



Future Hospital  
Commission

# Future hospital: Caring for medical patients

Executive summary  
September 2013

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## 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)<sup>1</sup>

*‘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)<sup>2</sup>

### Introduction

In March 2012 the Royal College of Physicians (RCP) established the Future Hospital Commission. *Future hospital: caring for medical patients*<sup>3</sup> sets out the Commission’s vision for hospital services structured around the needs of patients. This is a summary of that report, which was published in 2013. The report’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 report’s recommendations are centred on the need to design hospital services based on the needs of patients, and that deliver:

- 1 safe, effective and compassionate medical care for all who need it as hospital inpatients
- 2 high-quality care sustainable 24 hours a day, 7 days a week
- 3 continuity of care as the norm, with seamless care for all patients
- 4 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
- 5 effective relationships between medical and other health and social care teams
- 6 an appropriate balance of specialist care and care coordinated expertly and holistically around patients’ needs
- 7 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 also participated 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.<sup>1</sup>
- 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 the 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 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)<sup>4</sup>

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.<sup>1,5-9</sup>

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 Physician's report *Hospitals on the edge?*<sup>10</sup> sets 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:

- 1 a health system ill-equipped to cope with the needs of an aging population with increasingly complex clinical, care and support needs
- 2 hospitals struggling to cope with an increase in clinical demand

- 3 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
- 4 services that struggle to deliver high-quality services across 7 days, particularly at weekends
- 5 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.<sup>10</sup>

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 the RCP 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. Its report, *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 give 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 people<sup>4</sup> – 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

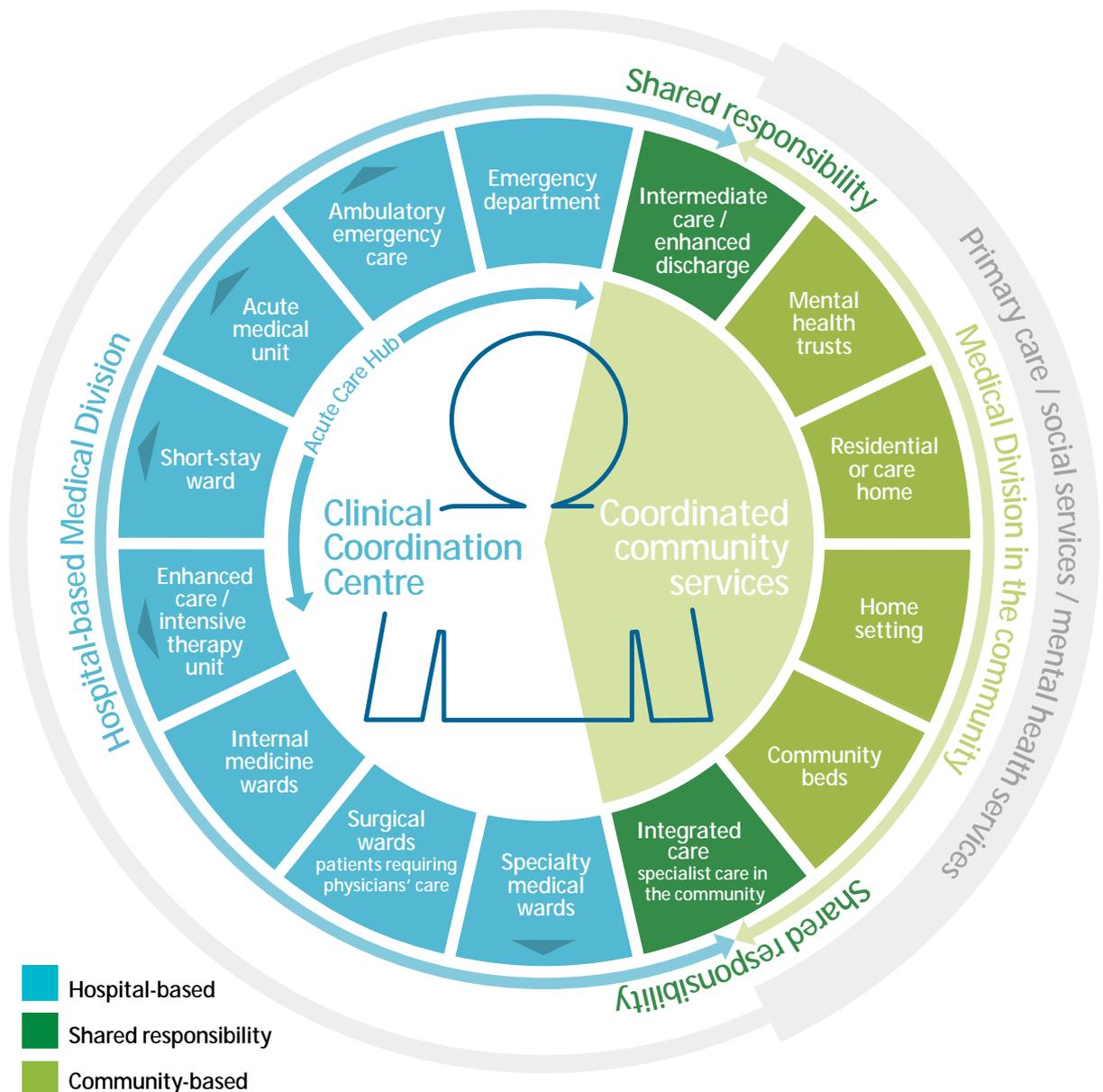
The Clinical Coordination Centre will be the operational command centre for the hospital site and Medical Division, including medical teams working into the community. It will provide healthcare staff with the information they need to care for patients effectively. It will hold detailed, real-time information 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.<sup>3</sup>

### 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 patients' clinical needs



**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.

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).

**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 diagnose 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.

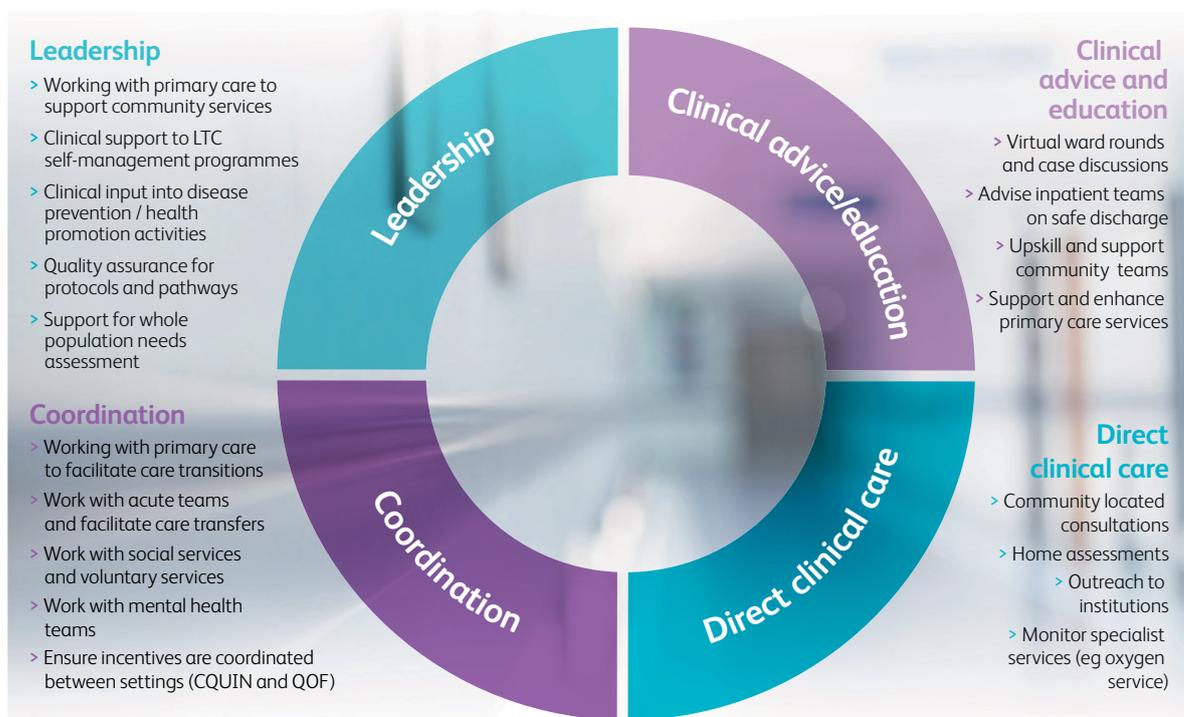
**Specialist medical care will not be confined to inside the hospital walls.** Medical teams will work closely with GPs and those working in social care to make sure that patients have swift access to specialist care when they need it, wherever they need it. Much specialised care will be delivered in 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.



**Generalist and specialist care in the future hospital.** Generalist care includes acute medicine, internal medicine, enhanced care and intensive care (excluding child health, obstetrics). Specialist components of care will be delivered by a specialist team who may also contribute to generalist care.

AHP = allied health professional; SOP = standard operating procedure.



**Integrated care in practice: extended roles for physicians in the community.**

CQUIN = Commissioning for Quality and Innovation; LTC = long-term conditions; 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 diagnose, 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:

- 1 specialisation of care – access to sufficient specialty expertise to deliver diagnosis, treatment and care appropriate to the specific hospital setting
- 2 intensity of care – access to sufficient expertise to manage, coordinate and deliver enhanced care to patients with critical illness
- 3 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.

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