist, Royal Derby Hospital

Education, training and research theme lead

Professor David Black FRCP

Senior censor and vice president for education and training, Royal College of Physicians

Additional support from:

Dr Krishna Chinthapalli MRCP(UK)

Clinical fellow, Royal College of Physicians and *BMJ*

Leadership and economics theme lead

Mr Martin Else Hon FRCP

Chief executive, Royal College of Physicians

Additional support from:

Mr Miguel Souto

Senior policy adviser, Royal College of Physicians

Continuity and patient experience lead

Dr Michael Rudolf FRCP

Medical director, Patient Involvement Unit, Royal College of Physicians

Representing:

Members of the RCP Patient and Carer Network

Additional support and coordination

Ms Nikki Coleman

Patient involvement administrator, Royal College of Physicians

Ms Linda Cuthbertson

Head of PR and public affairs, Royal College of Physicians

Ms Catharine Perry

Committee manager, Royal College of Physicians

Ms Joanna Reid

Managing editor, Royal College of Physicians

Ms Elaine Storey

Committee manager, Royal College of Physicians

Ms Geraldine Welham

Committee manager, Royal College of Physicians

Declarations of interest

David Black: Trustee, Royal Medical Benevolent Fund; dean director, HEKSS; RCP Council member; Faculty of Medical Leadership and Management member; medical editor, *Geriatric Medicine*

Linda Patterson: Trustee, Alzheimer's Society, 2010–13; trustee, White Ribbon Campaign, 2006–present.

Timothy Evans: Vice dean, Faculty of Intensive Care Medicine

List of case studies

The case studies below are listed in alphabetical order of trust/hospital. The cases described in the report are indicated by '[print only]' and their page number is given. The ones that are online say '[online only]' and can be found at www.rcplondon.ac.uk/fh-case-studies.

The case studies illustrate how elements of the Future Hospital Commission's vision can be put into practice, and adapted to local circumstances. They are intended to inform discussions at a local level. Although the detailed implementation of the future hospital vision will vary from hospital to hospital, services should be underpinned by the core principles articulated by the Commission.

Trust/hospital: **Brighton and Sussex University Hospitals**

Case study: A chief of medicine's responsibilities [online only]

Description of the case study explained by chief of medicine, Dr Lawrence Goldberg

Trust/hospital: **Countess of Chester Hospital**

56

Case study: Rapid response and enhanced discharge scheme [print only]

Description of the case study explained by Dr Frank Joseph

Trust/hospital: **Guy's and St Thomas' NHS Foundation Trust**

109

Case study: Improving patients' experience [print only]

Description of the case study explained by Eileen Sills

Trust/hospital: **Leeds Teaching Hospitals NHS Trust**

45

Case study: Acute neurology service [print only]

Description of the case study explained by Dr Edward Dunn

Trust/hospital: **Lewisham University Hospital**

50

Case study: Clinical assessment service [print only]

Description of the case study explained by Dr Elizabeth Aitkin

Trust/hospital: **London acute kidney injury network**

Case study: London acute kidney injury network [online only]

Description of the case study explained by Dr Chis Laing

Trust/hospital: **Mid Yorkshire Hospitals NHS Trust**

Case study: Acute cardiology service [online only]

Description of the case study explained by Dr Ian Wilson

Trust/hospital: Northumbria Healthcare NHS Foundation Trust Case study: Using patient experience data [print only] Description of the case study explained by Annie Laverty	107
Trust/hospital: Northumbria Healthcare NHS Foundation Trust Case study: Rigorous medical division recruitment [online only] Description of the case study explained by Dr David Evans and Dr Colin Doig	
Trust/hospital: Nottingham Queen's Medical Centre Case study: Ambulatory emergency care [print and online video] Description of the case study explained by Dr Jack Hawkins	52
Trust/hospital: Nottingham University Hospitals NHS Trust Case study: Hospital@Night Nerve Centre [print only] Description of the case study explained by Dr Dominic Shaw	95
Trust/hospital: Poole Hospital Foundation Trust Case study: Stable on-take teams [online only] Description of the case study explained by Dr Mike Masding	
Trust/hospital: Portsmouth Hospitals NHS Trust Case study: Increased research and patient participation [print only] Description of the case study explained by Professor Anoop Chauhan	101
Trust/hospital: Queen Elizabeth Hospital Case study: Dual/psychiatric care of dementia patients [online only] Description of the case study explained by Dr Catherine Kirkley	
Trust/hospital: Royal Brompton Hospital Case study: Telemonitoring used with patients with heart failure [online only] Description of the case study explained by Professor Simmonds	
Trust/hospital: Renal care Case study: Renal Patient View [print only] Description of the case study explained by Elaine Hanson	92
Trust/hospital: Sheffield Hospital Case study: Early geriatric assessment [online video only] Description of the case study explained by Professor Tom Downes	
Trust/hospital: Tees, Esk and Wear Valleys NHS Foundation Trust Case study: Creating a strong research culture [online only] Description of the case study explained by Dr Hillary Allan	
Trust/hospital: University Hospitals Birmingham Case study: Complex discharge ward [print and online video] Description of the case study explained by Dr Zoe Wyrko	67

Trust/hospital: University Hospitals Birmingham Case study: Performance monitoring on wards [print only] Description of the case study explained by Carole Cole	95
Trust/hospital: University Hospitals Nottingham Case study: Geriatrician review of older people with frailty [online only] Description of the case study explained by Dr David Seddon	
Trust/hospital: Whittington Health NHS Case study: Acute oncology service [print only] Description of the case study explained by Dr Pauline Leonard	43
Trust/hospital: Whittington Health NHS Case study: Integrated care for respiratory patients [online video only] Description of the case study explained by Dr Myra Stern, Dr Louise Restrict, and Dr Melissa Heightman	

Executive summary

'The patient must be the first priority in all of what the NHS does. Within available resources they must receive effective services from caring compassionate and committed staff working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.'

(Robert Francis QC)¹

'Patient safety should be the ever-present concern of every person working in or affecting NHS-funded care. The quality of patient care should come before all other considerations in leadership and conduct of the NHS, and patient safety is the keystone dimension of quality.'

(Don Berwick, 2013)²

Introduction

In March 2012 the Royal College of Physicians established the Future Hospital Commission. *Future hospital: caring for medical patients* sets out the Commission's vision for hospital services structured around the needs of patients, now and future. The Commission's recommendations are drawn from the very best of our hospital services, taking examples of existing innovative, patient-centred services to develop a comprehensive model of hospital care that meets the needs of patients, now and in the future.

Future hospital: caring for medical patients focuses on the care of acutely ill medical patients, the organisation of medical services, and the role of physicians and doctors in training across the medical specialties in England and Wales. However, people's needs are often complex, and hospital services must be organised to respond to all aspects of physical health (including multiple acute and chronic conditions), mental health and well-being, and social and support needs.

The model of care proposed by the Future Hospital Commission is underpinned by the principle that hospitals must be designed around the needs of patients. The Commission's recommendations are centred on the need to design hospital services that deliver:

- > safe, effective and compassionate medical care for all who need it as hospital inpatients
- > high-quality care sustainable 24 hours a day, 7 days a week
- > continuity of care as the norm, with seamless care for all patients
- > stable medical teams that deliver both high-quality patient care and an effective environment in which to educate and train the next generation of doctors
- > effective relationships between medical and other health and social care teams

- > an appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs
- > transfer of care arrangements that realistically allocate responsibility for further action when patients move from one care setting to another.

Care, treatment and support services need to be delivered in a range of ways, across a range of settings and by a range of professionals, all working in collaboration. It is clear that all parts of the health and social care system, and the professionals that populate it, have a crucial role to play in developing and implementing changes that improve patient care and meet the needs of communities.

Patients have been involved across the breadth of the Future Hospital Commission's work, informing and developing its recommendations. Experts from across health and social care have been involved in developing this vision for the future hospital. It was clear from patients and existing examples of good practice that hospital services in the future should be designed around 11 core principles.

In the hospital of the future:

- 1 Fundamental standards of care must always be met.¹
- 2 Patient experience is valued as much as clinical effectiveness.
- 3 Responsibility for each patient's care is clear and communicated.
- 4 Patients have effective and timely access to care, including appointments, tests, treatment and moves out of hospital.
- 5 Patients do not move wards unless this is necessary for their clinical care.
- 6 Robust arrangements for transferring of care are in place.
- 7 Good communication with and about patients is the norm.
- 8 Care is designed to facilitate self-care and health promotion.
- 9 Services are tailored to meet the needs of individual patients, including vulnerable patients.
- 10 All patients have a care plan that reflects their individual clinical and support needs.
- 11 Staff are supported to deliver safe, compassionate care, and committed to improving quality.

Future hospital: caring for medical patients sets out a vision for collaborative, coordinated and patient-centred care. Achieving this vision will require radical changes to the structure of our hospitals and ways of working for staff. The recommendations in this report must be the first step in a longer programme of activity designed to achieve real change across hospitals and the wider health and social care economy. The report's collated recommendations are provided in appendix 1.

The case for change

'Continuity of care cannot be achieved without fundamental change in the way that the NHS as a whole thinks about the role and priorities of the Acute General Hospital and how it is run.'

(King's Fund)³

All patients deserve to receive safe, high-quality, sustainable care centred around their needs and delivered in an appropriate setting by respectful, compassionate, expert health professionals. Staff working in the NHS want to provide good care for their patients, and many patients experience excellent care in our hospitals every day. However, recent reports of the care – or lack of care – received by some patients in our hospitals makes harrowing reading.^{1,4–8}

Our hospitals are struggling to cope with the challenge of an ageing population and increasing hospital admissions. All too often our most vulnerable patients – those who are old, who are frail or who have dementia – are failed by a system ill-equipped and seemingly unwilling to meet their needs. The Royal College of Physicians’ report *Hospitals on the edge*²⁹ set out the magnitude and complexity of the challenges facing healthcare staff and the hospitals in which they work – and the potentially catastrophic impact this can have on patient care. It described:

- > a health system ill-equipped to cope with the needs of an aging population with increasingly complex clinical, care and support needs
- > hospitals struggling to cope with an increase in clinical demand
- > a systematic failure to deliver coordinated, patient-centred care, with patients forced to move between beds, teams and care settings with little communication or information sharing
- > services that struggle to deliver high-quality services across 7 days, particularly at weekends
- > a looming crisis in the medical workforce, with consultants and medical registrars under increasing pressure, and difficulties recruiting to posts and training schemes that involve general medicine.⁹

The need for change is clear. The time has come to take action. Those working in the NHS have a responsibility to lead this change, supported by the organisations that represent them and empowered by national policy-makers. Organisations and professionals involved in health and social care – including doctors, nurses, politicians, hospitals and national bodies – must be prepared to make difficult decisions and implement radical change where this will improve patient care.

It was against this backdrop that, in March 2012, the Royal College of Physicians established the Future Hospital Commission, an independent group tasked with identifying how hospital services can adapt to meet the needs of patients, now and in the future. *Future hospital: caring for medical patients* sets out this vision.

Creating the future hospital

‘I don’t want to be passed round the wards: I’m a person, not a parcel.’

(Patient, Royal College of Physicians’ Patient and Carer Network)

1 A new principle of care

The Future Hospital Commission sets out a radical new model of care designed to encourage collective responsibility for the care of patients across professions and healthcare teams. It recommends new ways of working across the hospital and between hospital and the community, supported by financial and management arrangements that gives greater priority to caring for patients with urgent medical needs. This will mean aligning financial streams and incentives, both externally and internally, to ensure that acute services are appropriately supported.

Care should come to patients and be coordinated around their medical and support needs. However, it is not unusual for patients – particularly older people³ – to move beds several times during a single hospital stay. This results in poor care, poor patient experience and increases length of stay. In the future hospital, moves between beds and wards will be minimised and only happen when this is necessary for clinical care. Delivery of specialist medical care – such as cardiology and neurology services – will not be

limited to patients in specialist wards or to those who present at hospital. Specialist medical teams will work across the whole hospital and out into the community across 7 days.

Effective care for older patients with dementia will help set a standard of care of universal relevance to vulnerable adults. The design and delivery of services will also consider the specific needs of the most vulnerable patients and those known to have poorer levels of access and outcomes, eg patients with mental health conditions and patients who are homeless.

2 A new model of care

To coordinate care for patients, the Future Hospital Commission recommends that each hospital establish the following new structures.

Medical Division

The Medical Division will be responsible for all medical services across the hospital – from the emergency department and acute and intensive care beds, through to general and specialist wards. Medical teams across the Medical Division will work together to meet the needs of patients, including patients with complex conditions and multiple comorbidities. The Medical Division will work closely with partners in primary, community and social care services to deliver specialist medical services across the health economy.

The Medical Division will be led by the **chief of medicine**, a senior doctor responsible for making sure working practices facilitate collaborative, patient-centred working and that teams work together towards common goals and in the best interests of patients.

Acute Care Hub

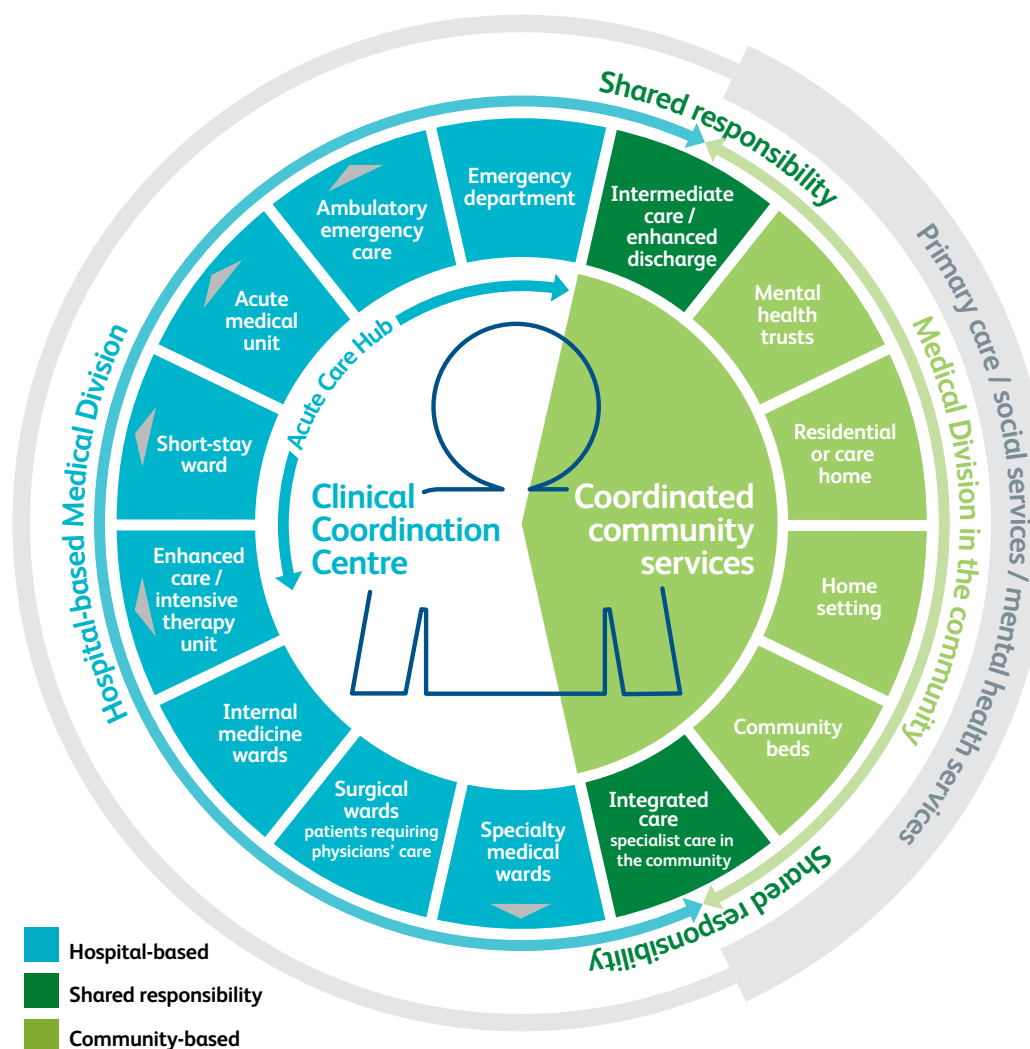
The Acute Care Hub will bring together the clinical areas of the Medical Division that focus on the initial assessment and stabilisation of acutely ill medical patients. These include the acute medical unit, the ambulatory care centre, short-stay beds, intensive care unit and, depending on local circumstances, the emergency department. The Acute Care Hub will focus on patients likely to stay in hospital for less than 48 hours, and patients in need of enhanced, high dependency or intensive care.

An **acute care coordinator** will provide operational oversight to the Acute Care Hub, supported by a Clinical Coordination Centre.

Clinical Coordination Centre

The Clinical Coordination Centre will be the operational command centre for the hospital site and Medical Division, including medical teams working into the community. It will provide healthcare staff with the information they need to care for patients effectively. It will hold detailed, real-time information on patients' care needs and clinical status, and coordinate staff and services so that they can be met. In the longer-term, this would evolve to include information from primary and community care, mental health and social care. This information would be held in a single electronic patient record, developed to common standards.

Further detail about these new structures is in chapter 3 of the main report.

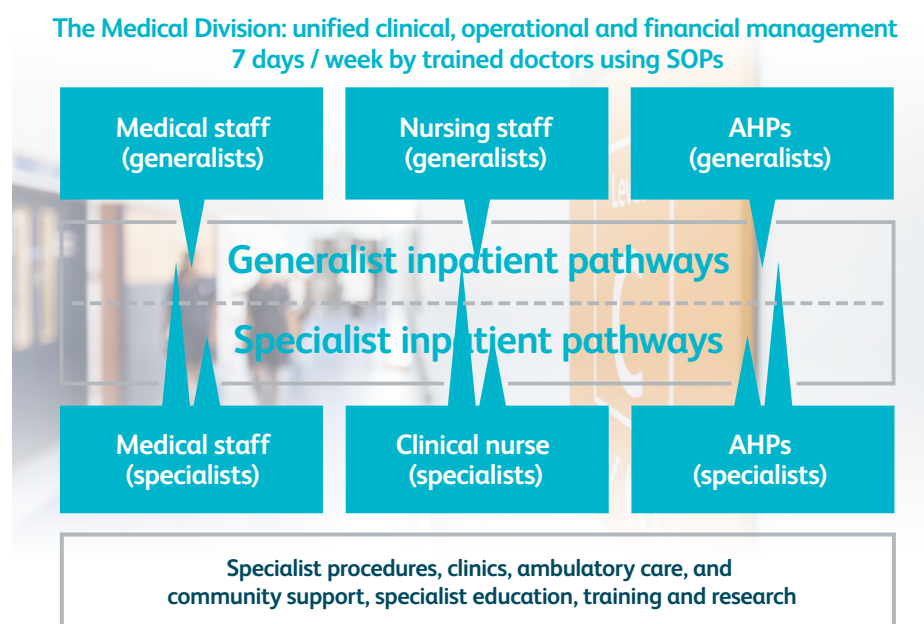


The Medical Division remit: circle of patient-centred care. Directional arrows (in the hospital-based Medical Division) denote areas of the future hospital where patients may be referred on to tertiary specialist care.

3 Seven-day care, delivered where patients need it

Advances in medical science mean that outcomes for many patients with a single medical condition have never been better. However, an increasing number of patients present at hospital, not with a single medical problem, but with multiple illnesses and a range of support needs due to conditions like dementia. Our hospitals are often ill-equipped to care for these patients.

We must bring the advances in medical care to *all* patients, whatever their additional needs and wherever they are in hospital or the community. This means specialist medical teams will work – not only in specialist wards – but across the hospital. Care for patients with multiple conditions will be coordinated by a single named consultant, with input from a range of specialist teams when their clinical needs require it. The remit and capacity of medical teams will extend to adult inpatients with medical problems across the hospital, including those on ‘non-medical’ wards (eg surgical patients).



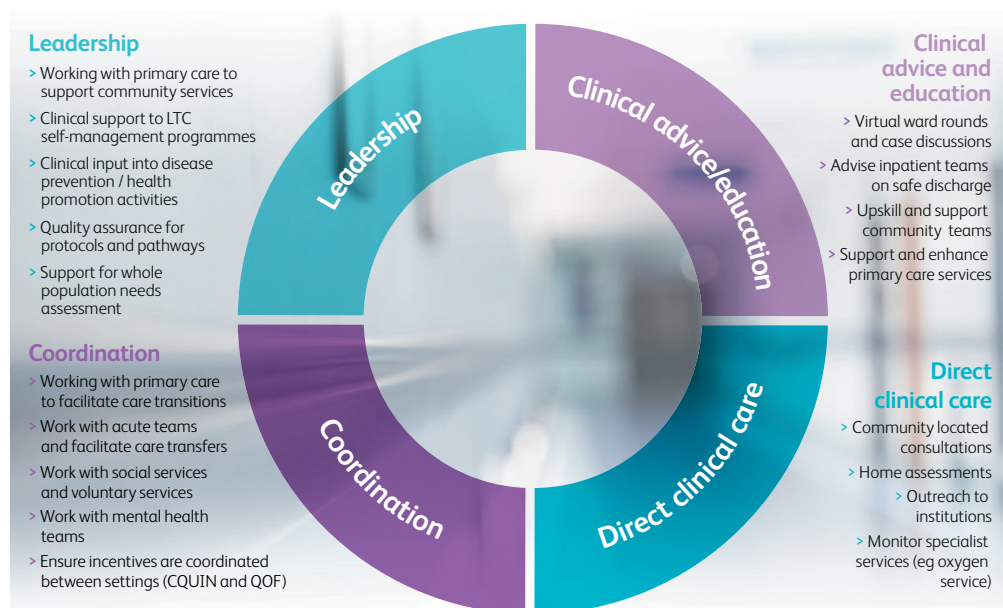
Generalist and specialist care in the future hospital. Generalist care includes acute medicine, internal medicine, enhanced care and intensive care. Specialist components of care will be delivered by a specialist team who may also contribute to generalist care. AHP = allied health professional; SOP = standardised operating procedure.

Once admitted to hospital, patients will not move beds unless their clinical needs demand it. Patients should receive a single initial assessment and ongoing care by a single team. In order to achieve this, care will be organised so that patients are reviewed by a senior doctor as soon as possible after arriving at hospital. Specialist medical teams will work together with emergency and acute medicine consultants to diagnosis patients swiftly, allow them to leave hospital if they do not need to be admitted, and plan the most appropriate care pathway if they do. Patients whose needs would best be met on a specialist ward will be identified swiftly so that they can be ‘fast-tracked’ – in some cases directly from the community.

When a patient is cared for by a new team or moved to a new setting, there will be rigorous arrangements for transferring their care (through ‘handover’). This process will be prioritised by staff and supported by information captured in an electronic patient record that contains high-quality information about patients’ clinical and care needs.

Specialist medical care will not be confined to inside the hospital walls. Medical teams will work closely with GPs and those working in social care to make sure that patients have swift access to specialist care when they need it, wherever they need it. Much specialised care will be delivered in or close to the patient’s home. Physicians and specialist medical teams will expect to spend part of their time working in the community, with a particular focus on caring for patients with long-term conditions and preventing crises.

To support this way of working, the performance of specialist medical teams will be assessed according to how well they meet the needs of patients with specified conditions across the hospital and health economy, not just those located on specialist wards.



Extended roles for physicians in the community. CQUIN = Commissioning for Quality and Innovation; LTC = long-term condition; MDT = multidisciplinary team; QOF = quality outcome framework.

Acutely ill medical patients in hospital should have the same access to medical care on the weekend as on a week day. Services should be organised so that clinical staff and diagnostic and support services are readily available on a 7-day basis. The level of care available in hospitals must reflect a patient's severity of illness. In order to meet the increasingly complex needs of patients – including those who have dementia or are frail – there will be more beds with access to higher intensity care, including nursing numbers that match patient requirements.

There will be a consultant presence on wards over 7 days, with ward care prioritised in doctors' job plans. Where possible, patients will spend their time in hospital under the care of a single consultant-led team. Rotas for staff will be designed on a 7-day basis, and coordinated so that medical teams work together as a team from one day to the next.

Care for patients should focus on their recovery and enabling them to leave hospital as soon as their clinical needs allow. This will be planned from when the patient is admitted to hospital and reviewed throughout their hospital stay. Arrangements for patients leaving hospital will operate on a 7-day basis. Health and social care services in the community will be organised and integrated to enable patients to move out of hospital on the day they no longer require an acute hospital bed.

Patients can be empowered to prevent and recover from ill health through effective communication, shared decision-making and self-management. Clinicians and patients will work together to select tests, treatments or management plans based on clinical evidence and the patient's informed preferences.

Patients should only be admitted to hospital if their clinical needs require it. For many, admission to hospital is the most effective way to set them on the road to recovery. However, it can be disorientating and disruptive. In the future, hospitals will promote ways of working that allow

emergency patients to leave hospital on the same day, with medical support provided outside hospital if they need it.

Doctors will assume clinical leadership for safety, clinical outcomes and patient experience. This includes responsibility to raise questions and take action when there are concerns about care standards, and collaborate with other teams and professions to make sure that patients receive effective care throughout the hospital and wider health and care system.

There will always be a named consultant responsible for the standard of care delivered to each patient. Patients will know who is responsible for their care and how they can be contacted. The consultant will be in charge of coordinating care for all patients on the ward, supported by a team. The consultant and ward manager will assume joint responsibility for ensuring that basic standards of care are delivered, and that patients are treated with dignity and respect. Nurse leadership and the role of the ward manager will be developed and promoted.

There will be mechanisms for measuring patients' experience of care. This information will be used by hospitals, clinical teams and clinicians to reflect on their practice and drive improvement. A Citizenship Charter that puts the patient at the centre of everything the hospital does should be developed with patients, staff and managers. This should be based on the NHS Constitution and embed in practice the principles of care set out by the Future Hospital Commission.

4 Education, training and deployment of doctors

Medical education and training will develop doctors with the knowledge and skills to manage the current and future demographic of patients. We need a cadre of doctors with the knowledge and expertise necessary to diagnosis, manage and coordinate continuing care for the increasing number of patients with multiple and complex conditions. This includes the expertise to manage older patients with frailty and dementia. Across the overall physician workforce there will be the skills mix to deliver appropriate:

- > specialisation of care – access to sufficient specialty expertise to deliver diagnosis, treatment and care appropriate to the specific hospital setting
- > intensity of care – access to sufficient expertise to manage, coordinate and deliver enhanced care to patients with critical illness
- > coordination of care – access to sufficient expertise to coordinate care for patients with complex and multiple comorbidity.

In order to achieve the mix of skills that delivers for patients, a greater proportion of doctors will be trained and deployed to deliver expert (general) internal medicine care. The importance of acute and (general) internal medicine must be emphasised from undergraduate training onwards, participation in (general) internal medicine training will be mandatory for those training in all medical specialties, and a more structured training programme for (general) internal medicine will be developed.

The contribution of medical registrars will be valued and supported by increased participation in acute services and ward-level care across all medical trainees and consultants, and enhanced consultant presence across 7 days.

What's next?

'We need to take responsibility for every patient that comes through the hospital door. Consultants need to reclaim responsibility for all aspects of medical care, whatever their specialty.'

(Hospital consultant)

The Future Hospital Commission was established by the Royal College of Physicians in March 2012. *Future hospital: caring for medical patients* is a report from the chair of the Future Hospital Commission, Professor Sir Michael Rawlins, to the RCP. The RCP is an independent body representing 28,500 fellows and members, mostly doctors working in the UK's hospitals. The RCP will respond to the report in autumn 2013.

The Future Hospital Commission's recommendations are just the first step in a longer programme of activity designed to achieve real change across hospitals and the wider health and social care economy in which they operate. In its response to the Commission's report, the RCP will set out how it will take this work forward and continue to drive improvement in hospital services across England and Wales.

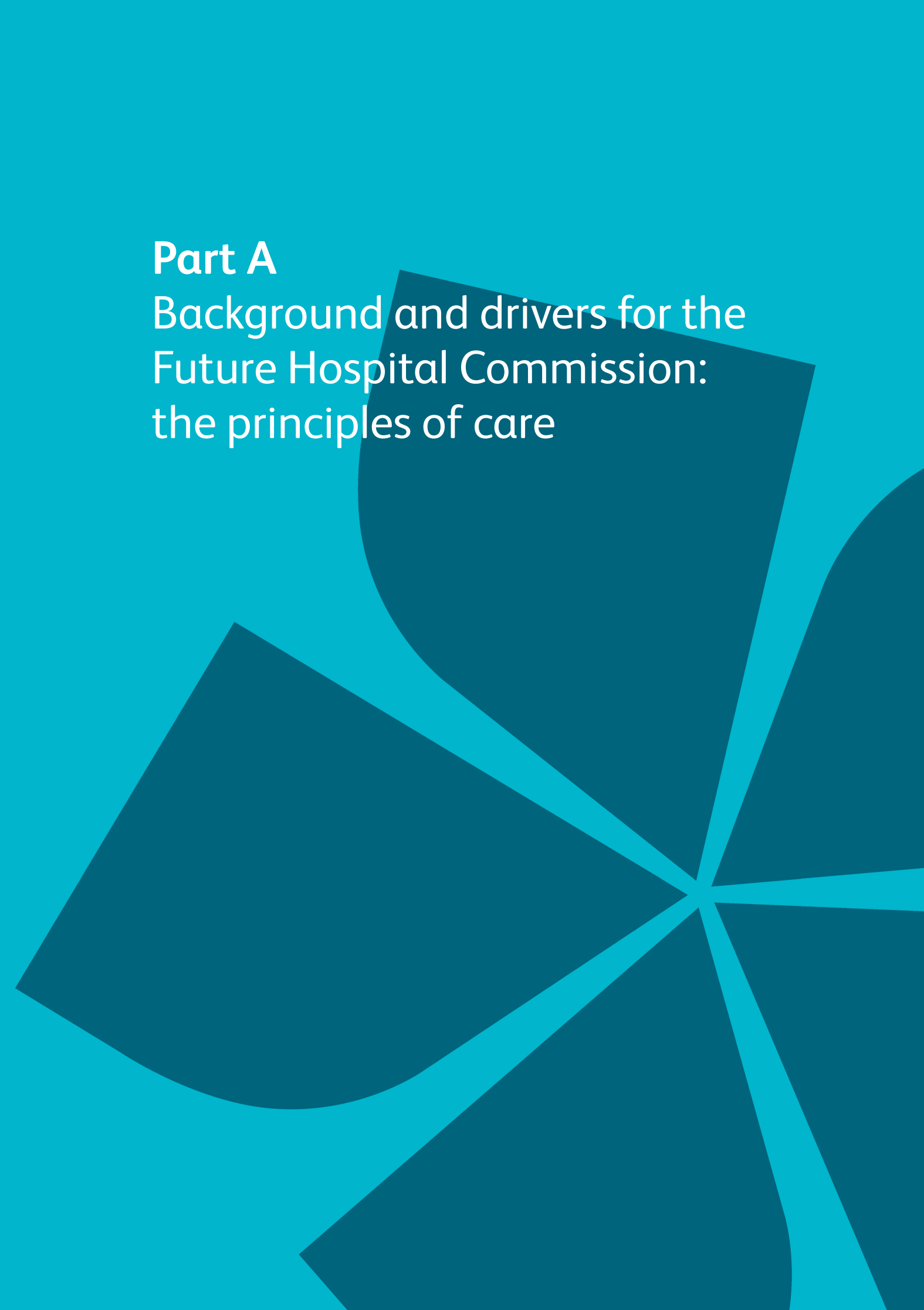
You can inform the Royal College of Physicians' response and next stage work by sending us your comments, ideas and examples of good practice. On the RCP website, you can read about existing examples of innovative practice and listen to doctors talking about how they achieved change in their hospital.

References

- 1 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chaired by Robert Francis QC. London: Stationery Office, 2013.
- 2 National Advisory Group on the Safety of Patients in England. *A promise to learn – a commitment to act: Improving the safety of patients in England*. London: National Advisory Group on the Safety of Patients in England, 2013.
- 3 Cornwell J, Sonola L, Levenson R, Poteliakhoff E. *Continuity of care for older hospital patients: a call for action*. London: King's Fund, 2012.
- 4 Care Quality Commission. *Time to listen: In NHS Hospitals. Dignity and nutrition inspection programme 2012*. Newcastle upon Tyne: Care Quality Commission, 2013.
www.cqc.org.uk/sites/default/files/media/documents/time_to_listen_-_nhs_hospitals_main_report_tag.pdf
- 5 Health Service Ombudsman. *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*, 2011. www.ombudsman.org.uk
- 6 Care Quality Commission. *Dignity and nutrition inspection programme: national overview*. Newcastle upon Tyne: Care Quality Commission, 2011.
www.cqc.org.uk/sites/default/files/media/documents/20111007_dignity_and_nutrition_inspection_report [accessed 16 August 2013].
- 7 Levenson R. *The challenge of dignity in care: upholding the rights of the individual*. London: Help the Aged, 2007.
- 8 Patients Association. *We have been listening, have you been learning?* Harrow, Middlesex: Patients Association, 2011.
- 9 Royal College of Physicians. *Hospitals on the edge? The time for action*. London: RCP, 2012.

Part A

Background and drivers for the
Future Hospital Commission:
the principles of care

The background of the slide features an abstract geometric design. It consists of several overlapping shapes in two shades of blue: a lighter teal and a darker teal. These shapes, which include large triangles and curved polygons, radiate from a central point on the right side of the slide, creating a dynamic, star-like pattern. The text is positioned in the upper left quadrant, overlaid on the lighter teal background.

1 Introduction and purpose of the report

‘The patient must be the first priority in all of what the NHS does. Within available resources they must receive effective services from caring compassionate and committed staff working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.’

(Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013)¹

‘Patient safety should be the ever-present concern of every person working in or affecting NHS-funded care. The quality of patient care should come before all other considerations in leadership and conduct of the NHS, and patient safety is the keystone dimension of quality.’

(Berwick review into patient safety, 2013)²

- 1.1 All patients deserve to receive safe, high-quality, sustainable care centred around their needs and delivered in an appropriate setting by respectful, compassionate, expert health professionals. Staff working in the NHS want to provide good care for their patients, and many patients experience excellent care in our hospitals every day. However, recent reports of the care – or lack of care – received by some patients in our hospitals makes harrowing reading. Reports from the last five years and beyond make clear the need for change: reports from the *Mid Staffordshire NHS Foundation Trust Public Inquiry*,¹ the Health Service Ombudsman (*Care and compassion?*, 2011),³ the Care Quality Commission (2011, 2013),^{4,5} the Levenson report (2007)⁶ and the Patients Association (*We have been listening, have you been learning?*, 2011),⁷ to name just a handful.
- 1.2 The causes of the failures of care described so vividly by these reports are complex. However, what is clear is that all too often our most vulnerable patients – those who are old, who are frail or who have dementia – are failed by a system ill-equipped and seemingly unwilling to meet their needs. The Francis Inquiry (2013)¹ in particular highlighted both human and system failures in the delivery of dignified and patient-focused care in a safe clinical environment.
- 1.3 Those working in the NHS have a responsibility to lead change, supported by the organisations that represent them and empowered by national policy-makers. To lead this change and recommend new models of care that deliver for patients, in March 2012 the Royal College of Physicians (RCP) established the Future Hospital Commission.⁸ *Future hospital: Caring for medical patients* sets out the Commission’s vision for hospital services structured around the needs of patients, now and in the future. The Commission’s recommendations are drawn from the very best of our hospital services, taking examples of the innovative, patient-centred services that exist now to develop a comprehensive model of hospital care that meets the needs of patients, now and in the future.

- 1.4 As a report to the Royal College of Physicians, the Commission's work focuses on the care of medical patients, hospital services and the role of physicians and doctors in training across the medical specialties. However, it is clear that all parts of the health and social care system, and the professionals who populate it, have a crucial role to play in developing and implementing changes that improve patient care and meet the needs of communities. The Commission hopes, therefore, that its recommendations to the RCP form only the first step in a longer programme of activity that results in real change across hospitals, and the wider health and social care economy in which they operate.

The needs of patients in the 21st century

- 1.5 The population of Great Britain has changed substantially since the inception of the NHS in 1948. There are 12 million more of us now and we are living longer. Life expectancy at birth is now 12 years longer than it was in 1948, and people aged over 60 make up nearly a quarter of Britain's population.⁹ Improved life expectancy represents a considerable success, but for some advancing age is associated with increased frailty and dependency. Half of those currently aged over 60 have a chronic illness and this proportion will rise as the population of those aged 85 or older doubles in the next 20 years.¹⁰
- 1.6 Unsurprisingly, the demographic of hospital inpatients has also changed substantially in the 65 years since the NHS was created. Nearly two-thirds of patients admitted to hospital are over 65 years old;¹¹ around 25% of hospital inpatients have a diagnosis of dementia;¹² and people over 85 years old now account for 22% of all days spent in our hospitals' beds.¹¹
- 1.7 This means that today's doctors manage patients who are not only older, but also have more comorbidities and a far greater complexity of illness than those they encountered when many of them qualified. It is increasingly important that patients are treated in a holistic way that takes account of all their clinical, care and support needs. However, existing service structures mean that all too often they risk becoming ensnared in outmoded pathways of care focused on managing single diseases or conditions, with little coordination across the hospital or the wider health and social care system.
- 1.8 Patients with complex and multiple conditions, including older patients with frailty and dementia, and those with long-term conditions, have the most to gain from greater collaboration and integration of services across professions and care settings. The future of the health service lies in collaborative management of patients between primary care, specialist (secondary) care and social care services, with financial, administrative and information architecture to support and promote this.
- 1.9 In this evolving model, the focus of care should be on prevention or anticipation of acute illness, managed by escalating personal and clinical care in the community, rather than defaulting to hospital admission. Successful integration means providing services that deliver seamless care for patients across settings, utilising modern communications technology to share information about patients' needs whether they are in hospital or in a community setting. At the same time, it is crucial to provide an identifiable clinician with overall responsibility for the care being delivered, at any point in time, in the community or in hospitals.

The challenges faced by our hospitals

- 1.10 Since its inception, the NHS has had to adapt to reconcile the changing needs of patients with advances in medical science. Change and the evolution of services is the backbone of the NHS. Hospitals need to meet the requirements of their local population, while providing specialised services to a much larger geographical catchment area. Depending on their scope and scale, hospitals have a greater or lesser focus on teaching, education and academic research. However, irrespective of their size, hospitals should accommodate the concentration of skilled staff and resources needed for the diagnosis and treatment of ill patients, 24 hours a day and 7 days a week. (See Box 1.)

Box 1. The Future Hospital Commission's definition of 'the hospital'.

The Future Hospital Commission developed its recommendations around the following definition of 'the hospital'. The hospital:

- is not necessarily based on one physical site
- includes a broad mix of medical specialties, although not necessarily comprehensive at any one site
- may include a mix of acute and elective care
- is a fusion of micro-healthcare systems within a hospital, working collaboratively
- should not be constrained by macro-service organisation (eg trust boundaries)
- is part of the wider health economy, providing services to defined populations
- links with primary and community care, and this interface may be blurred
- may be involved in postgraduate education and research.

- 1.11 Advances in medical science and technology have led to a huge increase in the scope, accuracy and range of diagnostic services, and of interventional procedures. In parallel, patient expectations and demands of healthcare provision have risen. For patients with acute conditions that affect a single organ or are confined to a single medical specialty, the opportunity to intervene effectively and safely has never been greater. However, it is older patients with multiple comorbidities who make up a growing proportion of emergency medical admissions and presentations.
- 1.12 Increased and early specialisation among medical staff in training, a national focus on improving outcomes in very specific clinical arenas (eg stroke, heart attacks) and process-driven targets (eg to reduce waiting times) has, in many hospitals, led to the fragmentation of hospital activity and services. This propagates waste and, most importantly, compromises the delivery of coordinated care to patients.
- 1.13 It is crucial that, while protecting the many advances in treatment and outcomes that have resulted from this focus on specialist medicine, the agenda moves towards meeting the increasing need for coordinated management of patients with multiple comorbidities. The challenge is to ensure that *all* patients, including those with multiple and complex conditions, receive the benefits brought about by advances across the medical specialties. This means developing models of care and a cohort of healthcare professionals focused on providing early expert holistic assessment and management of health and care needs for this group of patients. In order to deliver effective healthcare, hospitals not only must bring together the skills of staff, supported by

equipment and technology, but also need a system of process control to ensure that they function as organisations made up of genuinely interconnected and coordinated activities.

- 1.14 Placing 'the right patient in the right place, first time' is central to efficient and safe practice in acute medicine. Too often, process-driven targets designed to promote better care for patients have unintended consequences and can reinforce a fragmented system. For example, the achievement of the 4-hour wait standard for patients being admitted to hospital through the emergency department (ED) and the 18-week referral to definitive treatment standard remain a key focus for hospital executive management teams. Maintaining these executive targets, together with low infection rates, are often used as a key indicator of the success of a hospital, and are based on the desire to reduce waiting times endured by patients and ensure swift diagnosis and treatment, with associated improved outcomes. However, with increasing numbers of admissions and rising bed occupancy it can become difficult to achieve both the executive and clinical targets.
- 1.15 For example, as the time in the ED for a patient waiting to be admitted approaches 4 hours there is an overriding directive to move the patient out of the ED into any available bed. This may not be the 'right' bed on the most appropriate ward, and often results in appropriate specialist opinion being delayed, ward procedures not appropriate for the patient, and all too often an increase in length of stay for patients. With an increased length of stay, bed availability will be reduced and the ability to maintain patient flow from the ED to the wards affected adversely. This in turn will affect bed availability for non-elective surgical admissions and jeopardise the 18-week wait standard. The case for a 'whole hospital' approach, with a focus on outcomes and patient experience, is clear. To function effectively, teams across the hospital must work collaboratively in the pursuit of shared, patient-centred targets and goals. Crucially, hospitals must have the spare capacity to enable patients to be placed in the most appropriate location for their needs, cared for by expert staff. A hospital operating at a bed capacity level of 85% or higher is unlikely to have the available beds that allow patients to be placed where they need to be, rather than the first (or only) available bed.
- 1.16 Keeping people in hospital because they are waiting for the next intervention or step in the healthcare pathway, or because their move out of hospital is delayed pending arrangements for enhanced health or social care in the community, is common. However, this is an inappropriate and inefficient use of hospital beds and is bad for patient experience and outcomes. Patients should be able to leave hospital – with support where necessary – on the day their clinical needs mean they no longer require an acute hospital bed. Ensuring this can occur consistently across 7 days would help reduce the pressures on EDs and release considerable resources, a proportion of which should be reinvested to improve the efficiency and outcomes of inpatient care.
- 1.17 To respond effectively to these challenges, the concept of the hospital needs to change radically. The hospital must evolve from an institutional site-based model, where ward admission is required to 'unlock' access to expert staff and equipment, to become a nexus of clinical expertise and supporting technology organised to meet the needs of patients. This means challenging not only the type of care hospitals provide, but also where it is delivered. A move towards (traditionally in-hospital) specialist medical teams providing expert management of chronic disease in the community – in support of general practice – is necessary. This requires resources directed towards preventing exacerbations of chronic disease, relieving suffering, promoting wellness and physical independence.

The Future Hospital Commission

Background to the Future Hospital Commission

1.18 The RCP outlined many of the challenges faced by acute hospitals in its September 2012 report, *Hospitals on the edge?*,¹³ having become increasingly concerned that pressures on hospital services were adversely affecting the quality of care afforded to inpatients with medical illnesses. Patients reported being moved round the system ‘like parcels’. Over a quarter (28%) of consultant physicians surveyed by the RCP rated their hospital’s ability to deliver continuity of care and stable medical teams for patient care and education as poor or very poor.¹⁴ Formal and anecdotal feedback from patients and the RCP’s fellows and members highlighted concerns about hospitals’ ability to deliver:

- > high-quality care sustainable 24 hours a day, 7 days a week
- > continuity of care as the norm, with seamless care for all patients
- > stable medical teams that deliver both high-quality patient care and an effective environment in which to educate and train the next generation of doctors
- > effective relationships between medical and other health and social care teams
- > an appropriate balance of specialist care and care coordinated expertly and holistically around patients’ needs
- > transfer of care arrangements that realistically allocate responsibility for further action when patients move from one care setting to another.

1.19 It was in response to these concerns from patients and doctors that the RCP established the Future Hospital Commission in March 2012.

Scope of the Future Hospital Commission

1.20 The Future Hospital Commission’s work has been underpinned by the principle that hospitals must be designed around the needs to patients, with a primary objective to:

‘Identify optimal care pathways for adult inpatients with medical illness, with specific reference to organisation, delivery, standards and continuity of care.’

1.21 The Commission’s aim is to identify a system in which safe, effective and compassionate medical care can be delivered to all who need it as hospital inpatients. The Commission’s proposals are designed to take a long-term view, making radical recommendations where these are necessary to achieve safe, high-quality sustainable care. Its focus is on the design and delivery of hospital services in England and Wales. However, the principles articulated have wider relevance. The recommendations contained in this report aim to:

- > identify the optimal care pathway for adults with medical illnesses, with specific reference to organisation, processes and standards of care
- > outline a clinically driven model of care that is economically viable, widely applicable and sustainable, and takes 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
- other issues likely to impact significantly on the delivery of hospital services, such as new technologies and other innovations.
- > outline the means by which the hospital can assume an enhanced role as the hub of an integrated healthcare system, developing the physical and organisational structures to facilitate this role, while preserving those aspects of the current model that have proved successful
- > develop clinical staffing models and ways of working that will be needed to lead, coordinate and manage the new service; and the means by which staff can be trained to take on these roles
- > specify groups of patients disadvantaged by current models of care and who will become the focus of the proposed new system
- > indicate how management, administrative and information systems will need to adapt to support the proposed care system and enhance clinical, academic and audit activity
- > emphasise how the delivery of patient-centred, compassionate care will underpin all activities. This must be governed by consideration of the seven domains of quality (Box 2)
- > provide practical steps to work towards a longer-term vision utilising existing examples of good and innovative practice.⁸

Box 2. The seven domains of quality.¹⁵

Patient experience: The patient should be the definitive focus of healthcare delivery. 'Quality healthcare' may not be the same for every patient.

Effectiveness: Healthcare should be underpinned by the deployment of beneficial interventions at the right time and to the right patients.

Efficiency: Healthcare must make best use of limited resources. Avoidance of waste should apply to material and abstract (eg time, ideas) resources.

Timeliness: Timeliness is key to avoiding waits and potentially harmful delays in the delivery of healthcare, incorporating the deployment of health interventions to anticipate and prevent illness.

Safety: While risk in healthcare cannot be reduced to zero it must be actively managed with the minimisation of harm a definite objective.

Equity: Healthcare must strive for a level playing field, in which patients determine their own high-quality care, and in which the needs of the many and the few are balanced.

Sustainability: Sustainability should be viewed as a characteristic of healthcare which must run through and moderate other domains. Healthcare should be considered not only in terms of what can be delivered to an individual today, but also to the population in general and the patients of the future.

- 1.22 The focus of the Commission is the acute medical patient in a hospital setting. However, 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 configured to respond, not just to acute medical illness, but also to:
- > all aspects of physical health, including multiple acute and chronic conditions
 - > mental health and well-being
 - > social needs.
- 1.23 In recognising that people often have specific and complex needs, the Commission and its recommendations acknowledge 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 nucleus is the hospital and medical teams, the interface and interaction with other parts of the health and social care economy are fundamental aspects of its work. This will include consideration of primary care, social care and mental health services.

Evolution to the future hospital – adapting to local circumstances

- 1.24 All hospitals and health systems are underpinned by a common principle: services and systems must be designed around patients and their physical, psychological and social needs. However, hospitals differ in size, the range of services provided, the degree of integration with other healthcare providers, the population they serve and the extent to which they deliver training and research. Just as there is no 'one size fits all' for the delivery of healthcare to patients, there is no single, optimal approach to designing and delivering hospital services.
- 1.25 The recommendations set out in this report should therefore be adapted to the needs of the patients in the health economy served. Many services have been introduced and/or are undertaking innovative practices with this aim, working with patients and drawing upon specialist clinical and local knowledge. Indeed, the report draws together examples of local good practice which already go some way towards creating a holistic vision for the future of hospital services and the wider health economy in which they are based. Applying these exemplars more broadly will be a collaborative exercise between all those involved in the delivery of care, and will require ongoing monitoring and patient feedback.
- 1.26 The report's recommendations are neither closed nor exclusive. Adapting them to local circumstances will help reveal those changes to the organisation of care that improve the ability to meet the needs of patients in the future. However, the overriding objective should be to place patients and their physical, psychological and social needs at the very heart of the healthcare system.
- 1.27 The Commission recognises that its findings imply that tough decisions lie ahead. Reconfiguration will almost certainly be needed.¹⁶ No hospital can provide the range of services and expert staff needed to treat patients across the spectrum of all clinical conditions on a 7-day a week basis. We need to develop a new model of 'hub and spoke' hospital care, coordinated across health economies, centred on the needs of patients and communities and based on the

principle of collaboration, not just across health services but also with social care, transport planning etc. It is likely that in many areas, large health economies will be served, not by a number of district general or teaching hospitals, but by a smaller number of acute general hospitals hosting EDs and trauma services, acute medicine and acute surgery. These hospitals will be surrounded by intermediate 'local general hospitals' which, while not directly operating their own ED and acute admitting services on site, will contribute to step-down inpatient and outpatient care, diagnostic services and increasingly close integration with the community.

- 1.28 Public awareness of the growing evidence base supporting complex treatments places additional responsibilities on physicians to carefully weigh up and explain the likely effectiveness and safety of intervention in each patient. Highly specialised services will increasingly have to be provided in large centres. In parallel and wherever possible, less complex services must be developed and delivered in the community, in or close to the patient's home. Staff redeployment would enable much more comprehensive specialist service delivery to patients in their usual home setting. These services should be integrated with primary and social care to meet the health and care needs of patients 24 hours a day.

Engagement in designing the Future Hospital Commission's recommendations

- 1.29 In undertaking the work that has informed development of the report, the Future Hospital Commission embarked on a comprehensive programme of information gathering, deliberations and engagement. The Commission drew on the expertise of a range of professionals involved in the delivery of health and care, all of which were informed by the views of patient and carer groups. The full list of contributors to the Commission's work is contained in Appendices 8 and 9. In addition, there have been speaking engagements by members of the Commission's boards and working groups, targeted visits to hospitals and interviews with innovators 'on the ground', over 50 written submissions from experts in their field, and over 100 meetings and workshops in which the Future Hospital Commission's recommendations were discussed by members of the commission, experts in the field of health and social care, patient groups, healthcare professionals and policymakers.
- 1.30 This report of the Commission is presented in three parts, describing: its background, rationale and purpose, and the principles upon which it is based (Part A); the proposed new model of care (Part B); the essential changes in support systems and culture that will be needed to achieve change (Part C). In each of the report's 11 chapters examples of good practice already extant are provided and recommendations made emanating from the evidence presented.

References

- 1 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chaired by Robert Francis QC. London: Stationery Office, 2013.
- 2 National Advisory Group on the Safety of Patients in England. *A promise to learn – a commitment to act: Improving the safety of patients in England*. London: National Advisory Group on the Safety of Patients in England, 2013.
- 3 Health Service Ombudsman. *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*, 2011. www.ombudsman.org.uk
- 4 Care Quality Commission. *Dignity and nutrition inspection programme: national overview*. Newcastle upon Tyne: Care Quality Commission, 2011. www.cqc.org.uk/sites/default/files/media/documents/20111007_dignity_and_nutrition_inspection_report [accessed 16 August 2013].

- 5 Care Quality Commission. *Time to listen: In NHS hospitals. Dignity and nutrition inspection programme 2012*. Newcastle upon Tyne: Care Quality Commission, 2013. www.cqc.org.uk/sites/default/files/media/documents/time_to_listen_-_nhs_hospitals_main_report_tag.pdf
- 6 Levenson R. *The challenge of dignity in care: upholding the rights of the individual*. London: Help the Aged, 2007.
- 7 Patients Association. *We have been listening, have you been learning?* Harrow, Middlesex: Patients Association, 2011.
- 8 Future Hospital Commission. Royal College of Physicians: www.rcplondon.ac.uk/projects/future-hospital-commission [accessed 16 August 2013].
- 9 Ipsos MORI. *Britain 2012: Who do we think we are?* London: MORI, 2012.
- 10 Dilnot A, Warner N, Williams J. *Fairer care funding: the report of the Commission on Funding of Care and Support*. London: Department of Health, 2011.
- 11 Imison C, Poteliakhoff E, Thompson J. *Older people and emergency bed use: exploring variation*. London: King's Fund, 2012.
- 12 Alzheimer's Society. *Counting the cost: caring for people with dementia on hospital wards*. London: Alzheimer's Society, 2009.
- 13 Royal College of Physicians. *Hospitals on the edge? The time for action*. London: RCP, 2012.
- 14 Royal College of Physicians. *Membership engagement, benefits and publications research*. Research by Design Ltd. London: RCP, 2012. www.rcplondon.ac.uk/press-releases/quarter-physicians-say-continuity-care-poor-their-hospital [accessed 29 August 2013].
- 15 Atkinson S, Ingham J, Cheshire M, Went S. Defining quality and quality improvement. *Clin Med* 2010;10;6:537–9.
- 16 Academy of Medical Royal Colleges, National Voices, NHS Confederation. *Changing care, improving quality*. London: AoMRC, 2013.

2 Principles underpinning the care of medical patients

The hospital at the hub of a new system of care

- 2.1 Illness can occur at any time. The services needed to restore patients from ill health to recovery must therefore be available 7 days a week in the hospital and community according to patient need. The hospital must understand its place and purpose in the healthcare economy, and provide services that meet the needs of patients and the community, in collaboration with partners in primary and social care. The solutions to the current pressures on hospitals lie across the health and social care system, and depend on patients being able to move through the system without getting 'trapped' in certain settings, unable to access the care and support they need in order to recover or receive compassionate, dignified care at the end of life.
- 2.2 Conventional models of health service design in which a hospital site is the sole focus for the delivery of emergency, acute and elective services are dated. These models often lack the integration, collaboration, communication and information sharing across hospital and the healthcare settings necessary to effectively meet patient needs and provide streamlined and seamless care. Care must be delivered in the setting in which patients' clinical, care and support needs can best be met, and not merely delegated to the acute hospital site 'where the lights are on'. Hospital and community services must adapt to clinical need and develop new models of care based on a partnership between acute and primary care providers. This necessitates collaborative managerial and strategic approaches, and clinical teams committed to delivering seamless care for patients in locations and settings where their needs can best be met. In this context, the hospital must assume a new role. It must advocate and deliver services designed around the seven domains of quality (see Box 2, page 8) and facilitate an integrated approach with the broader healthcare system through which patients move seamlessly.
- 2.3 The optimal means of providing services within a locality is to ensure that high-quality effective care is provided from initial referral through local hospitals to specialist tertiary centres, and transfer of care to appropriate care facilities (home, care home, community hospital with intermediate care). This is likely to vary according to geography, but must be of the same quality and availability regardless of the age, clinical disorder or social circumstances of the patient.

Improving collaboration across health and social care

- 2.4 The priority for hospital services and their partners in community settings must be to prevent health crises and manage exacerbations of chronic disease. This is reliant on better promotion of self-care by patients and related improvements in the arrangements for contact with primary and community care services whenever increased clinical, physical, social and psychological support is needed. This means developing integrated services provided effectively in settings beyond the hospital walls, with specialist medical teams working out into the community in collaboration with professionals from primary and social care. Alternatives to hospital admission – supported by a comprehensive range of services including ambulatory ('day case') emergency care (AEC), continuing secondary care management in the community and expanded rehabilitation services (intermediate care) – have been shown to reduce admissions.¹ Therefore, for the patient who presents as an emergency in the future, a key question must be 'can this patient be managed in the community?'
- 2.5 Patients are most vulnerable when they present to hospital with an acute illness. This vulnerability increases if patients are frail, have cognitive impairment (eg dementia) and multiple or complex medical conditions. Viewed from the patient's or carer's perspective it is incomprehensible that current systems of care do not allow routine, immediate access to primary care records or information on even recent admissions or outpatient consultations occurring in the same or neighbouring hospital trusts.
- 2.6 The failure to develop effective communication systems to share information at key points in the patient's clinical pathway is the antithesis of patient-centred care and means the patient is disadvantaged right from their initial assessment in hospital. This in turn delays or impairs clinical decision-making, including diagnosis and treatment. Crucially, absence of information on the patient's usual health status and level of dependency can lead to a decision to admit when alternatives to admission (such as rehabilitation in the community or enhanced social support) would have met the patient's requirements more effectively and safely. Access to health records and alternatives to admission must be available 7 days a week.
- 2.7 Sadly, the older hospital inpatient with frailty, whose acute illness has been effectively treated but who has newly identified health or social care requirements in the community, can spend many additional days or weeks in hospital waiting for a start date for social care support at home, residential rehabilitation or a care home place. Inadequate funding and provision of community social services in particular, means that many patients, once hospitalised, experience a lack of urgency in setting up social care support to facilitate patients moving out of hospital. Studies of inpatient bed use in England indicate that up to 42–55% of hospital bed days could have been spent instead in the community at home with enhanced medical or care services or in a nursing home.²
- 2.8 For those patients who do require hospital admission, the first priority is the management of the acute illness. However, planning for a patient's move from hospital should commence from the first consultant review, with a consistent emphasis on enabling patients to leave hospital as soon as an acute medical bed is no longer required. Integrated health and social care services in the community should be geared to support this objective with, if necessary, continuing expert care that is delivered by hospital-based clinicians working outside the hospital setting in collaboration with primary and social care. This means that comprehensive, effective alternatives to hospital

admission must also be available 365 days a year to those with exacerbations of chronic disease, predictable or otherwise, or increased levels of dependency or social needs that do not mandate hospitalisation. Lack of collaboration across primary and secondary care, inadequate community and social services, and ineffective support of care home residents of whom there are some 400,000,¹ means that many older patients with frailty are admitted to acute hospital beds in which they wait for appropriate levels of health or social services support to become available.

The hospital's public health role

- 2.9 The future hospital will be more than a provider of acute care and elective services. The hospital and its staff also have an important role in promoting healthy behaviours and avoiding health harms. Most acute hospitals are significant employers in a local area and have an opportunity to promote healthy behaviour among their staff as well as patients and relatives. A hospital is a repository for technology, skills and expertise that should serve the whole community. Each hospital team needs to ensure that its expertise is being deployed to serve the needs of the whole population it serves. Hospitals will need therefore to work with public health teams (and, in England, local authority-led health and wellbeing boards) to measure and identify the needs of the population. This will include the need for health promotion, supported self-management (particularly for long-term conditions) and equality of access to all groups in society.
- 2.10 Analysis of top performing hospitals suggests that those that perform well are embedded in their local community.³ These hospitals embrace vertical integration and work with other agencies, including local government and primary care commissioners, to achieve a unified approach to health promotion in the area.
- 2.11 Health improvement work, such as smoking cessation and promotion of physical activity, can be supported by frameworks such as the National Institute for Health and Care Excellence (NICE) public health guidance for the workplace,⁴ the World Health Organization's health promoting hospitals guidance⁵ and 'every contact counts' initiative.⁶ Research shows that hospitals that implement NICE public health guidance tend to have a healthier and more productive workforce and better patient outcomes.⁷ Some hospitals already employ directly or take advice from a consultant trained in public health to support these measures. Health improvement work should be part of the integrated functions of a hospital with the behaviours targeted across the care spectrum, from primary, community and secondary care.

The acutely ill: managed in the right place by the right team

- 2.12 Patients who develop acute illness of a type or severity that cannot be satisfactorily managed in the community will continue to require access to coordinated expert care provided in hospital by expert clinical staff. These staff need to be supported by systems of care, resources and equipment that facilitate and enable prompt assessment, monitoring, diagnosis and treatment. The profound impact of treatment (eg parenteral antibiotics for severe sepsis, percutaneous coronary intervention for acute coronary syndrome, and thrombolysis for hyperacute stroke) make it imperative that patients who could benefit from these interventions can rapidly access specialist hospital assessment and admission pathways. This requires a coordinated approach involving public health education, ambulance trusts, emergency departments and specialist medical and diagnostic services (eg stroke and myocardial infarction services). Approaches that

look at delivery across the full pathway of care have been associated with the reductions in disease-specific mortality (eg for stroke services).⁸

- 2.13 The intensity of monitoring and treatment of acutely ill inpatients should match the acuity of illness and will dictate the clinical area (and the level of staffing) the patient requires. Patients who are clinically unstable, or have an increased acuity of illness assessed by the national early warning score (NEWS) are likely to require more intense monitoring in an enhanced care bed (level 1), high dependency unit (level 2) or intensive care unit (level 3).⁹ These patients will require immediate access to specialist, diagnostic and laboratory services 7 days a week.
- 2.14 The overriding objective should be continuity of care for patients, coordinated and delivered by a single consultant-led clinical team. The provision of care to any single acutely ill patient should be confined, as far as possible, to a single ward or adjacent wards to facilitate continuing care by the same team on successive days. The principle of continuity of care with a single team should also apply to successive clinical contacts with hospital-based services for the same index clinical problem; for example, follow-up in the community, outpatient department or ambulatory emergency care centre once a patient has left hospital.

An end to silo working: communication and continuity of care

- 2.15 The modest profile and influence of the consultants and ward managers with responsibilities for patients managed therein have had significant consequences. Physicians report a lack of continuity of care, budgetary constraints and staff shortages. Some 25% report that care in their own hospitals is poor.¹⁰
- 2.16 Clinical teams and departments too often work independently of each other. Furthermore, senior clinical staff in departments or directorates may perceive that patients who meet the criteria for specialty care by their service or directorate receive good care. It is important to recognise that the way data on service delivery are selected and analysed may reinforce 'silo' working by having an excessively narrow focus on just those patients who, for example, access inpatient beds run by a single medical specialty service. This means that the needs of patients in the hospital system not accessing these beds are neither recognised nor met. The current healthcare system is largely failing to deliver whole person care due to the historical compartmentalised approach that specialty medicine has provided.
- 2.17 The rising numbers of acutely ill patients presenting to hospital has led to reorganisation of 'front door' medical services in the past 15 years. This has led to the emergence of 'acute medicine' as a new specialty, and investment in the design, staffing and equipping of acute medical units (AMUs). This has greatly improved the care of patients during the first 48 hours of their admission. However, it has tended to add discontinuity to inpatient pathways for patients who do not return home directly from the AMU, but instead transfer to another ward within the hospital. This discontinuity is exacerbated when these transfers take place at night, after an interval of more than 24 hours, or when the patient is subjected to subsequent additional bed moves.
- 2.18 Patients report that the transfer ('handover') of care between in-hospital teams when a patient moves wards or between hospital and community teams when they leave hospital is often not

joined up, with poor information sharing and communication. Hospitals are often not set up to enable patients to move from hospital into the community on a 7-day basis, and primary care and community-based services are neither staffed nor organised to support patients back into the community 7 days a week. Furthermore, hospital-initiated follow-up plans can be inconsistent and poorly communicated, with the patient experiencing further discontinuity when subsequently reviewed by clinical staff who are unfamiliar with their clinical problems.

- 2.19 Transfers of patient care from hospital to community – and vice versa – should be organised around the needs of patients, operational 7 days a week, and not constrained by administrative and budgeting divisions. New models of care delivery by clinical staff will require considerable changes in service delivery and working patterns irrespective of where patients receive care within the health economy.

Administration and management

- 2.20 The purchaser–provider split in England has undermined more joined-up working between primary and secondary care, with similar experiences evident from other countries with similar funding models. Integration of social, primary and secondary care has been shown to benefit patients.¹¹ Where hospital services have developed with a focus on delivery of care on the hospital site then the assessment and monitoring of such services may fail to identify the unmet needs of patients elsewhere in the health system.
- 2.21 Current structures for budget setting and financial reporting within hospital often fail to adequately align the needs of patients with the actual care delivered. Easily measured units of performance can be over-represented (eg elective services and treatment for patients with single conditions); there may be much greater focus on activity that generates the most revenue; and the funding denominator may be a selected cohort of patients not reflective of needs across the health economy. For example, in a cardiology department it is much easier to record activity and costs related to coronary angiography than cardiology consultations carried out on the AMU or geriatric medicine wards. However, the latter may have a much greater impact on the quality of care, need for investigation and duration of stay, and related costs for the patient. Current financial reporting structures do not capture or support the degree of collaborative working between specialty teams that hospitalised patients with multiple comorbidities commonly require.
- 2.22 Increasing the effectiveness and efficiency of hospitals in financial and staffing terms is essential. The assessment, admission and clinical management of patients presenting as genuine medical emergencies is a key activity of all acute hospitals and provides the greatest challenge to the organisation in terms of the provision of high-quality care, patient safety and use of resources. The importance of the overall organisation of acute medical services to the quality of patient care and effective functioning of hospitals remains insufficiently recognised and under financed.

Delivering patient-centred care: four principles

- 2.23 Four principles underpin a system in which all patients receive continuous, holistic care in settings appropriate to their clinical and care needs viewed from their perspective. These principles – articulated below – are based on the seven domains of quality set out in chapter 1

(Box 2, page 8). They are complemented by a set of questions that all service planners and healthcare practitioners should consider when designing and delivering health services (Box 3).

Box 3. Service design: drivers underpinning the organisation of care for patients.

1 Do services deliver continuity of care?

- i Continuity:
 - > throughout a single episode of care / single hospital admission
 - > across several episodes of care (eg a series of acute illnesses)
 - > in chronic disease management.
- ii Continuity:
 - > of clinical staff and teams, with clear responsibility for the care of individual patients
 - > in transfer of care within and outside the hospital
 - > of patients records and information, and their transfer between and across settings
 - > of service across 7 days, with access to assessment, diagnostics, treatment, care and support across health and care settings.

2 Do services deliver patient-centred, compassionate and holistic care?

- i Services tailored to the needs of individual patients.
- ii Patient experience is valued as much as clinical outcomes and effectiveness, with feedback acted on at individual, ward, board and system level.
- iii Same standards, rights and responsibilities around compassionate, high-quality care across all health and care settings.
- iv Professional values, strong leadership and shared outcomes that actively promote:
 - a clinical leadership for the whole care of the patient
 - b responsibility for the physical and social environment within the care setting across all staff
 - c reflection and improvement at individual, team, service and system levels.
- v Individualised care plans devised and delivered across settings, and a concordat on collaborative, patient-centred assessment and care between health and social services.
- vi Sharing of patient-level clinical and social information across settings.

3 Do services deliver for vulnerable patients and patients with complex needs?

Health services should aim to set a standard of care of universal relevance by explicitly considering the following in service design:

- i Quality of care received by patients admitted to 'general' medical wards¹²
- ii High-quality, seamless care for patients with dementia
- iii People at the fringes of healthcare (eg adolescents and young adults, and people who are homeless, non-compliant or have mental health problems, learning disabilities or behavioural disorders).

- 2.24 **Continuity of care:** The first relates to continuity of care provided by clinical staff during a single hospital admission, across several episodes of acute illness and in chronic disease management. Continuity relating to the availability of a single patient record throughout the

health system, with proactive sharing of information and involvement of clinical staff with knowledge of the patient (particularly as they move through different care settings), is a vital part of this process. This facilitates self-care by patients and enables the provision of expert support by professionals working across the health system.

- 2.25 **Patient-centred care:** The second principle relates to individualised, compassionate, holistic and collaborative care in the community, hospital and social services. This care must be delivered by those adhering to professional values that assume clinical responsibility for the whole care of the patient, working at both the individual and system levels. Services that are tailored to the needs of individual patients must be developed and delivered by trained practitioners both in the community and hospital.
- 2.26 **Patient experience:** The third principle is focused on patient experience. As a general principle, patients should not move wards unless this is necessary for their clinical care. Care, including the professionals that deliver it, should come to patients. Patient experience should be valued as much as conventional measures of clinical outcomes and effectiveness. Timely detailed patient feedback must be developed together with systems to capture relevant data. Results of patient feedback must be acted upon, at the individual practitioner, ward and board levels.
- 2.27 **Vulnerable patients:** The fourth principle relates to vulnerable patients. The delivery of high-quality care to patients with dementia demands a particularly high standard of care across multiple domains including communication, multidisciplinary care, clinical decision-making and engagement with families and carers. Getting care right for the patient with dementia means achieving a standard of care of universal relevance to vulnerable adults. There is a requirement to re-focus on care delivery to patients who all too often are on the fringes of healthcare and do not fit in with the established norms for service provision. These include the homeless, the non-compliant, adolescents and young adults, and those with mental health problems, learning disabilities and behavioural disorders. Excluding such patients from community-based services on the basis of registration or being 'too difficult' denies patient-centred care and misses opportunities to prevent clinical crises.

Embedding the principles of patient care in service design and delivery

- 2.28 Finally, and most importantly, all services must be centred around providing patients with high-quality, compassionate care that meets their basic needs and strives to constantly improve. The principles set out in Box 5 (p21–22) have informed all the Future Hospital Commission's work and underpin all the recommendations contained in this report.
- 2.29 The Francis report¹³ highlighted an apparent lack of compassion among healthcare workers and failings in the delivery of basic care involving dignity, cleanliness, nutrition and hydration. The standards of care provided in any part of the hospital are the concern of everyone working within it. Responsibilities must extend beyond traditional ward or team boundaries. Hospitals should look to develop and promote a 'citizenship charter' based on the NHS Constitution,¹⁴ the principles of care articulated by the Future Hospital Commission (Box 5) and the 'Commitments to patients' set out in the report (inside front cover). This should be developed in collaboration with staff, senior managers, hospital chairs and boards, patients and carers, and the wider community (see chapter 11: Culture).

- 2.30 All physicians should feel responsible for the quality of basic care provided to patients, and take action whenever they become aware of this being inadequate, regardless of whether the patient is ‘under their care’ or not. This is at the heart of medical professionalism (see Box 4). Consultants have a responsibility to lead by example in the provision of care to patients, and identify and participate in service and system level initiatives designed to improve patient care. Consultants should embed the principles of the hospital’s citizenship charter (see para 2.29) in their daily practice, and promote it with junior staff and colleagues.¹⁵

Box 4. Medical professionalism – core principles and values.

1 Principles of medical professionalism¹⁵

Medicine is a vocation in which a doctor’s knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This aim is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability.

Doctors are committed to:

- i integrity
- ii compassion
- iii altruism
- iv continuous improvement
- v excellence
- vi working in partnership with members of the wider healthcare team.

2 Professional values must express the need:

- i **for clinical leadership** for the whole care of the patient, working at direct patient care and at system level to organise care for all patients. The ‘whole care of patients’ covers the care patients receive across specialties, across settings and all domains of quality (eg safety, outcomes and experience). This includes responsibility to raise questions and take actions when they have concerns about care standards.
- ii **to communicate** effectively with patients, their families and carers. Medical and other staff must be trained in communication methods with patients and their families, including the diagnosis and management of dementia and delirium.
- iii **to empower patients** through effective collaboration. Medical staff must acquire skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk).
- iv **to collaborate** with other teams and professions. Medical staff have a responsibility to communicate and collaborate with other teams and professionals to make sure patients receive smooth and effective care throughout the health and social care system.

- 2.31 In practical terms, this means that doctors must expect to provide clinical leadership for the whole care of the patient, working individually and at the system level. The ‘whole care of patients’ covers that received across specialties, across settings and in all domains of quality (eg safety, outcomes and experience). They must commit to communicating effectively with

patients, their families and carers, where necessary being trained in relevant methods, including those relating to the diagnosis and management of dementia and delirium. Finally, they must work to collaborate with and empower patients, acquiring skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk). Doctors must expect to be assessed annually in their compliance with these principles through appraisal, and to be called to account if they fall short in doing so (see chapter 11: Culture).

The Commission's vision for patient care

Box 5. Care for patients – core principles.

1 Fundamental standards of care must always be met¹³

Patients must:

- i be treated with kindness, respect and dignity, respecting privacy and confidentiality
- ii receive physical comfort including effective pain management
- iii receive proper food and nutrition and appropriate help with activities of daily living
- iv be in clean and comfortable surroundings
- v receive emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on themselves, their families and their finances.

2 Patient experience is valued as much as clinical effectiveness

Patient experience must be valued as much as clinical effectiveness. Patient experience must be measured, fed back to ward and board level and the findings acted on.*

3 Responsibility for each patient's care is clear and communicated

There must be clear and communicated lines of responsibility for each patient's care, led by a named consultant working with a (nurse) ward manager. Consultants may fill this role for a period of time on a rotating basis.

4 Patients have effective and timely access to care

Time waiting for appointments, tests, hospital admission and moves out of hospital is minimised.

5 Patients do not move wards unless this is necessary for their clinical care

Patients should not move wards unless this is necessary for their clinical care. Care, including the professionals that deliver it, should come to patients.

6 Robust arrangements for transferring of care are in place

There must be robust arrangements for the transfer of care:

- i between teams when a patient moves within the hospital
- ii between teams when staff shifts change
- iii between the hospital and the community.

(continued overleaf)

* The Future Hospital Commission supports the NICE quality standard¹⁶ on patient experience.

Box 5 *continued*

7 Good communication with and about patients is the norm

Communication with patients is a fundamental element of medical professionalism. There must be good communication with and about the patient, with appropriate sharing of information with relatives and carers. Medical and other staff must be trained in communication with patients and their families, including diagnosis and management of dementia and delirium.

8 Care is designed to facilitate self-care and health promotion

Working with, and empowering, patients is a fundamental aspect of medical professionalism. Shared decision-making should be the norm. Patients should have access to information, expert advice and education concerning their clinical status, progress and prognosis. Care should be designed to facilitate autonomy, self-care and health promotion. Medical staff must acquire skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk).

9 Services are tailored to meet the needs of individual patients, including vulnerable patients

Services must be tailored to the needs of individual patients, including older patients who are frail, patients with cognitive impairment, patients with sensory impairments, young people, patients who are homeless and patients who have mental health conditions. The physical environment should be suitable for all patients (eg those with dementia). Services will be culturally sensitive and responsive to multiple support needs.

10 All patients have a care plan that reflects their specific clinical and support needs

Patients must be involved in planning for their care. Patients' care preferences are checked and measures taken to optimise symptom management. Patients and their families must be supported in a manner that enhances dignity and comfort, including for patients in the remaining days of life.

11 Staff are supported to deliver safe, compassionate care and committed to improving quality

Hospitals will support staff to collectively and individually take ownership of the care of individual patients and their own contribution to the overall standard of care delivered in the health system in which they work. This should be supported by the development of a citizenship charter, based on the NHS Constitution.¹⁴ Doctors will be supported to embed the principles of medical professionalism in their practice. Staff well-being and engagement will be a priority, in order to promote good outcomes for patients.

References

- 1 The King's Fund. *Avoiding hospital admissions: What does the research evidence say?* London: King's Fund, 2010. www.kingsfund.org.uk/publications/avoiding-hospital-admissions [accessed 19 August 2013].
- 2 The King's Fund. *Data briefing: Emergency bed use: what the numbers tell us.* London: King's Fund, 2011. www.kingsfund.org.uk/publications/data-briefing-emergency-bed-use [accessed 16 July 2013].
- 3 Robinson P, Tyndale-Biscoe J. *What makes a top hospital?* The top hospitals programme. London: CHKS, 2012. www.chks.co.uk/Top-Hospitals [accessed 16 July 2013].
- 4 National Institute for Health and Care Excellence. www.nice.org.uk/Guidance/PHG/Published [accessed 19 August 2013].

- 5 International health promoting hospitals network. www.hphnet.org [accessed 19 August 2013].
- 6 Department of Health. *The NHS's role in the public's health*. A report from NHS Future Forum. London: DH, 2011.
- 7 Royal College of Physicians. *Implementing NICE public health guidance. A national organisational audit of acute NHS trusts in England*. London: RCP, 2011. www.rcplondon.ac.uk/resources/nice-public-health-guidance-workplace-organisational-audit [accessed 16 July 2013].
- 8 Royal College of Physicians. *National clinical guidelines for stroke*, 4th edition. Prepared by the Intercollegiate Stroke Working Party. London: RCP, 2012. www.rcplondon.ac.uk/sites/default/files/national-clinical-guidelines-for-stroke-fourth-edition.pdf [accessed 20 August 2013].
- 9 Royal College of Physicians. *Acute care toolkit 6: The medical patient at risk*. London: RCP, 2013. www.rcplondon.ac.uk/resources/acute-care-toolkit-6-medical-patient-risk [accessed 16 July 2013].
- 10 Royal College of Physicians. *Membership engagement, benefits and publications research*. Research by Design Ltd. London: RCP, 2012.
- 11 The King's Fund. *Integrated care for patients and populations: improving outcomes by working together*. A report to the Department of Health and the NHS Future Forum. London: King's Fund, 2012.
- 12 Overview of the Quality Mark for Elder-friendly Hospital Wards. www.rcpsych.ac.uk/quality/qualityandaccreditation/elder-friendlyqualitymark/overviewofthequalitymark.aspx [accessed 16 July 2013].
- 13 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chaired by Robert Francis QC. London: Stationery Office, 2013.
- 14 NHS Choices. *The NHS constitution: the NHS belongs to us all*. London: NHS Choices, 2013. www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx [accessed 5 August 2013].
- 15 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. Report of a working party. London: RCP, 2005.
- 16 National Institute for Health and Care Excellence. *Patient experience in adult NHS services*. Quality Standard QS15. London: NICE, 2012.

Part B

A new model of clinical care



A new model of clinical care

Introduction

The Future Hospital Commission aims to develop a new model of care that delivers safe, high-quality care for patients across seven days. In the future, hospital services must be designed to deliver continuity of care as the norm for all patients, including those with multiple and complex conditions. This means delivering specialist and general medical care that is coordinated to meet the clinical, care and support needs of all patients. This necessitates effective relationships between medical and other teams, and stable medical teams that deliver both excellent care and an effective environment in which to train the next generation of doctors. It will also require clear arrangements for providing ongoing care for patients when they need to move from one place of care to another, including when they leave hospital.

This part (Part B) of the Future Hospital Commission report recommends fundamental changes to the way hospitals organise and deliver care for medical patients. Its chapters set out a new structure for hospital services that is designed to encourage collective responsibility and accountability for the care of medical patients across professions and teams, and clinicians and managers (chapter 3). It recommends that these structural changes be accompanied by new ways of working across medical teams, across in-hospital wards and services, and between hospital and community services (chapters 4 and 5). Finally, it considers how we can develop services that meet the needs of specific vulnerable groups (chapter 6).

The specific recommendations contained in each of these chapters are intended as a 'road map' to achieve the Future Hospital Commission's long-term vision for our hospitals. This overarching vision articulates the key components that must underpin hospital services in the future.

Our vision of the future hospital – a new model of clinical care

- 1 **Hospital services that operate across the health economy:** Hospitals will be responsible for delivering specialist medical services (including internal medicine) for patients across the health economy, not only for patients that present to the hospital. Integrated working, shared outcomes and real-time communication of information with health and social care partners across traditional hospital and community boundaries will be the norm.
- 2 **Seven-day services in hospital:** Acutely ill patients in hospital will have the same access to medical care on Saturdays, Sundays and bank holidays as on a week day. Services will be organised so that consultant review, clinical staff (eg allied health professionals and specialist nurses), and diagnostic and support services are readily available on a 7-day basis.
- 3 **Seven-day services in the community:** Health and social care services in the community will be organised and integrated to enable patients to move out of hospital on the day they no longer require an acute hospital bed. Hospital procedures for transferring patient care to a new setting operate on a 7-day basis, with 7-day support from services in the community.
- 4 **Continuity of care as the norm:** Care will be organised to maximise the continuity of care provided by the individual consultant physician and key members of the clinical team, with staff rotas organised to deliver this. Once assessed in hospital, patients will not move beds unless their clinical needs demand it. When a patient is cared for by a new team or in a new setting, arrangements for transferring care (through handover) will be prioritised by staff supported by direct contact between staff and information captured in the electronic patient record. Physicians will provide continuity not only during the hospital admission, but also embed this into follow-up consultations and arrangements.
- 5 **Stable medical teams in all acute and ward settings, focused on the whole care of patients:** A greater number of medical and non-medical staff (including consultant physicians and trainees) will participate in the provision of acute services and general ward care, ensuring a balanced workload across medical services and career grades. There will be a consultant presence on wards over 7 days, with ward care prioritised in medical job plans. This will be supported by a longer-term programme to promote internal medicine and increase internal medicine skills and deployment across the medical workforce.
- 6 **Access to coordinated specialist care for all patients:** Patients will receive the best specialist care wherever they are in hospital. For patients with multiple and/or complex conditions, there will be input from a range of specialist teams according to clinical need, with a single named consultant responsible for coordinating care. Care will be organised so that there are clear arrangements for the delivery of specialty-specific care to patients wherever they are in hospital, with criteria that allow easy, rapid identification of patients requiring specialist care. Performance of specialist medical teams will be assessed according to how well they meet the needs of patients with specified condition/s across the hospital and health economy.
- 7 **Early senior review across medical specialties:** Patients will have access to early consultant review, which has been shown to improve outcomes for patients. This will include early senior review by specialist teams at 'the front door'. This will help prevent delays in obtaining specialist medical

review in patients with conditions known to benefit from such a review 7 days a week. For example, older patients with multiple comorbidities presenting as a medical emergency will have early access to comprehensive geriatric assessment, which is known to improve experience, outcomes and efficiency.

- 8 Intensity of care that meets patients' clinical and support needs:** The level of care available in hospitals will reflect the acuity and complexity of illness experienced by the current demographic of patients. There will be more enhanced care beds (level 1) relative to acute medical beds (level 0). Nurse staffing ratios will match patient requirements for higher intensity monitoring and treatment, including for those with cognitive impairment and/or frailty.
- 9 Medical support for all hospital inpatients:** The remit and capacity of medical teams will extend to adult inpatients with medical problems across the hospital, including those on 'non-medical' wards such as surgical patients. There will be 'buddy' arrangements between consultant physician teams and designated surgical wards to ensure reliable access to a consultant physician opinion seven days a week.
- 10 Focus on alternatives to acute admission and supporting patients to leave hospital:** Care will be organised so that ambulatory ('day case') emergency care is the default position for emergency patients, unless their clinical needs require admission. Systems will ensure ambulatory care patients continue to receive prompt specialist care aligned to their needs, maximising alternatives to acute hospital admission, and improving safety, outcomes and experience of patients. Early senior assessment will support a focus on advanced care planning, with planning for recovery / movement out of hospital starting from the point of first assessment.
- 11 Care delivered by specialist medical teams in community settings:** Much specialised care will be delivered in or close to the patient's home. Physicians and specialist medical teams will expect to spend part of their time working in the community, providing care integrated with primary, community and social care services with a particular focus on optimising the care of patients with long-term conditions and preventing crises.
- 12 Holistic care for vulnerable patients:** There will be high-quality, seamless care for patients with dementia. Effective care for this group of patients will help set a standard of care of universal relevance to vulnerable adults. The design and delivery of services will also consider the specific needs of the most vulnerable patients and those known to have poorer levels of access and outcomes, eg patients with mental health conditions and patients who are homeless. The provision of holistic care that meets patients' needs should be the responsibility of all staff. This will be in a hospital-level citizenship charter, based on the NHS Constitution (chapter 2, para 2.29, page 19).

3 A new organisational approach: the Medical Division

What is the Medical Division?

- 3.1 In the future hospital, a single unified Medical Division will be at the centre of the delivery of hospital-initiated and hospital-based care.* The Division will assume clinical, managerial and budgetary responsibility for all inpatient beds and clinical areas supporting the care of medical patients (with the exception of those aligned to paediatrics, obstetrics and possibly some specialised surgical wards). For large hospitals it is envisaged that the Division will be an overarching structure inclusive of several specialty medical directorate services. For smaller hospitals it may largely align with an existing single medical directorate where this already includes specialty medicine services (cardiology, respiratory medicine etc).
- 3.2 The Division will have access to, but may not necessarily administer, relevant diagnostic and laboratory services, the emergency department (ED), intensive care, mental health and palliative care services.
- 3.3 The Division will be physically housed on an acute hospital site, but its *clinical* responsibility will extend to community-based, intermediate care services including virtual wards, admission avoidance schemes and post-acute community- or home-based rehabilitation services. Direct clinical input from primary care will be required to provide the relevant skillmix to facilitate collaborative working (see summary of Medical Division, appendix 3).
- 3.4 The Division will oversee and administer current service level reporting models, incorporating the activity of contributing specialty services, to align resources to support patients' care throughout all clinical pathways (see chapter 8: Management).

*The precise structure of the Medical Division will vary according to factors such as the size of the hospital and the extent of services provided. The focus will be on integration of medical services to meet the needs of patients. This focus will not be confined to those cared for on the hospital site but will extend to patients in the population who would benefit from secondary care medical services irrespective of location (home setting and community healthcare facilities).

It is likely that smaller hospitals may by necessity be further advanced in terms of integration of their medical services, particularly those delivered on the hospital site – driven by the need for close cross-specialty working by consultant staff in order to meet the requirements of 7-day working and 24/7 on-call cover. For some acute services smaller hospitals may adopt the Medical Division model as a way to collaborate in the delivery of some acute services, eg out-of-hours endoscopy and percutaneous intervention for coronary ischaemia.

Resources the Medical Division will need to function effectively

- 3.5 The Medical Division will be required to take an overview of the individual needs of all patients both in hospital and within relevant parts of the local health system. Information technology will need to be developed that permits the effective exchange of information, both clinical and administrative, to facilitate this (see chapter 9: Information).
- 3.6 Thus, the activity of the Division will be underpinned by clinical data systems. These will supply the tools that directly facilitate clinical care and audit and performance data (eg patient reported outcome measures, PROMS) together with data on quality of care and outcomes (see chapter 9). Data collection and analysis will be tailored to support activity within the Acute Care Hub and Clinical Coordination Centre (CCC, paras 3.20–3.26), allowing identification in

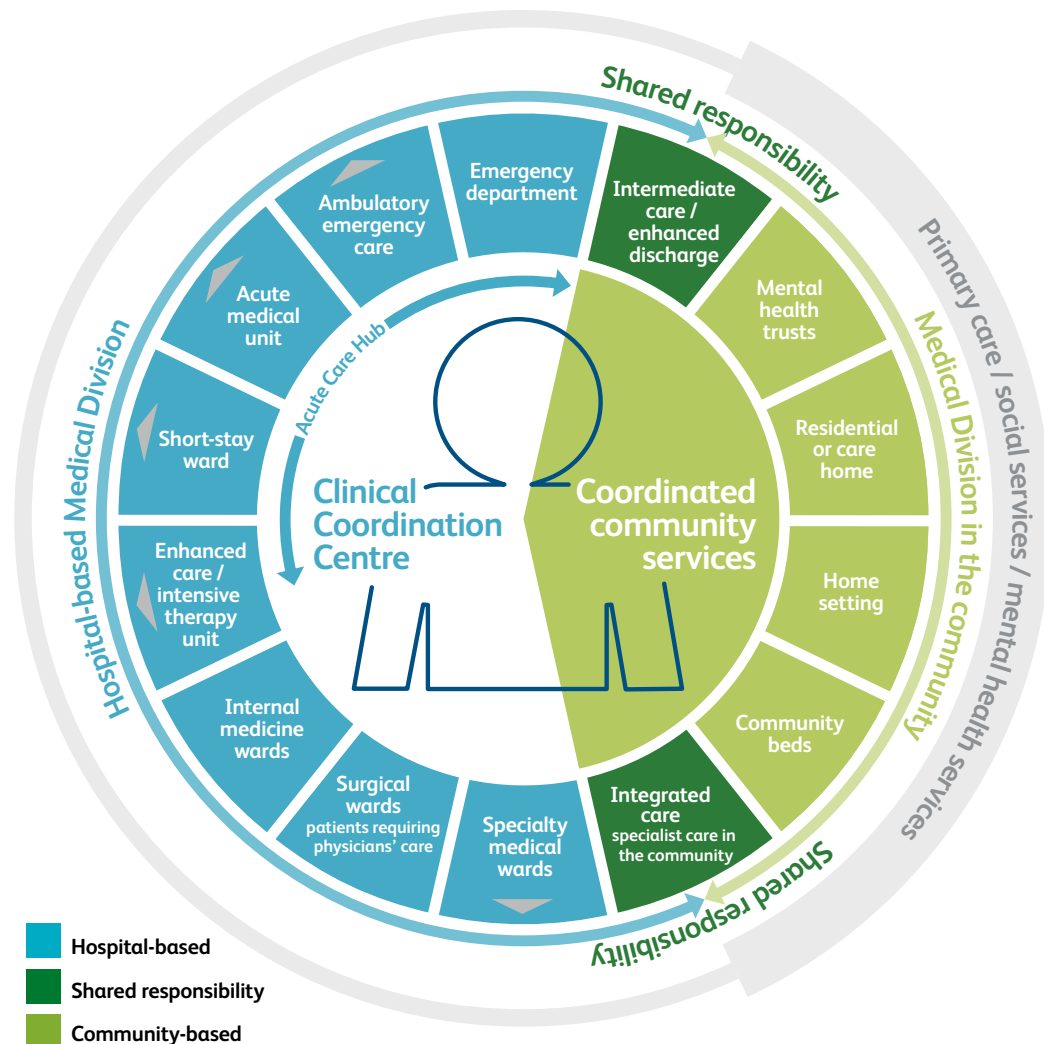


Fig 1. The Medical Division remit: circle of patient-centred care. Directional arrows (in the hospital-based Medical Division) denote areas of the future hospital where patients may be referred on to tertiary specialist care.

real time of bed or clinical service capacity within both the hospital and the local health system. Access to services in the community (eg for intermediate care, interim care home placement and ambulatory care) should be as readily available to patients as access to inpatients, both at the time of initial assessment and when admitted patients no longer require inpatient care.

Physical areas of responsibility of the Medical Division

- 3.7 The components of the Medical Division are shown in Fig 1. The physical areas of the hospital containing activity over which the Medical Division will have administrative responsibility are listed in Table 1, together with estimated staffing requirements.

Table 1. The Medical Division: areas of responsibility.

Location	Coordination link to Clinical Coordination Centre (overseen by acute care coordinator)	Unit	Role
Hospital site	Physician of the week	Acute Care Hub	Ambulatory emergency care (AEC) Acute medical unit Short-stay wards (predicted length of stay <48/72 hours) *Level 1 beds Intensive care service: Level 2 (high-dependency unit) and level 3 (intensive therapy unit) beds Emergency department
	Internal medicine consultant	Internal medicine (GIM) wards	Significant proportion of medical beds. Staffed by generalists with specialist input as required.
	Geriatric medicine consultant	Elderly care wards	Significant proportion of medical beds. Staffed by geriatricians and generalist juniors with specialist input as required.
	Specialty consultant	Specialty medical wards	Small proportion of beds. Staffed by specialist consultants with geriatric input as required.
	Linked internal medicine consultant	Surgical wards	Medical input provided by linked generalist consultant (and team) and anaesthetists.

(continued overleaf)

Table 1. continued

Location	Coordination link to Clinical Coordination Centre (overseen by acute care coordinator)	Unit	Role
	Specialty consultant	Medical outpatient services	Includes rapid access clinics aligned with ambulatory emergency care centre.
Medical Division: community services	Specialist nurse/consultant	Specialty services in the community	Aimed at supporting self-management, supporting community and primary care for patients with long-term conditions. Providing coordination across the care pathway.
	Community matron/service lead	Community services	Community-based, intermediate care services including virtual wards; admission avoidance schemes; post-acute 'enhanced discharge'; and rehabilitation/recuperation services.

For definitions of 0, 1, 2 and 3 levels, see Royal College of Physicians, Acute care toolkit 6: *The medical patient at risk: recognition and care of the seriously ill or deteriorating medical patient*. London: RCP, 2013.

The Acute Care Hub

- 3.8 The Acute Care Hub (ACH) will encompass the clinical areas assigned for the initial assessment and stabilisation of acutely ill medical patients and accommodate them for up to 48 hours after presentation, unless they require immediate access to a designated specialty bed and pathway of care. It is envisaged that the majority of patients in the Acute Care Hub will transfer to community care within this time frame (see summary of Acute Care Hub, appendix 3).
- 3.9 The Acute Care Hub will include the acute medical unit (AMU), short-stay ward, designated enhanced-care beds (level 1) and ambulatory emergency care (AEC, sections 5.5–5.8). The Acute Care Hub will be sized, staffed and resourced in accordance with the population served in terms of demand, casemix and emergency provision of relevant services. Administration of the Acute Care Hub through the Medical Division may include the ED and, where applicable, a primary care/triaging facility (see paras 5.9–5.12).
- 3.10 The Acute Care Hub will be aligned with and managed by the Clinical Coordination Centre (CCC, sections 3.20–3.26), but is likely to have direct, two-way communication and interchange with community-based services that can facilitate patient transfer to the correct facility, which

may be located at a different hospital or community-based site. Real-time information on capacity within the health economy and close working and communication with staff based outside hospital will facilitate patient transfer to the service or facility required. This may be located in another hospital, a community site or represent enhanced services provided in the patient's home.

- 3.11 Newly admitted, acutely ill patients may require an enhanced intensity of nursing and medical care not available in a standard acute medical bed (level 0). It is anticipated that the majority of the hospital's level 1 beds will be located within the Acute Care Hub. Optimal care of these patients will require a close working relationship with intensive care services for access to relevant clinical expertise and escalation and de-escalation of care according to patient need.
- 3.12 The Acute Care Hub will have rapid, 7-day access to relevant diagnostic (laboratory and imaging) services, which will be requested and booked electronically. These should include endoscopic and echocardiographic services, with immediate reporting and IT systems designed to share reports and results widely to support prompt clinical decision-making, including admission and moves from hospital, and inform staff with continuing care responsibilities.
- 3.13 The AEC centre (sections 5.5–5.8) should have waiting areas with seating, consulting rooms and facilities, and be run according to standard criteria for admission and transfer of care to other settings, to preclude their appropriation by an overstretched AMU resource.
- 3.14 Specific rooms should be available in the Acute Care Hub for practical procedures, and discussions with patient and/or carers.
- 3.15 The acute care coordinator will be key to the smooth operation of the Acute Care Hub and patient pathways both into and out of hospital. The acute care coordinator will have a clinical background and sufficient seniority and expertise to make decisions about the transfer and placement of patients. They will be supported in this role by senior clinical staff and robust, timely information supplied from the Clinical Coordination Centre.* To be effective, the coordinator will be on site based in the Clinical Coordination Centre within or adjacent to the Acute Care Hub for at least 12 hours a day, 7 days a week. It is likely that a few designated individuals with the necessary background and expertise will fill this rota. Overnight senior nursing staff with suitable training and support could continue to provide key elements of this role (see summary of acute care coordinator's role, appendix 3).

➤ **See online case study on stable on-take teams, Poole Hospital Foundation Trust**
(www.rcplondon.ac.uk/fh-case-studies)

Dr Mike Masding, consultant physician and head of Wessex Foundation School, explains how two stable admissions teams, one general medicine and one for the care of older people, produce a better service for patients, a shorter length of stay, and higher trainee satisfaction.

*The provision of operational information by the CCC will be led by an acute care coordinator. Patients presenting to acute services in hospital may require transfer to a variety of settings including community placement, specialty beds in hospital or another hospital site. The acute care coordinator will also provide expert advice to ward staff on step-down options in the community for inpatients as soon as they no longer require an acute medical bed.

Medical (specialty and non-specialty) and surgical wards

- 3.16 An area of responsibility for the Medical Division in the future hospital will be to develop, implement and oversee consultant-supervised and delivered care for all inpatients located on medical wards, both specialist and non-specialist. Within current structures much of this activity may be captured by medical specialty directorates. However, a particular focus for the Medical Division will be patient care requirements or activity that may be missed, or that falls between the remit of medical specialties. The Medical Division should promote a specific, continuing high-level focus on acute medical and (general) internal medicine activity, ensuring that this is valued at least as highly as other medical specialty services, is fully integrated with services throughout the health economy, and has the staffing and other resources to match patient demand (see paras 3.39–3.47 and chapter 4: Staffing).
- 3.17 Physicians with continuing care responsibilities on the Acute Care Hub should be freed of competing clinical duties for this period, which may be between 3 and 7 days, in order to maximise the continuity of care for patients in the Acute Care Hub. They will form part of a clinical team rostered as far as possible to work together over this period. Co-location of the AEC centre and a short-stay ward with the AMU will allow the admitting team to provide continuing care on successive days for those patients who continue to receive care in the Acute Care Hub. The consultant-led team(s) on the Acute Care Hub will attend the Clinical Coordination Centre or adjacent room twice daily for handover and coordination of care with specialty colleagues, the acute care coordinator and other clinical staff. Physicians with continuing care responsibilities on general medical or specialty medical wards may fulfil these duties for more extended periods. However, care should be organised to maximise continuity and provide 7-day cover, and these physicians should attend the Acute Care Hub's twice daily meetings as required, for example, as part of their medical specialty service.
- 3.18 The ageing demographic profile of patients on surgical wards means that their age and comorbidity profiles are similar to those of medical inpatients. The majority of clinical problems arising in these patients postoperatively are medical rather than surgical. Each consultant physician-led team should be linked with a designated surgical ward or wards. The first priority of this 'buddying' arrangement is to ensure that any medical patient 'outlying' on a surgical ward is identified as being under the care of the 'buddy' medical team. However, the buddy medical team will also be well placed to provide medical consultations on any surgical patient in whom medical problems arise, facilitating where necessary timely consultant physician review and/or takeover of ongoing care responsibilities. It is anticipated that, in time, physicians will work in a much more integrated way on surgical wards. Patients may be admitted under joint consultant physician and consultant surgeon care, with junior doctors increasingly delivering care under the supervision of physicians. Consultant surgeons may provide a more consultative service, focused on technical aspects of the surgery and postoperative complications. This arrangement will have major implications for surgical trainees – with all but the more senior trainees redeployed to physician-supervised duties and realigned to medical training programmes (see chapter 7: Education and training).
- 3.19 Geriatricians have pioneered co-management of surgical patients on orthopaedic wards through the development of orthogeriatric medicine, and this approach could be extended to other surgical wards (eg urology, vascular) where older patients particularly predominate.

The Clinical Coordination Centre

- 3.20 The Clinical Coordination Centre (CCC) will be the physical area from which all hospital and associated community care is coordinated for all patients with active clinical needs that fall within the remit of the organisation.
- 3.21 The Clinical Coordination Centre should be part of a suite of rooms in the Acute Care Hub – including a room of sufficient size to accommodate the medical and other clinical staff attending transfer of care meetings twice a day, 7 days a week.
- 3.22 The Clinical Coordination Centre will have monitors available to access electronic patient records, standard clinical referral, diagnostic and management protocols for all commonly encountered patient groups, on integrated care pathways. Access to this information should also be available in clinical areas throughout the hospital (see chapter 9: Information).
- 3.23 The Clinical Coordination Centre will have display facilities, upon which the electronic health record of all patients may be accessed and displayed during multidisciplinary team meetings. Other data systems will include those showing the location of all patients in the hospital, details of their admission and transfers of care in real time. Electronic access to the AEC centre (chapter 5) and rapid access clinic booking systems, and those of relevant diagnostics, specialty and generalist (acute medicine, (general) internal medicine) clinics should be accessible within the Clinical Coordination Centre.
- 3.24 For inpatients, measurement devices linked to a central clinical control system will be in place, enabling the remote monitoring of the patient location and their status (eg National Early Warning System, NEWS¹), on a 24/7 basis, with immediate response by staff to predefined clinical triggers. The information collected will also support more efficient and complete monitoring of adherence to bundles of care, serious untoward incidents and near misses, enabling trends to be identified early. Quality and safety will be monitored in real time and combined with information from serious untoward incidents, near misses and patient feedback. Although not the primary purpose, an additional benefit of such a system of monitoring would be to alert staff to the presence of a patient who may qualify for inclusion in a clinical trial.
- 3.25 Data for community services (intermediate care, rehabilitation etc) and social/domiciliary care will be displayed, as will interim or care home bed capacity (chapter 5). Within the Clinical Coordination Centre, telemonitoring, telephone and email helplines for patients and professionals will be staffed 7 days a week and linked where appropriate with primary care, providing support and advice for both patients and professionals. Responsibility for care will thus be shared between patients and practitioners in hospital and primary care, and continuously supported by a virtual dialogue.
- 3.26 In summary, the Clinical Coordination Centre will represent the operational command facility of the health economy and an important resource for hospital- or community-based staff.

How the Medical Division is managed and led

- 3.27 The Medical Division will assume responsibility for the provision of safe, high-quality, effective, compassionate and responsive care for all patients. It will be led by a chief of medicine, a senior

experienced physician who will report professionally to the medical director* and operationally to the chief operating officer or chief executive (see details of chief of medicine's role in appendices 3 and 5).⁺

- 3.28 The chief of medicine will lead all medical specialty directorates/services and coordinate their activity in delivering all medical care (see Table 1, section 3.7) within its remit; develop a culture and working practice that facilitates collaborative cross-specialty working; implement agreed clinical criteria that identify inpatients who require specialty review at admission, and ongoing specialist care throughout admission or referral for a relevant outpatient appointment after a patient has left hospital.
- 3.29 The chief of medicine, with relevant managerial support, will assume budgetary and administrative responsibility for integrated specialist medical care in both the hospital and the community. This pooling of resources aligned to the needs of acutely ill patients may extend to providing integrated services in the community and will complement existing financial reporting (chapter 8) and administrative arrangements within specialist services.
- 3.30 The chief of medicine will direct the activities of all consultant staff in the delivery of care. With the assistance of the director of medical education (DoME), they will allocate all junior and non-consultant medical staff to specific clinical services for periods designed to facilitate training, education and service delivery. To support this, the College tutor in medicine will report dually to the chief of medicine and the director of medical education. The role of the College tutor will extend to cover all trainees in physician specialties who are doing core or (general) internal medicine; in future, this will be almost all physician trainees.
- 3.31 Working with a shared culture and objectives across all medical specialty teams, the chief of medicine will motivate staff to provide care of the highest quality to patients, irrespective of their work base – hospital, community – or area of clinical practice, in line with the NHS Constitution and professional standards.^{2,3}
- 3.32 The chief of medicine will oversee safety and quality improvement and the monitoring of these within the work environment, seeking prescribed information from information systems (chapter 9) about adverse incident reporting, mortality and morbidity reviews and audit, according to national and locally agreed standards. This will include multidisciplinary review of performance data at consultant and team level.
- 3.33 Coordinated decision-making and information collection and sharing will be facilitated by a management structure and leadership cadre supported by appropriate IT infrastructure (chapter 9). A chief clinical information officer will work with both the chief of medicine and acute

*It is anticipated that the relationship between medical director and chief of medicine would be akin to the relationship developed between chief executive and chief operating officer in trust management. The chief of medicine will assume an operational leadership role with responsibility for maintaining quality standards across the division, developing patient pathways and coordinating individual teams in order to optimise the quality of care delivered. By contrast, medical directors in many trusts have a strategic focus with particular responsibility for managing performance standards and governance and play a pivotal role in the continuous professional development and revalidation of medical staff. The chief of medicine will report professionally to the medical director.

⁺Chiefs of medicine are likely to be senior and highly experienced medical practitioners, but may have limited experience of operational practices, team leadership, and financial responsibilities. Some of these skills and knowledge can be gained from training courses, but the chief executive can play a key role in providing mentoring to the chief of medicine and helping them to overcome any operational difficulties they may have.

care coordinator. The chief clinical information officer would be a senior clinical role providing links between IT projects, clinical requirements and patient care. He will work as the hospital's 'information champion', engaging and liaising with partner organisations to facilitate information sharing and ensuring strong clinical engagement in IT projects and systems. In a large hospital, this post is likely to be full-time, or close to full-time. The chief clinical information officer would advise on additional data collection, links with other IT systems within or outside the hospital, and assist in creating and refining the live dataset available to the acute care clinical team in order to support patient care.

- 3.34 The chief of medicine will ensure the development of, and adherence to, an agreed set of local clinical care operational performance standards operating throughout all medical specialties within the Division (eg 7-day working, planning for leaving hospital at first consultant review, collaboration with other teams, daily ward rounds in all care areas), underpinned by a professional culture linked to the NHS Constitution (see paras 4.11–4.14).²
- 3.35 The chief of medicine will work with trust members and governors, patient groups and commissioners to establish quality standards for care – fundamental, enhanced and developmental – in line with the recommendations of the Francis Inquiry.⁴ The chief of medicine will be responsible for monitoring performance against these quality standards and adherence to the NHS Constitution,² and the hospital's citizenship charter (para 2.29, page 19).
- 3.36 The chief of medicine will monitor, in conjunction with the director of medical education and clinical directors (where applicable), the service load and optimal deployment of all non-consultant medical staff, particularly specialty registrars (specialty trainees year 3 and above). The chief of medicine may be assisted by a designated trainee doctor; for example by creating a post of 'chief resident'. The chief of medicine would have a specific role in planning and recruitment of consultant staff, ensuring that junior medical staff are adequately supported throughout the Medical Division and (with the director of medical education) that their workload and training is monitored regularly.⁵
- 3.37 We recommend that a chief resident is designated in each acute hospital or trust to work closely with, and reporting to, the chief of medicine. The primary role of this individual will be to liaise between the junior medical staff working in the Medical Division and the chief of medicine and senior clinical managers responsible for delivery of the service.
- 3.38 The chief resident will be a key participant in planning service redesign and delivery in relation to junior medical staff deployment, rotas, workload and duties. This includes reaching agreement on arrangements to delegate specific duties to non-medical staff. The chief resident could also usefully contribute to the junior doctor educational programme, in conjunction with the College tutor, and initiatives relating to patient safety and quality improvement. This is an important role and the chief resident will have allocated time in their job plan for administration, and be supported by the team working with the chief of medicine. The individual appointed to the post should expect to enter a programme of leadership and management training tailored to their requirements and career aspirations.

Who will work in the Medical Division?

- 3.39 A substantial part of the consultant and trainee medical workforce and allied healthcare professionals will be allocated to staff the Acute Care Hub, the general medical and surgical

wards and the intensive care and enhanced care areas within the Medical Division on any given day (see Table 1, section 3.7; and chapter 4: Staffing).

- 3.40 Consultant staff will rotate through various areas of the Medical Division over a 12-month period, with greater or lesser participation in the acute medical take and ward management (general and specialist) according to their competencies. How this is applied in practice will need to be considered from trust to trust and will vary depending on local patient mix, throughput, capacity and skillmix of staff. However, this could translate as all consultants, and specialists, spending 25% or more of their annualised job plan in undertaking clinical duties with ongoing responsibility for patient care and general medical patients.
- 3.41 Junior medical staff will spend blocks of not less than 4 months working within the Medical Division and moving from Acute Care Hub (ACH, paras 3.8–3.10) to general or specialist wards according to their training needs. Processes should be put in place to ensure that this happens effectively (eg this could be coordinated and assessed by the chief resident, reporting to the director of medical education and chief of medicine).
- 3.42 Working in this way will increase structured senior cover to a 7-day week, provide an understanding of clinical pathways in and out of hospital to trained and trainee medical staff, and improve the experience of patients. Problems, challenges and solutions in different parts of the clinical pathway and reinforcement of the importance of shared objectives and culture, effective team working and seamless handover would be essential roles for all consultant staff working within the Medical Division.
- 3.43 Doctors will be called upon to institute and supervise treatment along a care pathway but may not necessarily deliver that care personally, when this can be done equally well or better by other health professionals. Physicians will be asked to support the delivery of specialist care in a devolved manner and to take responsibility for reviewing and improving clinical outcomes. This might include protocols to assist in standardised treatment, supervising a team of specialist nurses and allied health professionals who perform consultations and arrange relevant investigations, facilitating community management through multidisciplinary team meetings.
- 3.44 In particular, seamless handover and transition between responsible individuals within clinical teams will be closely supervised and audited. This will occur centrally at prescribed times and involve consultants, medical trainees and other clinical staff (nurses, therapists, physicians assistants/care practitioners) in or adjacent to the Clinical Coordination Centre (paras 3.20–3.26) and will be aligned in structure and process with the needs of patients.
- 3.45 Mechanisms for *all staff* to understand all parts of the Division will be facilitated by regular rotation through individual parts of the service (eg Acute Care Hub, AEC, general and specialist wards, and community services) for which individual staff have competencies; and via regular meetings with all team members (eg Schwartz Rounds,⁶ chapter 11). A feature of the Medical Division will be the drive towards coordinating the work of staff within a supportive working environment with strong leadership.
- 3.46 Every member of the Medical Division will be clear about their responsibility in supervising the delivery of care to patients within the hospital and in the community. Throughout, the emphasis will be on continuity of care delivered by the same staff in the same clinical setting. Thus, where

handover of clinical care is mandatory the process for this will be prioritised, and standardised and supported by up-to-date information in the electronic health record. Communication systems will be utilised extensively to enhance transfer of care. Documented agreed clinical pathways for each team will be developed, specific to the patients they care for and the location in which they are working. This will include a consultant review of all patients 7 days a week, unless it is determined that this will not affect their pathway of care.⁷

- 3.47 The tempo and prioritisation of planning for moves from hospital and its implementation by staff throughout the Medical Division should match assessment and admission activity by AMU staff. Each ward team will recognise their place in providing the continuum of care for patients and the need for patients to move out of hospital (with support where necessary) as soon as they no longer require an acute medical bed.⁸ To support this aim, planning for when a patient leaves hospital will commence at the time of the first consultant review and a provisional transfer of care plan will be communicated to the patient and carers within 24 hours of admission. Pathways to enable patients to move out of hospital must operate 7 days a week.

➤ **See online case study on rigorous Medical Division recruitment, Northumbria NHS Foundation Trust (www.rcplondon.ac.uk/fh-case-studies)**

Dr David Evans, medical director, explains how his trust invests 2 days in recruiting medical consultants to their multi-site team. The prospective candidates undergo rigorous personality tests, simulated consultations and meet all members of the multidisciplinary team with whom they will be working. The detailed analysis of a successful candidate forms part of their immediate appraisal and mentoring plans.

References

- 1 Royal College of Physicians. *National Early Warning Score (NEWS): standardising the assessment of acute-illness severity in the NHS*. Report of a working party. London: RCP, 2013.
- 2 NHS Choices. *The NHS constitution: the NHS belongs to us all*. London: NHS Choices, 2013. www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx [accessed 5 August 2013].
- 3 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. London: RCP, 2013.
- 4 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chaired by Robert Francis QC. London: Stationery Office, 2013.
- 5 Royal College of Physicians. *The medical registrar: empowering the unsung heroes of patient care*. London: RCP, 2013.
- 6 The Schwartz Center for Compassionate Healthcare. www.theschwartzcenter.org [accessed 15 July 2013].
- 7 Academy of Medical Royal Colleges. *Seven day consultant present care*. London: AoMRC, 2012.
- 8 Royal College of Physicians. *Acute care toolkit 2 – High-quality acute care*. London: RCP, 2011.

Summary of recommendations for a new organisational approach

- 1 Bring together medical services and staff into a single Medical Division** (MD, paras 3.1–3.7).
All medical specialty directorates and all directorates involved in the delivery of medical care should come together and develop a culture and working practices that facilitate collaborative, patient-centred working. This will include specialist teams working together to meet the needs of patients, including patients with complex conditions and multiple comorbidities. In the new Medical Division, all teams will:
 - allocate substantial resources to staffing the Acute Care Hub, general medical and surgical wards, intensive care and enhanced care areas (ACH, paras 3.39–3.47).
 - include a named consultant lead, 7 days per week, for any given ward area (with this name displayed prominently in the ward area). The consultant will be in charge of coordinating care for all patients in that space, and be supported by a team of junior medical staff and allied health professionals, and with extremely close links with the ward manager and other nursing leaders (chapter 11: Culture).
 - ensure that key/lead members of the Medical Division team attend the Clinical Coordination Centre daily to coordinate the care of their patients with relevant others, manage admissions, transfers out of hospital, and attend multidisciplinary team meetings (para. 3.21).
- 2 Bring together clinical areas focusing on initial assessment and stabilisation of acutely ill medical patients in a single Acute Care Hub** (ACH, paras 3.8–3.15).
The Acute Care Hub will focus on accommodating patients for up to 48 hours, and be sized, staffed and resourced in accordance with the population served in terms of demand, case mix and emergency provision of relevant services. It will need rapid and 7-day access to relevant diagnostic (laboratory and imaging) services, and rapid access to endoscopy, echocardiography and physiological testing. It is anticipated that the Acute Care Hub will be the location for the majority of the hospital's level 1 (enhanced care) beds and contain a dedicated ambulatory care centre. This Hub will be aligned with and managed via the Clinical Coordination Centre.
- 3 Establish a Clinical Coordination Centre as the operational command centre for both the hospital site and the Medical Division operating across the health economy, with strong links to all acute, specialist and primary care and community teams** (CCC, paras 3.20–3.38).
The Clinical Coordination Centre will be the focal point for data, feedback, team liaison and performance monitoring for physicians, clinical directors, the chief of medicine and the relevant clinical and administrative support team(s). It will collect detailed information 24 hours a day relating to patient demand and provision of services and related service capacity, in order to support continuing service improvement.
- 4 Establish new, senior, operational roles focused on prioritising the coordination of medical care:**
 - i **chief of medicine** – a senior clinician tasked with setting the standard and direction of the hospital-based and relevant community medical services. The chief of medicine (supported by a team) would be responsible for ensuring that all medical specialty directorates and all directorates involved in the delivery of medical care (emergency medicine, intensive care, oncology) develop a culture and working practices that facilitate collaborative cross-specialty working, including the implementation of agreed clinical guidelines (paras 3.27–3.36)
 - ii **acute care coordinator** – an operational role overseeing the Clinical Coordination Centre, and supporting the chief of medicine (para 3.15)
 - iii **chief resident** – a doctor in training, reporting to chief of medicine, and responsible for liaising between doctors in training in the Medical Division and the chief of medicine and senior clinical managers (paras 3.36–3.38).

4 Staffing the Medical Division

An increased role for the generalist and specialist

An increasing need for general medical skills

- 4.1 The clinical challenges of delivering consistent high-quality care to unselected medical patients should be recognised and rewarded. This includes the effective management of patients presenting to hospital as emergencies and for patients with multiple comorbidities on hospital wards who need to receive coordinated care throughout their hospital stay and beyond. At present those acting as 'generalists' are the undervalued champions of the acute hospital service. This cohort of expert generalists includes those practising in acute medicine, general medicine, geriatric medicine and intensive care, and the nursing and other clinical staff who manage these patients.
- 4.2 As alternatives to hospital admission and management protocols develop, unselected medical inpatients who remain in hospital for more than 48–72 hours have increasing complexity and acuity of illness. These patients are frequently more dependent, have multiple comorbidities including dementia, and require longer stays in hospital. Despite this, the general medical wards where these patients are managed have seen little or no enhancement of staffing or investment to improve efficiency or effectiveness of assessment, management, rehabilitation and transfer of care of these patients.
- 4.3 In many hospitals the boundaries of responsibility for patients who are cared for by medical specialists as opposed to those managed by generalists (acute medicine and general medicine) are blurred. Criteria for the involvement of specialty inpatient care are poorly defined. Even patients who do have an acute illness closely aligned to a single specialty may have little or no specialist-led or -delivered care during their admission. Examples include those admitted with diabetic ketoacidosis, severe cardiac failure or poorly controlled epilepsy. Criteria for determining which inpatients should be managed by specialists are often non-existent, with care defaulting to the admitting generalist (acute or general physician). Where clear criteria do exist, the patient remains at risk of being overlooked by the specialty if they are placed in a bed other than that designated to that specialty. In some hospitals medical specialties control the number of inpatients for whom they have ongoing responsibilities by restricting this to patients contained within a defined bed base.
- 4.4 Patients who do not fit clinical criteria for a specific specialist medical admission pathway should benefit from receiving continuing, coordinated care delivered by a trained generalist (acute or

(general) internal medicine or geriatric medicine physician) with in many cases specialists adopting a clearly defined consulting and intervention role. In these circumstances, specialty teams would reduce the number of inpatients for whom they have ongoing care (specifically relinquishing their complex older patients) and release bed capacity and trainees to generalist teams. Such redeployment of trainees, coupled with a renewed emphasis on the acquisition of the skills required to meet the needs of older patients if applied in (general) internal medicine in particular, would help rebalance the workload, enhance training, and re-enthuse trainees and consultants. The resulting enhanced trainee staffing would reduce the risk of fracturing team- and ward-based continuing care and learning due to intermittent on-call duties. In short, there is a good case for giving inpatients whose acute illness extends beyond the confines of a single system specialty a much greater opportunity for care by a stable generalist ward-based team. This team would be structured to ensure continuity of care and frequent senior review by a clinician assuming responsibility for the whole of the patient's care (see paras 3.39–3.47).

- 4.5 The code of conduct that would ensure high-quality care on these wards, and throughout the Medical Division (MD, paras 3.1–3.7, would include:
- > daily consultant input
 - > daily whole team meetings, which would include planning to enable patients to move out of hospital
 - > close collaboration with specialist clinical teams
 - > daily reporting to the Medical Division meetings at the Clinical Coordination Centre (paras 3.20–3.38)
 - > constant availability of senior clinicians to meet relatives/carers
 - > routine ward level meetings for all staff (including domestic, administrative and clinical) to review ward level data and opportunities for quality improvement and the Citizenship Charter (para 2.29)
 - > senior clinicians to provide the leadership of case conferences for complicated or complex patients (with dial-in for GPs and relevant community staff), and responsibility for dealing with urgent and emergency issues including staffing, patient flow and medical emergencies.
- 4.6 (General) internal medicine physicians are already heavily committed to the delivery of continuing care during hospitalisation and additional on-site care 7 days a week. Re-invigorating (general) internal medicine from its current lowly status would require radical re-skilling and restructuring of (general) internal medicine teams (see chapter 7: Education and training; and appendix 4, page 153).¹

➤ **See online case study on the London acute kidney injury network (www.rcplondon.ac.uk/fh-case-studies)**

Dr Chris Laing, consultant nephrologist, explains how the pan-London acute kidney injury network has been set up to meet the needs of the 10 million people in London and surrounding areas. The multidisciplinary, multispecialty network has used shared protocols, standardised procedures, and enhanced access to tertiary support to reduce variation in the management of patients with acute kidney injury, raising the standard of care for patients admitted acutely to any hospital and ensuring that those in need have rapid access to the limited tertiary centres.

The role of the specialist defined and extended

- 4.7 There is extensive evidence of improved patient outcomes with the use of early specialist care and treatment pathways for specific acute medical conditions, including stroke and acute coronary syndrome. This has led many national guidelines to support admission of patients with certain defined conditions to specialist units via fast-track pathways to specialist units.^{2,3} The improved outcomes may, however, be less marked in older patients or those with significant comorbidities.^{4,5} In the future hospital, every effort will be made to enhance specialist pathways that benefit patients, including entering the pathway direct from the community or the emergency department (ED) (see appendix 4, pp152–153). Patients identified on the acute medical unit (AMU) as meeting criteria for a specialist pathway may see an acute physician before a specialty consultant; however, the responsibility for continuing care resides with the latter, who should review the patient on the day of admission (see Table 2, para 5.8).
- 4.8 For many patients with chronic conditions, acute exacerbations are common. Ongoing monitoring and care provided by primary care and specialist medical teams seek to reduce the frequency and acuity of these acute exacerbations. For these patients, the Medical Division of the future hospital will need to facilitate community access to the specialist teams to support patient-centred management (see paras 5.21–5.27). Therefore the specialties will support, 7 days a week, community services for home-based or self-management of chronic conditions, rapid access ‘hot’ clinics or ‘frailty’ units for immediate investigation and review, including exclusion of conditions, fast-track pathways for proven intervention and aftercare services, and in-reach services to all medical wards including the Acute Care Hub (ACH, paras 3.8–3.15) or agreed pathways.
- 4.9 Responsibility for the delivery of specialist care will fall to the chief of medicine within the Division, and be managed day to day by clinical directors (where applicable), consultants and senior nursing staff. Divisional clinical directors for specialist services will report operationally to the chief of medicine (paras 3.27–3.36).
- 4.10 As now, areas of clinical practice in which proven benefits attributable to specialist care (eg acute myocardial infarction, stroke) will continue to receive patients via identified and easily accessed specialist pathways, starting in the community. Such patients will be cared for in specialty units, staffed and operated in precisely the same way as others within the Medical Division.
- 4.11 Rapid access to specialist services for inpatients is equally essential. Clear criteria must be agreed as to which patients require referral to specialty services and at what level (eg nurse specialist, specialty registrar, consultant), or require that service to take over ongoing care and manage according to agreed pathways, or remain under generalist care and be managed by agreed hospital-wide guidelines.

Whittington Health NHS Trust

Hospital size: 400 beds; acute take 32/24 hours.

Challenge faced: 9.9 % of patients with cancer in 2008 were diagnosed through the ED. Length of stay for patients with cancer was 19 days. The National Confidential Enquiry into Patient Outcome and Death report on chemotherapy stated poor outcomes.

Solution: Electronic oncology referral system with 24-hour inpatient response. Rapid access outpatient department slots, available to GP/ED. Electronic alert for all presentations/admissions of known oncology patients. Consultant-delivered 24-hour advice line to network of three hospitals.

Oversight for oncology emergency pathways.

Local context: Population 500,000; 580 new cancer patients a year.

Partners: Community Palliative Care Team, University College London Oncology Department.

Staffing: 2 whole-time equivalent (WTE) clinical nurse specialists, 10 programmed activities (PA) consultant oncologist, 6 PA consultant haemo-oncologist, associate 1 WTE specialist doctor.

Outcomes: Oncology patients' length of stay reduced by 64 %. British Oncology Association award winner 2010.

Further reading

King J, Ingham-Clark C, Parker C, Jennings R, Leonard P. Towards saving a million bed days: reducing length of stay through an acute oncology model of care for inpatients diagnosed as having cancer. *BMJ Qual Saf* 2011;20:718–24.

Case study: Acute oncology service

In their own words: The unique features we offer are rapid access to an oncologist and oncology advice in less than 24 hours, Monday to Friday. We have electronic access in our inbuilt computer request system, giving clinicians confidence that the case will usually be seen within the same day. We offer 'fast-track clinic access' to those who are not sick enough to need admission, enabling rapid discharge and patients seen within a week. Increasingly, local GPs request their own imaging, and when they get an ultrasound showing metastatic cancer they were unsure what to do next, so now they can book their patients in.

We have two alert systems. There is one in which all the patients who come to the emergency department (ED), whether they go home or get admitted, are notified to the whole oncology and community palliative care teams.

We have also developed a live alert system for patients who are on chemotherapy and are deemed high risk for febrile neutropenia. All those patients get put on a specific protocol, which goes to the London Ambulance Service and our ED system. Secondly, the minute they book into ED, we are all alerted. The whole point of that is to reduce that door-to-needle time.

We have a fantastic IT team here who were really responsive to clinical need, so I think our improved data collection is about both setting up a good system and clinical leadership.

The first thing I would say to others is scope your service. If things work well, don't change them but you could add to them. I think data collection is absolutely key. Before you rush into anything understand what the burden on your ED is every day. My wake-up call was when I believed I was

looking after patients on treatment. In our first pilot only 8% of our patients' problems were treatment related. The majority of our work was with newly diagnosed patients, so we changed what we were doing.

Acute oncology is about stopping that fragmentation of care. It has to be a multidisciplinary approach and clinicians are needed to change the minds of other clinicians.

FHC interviewed Dr Pauline Leonard, acute oncology consultant

Case study: Acute neurology service

In their own words: When I first started, I talked to physicians about what they wanted, which was, after they had done their morning AMU ward rounds, to identify the patients they struggled with neurologically and to know that later in the day someone like me would come and see them. So the number of referrals per day would vary according to the neurological confidence of that particular physician.

On Mondays, Wednesdays and Fridays I go to the new larger acute medical unit (AMU) across the way and see my patients there. They sometimes have just inpatients for this virtual acute clinic; at other times the physicians will have patients who were seen the day before, say, brought back to see me the following day. We also run acute clinics on Tuesdays and Thursdays. I have slots for casualty/AMU referrals from the previous couple of weeks. So we made sure that the inpatients or casualty referrals were prioritised but I also see GP referrals.

Our admission protocols are meant to move the right patients up to neurology from the emergency department (ED). So as well as direct admission for acute stroke patients, we have a list of Category A admissions, which includes suspected Guillain–Barré syndrome, papilloedema and spinal cord problems etc. If those are missed and I see one of those on the liaison rounds I'll just ring the ward and say we have a Category A admission and that means that we are forced to make a bed available even if we haven't got a bed at the time. It is sometimes quite a relief when I do that as these selected patients need close neurological observation.

I get the impression informally that the care has improved when I'm not there. When the service started the physicians missed spinal cord pathology a lot (once/month on average) and so I started raising awareness about just making sure they look for a sensory level. The quality of outpatient referrals to my clinics has also risen, often with appropriate tests already booked.

I think the important thing is first of all to listen to what the physicians want. What input is needed does vary and in general in-reach works very well, but it's making sure that you have got that balance right between also taking over the patients that shouldn't be sitting in acute medicine. If you start from the viewpoint that this replaced the specialist care, well it doesn't. But then there's an awful lot of patients that I think aren't even being discussed with a specialist and leave hospital having had tests done but are none the wiser as to their diagnosis. That is where a liaison service is particularly good and undoubtedly is better patient care.

FHC interviewed Dr Edward Dunn, consultant neurologist

Leeds Teaching Hospitals NHS Trust

Hospital size: 1,500 beds; 70 admissions every 24 hours.

Challenge faced: Patients attending the AMU had limited access to neurology opinion and often waited up to a week to see a specialty trainee on a general medicine ward.

Solution: Alternate-day acute neurology clinic accepted referrals from ED and AMU. A consultant neurologist was present on AMU on alternate days. Telephone advice from neurology registrar or consultant was available 7 days a week.

Local context: Trust split over two sites with neurology inpatient care provided in only one centre.

Partners: ED, AMU, neurology department.

Staffing: One consultant neurologist doing six programmed activities per week.

Outcome: Earlier diagnosis, reduction in length of stay for patients with neurological symptoms. Better targeted magnetic resonance imaging requests and other further investigations such as electroencephalography (EEG), electromyography (EMG) and lumbar puncture.

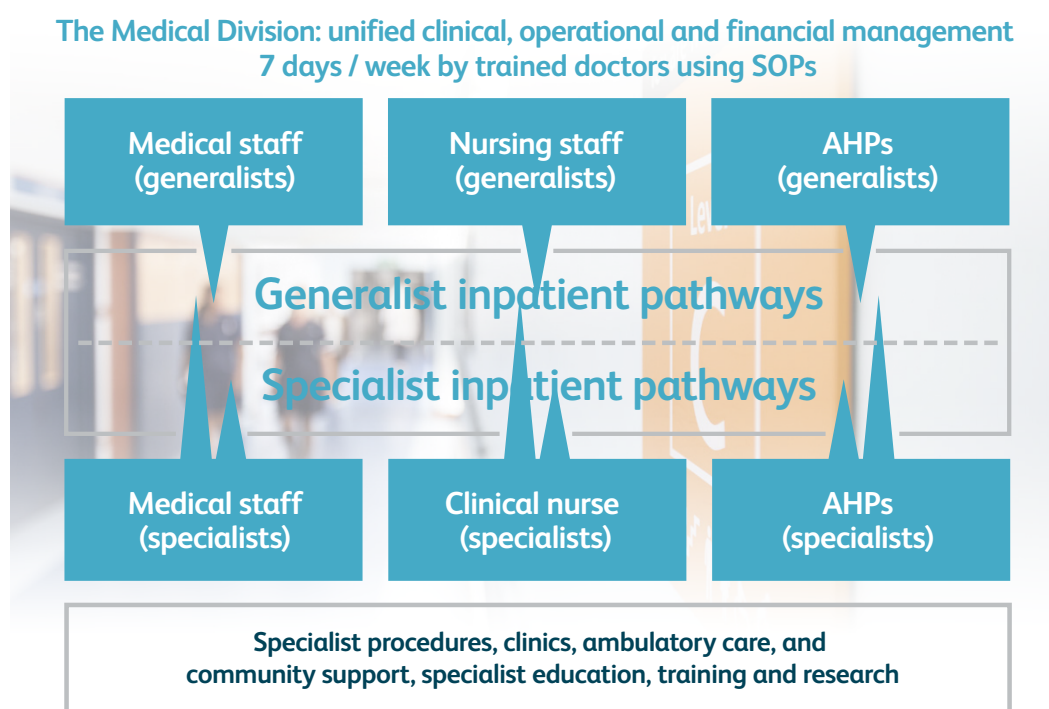


Fig 2. Generalist and specialist care in the future hospital. Generalist care includes acute medicine, internal medicine, enhanced care and intensive care. Specialist components of care will be delivered by a specialist team who may also contribute to generalist care. AHP = allied health professional; SOP = standardised operating procedure.

- 4.12 The criteria that define specialty involvement in patient care should be reviewed annually both in terms of the requirements for consultation, and to take over ongoing care responsibilities. The effectiveness of these arrangements should ultimately be the responsibility of the chief of medicine. Where there are designated specialty beds the process for accessing these should be reviewed annually according to ease of access for specified patients. In so doing hospitals with designated specialty beds should review their number according to patient need.
- 4.13 It will be incumbent on specialty services to participate in the work of the Medical Division, both hospital- and community-based (paras 3.16–3.19). Their representatives (nurse, registrar, consultant of the week) will attend twice daily handover meetings. It is likely that such a team will work together for a 5-day period providing outreach/consultation specialist services across the hospital and community (eg via helplines, outpatient clinics and ambulatory emergency care), working to agreed standards (eg electronic referral by 09:00, response and consultation by 13:00, 7 days a week) in order to facilitate patient management.
- 4.14 The interface between generalist and specialist services as envisaged is summarised in Fig 2.

➤ See online case study on an acute cardiology service, Mid Yorkshire Hospitals NHS Trust (www.rcplondon.ac.uk/fh-case-studies)

Dr Ian Wilson, consultant cardiologist, explains how the merger of two hospitals and two cardiology teams facilitated a revolution in cardiology care delivery in the Trust. The 10-strong consultant team now offer a 7 day a week consultant-delivered cardiology referral service to the whole hospital, including ED, AMU, ITU and medical and surgical wards. The ability to determine the care pathway early in patients presenting with acute cardiological complaints has improved the quality of care and dramatically reduced the length of stay for patients with cardiac disease. This has been assisted by an increased availability of an on-site interventional angioplasty service.

References

- 1 Kirthi V, Temple RM, Patterson LJ. Inpatient care: should the general physician now take charge? *Clin Med* 2012;12:316–19.
- 2 National Institute for Health and Care Excellence. *Stroke: diagnosis and initial management of stroke and transient ischaemic attack*. CG68. London: NICE, 2008.
- 3 Scottish Intercollegiate Guidelines Network. *Management of acute upper and lower gastrointestinal bleeding. A national guideline*. Edinburgh: SIGN, 2008.
- 4 Moore S, Gemmell I, Almond S *et al*. Impact of specialist care on clinical outcomes for medical emergencies. *Clin Med* 2006;6:286–93.
- 5 Wong P, Ramsewak A, Murray S *et al*. Effects of comorbidity and hospital care on 6-month mortality in patients with elevated cardiac troponin. *Postgrad Med J* 2007;83:332–7.

Summary of recommendations for staffing the Medical Division

1 Increase participation in and coordination of ward care provision and acute services by:

- i prioritising ward care provision in all medical job plans
 - ii using annualised job plans with blocks of time dedicated to the acute service with no conflicting clinical commitments in that time
 - iii measuring staffing demand and aiming to organise staffing that will accommodate at least two-thirds of maximum demand
 - iv planning coordinated job plans for teams
 - v providing mechanisms for all staff to understand all parts of the system; this may include rotation through individual services (eg Acute Care Hub, general wards and community services) or regular meetings with all team members (eg multidisciplinary team meetings)
- (See paras 4.5, 4.7 and 3.39–3.47.)

2 Organise care to focus on consistent early consultant review.

Patients are most vulnerable when they are admitted as medical emergencies to hospital. Consistent early consultant review improves these patients' outcomes. The focus of how care is organised in front door areas, the Acute Care Hub (ACH), should be on the quality, safety and continuity of the care delivered. Consultants and their medical teams should have dedicated duties in the ACH and be rostered together on successive days. Co-location of the acute medical unit, short-stay and ambulatory emergency care in the ACH will promote continuity of care and improve safety and teaching (see paras 4.7–4.11; 3.8–3.15; 5.3–5.4 and Table 2, page 53).

3 Develop the level of expertise in (general) internal medicine (see also chapter 7 for more detail).

Patients now rarely present to hospital with a medical problem confined to a single organ system. Medical specialty trainees should dual accredit with (general) internal medicine. The great majority of patients with longer lengths of stay in hospital are older patients and have multiple comorbidities. (General) internal medicine trainees should have the knowledge and expertise to care effectively for these inpatients (see paras 4.4–4.6).

4 Collaboratively define standard procedures that operate across the Medical Division.

These criteria should allow easy identification of patients requiring specialist care and entry to rapid admission pathways and the level of clinical input from the specialty required. These should be reviewed annually. This will help prevent delays in obtaining specialist medical review in patients with conditions known to benefit such a review 7 days a week. In particular older patients with multiple comorbidities presenting as medical emergencies should have early access to comprehensive geriatric assessment, because of the particular expertise geriatricians and their teams have in improving outcomes and using healthcare resources efficiently (see paras 4.11–4.14).

5 The hospital–community interface

Operational imperatives

- 5.1 Hospital services will merge operationally with those of the community at the Acute Care Hub (ACH, paras 3.8–3.15), with strategic coordination of this interface managed via the Clinical Coordination Centre (CCC, paras 3.20–3.26). Larger hospitals may choose to appoint a director of community liaison, working with the chief of medicine and medical director, to oversee the direction and operational management of services that work in the community and hospital settings.
- 5.2 In the future hospital, there will be clear communication with patients and carers to indicate which service is likely to meet their needs best. Ideally, a single switchboard or information portal would serve the healthcare needs of a community, aided by electronic transfer of information between urgent care facilities. ‘Joined-up’ administration of urgent care, walk-in centres, out-of-hours systems and the hospital-based parts of the Medical Division (MD, paras 3.1–3.7) will be crucially important, aided by shared referral pathways and care protocols.

At the front door: early, expert assessment

- 5.3 Patients presenting acutely to hospital require early assessment by the right clinician first time round, and do not benefit from having to repeat their history (see Table 2, page 53). Physicians will expect to work seamlessly within the emergency department (ED) and junior staff may be shared between the ED and the acute medical unit (AMU). Removal of artificial barriers between teams will facilitate rapid patient care and smooth handover.
- 5.4 Up to a third of patients admitted on the acute medical take are aged over 80, a cohort with the longest hospital length of stay. Avoiding admission in this group affords considerable potential benefit to both patients (reduced adverse events in hospital, improved patient experience) and resource utilisation. It is recommended that these patients should receive early comprehensive geriatric assessment (CGA; see Box 6, para 6.11) directed at detecting frailty syndromes including delirium and dementia.

Lewisham University Hospital

Hospital size: 450 beds. Acute take 25–40 patients/24 hours.

Challenge faced: Increasing older patients presenting to ED, with potentially prolonged stays exacerbated by hospitalisation.

Solution: Clinical assessment service based in ED. Front-door geriatric assessment for ED and community referrals (planning to expand to GP). Multidisciplinary team with occupational therapist, physiotherapist, social worker, nurses who rotate through front door and community services. Provide access to 72-hour community tariff beds, step-up beds and short-term enhanced home care. Supervised by same team.

Local context: Trust is combined acute and community trust.

Staffing: 2 whole-time equivalent (WTE) occupational therapists, 2 WTE physiotherapists, 1.5 band 6 nurse, 0.3 WTE consultant geriatrician, 2 WTE social assessors.

Outcome: For May–Sept 2012, an average reduction in hospital admissions of 30 patients per month.

Case study: Clinical assessment service

In their own words: Our service is seen as really helpful by the emergency department (ED) and medical teams. There has been a reduction in emergency admission of older people especially those who were referred from our local therapist assessment in ED, requiring further support. When a geriatrician assesses them, I can take the risk and get them home with support, as I know what is available in the community. The patients get better continuity of care, they see the same clinician in ED whom they then see in the community and that really helps their confidence in the team. The rotation of staff from acute care to the community means we understand much better what provision we can all give. I can now understand far better what can be provided within the community and the people from the community can now see the pressures on the acute sector, so we work much better together.

Mainly our service takes referrals from ED, although the community teams will now phone me and say, 'I'm not sure about this patient', so I will suggest, 'Well bring them in and we can assess them'. The team will also go to the 11am post-take general medicine multidisciplinary team meeting for everyone admitted in the

previous 24 hours and identify patients whom we think we can transfer back home or support in the community. I hope this promotes the service and shares learning. Direct GP referral is a big element that is missing and that's our next step.

It's a win-win situation for both the commissioners and us because it keeps people out of hospital and it's cheaper than a hospital bed. When I talk to patients most of them have said they are glad they didn't come into hospital. Having good relationships with the community teams, with the community matrons and the early supported discharge teams make it work.

For example, there was somebody I saw on the Bank Holiday weekend. It was all very non-specific so initially the thought from ED was 'send her home'. However, talking to her and to her family it was clear that she wasn't coping as well at home; she wasn't doing as much as she could and there had been a recent decline in function. We saw her and she had a marked postural drop so I reviewed her antihypertensive medication and because we didn't have a community bed at the time she went to one of our intermediate care beds. I saw her again yesterday – her mobility has improved, she is doing better and she will be going home with ongoing rehab in the community.

FHC interviewed Dr Elizabeth Aitken, consultant geriatrician and lead for the clinical assessment service

➤ **See online video case study on early geriatric assessment, Sheffield hospital (www.rcplondon.ac.uk/fh-case-studies)**

Professor Tom Downes, consultant geriatrician and IHI fellow of the Institute for Healthcare Improvement, talks about re-designing geriatric services to enable immediate access for GP and ED referrals to a geriatrician and expert team. The result is dramatic reductions in length of stay and in hospital mortality. He talks about the process of change and service re-design and the importance of the team in bringing this about.

A focus on ambulatory (day-case) emergency care

- 5.5 The RCP Acute Medicine Task Force defines ambulatory care as ‘clinical care which may include diagnosis, observation, treatment and rehabilitation not provided within the traditional hospital bed base or within the traditional out-patient services that can be provided across the primary/secondary care interface’.¹
- 5.6 There are many benefits to ambulatory emergency care (AEC). First, patients want to avoid unnecessary hospital admissions.² Second, patient experience is improved by reducing admission and therefore the risk of hospital-acquired infections. GPs can continue to manage patients safely at home once a definite diagnosis has been made (or excluded), and consequent advice on management is given. AEC enhances cost-efficiency by improving the use of resources.³ The provision of AEC will therefore be a core component of the Acute Care Hub and will include both diagnostic advice (led by acute or internal physicians) and specialty ‘hot clinics’ available 7 days a week, on referral from either GPs or the ED.
- 5.7 Effective AEC requires a whole systems approach achieved by reorganising the working patterns of emergency and diagnostic services. Key features of quality AEC include access to timely evidence-based diagnostics, short observation periods, involvement of skilled decision-makers, reassessment and finalised management plan before patients leave hospital, communication with the patient, GP and other healthcare professionals, and effective community services.⁴
- 5.8 Pioneers of AEC are moving away from specific pathways to an ‘exclusion’ approach, so that, where AEC is fully implemented, same-day care has become the default position for emergency patients, unless admission is clinically indicated.

Nottingham Queen's Medical Centre

Hospital size: 1,300 beds. Acute medical take 100–130 every 24 hours.

Challenge faced: High demand for medical assessment and difficulty transferring patients from the acute medical ward to the main medical wards

Local context: The Trust is based on two sites with key specialties (respiratory, renal, cardiology) based on another site.

Partners: NUHT 'Better For You' whole hospitals change programme.

Solution: Ambulatory emergency care (AEC) as default for all GP referrals to medicine. Consultant-led assessment with rapid access to diagnostics and specialist in-reach when required. Utilising reconfigured clinic space, redefining roles and providing this service 8am–10pm Monday–Friday.

Outcomes: 30–40 % of GP referrals discharged the same day. Average AEC stay 4 hours.

Case study: Ambulatory emergency care

In their own words: In the summer of 2010, capacity for our emergency patients was posing difficulties. Through our performance data, we found that 50% of acute medical patients were discharged within 15 hours, suggesting that some patients could be treated without requiring a bedded admission. It was clear that with appropriate systems change we could improve our service. The NHS Institute's suggestions for ambulatory emergency care (AEC) complemented our vision. Having demonstrated an improvement in pilots we set up a new clinical area.

Our starting vision is: everyone is ambulatory until proven otherwise. The majority of patients are referred to our AEC via their GP. We were keen not to detract from the excellent ambulatory care that already happens naturally in the emergency department (ED) into a transfer process that would prove inefficient for the service and patients. We could have opted for more limited staffing but in practice most patients are actually

clerked and assessed within AEC so we now have two consultants, three nurses and a clinical support worker. We have the same laboratory response times as ED for blood test results.

We don't offer return appointments but rely on our communication system with the GPs. All discharge summaries are emailed immediately to the patient's GP.

Having the support of the chief executive is essential. Ambulatory care is largely consultant delivered, and performing investigations rapidly is expensive. But you have to consider the wider implications of not having such a service, such as cancellation of important elective care, for example. At Nottingham University Hospitals having a team of acute physicians and acute medical nursing expertise has been important in introducing this change, as has the analysis of our performance data to identify areas for improvement. Having a clearly identifiable clinical area with seating has been crucial to our success, as has support from the other specialties with whom we work closely.

For example, I discharged two patients yesterday who had had blood tests, chest X-rays and ECGs as well as clinical assessment within 90 minutes of arrival. The patients were discharged with reassurance. There may be improvements to be made in managing some of these patients in the community, but having come to hospital they received a rapid, safe and excellent service.

FHC interviewed Dr Jack Hawkins, consultant in acute medicine

See also an online video with further information about this AEC service (www.rcplondon.ac.uk/fh-case-studies).

Table 2. Patient flow and designated consultant responsible for assessment and ongoing care.

Patient category	Initial assessment on AMU by	Placement	Ongoing care
Internal medicine not requiring admission (with early review in ambulatory care unit)	Acute medical team	Home – next-day return to ambulatory care	AMU consultant ^a
Specialty medicine not requiring admission (next-day review in ambulatory care)	Specialty team ± acute medical team	Home – next-day return to ambulatory care	Specialty consultant
Specialty medicine requiring front-door assessment to decide on admission or alternative (eg older people with frailty)	Specialist team at the front door (eg acute frailty MDT service)	Home or community placement or admission direct to elderly care	Geriatrician
Internal medicine predicted short stay <48 h	Acute physician	Transfer to AMU (Acute Care Hub)	AMU consultant ^a
Internal medicine predicted longer stay >48 h	Acute physician	Transfer when stable to medical ward	Consultant practising in internal medicine (general internal medicine, GIM) running ward
Primarily internal medicine with some specialty problem(s)	Acute physician ^a specialty team review/advice	Transfer when stable to medical ward	Consultant practising in internal medicine (GIM) running ward
Specialty medicine: need for specialty ongoing care identified by local agreed criteria	Acute physician (or specialty team according to local protocol)	Fast track to specialist bed (same day)	Specialty consultant
Deterioration in AMU and critically ill	Acute physician ^a specialty team	Level 2/3 bed (co-located with hub)	Intensive care medicine

AMU = acute medical unit; MDT = multidisciplinary team.
^aAMU consultant can refer to either an acute physician (acute internal medicine) or a (general) internal medicine physician.

Moving through the Acute Care Hub

- 5.9 For all patients who require admission to the AMU, the emphasis should be on organising rotas so that the consultant physician reviewing the patient on admission also reviews the patient the next day. This also applies to patients for whom ambulatory care is deemed appropriate.
- 5.10 For those requiring specialty care, the same consultant and clinical team would continue to provide care on the AMU through to when a patient leaves hospital, if this occurs within a short period (most feasible within 48 hours).
- 5.11 Longer lengths of stay for patients with specific conditions for which either the relevant care protocol requires extended (greater than 48 hours) admission or the requirements for rehabilitation are likely to mandate transfer to a specialist or general ward.
- 5.12 The capacity of the Acute Care Hub should be sufficient to accommodate all inpatients not requiring care in a specialist ward or area (eg critical care unit, intensive care unit), and who are likely to leave hospital within 48 hours of admission. It might be two to two and a half times the average acute medical take for a 24-hour period. In acute hospitals where the capacity of the AMU is similar to the size of the acute take in 24 hours, this mandates transfer out of almost all patients within 24 hours irrespective of the predicted length of stay (LOS).^{*} Structuring the Acute Care Hub (which includes short-stay beds) to have a capacity exceeding the size of the acute take in 24 hours offers greater potential for a larger proportion of patients to leave hospital direct from the Acute Care Hub. Currently, transfer out of the AMU commonly fractures continuity of care and each ward transfer adds up to 2 days to the length of stay.^{6,7}

Discharge no longer: planning the transition of care from hospital to the community

- 5.13 A vital step in ensuring that patients receive care in the right place at the right time is planning the transition from hospital to community (either residential or home setting) care. This should start at the beginning of an acute hospital admission and includes setting a date when the patient is scheduled to leave hospital after the first assessment. This means ensuring that ongoing care needs (clinical, social and psychological) are identified early on, involving the patient and carers in a multidisciplinary discussion to plan for the patient's return home or to a supportive setting outside the hospital, and providing agreed ongoing care plans including management of complications/deterioration from an acute condition.
- 5.14 A constant flow of activity means that a weekly meeting to plan transitions of care cannot meet the needs of either the patient or the system. Transition of care planning should therefore be incorporated into daily review processes and ward rounds.⁸

^{*}Snapshot summary data suggest that up to 50% of admitted patients can leave hospital directly from the AMU within 48 hours.⁵

Enhanced recovery and rehabilitation

- 5.15 A longer hospital stay leads to greater fragility for patients after they leave hospital.⁹ Planning recovery from the point of arrival, a concept known as enhanced recovery, could save an estimated 140,000 beds nationally¹⁰ and has been shown to be effective in specific clinical areas (eg colorectal surgery¹¹). There is growing expertise in implementing the principles of enhanced recovery after acute medical admission.
- 5.16 All patients should be on a pathway to enhance their recovery, facilitating earlier departure from hospital by minimising the physical and psychological stress responses. Patient preparation identifies relevant risks and commences rehabilitation as soon as possible. Proactive patient management components of enhanced recovery must be embedded across the entire pathway, before, during and after treatment.
- 5.17 Where possible patients must take an active role and take responsibility for enhancing their recovery, which includes paying attention to nutrition, hydration and mobility from the start of an inpatient journey. Staff need to be proactive in reviewing nil-by-mouth instructions, ceasing intravenous therapy once alternative routes are appropriate, and avoiding techniques that enforce bed rest (such as catheters, 24-hour intravenous fluids) as soon as possible.

‘Early supported discharge’

- 5.18 The hospital of the future will adopt a model of care that regards an inpatient stay as only one step along a pathway of care that extends from and back to the patient’s usual place of residence. The patient’s transit of that pathway needs to be smooth and efficient. Care provision should be continuous and relevant to the needs of the patient. Examples might include provision of home intravenous antibiotics, home subcutaneous therapy and home nebulised treatments.
- 5.19 In some cases further diagnostic monitoring and medical review are required and patients may choose to continue their care through the ambulatory care pathway described above, with immediate access to day-case services. In this case the inpatient team continue to supervise care through the AEC facility. These can be provided via a specific ‘hospital at home’ team in collaboration with the treating inpatient team or as part of a community team provided 7 days a week.
- 5.20 The future hospital will support a system of ‘discharge to assess’ in physiotherapy and occupational therapy.¹² This model of care, now used in a number of regions, means that the ability of patients to function and perform activities of daily living is assessed in their own environment, with immediate additional help and support arranged from the home setting. This system is contingent on collaborative, integrated working of the hospital social services, primary care and voluntary sector.

Countess of Chester Hospital

Hospital size: 600 beds. Acute take 30–50 patients/24 hours.

Challenge faced: High bed occupancy with 89% of patients over 65 remaining in an acute bed when medically stable (from audit data).

Solution: Combined enhanced supported discharge service and admission avoidance for older patients. Provides bridging social care, therapy at home, short-term medical care at home, 7 days a week. Service is hospital supervised, taking referrals from primary care, ED and medical wards. Serves up to 70 patients a week.

Partners: Countess of Chester Hospital Foundation Trust, Cheshire West and Chester Council, Cheshire and Wirral Partnership Community Foundation Trust, Hospital at Home. Teams delivering different elements of the pathway, unified and enhanced with some additional funding.

Local context: 21 unplanned adult care services available in West Cheshire.

Staffing: Initial service delivered by 0.6 whole-time equivalent (WTE) band 6 nurse, 1.0 WTE band 5 nurse, 7 WTE band 3 nurses, 0.7 WTE social care assessor, 1 WTE band 6 physiotherapist and 1 WTE band 6 occupational therapist.

Outcome: The scheme is planning to expand to take on more work, take referrals 7 days a week and include mental health support.

Case study: Rapid response and enhanced discharge scheme

In their own words: From my point of view the solution had to maintain patient flow through the hospital. There was a group of patients who needed maybe 24–48 hours of acute hospital care, and then a short period of rehab before they would be safe on their own. Early supported discharge was needed. In addition, the service needed to assess and support people to avoid their admission to hospital.

So we combined two separate teams. The service works flexibly, allocating resources to identify inpatients or concentrating efforts on avoiding admissions depending on where the demands are greater. The team accepts on average three patients from the wards and five from the community a day. We set out to look after 25 patients a week but we had to meet unprecedented demand and we now look after an average of 40 patients at any one time. There is a daily multidisciplinary team meeting in the hospital where the staff discuss the patients on the 'virtual ward'. The personnel who are community based understand the urgent need for hospital capacity on any given day and the hospital-based personnel are able to contribute to admission avoidance, thus maintaining hospital capacity.

The rapid response team is made up of physiotherapists, occupational therapists, nurses, and carers but is supported by the local Hospital at Home team. It was essential that we worked very

closely with them. Their remit is really admission avoidance but people who are ill go to the safest place they know, which is the emergency department (ED). We found that when there are bed pressures, the more effective model to maintain capacity in ED and the acute medical unit (AMU) was to identify patients who would benefit from this approach with the rapid response team, after their initial stabilisation.

To make this kind of service work, you need to sit down with your clinical commissioning group, social services and community provider and agree to pool resources to sustain safe and efficient care for patients in hospital. The two-pronged approach at the front and back end of the hospital allows patient flow and creates capacity to put the right patient in the right bed under the care of the right physician.

FHC interviewed Dr Frank Joseph, consultant endocrinologist and general medicine

Integrated acute and specialist care beyond the hospital walls

- 5.21 In describing integrated care in 2012, the King's Fund¹³ states: 'Integrated care means different things to different people. At its heart, it can be defined as an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs. To achieve integrated care, those involved with planning and providing services must impose the user's perspective as the organising principle of service delivery.'
- 5.22 The concept of integrated care, in particular for patients with long-term conditions, is strongly supported by patients, and patient groups, carers and healthcare professionals. Available evidence suggests that, by minimising waste, it will also be cost-effective. The most appropriate setting to deliver care can be determined through a series of simple questions (Fig 3).
- 5.23 The Commission proposes an integrated healthcare and social care economy with free movement of information and expertise across the structural borders of primary, secondary, community-based and social care. The precise model of integrated care will depend on the local health structures. Integrated care enables the provision of safe high-quality health and social care in all locations. There are numerous examples of effective integrated care, often along disease-specific pathways. Relevant models include identifying patients utilising health services at a high rate, using multidisciplinary teams working across in- and outpatient services, shared information channels for clinical data, using staff with experience of providing care in all settings and who understand the constraints of each, and empowering patients by providing case managers and supporting patient self-management. The work done in Torbay, which includes organisational integration of social care and health, demonstrates the benefits to patients and the system.¹⁴

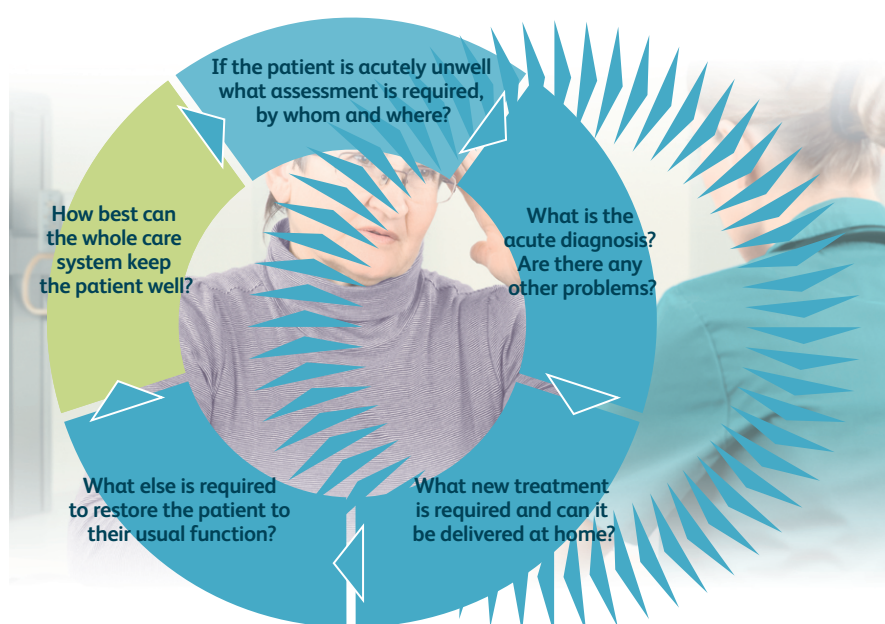


Fig 3. Considerations in the approach to care for patients with long-term conditions.

- 5.24 Currently, hospital-based teams have significant experience in the management of conditions that affect wide sectors of the community that they serve. However, not all of those with a condition receive the benefit of specialist attention and, in our efforts to provide more equitable access to health, the specialist resources available in a hospital need to be deployed in a way that maximises the benefit to the whole community and health economy. This is likely to involve physicians in the future hospital system working in the community and more closely with community colleagues to provide direct patient care, advice and education.

Teams delivering healthcare outside the hospital

- 5.25 Hospital-based centres for acute care services will be supported by the extension of hospital services into the community, developing alongside primary and social care services. These specialised services, currently largely hospital based, will be delivered in or close to the patient's home, usually by a cohort of staff linked to local hospitals working alongside primary and social care services 7 days a week. A National Voices report indicates that patients want coordination, not necessarily organisational integration.¹⁵ Currently, significant risks to patients occur when care is transferred between settings. Developments in information transfer will improve safety, as will a cadre of physicians and other clinical staff working along the care pathway (see chapter 9).
- 5.26 A primary focus will be on preventing crises in healthcare and personal care. Where this is not possible the default will be to provide integrated, patient-centred care at home or at a community setting close to home. In the event that hospital admission is required, services will be designed to allow return to the community on the day that an acute hospital bed is no longer required.
- 5.27 For many specialties and for general physicians, there is an increasing need to devote sessions to working in the community, thereby forming part of a team. This may be drawn from any or all of primary care, the medical specialties, psychiatry, physiotherapy, occupational therapy, social services and even the voluntary sector. The role of the integrated physician may include some or all of those shown in Fig 4.

➤ **See video case study online on integrated care for respiratory patients, Whittington Hospital, London(www.rcplondon.ac.uk/fh-case-studies)**

Doctors Myra Stern, Louise Restrict and Melissa Heightman talk about the benefits of providing integrated care for respiratory patients including those with chronic obstructive pulmonary disease, their shared vision and ethos, how their service has improved retention rates and motivation, and become a beacon for training in integrated care.

- 5.28 There are established examples of physicians working in this integrated fashion, crossing from the inpatient to the community arena, usually for patients with complex chronic conditions. Examples include community geriatricians, palliative care consultants, and integrated respiratory and diabetic physicians. These physicians require the technology and diagnostic services provided by the hospital so they may be based on the site of the hospital, and a close link between these teams and the acute inpatient services, with possible rotation of all staff between roles, ensures a shared understanding of where patients can receive the maximum value from their health service. These physicians work closely with GPs and other health professionals

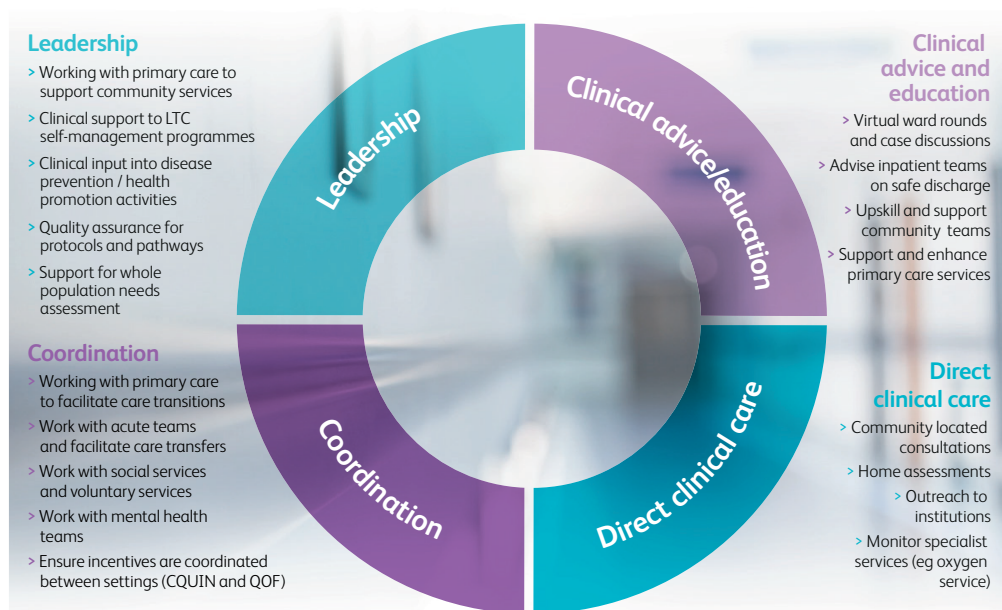


Fig 4. Extended roles for physicians in the community.

CQUIN = Commissioning for Quality and Innovation; LTC = long-term condition; MDT = multidisciplinary team; QOF = quality outcome framework.

working across acute and community settings. The sharing of information and joint working between and with GPs and social care is crucial. Leadership in the multidisciplinary teams working in the community will often be delivered collaboratively with GPs and negotiated locally, depending on available resources and local circumstances.

Appropriate support to care home residents

5.29 Around 400,000 people live in nursing or residential care and often have multiple morbidities and complex medical needs. These people need access to enhanced primary care from GPs and to community services, to manage their long-term conditions, deal with acute deterioration and plan end-of-life care. There is also evidence to suggest that their care is improved by involvement of the geriatric medicine physicians.^{16,17} The British Geriatrics Society support a collaborative approach with coordinated teams working together built on primary care and supported by a range of specialists (including geriatric medicine, mental health and others).¹⁷ There have been a number of local initiatives and pilot projects that demonstrate better care for patients with increased geriatric support to care home residents. This can be particularly effective when the community geriatric medicine team is linked to the acute services and care plans are shared between teams, so that care is provided in a more seamless fashion regardless of the patient's location.

5.30 Geriatricians and their specialist teams also have an important role in providing skills to the staff who work in care homes; pilot projects suggest that this may reduce the need for acute admissions.

Governance and organisational processes/infrastructure

- 5.31 The challenge for governance/organisational processes is to develop more effective ways of providing healthcare by supporting core, patient-centred processes, using technology to support improved patient services, and being flexible and adaptive in terms of resources and delivery.
- 5.32 The development of organisational processes that coordinate planned and unplanned care, so that neither impacts on the other, requires the development and review of administrative and organisational arrangements. These should include leadership and managerial/clinical/patient inputs, to ensure appropriate staffing structure, provision of equipment, technology and space to provide high-quality, patient-centred, sustainable and flexible patient services.
- 5.33 Leadership and governance processes to support equipment management, including a responsible lead and process for ensuring timely access, maintenance and replacement of all devices, and quality assurance and evaluation of new technologies, are needed (see chapter 8).

References

- 1 Royal College of Physicians. *Acute medical care: The right person, in the right setting – first time*. Report of the Acute Medicine Task force. London: RCP, 2007.
- 2 Davies CWH, Wimperis, J Green ES *et al*. Early discharge of patients with pulmonary embolism: a two-phase observational study. *Eur Respir J* 2007;30:708–14.
- 3 Frisse ME, Holmes RL. Estimated financial savings associated with health information exchange and ambulatory care referral. *J Biomed Inform* 2007;40(6s):S27–32.
- 4 NHS Institute for Innovation and Improvement. *Directory of ambulatory emergency care for adults*, 3rd edn. London: NHS Institute for Innovation and Improvement, 2012.
- 5 Subbe CP, Ward D, Lalip L *et al*. A day in the life of the AMU - the Society for Acute Medicine's benchmarking audit 2012 (SAMBA '12). *Acute Med* 2013;12(2):69–73.
- 6 Healthcare Commission (NHS Improvement). *Acute hospital portfolio review. Management of admissions in acute hospitals review of national findings*, 2006.
- 7 Marion ET, McMurdo I, Witham MD. Unnecessary ward moves. *Age Ageing* 2013; online doi:10.1093/ageing/aft079 (print in press).
- 8 Royal College of Physicians and Royal College of Nursing. *Ward rounds in Medicine: principles for best practice*. London: RCP, 2012.
- 9 Covinsky KE, Pierluissi E, Johnston CB. Hospitalization-associated disability: 'She was probably able to ambulate, but I'm not sure'. *JAMA* 2011;306:1782–93.
- 10 Enhanced Recovery Partnership Programme. *Delivering enhanced recovery: Helping patients to get better sooner after surgery*. London: Department of Health, 2010.
- 11 Adamina M, Kehlet H, Tomlinson GA *et al*. Enhanced recovery pathways optimize health outcomes and resource utilization: a meta-analysis of randomized controlled trials in colorectal surgery. *Surgery* 2011;149:830–40.
- 12 Philp I. Four principles to improve the care of older patients. *Health Service J* 2012;10 May:24.
- 13 King's Fund, Nuffield Trust. *Integrated care for patients and populations: Improving outcomes by working together*. A report to the Department of Health and NHS Future Forum. London: King's Fund, 2012.
- 14 Thistlethwaite P. *Integrating health and social care: Torbay case study*. London: King's Fund, March 2011.
- 15 National Voices. *National voices patient narrative*. London: King's Fund.
www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/principles_for_integrated_care_20111021.pdf [accessed 29 July 2013].
- 16 Lisk R, Yeong K, Nasim A *et al*. Geriatric input into care homes reduces emergency hospital admissions *Arch Gerontol Geriatr* 2012;55(2):331–7.
- 17 British Geriatrics Society. *Quest or quality in care homes*. A Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Improvement. London: BGS, 2011.
www.bgs.org.uk

Summary of recommendations for the hospital–community interface

1 Establish a Medical Division with oversight of and collaborative responsibility for specialist medical services across the hospital and wider health economy.

Delivery of specialist medical care should not be confined to those patients who present at hospital or are located in the services' designated beds or clinics in hospital, but should operate across the whole hospital and wider health economy (see paras 5.1–5.2; and chapter 3). To support this:

- i The Medical Division, led by a chief of medicine, should work closely with partners in primary, community and social care service to develop shared models of delivery and outcomes for all the specialist medical services (including internal medicine) across the hospital and health economy.
- ii Specialist physicians should assess the performance of their service according to how well it meets the needs of patients with specified needs/conditions across the hospital and health economy.

2 In hospital, develop systems that support a single initial point of assessment and ongoing care by a single team.

- i Develop clinical criteria that define which patients require specialty consultation, advice or management on a specific pathway. This will be supported by clearly defined specialist services available to provide rapid assessment in 'front door' areas to facilitate fast track referral to specialty pathways (see paras 5.3–5.4; and 4.7–4.14).
- ii Patients assessed as likely to have a stay in hospital of less than 48 hours will usually be admitted to the acute medical unit *unless* their requirements for rehabilitation are likely to mandate care on a specialist or internal medicine ward. Protocols for routes of admission should be developed.
- iii Patients admitted to the acute medical unit should be under the care of a single consultant-led team. The same should apply to patients for whom ambulatory care is deemed appropriate. This will mean designing rotas that allow the consultant reviewing the patient on admission to review the patient the next day. Arrangements must be in place to ensure that specialty care is accessible to patients in all locations across the hospital (see paras 5.9–5.12 and Table 2, page 53).

3 Increase the focus on ambulatory (day case) emergency care, enhanced recovery and 'early supported discharge'.

The focus should be on developing systems and ways of working that enable patients to leave hospital safely as soon as their clinical needs allow. To support this:

- i Ambulatory emergency care should be the default position for emergency patients, unless admission is required on the basis of clinical need. This will require changes to ways of working, including ensuring early involvement of senior decision-makers, particularly consultants (see paras 5.5–5.8).
- ii Planning for recovery should happen from the point of admission. This 'enhanced recovery' will require proactive review and communication with patients to encourage effective self-management (see paras 5.13–5.17).
- iii Systems that encourage 'early supported discharge' should be developed. These can include specific 'hospital at home' teams working in collaboration with the treating inpatient team or as part of a community team operating on a 7-day/week basis (see paras 5.18–5.20).
- iv Collaborative 'discharge to assess' models that allow patients' care and support needs to be assessed in their own homes should be developed (see para 5.20).

4 Develop new systems and ways of working that deliver more specialist medical care outside the hospital setting (see paras 5.21–5.30).

The growing needs of patients for secondary care services cannot be met by confining these services to the hospital site. To better meet patients' needs across the health economy:

- i Physicians should expect to spend part of their time working in the community, providing expert care integrated with primary, community and social care services.
- ii Physicians should take a lead in developing specialist models of care that operate beyond the 'hospital walls' and into the community (including in care homes).
- iii There should be a particular focus on optimising the care of patients with long-term conditions and preventing crises.

5 Develop systems that enable hospitals to become the hub of clinical expertise and supporting technology for the local population, particularly in relation to diagnostics and treatment (see paras 5.31–5.33). This can be supported by the development of:

- i Shared referral pathways and care protocols across the system to support integrated working with health and social care partners. This would be underpinned by rapid, relevant sharing of information, mechanisms for rapid admission and referral, and effective arrangements for enabling patients to leave hospital, with support where necessary.
- ii Information systems that bring together all relevant clinical information, including that from primary and community care, mental health, social and hospital services in one electronic patient record (EPR). Immediate access to this comprehensive Electronic Patient Record is particularly important in the assessment of patients presenting as a medical emergency. (See also chapter 9: Information.)
- iii An in-hospital Clinical Coordination Centre that collates and disseminates information that allows patients' needs to be matched to the care and service capacity available within the health economy. This should support the joined-up administration of urgent care, 'out-of-hours' systems and hospital-based parts of the Medical Division (see paras 3.20–3.26).

6 Specific services: care for older people with frailty, people with mental health conditions, people who are homeless, and young people and adolescents

Care of the older patient with frailty: the extent and nature of the challenge

- 6.0 There is no ‘one size fits all’ for patients, including older patients. As with younger patients, many older people may have straightforward single clinical problems – such as heart attacks and gastrointestinal (GI) bleeding – and can flow through the system in the same way. However, many older patients have multiple, complex, interacting problems, with exacerbations of chronic conditions. It is these patients for whom the current system does not cater well. Fragmented, disjointed care – with multiple ward moves, inconsistent teams and numerous clinical handovers – is bad for all patients, but is particularly high risk for this group. It leads to increased risk of clinical incidents, reduced quality, reduced patient satisfaction, increased risk of complaints, communications breakdowns and operational inefficiency. Much of what is advocated by the Future Hospital Commission is designed to tackle this issue.
- 6.1 The Francis Inquiry highlighted profound failings in the standard of basic, essential care delivered particularly to older patients on medical wards.¹ It raised fundamental questions about the level of investment trusts make in staff and their training, and concerning the effectiveness of trust management and regulatory bodies to ensure that patients receive the care they need. However, the majority (65%) of people admitted to hospital are older than 65, and at any one time 70% of hospital beds are occupied by this age group.²
- 6.2 Although the outcomes for patients under 65 years old with an acute illness clearly aligned with a medical specialty service have never been better, older patients with an ill-defined acute illness and multiple comorbidities is much more commonly encountered on the acute medical take. However, the newly admitted 80-year-old with dementia can be viewed at best as a surprise on the receiving ward and at worst as a burden and subjected to discrimination.³ There is increasing evidence of substandard care provided to many older patients,^{1,4,5} with care poorly coordinated and reports of patients being moved between wards and within wards ‘like parcels’.⁶
- 6.3 In older patients with multiple comorbidities presenting acutely to hospital, there is a growing need for a much more collaborative approach to diagnosis and treatment. Unfortunately, more holistic, generalist ongoing care from geriatricians is needed than can be delivered within the

current service provision of most hospitals. Many older patients are admitted with presenting problems that do not fit neatly within a single organ-defined specialty. The pressure on acute medical services is such that many patients are allocated to the first available bed, sometimes in a specialist medical ward only loosely aligned to their perceived major illness.

- 6.4 Patients with multiple comorbidities deemed to be 'general medical' patients are poorly tolerated on specialty medical wards and can be viewed as occupying a specialist bed inappropriately – they are perceived to be in the 'wrong place'⁴ with a concomitant risk they will be transferred to another ward when a patient considered more deserving of a specialty bed is admitted. Indeed, older patients may be moved four or five times during a hospital admission causing considerable distress⁷ and inefficient and ineffective use of resources.³ Moreover, such an approach represents the antithesis of patient-centred care, fractures continuity, compromises patient safety and leads to uncertainty about who is in charge and responsible for their well-being. Physicians report that lack of continuity of care is their principal concern, trumping budgetary constraints and staff shortages.⁸
- 6.5 The great majority of medical patients admitted as emergencies who require 5 or more days in hospital are older people who are frail and have multiple comorbidities. In these circumstances even a relatively mild acute illness may precipitate physiological decompensation. Extended periods in bed during a hospital admission and hospital-acquired infections are major factors which may further compromise independent functioning.⁹
- 6.6 Lack of continuity of care is a particular problem for older patients who are more likely to be hospital inpatients (and readmitted within a short time), have longer lengths of stay (particularly if they are frail, have dementia or multiple comorbidities), and are likely to suffer from poor standards of care and multiple moves between medical teams and wards. Thus, the national inpatient survey (2011)¹⁰ found that 28% of respondents reported being cared for on two wards and 8% in three or more; and physicians reported concerns to the RCP about patients moving 'up to 4 or 5 times' during a single admission. Older patients are more vulnerable to being moved in hospital and find this particularly distressing.⁷
- 6.7 For the older patient, a prolonged period as an inpatient can be a life-changing event. Unfamiliar routines, noise, discontinuity of staff, uncertainties about their illness and leaving hospital, lack of sleep, and adverse effects of treatments undermine physical recovery and functional independence. The effect of these insults is exacerbated in patients with cognitive dysfunction or dementia, and can worsen cognitive function. Consequently, at the point these patients leave hospital, they may be more dependent on long-term care in the community than they were prior to admission, both in their usual home setting and in long-term residential care.⁹
- 6.8 Hospitalisation too often means that a patient is expected to conform to an inpatient routine organised around the duties of the staff delivering the service rather than the needs of the patient, with ward staffing and facilities commonly designed to meet the requirements of patients with lesser levels of dependency.

Care of the older patient with frailty: optimal assessment in hospital

- 6.9 Older patients with frailty who come to hospital as medical emergencies frequently have complex needs which can lead to an atypical presentation. Optimally, a comprehensive geriatric assessment (CGA) should be performed on arrival (Box 6).¹¹ This permits the development of a multifaceted therapeutic plan to enhance recovery and promote independence. One model of CGA involves admission to a specialist geriatric ward where assessment, acute care and rehabilitation are managed by a specialist team. These have been variably termed elderly care assessment units (ECAUs), acute care for elders (ACE) units, and geriatric evaluation and management units (GEMUs) (see chapter 5: Hospital-Community).
- 6.10 CGA has been shown to increase the likelihood that patients will survive and move back to their own homes after emergency admission.¹² The clinical impact of CGA is greatest where it is performed on wards designated for this process, with an associated potential cost reduction (compared with general medical care).
- 6.11 There are significant workforce implications for the expanded use of CGA. Many more geriatricians would be needed to see all these patients on the acute medical unit (AMU), which would mean embedding members of the geriatric multidisciplinary team (therapists, specialist nurses) to be available over extended 12-hour shifts.¹³ The British Geriatrics Society has made recommendations as to how they plan to work in the future hospital (Box 6).

Box 6. British Geriatrics Society: the comprehensive geriatric assessment

Geriatricians have a unique role as the only specialty with a focus on acute illness and rehabilitation of frail older people. The evidence-based application of comprehensive geriatric assessment (CGA) is central to this specialist practice. There is strong evidence for specialist units (eg wards) for the post-acute optimisation of patients' recovery, using a multidisciplinary CGA approach. There is no established 'best model' to bring multidisciplinary CGA expertise to all patients who need it at the 'front door' and onwards in the acute hospital medical service, but the key components are:

- > assessment to target individuals into community-based services in lieu of hospital admission
- > age-attuning acute medical admission units, with both the environment and processes of care
- > early recognition and response to geriatric syndromes: delirium, falls, immobility, functional loss
- > proactive identification of suitable patients for rapid follow-up in specialist clinics
- > end-of-life care is a core medical skill but geriatricians can be expected to provide expert support
- > multidisciplinary rehabilitation and expert discharge planning for patients with complex needs.

➤ See online case study on geriatrician review of older people with frailty, University Hospital Nottingham (www.rcplondon.ac.uk/fh-case-studies)

Dr David Seddon, consultant geriatrician, University Hospital Nottingham, explains how early consultant review of older people with frailty, coupled with an integrated discharge team, can result in care improvements, including reduction of unnecessary medication, a saving in bed days, better planned and earlier discharge, and prevention of unsafe discharge.

Care of the older patient with frailty: alternatives to hospital admission

- 6.12 Evidence supporting the increased use of alternatives to admission for a significant proportion of older people with frailty is sadly lacking. However, where hospital admission can be avoided the potential benefits are considerable. In addition, the patient has a better chance of maintaining their independence and existing community support networks. Alternatives to hospital admission include ambulatory emergency care (AEC), primary and secondary care services designed to provide medical support to patients in their usual domestic setting (home or a residential care facility), provision of residential rehabilitation place or rehabilitation provided to the patient at home.

People with mental health conditions

- 6.13 It has been recognised that up to half of those patients admitted to acute hospitals have a mental health condition,¹⁴ including depression, dementia and delirium. Many comorbid mental health problems go undiagnosed or untreated and without effective intervention, leading to poorer outcomes. This also has a significant financial implication, as coexisting mental health problems cost the NHS approximately £13.5 billion a year on physical health services.¹⁵ In future, hospitals must ensure that they provide appropriate mental health support.
- 6.14 Within general and acute hospitals, liaison psychiatry services have been identified as critical to addressing the mental health needs of patients by reducing admissions and readmissions, shortening length of stay and decreasing healthcare costs for medically unexplained symptoms as well as other mental health conditions.¹⁵ These services can also help improve the mental health awareness across health professionals to better embed the consideration of psychological factors in the routine care of patients. There is considerable variation, however, in the scale and organisation of such services, with some hospitals having little or no such provision.
- 6.15 To realise their full potential, all general and acute hospitals should have a dedicated on-site liaison psychiatry service. Guidance suggests these should be provided across 7 days, with hours of on-site availability determined by local need, the provision of alternative services and a formal cost-benefit analysis.¹⁵ All should provide an on-site multidisciplinary team to cover all wards and the emergency department (ED)/AMU 7 days a week, for a minimum of 12 hours a day, with appropriate access out of hours.
- 6.16 Core clinical standards for mental health disorders and related problems must be met in all acute hospitals. Rapid access to specialist psychiatric support should be a priority for emergency referrals, especially where patients present an immediate risk to themselves, other patients or staff, including those admitted following self-harm. Priority should also be given to other patients throughout the hospital where mental health assessment is needed to guide clinical management decisions such as further investigation or treatment, or where a patient is considered medically fit to leave hospital. Plans for outpatient follow-up for medical and mental healthcare should be made simultaneously.
- 6.17 Liaison psychiatry services play a role in the multidisciplinary management of patients with long-term conditions. Integrated care teams with responsibility for patients with long-term conditions must include expertise in treating mental illness. Increasingly, patients with severe

mental illness also suffer with medical comorbidities and these must be treated in parallel. A significant mortality gap (8–14.6 years of life lost in men)¹⁶ exists between patients with severe mental illness and age-matched counterparts. Physicians must therefore offer a liaison service to mental health trusts.

6.18 It is recommended that:

- > All general and acute hospitals should have a dedicated on-site liaison psychiatry service. This service should cover all wards and the ED/AMU 7 days a week, for a minimum of 12 hours a day, with appropriate access out of hours.
- > Physicians must offer a liaison service to mental health trusts, to meet the needs of patients with severe mental illness and medical comorbidities.
- > Rapid access to specialist psychiatric support should be a priority for emergency referrals, where patients are an immediate risk to themselves, other patients or staff, including those admitted following self-harm.
- > Priority should also be given to other patients throughout the hospital where mental health assessment is needed to guide clinical management decisions such as further investigation or treatment or where a patient is considered medically fit to leave hospital.

➤ **See online case study on dual/psychiatric care of dementia patients, Queen Elizabeth Hospital, Gateshead (www.rcplondon.ac.uk/fh-case-studies)**

Dr Catherine Kirkley, consultant psychiatrist, explains how the dual medical/psychiatric care provided on one ward for patients with dementia and severe mental health issues provides better care, better management of aggression and agitation, and minimal resort to artificial feeding and hydration.

Patients who are homeless

- 6.19 For people whose lives are chaotic the hospital may seem to be their only source of healthcare. Such vulnerable patients are often afflicted with the trimorbidity of physical illness, mental health problems and substance misuse (including alcohol).¹⁷ Achieving whole-person care in hospital for these patients will require a team approach that must include an appreciation of the social issues they are contending with.
- 6.20 The Faculty for Homeless and Inclusion Health has derived standards for health services for homeless people that provide guidance for commissioners and providers on what interventions will facilitate a quality service. These include a focus on care coordination, enhanced access to care, case management for complex cases, prioritising health promotion and service-user involvement in service design and evaluation.¹⁸
- 6.21 Providing quality care to homeless patients often means providing coordination and advocacy for a complex medical and social situation. The Pathway model¹⁹ – pioneered at University College London Hospitals (UCLH) but now under evaluation in several trusts – has shown that by aiming to provide a link between the various medical and social teams involved in a patient's care, they have improved the patient experience, and achieving greater efficiency has also helped reduce costs.²⁰ The Pathway model includes a GP, a nurse and a care navigator who link with the patient, the various hospital teams, multiple voluntary agencies, and social and housing services to ensure that the patient is enabled to receive the medical treatment and convalescence they

Case study: Complex discharge ward

In their own words: The ward was set up in response to a winter bed crisis which persisted into the summer, and a large number of patients had completed their acute medical treatment but were waiting for social services' input.

We started with nine beds, and we now have 31 on the unit. Bed occupancy ranges between 23 and 31 according to demand. The majority of patients are older people with frailty, and most have dementia. We do occasionally have some younger patients, but they still have complex physical and mental health needs.

To access the ward, a patient has to have completed their medical treatment, physiotherapy and occupational therapy, and be 'as good as they're going to be'; some patients are waiting for equipment to be delivered that is essential for discharge. All patient transfers have to be approved by a consultant geriatrician. I also occasionally take patients directly from the admissions unit. They are often people with dementia who cannot return home safely, and social services are unable to provide an emergency placement. We therefore avoid a move and take them directly into the delayed discharge ward.

Obviously we know that moves for older people can cause increased rates of delirium, but this isn't actually a problem that we've had. We think we have achieved this by insisting on daytime transfers and because the environment the patient is coming on to is so geared up for them.

We also have rates of falls that are below average. I think this is because we allow patients to mobilise with supervision as part of the normal mindset of the ward. It's very much a culture of getting up out of bed, dressing in normal clothes and normal shoes, and walking about the ward if someone is able to. We have lots of chairs and places to sit around the ward so someone can get up, move around and actually have a destination to walk to. We have dining tables in each of the bays and we encourage the patients to socialise. We have a large television in each of the bays because, even with a significant amount of cognitive impairment, the men enjoy watching sport, and the ladies sit down in the afternoons and watch films together. The ward staff regularly carry out other activities with the patients.

If someone were considering a similar service, they should make sure their environment is appropriate. Make sure your nursing levels are appropriate and that you have a very strong manager. Dig your heels in about junior doctor cover because these patients are vulnerable and will get unwell, and are entitled to receive a good level of medical care. The patients need to be medically stable and ready for discharge, but with medical and nursing needs appropriate for that environment. Being firm about those points leads to excellent results.

FHC interviewed Dr Zoe Wyrko, consultant geriatrician. See also online video about this discharge ward (www.rcplondon.ac.uk/fh-case-studies)

University Hospital Birmingham

Challenge faced: Significant numbers of patients were awaiting care package organisation or transfer of care, prolonging their hospital stay.

Solution: A dedicated ward area with nurses attuned to the needs of frail patients, particularly those with dementia. Focus on hospital discharge organisation.

Local context: Acute trust

Staffing: Consultant with two programmed activities, one whole time equivalent junior doctor. Nursing staff and visiting members of a multidisciplinary team.

Outcome: From being a pilot this is now a permanently funded ward with an average length of stay of 7–10 days. Its hospital-acquired infection rates and falls rates are lower than the hospital average.

require. Regular face-to-face meetings with all agencies that provide services for homeless patients in the area provide a shared understanding of patients' needs and can identify solutions to the complex social situations these patients often face.

- 6.22 Patients struggling to cope with the trimorbidity commonly associated with homelessness tend to have long-term health needs. It is imperative that they are able to access primary healthcare and services specific to their needs, in the community. Planning for when patients leave hospital must include organising transfer of care to an appropriate clinician. GP-led in-reach to hospital to provide coordination for the homeless (as in the Pathway model, described above) has proved to be invaluable in providing higher-quality care that is cost effective and can provide greater continuity.²⁰

Young adults and adolescents

- 6.23 Young adults and adolescents have specific health needs related to their developmental status. These need to be acknowledged and appropriately addressed. Although emerging adults have similar logical competencies as adults, they have different social and emotional factors which contribute to differences in decision-making, risk-taking and health-seeking behaviour. Recent neuroscientific advances reveal that adolescent brain development continues into the mid twenties. It is essential to adopt a developmentally appropriate approach in adult care whenever adolescents and young adults present.
- 6.24 The health of young people, as distinct from that of children and adults, has received increasing recognition in national policies and guidance with an emphasis on 'transition'. However, implementation is patchy. There are particular problems in acute settings when adolescents and young adults 'crash-land' into hospitals which are unfamiliar with managing their particular medical condition. Many young adults over the age of 16 are admitted acutely unwell and diagnosed with a condition for the first time. These are not part of any 'transitioning' group. The needs of this group are rarely acknowledged although they make up a considerable proportion of the age group using health services. These life-changing events and how healthcare staff manage young adults have an impact on health-seeking behaviour that is life-long.
- 6.25 The age group 16–24 years accounts for 12% of the UK's resident population. Between 1996 and 2010, emergency admissions among 16- to 19-year-olds increased by a dramatic 43%. Hospital admissions among 10- to 19-year-olds for diabetes, asthma and epilepsy – the three most common long-term conditions affecting young people – have increased by more than 26% over the past eight years.²¹ In adolescent-onset cancer, mortality rates have failed to see the improvements observed in childhood and/or adult cancer. Data show that renal transplant survival falls off in young adults by as much as a third compared with children. For young people with childhood onset long-term conditions such as diabetes, transfer to adult care can be associated with far worse outcomes. The national diabetes audit²² noted that mortality is highest in people with diabetes aged 15–35 although the causes cannot be identified. Rates of depression are disproportionately high in this age range. The 'You're welcome' quality criteria provide robust generic standards.²³ These are useful in objective assessment of health-service provision as a benchmark which can be audited against. There are very few incentives for trusts to take any notice of them in the presence of other competing priorities.

- 6.26 Adolescents and young adults who require admission have shorter lengths of stay, high rates of self-discharge and are more likely to have most or all of their inpatient care in the Acute Care Hub. Hospital admission may offer only a short window for acute care staff to assess and treat the patient and liaise with the appropriate specialist service. These staff in particular would benefit from additional training and competencies to improve management of this patient group, build rapport and identify their needs, thus helping to improve compliance with specialist follow-up arrangements in outpatients or ambulatory emergency care facility. For many of these patients early involvement of the general practice team or specialist staff, either in tertiary centres or in the community, can help the young person navigate the health system. This will also shorten length of stay, reduce the need for readmission and improve continuity and coordination of care.
- 6.27 Identify a single point of contact/key person in secondary care who can coordinate the other healthcare professionals. Specialist nurses are crucial and underpin the success of many adolescent/young-adult units. Ensure better communication between tertiary and secondary care. Consider the use of personal care plans for emergencies.
- 6.28 Transition as a process can improve the continuity of care from paediatrics to adult care. Part of the preparation must include what to expect on admission to an adult ward: the role of parents/guardians and the support needed for them, as well as for young people who need to gain their independence over a time period at a pace that they can cope with.

References

- 1 *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005 – March 2009*. Chaired by Robert Francis QC. London: Stationery Office, 2010.
- 2 Cornwell J, Levenson R, Sonola L *et al*. *Continuity of care for older hospital patients: a call for action*. London: Kings Fund, March 2012 [http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/continuity-of-care-for-older-hospital-patients-mar-2012.pdf]
- 3 Lievesley N. *Ageism and age discrimination in secondary health care in the United Kingdom: a review from the literature*. London: Centre for Policy on Ageing, 2009.
- 4 Tadd W, Hillman A, Calnan S, *et al*. NIHR Service Delivery and Organisation Programme 2011. *Dignity in Practice: An exploration of the care of older adults in acute NHS Trusts*. www.bgs.org.uk/pdf/cms/reference/Tadd_Dignity_in_Practice.pdf [accessed 29 August 2013].
- 5 Care Quality Commission. *Dignity and Nutrition Inspection Programme: national overview*. Newcastle upon Tyne: Care Quality Commission, 2011.
- 6 Goodrich J, Cornwall J. *Seeing the person in the patient: the point of care review paper*. London: The King's Fund, 2008.
- 7 The King's Fund. *Continuity of care for older hospital patients. A call for action*. London: The King's Fund, 2012.
- 8 Royal College of Physicians. *Membership engagement, benefits and publications research*. Research by Design Ltd. London: RCP, 2012. www.rcplondon.ac.uk/press-releases/quarter-physicians-say-continuity-care-poor-their-hospital [accessed 29 August 2013].
- 9 Covinsky KE, Pierluissi E, Johnston CB. Hospitalization-associated disability: 'She was probably able to ambulate, but I'm not sure'. *JAMA* 2011;306:1782–93.
- 10 National inpatient survey (2011). www.nhssurveys.org/survey/1016 [accessed 6 August 2013].
- 11 Royal College of Physicians. *Acute care toolkit 3. Acute medical care for frail older people*. London: RCP, 2012.
- 12 Ellis G, Whitehead MA, Robinson D, O'Neill D, Langhorne P. Comprehensive geriatric assessment for older adults admitted to hospital (review). *Cochrane Database Syst Rev* 2011;(7):CD006211.
- 13 Ellis G, Whitehead MA, Robinson D, O'Neill D, Langhorne P. Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials. *BMJ* 2011;343:d6553.

- 14 Silverstone P. Prevalence of psychiatric disorder in medical inpatients. *J Nerv Ment Dis* 1996;184:43–51.
- 15 Parsonage M, Fossey M, Tutty C. *Liaison psychiatry in the modern NHS*. London: Centre for Mental Health, 2012.
- 16 Chang C-K, Hayes RD, Perera G *et al*. Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. *PLoS ONE* 2011;6(5):e19590.
- 17 Department of Health. *Healthcare for single homeless people*. London: DH Office of the Chief Analyst, 2010. www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/Healthcare_for_single_homeless_people.pdf [accessed 6 August 2013].
- 18 The Faculty for Homeless Health, College of Medicine. www.londonpathway.org.uk/uploads/homeless_health_standards.pdf [accessed 6 August 2013].
- 19 Pathway: Healthcare for homeless people. www.pathway.org.uk [accessed 2 September 2013].
- 20 Hewett N, Halligan A, Boyce T. A general practitioner and nurse led approach to improving hospital care for homeless people. *BMJ* 2012;345:e5999.
- 21 Hargreaves DS, Viner RM. Children's and young people's experience of the National Health Service in England: a review of national surveys. *BMJ* 2012;97:661.
- 22 National Diabetes Audit. www.hscic.gov.uk/nda
- 23 Department of Health. *You're welcome: quality criteria for young people friendly health services*. London: DH, 2011. www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services [accessed 6 August 2013].

Summary of recommendations for specific services (for older people with frailty, people with mental health conditions, people who are homeless, and young people and adolescents)

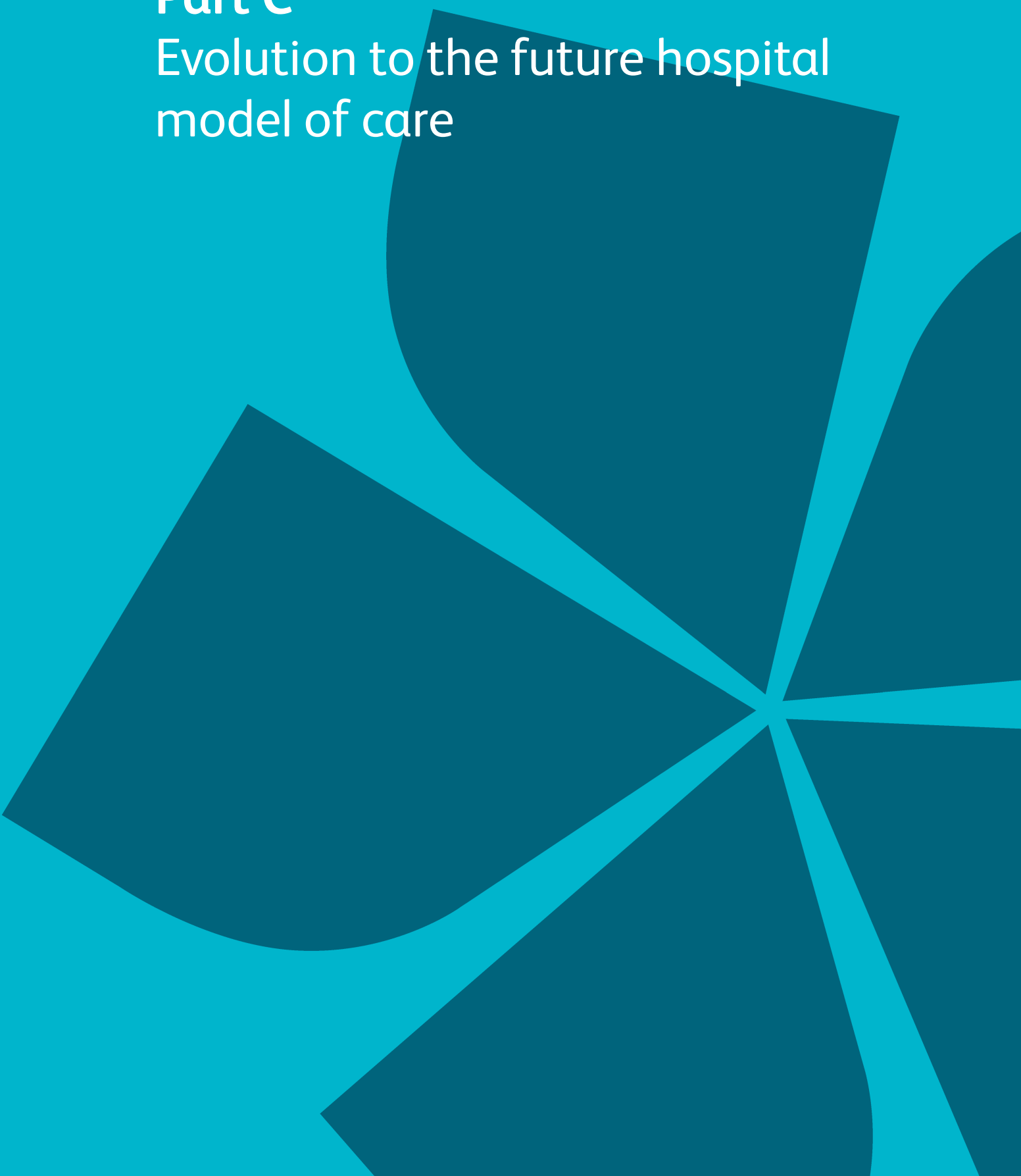
- 1 **Perform a comprehensive geriatric assessment on older people with frailty arriving at hospital as a medical emergency** (see paras 6.9–6.11).
- 2 **Develop liaison psychiatry services to improve services for people with mental health conditions** (see paras 6.13–6.18). It is recommended that:
 - i All general and acute hospitals should have a dedicated on-site liaison psychiatry service. This service should cover all wards and the emergency department / acute medical unit 7 days a week, for a minimum of 12 hours a day, with appropriate access out of hours.
 - ii Physicians must offer a liaison service to mental health trusts, to meet the need of patients with severe mental illness and medical comorbidities.
 - iii Rapid access to specialist psychiatric support should be a priority for emergency referrals, where patients are an immediate risk to themselves, other patients or staff, including those admitted following self-harm.
 - iv Priority should also be given to other patients throughout the hospital where mental health assessment is needed to guide clinical management decisions such as further investigation or treatment or where a patient is considered medically fit for discharge.
- 3 **Develop services that deliver coordination, enhanced access and advocacy for other vulnerable groups.**
 - i **People who are homeless.** Hospitals should develop models of care that deliver for people who are homeless by developing services that embed core standards.^a (See paras 6.19–6.22.)
 - ii **Young people and adolescents.** Hospitals should develop models of care that deliver for young people and adolescents by developing services that embed core standards.^b (See paras 6.23–6.28.)

^aThe Faculty for Homeless Health, College of Medicine. www.londonpathway.org.uk/uploads/homeless_health_standards.pdf [accessed 6 August 2013].

^bDepartment of Health. *You're welcome: quality criteria for young people friendly health services*. London: DH, 2011. www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services [accessed 6 August 2013].

Part C

Evolution to the future hospital model of care



Evolution to the future hospital model of care

Introduction

In order to achieve the new model of care described in Part B of this report, there must also be a range of other changes to the way we plan, design, deliver and support hospital services. Evolution to the new model demands a renewed focus on the needs of patients. Current and future patient needs must underpin all aspects of service design: from the way medical professionals train and work, to how information is gathered, used and shared; from managerial and financial structures, to the way staff are supported to deliver the standard of care all patients deserve.

This part (Part C) of the Future Hospital Commission report recommends fundamental changes to the education, training and deployment of medical professionals (chapter 7). It proposes changes to the way we manage and fund hospital services in order to support the new model of clinical care for medical patients (chapter 8) and makes recommendations that aim to build an innovative NHS (chapter 10). It recommends a movement towards new health service information systems focused on facilitating expert, tailored care for individual patients and driving quality improvement (chapter 9). It closes by focusing on the central thread of the Future Hospital Commission report: how hospitals and professionals can build a patient-centred culture in which all are treated with compassion and respect (chapter 11).

The specific recommendations contained in each of these chapters are intended as a 'road map' to achieve the Future Hospital Commission's long-term vision for our hospitals. This overarching vision articulates the key components that must underpin hospital services in the future.

Our vision of the future hospital – evolution to the future hospital vision of care

- 1 **The medical workforce meets the needs of patients across the system:** Medical education and training will develop doctors with the knowledge and skills to manage the current and future demographic of patients. This includes the expertise to manage older patients with frailty and dementia, and lead and coordinate the ‘whole care’ of patients in hospital and into the community. Across the overall physician workforce there will be the skills mix to deliver appropriate: specialisation of care (ie access to sufficient specialty expertise to deliver diagnosis, treatment and care appropriate to the specific hospital setting); intensity of care (ie access to sufficient expertise to manage, coordinate and deliver enhanced care to patients with critical illness); and coordination of care (ie access to sufficient expertise to coordinate care for patients with complex and multiple comorbidities). Most physicians, whatever their specialty, will possess and deploy a combination of these skills across their careers.
- 2 **Internal medicine is valued and promoted:** The importance of acute and (general) internal medicine is emphasised from undergraduate training onwards, and acute and (general) internal medicine is attractive to doctors at all stages of their careers. A greater proportion of doctors are trained and deployed to deliver expert (general) internal medicine care, developing the knowledge and expertise necessary to diagnose, manage and coordinate continuing care for the increasing number of patients with multiple and complex conditions. The contribution of medical registrars is valued, and they are supported by structured training in (general) internal medicine, increased participation in acute services and ward-level care by all medical trainees and consultants, and enhanced consultant presence across 7 days.
- 3 **Clinical workloads are regularly reviewed:** Workforce planning is undertaken with an appreciation of clinical demand and the professional skills mix required to meet this demand. Attention is paid to variation in demand and peak time of day to ensure staffing can adequately meet the demand. The organisation of workloads and allocation of tasks are underpinned by a clear understanding of professional roles and responsibilities.
- 4 **Non-elective medical care is prioritised:** Management structures, financial models and leadership roles will be designed to support and enhance the delivery of high-quality non-elective and urgent care, and embed strong clinical leadership.
- 5 **Information is used to support care and measure success:** Clinical records will be patient-focused and contain accurate, high-quality information on patients’ clinical and care needs. Information will be held in a single electronic patient record, developed to common standards and viewable in both the hospital and community in order to support the coordination of care.
- 6 **Hospitals and the healthcare system are innovative and research-driven:** Research – and staff involvement in research – is valued and supported at the highest level in the hospital, and the opportunity to participate is promoted to patients.
- 7 **Fundamental standards of patient care will always be met:** The principles of basic patient care will underpin the design and delivery of all hospital services and professional practice. Patients will always:
 - i be treated with kindness, respect and dignity, respecting privacy and confidentiality
 - ii receive physical comfort including effective pain management

- iii receive proper food and nutrition and appropriate help with activities of daily living
- iv be in clean and comfortable surroundings
- v receive emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on themselves, their families and their finances.
(*Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chaired by Robert Francis QC. London: Stationery Office, 2013.)

8 A patient-centred culture will operate, delivering compassion and respect for all patients: Hospital services and professional practice will be based around ten core principles:

- i **Patient experience is valued as much as clinical effectiveness.** Patient experience is measured, fed back to ward and board level, and findings acted on.
- ii **Responsibility for each patient's care is clear and communicated.** This is led by a named consultant working with a (nurse) ward manager.
- iii **Patients will have effective and timely access to care.** Time waiting for appointments, tests, hospital admission and moves from hospital will be minimised.
- iv **Patients will not move wards unless this is necessary for their clinical care.** Care, including the professionals who deliver it, will come to patients.
- v **Robust arrangements for transfers of care will be in place.** These arrangements will operate between teams when a patient moves within the hospital, between teams when staff shifts change, and between the hospital and the community.
- vi **Good communication with and about patients will be the norm.** This will include appropriate sharing of information with relatives and carers.
- vii **Care will be designed to facilitate self-care and health promotion.** Patients will have access to information, expert advice and education, and will be empowered to manage their care by trained staff.
- viii **Services will be tailored to meet the needs of individual patients,** including vulnerable patients. The physical environment will be suitable for all patients (eg those with dementia); services will be culturally sensitive and responsive to multiple support needs.
- ix **All patients will have a care plan that reflects their specific clinical and support needs.** Patients will be involved in planning their care. Patients, their families and carers will be supported by expert staff in a manner that enhances dignity and comfort.
- x **Staff will be supported to deliver safe, compassionate care and will be committed to improving quality.** Hospitals will support staff to take individual and collective ownership of the care of individual patients and their contribution to the overall standard of care delivered in the health system in which they work.

9 Doctors will embed the principles of medical professionalism in their daily practice: Medical professionals are committed to integrity, compassion, altruism, continuous improvement, excellence and working in partnership with members of the wider healthcare team (Royal College of Physicians' *Doctors in society*, 2005). Doctors assume clinical leadership (at individual patient and system level) for the care patients receive across specialties, across settings and across all domains of quality, eg safety, clinical outcomes and patient experience. This includes responsibility to raise questions and take action when there are concerns about care standards; communicate effectively with patients, their families and carers, and empower them through effective collaboration; and collaborate with other teams and professions to make sure patients receive smooth and effective care throughout the health and social care system.

7 The changing workforce: meeting the needs of patients across the system

The medical workforce: current pressures and constraints

- 7.1 In future, responsibility for the delivery of care must be assumed by trained practitioners (see appendix 6: Medical workforce explained). Ensuring continuity of care and moving towards integration of hospital and community healthcare provision 7 days a week in a sustainable fashion will be primary objectives.
- 7.2 However, recruitment of doctors into certain medical specialties has become increasingly difficult. Competition ratios for applications to core medical training (CMT) are lower than any other hospital-based specialty and are roughly equal to those for general practice. Only 27% of Foundation year 2 doctors wish to pursue a career in hospital medicine, the majority (81.4%) citing the adverse work–life balance of medical registrars as a major deterrent.¹
- 7.3 Only 76.5% of core medical trainees definitely plan to continue in hospital medicine and some 8.5% of medical registrars plan to leave the medical profession completely.¹ Their role is increasingly seen as difficult, onerous and poorly supported – suffering a lack of clarity as to what is expected of them with significant variability from trust to trust.
- 7.4 Medical registrars cite the following as valued experiences: leadership and caring for acutely unwell patients, the large diversity of clinical problems encountered on call, the unpredictability of the medical take, training junior members of the team and working together with others to achieve a common goal. Most feel that their time out of hours was when they had the greatest opportunity to affect patient care through executing their role as the senior clinical decision-maker for the whole trust. Advising non-medical specialties, such as surgical teams, the emergency department and GPs, are seen as priorities which provide valuable training opportunities.¹
- 7.5 Excessive workload is the most common reason cited by junior doctors for not wanting to be a medical registrar. Some 25% of medical registrars describe their workload as ‘unmanageable’ and 66% describe it as ‘heavy’.¹ The appointment has become less desirable in terms of work–life balance. Although the number of hours that junior doctors can work in the UK is unlikely to change, there has been a steady increase in hospital admissions over the past decade, and a majority of medical registrars believe that the volume and intensity of their workload while on call can be overwhelming.

Achieving a balance of holistic and specialist care: the importance of team working and leadership

- 7.6 Fragmented care is bad care. Fragmented teams undermine continuity of care for patients, which often has a detrimental impact on clinical outcomes, patient experience and efficiency. Medical registrars recognise the importance of knowing the members of the team they work with. The introduction of shift working has reduced or minimised continuity of staffing within medical teams. Furthermore, effective leadership and supervision are difficult when the capabilities and/or training needs of junior colleagues are unknown and change frequently.¹
- 7.7 A common perception among medical registrars is that in most hospitals there is no senior leadership for (general) internal medicine, the service that is delivered largely by the team undertaking the acute medical take, or by isolated individuals. As such, support and encouragement in acute and general medical training and service delivery are perceived to be lacking. Registrars have reported that, when they tried to approach their seniors to report problems or suggest solutions, they were not listened to and their concerns were not acted upon.¹

A new focus on general medicine in the hospital and community settings

- 7.8 Acute and (general) internal medicine need to be made more attractive to doctors at all stages of their careers (see appendix 4, pp153–4). The competencies possessed by consultants in both specialties (together with those of intensive care medicine) render them fit to lead, manage and/or deliver care across the whole care pathway. Those with acute care competencies may be more suited to work within the acute medical unit, whilst those trained in (general) internal medicine may undertake the delivery of ward care (see paras 3.39–3.47 and appendix 4, p154). Clearly, intensivists will manage those patients with the highest levels of dependency, providing outreach and support to colleagues in other areas of the pathway.
- 7.9 The breadth of clinical experience conferred by training in acute and general medicine, coupled with the broad view of care, means that assuming this responsibility (within the Medical Division (MD, paras 3.1–3.7) and associated management structure, headed by a (generalist) chief of medicine (see paras 3.27–3.28)) should afford both prestige and opportunities for career development likely to engender ambition in trainees (see Part B).
- 7.10 The Medical Division will have overall responsibility for all patient beds, excluding child health and obstetrics (see chapter 3). There will be increased medical consultant involvement, and responsibility for patients with medical problems based in other areas of the hospital, including surgical wards. The trained (and therefore trainee) workforce implications of assuming this approach need to be modelled (see paras 3.39–3.46).
- 7.11 In particular much more integrated working of physicians with consultant surgeons on ‘surgical’ wards may evolve to co-management of patients or even consultant physicians becoming largely responsible for ongoing inpatient care (see paras 3.18–3.19). Many wards could lose their designation as ‘surgical’, with patients placed in ward areas primarily according to their acuity of illness. This would have major implications for surgical trainees. Potentially all but the more

senior trainees would be redeployed to physician-supervised duties and re-aligned to medical training, expanding the pool of trainees within a single training programme available to look after patients on almost all hospital wards.

- 7.12 Workforce planning should be undertaken with an appreciation of the clinical demand and the skillmix required to meet this demand (see appendix 4, pp154–5). Attention needs to be paid to the variation in demand and the peak times of day or week to ensure that staffing can adequately meet that demand. The RCP’s acute care toolkit 4, *Delivering a 12-hour, 7-day consultant presence on the AMU*, makes recommendations on consultant staffing and working practice according to workload.²
- 7.13 The Medical Division will devise and promote clear guidance on care pathways. This will mandate specialty input and anticipated specialty response at the appropriate levels (eg practitioner’s assistant, advanced nurse practitioner, registrar, consultant). The Medical Division will require each group of specialists to support and upskill their acute and general medical trainees, and trained colleagues, through regular consultation, case discussion and more formal educational channels (see paras 4.11–4.14).
- 7.14 Care must be delivered seamlessly across the primary, secondary and social environments, and be reflected in individualised care plans for patients (see chapters 5 and 11).

What does this model mean for medical education and training?

- 7.15 Medical education and training must evolve to respond to the changing needs of the population and the healthcare workforce. Different adjunct training, for example in the potential and use of information technology (see chapter 9) and genomics, will become essential knowledge for hospital and community-based practitioners in the future. Learning how to respond to patient feedback, focusing on compassionate care, reflective clinical practice and skills in shared decision-making are also essential. Lifelong learning skills and access to mentoring will be important systems for continuing professional development.
- 7.16 The curriculum of undergraduate training (at medical school) must emphasise the importance of acute and (general) internal medicine. Community placements for medical students and trainees will be required. Such a broad-based training programme might include acute and/or (general) internal medicine, community care, psychiatry and general practice. Consideration should be given to when community care rotations, supervised by specialists, are most useful for trainees and patients. This may be later in training. Most training for any doctor should occur in the setting in which they will eventually be primarily working. This may mean partly community and secondary care environments for physicians, rather than tertiary care centres.
- 7.17 At the undergraduate level, extended clinical placements under the umbrella of generalism, possibly in the third year of 5 years and second year of graduate entry programmes, which includes both hospital and community practice (including primary care), would be highly desirable. The establishment of the Medical Division would facilitate such an approach. The expectation that most physicians will become highly specialised in a narrow field must be changed. The recognition that 7-day working is a requirement of all medical practitioners must be reinforced (see appendix 4, pp151–2).

- 7.18 In the short term, expansion of existing training opportunities in acute and (general) internal medicine will be needed as increased participation in service provision and education in acute and/or (general) internal medicine will become a requirement for all medical specialties. In the longer term, the option of a certificate of completion of training in (general) internal medicine should be explored. This would involve a remodelled training pathway in which all trainees focus either on acute or (general) internal medicine before specialisation occurs.

Non-clinical core skills for medical professionals: clinical leadership

- 7.19 Doctors should be committed to integrity, compassion, altruism, continuous improvement, excellence and working in partnership with members of the wider healthcare team. There should be a move away from outmoded notions of mastery, autonomy, privilege and self-regulation.³ Consequently, doctors must commit to leadership in health in order to accelerate improvement in health outcomes and instigate this cultural shift⁴ (see chapter 11 and box 4, para 2.30). The Faculty of Medical Leadership and Management was established in 2011 and is a UK-wide organisation that aims to promote the advancement of medical leadership, management and quality improvement at all stages of the medical career for the benefit of patients.
- 7.20 There is therefore a clear need for an effective institutional framework that will allow doctors to be active participants in shaping the landscape of healthcare, and not simply passive responders to prevailing circumstances. Doctors, as stewards of quality, must be able and empowered to take on a greater role in health service management and leadership. Medical leadership exists across four distinct levels: the individual doctor, the front-line clinical team, the local service entity (NHS or others) and the national policy stage.
- 7.21 Medical leaders have to apply the principles of evidence-based decision-making to their work even if this isn't in their individual interest. Medical leaders are supported by peer networks and appropriate education and training, in line with the Medical Leadership Competency Framework (MLCF).⁵
- 7.22 The development of competence in leadership has been a requirement for doctors since the MLCF was incorporated into both undergraduate and postgraduate curricula in 2009 and 2010 respectively. The MLCF is based on the concept of shared leadership, where leadership is the responsibility of everyone, and it sets out the leadership competencies that doctors need to become more actively involved in the planning, delivery and transformation of health services.
- 7.23 Trainees can use everyday situations to learn these skills and trainers and educational supervisors can use the MLCF to enable opportunities for learning. One approach is to look at the different activities of a team or department. This might include projects about quality improvement,* patient safety, risk management, complaints, guidelines, audit, improving efficiency, improving

*The RCP's Learning to Make a Difference project which supported trainees to undertake a Quality Improvement project has been highly successful and is being expanded. As well as identifying opportunities for improvement, feedback is that participation in these types of project also support the development of leadership skills in trainees. www.rcplondon.ac.uk/projects/learning-make-difference-ltmd [accessed 16 July 2013].

training or work on patient experience. These activities are a rich source of work-based learning opportunities, and have a considerable impact on the care given to patients.

Information technology and education and training

- 7.24 Accurately recorded data on activity, diagnoses and procedures can inform the assessment of trainee activity and performance. Training in record-keeping based on an approved, standardised and structured format should be included from the earliest stages in medical school.
- 7.25 Informatics training for clinicians is vital to enable them to make effective use of information and information systems (see chapter 9). There is a need for all clinicians to be competent in the use of electronic health records, information governance and appropriate sharing of information, and the use of aggregated clinical information. The value of coded data should also be covered, for example it is important that junior doctors understand that mortality statistics are derived from death certificates, hence the importance of accurate and detailed coding of cause of death.
- 7.26 There is also a need for specific training and development for clinicians working with telehealth, including tele-consultations, so that they are able to change working practices to make both safe and effective use of these technologies.
- 7.27 The role of the chief clinical information officer (CCIO) (see para 3.33) is still evolving and needs to be clearly defined and promoted. The main competencies required to fulfil this role need to be identified, and training made available to enable clinicians to develop the skills required. The appointment of CCIO (and associate, deputy etc) should attract prestige, authority, support, and terms and conditions of service that make it a highly desirable career aim.
- 7.28 Patients and carers need to be aware of the availability of patient portals and other new ways of accessing their records and communicating with their clinicians. They may also need support and guidance on how to use shared and patient-controlled records safely and effectively.

References

- 1 Royal College of Physicians. *The medical registrar: Empowering the unsung heroes of patient care*. London: RCP, 2013.
- 2 Royal College of Physicians. *Acute care toolkit 4. Delivering a 12-hour, 7-day consultant presence on the acute medical unit*. London: RCP, 2012.
- 3 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. Report of a working party. London: RCP, 2005.
- 4 Royal College of Physicians. *Future physician: changing doctors in changing times*. Report of a working party. London: RCP, 2010.
- 5 NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges. *Medical leadership competency framework: enhancing engagement in medical leadership*, third edition. Coventry: NHS Institute for Innovation and Improvement, 2010.

Summary of recommendations for the changing workforce

Short term (0–6 months)

- 1 Assess how the current medical workforce needs to adapt to deliver the future model of care required by patients.**

Responsibility for the delivery of care must be assumed by trained practitioners. The medical workforce will need to adapt to ensure it can meet demographic pressures, and deliver continuity of care, 7-day services, and integration of hospital and community healthcare in a sustainable fashion. The shape and skill set of the workforce required must then be defined at a national and local level (see paras 7.8–7.12).

Medium term (6–24 months)

- 2 Medical consultants should allocate appropriate time to working in acute and/or (general) internal medicine in the Medical Division.**

The role, time commitment and management/clinical supervision of those working and training in acute and/or (general) internal medicine in the Medical Division should increase. A majority of medical consultants who are experienced in acute and/or (general) internal medicine must allocate an appropriate time (estimated at 20–25 %) working in these areas to provide leadership, supervision, education and training. The proposed new model of care will be adopted simultaneously by the medical specialties, where there are examples of improvements in patient care and efficiency. (See paras 7.8–7.13. See also paras 3.39–3.47 and chapter 4.)

- 3 Expand the number of trainees working in acute and (general) internal medicine in the Medical Division.**

There should be planned growth in numbers of trainees in acute and (general) internal medicine. In addition to this, curricula and time allocations to (general) internal medicine in the medical specialties should be changed to increase participation in the planned Medical Division, within a timescale of 2 or 3 years (see paras 7.11 and 7.15–7.18).

Longer term (2–5 years)

- 4 Dual training with (general) internal medicine should be the norm across the physicianly specialties.**

Participation in (general) internal medicine will be mandatory for those training in all medical specialties. The model of a Medical Division assuming overall leadership and responsibility for the delivery of care is designed in part to facilitate and promote the development of (general) internal medicine and chronic disease management and multi-morbidity (see para 7.18).

- 5 Promote and develop (general) internal medicine as a specialty of standing equal to all other medical specialties.**

(General) internal medicine should be promoted as a valuable and attractive career option, alongside acute and intensive care medicine. The mechanisms for doing this – and ensuring (general) internal medicine, acute medicine, emergency medicine, intensive care medicine, geriatric medicine, etc remain attractive career options – should be explored. This would complete the senior workforce needed for the delivery of the care pathway (see para 7.8 and appendix 4, pp153–4).

- 6 Develop a more structured training programme for (general) internal medicine.**

In the future, the GMC-approved curriculum for (general) internal medicine should be applied to all training posts in physicianly specialties. This would be modified in time to encompass significant

appointments in community-based and primary care, and surgical and obstetric wards within the hospital environment. Increased liaison with anaesthetists in the pre-operative assessment of patients, providing support for enhanced care areas, and a clear interface with the existing specialties of acute medicine and care of older people are anticipated. Key competencies would involve leadership and coordination of patient care across different physical areas and specialties and chronic disease management (see para 7.13).

7 Consider developing the position of chief resident within all acute hospitals.

The chief resident, a trainee doctor, would act in a liaison role between medical staff in training working in the Medical Division and the chief of medicine and senior clinical managers. This leadership development post would have a key role in planning the workload of medical staff in training, medical education programmes and quality improvement initiatives (see paras 3.36–3.37).

8 Evaluate, develop and incorporate other medical roles into the future hospital model.

- i The staff and associate specialist grade should be evaluated, developed and incorporated into the future clinical team in a role and at a level of responsibility appropriate to their competencies.
- ii The roles of advanced nurse practitioner and physician's associate should be evaluated, developed and incorporated into the future clinical team in a role and at a level of responsibility appropriate to their competencies (see appendix 6).

8 Management: prioritising non-elective medical care and developing relevant tools

Costing, funding and payment

- 8.1 Any proposed new model of care will need to be applied within the context of financial constraints currently facing the NHS (2013). Additional funding is unlikely to be available in the near future. The focus on elective care within the current system has meant that not enough attention has been given to emergency care. Funding models structured around what happens in elective care do not work well for emergency care, and are likely to need a different approach. The application of these funding models to emergency care has effectively meant that it has been chronically underfunded in relation to elective care. Consequently, while maintaining the gains made in elective care, we need to rebalance resource allocation to prioritise non-elective and urgent care. To be sustainable, this will need to be accompanied by the development of new funding models that do not favour elective and procedural services at the expense of urgent care.
- 8.2 Different contexts, services and conditions require different payment approaches. For example, in England, Payment by Results (PbR) has been found to be more applicable to elective care and less suited to acute care.¹ Evidence supports the analysis that activity-based payment systems (of which PbR is one example) work better for straightforward elective conditions, but do not work well for complex emergency patients with multiple conditions. This sort of payment system tends to increase fragmentation of care, reduce coordination and increase costs. Systems must also be flexible and adjusted in the light of experience of their impact, changing objectives according to the context in which they operate.¹ Further developments in payment approaches will need to be supported by high-quality data and analysis. Any system that is not underpinned by reliable data and analysis will lack compliance or risks leading to unintended and unwanted consequences.¹
- 8.3 In recognising this need for variation, examples of the different funding models currently being developed in the NHS include the so-called Year of Care Funding Model. This aims to deliver integrated health and social care for people with long-term conditions by providing an annual budget based on the level of need, to cover all the care episodes a patient receives over a period of 12 months. This is currently being trialled by the Department of Health.² By contrast, the Pathway Funding Model sets prices in relation to a bundle of services covering an episode of care involving a number of providers (eg maternity pathway).¹

- 8.4 Underpinning this are the efforts of Monitor (the NHS England economic regulator) to develop Patient-Level Information and Costing Systems (PLICS) that will combine activity, and financial and operational data to more accurately price individual episodes of patient care.³

Clinical leadership in financial and operational management

- 8.5 The chief of medicine (paras 3.27–3.38) must have the financial and operational management authority and responsibilities necessary to facilitate service development that will improve patient care, and identify and implement efficiency initiatives. This must include cooperation with non-clinical managers – greater hospital efficiency is associated with stronger cooperation between general managers and doctors.⁴
- 8.6 Clinical leadership at board level in NHS trusts significantly improves quality outcomes.⁵ The NHS needs to foster medical professionalism and leadership, with doctors as active participants in shaping the landscape of healthcare, working within a motivated and committed workforce, and demonstrating professionalism and leadership within healthcare teams (paras 7.19–7.23 and chapter 11).

Service-line management

- 8.7 Service-line management, as outlined by Monitor, provides key principles that could broadly be applied via an organisational structure that allows clinical service lines to operate as an autonomous business unit, with clear accountability and decision-making, together with strategic and annual planning processes that support clinicians and managers to set, monitor and achieve short- and long-term service objectives.
- 8.8 Effective performance management systems and timely, relevant information provides the financial and operational picture for each service line and ensures informed decision-making.⁶ This needs to be underpinned by a strong service-line reporting system that gathers and analyses information in a timely way and genuinely devolves responsibilities⁷(see footnote on page 88). Service-line reporting will only work if the money is in the right place to start with and the misalignment of resources between non-elective and elective services is rebalanced. A reconsideration of the board's role and engagement with clinical leaders about their changed role and responsibilities, supported by appropriate training, will be needed.⁸
- 8.9 For most acute trusts the income and expenditure associated with non-elective services is likely to form the largest proportion of overall resources consumed by the organisation. It is only in those hospitals with large tertiary/elective services that this financial pattern is less significant.
- 8.10 Despite this feature of financial distribution it is still argued that funding through the commissioning processes is poorly aligned with the actual demands of the service. In short, current funding models for hospitals favour elective and procedural services over the delivery of general urgent care. The latter should form a much greater proportion of total income with consequent potential resource for these functions. Furthermore, service-line reporting probably rightly discourages the notion of cross-subsidies and therefore reduces the opportunities for internal redistribution of resources from elective to non-elective (should finances allow) to mitigate the misalignment of service income.⁸

- 8.11 The causal factors behind this misalignment issue are complex. First, the tariff is underpinned by the collection of hospital reference costs. Where services are more clearly definable (eg single condition/elective/procedure-based) in designated units (eg endoscopy units, cardiology units), the resources attached to these activities are more clearly attributable.⁹ This encourages a tendency, not necessarily a deliberate one, to make these services the default areas for cost attribution. For example, cardiologists are allocated to their base ward/unit and any general ward support/provision time is not necessarily reallocated. This may also apply to associated indirect and other overhead costs. The result is that in general acute care reference costs are under-weighted, which is less well coded and defined and becomes a reflection of residual costs. These reference costs, with their inherent bias, are then translated ultimately into tariffs.
- 8.12 Following this tendency to relatively under/over cost, the application of commissioning rules has exacerbated the situation. For clear elective national tariff-based activities, there is encouragement for providers to expand activity because the price per unit is strong and largely volume based. On the other hand, complex acute care is difficult to clinically code in depth and is usually part of some block arrangement – the latest national guideline setting volumes at 2008/09 levels with 30% marginal commissioner payment rates.¹⁰
- 8.13 It is crucial that these funding anomalies are resolved either through general improvement in coding and costing methodology, normative adjustments to tariff based on best practice, and/or local determination based on optimum patient care as agreed between commissioners and providers.

References

- 1 The King's Fund. *Payment by Results. How can payment systems help to deliver better care?* London: The King's Fund, 2012. www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf [accessed 16 July 2013].
- 2 Department of Health. *QIPP long-term conditions. Supporting the local implementation of the Year of Care Funding Model for people with long-term conditions.* London: DH, 2012. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133652.pdf [accessed 16 July 2013].
- 3 Monitor. *Costing patient care: Monitor's approach to costing and cost collection for price setting.* London: Monitor, 2012.
- 4 Nuffield Trust. *Can NHS hospitals do more with less?* London: Nuffield Trust, 2012.
- 5 Veronesi, G, Kirkpatrick, I, Vallascas, F. *Clinicians in management: does it make a difference?* Leeds: Leeds University Business School, 2012.
- 6 Monitor: Service-line management. www.monitor-nhsft.gov.uk/home/our-publications/browse-category/developing-foundation-trusts/service-line-management [accessed 16 July 2013].
- 7 Bohmer RMJ. The four habits of high-value health care organizations. *N Engl Med* 2011;365:22.
- 8 The King's Fund. *Service-line management: can it improve quality and efficiency?* London: The King's Fund, 2012.
- 9 Monitor. *An evaluation of the reimbursement system for NHS-funded care. Report for Monitor.* London: PwC, 2012. www.monitor-nhsft.gov.uk/sites/default/files/Evaluation%20Report%20-%20Full%20Report%20FINAL.pdf [accessed 16 July 2013].
- 10 Department of Health. *Payment by results guidance for 2013–14.* London: DH, 2013. www.wp.dh.gov.uk/publications/files/2013/02/PbR-Guidance-2013-14.pdf [accessed 16 July 2013].

Summary of recommendations for management: prioritising non-elective medical care

1 Rebalance resource allocation to prioritise non-elective and urgent care.

This will need to be accompanied by the development of new funding models that do not favour elective and procedural services at the expense of urgent care. The delivery of general urgent care should form a greater proportion of total income. In England, existing funding anomalies must be resolved through general improvements in coding and costing methodology, normative adjustments to tariff based on best practice, and/or local determination based on optimum patient care as agreed between commissioners and providers (see paras 8.10–8.13).

2 Ensure strong service-line management and reporting systems that genuinely devolve responsibility to clinical service lines.

This will need to be accompanied by realigned resources; reconsideration of board role; engagement with clinical leaders about changed roles and responsibilities, including training where necessary (see paras 8.7–8.9).

3 Give the chief of medicine sufficient financial and operational management authority to effect change, with strong cooperation with non-clinical managers (see para 8.5, and paras 3.27–3.38).

4 Develop strong clinical leadership from board level to individual clinical teams (see paras 8.5–8.6, paras 7.19–7.23, and chapter 11).

*This approach aligns with Bohmer's *The four habits of high-value health care organizations*:

- 1 **Specification and planning:** decisions and activities specified in advance and based on explicit criteria, investment in advance planning of subgroups and pathways rather than on the utilisation of expensive resources.
- 2 **Infrastructure design:** microsystems are deliberately designed and integrated to match defined subpopulations and pathways, staff are matched to work by skills and training, management systems are mutually reinforcing.
- 3 **Measurement and oversight:** measurement of clinical operations is primarily used internally (external audiences are a secondary driver), more data are collected than required for external reporting, measurements tend to be developed or refined internally, measurement activities are integrated with other organisational priorities.
- 4 **Self-study/a learning organization:** positive and negative deviance in outcomes is examined, clinical knowledge is treated as an organizational property, a culture that supports learning by encouraging dissenting views is nurtured.

9 Using information to support care and measure success

Clinical information and the delivery of compassionate, effective healthcare: the need for data

- 9.1 Information about healthcare is generated from data collected during clinical interactions and ensures that those who need to know are informed about essential facts and decisions relating to the patient's health and care. Clinicians use the history, basic measures of physiological function and clinical assessment to help them make a diagnosis and to assess response to treatment, supported by data from investigations and feedback from patients. More complex conditions require more detailed measures, but the principles remain the same.
- 9.2 Patient-derived clinical information also has many secondary uses. Clinicians and their teams need data on clinical processes and outcomes in order to audit and improve the quality of care that they deliver and to inform professional regulation and revalidation. Hospital managers and clinical leaders can use aggregated data to monitor and improve the quality of care that their organisations deliver. Regulators, commissioners and the wider public also need access to this information. Importantly, routinely collected clinical data can support research and development (see chapter 10).
- 9.3 Patients need to have access to the content of their record to enhance their understanding of their illness, support shared decision-making and enable them to self-manage their condition(s).
- 9.4 Clinicians should have access to data of sufficient quality to meet professional obligations to audit the quality of care that they and their colleagues deliver, and to work towards constant improvement of care through participation in national clinical audits and other quality improvement activity. They should also routinely access data from patient feedback, complaints and clinical incidents to support wider learning, reflection and quality improvement.

Clinical data collection and uses: the current situation

- 9.5 High-quality, structured and standardised records are the cornerstone of individual care, and the primary source of information about services. Records should be focused on the individual patient, providing a summary that is available to both themselves and the professionals who care

for them, and enabling more detailed specialist data collection where appropriate. Innovative use of information and communications technologies should support the processes of care, with the aim of improving quality, efficiency and the patient experience.

- 9.6 Unfortunately, there is at present inadequate alignment between clinical data collection and its potential uses. Information generated through routine clinical activity is not harnessed appropriately and the precision and quality of recorded data are not fit for many of the purposes outlined above. In many organisations data about a single patient are held in different systems and structures, and use different definitions, thereby severely limiting opportunities for integration and aggregate analysis.
- 9.7 As a result, separate and time-consuming data collection exercises are often currently undertaken for each different purpose. Duplicate data collections may be needed to monitor activity, performance, quality and outcomes; this is inefficient and leads to transcription errors. Organisation-wide measures are often generated centrally, without full understanding of clinical or operational implications. As a result they may be inadequate or misleading.
- 9.8 In the NHS, clinicians have had little input into clinical coding, and routinely generated data have been used mainly to inform financial processes. By contrast, national clinical audit data have had high levels of credibility because they are mostly generated and validated by clinicians. If we are to achieve a single reliable source of data for multiple purposes, record keeping and data definitions must be standardised, including the implementation of SNOMED Clinical Terms (systematically organised, computer processable collection of medical terms) on all clinical information systems. This will enable clinical terms to be automatically coded within computer systems. Clinicians must understand the importance of accurate record keeping, including precise use of clinical terms.

The clinical record: key principles

- 9.9 The primary focus of clinicians is the individual patient. Information and communications technology should aim to improve the quality and safety of care that they deliver, and empower patients to be effective members of their care teams, thus improving their experience. Except in rare circumstances, the information needs of the hospital at every level should be met from data recorded through routine clinical activity. There should be minimal duplication of data collection.
- 9.10 Systems for collecting and recording data should be electronic. Where this is not currently possible it should be a priority to achieve it. In the electronic environment, clinical records must have a standardised structure, so that they can be reused across settings and applications reliably. The RCP Health Informatics Unit has led the development of standards for the structure and content of clinical records. These were approved by 50 organisations representing medical, nursing and allied health professions.¹ We recommend that these standards provide the structure for clinical records, both paper based and electronic, and that they are included as a requirement for procurement of electronic health records (EHRs). The newly established Professional Records Standards Body (PRSB) should become the focus for multidisciplinary record standards in the future.

- 9.11 A unique identifier for patients that is valid across all settings should be mandatory for all clinical records. In England, this is the NHS number. The use of 'hospital numbers' must be phased out as a priority.
- 9.12 Clinical records should be patient focused and the inputs generated in partnership with patients and carers. The quality must be good enough both to inform individual patient care and, when anonymised and aggregated, to facilitate audit, quality improvement, performance assessment, training and research. Clinicians and front-line managers should have need-to-know access to all the information that they need to deliver care to patients as efficiently and safely as possible.
- 9.13 Patients, and where appropriate carers, should be fully engaged in the design and implementation of EHR systems and other digital health tools, and be able to contribute to their record on an ongoing basis through self-monitoring and feedback. Innovation in information and communications technologies should be embraced to improve quality of care and the patient experience. They should also be used to develop new models of care, aimed at keeping patients out of hospital and, wherever possible, enabling care to take place in their own home (see chapter 5).
- 9.14 A single (virtual) patient record should be viewable in both the hospital and community to ensure that the multidisciplinary team supporting the patient has the information necessary to deliver excellent and joined-up care.
- 9.15 Records must be structured and the content coded, so that information that is shared between different EHR systems can be reused. Ideally a single integrated and structured summary record should be available in all sectors. For example, a GP referral containing a structured and coded record of current and relevant previous medications, plus any adverse drug reactions, can save clinician time and improve patient safety if transferred into the hospital admission record.² Electronic communication of referrals, outpatient letters and discharge summaries between primary and secondary care, using structured documents taken from structured records, with coding where appropriate, will enable reuse of information.
- 9.16 Coded data allow reminders and alerts to fire automatically, prompting safer prescribing or better adherence to clinical guidelines. Accurately recorded (and coded) diagnostic terms allow patients to be categorised at higher levels (eg aggregating colophony with other causes of occupational asthma, or asthma with chronic obstructive pulmonary disease (COPD) to identify all patients with chest diseases), for audit, disease registries or identification of patients suitable for research projects. SNOMED Clinical Terms (CTs) should be implemented universally on clinical information systems to enable clinical terms to be automatically coded.
- 9.17 The reporting of clinical incidents via a standardised recording structure should become part of the routine processes of clinical record keeping. The recording of details of adverse events and near misses should become the norm, so that information identifying causes of incidents can be analysed and appropriate mitigating processes put in place. Through this process patients can be informed, increasing transparency and accountability (see chapter 11).
- 9.18 Structured summaries must be employed. Reading lengthy sets of notes can be time-consuming and notes often lack chronology or signposting to items of importance. This system is expensive

for the NHS and poses potential patient safety risks. Scanning and electronic storage of notes has addressed some of these logistic issues, but electronic notes are often simply scanned versions of the paper record with the same usability problems.

- 9.19 Records must be accessible whenever and wherever they are needed in real time, both at the bedside and wherever care is provided in the hospital or community. Within the hospital, this means data recording and access at the point of care, using mobile devices, where appropriate. In the community, it means providing secure online access off the hospital site. It also means supporting care transitions, by sharing information electronically within and between disciplines and care settings.
- 9.20 Standardisation of online health records is essential. Locally agreed or regional standards will disadvantage patients and staff as they move around the country or abroad. National standards are needed to enable cross-border flows with other countries in Europe and internationally. Account should also be taken of the standards for EHRs for web accessibility (BS8878 is the British web accessibility code of practice).²
- 9.21 Clinical leadership in information and information technology should be encouraged and supported, including the appointment at board level of a chief clinical information officer, and board level oversight of development and continuing use of technology to manage, deliver and assess care (see para 3.30, and paras 7.24–7.28).

Case study: Renal Patient View

The renal community provides secure web-based access for patients with kidney disease to their test results and other information from their record, using Renal Patient View (www.renalpatientview.org). There is also a discussion forum and a section through which people can enter their own findings, eg blood pressure, weight.

This service only costs £3.50 per patient per year and has 17,000 registered users, including the vast majority of people with end stage kidney failure.

An evaluation carried out in 2012, by Dr Felix Mukoro on behalf of NHS Kidney Care, reported that patients found it valuable in managing their condition.

Further reading

Renal Patient View: a system which provides patients online access to their test results. Final Evaluation Report. NHS Kidney Care.

In a service user's view: The overriding advantage of Renal Patient View (RPV) is being able to check my blood test results the morning after an appointment, without having to ring the hospital or wait until my next appointment. This is particularly useful at the moment as my kidney is reaching the end of its 'shelf-life', so my blood test results are even more significant in making decisions about my ongoing treatment and, added to advice from my consultant, will help me to decide when it would be appropriate to start dialysis.

The other huge advantage of RPV is that medical staff at other hospitals and clinics have access to my most recent blood test results and my current list of medication. Whilst on holiday, I suffered a deep vein thrombosis on the Isle of Wight and doctors at St Mary's Hospital were able to access and check my recent blood test history before prescribing warfarin.

Technology to improve the patient experience (see also chapter 11)

- 9.22 In some general practices patients have the ability to make appointments and re-order medications online, as well as being able to see their own records. Hospital patients should benefit from similar facilities, enabling them to access a summary of their hospital records from both within the hospital and in the community. The content of this record should be linked to explanatory information, and the record itself should be interactive, enabling individuals to record their own experience and share it with their clinicians. Exactly what data patients want to see in an online hospital record still need to be defined, eg a summary of their contacts with the hospital or a regularly updated management plan. Patients and carers need to be engaged in the design of patient access systems from the outset, to ensure that their needs are met.
- 9.23 Patients should also be able to book appointments, receive reminders and check investigation results online and be able to record/upload their own findings, such as weight or glucose levels. Hospital records should be integrated into a virtual summary patient record that conforms to national standards, and contribute to a single comprehensive summary of the hospital records, so that the patient can see his or her record.
- 9.24 Wider use of email and text would provide alternative means of communication between patient and clinician, eg for consultations or appointment and medication reminders. Providing alternative ways of communicating with the hospital, such as email, phone and text, would improve access to clinical advice and support when patients need it. Early studies suggested that email exchanges took 3 minutes per patient and that fewer face-to-face contacts might result.³ By contrast, a more recent investigation suggested that providing patients with such electronic access to clinicians and their records may not release resources.⁴
- 9.25 Online access, eg via mobile phones, to information about the hospital, such as visiting hours, radio and television channels, shops, religious contacts/services and other hospital activities (eg art exhibitions, music), would also enhance the patient experience. Not only patients and their carers, but also health professionals and system developers would benefit from publication of an agreed set of quality criteria for clinical and health promotion systems and apps.
- 9.26 Using technology to provide support in the community helps keep patients out of hospital, and reduces demand on outpatient services among those with long-term conditions, by enabling self-management and support using telephone/text/email helplines. Helplines linked with the Clinical Coordination Centre (CCC, paras 3.20–3.26) would mean that a pool of professionals would be accessible to provide advice or route individuals to appropriate support.
- 9.27 Remote monitoring using telehealth devices linked to a clinical control system, so that professionals are alerted and can respond quickly to problems, could avoid unnecessary appointments and increase intervals for stable patients with chronic conditions, and a 'safety net' for those developing problems between planned visits.
- 9.28 Virtual clinics or ward rounds using Skype teleconference, video conference or instant messaging (an encrypted and secure form of consultation) will enable patients to remain in their home or care home and bring together their clinical team around them to review progress and agree care plans with them.

- 9.29 At present, there is little evidence of the level of usage of computers, social media, smart phones, etc among patients. There is a need to understand this so that appropriate methods of access are provided and patients not disadvantaged. Collecting information about patient communication needs and preferences would help provide appropriate access routes.

➤ **See online case study on telemonitoring used with patients with heart failure, Royal Brompton Hospital (www.rcplondon.ac.uk/fh-case-studies)**

Professor Simonds, consultant respiratory and sleep medicine, explains how telemonitoring improved outcomes for patients with heart failure and is now being tested for patients with respiratory failure including chronic obstructive pulmonary disease (COPD). For heart failure patients, GP and emergency department visits were reduced, and there were self-reported improvements in patients' quality of life and drug compliance; the study explores the role of telehealth in COPD.

Access to knowledge

- 9.30 Patients need access to trustworthy validated information on which they can base decisions made jointly with their physician. Clinicians and patients should have immediate access to reputable evidence from the research literature, guidelines, and decision support alerts and reminders derived from these.
- 9.31 Data recorded at the point of care should feed as many purposes as possible, including coordination of research studies, audit, and collection and analysis of performance metrics. Links from the structured patient record should automate this access to knowledge and guidelines, thus providing both patients and clinicians with easy access to guidance such as Map of Medicine (www.mapofmedicine.com) and NICE guideline summaries.

Use of the clinical record

- 9.32 Managers and clinical leaders should ensure that clinical data are integrated, analysed and presented in meaningful ways – in identifiable or anonymised formats at the following levels:
- a *Individual patients*: to inform day-to-day decisions about clinical care by both patients and clinicians.
 - b *Clinicians and clinical teams*: to support learning, quality improvement, audit, the revalidation needs of doctors and the requirements of other staff.
 - c *Hospitals and trusts*: to inform patients, the public, commissioners and regulators.
 - d *Patient groups*: to support safety, quality improvement and research.
- 9.33 Indicators or measures of outcome or quality such as Patient-reported Outcome Measures (PROMs), Patient-reported Experience Measures (PREMs) and clinical incidents should be recorded in the patient record. Aggregated clinical care data should be integrated with PROMs, and operational and financial data, to provide workable measures at each level.
- 9.34 Hospital-level measures should be of sufficient number to provide a meaningful reflection of patient care, quality, outcomes and efficiency, but not so numerous that they become unmanageable (see chapter 11). Correction for case mix should be carried out where relevant. Measures used should always be validated.

Case study: Performance monitoring on wards

Patient Information and Communications System (PICS), was developed in-house at the University Hospitals Birmingham NHS Foundations Trust and is now available on every inpatient ward. It looks like a complex car dashboard, with needles on the dial monitoring performance on measures such as infection levels following surgery and falls by frail patients. The timing of drug doses is recorded, as is the diagnosis and treatment of bedsores – an indicator of neglect. A dial registers green to show that performance is getting better. A fall in efficiency (benchmarked against comparable wards and recent performance) earns a red or amber rating. All of this – and the response of the ward sister and matron – shows up on senior managers' own dashboards, allowing them to chase up lapses quickly.

University Hospitals Birmingham NHS Foundation Trust

Challenge faced: to find a means of monitoring patient care that will flag up problems early.

Solution: Patient Information and Communications System (PICS) monitors measures like infection levels after surgery; falls; drug doses; bedsores. A traffic light system shows improvements or falls in performance levels.

Outcome: PICS is available on every ward at the trust and enables senior managers to address problems quickly.

The system also irons out the mistakes which arise from staff misreading handwriting, a common cause of wrong dosages as clinicians can use lightweight Motion C5 handheld data input devices at the patients' bedside. Barcode scanners within the C5 mean that the trust will also be able to identify patients before drugs are administered.

Case study: Hospital@Night Nerve Centre

A wireless call handling and task management system has been introduced for out-of-hours care at Nottingham University Hospitals NHS Trust. Clinical tasks are logged centrally in a standard format and passed to a coordinator via a tablet PC for triage and allocation to an appropriate team member via an on-call mobile phone. When the team member accepts the task, it is added to the task list on their mobile and remains active and visible to the coordinator and team member until completed or reassigned.

Nottingham University Hospitals NHS Trust

Challenge faced: Use of technology to improve out-of-hours care, reduce untoward incidents and length of stay, and make efficiency savings.

Solution: Clinical tasks are logged in a standardised format using a tablet PC. Tasks are then allocated to a team member's task list on their mobile phone. The task remains active until completed or reassigned.

Outcome: The scheme succeeded in reducing untoward incidents, length of stay, and peri-arrest calls.

An evaluation of the scheme has identified reductions in untoward incidents, length of stay, and peri-arrest calls. These improvements, allied to informed service developments, have led to substantial savings, assessed independently to equate to a return on investment in four months.

FHC interviewed Dr Dominick Shaw, associate clinical professor and honorary consultant

- 9.35 To optimise the efficiency and effectiveness of the care process, clinical information should be integrated with information about resources, and made available in real time to those who need it to schedule, deliver and monitor care.
- 9.36 Information should be shared within the care pathway where this will bring benefits to patients. Information sharing should also include the use of routinely collected data for quality improvement and research, and to help patients choose places for care.
- 9.37 Clinicians, patients, their carers and the public need appropriately presented knowledge from a reliable source to be available at the point of care. Reminders or alerts based on these resources will also help improve quality and safety, and narrow the gap between best evidence and practice.
- 9.38 Reporting of clinical incidents should become part of the routine processes of clinical record keeping. This requires that there should be a standardised structure for the recording of clinical incidents. In this way, the concept of understanding when things go wrong should become the norm; the information that identifies causes of incidents can then be analysed and appropriate mitigating processes put in place, and patients can be informed as appropriate to increase transparency and accountability.

Enhanced research capability (see chapter 10)

- 9.39 Use of electronic records in hospitals that comply with standard structures will provide a wealth of information to support research on an ongoing basis, without the overheads of separate data collections. The outputs of research are vital in developing evidence-based care, and to improve safety, quality of clinical outcomes and cost-effectiveness. Developments in new technology provide an opportunity for patients to be informed about and able to consent to participate in research studies. For example, some hospitals are using their website and social media to describe research developments and encourage interested patients to consider contacting researchers to participate in randomised trials or other studies.

References

- 1 Health and Social Care Information Centre, Academy of Medical Royal Colleges. *Standards for the clinical structure and content of patient records*. London: HSCIC, 2013.
- 2 British web accessibility code of practice (BS8878). www.bsigroup.com/en-GB/about-bsi/media-centre/press-releases/2010/11/Digital-Inclusion-First-British-Standard-to-Promote-Web-Accessibility-Globally/ [accessed 16 July 2013].
- 3 Borowitz SM, Wyatt JC. The origin, content, and workload of email consultations. *JAMA* 1998;280:1321–4.
- 4 Palen TE, Ross C, Powers JD, Xu S. Association of online patient access to clinicians and medical records with use of clinical services. *JAMA* 2012;308:2012–19.

Summary of recommendations for using information to support care and measure success

- 1 All systems for recording data about patients should be electronic.**
Where this is not currently possible it should be a priority to achieve it (see paras 9.10–9.21).
- 2 The individual patient must be the primary focus of electronic patient records and systems.**
Hospitals should ensure that in the migration to electronic patient records, the primary focus is the individual patient, not their disease, intervention or the context in which they are seen (see paras 9.9–9.13).
- 3 Clinical data should be recorded according to national standards for structure and content.**
This includes data contained in case notes, handover documents and other formats. The NHS number should be the universal identifier in England and Wales (see paras 9.10–9.15).
- 4 The information needs of the hospital at every level should be generated from data recorded in the patient record in the course of routine clinical care** (except in rare circumstances).
There should be minimal duplication of data collection for both direct and indirect patient care (see para 9.9).
- 5 Data held in the record should be validated by both the clinician and the patient.**
This validation would help ensure that the data quality is good enough for both individual patient care and (when anonymised and aggregated) to inform other purposes. These other purposes include audit, quality improvement, performance assessment, commissioning, training and research. Clinicians should ensure the quality of data by keeping accurate clinical records in standardised format, and supporting clinical coding processes (see paras 9.12–9.19).
- 6 Patient records and information systems should be accessible to patients.**
Patient records and information systems should enable patients and, where appropriate, carers, to access and contribute to the information needed to manage their condition effectively (see paras 9.13–9.15).
- 7 Hospitals should embrace innovation in information and communications technologies in order to develop new models of care, and to improve quality of care and the patient experience.**
All applications must conform to national standards for safety and quality (see paras 9.22–9.29, and chapter 10).
- 8 Encourage and support clinical leadership in information and communications technology.**
This should include the appointment at board level of a chief clinical information officer (see paras 9.12, 3.33 and 7.24–7.28).

10 Research and development

The value of research

- 10.1 Clinical research is an integral part of medicine, and a critical approach to the evaluation of evidence is a fundamental attribute for all doctors. Significant progress has been made in delivering a strong research environment within the NHS over the past decade, acknowledging the significant contributions that health research can make to the health and wealth of the UK. Welcome commitments to placing research at the heart of the NHS have been made, evidenced by the introduction of a duty to engage in and promote research, including the use of research evidence, at all levels of the reformed NHS (Health and Social Care Act 2012).¹ The present NHS Constitution underlines the importance of clinical research and states that there is a ‘commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.’²
- 10.2 There is significant public support for research in the NHS. A poll in 2011 found 97% of adults thought the NHS should support research into new treatments, 72% thought they would take part in a trial and 80% thought they would take part in other research studies, for example by providing researchers with access to their records.³
- 10.3 Evidence suggests that patients in teaching or research-active institutions have better outcomes than those in other institutions. For colorectal cancers, preliminary data in NHS hospitals suggests that increased research activity is associated with improved patient outcomes.⁴ Such institutions are certainly likely to benefit from earlier access to and adoption of new treatments, technologies and approaches; and the healthcare professionals within them will develop better expertise in these new approaches.
- 10.4 The value of life sciences in driving economic growth has been recognised. The UK pharmaceutical sector invests nearly £12 million per day in research and development, and has created almost a quarter of the world’s top 100 medicines.^{5,6}

➤ **See online case study on creating a strong research culture, Tees, Esk and Wear Valleys NHS Foundation Trust (www.rcplondon.ac.uk/fh-case-studies)**

Dr Hillary Allan, R&D manager, describes establishing an integrated RD team, and building up research from 3 clinical studies to 30, and increasing patient recruitment five-fold. Partnership with Durham University, funding from the National Institute of Health Research, and involvement of service users have all contributed to their success.

Supporting staff to carry out research

- 10.5 Some commentators argue there is a moral imperative to be involved with research,⁷ and there is no doubt that physicians play a critical role in facilitating its execution through the NHS. The future hospital must support and deliver high quality health research in the NHS.
- 10.6 Research must be valued at the executive and non-executive levels to better underpin effective monitoring of activity, facilitate involvement for staff and patients, and engagement with relevant national coordinating bodies (eg the Health Research Authority, National Institute for Health Research, comprehensive local research networks) and academic or commercial partners. Crucially, the role of research as a driver of improvement in clinical services is recognised nationally and locally. The link between research activity and service quality should help further embed research as core business in the hospitals of the future.
- 10.7 All NHS trust boards should receive a regular report on research activity. The Academy of Medical Sciences has recommended that an executive director of each NHS Trust should be responsible for not only promoting research within the organisation, but should also report on current activity (including metrics) regularly. Some trusts incorporate performance indicators for research as part of their routine quality and performance report.⁵
- 10.8 For the NHS to deliver and see the benefits of high-quality research and innovation, those involved in research must be able to integrate clinical and research commitments. Careful planning and generation of capacity is essential to balance the pressures of service delivery against the importance of delivering high-quality training, and ensuring that those involved in research have protected time for these endeavours. They also need to be encouraged, supported and rewarded at all levels of their career.

Measuring research performance

- 10.9 The National Institute of Health Research (NIHR) has set up a research league table that provides a summary of the number of studies and number of study participants for all NHS organisations, to make the research performance of NHS trusts transparent and publicly available.⁸ Trusts can see how the studies they deliver from the Clinical Research Network portfolio are distributed across therapy areas, to assess the relative opportunity of research participation for patients with different conditions. In 2013 this will extend to showing further information, including the proportion of studies that are commercial or interventional. However, the league table is not linked to targets, clinical funding or quality assessments.
- 10.10 Performance indicators should be linked to the NIHR Clinical Research Network high level objectives: number of participants, number of studies, proportion of studies achieving target recruitment, proportion obtaining NHS permission within 40 calendar days, and proportion recruiting first participant within 30 calendar days after permission (70 days in total).^{8,9}
- 10.11 The ongoing Shape of Training review should ensure that, in any changes to postgraduate education, academic opportunities are available and attractive within both specialist and generalist training routes (see chapter 7).¹⁰ Moreover, training must equip all trainees with the professional judgement to interpret, apply and embed research findings and the output of innovation, as well as provide important leadership.

Case study: Increased research and patient participation

Before 2009, Portsmouth Hospitals NHS Trust did not have a research strategy. There were pockets of research in various departments, but these were mainly driven by academic physicians. There were less than six research nurses and minimal funding – all the metrics were clinical.

Professor Anoop Chauhan, the director of research, remembers it was very difficult to convince the Board of the importance of research. He notes, 'You can't just say it will increase knowledge. The other arguments are that engaging with research is a quality marker and not merely a choice. Research allows income generation from funders and from performance-related payments, such as from CQUIN. Research is also important to retain and develop a skilled consultant workforce, and is likely to facilitate innovation and quality improvement.'

He prepared a clear business case, which also outlined how the funding would trickle through to every department of the hospital, and convinced the chief executive of the merits.

In 2009, the Trust Board approved a five-year research strategy at this Trust. They initially obtained increased funding and support from commercial organisations and the National Institute for Health Research (NIHR), which was used to increase the size of the research office with more facilitators and research nurses. They then looked at the patient journey to identify where the opportunities were to engage with patients. One of the aims was to ensure that the right patient would know about the right trials within the Trust and to foster this. Colleagues are now aware of other ongoing research and enrol patients on to those studies too. They also introduced clinical trials software and restructured their approval process. These measures have led to a five-fold increase in the number of studies since 2009 (40 to 200), and a four-fold increase in the number of patients recruited (901 to 3,840). They also now take less than 30 days to approve a study and are the best in the region, compared to 66 days before 2009.

In addition, a research nurse online forum was set up for the 60 nurses to share best practice and for recruitment. Such practice could, for example, include doing night shifts for a study recruiting asthma patients – because most emergency asthma admissions occur out-of-hours. Awards were introduced for the best research teams in the hospital and these are given for commercial, observational and interventional studies. A dedicated pharmacy team has been formed for clinical trials and there is extra funding for radiographers to participate in research.

Professor Chauhan's advice is that researchers should have a roadmap and know what they want to achieve. They need to make sure that board members will support them in the long-term. Their future plans at the Trust now also extend into the community and he hopes to increase recruitment of patients into studies in joint clinics with GPs.

Portsmouth Hospitals NHS Trust

Hospital size: 1,200 beds.

Challenge faced: Pockets of research were carried out, but there was no research strategy.

Solution: A five-year research strategy was approved by the Trust Board, with funding from other organisations. Patients and clinicians were made aware of trials that could benefit patients. An online forum for research nurses was set up to share best practice and information on recruiting patients.

Outcome: There has been a five-fold increase in the number of studies since 2009 (40 to 200), and a four-fold increase in the number of patients recruited (901 to 3,840).

Patient involvement in research

- 10.12 Patients should be made aware of all ongoing research activity in the hospital and should be given the opportunity to participate where appropriate. This includes observational studies, clinical trials, and the use of data from patient records for research.
- 10.13 Hospitals should also seek patient involvement in the identification of research questions (eg DUETs) and in the conduct of research studies.
- 10.14 The results of studies should be disseminated to patients who have participated.¹¹

References

- 1 Health and Social Care Act, 2012. www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets [accessed 16 July 2013].
- 2 NHS Choices. *The NHS constitution: the NHS belongs to us all*. London: NHS Choices, 2013. www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx [accessed 5 August 2013].
- 3 Association of Medical Research Charities. Public support for research in the NHS, 9 June 2011. www.ipsos-mori.com/Assets/Docs/Polls/amrc-public-support-for-research-in-the-NHS-ipsos-mori-topline.pdf [accessed 13 August 2013].
- 4 Taylor DH Jr, Whellan DJ, Sloan FA. Effects of admission to a teaching hospital on the cost and quality of care for Medicare beneficiaries. *N Engl J Med* 1999;340(4):293–9.
- 5 Academy of Medical Sciences. *A new pathway for the regulation and governance of health research*. London: AMS, 2011. www.acmedsci.ac.uk/download.php?file=/images/project/130734957423.pdf [accessed 13 August 2013].
- 6 Health Economics Research Group, Office of Health Economics, RAND Europe. *Medical Research: what's it worth? Estimating the economic benefits from medical research in the UK*. London: UK Evaluation Forum, 2008.
- 7 Harris J. Scientific research is a moral duty. *J Med Ethics* 2005;31(4):242–8.
- 8 NIHR Clinical Research Network research table, 2012. www.guardian.co.uk/healthcare-network-nihr-clinical-research-zone/table/2012-trust-research-activity [accessed 16 July 2013].
- 9 NIHR Clinical Research Network objectives. 2013. www.crncc.nihr.ac.uk/about_us/performance_objectives [accessed 16 July 2013].
- 10 Shape of Training review, 2013. www.shapeoftraining.co.uk/ [accessed 16 July 2013].
- 11 The UK Database of Uncertainties about the Effects of Treatments (UK DUETs). www.library.nhs.uk/duets/ [accessed 16 July 2013].

Summary of recommendations for research and development

- 1 All hospital boards should receive a regular report of research activity.**
It is recommended that an executive director is responsible for promoting research within the hospital and reporting on research activity on a regular basis (see paras 10.6–10.7).
- 2 Clinical and research commitments of staff must be integrated.**
Careful planning and generation of capacity are essential in order to balance service delivery, high quality training and ensure that those undertaking research have protected time for this work (see para 10.8).
- 3 Academic opportunities should be available and attractive, and research skills promoted among medical trainees** (see para 10.11).
- 4 Patients should be given the opportunity to participate in research where appropriate** (see paras 10.12–10.14).

11 Building a culture of compassion and respect

The national agenda

- 11.1 The development of an NHS Constitution¹ in England was one of several recommendations from Lord Darzi's report (2009–10),² describing the purpose, principles and values of the service and what staff, patients and the public can expect from it. In England, service providers and commissioners of NHS care have had a legal obligation to take the Constitution into account in all their decisions and actions.¹
- 11.2 Concurrently, the Equality Act 2010³ imposed a duty on public bodies to have due regard to the need to eliminate discrimination and to advance equality of opportunity. Within the care environment, application of this legislation should lie at the heart of professionalism and the drive to optimise not only the technical but also the emotional aspects of care that all relate to patient experience. The Act provides an important legal framework which should improve the experience of all patients using NHS services.
- 11.3 Despite these policy initiatives, there is evidence to suggest that further work is needed to deliver the best possible experience for users of NHS services. The Francis Inquiry⁴ revealed that in Mid Staffordshire NHS Foundation Trust patients did not receive high-quality care and their basic needs were neglected. They were not treated with respect and compassion. A change of culture in the NHS which puts patients first, respects their dignity and ensures good holistic care was called for. Concerns were expressed about other aspects of healthcare including poor communication, the quality of the physical environment and relationships with patients' families.
- 11.4 The need to ensure a focus – not just on clinical outcomes – but on a patient's experience of care was gaining significant momentum amongst both policymakers and frontline professionals. In February 2012, the National Institute for Health and Care Excellence (NICE) published guidance on patient experience, *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services*.⁵ This has been distilled into commissioning guidance as a Quality Standard (QS 15),⁶ prioritising key aspects of service delivery and professional behaviours that will enhance the quality and the experience of care. In addition, there is guidance specific to adult mental health entitled *Service user experience in adult mental health*.⁷ At the heart of this work was a strong message about the importance of culture shift in the way the NHS engages and works with patients. This is a conceptual shift towards shared decision-making and active engagement of patients and the family in decisions underpinning their care.

- 11.5 To ensure this culture shift towards improved care for patients, all healthcare services should be designed around the ‘seven domains of quality’. The seven domains of quality are defined as:⁸
- i **Patient experience:** The patient should be the definitive focus of healthcare delivery. ‘Quality healthcare’ may not be the same for every patient.
 - ii **Effectiveness:** Healthcare should be underpinned by the deployment of beneficial interventions at the right time and to the right patients.
 - iii **Efficiency:** Healthcare must make best use of limited resources. Avoidance of waste should apply to material and abstract (eg time, ideas) resources.
 - iv **Timeliness:** Timeliness is key to avoiding waits and potentially harmful delays in the delivery of healthcare, incorporating the deployment of health interventions to anticipate and prevent illness.
 - v **Safety:** While risk in healthcare cannot be reduced to zero, it must be actively managed with the minimisation of harm a definite objective.
 - vi **Equity:** Healthcare must strive for a level playing field, in which patients determine their own high-quality care, and in which the needs of the many and the few are balanced.
 - vii **Sustainability:** Sustainability should be viewed as a characteristic of healthcare which must run through and moderates other domains. Healthcare should be considered not only in terms of what can be delivered to an individual today, but also to the population in general and the patients of the future.

Valuing patient experience

- 11.6 The quality statements contained in the NICE quality standard for patient experience⁶ are evidence-based and designed to inform the planning of services which are aimed at ‘improving the patient’s experience of care’. This work benefited from the largest synthesis of patient evidence published as a systematic meta synthesis.⁶ From the analysis of the evidence, five key themes emerged. These are:

- > knowing the patient as an individual
- > the essential requirements of care
- > tailoring healthcare services for patients
- > continuity of care and relationships
- > enabling patients to participate in their care.

These themes should be the focus of a shift in the thinking and practice of healthcare professionals. Service redesign to enable this is a key aspect of establishing a culture of care, a culture where the patient is managed as a whole person. This means moving away from a culture in which patients are all too often viewed as commodities with specialist needs. In practice, for many patients this has meant seeing as many as three or four different specialists with no single clinician overseeing their care.

- 11.7 To address this, and embed the NICE quality standard in practice, we must change current models of service delivery. This means moving away from the commodification of care to a relationship built on trust, reciprocity, empathy and politeness, where healthcare professionals take responsibility for delivering holistic care.

Case study: Using patient experience data

In their own words: The trust relies on national surveys to benchmark their data. Feedback from 20,000 patients every year is independently provided by Patient Perspective, a contractor approved by the Quality Care Commission. Northumbria's focus is on the areas that matter most to patients. The surveys are deliberately sent out in the 2 weeks after discharge, when patients are statistically at their least satisfied and perhaps more free to tell us why.

A 'Two minutes of your time' exit survey is in place to cover the friends and family question. In June 2010 Northumbria developed their real-time programme designed around key domains of care. Feedback is given to staff within 24 hours and shared with patients, families and the public. Consultants get individual feedback on what patients have said about them, which is then included in their appraisal.

The trust also works with a team of patient advocates from Age UK who consider the experience of the service from the perspective of a person with dementia who is unable to provide feedback.

Across the trust, feedback scores in key domains (such as respect and dignity or cleanliness) are high and a level of 90% is set as the bar. Wards or services falling below this are expected to review patient feedback and use this to consider changes and improve.

One outlying medical ward team, for example, came up with the idea of dignity boxes which included nightwear and basic toiletries for those patients arriving in hospital without these. One of the unintended consequences was the opportunity for staff to spend more time with patients, talking whilst applying hand cream which was in the box. Wards are also supported to improve, with staff released for person-centred training in dementia and delirium where appropriate.

In the annual NHS staff survey, the trust performs exceptionally well, with 94% feeling that their work makes a real difference.

Northumbria Healthcare NHS Foundation Trust

Trust size: Northumbria Healthcare Trust provides acute and community health services and adult social care to a population of over half a million people in the North East. The trust runs nine hospitals (three general hospitals plus six community hospitals) and employs about 9,000 staff.

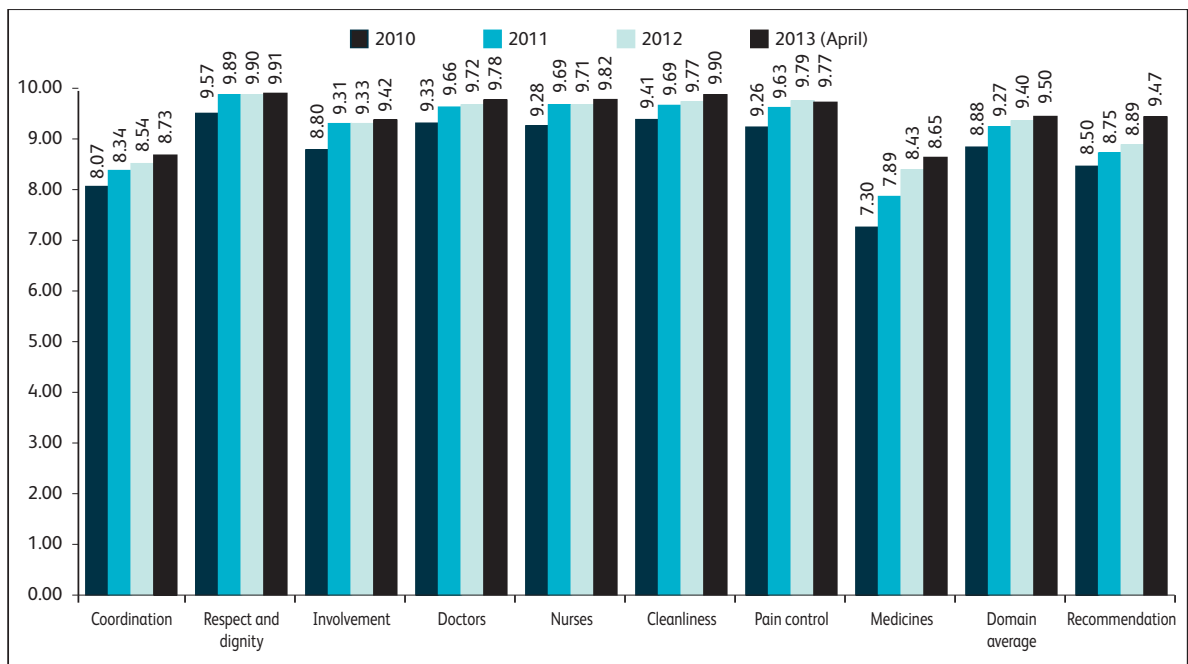
Challenge faced: The trust has a vision of healthcare provision where the patient is at the centre of all activity.

Solution: Part of the solution involved establishing mechanisms for collecting patient experience measures and using this information to improve care and services.

Local context: The trust has a strong operational structure that functions across all sites, and is supported and trusted by staff. The trust has a quality council and has appointed a director of patient experience.

Outcome: The trust consistently ranks amongst the best in England, and is highly rated by regulators. It has won numerous national and regional awards for quality of management, quality of care and clinical service redesign.

In 2012, King's Fund researchers identified Northumbria as one of the 30 trusts in the country that consistently deliver a good patient experience in inpatient, outpatient and emergency department settings. It is the only trust to have won three consecutive awards from the Patient Experience Network.



Real-time improvements. Feedback on eight domains over 3 years, from more than 12,000 patients.

Patient experience data are also used as a valuable tool in monitoring quality improvement projects. The trust has recently overhauled its hip fracture pathway. Patient mortality has halved and Northumbria provides leading NHS care for best practice tariff and time to surgery.

FHC interviewed Annie Laverty, director of patient experience

Case study: Improving patients' experience

Eileen Sills has been working at the trust as chief nurse since 2005 and there are two particular measures she has implemented to improve the quality of care in the hospital.

Clinical Fridays

When Eileen Sills was first appointed as chief nurse at Guy's and St Thomas' NHS Foundation Trust in 2005, she wanted to close the gap between the 'board and the ward' and increase the senior nursing clinical visibility. She introduced the scheme 'Back to the floor Fridays'. Every Friday, every senior nurse would spend the day working in their clinical department, putting themselves in the shoes of their patients and their junior staff. This scheme has now become well embedded, and the trust has a reputation for strong effective nursing leadership.

Although this was accepted, there were initial anxieties about whether this was manageable in the context of their workload, and also what exactly senior nurses would be asked and expected to do clinically. All the obstacles were overcome and they now all work at least one day a week in a clinical environment. The senior nurses choose what they will do; they may observe care, work alongside a junior

colleague, care for their own group of patients; or just sit and talk and listen to patients tell them about their experiences. If working clinically, they all work within their scope of clinical competence.

As Eileen puts it, 'You have to go and see what it's really like if you are going to effectively lead and be a voice for your staff and your patients'. She says that the initiative has led to very high levels of visibility of senior staff within the hospital, which patients and other staff welcome. Also, it helps the senior management to pick up departmental issues more quickly.

Extending this, on Friday afternoons, the senior nursing workforce all attend a one-hour meeting to discuss the previous week's clinical indicators and patient experience, known as the 'safe in our hands' briefing. This drop-in session is open to all staff and is attended by members of the general management team and medical consultants too. In a typical meeting, they begin by looking at the overall activity indicators, such as the number of elective and emergency admissions. They then go on to discuss the number of emergency department (ED) 4-hour target breaches and theatre cancellations.

They also specifically look at patient harm events. The number of patients at risk of falls, the number that have falls and the number sustaining injuries are all scrutinised with data broken down by ward. Similarly, the incidence of pressure ulcers, medication errors, MRSA bacteraemia, and *Clostridium difficile* infections are all assessed. Ward sisters and matrons often attend to present about a particular issue and whether any learning from the incident has happened and can be shared.

Another part of the meeting looks at patient feedback using the newly launched NHS Friends and Family Test. Currently the focus is on obtaining a response rate of at least 20% – from July 2013 the government will make results public and has asked for a minimum response rate of 15%.

Some meetings include presentations to help share best practice and ideas. At the meeting that the Future Hospital Commission attended, two ward sisters gave a detailed account of the Commissioning for Quality and Innovation targets and outcomes on patient experience for their wards. Both wards had performed worse than expected the previous year and so discussed their action plan and the significant improvements that had been made in the current year. Eileen was keen to emphasise the importance of learning from other wards – 'benchmarking' with wards that have performed well on a certain indicator and to see what they do differently.

Guy's and St Thomas' NHS Foundation Trust

Size of hospital: Guy's and St Thomas' NHS Foundation Trust is an 1,100-bedded integrated community teaching hospital.

Challenge: To improve the quality of care for patients.

Solution: Two measures in particular were used. (1) 'Clinical Fridays' when senior nurses spend one day a week working with junior staff and patients in their departments. Patient harm events are also monitored and addressed regularly. (2) 'Barbara's story', a video about a patient with dementia and her experience of hospital, has been shown to staff to highlight the point of view of the patient. The video is supplemented by a pack on dementia and a discussion about the video. This led to changes in staff behaviour, which is monitored using standard measures.

Staffing: 12,500 staff. 10,000 staff have attended the video and discussion.

Outcome: 77 % of staff would recommend the hospital as a place to work. 94 % of patients have said they would recommend the hospital to a friend.

Barbara's Story

'Barbara's Story' is a short video of a patient journey that was launched on 21 September 2012 at the trust. The film is aimed at raising the level of awareness about what it is like to be an older person with dementia. The plan is to train all 12,500 staff over 6 months, and to date over 11,000 staff have attended. Training sessions run throughout the week, either as drop-in sessions or in a local department. The film is 13 minutes long and focuses on the 'small things that matter', and was developed by the trust. Initially Eileen had not wanted to release this to other organisations, but given its impact and the external interest, it is now being developed into a training package for wider release, which will be free to the NHS.

Alongside the video, staff receive an information pack on dementia, which includes the 'This is Me' document created by the Royal College of Nursing and the Alzheimer's Society, and information sheets on 'What is dementia?', 'Dealing with aggressive behaviour', 'Safeguarding adults at risk', and 'Understanding and respecting the person with dementia'. Contact details for the dementia and delirium team in the trust are provided, which includes an acute and community clinical nurse specialist.

In the professionally produced video, an actress, Barbara, plays the part of an elderly woman with dementia. She starts by getting into a taxi to come to hospital for her outpatient appointment. The video then follows her through the hospital corridors, to the reception desk, the outpatient waiting room, the consultation room and her subsequent admission to a ward. Throughout there are examples of poor, indifferent and exemplary care.

Eileen supplements this with other powerful messages. She speaks about how every interaction with a patient matters, how welcoming and calm environments are important for people with dementia, how service could be compared with other industries and how anybody in an organisation can stop and help. Scenes in the video were carefully chosen to be relevant to the hospital. For example, there is one scene where Barbara is taken to her ward bed in a wheelchair and a nurse has a discussion with the porter. Talking 'over' patients was identified as a local issue within the trust, with the trust ranking in the bottom 20% for this question as part of the national inpatient survey in previous years.

The impact in the organisation has been very humbling, with staff doing little things differently, and the level of awareness is outstanding. Following a successful bid to the Burdett Trust there are now six further episodes being filmed which will follow Barbara's journey through different clinical scenarios. The film is also being formally evaluated by London South Bank University.

Eileen genuinely believes that this programme and engagement has led to a very positive response to the Francis report, and around 2,000 staff have participated in listening events and briefings.

Measuring patient experience – an overview of existing data sources

- 11.8 Mechanisms should be developed to measure patient experience on an ongoing, structured and real-time basis. This should include reviewing and triangulating existing data, and establishing new systems that enable the real-time reporting of patient experience (such as that developed by Northumbria Healthcare NHS Foundation Trust – see case study).
- 11.9 Most acute trusts collect patient feedback via a number of sources, including: national and ward-level patient surveys; interviews and focus groups; forums; formal and informal complaints made via patient advisory liaison services (PALS); comments on websites (eg NHS Choices);⁹ and feedback on the performance of individual clinicians used for appraisal or revalidation purposes. It is important that this information is triangulated and placed in the public domain to drive up the performance of healthcare organisations, and provide patients with information about the quality of care they are likely to receive (see chapter 9: Information).
- 11.10 There are a number of additional national sources of information. The National Patient Survey¹⁰ obtains data from each NHS trust for annual performance monitoring. Around 1.5 million respondents are involved. However, it is not clear how much of this information is viewed by hospital boards or looked at by individual staff or teams.
- 11.11 Patient Reported Outcomes Measures (PROMs) gather information on a patient's health status or health-related quality of life.¹¹ They are typically short, self-completed questionnaires which measure health status or quality of life at a single point in time. Generic PROMs give an overall assessment of well-being, and disease-specific measures consider outcomes in particular groups of patients. These data have been routinely collected in the NHS from surgical procedures.
- 11.12 In England, the Friends and Family Test has been introduced from April 2013.¹² Patients are asked within 48 hours of leaving hospital whether they would recommend hospital wards and emergency departments (EDs) to their friends and family if they needed similar care or treatment. The results have been published on the NHS Choices website since July 2013.¹²
- 11.13 The 15 Steps Challenge¹³ is a series of toolkits developed with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders, to help look at care in a variety of settings through the eyes of patients and service users, to help capture what good-quality care looks, sounds and feels like. Each toolkit provides a series of questions and prompts to guide patients, service users, carers and NHS staff through their first impressions of a care setting, ie within walking 15 steps into a ward area.
- 11.14 The Commissioning for Quality and Innovation (CQUIN)¹⁴ payment framework has been employed by some commissioners to reward excellence by linking a proportion of providers' income to the achievement of local goals of improved patient experience. Patient experience can also be measured against the NICE quality standards for patient experience.⁶ It is intended that the results should be used by commissioners of services.

Healthcare delivery: team working, communication and continuity

- 11.15 Healthcare professionals who lead the delivery of care, both at the bedside and in designing

processes and systems, need to show clinical leadership based on underlying values of professionalism. The Royal College of Physicians (RCP) has developed guidance on professionalism.^{15,16} This has been further developed to encapsulate the new model of care envisaged by the Future Hospital Commission (see chapter 2, box 4: medical professionalism).

- 11.16 Doctors need to lead the development of structures and systems that better deliver holistic care for patients. They should be supported by hospital structures that focus on the provision of high-quality, continuous care for patients (see new model of care proposed in chapters 3–6). When admission to hospital is needed, patients should not be moved from ward to ward. This increases length of stay and makes their experience of hospital worse. Evidence also indicates that when patients are admitted to a ward dealing with a specialty with which they do not appear to ‘fit’, poorer standards of care follow.¹⁷
- 11.17 The system must enable patients to be admitted to the ‘right’ place first time and be cared for by skilled staff, whatever their condition or complexity of disease. This means adopting a patient-centred culture in which the needs of the patient rather than the organisation dictate care policy.
- 11.18 Communication between professionals has been eroded in recent years by the pace of work, the fact that patients under the care of a consultant may be scattered on different wards, and that different medical teams may be visiting one ward to look at just a few patients. Sometimes it is unclear who is assuming responsibility for the patient (see chapters 3–5).
- 11.19 The delivery of holistic care is the joint responsibility of doctors and nurses. There must always be a named consultant responsible for the standard of care delivered to each patient. Patients should be given written information about which consultant is responsible for their care and how they might be contacted. The named consultant will work with a ward manager and assume joint responsibility (over a specified period) to ensure basic standards of care are met, and that patients are treated with dignity and respect.
- 11.20 Developing nurse leadership is an essential part of this process, as is the key role of the ward manager.¹⁸ The chief nursing officer of England has recently launched a new strategy for nursing, midwifery and care staff based on care, compassion, competence, communication, courage and commitment.¹⁸
- 11.21 Good communication between ward staff and across professions and teams is essential. Effective ward rounds can be one important tool for achieving this. A recent report published jointly by the RCP and Royal College of Nursing provided guidance on scheduling, structuring and preparing ward rounds.¹⁹ Ward rounds should be coordinated between medical and nursing staff. Post-round reviews with allocation of tasks and patient participation were reviewed, as were preparation for patients in advance of the ward round, promoting shared decision-making and self-management; protecting vulnerable patients, with nurses and doctors in training ensuring that their needs are articulated and addressed; ensuring nursing involvement; sharing information with the patient; ensuring patients are informed of all key decisions about their care; the use of safety checklists to reduce omissions and variations in practice, and in transition of care planning; setting a date for departure from hospital and giving patients a detailed plan on how to manage their care outside hospital.

Responding to the needs of specific groups of patients

- 11.22 Health and care professionals must respond to individual patients' needs (see chapter 6 for further information). Many of those in hospital today are older people with conditions related to frailty, including cognitive impairment. Some have sensory impairments, such as hearing or sight loss, and mobility problems needing aids for walking. Patients with learning difficulties also have specific needs.²⁰
- 11.23 Patients with cognitive impairment (including dementia) occupy 25% of hospital beds²¹ and the knowledge and skills to deal with their special needs and the appropriate attitude are required by all staff. Such patients are encountered in all ward environments and are more susceptible to developing acute confusion or delirium. The National Dementia Strategy has called for each hospital to have a named dementia champion to ensure that these patients receive the right care guided by organisational policies to support staff to deal with these patients in the right way.²²
- 11.24 People with dementia may not be able to provide a clinical history at the time of hospital admission. The so-called 'This is Me' documentation,²³ filled out with the patient by their family at home in advance of admission, provides information likely to improve personalised care. Developing models of care that meet the needs of these patients can set a standard of universal relevance to the provision of in-hospital care for adults with medical illness. Assessment schemes based around the needs for this cohort of patients should continue to be promoted and developed.²⁴
- 11.25 Patients who are dying need access to palliative care. For those with life-limiting illnesses, decisions about care escalation must be made before an acute deterioration occurs. The use of advanced care plans, developed in conjunction with the patient or, if incapacitated, with their carers, is essential. Clinical decisions about ceilings of care, based on patients' and carers' wishes alongside projected clinical outcomes, need to be made, as well as decisions about resuscitation. Clinical skills are needed to recognise when a patient is dying, as well as skills in communicating with patients and relatives when that is the case.²⁵

Shared decision-making

- 11.26 Shared decision-making and effective self-management should be promoted. Good communication is a therapeutic element of care which not only provides information, but also facilitates and engages patients in shared decisions by empowering them to express their personal needs and preferences.
- 11.27 Those with long-term conditions can improve their health and quality of life by taking an active role in their own care, through self-management. This can be taught, but also involves providing access to information technology, and skilled support from motivated clinicians.
- 11.28 In such circumstances, clinicians and patients work together to select tests, treatments or management plans, and support packages based on clinical evidence and the patient's informed preferences. Evidence-based information is provided about each option, including potential outcomes and areas of uncertainty. Decision support counselling and a system for recording and implementing patients' informed preferences are needed.

- 11.29 Shared decision-making is viewed as an ethical imperative by the professional regulatory bodies. Evidence suggests that patients wish to be more involved than they currently are in making decisions about their own health and healthcare. Those who participate in managing their health and healthcare have better outcomes than passive recipients.^{26,27}
- 11.30 To be effective proponents of shared decision-making, professionals must acquire skills in motivational interviewing and explanation of risk. Patients need to have developed the self-confidence needed to engage in decisions about their care.^{28,29}
- 11.31 For those who lack capacity for decision making, relatives may need to become involved, although issues of consent and 'best interests' are not well understood.³⁰ All staff dealing with older people must possess an understanding of the Mental Capacity Act 2007 and Deprivation of Liberty Safeguards.³¹
- 11.32 Patients should have a personalised electronic health record available to them and their carers, updated regularly and with a facility for the patient (or someone acting on their behalf) to enter questions about their care (see chapter 9 for further information).

Compassionate care: supporting staff

- 11.33 It must be assumed that staff want to provide good care for their patients. Compassionate care is more likely to ensure efficiency and good outcomes, so finding ways and identifying resources to nurture kindness and compassion in the health service will ultimately prove cost effective. There is an association between how much staff feel valued and engaged by the organisation they work in, and the quality of care given to patients. Evidence suggests that staff can be encouraged to engage by managers giving them autonomy, enabling them to use a range of skills, ensuring jobs are satisfying – such as seeing something through and giving them support, recognition and encouragement.³²
- 11.34 It is the responsibility of the hospital to provide systems of care which give a good patient experience and to provide environments which are conducive to healthcare, in which patients feel cared for and not alienated. The Point of Care programme³³ to improve patient experience focuses on the hospital and the experience of staff in influencing patients' experiences of care. The system emphasises that all actions and systems have a potential impact on patients and their families. Mentoring and teamwork can provide supportive environments, and good role modelling by senior staff is essential. Studies have shown the following to be critical in assuming patients' experience of care:³⁴
- > strong committed senior leadership
 - > communication of strategic vision
 - > sustained focus on employee satisfaction
 - > adequate resourcing for care delivery design
 - > building staff capacity to support patient-centred care
 - > accountability and incentives
 - > culture strongly supportive of change and learning.

- 11.35 Doctors who see patients must collect feedback from those they have interacted with in their own practice at least once every 5 years, for the purposes of revalidation. Doctors, and other staff, should be supported to reflect on feedback received from patients.
- 11.36 The need for reflective practice should be built into training and the requirements for continuous professional development (CPD). There is good evidence from a recent General Medical Council report on CPD for doctors that there remains a cultural mountain to climb as far as attitudinal change is concerned.³⁵ The Schwartz Center for Compassionate Healthcare in the USA has developed the concept of monthly, one-hour sessions for staff from all disciplines and all levels to discuss difficult emotional and social issues arising from patient care. Recent evaluation has shown that such Schwartz Rounds are valuable.³⁶ Hospitals should invest in tools such as these that promote reflective practice. A Citizenship Charter should be developed by hospitals to embed the NHS Constitution and principles set out by the Future Hospital Commission into daily practice of all staff. This should be developed locally, with involvement from both staff and patients.

Health of the medical workforce

- 11.37 The 2009 Department of Health (DH) survey of NHS staff health found associations between better staff health and well-being and patient outcomes, including reduced MRSA rates, lower standardised mortality rates and greater patient satisfaction scores.³⁷
- 11.38 In the 2010 census of consultant physicians in the UK, 44% of consultants said that they always or often felt that they worked under excessive pressure.³⁸ A survey of medical registrars in 2011 found that 71% considered their workload 'heavy' and a further 27% considered it 'unmanageable'. 22% felt 'not very well supported' by their seniors, and 19% of medical registrars perceived that in general, they were 'not very valued' within the hospital setting.³⁹
- 11.39 A 2010 national audit measured implementation of NICE public health guidance for the workplace across hospitals in England.⁴⁰ It looked at overarching board engagement, and then the individual pieces of guidance (staff mental well-being, smoking cessation, obesity, physical activity and management of sickness absence). The audit found variable and sometimes very low levels of implementation; for example, little compulsory management training in areas of staff well-being, and poor promotion of healthy food in hospital shops and vending machines.⁴⁰
- 11.40 The design of the future hospital should take into account the known risk factors for work-related psychological distress and ill health; and the organisational human resource practices associated with patient mortality. Any redesign also creates an opportunity to address common lifestyle factors that influence physical and mental well-being; for example, physical activity, diet, smoking and alcohol.
- 11.41 Several government documents indicate a commitment to supporting NHS staff health. The NHS Constitution commits the NHS to providing support and opportunities for staff to maintain their health, well-being and safety,¹ and the newly published NHS mandate expects the NHS, as the country's largest employer, to make an important contribution to helping the population stay in good health 'by promoting the mental and physical health and wellbeing of its own workforce'.⁴¹ The 2009 Boorman review lists evidence-based recommendations³⁷ and in

2011 the DH published *NHS Health and Well-being Improvement Framework*.⁴² This report supports the implementation of the recommendations in the 2009 review, ‘to ensure that the future healthcare system is one built on an engaged, healthy and productive workforce’.

- 11.42 Hospitals should make staff well-being and engagement a priority to ensure high-quality patient care.

References

- 1 NHS Choices. *The NHS Constitution*. www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx [accessed 6 August 2013].
- 2 Darzi A. *High quality care for all. NHS next stage review: final report*. London: Department of Health, 2008.
- 3 Equality Act 2010. www.gov.uk/equality-act-2010-guidance [accessed 16 July 2013].
- 4 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chaired by Robert Francis QC. London: Stationery Office, 2013. www.midstaffspublicinquiry.com/report [accessed 16 July 2013].
- 5 National Institute for Health and Care Excellence. *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services*. Clinical guideline 138. London: NICE, 2012. <http://guidance.nice.org.uk/CG138> [accessed 16 July 2013].
- 6 National Institute for Health and Care Excellence. *Quality standard for patient experience in adult NHS services*. Quality standard 15. London: NICE, 2012. <http://guidance.nice.org.uk/QS15> [accessed 16 July 2013].
- 7 National Institute for Health and Care Excellence. *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*. Clinical guideline 136. London: NICE, 2011. <http://guidance.nice.org.uk/CG136> [accessed 16 July 2013].
- 8 Atkinson S, Ingham J, Cheshire M, Went S. Defining quality and quality improvement. *Clin Med* 2010;6:537–9.
- 9 NHS choices. www.nhs.uk/Pages/HomePage.aspx [accessed 15 July 2013].
- 10 National Patient Survey. The NHS National Patient Survey Programme. www.nhssurvey.org [accessed 12 August 2013].
- 11 NHS choices. Patient reported outcome measures. www.nhs.uk/NHSEngland/thenhs/records/proms/Pages/aboutproms.aspx
- 12 NHS Choices. The NHS friends and family test. www.nhs.uk/NHSEngland/AboutNHSservices/Pages/nhs-friends-and-family-test.aspx [accessed 15 July 2013].
- 13 NHS Institute for Innovation and Improvement. *The Fifteen Steps Challenge. Quality from a patient's perspective*. www.institute.nhs.uk/productives/15stepschallenge/15stepschallenge.html [accessed 15 July 2013].
- 14 NHS Institute for Innovation and Improvement. Commissioning for Quality and Innovation (CQUIN) payment framework. www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html [accessed 12 August 2013].
- 15 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. Report of a Working Party. London: RCP, 2005.
- 16 Royal College of Physicians. *Future physician: changing doctors in changing times*. Report of a working party. London: RCP, 2010.
- 17 Tadd W, Hillman A, Calnan S *et al*. *Dignity in practice: An exploration of the care of older adults in acute NHS trusts*. National Institute for Health Research Service Delivery and Organisation Programme, 2011. www.netscc.ac.uk
- 18 Department of Health. *Compassion in practice. Nursing, midwifery and care staff. Our vision and strategy*. London: DH, 2012. www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf [accessed 15 July 2013].
- 19 Royal College of Physicians, Royal College of Nursing. *Ward rounds in medicine: principles for best practice*. London: RCP, 2012.
- 20 Care Quality Commission. *Learning disability services, 2012. Inspection programme, national overview*. www.cqc.org.uk
- 21 Alzheimer's Society. *Counting the cost: Caring for people with dementia on hospital wards*. London: Alzheimer's Society, 2009.

- 22 Department of health. *Living well with dementia: a national dementia strategy*. London: DH, 2009. www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf
- 23 Royal College of Nursing, Alzheimer's Society. *This is Me*. www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1290 [accessed 15 July 2013].
- 24 Overview of the Quality Mark for Elder-friendly Hospital Wards. www.rcpsych.ac.uk/quality/qualityandaccreditation/elder-friendlyqualitymark/overviewofthequalitymark.aspx [accessed 16 July 2013].
- 25 End of Life Care Strategy – promoting high quality care for all adults at the end of life, July 2008. <http://webarchive.nationalarchives.gov.uk>
- 26 Angela Coulter, Alf Collins. *Making shared decision-making a reality. No decision about me, without me*. London: King's Fund, 2011. www.kingsfund.org.uk
- 27 Mulley A, Trimble C, Elwyn G. *Patients' preferences matter. Stop the silent misdiagnosis*. London: King's Fund, 2012. www.kingsfund.org.uk
- 28 Fischer M, Ereaut G. *When doctors and patients talk: making sense of the consultation*. London: Health Foundation, 2012. <http://www.health.org.uk/publications/when-doctors-and-patients-talk-making-sense-of-the-consultation> [accessed 12 August 2013].
- 29 Health Foundation. *Co-creating Health*. www.health.org.uk/areas-of-work/programmes/co-creating-health [accessed 12 August 2013].
- 30 Mental Capacity Act 2007. www.justice.gov.uk
- 31 Department of Health. *Mental Capacity Act: deprivation of liberty safeguards*. London: DH, 2010. www.gov.uk/government/publications/mental-capacity-act-deprivation-of-liberty-safeguards [accessed 15 July 2013].
- 32 West M, Dawson J. *Employee engagement and NHS performance, 2012*. www.kingsfund.org.uk/leadershippreview [accessed 30 August 2013].
- 33 The Point of Care programme. www.kingsfund.org.uk/audio-video/point-care-programme-helping-nhs-see-person-patient [accessed 15 July 2013]
- 34 Luxford K, Safran DG, Delbanco T. Promoting patient-centred care: a qualitative study of facilitation and barriers in healthcare organisations with a reputation for improving the patient experience. *Int J Quality Healthcare* 2011; 23:5.
- 35 Mathen N, Mitchell C, Hunn A. *Assessing the impact of continuing professional development (CPD) on doctors' performance and patient/service outcomes*. General Medical Council 2013. Research by the University of Sheffield.
- 36 The Schwartz Center for Compassionate Healthcare. www.theschwartzcenter.org/ [accessed 15 July 2013].
- 37 NHS Health and Wellbeing. The Boorman review. www.nhshealthandwellbeing.org/FinalReport.html [accessed 15 July 2013].
- 38 Federation of the Royal Colleges of Physicians of the United Kingdom. *Census of consultant physicians and medical registrars in the UK, 2010: data and commentary*. London: RCP, 2011.
- 39 Royal College of Physicians. *Hospital workforce: fit for the future?* London: RCP, 2013.
- 40 Royal College of Physicians. *Implementing NICE public health guidance for the workplace: an national organisational audit of NHS trusts in England*. London: RCP, 2011.
- 41 Department of Health. *The mandate: a mandate from the government to the NHS Commissioning Board, April 2013 to March 2015*. London: DH, 2012. www.gov.uk/government/publications/the-nhs-mandate [accessed 15 July 2013].
- 42 Department of Health. *NHS Health & Well-being Improvement Framework*. London: DH, 2011. www.gov.uk/government/publications/nhs-health-well-being-improvement-framework [accessed 15 July 2013].

Summary of recommendations for building a culture of compassion and respect

1 Design healthcare services around the ‘seven domains of quality’.^a (See paras 11.5–11.7.)

The seven domains of quality are defined as:

- i **Patient experience:** The patient should be the definitive focus of healthcare delivery. ‘Quality healthcare’ may not be the same for every patient.
- ii **Effectiveness:** Healthcare should be underpinned by the deployment of beneficial interventions at the right time and to the right patients.
- iii **Efficiency:** Healthcare must make best use of limited resources. Avoidance of waste should apply to material and abstract (eg time, ideas) resources.
- iv **Timeliness:** Timeliness is key to avoiding waits and potentially harmful delays in the delivery of healthcare, incorporating the deployment of health interventions to anticipate and prevent illness.
- v **Safety:** While risk in healthcare cannot be reduced to zero, it must be actively managed with the minimisation of harm a definite objective.
- vi **Equity:** Healthcare must strive for a level playing field, in which patients determine their own high-quality care, and in which the needs of the many and the few are balanced.
- vii **Sustainability:** Sustainability should be viewed as a characteristic of healthcare which must run through and moderates other domains. Healthcare should be considered not only in terms of what can be delivered to an individual today, but also to the population in general and the patients of the future.

2 Embed patient experience in service design and delivery (see paras 11.5–11.7).

The guidance on *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services*, published by the National Institute for Health and Care Excellence, and the accompanying Quality Standard should underpin the design and delivery of all adult NHS services.

3 Develop mechanisms for measuring patient experience on an ongoing, structured and real-time basis, and publish the results in the public domain (see paras 11.8–11.14, and chapter 9).

Patient experience data should be triangulated and reviewed to ensure the best possible information is available to: inform patients and the public; encourage hospitals, clinical teams and individual clinicians to reflect on their practice and drive improvement; and (potentially) reward excellence by linking income to the achievement of local goals of improved patient experience. Systems that enable the real-time reporting of patient experience (such as that at Northumbria Healthcare NHS Foundation Trust) should be promoted across the health system.

4 There must always be a named consultant responsible for the standard of care delivered to each patient.

Patients should be given written information about which consultant is responsible for their care and how they can be contacted. The named consultant will work with a ward manager and assume joint responsibility over a specified period to ensure that basic standards of care are being delivered, and that patients are being treated with kindness and respect (see paras 11.18–11.21).

5 Develop nurse leadership and promote the role of the ward manager.

The delivery of holistic care to patients is a joint responsibility of doctors and nurses. Ward managers are at the centre of the patient experience and must have the status and authority to oversee standards of care

^aAtkinson S, Ingham J, Cheshire M, Went S. Defining quality and quality improvement. *Clin Med* 2010;6:537–9.

delivery and the ward environment. The Future Hospital Commission supports the principles set out in the Royal College of Nursing publication, *Breaking down barriers, driving up standards*.^b (See paras 11.18–11.21.)

6 Coordinate ward rounds between medical and nursing staff (see para 11.21).

There should be clear allocations of responsibility in preparation for and following ward rounds in order to promote patient participation, protect vulnerable patients and ensure nursing involvement. Future management plans for patients need to be discussed between doctors and nurses, as well as other members of the healthcare team and the patient, with excellent communication, so that everyone is working towards the same goal, within and between teams. The Future Hospital Commission supports the recommendations of *Ward rounds in medicine*.^c

7 Promote communication, shared decision-making and effective self-management (see paras 11.26–11.32).

Clinicians and patients should work together to select tests, treatments or management plans, and support packages based on clinical evidence and the patient's informed preferences. In order to achieve this:

- i Evidence-based information should be provided about patients' options, including potential outcomes and areas of uncertainty.
- ii Decision support counselling and a system for recording and implementing patients' informed preferences are needed.
- iii Medical and other staff must be trained in communication with patients and their families, including around the diagnosis and management of dementia and delirium.
- iv Medical staff must acquire skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk).

8 Give staff time and support to deliver safe, high-quality patient-centred care.

Hospitals must review staffing ratios and staffing capacity to ensure that they reflect the complexity and needs of the current patient mix across all wards (see paras 11.33–11.42, and 3.11).

9 Invest in tools that support individual responsibility, shared ownership and reflective practice.

- i Staff must collectively and individually take ownership of the care of individual patients, and of their contribution to the overall standard of care delivered in the health system in which they work. Staff must be supported and encouraged to do this by colleagues, senior staff and the board through the development of a Citizenship Charter (building on the NHS Constitution). This should put the patient at the centre of everything the hospital does, be developed with patients, staff, managers and governors, and be a priority for all trusts (see paras 11.15–11.17, 11.35–11.36, and 2.29).
- ii Hospitals must invest in systems that enable staff to reflect on the care they deliver. This includes building reflective practice into training and the requirements for continuing professional development, developing good appraisal processes for staff, and investing in mechanisms that enable staff from all disciplines and all levels to discuss difficult emotional and social issues arising from patient care (eg Schwartz Center Rounds®). (See paras 11.35–11.36.)

10 Hospitals should make staff well-being and engagement a priority to ensure high-quality patient care (see paras 11.33–11.42).

^bRoyal College of Nursing. *Breaking down barriers, driving up standards: the role of the ward sister and charge nurse*. London: RCN, 2009.

^cRoyal College of Physicians, Royal College of Nursing. *Ward rounds in medicine: principles for best practice*. London: RCP, 2012.

Appendices

The background of the page features an abstract geometric design. It consists of several overlapping shapes in two shades of blue: a lighter teal and a darker teal. The shapes are angular and organic, creating a dynamic, layered effect. One large dark teal shape is prominent in the upper right, while another large teal shape is in the lower left. They intersect to form various geometric patterns and negative spaces.

Appendix 1

Future hospital principles, vision, recommendations and commitments to patients

Principles underpinning the future hospital

Principles for patient care

Hospitals and health professionals must provide patients with high-quality, compassionate care that meets their clinical and support needs. To achieve this, hospitals and other health services must in the future be designed around 11 principles of care. These principles are at the core of the Future Hospital Commission's work and underpin each of its recommendations.

Care for patients – core principles

1 Fundamental standards of care must always be met

Patients must:

- i be treated with kindness, respect and dignity, respecting privacy and confidentiality
- ii receive physical comfort including effective pain management
- iii receive proper food and nutrition and appropriate help with activities of daily living
- iv be in clean and comfortable surroundings
- v receive emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on themselves, their families and their finances.

2 Patient experience is valued as much as clinical effectiveness

Patient experience must be valued as much as clinical effectiveness. Patient experience must be measured, fed back to ward and board level, and the findings acted on.

3 Responsibility for each patient's care is clear and communicated

There must be clear and communicated lines of responsibility for each patient's care, led by a named consultant working with a (nurse) ward manager. Consultants may fill this role for a period of time on a rotating basis.

(continued overleaf)

Care for patients – core principles – *continued*

4 Patients have effective and timely access to care

Time waiting for appointments, tests, hospital admission and moves out of hospital is minimised.

5 Patients do not move wards unless this is necessary for their clinical care

Patients should not move wards unless this is necessary for their clinical care. Care, including the professionals who deliver it, should come to patients.

6 Robust arrangements for transfer of care are in place

There must be robust arrangements for the transfer of care:

- i between teams when a patient moves within the hospital
- ii between teams when staff shifts change
- iii between the hospital and the community.

7 Good communication with and about patients is the norm

Communication with patients is a fundamental element of medical professionalism. There must be good communication with and about the patient, with appropriate sharing of information with relatives and carers. Medical and other staff must be trained in communication with patients and their families, including diagnosis and management of dementia and delirium.

8 Care is designed to facilitate self-care and health promotion

Working with, and empowering, patients is a fundamental aspect of medical professionalism. Shared decision-making should be the norm. Patients should have access to information, expert advice and education concerning their clinical status, progress and prognosis. Care should be designed to facilitate autonomy, self-care and health promotion. Medical staff must acquire skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk).

9 Services are tailored to meet the needs of individual patients, including vulnerable patients

Services must be tailored to the needs of individual patients, including older patients who are frail, patients with cognitive impairment, patients with sensory impairments, young people, patients who are homeless and patients who have mental health conditions. The physical environment should be suitable for all patients (eg those with dementia). Services will be culturally sensitive and responsive to multiple support needs.

10 All patients have a care plan that reflects their specific clinical and support needs

Patients must be involved in planning for their care. Patients' care preferences are checked and measures taken to optimise symptom management. Patients and their families must be supported in a manner that enhances dignity and comfort, including for patients in the remaining days of life.

11 Staff are supported to deliver safe, compassionate care and committed to improving quality

Hospitals will support staff to collectively and individually take ownership of the care of individual patients and their own contribution to the overall standard of care delivered in the health system in which they work. Doctors will be supported to embed the principles of medical professionalism in their practice. Staff well-being and engagement will be a priority, in order to promote good outcomes for patients.

Responsibilities for the care of patients must extend beyond traditional ward or team boundaries. Hospitals should look to develop and promote a ‘citizenship charter’ based on the NHS Constitution, the principles of care articulated by the Future Hospital Commission (above), and the ‘Commitments to patients’ set out at the end of this appendix. This should be developed in collaboration with staff, senior managers, hospital chairs and boards, patients and carers, and the wider community.

Principles of medical professionalism

Doctors must expect to provide clinical leadership for the whole care of the patient, working individually and at the system level. All physicians should feel responsible for the quality of basic care provided to patients, and take action whenever they become aware of this being inadequate, regardless of whether the patient is ‘under their care’ or not. This is at the heart of medical professionalism.

Medical professionalism – core principles and values*

1 Medicine is a vocation in which a doctor’s knowledge, clinical skills and judgement are put in the service of protecting and restoring human well-being. This aim is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility and appropriate accountability. Doctors are committed to:

- i integrity
- ii compassion
- iii altruism
- iv continuous improvement
- v excellence
- vi working in partnership with members of the wider healthcare team.

2 Professional values must express the need:

- i **for clinical leadership** for the whole care of the patient, working at direct patient care and at system level to organise care for all patients. The ‘whole care of patients’ covers the care patients receive across specialties, across settings and all domains of quality (eg safety, outcomes and experience). This includes responsibility to raise questions and take actions when they have concerns about care standards.
- ii **to communicate** effectively with patients, their families and carers. Medical and other staff must be trained in communication methods with patients and their families, including the diagnosis and management of dementia and delirium.
- iii **to empower patients** through effective collaboration. Medical staff must acquire skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk).
- iv **to collaborate** with other teams and professions. Medical staff have a responsibility to communicate and collaborate with other teams and professionals to make sure patients receive smooth and effective care throughout the health and social care system.

*Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. London: RCP, 2005.

The Commission's vision for the future hospital

The Future Hospital Commission aims to develop a new model of care that delivers safe, high-quality care for patients across 7 days. In the future, hospital services must be designed to deliver continuity of care as the norm for all patients, including those with multiple and complex conditions. This means delivering specialist and general medical care that is coordinated to meet the clinical, care and support needs of all patients, with clear arrangements for providing ongoing care for patients when they need to move from one place of care to another, including when they leave hospital.

Evolution to this new model of care will involve a range of changes to the way we plan, design, deliver and support hospital services. The focus must be on how hospitals and professionals can build a patient-centred culture in which all are treated with compassion and respect. Current and future patient needs must underpin all aspects of service design: from the way medical professionals train and work, to how information is gathered, used and shared; from managerial and financial structures, to the way staff are supported to deliver the standard of care all patients deserve.

The Commission's overarching vision for the future hospital articulates key components of hospital services in the future.

A new model of clinical care

- 1 Hospital services that operate across the health economy:** Hospitals will be responsible for delivering specialist medical services (including internal medicine) for patients across the health economy, not only for patients who present to the hospital. Integrated working, shared outcomes and real-time communication of information with health and social care partners across traditional hospital and community boundaries will be the norm.
- 2 Seven-day services in hospital:** Acutely ill patients in hospital will have the same access to medical care on Saturdays, Sundays and bank holidays as on a week day. Services will be organised so that consultant review, clinical staff (eg allied health professionals and specialist nurses), and diagnostic and support services are readily available on a 7-day basis.
- 3 Seven-day services in the community:** Health and social care services in the community will be organised and integrated to enable patients to move out of hospital on the day they no longer require an acute hospital bed. Hospital procedures for transferring patient care to a new setting operate on a 7-day basis, with 7-day support from services in the community.
- 4 Continuity of care as the norm:** Care will be organised to maximise the continuity of care provided by the individual consultant physician and key members of the clinical team, with staff rotas organised to deliver this. Once assessed in hospital, patients will not move beds unless their clinical needs demand it. When a patient is cared for by a new team or in a new setting, arrangements for transferring care (through handover) will be prioritised by staff supported by direct contact between staff and information captured in the electronic patient record. Physicians will not only provide continuity during the hospital admission, but also embed this into follow-up consultations and arrangements.

5 Stable medical teams in all acute and ward settings, focused on the whole care of patients:

A greater number of medical and non-medical staff (including consultant physicians and trainees) will participate in the provision of acute services and general ward care, ensuring a balanced workload across medical services and career grades. There will be a consultant presence on wards over 7 days, with ward care prioritised in medical job plans. This will be supported by a longer-term programme to promote internal medicine and increase internal medicine skills and deployment across the medical workforce.

6 Access to coordinated specialist care for all patients: Patients will receive the best specialist care wherever they are in hospital. For patients with multiple and/or complex conditions, there will be input from a range of specialist teams according to clinical need, with a single named consultant responsible for coordinating care. Care will be organised so that there are clear arrangements for the delivery of specialty-specific care to patients wherever they are in hospital, with criteria that allow easy, rapid identification of patients requiring specialist care. Performance of specialist medical teams will be assessed according to how well they meet the needs of patients with specified condition(s) across the hospital and health economy.

7 Early senior review across medical specialties: Patients will have access to early consultant review, which has been shown to improve outcomes for patients. This will include early senior review by specialist teams at ‘the front door’. This will help prevent delays in obtaining specialist medical review for patients with conditions known to benefit such a review 7 days a week. For example, older patients with multiple comorbidities presenting as a medical emergency will have early access to comprehensive geriatric assessment, which is known to improve experience, outcomes and efficiency.

8 Intensity of care that meets patients’ clinical and support needs: The level of care available in hospitals will reflect the acuity and complexity of illness experienced by the current demographic of patients. There will be more enhanced care beds (level 1) relative to acute medical beds (level 0). Nurse staff ratios will match patient requirements for higher intensity monitoring and treatment, including for those with cognitive impairment and/or frailty.

9 Medical support for all hospital inpatients: The remit and capacity of medical teams will extend to adult inpatients with medical problems across the hospital, including those on ‘non-medical’ wards such as surgical patients. There will be ‘buddy’ arrangements between consultant physician teams and designated surgical wards to ensure reliable access to a consultant physician opinion 7 days a week.

10 Focus on alternatives to acute admission and supporting patients to leave hospital: Care will be organised so that ambulatory (‘day case’) emergency care is the default position for emergency patients, unless their clinical needs require admission. Systems will ensure ambulatory care patients continue to receive prompt specialist care aligned to their needs, maximising alternatives to acute hospital admission, and improving safety, outcomes and experience of patients. Early senior assessment will support a focus on advanced care planning, with planning for recovery/movement out of hospital starting from the point of first assessment.

11 Care delivered by specialist medical teams in community settings: Much specialised care will be delivered in or close to the patient’s home. Physicians and specialist medical teams will expect to spend part of their time working in the community, providing care integrated with primary,

community and social care services with a particular focus on optimising the care of patients with long-term conditions and preventing crises.

- 12 Holistic care for vulnerable patients:** There will be high-quality, seamless care for patients with dementia. Effective care for this group of patients will help set a standard of care of universal relevance to vulnerable adults. The design and delivery of services will also consider the specific needs of the most vulnerable patients and those known to have poorer levels of access and outcomes, eg patients with mental health conditions and patients who are homeless. The provision of holistic care that meets patients' needs should be the responsibility of all staff. This will be embedded in a hospital-level citizenship charter, based on the NHS Constitution.

Evolution to the future hospital vision of care

- 13 The medical workforce meets the needs of patients across the system:** Medical education and training will develop doctors with the knowledge and skills to manage the current and future demographic of patients. This includes the expertise to manage older patients with frailty and dementia, and lead and coordinate the 'whole care' of patients in hospital and into the community. Across the overall physician workforce there will be the skills mix to deliver appropriate: specialisation of care (ie access to sufficient specialty expertise to deliver diagnosis, treatment and care appropriate to the specific hospital setting); intensity of care (ie access to sufficient expertise to manage, coordinate and deliver enhanced care to patients with critical illness); and coordination of care (ie access to sufficient expertise to coordinate care for patients with complex and multiple comorbidities). Most physicians, whatever their specialty, will possess and deploy a combination of these skills across their careers.
- 14 Internal medicine is valued and promoted:** The importance of acute and (general) internal medicine is emphasised from undergraduate training onwards, and acute and (general) internal medicine is attractive to doctors at all stages of their careers. A greater proportion of doctors are trained and deployed to deliver expert (general) internal medicine care, developing the knowledge and expertise necessary to diagnosis, manage and coordinate continuing care for the increasing number of patients with multiple and complex conditions. The contribution of medical registrars is valued, and they are supported by structured training in (general) internal medicine, increased participation in acute services and ward-level care by all medical trainees and consultants, and enhanced consultant presence across 7 days.
- 15 Clinical workloads are regularly reviewed:** Workforce planning is undertaken with an appreciation of clinical demand and the professional skills mix required to meet this demand. Attention is paid to variation in demand and peak time of day to ensure staffing can adequately meet the demand. The organisation of workloads and allocation of tasks is underpinned by a clear understanding of professional roles and responsibilities.
- 16 Non-elective medical care is prioritised:** Management structures, financial models and leadership roles will be designed to support and enhance the delivery of high-quality non-elective and urgent care, and embed strong clinical leadership.
- 17 Information is used to support care and measure success:** Clinical records will be patient-focused and contain accurate, high-quality information on patients' clinical and care needs. Information will be held in a single electronic patient record, developed to common standards and viewable in both the hospital and community in order to support the coordination of care.

18 Hospitals and the healthcare system are innovative and research driven: Research – and staff involvement in research – is valued and supported at the highest level in the hospital, and the opportunity to participate is promoted to patients.

19 Fundamental standards of patient care will always be met: The principles of basic patient care will underpin the design and delivery of all hospital services and professional practice. Patients will always:

- i be treated with kindness, respect and dignity, respecting privacy and confidentiality
 - ii receive physical comfort including effective pain management
 - iii receive proper food and nutrition and appropriate help with activities of daily living
 - iv be in clean and comfortable surroundings
 - v receive emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on themselves, their families and their finances.
- (*Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chaired by Robert Francis QC. London: Stationery Office, 2013.)

20 A patient-centred culture will operate, delivering compassion and respect for all patients: Hospital services and professional practice will be based around 10 core principles:

- i **Patient experience is valued as much as clinical effectiveness.** Patient experience is measured, fed back to ward and board level, and findings acted on.
- ii **Responsibility for each patient's care is clear and communicated.** This is led by a named consultant working with a (nurse) ward manager.
- iii **Patients will have effective and timely access to care.** Time waiting for appointments, tests, hospital admission and moves from hospital will be minimised.
- iv **Patients will not move wards unless this is necessary for their clinical care.** Care, including the professionals who deliver it, will come to patients.
- v **Robust arrangements for transfers of care will be in place.** These arrangements will operate between teams when a patient moves within the hospital, between teams when staff shifts change, and between the hospital and the community.
- vi **Good communication with and about patients will be the norm.** This will include appropriate sharing of information with relatives and carers.
- vii **Care will be designed to facilitate self-care and health promotion.** Patients will have access to information, expert advice and education, and will be empowered to manage their care by trained staff.
- viii **Services will be tailored to meet the needs of individual patients,** including vulnerable patients. The physical environment will be suitable for all patients (eg those with dementia); services will be culturally sensitive and responsive to multiple support needs.
- ix **All patients will have a care plan that reflects their specific clinical and support needs.** Patients will be involved in planning their care. Patients, their families and carers will be supported by expert staff in a manner that enhances dignity and comfort.
- x **Staff will be supported to deliver safe, compassionate care and will be committed to improving quality.** Hospitals will support staff to take individual and collective ownership of the care of individual patients and their contribution to the overall standard of care delivered in the health system in which they work.

21 Doctors will embed the principles of medical professionalism in their daily practice. Medical professionals are committed to integrity, compassion, altruism, continuous improvement, excellence and working in partnership with members of the wider healthcare team (Royal College of Physicians' *Doctors in society*, 2005). Doctors assume clinical leadership (at individual patient and system level) for the care patients receive across specialties, across settings and across all domains of quality, eg safety, clinical outcomes and patient experience. This includes responsibility to raise questions and take action when there are concerns about care standards; communicate effectively with patients, their families and carers, and empower them through effective collaboration; and collaborate with other teams and professions to make sure patients receive smooth and effective care throughout the health and social care system.

Achieving the future hospital vision – 50 recommendations

The Commission's specific recommendations set out a 'road map' for achieving the vision of a future hospital in which all patients receive safe, high-quality care coordinated to meet their clinical and support needs across 7 days. The Commission's recommendations are drawn from the very best of our hospital services, taking examples of the innovative, patient-centred services that exist now to develop a comprehensive model of hospital care fit for the future.

The recommendations focus on the care of medical patients, hospital services, and the role of physicians and doctors in training across the medical specialties. However, it is clear that all parts of the health and social care system, and the professionals who populate it, have a crucial role to play in developing and implementing changes that improve patient care and meet the needs of communities. The Commission hopes that these recommendations will form the first step in a longer programme of activity that results in real change across hospitals, and the wider health and social care economy in which they operate.

A new organisational approach (chapter 3)

1 Bring together medical services and staff into a single Medical Division.

All medical specialty directorates and all directorates involved in the delivery of medical care should come together and develop a culture and working practices that facilitate collaborative, patient-centred working. This will include specialist teams working together to meet the needs of patients, including patients with complex conditions and multiple comorbidities. In the new Medical Division, all teams will:

- i allocate substantial resources to staffing the Acute Care Hub, general medical and surgical wards, intensive care and enhanced care areas
- ii include a named consultant lead, 7 days per week, for any given ward area (with this name displayed prominently in the ward area). The consultant will be in charge of coordinating care for all patients in that space, and be supported by a team of junior medical staff and allied health professionals, and with extremely close links with the ward manager and other nursing leaders
- iii ensure that key/lead members of the Medical Division team attend the Clinical Coordination Centre daily to coordinate the care of their patients with relevant others, manage admissions, and transfers out of hospital, and attend multidisciplinary team meetings.

2 Bring together clinical areas focusing on initial assessment and stabilisation of acutely ill medical patients in a single Acute Care Hub.

The Acute Care Hub will focus on accommodating patients for up to 48 hours, and be sized, staffed and resourced in accordance with the population served in terms of demand, case mix and emergency provision of relevant services. It will need rapid and 7-day access to relevant diagnostic (laboratory and imaging) services, and rapid access to endoscopy, echocardiography and physiological testing. It is anticipated that the Acute Care Hub will be the location for the majority of the hospital's level 1 (enhanced care) beds and contain a dedicated ambulatory care centre. This Hub will be aligned with and managed via the Clinical Coordination Centre.

3 Establish a Clinical Coordination Centre as the operational command centre for both the hospital site and the Medical Division operating across the health economy, with strong links to all acute, specialist and primary care and community teams.

The Clinical Coordination Centre will be the focal point for data, feedback, team liaison and performance monitoring for physicians, clinical directors, the chief of medicine and the relevant clinical and administrative support team(s). It will collect detailed information 24 hours a day relating to patient demand and provision of services and related service capacity, in order to support continuing service improvement.

4 Establish new, senior, operational roles focused on prioritising the coordination of medical care.

- i **Chief of medicine** – a senior clinician tasked with setting the standard and direction of the hospital-based and relevant community medical services. The chief of medicine (supported by a team) would be responsible for ensuring that all medical specialty directorates and all directorates involved in the delivery of medical care (emergency medicine, intensive care, oncology) develop culture and working practices that facilitate collaborative cross-specialty working, including the implementation of agreed clinical guidelines.
- ii **Acute care coordinator** – an operational role overseeing the Clinical Coordination Centre, and supporting the chief of medicine.
- iii **Chief resident** – a doctor in training, reporting to the chief of medicine, and responsible for liaising between doctors in training in the Medical Division and the chief of medicine and senior clinical managers.

Staffing the Medical Division (chapter 4)

5 Increase participation in and coordination of ward care provision and acute services by:

- i prioritising ward care provision in all medical job plans
- ii using annualised job plans with blocks of time dedicated to the acute service with no conflicting clinical commitments in that time
- iii measuring staffing demand and aiming to organise staffing that will accommodate at least two-thirds of maximum demand
- iv planning coordinated job plans for teams
- v providing mechanisms for all staff to understand all parts of the system; this may include rotation through individual services (eg Acute Care Hub, general wards and community services) or regular meetings with all team members (eg multidisciplinary team meetings).

6 Organise care to focus on consistent early consultant review.

Patients are most vulnerable when they are admitted as medical emergencies to hospital. Consistent early consultant review improves these patients' outcomes. The focus of how care is organised in front door areas, the Acute Care Hub (ACH), should be on the quality, safety and continuity of the care delivered. Consultants and their medical teams should have dedicated duties in the ACH and be rostered together on successive days. Co-location of the acute medical unit, short-stay and ambulatory emergency care in the ACH will promote continuity of care and improve safety and teaching.

7 Develop the level of expertise in (general) internal medicine.

Patients now rarely present to hospital with a medical problem confined to a single organ system. Medical specialty trainees should dual accredit with (general) internal medicine. The great majority of patients with longer lengths of stay in hospital are older people and have multiple comorbidities. (General) internal medicine trainees should have the knowledge and expertise to care effectively for these inpatients.

8 Collaboratively define standard procedures that operate across the Medical Division.

These criteria should allow easy identification of patients requiring specialist care and entry to rapid admission pathways and the level of clinical input from the specialty required. These should be reviewed annually. This will help prevent delays in obtaining specialist medical review in patients with conditions known to benefit such a review 7 days a week. In particular older patients with multiple comorbidities presenting as medical emergencies should have early access to comprehensive geriatric assessment, because of the particular expertise geriatricians and their teams have in improving outcomes and using healthcare resources efficiently.

The hospital–community interface (chapter 5)

9 Establish a Medical Division with oversight of and collaborative responsibility for specialist medical services across the hospital and wider health economy.

Delivery of specialist medical care should not be confined to those patients who present at hospital or are located in the services' designated beds or clinics in hospital, but should operate across the whole hospital and wider health economy. To support this:

- i The Medical Division, led by a chief of medicine, should work closely with partners in primary, community and social care service to develop shared models of delivery and outcomes for all the specialist medical services (including internal medicine) across the hospital and health economy.
- ii Specialist physicians should assess the performance of their service according to how well it meets the needs of patients with specified needs/conditions across the hospital and health economy.

10 In hospital, develop systems that support a single initial point of assessment and ongoing care by a single team.

- i Develop clinical criteria that define which patients require specialty consultation, advice or management on a specific pathway. This will be supported by clearly defined specialist services available to provide rapid assessment in 'front door' areas to facilitate fast-track referral to specialty pathways.

- ii Patients assessed as likely to have a stay in hospital of less than 48 hours will usually be admitted to the acute medical unit *unless* their requirements for rehabilitation are likely to mandate care on a specialist or internal medicine ward. Protocols for routes of admission should be developed.
- iii Patients admitted to the acute medical unit should be under the care of a single consultant-led team. The same should apply to patients for whom ambulatory care is deemed appropriate. This will mean designing rotas that allow the consultant reviewing the patient on admission to review the patient the next day. Arrangements must be in place to ensure that specialty care is accessible to patients in all locations across the hospital.

11 Increase the focus on ambulatory (day case) emergency care, enhanced recovery and ‘early supported discharge’.

The focus should be on developing systems and ways of working that enable patients to leave hospital safely as soon as their clinical needs allow. To support this:

- i Ambulatory emergency care should be the default position for emergency patients, unless admission is required on the basis of clinical need. This will require changes to ways of working, including ensuring early involvement of senior decision-makers, particularly consultants.
- ii Planning for recovery should happen from the point of admission. This ‘enhanced recovery’ will require proactive review and communication with patients to encourage effective self-management.
- iii Systems that encourage ‘early supported discharge’ should be developed. These can include specific ‘hospital at home’ teams working in collaboration with the treating inpatient team or as part of a community team operating on a 7-day/week basis.
- iv Collaborative ‘discharge to assess’ models that allow patients’ care and support needs to be assessed in their own homes should be developed.

12 Develop new systems and ways of working that deliver more specialist medical care outside the hospital setting.

The growing needs of patients for secondary care services cannot be met by confining these services to the hospital site. To better meet patients’ needs across the health economy:

- i Physicians should expect to spend part of their time working in the community, providing expert care integrated with primary, community and social care services
- ii Physicians should take a lead in developing specialist models of care that operate beyond the ‘hospital walls’ and into the community (including in care homes)
- iii There should be a particular focus on optimising the care of patients with long-term conditions and preventing crises.

13 Develop systems that enable hospitals to become the hub of clinical expertise and supporting technology for the local population, particularly in relation to diagnostics and treatment.

This can be supported by the development of:

- i Shared referral pathways and care protocols across the system to support integrated working with health and social care partners. This would be underpinned by rapid, relevant sharing of information, mechanisms for rapid admission and referral, and effective arrangements for enabling patients to leave hospital, with support where necessary
- ii Information systems that bring together all relevant clinical information, including that from primary and community care, mental health, social and hospital services in one electronic patient

record (EPR). Immediate access to this comprehensive EPR is particularly important in the assessment of patients presenting as a medical emergency. (*See chapter 9 for further recommendations on the use of information*)

- iii An in-hospital Clinical Coordination Centre that collates and disseminates information that allows patients' needs to be matched to the care and service capacity available within the health economy. This should support the joined-up administration of urgent care, 'out-of-hours' systems and hospital-based parts of the Medical Division.

Specific services: care for older people with frailty, people with mental health conditions, people who are homeless, and young people and adolescents (chapter 6)

14 Perform a comprehensive geriatric assessment on older people with frailty arriving at hospital as a medical emergency.

15 Develop liaison psychiatry services to improve services for people with mental health conditions.

It is recommended that:

- i all general and acute hospitals should have a dedicated on-site liaison psychiatry service. This service should cover all wards and the emergency department/acute medical unit 7 days a week, for a minimum of 12 hours a day, with appropriate access out of hours
- ii physicians must offer a liaison service to mental health trusts, to meet the need of patients with severe mental illness and medical comorbidities
- iii rapid access to specialist psychiatric support should be a priority for emergency referrals, where patients are an immediate risk to themselves, other patients or staff, including those admitted following self-harm
- iv priority should also be given to other patients throughout the hospital where mental health assessment is needed to guide clinical management decisions such as further investigation or treatment or where a patient is considered medically fit for discharge.

16 Develop services that deliver coordination, enhanced access and advocacy for other vulnerable groups.

- i **People who are homeless.** Hospitals should develop models of care that deliver for people who are homeless by developing services that embed core standards for homeless health.
- ii **Young people and adolescents.** Hospitals should develop models that deliver age appropriate care.

The changing workforce (chapter 7)

Short term (0–6 months)

17 Assess how the current medical workforce needs to adapt to deliver the future model of care required by patients.

Responsibility for the delivery of care must be assumed by trained practitioners. The medical workforce will need to adapt to ensure that it can meet demographic pressures, and deliver continuity of care, 7-day services, and integration of hospital and community healthcare in a sustainable

fashion. The shape and skill set of the workforce required must then be defined at national and local levels.

Medium term (6–24 months)

18 Medical consultants should allocate appropriate time to working in acute and/or (general) internal medicine in the Medical Division.

The role, time commitment and management/clinical supervision of those working and training in acute and/or (general) internal medicine in the Medical Division should increase. A majority of medical consultants who are experienced in acute and/or (general) internal medicine must allocate an appropriate time (estimated at 20–25%) working in these areas to provide leadership, supervision, education and training. The proposed new model of care will be adopted simultaneously by the medical specialties, where there are examples of improvements in patient care and efficiency.

19 Expand the number of trainees working in acute and (general) internal medicine in the Medical Division.

There should be planned growth in numbers of trainees in acute and (general) internal medicine. In addition to this, curricula and time allocations to (general) internal medicine in the medical specialties should be changed to increase participation in the planned Medical Division, within a timescale of 2 or 3 years.

20 Dual training with (general) internal medicine should be the norm across the physicianly specialties.

Participation in (general) internal medicine training will be mandatory for those training in all medical specialties. The model of a Medical Division assuming overall leadership and responsibility for the delivery of care is designed in part to facilitate and promote the development of (general) internal medicine and chronic disease management and multiple morbidity.

Longer term (2–5 years)

21 Promote and develop (general) internal medicine as a specialty of standing equal to all other medical specialties.

(General) internal medicine should be promoted as a valuable and attractive career option, alongside acute and intensive care medicine. The mechanisms for doing this – and ensuring (general) internal medicine, acute medicine, emergency medicine, intensive care medicine, geriatric medicine, etc remain attractive career options – should be explored. This would complete the senior workforce needed for the delivery of the care pathway.

22 Develop a more structured training programme for (general) internal medicine.

In the future, the GMC-approved curriculum for (general) internal medicine should be applied to all training posts in physicianly specialties. This would be modified in time to encompass significant appointments in community-based and primary care, and surgical and obstetric wards within the hospital environment. Increased liaison with anaesthetists in the pre-operative assessment of patients, providing support for enhanced care areas, and a clear interface with the existing specialties of acute medicine and care of the elderly are anticipated. Key competencies would involve leadership and coordination of patient care across different physical areas and specialties and chronic disease management.

23 Consider developing the position of chief resident within all acute hospitals.

The chief resident, a trainee doctor, would act in a liaison role between medical staff in training working in the Medical Division and the chief of medicine and senior clinical managers. This leadership development post would have a key role in planning the workload of medical staff in training, medical education programmes and quality improvement initiatives.

24 Evaluate, develop and incorporate other medical roles into the future hospital model.

- i The staff and associate specialist grade should be evaluated, developed and incorporated into the future clinical team in a role and at a level of responsibility appropriate to their competencies.
- ii The roles of advanced nurse practitioner and physician associate should be evaluated, developed and incorporated into the future clinical team in a role and at a level of responsibility appropriate to their competencies.

Management: prioritising non-elective medical care (chapter 8)

25 Rebalance resource allocation to prioritise non-elective and urgent care.

This will need to be accompanied by the development of new funding models that do not favour elective and procedural services at the expense of urgent care. The delivery of general urgent care should form a greater proportion of total income. In England, existing funding anomalies must be resolved through general improvements in coding and costing methodology, normative adjustments to tariff based on best practice and/or local determination based on optimum patient care as agreed between commissioners and providers.

26 Ensure strong service-line management and reporting systems that genuinely devolve responsibility to clinical service lines.

This will need to be accompanied by realigned resources; reconsideration of board role; engagement with clinical leaders about changed roles and responsibilities, including training where necessary.

27 Give the chief of medicine sufficient financial and operational management authority to effect change, with strong cooperation with non-clinical managers.

28 Develop strong clinical leadership from board level to individual clinical teams.

Using information to support care and measure success (chapter 9)

29 All systems for recording data about patients should be electronic.

Where this is not currently possible it should be a priority to achieve it.

30 The individual patient must be the primary focus of electronic patient records and systems.

Hospitals should ensure that, in the migration to electronic patient records, the primary focus is the individual patient, not their disease, intervention or the context in which they are seen.

31 Clinical data should be recorded according to national standards for structure and content.

This includes data contained in case notes, handover documents and other formats. The NHS number should be the universal identifier in England and Wales.

32 The information needs of the hospital at every level should be generated from data recorded in the patient record in the course of routine clinical care (except in rare circumstances).

There should be minimal duplication of data collection for both direct and indirect patient care.

33 Data held in the record should be validated by both the clinician and the patient.

This validation would help ensure that the data quality is good enough for both individual patient care and (when anonymised and aggregated) to inform other purposes. These other purposes include audit, quality improvement, performance assessment, commissioning, training and research. Clinicians should ensure the quality of data by keeping accurate clinical records in a standardised format, and their support for clinical coding processes.

34 Patient records and information systems should be accessible to patients.

Patient records and information systems should enable patients and, where appropriate, carers, to access and contribute to the information needed to manage their condition effectively.

35 Hospitals should embrace innovation in information and communications technologies in order to develop new models of care, and to improve quality of care and the patient experience.

All applications must conform to national standards for safety and quality.

36 Encourage and support clinical leadership in information and communications technology.

This should include the appointment at board level of a chief clinical information officer.

Research and development (chapter 10)

37 All hospital boards should receive a regular report of research activity.

It is recommended that an executive director is responsible for promoting research within the hospital and reporting on research activity on a regular basis.

38 Clinical and research commitments of staff must be integrated.

Careful planning and generation of capacity are essential in order to balance service delivery, high quality training and ensure that those undertaking research have protected time for this work.

39 Academic opportunities should be available and attractive, and research skills promoted among medical trainees.

40 Patients should be given the opportunity to participate in research where appropriate.

Building a culture of compassion and respect (chapter 11)

41 Design healthcare services around the ‘seven domains of quality’.

The seven domain of quality are defined as:

- i **Patient experience:** The patient should be the definitive focus of healthcare delivery. ‘Quality healthcare’ may not be the same for every patient.
- ii **Effectiveness:** Healthcare should be underpinned by the deployment of beneficial interventions at the right time and to the right patients.

- iii **Efficiency:** Healthcare must make the best use of limited resources. Avoidance of waste should apply to material and abstract (eg time, ideas) resources.
- iv **Timeliness:** Timeliness is key to avoiding waits and potentially harmful delays in the delivery of healthcare, incorporating the deployment of health interventions to anticipate and prevent illness.
- v **Safety:** Although risk in healthcare cannot be reduced to zero, it must be actively managed with the minimisation of harm a definite objective.
- vi **Equity:** Healthcare must strive for a level playing field, in which patients determine their own high-quality care, and in which the needs of the many and the few are balanced.
- vii **Sustainability:** Sustainability should be viewed as a characteristic of healthcare which must run through and moderate other domains. Healthcare should be considered in terms of what can be delivered not only to an individual today, but also to the population in general and the patients of the future.

42 Embed patient experience in service design and delivery

The guidance on *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services*, published by the National Institute for Health and Care Excellence, and the accompanying Quality Standard should underpin the design and delivery of all adult NHS services.

43 Develop mechanisms for measuring patient experience on an ongoing, structured and real-time basis, and publish the results in the public domain.

Patient experience data should be triangulated and reviewed to ensure the best possible information is available to: inform patients and the public; encourage hospitals, clinical teams and individual clinicians to reflect on their practice and drive improvement; and (potentially) reward excellence by linking income to the achievement of local goals of improved patient experience. Systems that enable the real-time reporting of patient experience (such as that at Northumbria Healthcare NHS Foundation Trust) should be promoted across the health system.

44 There must always be a named consultant responsible for the standard of care delivered to each patient.

Patients should be given written information about which consultant is responsible for their care and how they can be contacted. The named consultant will work with a ward manager and assume joint responsibility over a specified period to ensure that basic standards of care are being delivered, and that patients are being treated with kindness and respect.

45 Develop nurse leadership and promote the role of the ward manager.

The delivery of holistic care to patients is a joint responsibility of doctors and nurses. Ward managers are at the centre of the patient experience and must have the status and authority to oversee standards of care delivery and the ward environment. The Future Hospital Commission supports the principles set out in the Royal College of Nursing publication, *Breaking down barriers, driving up standards*.

46 Coordinate ward rounds between medical and nursing staff.

There should be clear allocations of responsibility in preparation for and following ward rounds in order to promote patient participation, protect vulnerable patients and ensure nursing involvement. Future management plans for patients need to be discussed between doctors and nurses, as well as

other members of the healthcare team and the patient, with excellent communication, so that everyone is working towards the same goal, within and between teams. The Future Hospital Commission supports the recommendations in the Royal College of Physicians and Royal College of Nursing publication, *Ward rounds in medicine*.

47 Promote communication, shared decision-making and effective self-management.

Clinicians and patients should work together to select tests, treatments or management plans, and support packages based on clinical evidence and the patient's informed preferences. In order to achieve this:

- i Evidence-based information should be provided about patients' options, including potential outcomes and areas of uncertainty.
- ii Decision support counselling and a system for recording and implementing patients' informed preferences are needed.
- iii Medical and other staff must be trained in communication with patients and their families, including around the diagnosis and management of dementia and delirium.
- iv Medical staff must acquire skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk).

48 Give staff time and support to deliver safe, high-quality patient-centred care.

Hospitals must review staffing ratios and staffing capacity to ensure that they reflect the complexity and needs of the current patient mix across all wards.

49 Invest in tools that support individual responsibility, shared ownership and reflective practice.

- i Staff must collectively and individually take ownership of the care of individual patients, and of their contribution to the overall standard of care delivered in the health system in which they work. Staff must be supported and encouraged to do this by colleagues, senior staff and the board through the development of a Citizenship Charter (building on the NHS Constitution). This should put the patient at the centre of everything the hospital does, be developed with patients, staff, managers and governors, and be a priority for all trusts.
- ii Hospitals must invest in systems that enable staff to reflect on the care they deliver. This includes building reflective practice into training and the requirements for continuing professional development, developing good appraisal processes for staff, and investing in mechanisms that enable staff from all disciplines and all levels to discuss difficult emotional and social issues arising from patient care (eg Schwartz Center Rounds®).

50 Hospitals should make staff well-being and engagement a priority, in order to ensure high-quality patient care.

Future hospital: Our commitments to patients

Hospitals and healthcare staff are encouraged to make the following commitments about how they will care for patients. These commitments are designed to communicate to patients the care they should expect when they are admitted to hospital.

Our commitment to patients – Moving beds

- > We will move you only 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 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 why you are there (unless there are circumstances that mean this is not appropriate).

Our commitment to patients – Communication

- > We will make sure you know who is in charge of your care at all times.
- > We will discuss your care with you and take your wishes into account.
- > We will keep you informed about your illness, tests, treatment and care.
- > We will make sure you know who to speak to if you have any questions or concerns about your care.
- > We will make sure that all medical staff who review, treat and look after you are well informed about you and your illness. As far as possible, we will make sure that you are looked after on one ward, with one medical team in charge of your care.
- > If you need to be cared for by a new team or on a new ward, we will explain the reasons for this in advance.
- > We will make sure new staff introduce themselves and explain their role.

Our commitment to patients – Leaving hospital

- > We will plan the care and support you need after leaving hospital in discussion with you.
- > We will keep you informed about plans for when you leave hospital throughout your hospital stay.
- > We will be clear about the arrangements for your care after you leave hospital.
- > We will make sure you know who to contact if you become unwell after you leave hospital.
- > We will make sure that any staff providing care for you outside hospital know what happened during your hospital stay.
- > We will make sure arrangements are in place to get you home safely at the end of your hospital stay.

Appendix 2

Recommendations for the RCP

- 1 The RCP should work with a selection of hospitals to review the impact of the Future Hospital Commission's recommendations. This work should focus on establishing how the future hospital model can be implemented across hospitals, and the wider implications for hospitals, healthcare teams, patients and the wider healthcare economy. This will involve working with other health and academic bodies to ensure the successful identification, operation and evaluation of pilot sites.
- 2 The RCP should explore the Commission's recommendations with other healthcare professionals and groups, including other royal colleges, specialist societies, employer organisations and patient groups. This could take the form of a post-report consultation exercise. The aim of this exercise should be to:
 - a understand the potential impact on medical education, training and deployment
 - b develop more detailed recommendations around the operation and interaction of medical and other teams
 - c identify further examples of existing good practice and link with other initiatives around 7-day working, reconfiguration and the integration of care.
- 3 The RCP should continue to communicate the impact of the *Future hospital* on patients, patient care and healthcare staff. This will involve ongoing engagement with medical and other healthcare professionals, the public, politicians, policy-makers and hospital managers. The development of tools to support the understanding and implementation of the Commission's proposals should be considered – from briefing papers to practical toolkits to support improved ways of working.
- 4 The RCP should identify routes of influence and key stakeholders responsible for implementing the Commission's recommendations and develop a comprehensive influencing plan for England and Wales. In England, this should include consideration of the potential role of new health service structures, including clinical commissioning groups, local education and training boards, and academic health science networks.
- 5 The RCP should explore how it can develop and utilise its existing committees and networks to develop and promote the messages set out in the Future Hospital Commission report. For example, through the development of regional 'future hospital champions'.

- 6 The RCP should promote the sharing of good practice across the country, and facilitate greater collaboration. In order to do this, the RCP should explore options for collecting and promoting examples of good practice in service design and redesign. For example:
 - a via online case studies and discussion forums
 - b by establishing a new online, peer-reviewed Future Hospital journal
 - c through the ongoing development of the RCP's clinical commissioning hub.*
- 7 The RCP should identify priorities for further investigation. The RCP should consider undertaking specific work to explore:
 - a the promotion of (general) internal medicine
 - b integration and collaboration across hospital and community settings
 - c safe and appropriate staffing levels
 - d staff roles and deployment in the future hospital model, including clinical leadership models that support the 'whole care' of patients.
- 8 The RCP establish how the Future Hospital Commission's vision can be embedded across the breadth of its work, from education, training and professional development, to quality improvement and leadership. This should include continuing to develop programmes of work that:
 - a support a renewed focus on standards of ward-based care (eg the 'Quality Mark for elder-friendly wards')⁺ and patient experience
 - b aim to develop a medical profession focused on empowering patients to manage their own care (eg through activities around shared decision-making and building an engaged workforce)
 - c develop the environment necessary to support coordinated patient care (eg projects focused on health informatics and medical ward rounds)
 - d support doctors – both consultants and doctors in training – to raise and address concerns about patient care in their hospital.
- 9 The RCP should explore establishing a Future Hospital Implementation Group involving a broad spectrum of partners to oversee this work. This group should also ensure alignment with the RCP's and the medical profession's response to the Francis Inquiry.

*Royal College of Physicians. www.rcplondon.ac.uk/projects/clinical-commissioning-hub

⁺Royal College of Psychiatrists. Overview of the Quality Mark for Elder-Friendly Hospital Wards. www.rcpsych.ac.uk/quality/qualityandaccreditation/elder-friendlyqualitymark/overviewofthequalitymark.aspx

Appendix 3

The future hospital described: overview of new models and roles

1 New structures in the future hospital

Medical Division (see chapter 3 for full description)

In brief: *The Medical Division will assume clinical, managerial and budgetary responsibility for all inpatient beds and clinical areas supporting the care of medical patients (with the exception of those aligned to paediatrics, obstetrics and possibly some specialised surgical wards).*

a We suggest bringing together medical services and staff into a single Medical Division.

All medical specialty directorates and all directorates involved in the delivery of medical care (emergency medicine, intensive care, oncology) should come together and develop a culture and working practices that facilitate collaborative, patient-centred working. This would include specialist teams working together to meet the needs of patients, including patients with complex conditions and multiple comorbidities.

b The Medical Division would need:

- > a unified managerial and financial structure
- > strong clinical leadership through a new chief of medicine and supporting team
- > a 'Clinical Coordination Centre' led by an acute care coordinator – a single coordinating point for clinical, staffing and service monitoring and deployment
- > to be staffed by an extended multidisciplinary team engaged with admission through to leaving hospital and back into the community
- > block working and annualised job planning across 7 days for medical staff and teams working in the Medical Division, including greater rotation through the acute medical take and participation in the management of 'general' wards
- > greater specialist in-reach and outreach across wards and into the community, with shared outcomes across teams, wards and pathways
- > handover and transition meetings at prescribed times, involving consultants, medical trainees and other clinical staff (nurses, therapists, physician's assistants/care practitioners)

- > the implementation of agreed clinical criteria that identify inpatients who require:
 - specialty review on admission
 - ongoing specialty care throughout admission
 - referral for a specialty consultation early in the course of admission.

c What services would be included in the Medical Division?

Services provided by the Medical Division would include:

- > acute internal medicine and (general) internal medicine service (including the ‘acute take’ service)
- > specialty medical services
- > intensive care service
- > emergency department (ED)
- > nursing staff and allied health professions involved in acute care, including pharmacists
- > medical care to patients receiving surgery in hospital
- > access to rapid diagnostics (imaging and laboratory)
- > access to mental health
- > access to palliative care
- > interface with community-based:
 - GPs
 - physical facilities (eg primary care, enhanced care)
 - care homes
 - social care and support
 - mental health.

d The focus of the Medical Division and its teams would be:

- > delivering a 7-day service
- > ensuring acutely ill patients (medical and surgical) are located in areas according to severity of illness and/or the intensity of clinical services required to care for them
- > making sure patients with complex needs, including older people with multiple comorbidities, have coordinated access to multiple specialists (as appropriate) in order to support both their medical and care needs
- > providing patients requiring acute surgical services with more structured management of their medical problems
- > making sure the right person is made available with the right skills for undertaking tasks, irrespective of professional label
- > early senior review
- > early (multidisciplinary) planning for leaving hospital, with advanced care and support plans developed in conjunction with the patient and/or the family/carers
- > ambulatory care
- > delivering multiprofessional care that spans the entire patient pathway and is integrated at all levels to promote quality of care, seamless transition and cost efficiency from admission through to leaving hospital and back into the community.

In practice, this would mean implementing policies, procedures and ways of working that embed these operational principles. This would require the Medical Division and its constituent teams to:

- > deliver a shared culture and objectives across all medical specialty teams, underpinned by local/national standards, standard operating procedures and a single, electronic assessment and care plan accessible to all staff via the Clinical Coordination Centre
- > clearly delineate tasks and responsibilities – doctors will be called upon to institute and supervise treatment along a care pathway but may not deliver that care, which may be done better by other health professionals
- > Develop protocols to assist in standardised treatment, supervising a team of allied health professionals who perform consults, investigations, pathway delivery, and facilitating community management through multidisciplinary team leadership and input. Physicians will be asked to support the delivery of specialist care in a devolved manner and take responsibility for reviewing and improving the clinical outcomes.

Acute Care Hub (see chapter 3 for further information)

In brief: *The Acute Care Hub brings together the clinical areas of the hospital that focus on the initial assessment and stabilisation of acutely ill medical patients, including the acute medical unit, ambulatory care centre, short-stay bed capacity and (dependent on local circumstances) the emergency department. It is one part of the Medical Division.*

- a We suggest bringing together clinical areas focusing on initial assessment and stabilisation of acutely ill medical patients in a single Acute Care Hub. This would include:
 - > acute medical unit (AMU)
 - > ambulatory care centre
 - > short-stay bed capacity
 - > augmented care facility
 - > ED (depending on local circumstances).
- b The Acute Care Hub should focus on accommodating for up to 48 hours – envisaging that the majority of patients in the Acute Care Hub would be transferred to community care.
- c It should be sized, staffed and resourced in accordance with the population served in terms of demand, casemix and emergency provision of relevant services.
- d It should be aligned with and managed via the Clinical Coordination Centre.
- e It is anticipated that the majority of the hospital's level 1 (enhanced care) beds will be located within the Acute Care Hub.
- f Rapid and 7-day access to relevant diagnostic (laboratory and imaging) services would be provided. Rapid access to endoscopy, echocardiography and physiological testing will be mandatory. Electronic access to clinic and community care appointment systems will be essential.
- g Dedicated ambulatory care centre designed as a sophisticated outpatient department with seated waiting areas, consulting rooms and facilities for procedures is proposed.
- h Specific rooms should be available in the Acute Care Hub for practical procedures, discussions with patient and/or carers about sensitive medical decisions, and for palliative care provision.

Clinical Coordination Centre (see chapter 3 for further information)

In brief: *The Clinical Coordination Centre is the single coordinating point for clinical, staffing and service monitoring and deployment. It would be based in the hospital, but would coordinate medical care across the health economy.*

The Clinical Coordination Centre (CCC) is:

- > the operational command centre for both the hospital site and the Medical Division operating across the health economy, with strong links to all acute, specialist and primary care and community teams
- > the physical area from which all hospital and relevant community care is coordinated for all patients who are the responsibility of the Medical Division.

The Clinical Coordination Centre would:

- > be the operational base 7 days a week for the acute care coordinator, supporting the duties of the on-call physician(s), senior nurses and allied health professionals
- > be the focal point for data, feedback, team liaison and performance monitoring for physicians, clinical directors, the chief of medicine and the relevant clinical and administrative support team(s)
- > collate and share information identifying each member of staff with lead responsibilities within the Medical Division on any given day and their contact details. Also included would be information on any staff shortages and actions taken to mitigate the effects of such shortages
- > host daily clinical handover meetings with video/teleconference links to external sites and teams
- > collect detailed information 24 hours a day relating to patient demand and provision of services and related service capacity, in order to support continuing service improvement
- > be a 24/7 central coordination point for tele-monitoring, telephone and email helplines for patients and professionals, operating in partnership with primary care
- > support the development and adherence to care pathways, record clinical incidents, identify service requirements and patterns of clinical demand with access to data, including:
 - service capacity (physical, staff) on hospital site and in the community
 - staff rotas, duties and availability
 - clinical information from the electronic patient record (EPR)
 - location, acuity of illness and clinical status
 - results of new investigations and imaging
- > provide an automated system for registering, logging and communicating when prompted by predefined clinical triggers with alerts for clinical staff in circumstances such as
 - patient approaching defined upper waiting time defined by that service
 - deteriorating patient (change in National Early Warning Score (NEWS))
 - booked outpatient enters hospital
 - high-risk patient presents to ED
 - patient who is potentially eligible for a clinical trial
 - clinical incidents, near misses and registered complaints.

2 Key roles in the future hospital

This new vision of how the front end of the hospital and beyond will work in practice is supported with creation of new roles and expansion of existing positions, responsible for the placement and care of patients who need acute medical admission. How these roles fit together and are implemented in practice will depend on the size and nature of hospitals and other local circumstances.

Chief of medicine (see chapter 3 for further information)

In brief: *The senior clinician responsible for leading the Medical Division, reporting professionally to the medical director and operationally to the chief executive.*

The management would be tailored to the size of the hospital and range of services provided, and the nature and scope of the role are likely to vary. However, there are some common principles:

- > Chief of medicine would be a senior clinician tasked with setting the standard and direction of the hospital-based and relevant community medical services.
- > They would report professionally to the medical director and operationally to the chief operating officer or chief executive.
- > In larger hospitals, the chief of medicine would chair the medical board made up of clinical directors of specialties and therapy services, the head nurse and senior representatives of community-based services (including primary care physicians in their role as staff members of community services such as 'step down' intermediate care).
- > They could assume a budgetary responsibility.
- > They would be provided with an appropriate level of administrative and managerial support. Clinical support would be delivered via:
 - acute care coordinator (running the Clinical Coordination Centre), with an individual or team assuming that role in rotation
 - chief clinical information officer
 - director of medical education
 - core team including directors of nursing, allied health professionals, social and community care and the specialty or divisional directors
 - chief resident.

The duties of the chief of medicine would include:

- > ensuring that all medical specialty directorates and all directorates involved in the delivery of medical care (emergency medicine, intensive care, oncology) develop a culture and working practices that facilitate collaborative cross-specialty working, including the implementation of agreed clinical guidelines
- > addressing gaps in care and discontinuity of care
- > setting care performance standards including generic standards operating throughout all medical specialties who work within the Division (eg 7-day working, planning for leaving hospital at first consultant review, collaboration with other teams, daily board rounds on all wards)
- > fostering strong working relationships with commissioners and providers across the local health economy, working with local commissioners to establish and monitor quality standards of care (in line with the recommendations of the Francis Inquiry)
- > overseeing the development and monitoring of an agreed set of local clinical guidelines
- > focusing on developing staff culture (eg development and application of a Citizenship Charter/NHS Constitution/Francis Inquiry findings)
- > monitoring the service load and optimal deployment of all non-consultant medical staff, particularly specialist registrars
- > having a specific role in planning and recruitment of consultant staff, ensuring that junior medical staff are adequately supported throughout the Division and that their workload and training are monitored regularly

- > developing, coordinating and leading major-incident policy and planning within the locality (through the Clinical Coordination Centre).

Acute care coordinator (see chapter 3 for further information)

In brief: *The acute care coordinator has operational responsibility for overseeing the Clinical Coordination Centre and Acute Care Hub in support of the chief of medicine.*

The acute care coordinator would:

- > be an operational role overseeing the Clinical Coordination Centre and Acute Care Hub, and supporting the chief of medicine
- > assume the role either permanently or for a block of continuous time (eg a 5-day period), with rotas designed on a rolling 7-day basis
- > be based in the Acute Care Hub to ensure close working with the acute team, receiving referrals and assessing acutely ill patients
- > represent the Acute Care Hub at Clinical Coordination Centre meetings to ensure knowledge of ward transfers throughout the hospital and thereby be able to advise/assist ward teams in overcoming barriers to safe moves out of hospital
- > identify and place patients presenting with acute illness in hospital or community settings that meet their requirements
- > be able to advise clinical staff about the ambulatory emergency care service and medical specialty and internal medicine outpatient services to facilitate moves out of hospital or as an alternative to admission
- > have clinical experience, and sufficient seniority and expertise to make decisions about placement of patients
- > possess detailed knowledge of the provision of acute health and social services both in their secondary care and community environment.

Divisional medical team

The team would comprise the consultant and trainee medical workforce and allied healthcare professionals. Teams in the Medical Division would:

- > allocate substantial resources to staffing the Acute Care Hub, general medical and surgical wards, intensive care and enhanced care areas
- > include a named consultant lead, 7 days per week, for any given ward area (with this name displayed prominently in the ward area). The consultant would be in charge of coordinating care for all patients in that space, and be supported by a team of junior medical and allied health professionals, with extremely close links with the ward sister and other nursing leaders
- > ensure key/lead members of the Medical Division team attend the Clinical Coordination Centre daily to coordinate the care of their patients with relevant others, manage admissions, transfers, and attend multidisciplinary team meetings.

Chief resident (see chapter 3 for further information)

In brief: *A medical trainee responsible for liaising between the junior medical staff working in the Medical Division and the chief of medicine and senior clinical managers.*

The chief resident would:

- > work with and report to the chief of medicine
- > act in a liaison role between the junior medical staff working in the Medical Division and the chief of medicine, and senior clinical managers responsible for delivery of the service
- > be a key participant in planning service redesign and delivery in relation to junior medical staff deployment, rotas, workload and duties. This includes reaching agreement on arrangements to delegate specific duties to non-medical staff
- > usefully contribute to the junior doctor educational programme, in conjunction with the RCP college tutor, and initiatives relating to patient safety and quality improvement
- > have allocated time in their job plan for administration and be supported by the team working with the chief of medicine
- > expect to enter a programme of leadership and management training tailored to their requirements and career aspirations.

Appendix 4

The future hospital explained

This appendix answers the following questions:

- 1 How will the future hospital deliver safe, coordinated care for patients across 7 days?
- 2 How will the future hospital deliver coordinated specialist care for all?
- 3 How can the future hospital and education and training structures promote (general) internal medicine?
- 4 How will medical work plans be organised in the future hospital?
- 5 How can hospitals assess the workforce needs of the future hospital?

1 How will the future hospital deliver safe, coordinated care for patients across 7 days?

At ward level

- > There will be a consultant presence on wards over 7 days, with ward care prioritised in medical job plans.
- > There will be a named consultant responsible for the care delivered to each patient, every day. Patients should be given written information about which consultant is responsible for their care and how they can be contacted. This consultant will be in charge of coordinating care for all patients on the ward.
- > The named consultant will work with a ward manager and assume joint responsibility for ensuring that basic standards of care are being delivered, and that patients are treated with respect, compassion, kindness and dignity.
- > To support this, nurse leadership and the role of the ward manager will be developed and promoted.
- > There will be a greater role for doctors working as 'generalists' and geriatric medicine physicians in coordinating and providing continuing inpatient care. These 'generalists' will include acute and intensive care doctors and consultants deploying their skills in (general) internal medicine in dedicated blocks of time. These doctors will assume responsibility for the 'whole care' of patients, coordinating specialist input from other consultants and medical teams for all patients whose clinical needs require it, wherever they are in hospital.
- > Every non-medical ward will have a linked medical team with a named consultant lead. This team will provide input to patients with medical needs, eg surgical patients with medical needs.
- > Hospitals will review staffing levels to ensure that they reflect the complexity and needs of the current patient mix across all wards. The intensity of patient care, including nursing numbers, will match patient needs, including for patients who have dementia or are frail.

- > There will be clinical handover meetings at each shift change and arrangements for medical ward rounds will involve the nursing team and other key professionals, with responsibility for preparation and follow-up clearly allocated. There will be whole team meetings with other professionals to review each patient's care plan and their arrangements for recovery and leaving hospital.

At hospital level

- > There will be a new Medical Division, responsible for all medical services across the hospital – from the emergency department and acute and intensive care beds, through to general and specialist wards. It will be led by a senior doctor (the chief of medicine) who will make sure that teams work together towards common goals and in the best interests of patients.
- > A greater number of medical staff (including consultant physicians and trainees) will participate in the provision of acute services and 'general' ward care, ensuring a balanced workload across medical services and career grades. This will be supported by a longer-term programme to promote internal medicine and increase internal medicine skills and deployment across the medical workforce.
- > There will be daily contact between the chief of medicine, acute care coordinator, key ward staff and staff tasked with coordinating patient care and transfer within hospital and into community services. This will involve one or more meetings daily (in person or virtually) in the Clinical Coordination Centre. The focus of these meetings will be on movements on or off the wards, across the acute service and other transitions of care.
- > Once admitted to hospital, patients will not move beds unless their clinical needs demand it. When a patient is cared for by a new team or moved to a new setting, there will be rigorous arrangements for transferring their care (through 'handover'). This process will be prioritised by staff and supported by information captured in an electronic patient record that contains high-quality information about patient's clinical and care needs.
- > Expert, senior input will often be 'front-loaded' to provide expert diagnosis and care planning for patients as soon as possible when they arrive in hospital. This will mean making sure that specialist medical teams are available at the hospital 'front door' for dedicated blocks of time. Specialist medical teams will work together with emergency and acute medicine consultants to diagnosis patients swiftly, allow them to leave hospital if they do not need to be admitted, and plan the most appropriate care pathway if they do. If a patient's care needs permit, these consultants and specialist medical teams may move to a more consulting role, with oversight on an ongoing basis and in accordance with agreed procedures.
- > Specialist medical teams, nurses and GPs will have a specific focus on continuity of care for patients within their remit who have repeated admissions or complex care needs. Communication systems will alert these staff to the admission of patients known to them (eg patients who are homeless or have a mental health condition). The specialist medical teams will support ward staff, and help to 'pull' patients back into the community.
- > The Clinical Coordination Centre will be supported by data on service capacity and patient referrals. This will enable the acute care coordinator and clinical teams to match service capacity and resources to patient need in hospital or in the community.
- > Information systems will be in place to enable clinical data to be entered and accessed electronically in a single standardised record, available to all clinical staff in both hospital and community settings.
- > Consultants, supported by specialist nurses, the acute care coordinator and the chief of medicine, will ensure that local operational performance standards are adhered to.

At health economy level

- > Specialist medical care will not be confined to inside the hospital walls. The Medical Division's remit will extend to the provision of specialist medical services across the health economy, working closely with partners in primary, community and social care services. They will deliver and manage services together, with shared outcomes focused on the needs of patients.
- > Physicians and specialist medical teams will expect to spend part of their time working in the community, with a particular focus on caring for patients with long-term conditions and preventing crises. Much specialised care will be delivered in or close to the patient's home. There is considerable scope for specialty medicine services to follow the lead of geriatricians, respiratory physicians and diabetologists and extend expert care into the community, particularly for older patients with chronic long-term conditions.
- > Performance of specialist medical teams will be assessed according to how well they meet the needs of patients with specified condition/s across the hospital and health economy.
- > The clinical teams providing specialist medical care in the community are an inherent part of the Medical Division and will participate in Clinical Coordination Centre meetings to facilitate expert assessment and transitions of care between settings.
- > Information systems will be built around the needs of patients, irrespective of their location in the health economy. This should support self-care and ready access to primary, community and specialist care as required to manage long-term conditions or acute illness. The information held in the Clinical Coordination Centre would evolve to include information from hospital services, primary and community care, mental health and social care, all held in a single electronic patient record. There would be rapid, relevant sharing of information across the local health economy, mechanisms for rapid admission and referral to hospital, and effective arrangements for patients ready to leave hospital. The electronic patient record, like the provision of health and social care, should be seamless and joined up between care providers.
- > Information systems should enable patients to coordinate their care including obtaining expert advice, making appointments, and receiving clinical letters, reports and results.

2 How will the future hospital deliver coordinated specialist care for all?

Specialist teams will need to adopt new ways of working to ensure that patients receive rapid expert advice and access to specialist services. These will include the following:

- > Agreement across the Medical Division on the clinical criteria that define which patients require a specialty consultation, advice or management on a specific pathway (eg a patient with an acute stroke requiring access to stroke services).
- > Regular review of the number of designated specialty inpatient beds according to patient needs (eg annual review).
- > Arrangements in place to ensure that specialty care is accessible to all patients irrespective of their location in the hospital. Shared responsibility for the quality of clinical care and clinical outcomes for patients with conditions relevant to that specialty, irrespective of patient location.
- > Clearly defined specialist services available to provide rapid assessment in 'front door' areas to facilitate fast-track referral to specialty pathway or expert ambulatory care.
- > For each specialty, a named specialty lead available each day to patients under the care of the Medical Division.

- > Standardised operating procedures to support other clinical teams in all settings to provide care for patients who have a given condition.
- > Rapid access to specialist clinics or to specialist services provided within the framework of ambulatory emergency care (AEC).
- > Integrated working in the community alongside primary care and community services to assist in the management of long-term conditions, new assessment, and to promote self-management, proactive case management and enhanced hospital discharge.
- > Provision of enhanced structured specialty training, eg in geriatrics or ongoing care responsibilities in internal medicine, to ensure that many more trained doctors have specific skills to meet the needs of patients, particularly those who are older, frail, or have multiple comorbidities.
- > Consultant presence on wards over 7 days, with ward care prioritised in medical job plans.
- > A greater role for doctors working as 'generalists' and geriatric medicine physicians in coordinating and providing continuing inpatient care. These doctors will assume responsibility for the 'whole care' of patients, coordinating specialist input from other consultants and medical teams for all patients whose clinical needs require it, wherever they are in hospital.
- > Performance of specialist medical teams will be assessed according to how well they meet the needs of patients with specified condition/s across the hospital and health economy.

3 How can the future hospital and education and training structures promote (general) internal medicine?

The future hospital model relies on the creation of a cadre of doctors expert in the management of patients and diagnosis, and committed to coordinating care for patients across medical specialties and care settings. This will necessitate a suite of changes – from training to deployment – not just for those currently working as 'generalists', but also those working in specialty fields. Work in this area is likely to be ongoing, and involve a suite of changes at hospital and national level, including to the structure of medical education and training.

- > A greater number of medical staff (including consultant physicians and trainees) should participate in the provision of acute services and 'general' ward care, ensuring a balanced workload across medical services and career grades. This more balanced workload, with more appropriate supervision and training, should help promote internal medicine as an attractive career pathway.
- > (General) internal medicine should be perceived as a specialty on a par with any other. The name of 'general internal medicine' should be changed to 'internal medicine'. The impressive element of diagnostics should be promoted, for example by reclaiming 'grand rounds' where complex cases are presented as learning opportunities.
- > 'Generalists' should be promoted as specialists in diagnosis, quality improvement and whole systems leadership, medical education and coordination. The key competencies required to be an effective 'generalist' should be promoted in order to demonstrate and develop internal medicine as an interesting and varied career pathway. Key elements of an internal medicine career pathway might include: community working and long-term conditions care; service and system-level quality improvement; expert diagnosis, care management and coordinated treatment planning; and clinical leadership roles.
- > Dual training with (general) internal medicine should be mandatory across the physicianly specialties and increase the workforce participating in acute and/or (general) internal medicine throughout their careers.

- > A more structured training programme for (general) internal medicine should be developed. In the future, a curriculum for (general) internal medicine approved by the General Medical Council should be applied to all training posts in the physicianly specialties.
- > Training in (general) internal medicine must be educational, involve rotation through other specialties to get experience of management of complex, clinically interesting cases and procedures. More rigorous training assessment should be considered, eg separate annual review of competence progression (ARCP), separate supervisor and specialty certificate examination in (general) internal medicine.
- > The working environment for medical registrars should be improved through continued focus on building stable teams and working patterns that deliver continuity of care for patients and appropriate access to and supervision by consultants.
- > There should be standard operating procedures for specialty referrals so that (general) internal medicine is delivered in a structured, consistent way with agreed areas of responsibility across teams.
- > Role models working in (general) internal medicine should be promoted and developed. The chief of medicine and chief resident roles proposed by the Future Hospital Commission would support this.
- > The academic prestige of (general) internal medicine should be promoted, eg academic chairs in (general) internal medicine, links to clinical excellence awards or similar.
- > A national body for (general) internal medicine could be developed to promote the specialty, and provide supportive and educational opportunities for doctors working in (general) internal medicine.

4 How will medical work plans be organised in the future hospital?

- > Ward care provision and participation in the acute service should be prioritised in medical job plans.
- > There should be annualised medical job plans with blocks of time dedicated to the acute service with no conflicting clinical commitments in that time.
- > Consultant career planning (or review) should allow for development in 'generalist' roles. This is likely to involve working in roles that differ in intensity over time.
- > Staffing capacity should be organised to accommodate at least two-thirds of maximum demand.*
- > This means accepting that there will be 'down time' for staff that should be used for education and professional development.
- > There should be coordinated job plans for teams. This applies to groups of physicians responsible for acute care duties and also to the multidisciplinary team. This facilitates clear role definition and contributions to be defined. It also enables colleagues to maximise the service they provide as a team and the support they give to each other to perform personal tasks.†
- > There should be documented agreed standard operating procedures for the teams, specific to the location in which they are working.
- > There should be mechanisms for all staff to understand all parts of the system. This may include rotation through individual services (eg Acute Care Hub, general wards, and community services) or regular meetings with all team members (eg multidisciplinary team meetings).

*Health Foundation. *Improving patient flow*. London: Health Foundation, 2013.

†NHS Employers. Team job planning. *Job planning handbook*. www.nhsemployers.org/SiteCollectionDocuments/Team_job_planning_aw_050309.pdf

5 How can hospitals assess the workforce needs of the future hospital?

a Understanding local need and capacity

In order to function effectively and meet the needs of patients and the communities they serve, hospitals need to understand the specific conditions in which they operate. This means assessing:

- > patient input (eg presentations and admissions)
- > patient needs (eg diagnosis, treatment and care needs)
- > services available on-site, including hours available
- > access to services off-site and 'out-of-hours'
- > on-site capacity – physical (eg bed capacity)
- > on-site capacity – staffing (including breakdown of workload by staff type)
- > staffing skills mix (by profession; by qualification, career grade and specialty).[‡]

b Understanding the physician workforce

Physicians will play a key role in ensuring that patients receive the care, diagnosis and treatment they need. It is therefore crucial to understand the spectrum of care required by patients and ensure a physician workforce that can deliver it. Hospitals will need an overall physician workforce that collectively delivers across the following three areas of care:

- > **specialisation of care needs** – access to sufficient specialty expertise to deliver diagnosis, treatment and care appropriate to the specific hospital setting
- > **intensity of care needs** – access to sufficient expertise (and patient:staff ratios) to manage, coordinate and deliver enhanced care to patients with critical illness; for example, patients requiring enhanced (level 1), high dependency (level 2) or intensive (level 3) care
- > **coordination of care needs** – access to sufficient expertise to coordinate care for patients with complex and multiple comorbidities (including frailty and dementia), irrespective of hospital inpatient setting.

Most physicians, whatever their specialty, will possess and deploy a combination of these skills. However, there will be areas in which some specialties have particular skills, experience and training.

In addition, the individual and collective physician workforce should have the skills to deliver across all aspects of medical professionalism, including:

- > leadership
- > improvement
- > innovation.

c Deploying physicians across their careers

Across a single physician's career, the balance of time spent focusing on each of the three aspects of care (specialisation, intensity and coordination) is likely to vary.

[‡]Academy of Medical Royal Colleges. *Seven day consultant present care*. London: AoMRC, 2012.

Similarly, although all physicians should be equipped with the core skills of medical professionalism from the start of their careers, these attributes and areas of expertise are likely to evolve as their careers develop. Therefore, allowing flexible deployment as careers develop will enable hospitals to take advantage of the skills and expertise developed. It will also help ensure that expert physicians are able to continue to contribute to the future hospital across their careers and in the best interests of patient care, and maintain their well-being.

Appendix 5

View from the chief of medicine

The Future Hospital Commission envisages a new role for a senior doctor, the chief of medicine. The chief of medicine will lead the hospital's Medical Division, and be responsible for the coordination and delivery of all medical services. This role is described in chapter 3. The exact nature and duties of this role, and the facilities and staff that support it, will vary from hospital to hospital depending on scale and scope. However, a snapshot of their activities and responsibilities, provided from the perspective of the chief of medicine, is given below.

Transfer of care meeting

I arrive at the Clinical Coordination Centre (CCC) first thing when the new Medical Division team takes over. The key doctors and nurses responsible for the care of very ill patients for the week ahead gather at the same time to receive a briefing from the night team about existing patients and their needs, introduce themselves to colleagues, and familiarise themselves with the clinical responsibilities for the coming week.

This 'transfer of care' briefing includes:

- > the acute care coordinator
- > the doctors in training working in the general medical service, including the 'chief resident'
- > the consultants allocated to the acute medical unit (AMU), augmented care area and general medical wards
- > specialists who will provide us with on-call and consultation services during the next week (including consultants expert in the treatment of stroke, heart attacks and heart failure, respiratory problems, gastrointestinal bleeding, care of the elderly, and care of the dying)
- > the lead nurses and/or advanced practitioners in these specialties
- > the outreach intensive care doctor of the week
- > the allied health professionals allocated to the medical service.

That's a lot of people to remember! But, it's backed up with information on screens displaying the names, roles, locations and contact details (bleep and mobile) of all staff working in the Medical Division team that day. As the Medical Division and its teams work out into the community, there are also details of the member of staff responsible for coordinating with community teams. We also have the details of our tertiary clinical networks, the liaison psychiatry team, and other clinical colleagues, such as

pharmacists, radiologists and surgeons. We also have good links with local GPs, and there are facilities for them to dial in to the meeting if necessary.

Information shared at the meeting

The screens in the Clinical Coordination Centre tell us how many patients are currently in the hospital, and how ill they are (using the National Early Warning Score to detect patients whose condition is deteriorating). This is all linked to the electronic patient record (EPR). The Picture Archive and Communication System (PACS) is available for image display, and is also used in the X-ray meeting with consultant radiologists. Software to record multidisciplinary team meetings (MDTs), and conversations with relatives and carers is also accessible.

In the transfer of care meeting, the team settles down to look at the screens where the patient data are displayed. The night team (last night in this hospital, that consisted of one AMU consultant and two ward consultants, supported by a team of doctors in training) summarise the clinical state of patients in the AMU. They identify patients within the general medical wards and enhanced care areas who either need opinions from specialist medical teams, or have had clinical problems overnight that need to be addressed.

The social care team for the week is introduced. The hospital is fortunate in having its information systems linked to local general practices, care homes and other relevant community facilities. In our area, this includes three urgent care centres (UCCs) run by the hospital 12 hours a day, 7 days a week. This ensures that patients can leave hospital for their home or another care setting on a daily basis, or be seen at the UCC should this prove to be necessary.

At the meeting I usually give a five-minute talk about the work of the hospital or Division in the previous week (with which those present may not be familiar), put up a five-minute clinical case quiz of a patient presenting the previous week, or emphasise any issue (eg bad weather, local festival) that may impact on the service in the coming week.

As many members of the team as possible will meet for an X-ray meeting and to discuss any other relevant clinical matters at 1.00pm. The team will then reassemble to hand over to the night team from 6.30pm. These meetings are repeated throughout the 7 days.

Facilities in the Clinical Coordination Centre

The development of the Clinical Coordination Centre has been a revelation. When they were reorganising the layout of the hospital, the management team were quick to involve clinicians so it really meets our needs. As well as gathering real-time information to help us coordinate care for patients, it has a range of other facilities.

Along the side of the room, there are volumes containing the standard operating procedures for the hospital, including the clinical care pathways. Offices – including mine – lie off this room to one end, next to a seminar room which we use to run through interesting cases or ‘walk through’ care from the perspective of an individual patient. Informal tutorials occur throughout the week as part of the teaching programme, supervised by the hospital’s director of education and chief resident. There are booths with computers linked into educational and reference facilities for senior and trainee doctors to use. There is a rest area equipped with coffee-making facilities and more comfortable seats for the night team.

The Patient Advice and Liaison Service (PALS) – who provide advice and information to patients, relatives and carers, and address complaints – is based just outside. Being in close proximity to PALS helps them address issues quickly and directly with members of the team here. We also have private rooms in which relatives, patients and carers can meet both medical and social support staff.

This week's staffing levels

This week the Acute Care Hub (which houses the AMU, enhanced care area and ambulatory care centre) will have two consultants in the AMU, although they have access to the specialty consultants of the week to help out as needed. I like to nominate one of them as acute care coordinator, as this area requires particular attention and leadership.

For my hospital, there can be anything up to six other consultant staff plus their allocated trainee doctors who will cover the eight medical wards and provide input for medical patients on four surgical wards. The majority possess the competencies to work in all areas as needed, which allows me to deploy reinforcements to areas of the Division that are under particular pressure. This week, of the six working on the wards, four are 'seconded' from their specialist services to provide part of their commitment to (general) internal medicine (GIM) – typically this amounts to 20–25% of their time across the year. The others have decided to pursue a career in (general) internal medicine and/or acute medicine.

The chief resident is also a key member of my team. She is a trainee gastroenterologist, but is taking time out from her medical training programme to take up this management post. She will manage the medical trainees, allocating them to the AMU, enhanced care area and wards. At the end of the transfer-of-care meeting she will provide each with their training objectives for the week and allied teaching programme.

Ways of working

Consultants responsible for each ward area review patients over 7 days – sometimes twice a day – unless we decide that this will not change their pathway of care. The consultants make sure that the patients' NEWS scores are updated, and their 'escalation of care' sheets are reviewed. They will contact appropriate specialist teams according to the hospital's agreed protocols of care, and make themselves available to relatives and carers as a central part of their role. In brief, they assume total responsibility for the level and quality of care delivered to patients on the ward, working closely with the ward manager.

The specialist areas (coronary care, stroke unit, respiratory failure unit, care of the elderly/cognitive impairment) are run in the same way, with a consultant of the week in attendance. They frequently request 'generalist' opinions (eg from acute and intensive care doctors) or other specialists (eg geriatric medicine consultants), and provide specialist consultation across the Medical Division.

I also arrange for direct communication with GPs to advise about patients suitable for rapid turnaround, and patients who may need assessing on my unit. We often have GPs supporting us in this way in the hospital. As well as providing more joined-up care for patients, this has really improved our communication and our understanding of the challenges that we face across primary and secondary care. It has also fostered some innovative new ways of working.

My responsibility leading and delivering medical care

After the morning transfer-of-care meeting, I have my weekly meeting with the medical director, the director of nursing, allied health professional lead and the PALS representative. This operational group will review our patient feedback from the previous week, and work down the quality dashboard.

I may meet family members of a patient who has died. Part of my role, and that of the director of nursing, is to review and deal with complaints concerning the management of patients within the Division and to ensure that all staff comply with the Citizenship Charter. This was developed by the local care community and patients, and aims to embed an individual and collective responsibility for standards of care in all staff working in the hospital.

Later in the morning I shall be meeting the finance director, as I also have budgetary responsibility for the service. We are undergoing a workforce review at present to identify and predict future needs for the hospital within the Acute Care Hub and beyond, as the hospital aims to extend its services into the community. I will also meet each of the medical specialty leads to ensure that they are satisfied with the service they are providing to the patients, both within the hospital and externally to general practice and augmented care centres.

As well as leading the Division, I also still have an important role caring for patients. This afternoon I will assist in the AMU caring for patients. To carry out this role successfully, it is vital that I maintain my medical knowledge and skills. I need to see my teams working in practice, and I still provide expert consultation for patients. I'm passionate about internal medicine and hope that I encourage other doctors in the Division to see what a rewarding career pathway it can be. My chief resident in particular is clearly a medical leader of the future, with a real passion for quality improvement work.

➤ See online case study on the role of a chief of medicine at Brighton and Sussex University Hospitals (www.rcplondon.ac.uk/fh-case-studies)

Dr Lawrence Goldberg, consultant nephrologist and chief of medicine, talks about the medical divisional structure in Brighton, the responsibilities of the chief of medicine, the challenges and the vision for the future of the role.

Appendix 6

The medical workforce explained

National changes to postgraduate medical education

Health Education England (HEE) was established in June 2012. Its function is to provide national leadership and coordination for education and training within the health and public health workforce in England. It is also tasked with supporting healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of local education and training boards (LETBs), and with ensuring that the shape and skills of the health and public health workforce evolve with demographic and technological change.

The board of each LETB contains a majority of providers which will engage the service far more in both the delivery of education and its strategic planning. It is expected that the type of physician trained in the future will be one that primarily meets the future needs of the service.

HEE is also one of seven joint, UK-wide sponsors of the Shape of Training review (www.shapeoftraining.co.uk) which is expected to be completed by September 2013. The other partners are the Academy of Medical Royal Colleges, the General Medical Council (GMC), the Medical Schools Council, NHS Education Scotland, NHS Wales and the Northern Ireland Department of Health (DH), Social Services and Public Safety. Together, they make up the sponsoring board for the review. The review's aim is to make sure that postgraduate training produces effective doctors who are fit to practise in the UK, provide high-quality and safe care, and meet the needs of patients and the service both now and in the future.

Shape of Training will look at potential reforms to the structure of postgraduate medical education and training across the UK and will consider issues proposed in this report, including the proper balance between specialism and generalism in medicine, the implications for education and training of more healthcare being delivered in the community, how to balance the workforce demands of health services with the learning needs of trainees and how to create flexible models of training that can respond to the changing requirements of both patients and healthcare services.

The Shape of Training review follows significant developments in UK medical education and training in recent years, including reports such as *Aspiring to excellence* (authored by Sir John Tooke, 2008)* that

**Aspiring to excellence*. Finding and final recommendations of the independent inquiry into Modernising Medical Careers. Led by Professor Sir John Tooke. www.medschools.ac.uk/AboutUs/Projects/Documents/Final%20MMC%20Inquiry%20Jan2008.pdf

followed the independent inquiry into Modernising Medical Careers. Following Tooke, other inquiries and reports highlighted the need to develop the current structure of postgraduate medical training so it continued to provide consistent, high-quality training for doctors throughout the UK.

HEE already has some schemes in existence relevant to the Future Hospital, such as *Better Training Better Care*, which oversees pilot projects on new models of training; for example, the use of telemedicine to allow consultants to participate remotely in night-shift handovers. Simulation training for multiprofessional teams enables them to manage serious incidents more effectively.

The current medical workforce: medical trainees

Specialty trainee numbers are currently determined nationally, a role assumed by HEE in conjunction with the royal colleges, specialist societies, postgraduate deans and LETBs.

The Centre for Workforce Intelligence (CfWI) was formed following a review of the NHS published in 2008, *A high quality workforce*, which highlighted the need for better workforce planning across the health and social care system. The government's White Paper *Equity and excellence: liberating the NHS*, published in July 2010, states that 'the Centre for Workforce Intelligence will act as a consistent source of information and analysis, informing and informed by all levels of the system'.

In responding to the Shape of Training review the RCP has proposed that all doctors should be offered more flexible job plans to allow less than full-time working, career breaks and a healthier work–life balance. A larger number of both trainees and consultants with training in (general) internal medicine would allow more flexibility in delivering clinical care according to the model proposed here.

Individual trainees should retain the flexibility to do research or undertake other out-of-programme experience, accepting that the demands of timeline and geography need to be accommodated.

Academic trainees in particular are required to complete academic training alongside clinical training, for example by taking time out to complete a PhD (chapter 10). The needs of individual trainees must be taken into account and training programmes must enable them to take time out of the clinical training pathway, and to move back into it at an appropriate point. Such flexibility would be aided by moving to a competence-based curriculum from a time-based system. They should be able to progress at a pace that reflects their clinical and academic abilities. Trainees should be actively involved in planning their competency acquisition and in conversations about their progression.

The RCP also supports the concept that all who wish to take time out of training for voluntary work, medical education, and medical management, leadership or IT should be permitted to do so. Also, taught MSc or MD degrees in clinical subjects or health service research should be available to all doctors in training (chapter 10).

Trust doctors, clinical fellows and trust grades

This is an unregulated group. Appointments to these grades have varying meanings, contractual arrangements, and terms and conditions. Temporary usually short-term contracts are customarily awarded with little development/educational support provided.

Doctors in these grades range in their competency from Core Medical Training (CMT) level to those with Certificates of Eligibility for Specialist Registration (CESR) or Certificate of Completion of Training (CCT) awaiting consultant appointments. They are not covered under the Specialty and Associate Specialist Contract. Such doctors are often employed by trusts to cover gaps in rotas where trainees with national training numbers have been removed. Around 200 such posts were created in three trusts alone in London in autumn 2012.

Staff and associate specialist doctors

Staff and associate specialist (SAS) doctors are non-consultant grade, non-training doctors, and currently comprise two groups:

- > **Associate specialists** are senior doctors with significant experience and skills able to work independently at consultant level. Examples exist of associate specialists running acute medical units (AMUs), taking part in unselected on call and contributing equally with consultants on specialist rotas (eg in thrombolysis, endoscopy). Such doctors can contribute to teaching, research, appraisal and educational supervision of trainees. They have a key role in outpatient services working independently. Associate specialists have a 'named consultant' to whom they are responsible but of whom they work largely independently. Although this grade has been closed to new entrants since 2009, there is an appropriate national salary structure and contract.
- > **Specialty doctors** must have four years' full-time equivalent (FTE) postgraduate training in UK of which two years must have been in the relevant specialty. It is the employer's responsibility to determine the competencies required for the post and to ensure the doctor can fulfil them. The doctor has a professional obligation to perform to these competencies. Threshold 1 specialty doctors require more supervision than those in threshold 2. A national salary structure exists, the highest point of which is significantly lower than that of associate specialist.

In the 2012 Academy of Medical Royal Colleges (AoMRC) publication, *Benefits of consultant delivered care*, the benefits referred to were considered in comparison to trainees only. The contribution from SAS doctors was not considered. The association of SAS doctors and the AoMRC SAS Committee strongly argued that wherever the term consultant is used, a rider is included, for example: 'or senior doctor with appropriate competencies, to include those in associate specialist and senior specialty and staff grade posts,' or to use the term senior doctor.

In the AoMRC paper on 7-day working, SAS doctors were acknowledged as working at consultant level. The Academy intends the term 'consultant' to include any doctor who is on the GMC specialist register or certain senior doctors with appropriate competencies, to include those in staff, associate specialist and senior specialty doctor grade posts and consultant clinical scientists.

The SAS doctors are working at consultant level in supporting acute admissions and providing patient care. Significant numbers of SAS doctors in other specialties (eg emergency medicine, anaesthetics, orthopaedics and psychiatry) support essential services by working at consultant level, unsupervised. SAS doctors have specialty expertise and can contribute their specialist knowledge to emergency or 'hot' clinics in a range of specialties including syncope, gastroenterology, endocrine services, stroke/TIA clinics and can provide specialist testing in a variety of specialties (eg Echo, endoscopy, and specialist procedures) (Box 7).

Box 7 The numbers: staff and associate specialist doctors (2011; all figures refer to whole-time equivalents).

- Total of 3,286 associate specialists in UK, 4,889 specialty doctors, 702 staff grades
- The regions with highest number of SAS doctors are London, South West, West Midlands and North West. In the South West, SAS doctors account for 30 % of trained workforce
- Variation between trusts within regions
- Most associate specialists are above 50, with reduced numbers below 45 years of age, in contrast to consultants where greatest number are in 40–45 age group
- Specialty with highest numbers of SAS doctors is emergency medicine. For example, 1,100 consultants, 651 SAS doctors. Other areas are psychiatry, trauma and orthopaedics, anaesthetics
- In medicine, specialties with highest number of SAS doctors are care of older people, genitourinary medicine, dermatology, cardiology and diabetes/endocrinology.
- Some specialties form 25 % of the senior medical workforce

Health and Social Care Information Centre. *NHS staff – 2001–2011* (detailed results table). March 2012. [www.hscic.gov.uk/searchcatalogue?productid=4876&topics=1 % 2fWorkforce % 2fStaff+numbers&sort=Relevance&size=10&page=4#top](http://www.hscic.gov.uk/searchcatalogue?productid=4876&topics=1%2fWorkforce%2fStaff+numbers&sort=Relevance&size=10&page=4#top) [accessed 4 September].

Consultants/specialty trained doctors (ie those in possession of a CCT)

Competencies gained pre-CCT (Certificate of Completion of Training) should be based on knowledge and skills required by the majority of post-CCT practitioners. The competencies should be more transferable, which would allow more flexibility in changing specialties and training more doctors for certain specialties.

The term ‘consultant’, which defines status, terms and conditions of service (increasingly locally defined and agreed), may or may not be helpful to patients and the wider NHS. Employment of trained doctors rather than consultants might assist this. For those who are nearing the completion of their CCT, ‘acting up’ to assume a trained role under supervision would assist the transition between grades.

Mandatory mentoring, specific induction and support mechanisms, and formal clinical management oversight of those appointed post-CCT as independent practitioners should be introduced. Thus, although the CCT is a nationally recognised requirement by employers and the GMC, it is important for the service and employer to understand that many or most physicians will undergo further post-CCT training.

There should be more opportunity for consultants at all stages of their career, by agreement with their employing organisation, to change their workload. Post-CCT training, in the form of credentials or fellowships, needs to be nationally planned, organised, managed and funded to best serve the changing needs of the patient population.

There should be a phased and structured consultant career with further professional development and learning throughout. The appointment of chief of medicine (and associate, deputy, etc) should attract prestige, authority, support and terms and conditions of service likely to make it a highly desirable career aim.

Non-medically qualified care practitioners: physician associate

The role of the physician associate (PA), backed up by statutory regulation, should be developed. Regulated PAs should be able to prescribe in the same way nurses can in the current system.

The PA* role has been a part of the healthcare community for 40 years in the USA, but is still relatively new to the UK, having been developed centrally through the DH's 'New Ways of Working' programme, as well as through local initiatives. A national Competence and Curriculum Framework was published by the DH in 2006,[†] having been developed by a group chaired jointly by the RCP and the Royal College of General Practitioners (RCGP) and involving university and strategic health authority (SHA) representatives, USA-trained PAs working in the UK and members of patient panels. It was reviewed and revised in the light of experience earlier this year[‡] and continues to provide a national structure for PA training and assessment.

Many of those entering PA training are new to the health service. The development of this new cadre is therefore less unlikely to denude existing health professions of experienced and skilled practitioners in the way that some other middle-level provision might.

PAs train to fulfil a role within the medical team and work always as dependent practitioners to one or more supervising doctors, although this does not affect their individual accountability. PAs are described in the national Competence and Curriculum Framework as 'a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment ... under defined levels of supervision.'^{§**} In training to work in this manner PAs are provided with the knowledge and skills to reason clinically, to undertake a diagnostic process and to plan and manage treatment. These generic skills can then be applied to and refined in the specific context of particular clinical fields.

PAs training in the UK undertake an approved masters-level programme based on the Competence and Curriculum Framework and must pass the programme (2 years; 50/50 theory and clinical experience) as well as the national examination (run jointly by the universities offering programmes), which ensures a common minimum standard. PAs undergo a recertification examination on a six-yearly basis which requires them to demonstrate the maintenance of broad cross-field knowledge, whichever field they happen to be working in. PAs are therefore able to work in a similar way to that envisaged for doctors providing a (general) internal medicine service. When working with highly specialised teams, PAs' broad competence can help to ensure that comorbidities outside the particular specialist field are not missed.

There are 150 PAs currently working in the NHS (of whom 130 are UK qualified) across approximately 30 trusts and a similar number of general practices. In the secondary care setting they work in a wide

*The term 'physician associate' is replacing the term 'physician's assistant' because 'assistant' has particular connotations in the context of Agenda for Change and, as a result, in the NHS more generally. It also serves to differentiate the profession from a title used by a number of other groups who are not trained in line with the Competence and Curriculum Framework.

[†]Department of Health. *The Competence and Curriculum Framework for the physician assistant*. Leeds: DH, 2006.

[‡]Physician Assistant Managed Voluntary Registration Commission (PAMVRC). *The Competence and Curriculum Framework for the physician assistant 2012*. www.paregister.sgul.ac.uk

[§]Department of Health. *The NHS's role in the public's health. A report from NHS Future Forum*. London: DH, 2011.

^{**}Royal College of Physicians, Faculty of Occupational Medicine. *Implementing NICE public health guidance. An audit of acute NHS trusts*. London: RCP, 2011.

variety of specialties: acute medicine/admissions units, emergency department (ED), older people care, paediatrics and mental health. A significant number also work in surgical specialties.

There is currently a Managed Voluntary Register (MVR) to which most PAs practising in the UK have signed up (www.paregister.sgul.ac.uk). As the title is currently unprotected, successful completion of an approved course and the national examination are important prerequisites for inclusion. Maintenance on the register requires PAs to undertake continuing professional development (CPD) and to meet professional conduct standards (as other professions, and modelled on the GMC systems) as well as to pass the recertification exam. Trusts are encouraged to make inclusion on the MVR a requirement for any PA they employ.

Although to date all UK PA programmes have signed up to the standards enshrined in the Competence and Curriculum Framework and to the national examination, there is nothing currently to stop a university, or even a trust, from starting a programme that sets different criteria for qualification. The report also notes that a voluntary register cannot provide a culture/ethical framework for the whole profession in the way that statutory registration does. Valuable support for the profession and for registration has also recently come from the College of Emergency Medicine and from the interim report of the Emergency Medicine Taskforce set up by the DH in September 2011. Although the number of PAs already contributing to primary and secondary care in the UK demonstrates that lack of statutory registration doesn't create an insurmountable problem, it is undeniably a significant limit on their wider use. Statutory registration would allow PAs to make a more effective contribution to the health service and the health economy as well as offering better protection to the public.

Non medically qualified care practitioners: advanced nurse practitioners (ANPs)

The role of the ANP has evolved slowly and in an ad hoc manner, resulting in a lack of clear definition of ANP roles and responsibilities. The Royal College of Nursing (RCN) recently published a guide on training and standards for ANPs which, along with competencies published separately for England (DH), Wales and Scotland, should help to rectify this situation. ANPs' roles have developed in a wide range of clinical settings from primary to tertiary care and advanced practice (and ANP status) is normally restricted to the particular clinical field in which their role and expertise has developed. As such, they fit clearly into the specialist model of medical provision, even when that is the specialism of dealing with the undifferentiated patient in primary care. The ANP role is seen as including assessing the patient (including physical examination), making a differential diagnosis and ordering relevant investigations, providing treatment (including prescribing) and admitting/discharging patients.

Although 'highly developed nursing knowledge and skills' form the foundation on which ANP practice is developed, it is not clear how nursing knowledge and skills inform practice in what are traditionally non-nursing roles. The route by which people become ANPs ensures they are entirely familiar with the clinical environment when they assume the role. There is considerable stress on autonomy although it is recognised that collaboration is important. Whilst recognising that the patient remains under the overall care of a medical consultant, the RCN report is less clear about whether ANPs would consider themselves, in as far as they deliver medical care, as being a part of the medical team. There is an expectation that, in order to enable these roles, ANPs will have received a masters' degree level of education. A number of ANP programmes have now been developed.

Appendix 7

Glossary

The terms below marked with an asterisk are concepts proposed by the Future Hospital Commission (see chapter 3 and appendix 3 for more details).

Acute care coordinator* The acute care coordinator has operational responsibility for overseeing the Clinical Coordination Centre and Acute Care Hub in support of the chief of medicine (see definitions below).

Acute medicine The part of (general) internal medicine concerned with the immediate and early specialist management of adult patients suffering from a wide range of medical conditions who present to, or from within, hospitals requiring urgent or emergency care.

Acute care for elders unit (ACE), see elderly care assessment unit.

Acute Care Hub (ACH)* The ACH brings together the clinical areas of the hospital that focus on the initial assessment and stabilisation of acutely ill medical patients, including the acute medical unit, ambulatory care centre, short-stay bed capacity and (dependent on local circumstances) the emergency department.

Acute medical unit (AMU) An assessment and admissions unit for acutely unwell medical patients.

Acute trust An NHS body that provides secondary care or hospital-based healthcare services from one or more hospital sites.

Advanced nurse practitioner (ANP) The ANP's role includes assessing the patient (including physical examination), making a differential diagnosis and ordering relevant investigations, providing treatment (including prescribing) and admitting/discharging patients.

Allied health professional (AHP) The term allied health professional encompasses many different roles, including therapists, dietitians, occupational therapists, paramedics physiotherapists, radiographers, and speech and language therapists.

Ambulatory emergency care (AEC) Ambulatory emergency care is medical care delivered on an outpatient basis to emergency patients who visit hospital and depart on the same day. This can reduce

hospital admissions for patients (often with chronic conditions) for whom it is possible to prevent acute exacerbations through improved self-management, disease management or case management, or lifestyle interventions.

Annualised job plans Annualised job plans are working patterns that are planned and organised on a whole year basis.

Block working Block working is a pattern of rota working that allocates set 'blocks' of time to particular roles, locations and functions.

Bundles of care A set of linked, evidence-based interventions for a defined patient population and care setting.

Centre for Workforce Intelligence (CfWI) The national authority on workforce planning and development providing advice and information to the NHS and social care system.

Chief clinical information officer* Senior clinician providing links between IT systems and projects, clinical requirements and patient care, to ensure strong clinical engagement in information systems and projects.

Chief of medicine* The senior clinician responsible for leading the Medical Division, reporting professionally to the medical director and operationally to the chief executive.

Chief operating officer (COO) The senior manager responsible for managing an organisation's day-to-day operations. The COO reports to the organisation's chief executive.

Chief resident* A medical trainee responsible for liaising between the junior medical staff working in the Medical Division and the chief of medicine and senior clinical managers responsible for delivery of the service.

Chronic disease A disease, condition or health problem which persists over a long period of time. Examples include arthritis, diabetes and hypertension.

Citizenship Charter* The charter would set out what a patient can expect to receive in hospital, the standards of those services and the rights of patients and staff.

Clinical Coordination Centre (CCC)* The CCC would be the single coordinating point for clinical, staffing and service monitoring and deployment. It would be based in the hospital, but would coordinate medical care across the health economy, with links to primary and social care.

Clinical incident An occurrence or event, generally an untoward, or unwelcome occurrence, eg a complication of an existing disease, a mishap affecting a patient in hospital.

College tutor Based at local hospitals, the role of college tutor (a hospital consultant) is filled by a fellow of the Royal College of Physicians. The appointed local (hospital-level) college tutor supervises training of trainees in medical specialties who are doing core or (general) internal medicine within a particular hospital. The college tutor links with the Royal College of Physicians' regional network.

Comorbidity The simultaneous presence of two or more health conditions or diseases in the same patient.

Commissioning for Quality and Innovation (CQUIN) payment framework The CQUIN payment framework enables commissioners to link a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Comprehensive geriatric assessment (CGA) The British Geriatric Society define comprehensive geriatric assessment as 'a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances. The purpose is to plan and carry out a holistic plan for treatment, rehabilitation, support and long term follow up'.

Critical care unit (CCU) A specialist hospital ward that provides intensive care (treatment and monitoring) for people in a critically ill or unstable condition. See also Intensive care unit.

Dementia champion A named person in each hospital who will ensure that patients with dementia receive the right care guided by organisational policies that support staff in dealing with these patients in the right way.

Director of community liaison* A director of community liaison may be appointed to work with the chief of medicine and medical director to oversee the direction and operational management of services that work in the community and hospital settings.

Director of medical education* The director of medical education, with the chief of medicine and clinical directors, will monitor the service load, optimal deployment, support and training of all non-consultant medical staff, particularly specialist registrars and junior medical staff.

Early supported discharge (ESD) Early supported discharge describes pathways of care for people transferred from an inpatient environment to a community setting to continue a period of rehabilitation with the support of both hospital-based and community teams.

Elderly care assessment unit (ECAU) A specialist geriatric ward where assessment, acute care and rehabilitation are managed by a specialist team.

Electronic patient record (EPR) The file stored on a computer which records information about the patient's current health and history.

End-of-life care Care that helps those with advanced, progressive, incurable illness to live as well as possible until they die

Enhanced care (level 1) Care for patients who require a more intensive level of monitoring and support than is possible in a general ward bed (level 0), but slightly less than that given in high dependency (level 2) or intensive care bed (level 3).

Enhanced recovery Enhanced recovery is an evidence-based model of care in which a patient's recovery is planned from the point of arrival. Enhanced recovery requires proactive review and communication

with patients to encourage effective self-management. The concept of enhanced recovery was originally developed to create fitter patients who recover faster from major surgery.

Faculty of Medical Leadership and Management A UK-wide organisation that aims to promote the advancement of medical leadership, management and quality improvement at all stages of the medical career for the benefit of patients.

‘Frailty’ units A specialist unit, led by the geriatric medicine team, focused on the needs of older patients with frailty conditions, including dementia.

(General) internal medicine Diagnosis and management of inpatients with a variety of medical disorders both common and complex, in addition to patients with acute illness.

‘Generalist’ or generalist physician A physician whose practice is not oriented in a specific medical specialty (eg organ- or system-specific specialty, such as cardiology) but instead covers a variety of medical problems.

Geriatric evaluation and management unit (GEMU) see Elderly care assessment unit.

Health Education England (HEE) The national organisation responsible for overseeing the education, training and personal development of the health and healthcare workforce for England.

High dependency unit (HDU)(level 2) A high dependency unit is for people who need more intensive observation, treatment and nursing care than is possible in a general ward (level 0) or enhanced care (level 1) bed, but slightly less than that given in an intensive care bed (level 3).

Holistic medicine An approach to medical care that emphasises the study of all aspects of a person’s health.

Integrated care Free movement of information and expertise across the structural borders of primary, secondary, community-based and social care.

Intensive care/therapy unit (ICU/ITU) An intensive care unit is for people whose conditions are life-threatening and who need constant, close monitoring and support from equipment and medication to keep normal body functions going. Staff are highly trained in caring for the most severely ill patients. Intensive care beds (level 3) provide more intensive observation, treatment and nursing care than is possible in a general ward (level 0), enhanced care (level 1) or high dependency (level 2) bed.

Map of Medicine A collection of evidence-based, practice-informed care maps which connect all the knowledge and services around a clinical condition.

Medical Division* The Medical Division will assume clinical, managerial and budgetary responsibility for all inpatient beds and clinical areas supporting the care of medical patients (with the exception of those aligned to paediatrics, obstetrics and possibly some specialised surgical wards).

Medical Leadership Competency Framework The leadership competencies that doctors need to become more actively involved in the planning, delivery and transformation of health services.

Monitor The sector regulator for health services in England. Monitor assesses NHS trusts for foundation

trust status, ensures foundation trusts are well led, sets prices for NHS-funded care and supports commissioners to protect essential healthcare services for patients if a provider gets into financial difficulty.

National Early Warning Score (NEWS) An early warning scoring system published by the Royal College of Physicians to facilitate timely assessment of acutely ill patients in a standardised way across the NHS.

National Institute for Health Research (NIHR) The organisation responsible for coordinating and supporting patient-centred health research within the NHS.

Near miss A situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient.

NHS Choices The main online portal to the NHS, providing health information for patients and health professionals and health service directories.

NHS Constitution Document setting out what patients, the public and staff can expect from the NHS and what the NHS expects from them in return, incorporating legally enforceable rights and additional non-binding pledges.

National Institute for Health and Care Excellence (NICE) An independent organisation that provides national guidance on the promotion of good health and the prevention and treatment of ill health.

NICE Quality Standard A concise set of prioritised statements released by NICE, designed to drive measurable quality improvements within a particular area of health or care.

Out-of-hours services Services provided outside 'standard' working hours (eg in the evenings and at weekends).

Outlier Inpatient located on a ward that provides services not aligned with their specific needs (eg a medical patient placed on a surgical ward).

Outpatient A patient who attends a hospital or clinic for treatment that does not require an overnight stay.

Outreach services Services delivered, often in collaboration between specialist and community providers, to patients regardless of location; for example, via specialist help lines and outpatient clinics.

Patient advisory liaison service (PALS) Services that provide information, advice and support for patients, families and carers.

Patient-level Information and Costing Systems An NHS funding system that measures the resources consumed by individual patients. Patient-level costs are calculated by tracing resources actually used by a patient and the associated costs. Patient-level Information and Costing Systems represent a change in the costing methodology in the NHS from a predominantly 'top-down' allocation approach through service-line reporting based on averages and apportionments, towards a more direct approach based on the actual interactions and interventions related to individual patients.

Patient-reported Experience Measures (PREMs) Tool to measure and capture data on patients' experience of care, rather than the outcome of that care.

Patient-reported Outcome Measures (PROMs) Patient-reported Outcome Measures assess the quality of care delivered to NHS patients from the patient perspective. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires.

Pathway of care The route followed by the patient into, through and out of NHS and social care services.

Pathway funding A funding model involving a bundle of services (usually involving multiple providers) covering an episode of care.

Payment by Results The system in England under which commissioners pay healthcare providers for each patient seen or treated. The tariff for a particular unit of healthcare provision is determined nationally and is contingent on factors such as outcome, whether best practice was used, and the complexity of the individual patient's needs.

Percutaneous coronary intervention (PCI) A non-surgical procedure carried out by interventional cardiologists to treat narrowed coronary arteries in patients with coronary heart disease.

Physician assistant Term now replaced by the term 'physician associate' – see below.

Physician associate (PA) A healthcare professional who is licensed to practise specific aspects of medicine under the supervision of a doctor.

Picture Archiving and Communication System (PACS) A system that allows radiological images to be stored and viewed electronically.

Point-of-care programme A programme that emphasises that all actions and systems have a potential impact on patients and their families.

Primary care Many people's first point of contact with the NHS. In addition to GP practices, primary care covers dental practices, community pharmacies and high street optometrists.

Professional Records Standards Body (PRSB) The Professional Records Standards Body for health and social care is responsible for ensuring that the requirements of those who provide and receive care and support can be fully expressed in the structure and content of health and social care records.

Rapid access ('hot') clinics A clinic providing prompt and early specialist assessment and access to treatment.

RCP Health Informatics Unit The Unit is responsible for promoting and developing health informatics skills and leadership for clinicians and producing evidence- and consensus-based standards for electronic healthcare records and communications.

Schwarz Center Rounds A regular session for staff from all disciplines to discuss difficult emotional and

social issues arising from patient care, developed by the Schwartz Center for Compassionate Healthcare in the USA.

Secondary care Service provided by medical specialists who generally do not have first contact with patients, instead having patients referred to them by other healthcare professionals, such as GPs. Secondary care services include those provided by hospitals.

Service-line management (SLM) The identification and management of specialist clinical areas as distinct operational units.

Service-line reporting (SLR) Provision of the necessary data on financial performance, activity, quality and staffing to support service-line management.

Shape of Training review A current review (2013) of potential reforms to the structure of postgraduate medical education and training across the UK, sponsored by a number of bodies, including Medical Education England, the General Medical Council and the Academy of Medical Royal Colleges.

SNOMED Clinical Terms International standard clinical terminology adopted by NHS England. A standard clinical terminology is needed to ensure that information is consistent and transferable between clinical information systems in different care settings.

Specialty medicine Care provided by a physician who is a specialist in internal medicine (trained in general internal medicine (GIM)). This includes care provided by a physician working in one of the organ-specific medical specialties (eg cardiology, respiratory or renal medicine), or by a geriatric medicine physician managing older patients in a specialist capacity.

Staff grade and associate specialist (SAS) doctor A non-training grade of doctors encompassing both associate specialists (non-consultants who are able to work independently at consultant level) and specialty doctors (doctors with at least four years' postgraduate training in the UK, including two years in the specialty they are working in).

Telehealth The use of communication and information technologies to deliver clinical care, or non-clinical health-related services such as education, where the individuals involved are not at the same location.

Urgent care centre (UCC) Services predominantly provided by primary care-based staff, both in and out of 'standard' hours. Often co-located with emergency departments.

Virtual clinics or ward rounds An opportunity for the clinical team to review a patient's progress and agree care plans without the patient needing to be present, using telecommunications technology.

Walk-in centres Providers of healthcare services in the community that can be accessed by patients without an appointment.

Year of Care Funding A funding model based on a patient's predicted individual needs over a year (usually involving multiple providers), rather than on individual episodes of illness.

Appendix 8

Members of work streams for the Future Hospital Commission

The chair of the Future Hospital Commission, Sir Michael Rawlins, would like to thank all the work stream members for their contribution to the *Future hospital* report.

People work stream

Dr Andrew Goddard MD FRCP (*Chair*)

Director, Medical Workforce Unit, Royal College of Physicians; consultant gastroenterologist, Royal Derby Hospital

Dr Tim Battcock MBChB FRCP

Censor, Royal College of Physicians

Dr Ella Chaudhuri MBChB MRCP(UK)

MRCP(London)

Clinical fellow, Royal College of Physicians

Dr Dennis Cox MA FRCGP

Royal College of General Practitioners

Dr Krishna Chinthapalli MBBS MRCP(UK)

MRCP(London)

Clinical fellow, Royal College of Physicians and *BMJ*

Mrs Elizabeth Goodier

Patient and Carer Network, Royal College of Physicians

Dr Andrew Jeffrey MBChB FRCP FRCP(Edin)
FFICM

Censor, Royal College of Physicians

Professor PG Kopelman MD FRCP

Censor, Royal College of Physicians

Dr Joanna Lawson MRCP FRCP

Associate specialist, Royal Victoria Infirmary, Newcastle-upon-Tyne

Dr Nick Levell MBChB FRCP

Consultant dermatologist, Norwich and Norfolk University Hospital

Mr Patrick Mitchell

Director of national programmes – medical education, Health Education England

Dr Vicky Osgood MBBS FRCOG FRCGP

Assistant director of postgraduate medical education, General Medical Council

Professor Nick Ross BA(Arch) SRN DipN(Lon)
CertEdFE MA(CDHFE)

Head of academic innovation, College of Medical and Dental Science, University of Birmingham

Mr Gerard Sullivan

Patient and Carer Network, Royal College of Physicians

Ms Geraldine Welham

Committee manager, Royal College of Physicians

Dr Sian Williams MBBS MRCP(UK) MFOM

Clinical director, Health and Work Development Unit, Royal College of Physicians

Declarations of interest

Dr Tim Battcock: member of the British Medical Association

Dr Dennis Cox: member of the Labour Party

Dr Andrew Jeffrey: member and former chairman of NACT UK

Dr Nick Levell: member of BAD; trustee of UK Dermatology Clinical Trials Network; associate editor, *Textbook of dermatology*, receives small fee from Wiley Blackwell

Dr Vicky Osgood: employed full time by the General Medical Council

Professor Nick Ross: member, UK & Ireland Universities Board for Physician Assistant Education (UKIUBPAE) and the Joint Board of UKIUBPAE and the UK Association of Physician Assistants (UKAPA)

Dr Sian Williams: member of the NHS Consultants Association

Place and Process work stream

Dr Patrick Cadigan FRCP FRCP(Edin) (*Chair*)
Registrar, Royal College of Physicians; consultant physician and cardiologist, Sandwell Hospital, Birmingham

Dr Mark Temple MD FRCP (*Chair*)
Acute care fellow, Royal College of Physicians; consultant physician and nephrologist, Heart of England Foundation Trust, Birmingham

Mrs Pamela Barnes MBE Hon FRCPCH

Patient and Carer Network, Royal College of Physicians

Dr Liz Berkin FRCP

Deputy medical director, Joint Royal College of Physicians Training Board

Dr John De Caestecker MD FRCP

Regional Adviser, Royal College of Physicians; honorary senior lecturer in gastroenterology, University of Leicester Medical School; consultant gastroenterologist, University Hospitals of Leicester NHS Trust

Professor Peter Clark MD FRCP

Consultant oncologist, Clatterbridge Centre for Oncology, Merseyside

Dr Ruth Dobson MRCP(UK) MRCP(London)

Trainees Committee, Royal College of Physicians

Dr Rhid Dowdle OBE FRCP FEFIM FSAM

Consultant physician and cardiologist, Royal Glamorgan Hospital; Cwm Taf Health Board, NHS Wales

Professor Thomas Downes MRCP(UK)

MRCP(London)
Consultant physician and geriatrician, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Jonathan Fielden FRCP

Medical director, Medicine Board; consultant intensivist, University College London Hospitals NHS Foundation Trust

Dr Daniel Flanagan MD FRCP

Consultant physician and endocrinologist, Derriford Hospital, Plymouth

Mr Andrew Foster

CEO, Warrington, Wigan and Leigh NHS Trust

Dr Michael Glynn MD FRCP

Censor, Royal College of Physicians; consultant physician and gastroenterologist, The Royal London Hospital

Dr Neil Gittoes MBChB PhD FRCP

Consultant physician and endocrinologist,
associate medical director for clinical partnerships,
Queen Elizabeth Hospital Birmingham

Dr Simon Hibberd FRCGP MRCP

GP, South Norfolk Clinical Commissioning Group

Mrs Suzie Hughes

Patient and Carer Network, Royal College of
Physicians

Dr Frank Joseph MD FRCP

New Consultants Committee, Royal College of
Physicians

Consultant physician in endocrinology and
diabetes, Countess of Chester NHS Hospital
Foundation Trust

Dr Duncan Loft MD FRCP

Consultant gastroenterologist, University Hospitals
Coventry and Warwickshire

Dr Pippa Medcalf FRCP

Trustee councillor, Royal College of Physicians
Consultant physician, Gloucestershire Royal
Hospital

Dr Jonathan Myers MRCP(UK) MRCP(London)

Chair, Trainees Committee, Royal College of
Physicians

Capt JP Nolan

Adviser on acute emergency and critical care,
Royal College of Nursing; nursing officer, 256 City
of London Field Hospital, British Army

Ms Catharine Perry

Committee manager, Royal College of Physicians

Dr Christopher Roseveare FRCP

President, Society of Acute Medicine; acute
medicine consultant, University Hospital
Southampton NHS Foundation Trust

Dr Georgina Russell MRCP(UK)

MRCP(London)
Clinical fellow, Royal College of Physicians

Dr Andrew Stein FRCP

Consultant nephrologist, University Hospitals
Coventry and Warwickshire

Dr Jonathan Steel FRCP

General practitioner, Dursley, Gloucestershire

Dr David Walker FRCP

Consultant cardiologist, Conquest Hospital, East
Sussex

Dr Peter Winocour MD FRCP

Consultant physician, clinical director, East and
North Hertfordshire NHS Trust

Declarations of interest

John De Caestecker: member, British Society of
Gastroenterology

Rhid Dowdle: RCP representative on NCEPOD
(to 29 November 2012); member, Society for Acute
Medicine

Jonathan Fielden: governing body member,
Aylesbury Vale Clinical Commissioning Group;
advisory board member, The Learning Clinic;
member, National Stakeholder Forum; employer
member, National ACCEA Committee

Neil Gittoes: member, Society for Endocrinology;
American Endocrine Society; National
Osteoporosis Society; Bone Research Society
(formerly Bone and Tooth Society); American
Society for Bone and Mineral Research; National
Association for the Relief of Paget's Disease

Michael Glynn: editor, *Hutchison's clinical
methods*, Elsevier Health Sciences

Simon Hibberd: I am a director and provide
financial support to Breckland Care at Home, a
community interest company that supplies home
care in central Norfolk. I am a director and
received dividends from Elmham Clinical services,
which provides care for an army barracks and
intermediate care beds. I am a partner at Elmham
Surgery – PMS contract primary care.

Suzie Hughes: member of the Labour Party

Pippa Medcalf: member, British Geriatrics Society, Society for Acute Medicine, General Medical Council, British Medical Association

Christopher Roseveare: editor, *Acute medicine* journal (received £900 by Rila Publications Ltd per edition; four editions per year)

Data for improvement work stream

Dr Kevin Stewart FRCP (*Chair*)
Clinical director, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians; consultant geriatrician, medical director and deputy CEO, Winchester and Eastleigh NHS Trust

Professor John Williams FRCP (*Chair*)
Director, Health Informatics Unit, Royal College of Physicians; professor of health services research, College of Medicine, Swansea University

Dr Peter Belfield FRCP
Censor, Royal College of Physicians

Dr Benjamin Bray MRCP(UK)
Clinical fellow, Royal College of Physicians

Professor Iain Carpenter MD FRCP
Associate director, Health Informatics Unit, Royal College of Physicians; emeritus professor, University of Kent

Mrs Jan Hoogewerf
Programme manager, Health Informatics Unit, Royal College of Physicians

Ms Margaret Hughes BSc (Hons)
Patient and Carer Network, Royal College of Physicians

Ms Catharine Perry
Committee manager, Royal College of Physicians

Dr John Soong MRCP(UK) MRCP(London)
Clinical fellow, Royal College of Physicians

Dr Ian Starke MD FRCP FRCP(Edin)
Revalidation lead, Royal College of Physicians; consultant geriatrician, University Hospital Lewisham

Mr Phil Willan MSc
Patient and Carer Network, Royal College of Physicians

Declarations of interest

Phil Willan: member of a number of Royal College of Physicians' committees; member of Medicines and Healthcare products Regulatory Agency (MHRA) advisory groups (Pharmacovigilance Expert Advisory Group; Cardiovascular, Diabetes, Renal, Respiratory and Allergy Medicine Expert Advisory Group; Patient and Public Engagement Expert Advisory Group); member of the National Cancer Research Network; member of Clinical Studies Group for Upper Gastrointestinal Cancer, and Consumer Liaison Group; member of Healthcare Quality Improvement Partnership; member of Renal Transplant Clinical Services Group at NHS England.

Margaret Hughes: member of several Royal College of Physicians' committees; member of the British Orthopaedic Association Patient Liaison Group; member of Arthritis Research UK's Clinical Studies Group in Spondyloarthritis; member of Service User Network; member of the Independent Advisory Group, Medical & Surgical Outcome Review Programme and the National Joint Registry Patient Group – all part of the Healthcare Quality Improvement Partnership; reviewer, Health Technology Assessment Programme, National Institute for Health Research; elected governor of Wrightington Wigan and Leigh Foundation Trust Hospital; lay member, NHS England; member of North West Manchester Crohn's & Colitis UK; and several other local and regional support organisations.

Planning and infrastructure work stream

Professor Linda Luxon CBE FRCP (*Chair*)

Treasurer, Royal College of Physicians; consultant physician in neuro-otology, University College London Hospitals NHS Foundation Trust; emeritus professor of audiovestibular medicine, University College London

Mr Robert Bell

Director of clinical support and facilities management, Blackpool Teaching Hospitals NHS Foundation Trust

Ms Laura Brennan

Past policy adviser, Royal College of Physicians

Professor Bruce Campbell FRCP

Consultant vascular surgeon, Royal Devon and Exeter NHS Foundation Trust; chair, Interventional Procedures and Medical Technologies Advisory Committees, National Institute for Health and Care Excellence

Dr Pete Cavanagh MRCP FRCR

Vice president and dean of the Faculty of Clinical Radiology

Mr Gavin Maxwell

Patient and Carer Network, Royal College of Physicians

Dr Ron Newall

Patient and Carer Network, Royal College of Physicians

Dr David Pencheon OBE FFPHM

Director, Sustainable Development Unit for NHS England and Public Health England

Dr Gerrard Phillips MA DM FRCP

Respiratory consultant, Dorset County Hospital; censor, Royal College of Physicians

Dr Archie Prentice FRCP FRCPath

President, Royal College of Pathologists

Dr Jonathan Shribman FRCP

General practitioner, Bugbrooke Medical Centre, Northamptonshire

Ms Elaine Storey

Committee manager, Royal College of Physicians

Mr Garry Swann

Consultant nurse, Heart of England NHS Foundation Trust

Professor Wendy Tindale

Consultant clinical scientist, Sheffield Teaching Hospitals

Dr Richard Tiner FFPM

Past president of the Faculty of Pharmaceutical Medicine

Dr Charles Tomson DM FRCP

Renal consultant, North Bristol NHS Trust

Declarations of interest

Pete Cavanagh: member, Royal College of Radiologists

Richard Tiner: member, British Medical Association

Patients and compassion work stream

Dr Linda Patterson OBE FRCP (*Chair*)

Clinical vice-president, Royal College of Physicians; consultant physician in general and geriatric medicine, East Lancashire Primary Care Trust

Ms Sally Brearley

Patient representative and lay member, National Quality Board

Dr Penelope Campling

Consultant medical psychotherapist, Leicester

Mrs Carol Caporn

Patient and Carer Network, Royal College of Physicians

Dr Peter Alf Collins FRCA FRCP

Consultant in pain management, Taunton and Somerset NHS Foundation Trust; clinical associate, The Health Foundation

Dr Jocelyn Cornwell

Director, The Point of Care Foundation; senior fellow, The King's Fund

Ms Jennifer Dewhurst

Patient and Carer Network, Royal College of Physicians

Professor Katherine Fenton OBE

Chief nurse, University College London Hospitals

Professor Rowan Harwood FRCP MA MSc MD

Consultant physician; professor of geriatric medicine, Nottingham University Hospital NHS Trust

Dr Elizabeth Haxby MBBS MA MSc FRCA

Lead clinician in clinical risk, Royal Brompton and Harefield NHS Foundation Trust

Ms Nicky Hayes

Consultant nurse for older people, King's College Hospital NHS Trust

Dr Mark Holland FRCP

Consultant physician in acute medicine, University Hospital of South Manchester NHS Foundation Trust

Dr Annie Laverty

Director of patient experience, Northumbria Healthcare NHS Trust

Dr Nick Lewis-Barned FRCP FRACP

Clinical fellow for shared decision-making and support for self-management, Royal College of Physicians; consultant physician in diabetes and endocrinology, Northumbria Healthcare NHS Trust

Dr Susannah Long MRCP(UK) MRCP(London) PhD

Consultant geriatrician, Imperial College Healthcare NHS Trust; honorary clinical lecturer, Imperial College London

Dr Jacqueline Morris FRCP

Member, National Dignity Council; honorary research associate, Research Department of Primary Care and Population Health, University College London Medical School

Professor Jeremy Murphy DM FRCP

Council member, Royal College of Physicians

Dr Caroline Nicholson

National Institute for Health Research post-doctoral research fellow, King's College London

Dr Louise Restrict FRCP

Integrated respiratory consultant physician, Whittington Health and NHS Islington; London Respiratory Team co-lead from 2010 to 2013

Professor Trudie Roberts FRCP

Director, Leeds Institute of Medical Education

Dr Angela Robinson FRCP

Genitourinary medicine/HIV physician, Mortimer Market Centre, Central and North West London NHS Foundation Trust

Ms Elaine Storey

Committee manager, Royal College of Physicians

Dr Bee Leng Wee FRCP

Consultant and senior clinical lecturer in palliative medicine, Sir Michael Sobell House, Oxford University Hospitals NHS Trust and Harris Manchester College, University of Oxford

Declarations of interest

Rowan Harwood: consultant to Red and Yellow Care, a dementia-specialist integrated housing and healthcare company; member, British Geriatrics Society and Age UK

Mark Holland: secretary, Society for Acute Medicine

Jacqueline Morris: trustee and vice president, Patients Association

Bee Leng Wee: member, Association for Palliative Medicine of Great Britain and Ireland

Appendix 9

Contributors

The chair of the Future Hospital Commission, Sir Michael Rawlins, would like to thank the following people and groups for their contributions to the *Future hospital* report.

Patient and Carer Network

Royal College of Physicians

Dr Elizabeth Aitken FRCP MBBS

Consultant physician general and elderly medicine, Lewisham Healthcare NHS Trust

Hilary Allan

R&D manager, Tees, Esk and Wear Valleys NHS Foundation Trust

Dr Amit Arora MD FRCP MSc

Consultant physician/geriatrician and honorary clinical lecturer, University Hospital of North Staffordshire

Mr Simon Barton

General manager, Acute Medicine, Nottingham University Hospitals NHS Trust

Dr David Beaumont MB FRCP MBA

Consultant physician and geriatrician, former medical director, Queen Elizabeth Hospital, Gateshead

Professor Derek Bell MD FRCP FRCP(Edin)

Professor of acute medicine, Imperial College London

Professor Nigel (Ben) Benjamin FMedSci

Consultant in acute medicine and director R&D, South Devon Healthcare NHS Foundation Trust, Torbay Hospital, Torquay

Dr Brian Bourke FRCP

Consultant physician and rheumatologist, St George's Hospital London; chairman, General (Internal) Medicine Specialty Advisory Committee, JRCPTB

Dr Janet Butler PhD MRCP MRCPsych

Consultant liaison psychiatrist, Liaison Faculty, Royal College of Psychiatrists

Laura Cameron

Integrated discharge team manager, Nottingham University Hospitals NHS Trust, Queens Medical Centre

Anoop Chauhan

Director of research/respiratory consultant physician/professor of respiratory medicine, Portsmouth Hospitals NHS Trust

Dr Vincent Connolly MD FRCP(London and Glasgow)

Consultant physician and clinical director, Emergency Care Intensive Support Team, James Cook University Hospital, Middlesbrough

Dr Simon Conroy

Head of service/honorary senior lecturer, Geriatric Medicine, University Hospitals of Leicester

Dr Christopher Davidson MB FRCP

Consultant cardiologist, Royal Sussex County Hospital

Christopher Davies

Head of business development, Walsall Healthcare NHS Trust

Dr Kwasi Debrah MBBS FRCP

Deputy chair, England Council of British Geriatrics Society; consultant physician and geriatrician, Frimley Park Hospital

Dr J Colin Doig FRCP

Consultant cardiologist and physician, Northumbria Healthcare NHS Foundation Trust

Dr Ed Dunn MD FRCP

Representative for the Association of British Neurologists
Consultant neurologist, Leeds Teaching Hospitals

Russell Emeny

Director, NHS Urgent and Emergency Care Intensive Support Team (ECIST); NHS Interim Management and Support (IMAS)

Mr David Evans BA MPhil IEng FIOSH FIET MAmSSE LFOH

RCP Patient and Carer Network; safety engineer and occupational hygienist

Dr Lawrence Goldberg MD FRCP

Consultant nephrologist and chief of medicine, Brighton and Sussex University Hospitals NHS Trust

Dr Lucy Hansen FRCP

Acute care physician, clinical lead for acute medicine and ambulatory care, Northumbria Healthcare NHS Foundation Trust

Mr Paul Harriman MBA TDCR FETC HDCR(R) DCR(R)

Assistant director, Service Improvement, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Adam Harris MD FRCP

Consultant physician and gastroenterologist, Tunbridge Wells Hospital; chair, British Society of Gastroenterology Clinical Services and Standards Committee

Dr Robert Hawkins BM BS MRCP

Nottingham University Hospital Trust

Dr Melissa Heightman MRCP

Specialty registrar in integrated respiratory and GIM, Whittington Health NHS

Dr Nigel Hewett OBE FRCGP

Medical director, London Pathway; salaried GP, University College Hospital London

Dr Clare Higgs MD FRCP

Member, Acute Care Committee of the Royal College of Physicians; consultant physician and rheumatologist, Northwick Park Hospital, Harrow

Colonel Tim Hodgetts CBE PhD MMed MBA FRCP

Medical director, HQ Allied Rapid Reaction Corps; honorary professor of emergency medicine, University of Birmingham

Dr Suzy Hope MRCP(UK)

Geriatrics specialty registrar, Southwest Peninsula Deanery; British Geriatrics Society England Council trainee representative

Dr William Hubbard MA FRCP

Head of medicine, consultant physician and cardiologist, Royal United Hospital NHS Trust, Bath

Sandra Hynes

Deputy programme director, The Community Programme, Hosted by Nottingham University Hospitals on behalf of the health and social care community in south Nottinghamshire

Jane Ingham

Director of clinical standards, Royal College of Physicians

Dr David Jenkins DM FRCP

Consultant physician and endocrinologist, Worcestershire Royal Hospital; secretary, West Midlands Physicians' Association

Dr Richard Jennings MBChB MRCP DTM&H MSc PhD

Divisional director, integrated care and acute medicine; consultant, infectious diseases and acute medicine

Professor Jonathan Kay

Clinical informatics director, NHS England

Dr Jim Kelly

Consultant physician elderly care medicine;
clinical lead, Developing Better Services Hospitals
Project, Western Health and Social Care Trust,
Northern Ireland

Dr Catherine Kirkley MBChB MRCPsych

Consultant liaison old age psychiatrist, Queen
Elizabeth Hospital, Gateshead

Peter Knight

Deputy director, head of research information and
intelligence, Research and Development
Directorate, Department of Health

Martin Kuper

Medical director, Whittington Health NHS

Dr Chris Laing MBChB MD MRCP

Consultant nephrologist, associate medical
director (patient safety), Royal Free London NHS
Foundation Trust; chair, London Acute Kidney
Injury Network (Strategic Clinical Networks, NHS
England, London Region)

Annie Laverty

Health Foundation Generation Q fellow, director
of patient experience and speech and language
therapist, Northumbria Healthcare NHS
Foundation Trust

Dr Pauline Lennard MD FRCP

Consultant medical oncologist, Whittington Health

Dr Ivan Le Jeune BMBCh MA PhD MRCP

Consultant acute and respiratory physician,
Nottingham University Hospitals NHS Trust

Howard Leicester

One Voice Coalition for Accessible ICT

Dr Andrew Lewington BSc MEd MD FRCP FRCPE

Consultant renal physician/honorary clinical
associate professor, Leeds Teaching Hospitals;
The Renal Association

Dr Matthew Lewis MSc MD FRCP

Consultant gastroenterologist, divisional director
for medicine and emergency care, Sandwell and
West Birmingham Hospitals NHS Trust

Dr Robert Logan DM FRCP

Consultant physician, King's College Hospital NHS
Foundation Trust

Dr Ken Lunn

Director of information standards, Health & Social
Care Information Centre

Matthew Mead

Multidisciplinary group manager, INWL
Integrated Care Pilot

Christine Outram

Director of intelligence and strategy, NHS
England

Henry Pares

My Data Policy Development lead, NHS
England

Dr Mehool Patel FRCP

Consultant physician in general, geriatric and
stroke medicine, Lewisham Healthcare NHS Trust;
chair, England Council of British Geriatrics
Society

Professor Mike Pringle CBE MD FRCGP FRCP

President, Royal College of General Practitioners

Mr Mike Reed MD FRCS(T&O)

Consultant trauma and orthopaedic surgeon,
Northumbria Healthcare NHS Foundation Trust

Dr Alan Rees BSc MD FRCP

Chairman of the Society of Physicians in Wales
and consultant physician in diabetes,
endocrinology and clinical lipidology at the
University Hospital of Wales, Cardiff

Dr Louise Restrict FRCP

Integrated respiratory consultant physician,
Whittington Health and NHS Islington; co-lead,
London Respiratory Team (2010–13); member,
British Thoracic Society and IMPRESS

Dr Shirley Rigby MD FRCP

Consultant physician and rheumatologist, South
Warwickshire NHS Foundation Trust, Warwick

Dr Tim Robbins MBCh MA

Academic FY1, University Hospitals Coventry and Warwickshire NHS Trust

Dr Gareth Roberts MBBS BSc MRCP

Registrar in respiratory medicine, University College London Hospitals NHS Foundation Trust

Dr David Seddon MD FRCP

Regional adviser, Royal College of Physicians; consultant physician, Health Care of Older People, University Hospital Nottingham

Eileen Sills CBE

Chief nurse and director of patient experience, Guy's and St Thomas' NHS Foundation Trust

Kate Silvester BSc MBA FRCOphth

Honorary associate professor at Warwick Medical School; Kate Silvester Ltd

Professor Anita K Simonds MD FRCP

Consultant in respiratory and sleep medicine, NIHR Respiratory Biomedical Research Unit, Royal Brompton and Harefield NHS Foundation Trust

Dr Andrew Stein MD FRCP

Consultant in acute and renal medicine, University Hospitals Coventry and Warwickshire NHS Trust (UHCW), Coventry

Dr Myra Stern FRCP

Consultant in integrated respiratory medicine, Whittington Health NHS, London, UK

Dr Eliot Sykes MBBS BMedSci MRCP FRCA FFICM

Consultant in anaesthesia and ICM, Emergency Surgery and Elective Care Business Unit director, Northumbria Healthcare NHS Foundation Trust

Professor Harold Thimbleby Hon FRCP

Professor of computer science, Swansea University

Ms Deborah Thompson

Programme director, Ambulatory Emergency Care Delivery Network, NHS Elect

Dr Louella Vaughan MBBS MPhil DPhil FRACP

Senior clinical research lead, Northwest London CLAHRC, Chelsea and Westminster Hospital, London; research committee chair, Society for Acute Medicine

Dr Geoff Watson FRCA

Consultant anaesthetist, Hampshire Hospitals Foundation Trust; former clinical director of planned care, NHS South of England

Dr Jane Wells MSc FFPH

Independent consultant in public health

Siân Williams MA MSc DipHSM

Programme manager, NHS London Respiratory Team (until June 2013 closure) and IMPRESS, joint initiative between British Thoracic Society (BTS) and Primary Care Respiratory Society UK (PCRS-UK)

Dr Ian Wilson BSc MD FRCP

Consultant cardiologist; vice president training, British Cardiovascular Society, Mid Yorkshire Hospitals NHS Trust, Wakefield

Marlene Winfield OBE

Adviser on patient/carer policy

Professor Jeremy Wyatt DM FRCP

Clinical lead for new technologies, Health Informatics Unit, Royal College of Physicians; leadership chair of eHealth research, University of Leeds

Dr Zoe Wyrko MBChB MMedSci MRCP

Consultant geriatrician, Queen Elizabeth Hospital Birmingham; honorary secretary, British Geriatrics Society

Contributing organisations

Architects for Health

Royal College of General Practitioners, Health Informatics Group

British Geriatrics Society

Declaration of interest

Harold Thimbleby: trustee, Clinical Human Factors Group