



Delivering the future hospital

Full report

November 2017

Future Hospital Programme

The Future Hospital Programme was established in 2013 to implement the recommendations of the Royal College of Physicians' [Future Hospital Commission](#).

Royal College of Physicians

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Future Hospital Programme
Care Quality Improvement Department
Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

www.rcplondon.ac.uk

Registered Charity No 210508

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Foreword Jane Dacre, PRCP

Future Hospital: Caring for medical patients was that rare thing in medicine – a report that was radical, engaging and popular, full of new ideas and solutions to the common problems that beset the NHS. The product of 18 months' work by dozens of people, including patients and carers, it outlined a new blueprint for health services – a blueprint that would bring care to the patient where they were in the hospital, and identify and care for deteriorating patients in the community before they needed to go to hospital. It hit the headlines, garnered support from government, the NHS and the health professions, and saw its ideas incorporated into national initiatives such as NHS England's Five Year Forward View.

My predecessor Sir Richard Thompson vowed he would not let the report sit on a shelf, and he was true to his word. The RCP invested in a 3-year Future Hospital Programme (FHP) to implement the recommendations of the report, provide proof of concept and turn the words on paper into real, measurable improvements in patient care. As the RCP president who took over responsibility for its implementation I am proud to say that it has done exactly that – the diverse elements of the programme have shown genuine and replicable successes.

The results – increased patient satisfaction, meaningful patient engagement, saving of money and resources, reduced admissions, patients treated more safely and effectively, increased clinician engagement, higher morale in FHP units leading to easier recruitment, improved self-management of conditions – are impressive and inspiring.

As Sir Richard said in his own foreword to the original report, 'Delivering radical change is not easy. It will mean evolution, difficult decisions and strong leadership.' And so it has proved. Common challenges across the FHP projects included limited resources, staff changes and vacancies, local structures actively hindering new patterns of working, and issues with data collection and sharing. Overcoming these difficulties makes the successes more remarkable.

The FHP demonstrated beyond doubt the value of both small and large investments for improvement projects, the need for strong leadership and inspirational staff who can lift team morale, the value of patient engagement and representation, and the need for stable teams and structures to support change.

Most importantly, we established that we can enact change against the background of the challenges described earlier. We now have a cadre of change champions from across the programme, whose experiences can inform those looking to replicate the improvement projects in their own trusts and community services.

Although the formal FHP is drawing to a close as a separate entity, the learning will be incorporated into the RCP's new Quality Improvement Programme, which will provide support to clinicians and their teams to deliver improvements in care and services. The programme will include a faculty of QI experts, develop training and education in QI, create networks and offer bespoke support to physicians, teams and organisations. The chief registrar scheme, which has been so successful in engaging our trainees in quality improvement programmes, will continue to be supported, with an ongoing network to support career development in QI after leaving the scheme.

I would like to offer my heartfelt thanks to every patient, every health professional, and every manager involved in the programme, for their commitment, their determination and their belief in Future Hospital. It was always about people, and it always will be.

Professor Jane Dacre
RCP President



Foreword Elisabeth Davies, PCN Chair

Patient and public involvement isn't always easy and rarely offers a quick fix solution. If it's going to succeed it often needs the deep-seated commitment of key individuals, working together to deliver a clear and unshakable vision for how services can be made measurably better by involving and engaging service users. It is this commitment – to both involvement and person-centred care – that has been a true hallmark of the Future Hospital Programme (FHP) from the outset.

This commitment has been woven into many of the different projects within the FHP, but there's no doubt in my mind that it's within the development sites that we've come closest to being able to deliver co-production. The RCP Patient and Carer Network (PCN) has been involved not just locally but in the project governance and design, including the recruitment and selection of the sites. It's therefore no surprise that this is the area where patient and public involvement has been most effective and where we've faced some challenges too.

We've seen improved patient experience reported at each development site. Patient representatives (both from the PCN and local lay representatives) have often taken the lead in defining and sometimes even collecting patient experience data. They've helped produce new information leaflets and they've set up new ways of engaging patients, including a Patient Advisory Group. At its best they've been very much equal partners within the quality improvement team.

The challenges they've faced in many ways echo the challenges for the wider development sites. PCN and lay reps have had to deal with the impact of changes to project management teams and losing those staff who have previously championed patient involvement. These factors have a knock-on effect on whether involvement has always felt meaningful and whether it can be embedded into routine practice – this isn't about a 'nice to have' but about the importance of understanding and measuring what matters most to patients.

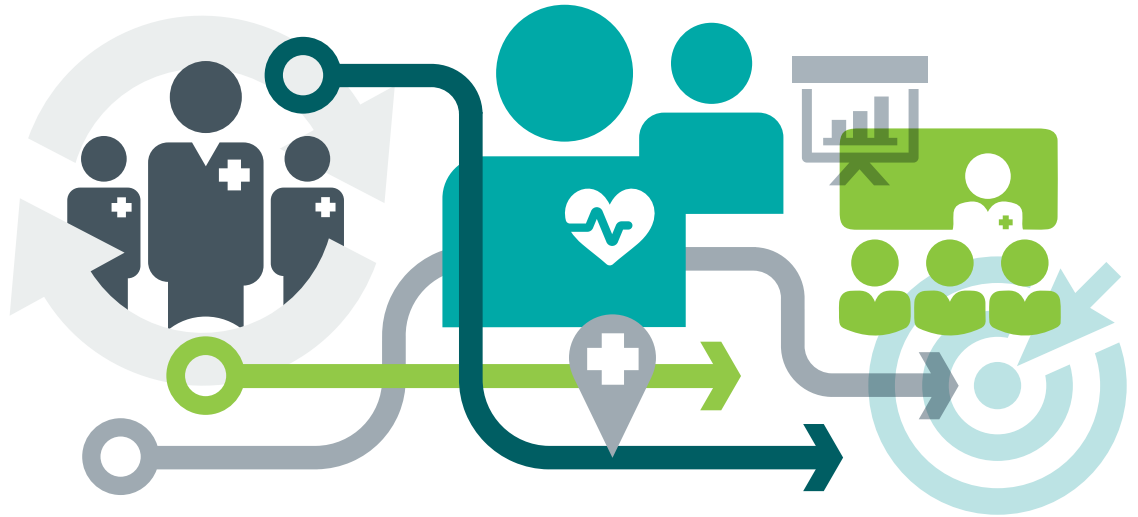
Are there any surprises in this? Probably not when it comes to the challenges but familiarity doesn't make the learning and reflections set out within this report any less significant or useful.

What I am really struck by is that, as with so many aspects of healthcare, despite the systems and complexities, effectiveness so often comes down to the trust and the relationships that can be established between individuals. In the FHP I have met some exceptional individuals – our PCN development site leads, local lay representatives and clinicians and managers who have demonstrated true leadership and a commitment to improving the quality of what matters most to patients.

Current pressures mean it is more important than ever to design and deliver services based on the needs of patients and carers. This report is a testimony to what can be achieved.

A handwritten signature in dark ink, reading 'Elisabeth Davies'.

Elisabeth Davies
Chair, RCP Patient and Carer Network



Summary

What was the Future Hospital Programme?

The Future Hospital Programme (FHP) was established by the Royal College of Physicians (RCP) in response to the seminal Future Hospital Commission (FHC) report.¹ The report described a new model of patient-centred care underpinned by a core set of principles and new approaches to leadership and training.

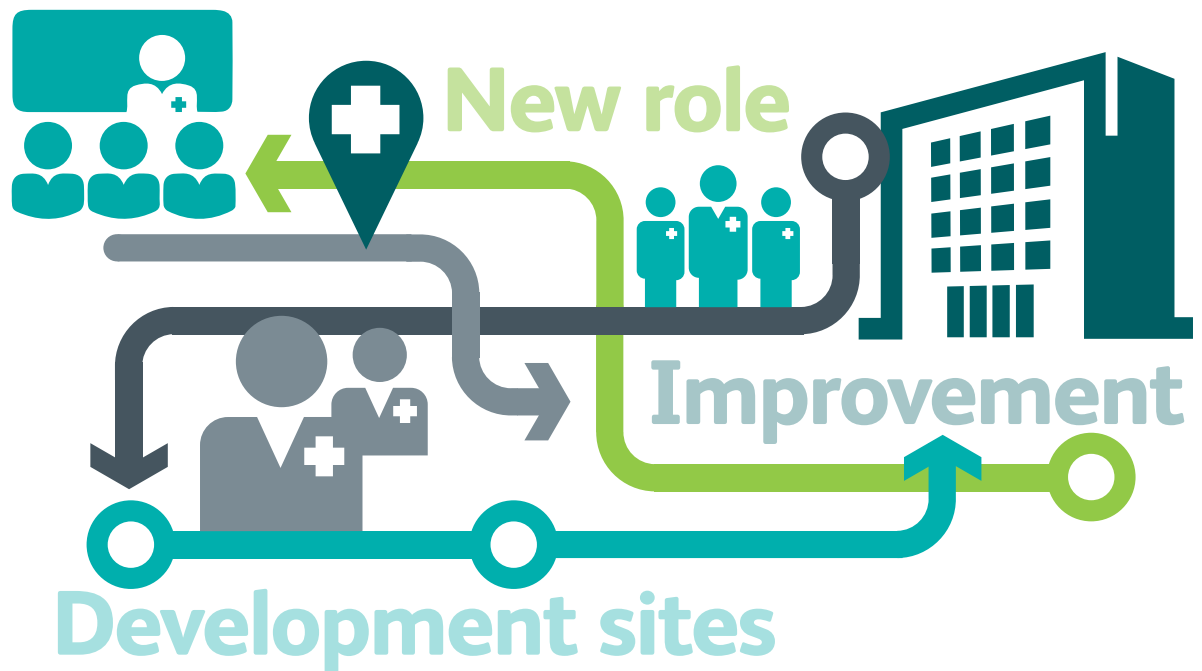
The FHP put this vision into practice with clinical partners across England and Wales in order to evaluate the real-world impact of the FHC's recommendations. At its heart was the need to change and improve services for patients. The FHP demonstrated the RCP's commitment to being part of the wider solution to the challenges being faced by the NHS.

What was different about the FHP?

NHS staff and patients are currently exposed to a raft of service improvement and transformation programmes as healthcare organisations strive to cope with increasing demand and constrained budgets.

The FHP was a new venture for the RCP. It represented a unique, comprehensive programme of activity which included: eight FH development sites (selected, supported local healthcare project teams); a pilot of a new role of chief registrar (a senior clinical leadership role for experienced trainee doctors); and other workstreams relating to person-centred care, young adults and adolescents and integrated care. The FHP:

- > **championed patient experience and patient-centred care throughout, by facilitating leadership by patients, carers and the public and their involvement in service redesign and delivery from the outset**
- > **embedded in clinical practice the FHC 'blueprint' and its 11 principles of patient care'**
- > **applied a standardised approach to measuring the impact of new ways of working through quality improvement methodology**
- > **supported development sites to improve front-line services within existing local resources with no additional transformational funding**
- > **advocated a front-line clinician-led approach to improvement by selecting eight sites with strong, multiprofessional team working and patient engagement, from inception through to implementation**
- > **led on the development of future clinical leaders through a bespoke leadership, management and improvement programme as part of the chief registrar project**
- > **used the expertise, resource and influence of a medical royal college to support improved patient care**
- > **commissioned independent evaluation by academic organisations.**





Key learning

1. Ensure patients and carers are at the centre of healthcare design and delivery

From the outset, the FHP championed patient involvement. Patients were involved in the design and delivery of all development site improvement projects to varying extents. It is recognised that full, meaningful integration of patient representatives into clinical teams remains a challenge. Learning from the development sites showed that successful patient involvement in service design and delivery can be achieved by:

- > harnessing the individual strengths and skills of patient representatives
- > appointing at least two patient representatives to each clinical team and fostering mutual support and cross cover, to maintain continuity and to obtain a wider viewpoint
- > peer support provided by an organised patient group, for example the RCP's Patient and Carer Network (PCN) or National Voices
- > ensuring that clinical teams continuously reflect on, and refine the role of patient representatives
- > identifying a member of the clinical team to act as a main point of contact for patient representatives; ideally, this should be the project lead
- > ensuring that the patient's voice is heard and not marginalised by terminology, clinical decision making, professional relationships and hierarchy.

Development sites benefited from the varied backgrounds and experience of their patient representatives. Patients authored project reports, blogs and journal articles, led the redesign of a website to host resources for clinicians and the public, and presented at FHP learning events.



2. Provide local support for teams to improve patient care in a financially constrained, politically exposed healthcare system.

Almost all development site projects were put at risk or adversely impacted by systemic pressures in their organisation. Unprecedented healthcare demand led to reorganisation and staff redeployment while staff vacancies disrupted teams. These challenges were mitigated by:

- > ensuring board-level sponsorship, support and alignment with wider organisational and health economy priorities from the outset
- > strong clinical and managerial leadership across primary, secondary, tertiary and social care
- > patient involvement at every stage of the project, which engaged and motivated staff and managers and ensured a focus on goals that were meaningful to patients
- > ensuring that wide staff engagement, resilience and morale were top priorities
- > professionals having time, space and support to focus and participate in improvement activities outside of routine clinical practice.

The absence of RCP funding for service provision, or staff recruitment, in development site host organisations meant that improvements were achieved within existing budgets and, consequently, readily sustainable.

One Future Hospital development site team aimed to integrate respiratory services across central and south Manchester. Ensuring staff engagement across two large organisations was crucial for making progress. Regular meetings were held for teams to share ideas and collaborate on how integration would benefit patient care.



3. Develop a collaborative learning structure to enable healthcare teams to successfully implement improvement projects

Over its span, the FHP refined a series of educational and supportive interventions to help individuals and teams successfully implement improvement projects, which included:

- > collaborative learning opportunities
- > sharing project successes and failures both within and outside the FHP
- > fostering a wider community of interest to share best practice and learning
- > building peer support, particularly valued by chief registrars embarking on a unique and new role
- > training in improvement methodology
- > training in developing and implementing patient experience data collection and disseminating this to drive improvement.

The FHP facilitated regular learning events for Future Hospital development sites to meet, share learning, network and find solutions to common challenges, which were highly valued by teams. Likewise, through the Future Hospital chief registrar scheme, chief registrars were encouraged to collaborate and share learning through regular training days held at the RCP.



4. Collect and analyse data to support ongoing improvements to patient care

The FHP provided all development site teams with training and support from experts in quality improvement and data analysis from the outset. Teams which included a local data analyst utilised statistically valid methodology more extensively, with an enhanced ability to demonstrate the impact of their interventions. These analysts helped to upskill clinical colleagues to utilise data to improve the care delivered to patients.

There remains limited expertise in the wider NHS in applying the 'measurement for improvement' model. Significant input is required to:

- > recruit and upskill data analysts
- > embed data analysts into clinical teams at the outset of improvement projects
- > support and train clinical teams to ensure the right data are collected, analysed and interpreted to measure the improvement in care sought
- > support clinical teams in collecting and interpreting patient experience data
- > focus on data that measure the true impact of clinically-led improvement or change
- > focus on data that enable clinical teams to improve patient-centred care and outcomes.

Development site projects adopted the Institute for Healthcare Improvement measurement for improvement model, which includes repeated Plan, Do, Study, Act (PDSA) cycles to drive continuous improvement.

The Future Hospital Programme has demonstrated that a patient-centred approach to improving services can help deliver better care for patients by more motivated, engaged staff.



5. Develop future clinical leaders

Clinical leadership, prestige and professional pride were significant drivers for success throughout the FHP. The chief registrar scheme was launched at a time when medical trainees felt undervalued and morale in the workforce was at an all-time low. The chief registrar pilot demonstrated:

- > **the value of the role of chief registrar for individuals, patients, their organisation and the NHS**
- > **the need for future clinical leaders to have structured leadership, improvement and management training, while remaining engaged in the delivery of acute, front-line care.**

Chief registrars are the NHS's future clinical leaders and take a leading role in developing innovative improvement projects that address key local challenges.



6. Partnership working between the RCP and local teams is an effective model for improving aspects of patient care

The FHP was a new initiative for the RCP. The prestige of being badged as part of the RCP's FHP was held in high regard by clinical teams, managers and healthcare boards. Affiliation with the RCP:

- > **helped to gain organisation board-level support, which in turn accelerated local decision making processes**
- > **attracted positive local and national media and political attention which supported dissemination**
- > **enabled further progress through links with other national NHS organisations (for example the Society of Acute Medicine)**
- > **facilitated networking, shared learning and structured training**
- > **provided project management support, with exposure to national clinical leaders and expertise.**

The FHP was a new initiative for the RCP. The prestige of being badged as part of the RCP's FHP was held in high regard by clinical teams, managers and healthcare boards.

Successes

The right doctors assessed acutely ill patients early and as close to the hospital front door as possible

Future Hospital projects showed:

- > patients on surgical pathways who had access to acute physicians and geriatricians, used ambulatory care more and had shorter hospital lengths of stay
- > patients receiving comprehensive geriatric assessment from a specialist multidisciplinary team tended to have a shorter length of stay in hospital.



Specialist medical care extended seamlessly into the community so that patients at home, or close to home benefit from integrated specialist and community-based care

Future Hospital projects showed:

- > patients with frailty who received specialist care in the community experienced fewer emergency visits to hospital
- > patients with respiratory illness experienced longer intervals between emergency admissions once specialist services were integrated
- > patients with access to telemedicine were able to receive specialist care in the community, which resulted in reduced travel time and costs for both patients and physicians
- > frail, older patients given enhanced community assessment, experienced a reduction in admissions to hospital due to falls.

Patient experience is valued as much as clinical effectiveness

Future Hospital projects showed:

- > patient representation was embedded in each of the development site teams.
- > local patient representatives were complemented by a member of the RCP's PCN.
- > improved patient experience was reported consistently at each of the development sites.
- > teams needed support to collect and analyse patient experience data in real time.



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

Future Hospital projects showed:

- > project teams were able to build on their success through the creation of new posts and improved recruitment
- > sites reported improved resilience, staff morale, team working and collaboration across healthcare boundaries. There was also expansion and replication of their projects in new locations.

External recognition

The FHP and its projects were recognised as beacons of excellence.

- > Several of the development sites and the chief registrar project were recognised with national nominations and awards, including the HSJ award for 'Improving Outcomes through Learning and Development'.
- > Project teams were visited by health ministers and members of parliament.
- > The overall FHP won the LaingBuisson award for innovation in care in 2016.



Conclusions

The FHP has demonstrated that a patient-centred approach to improving services can help deliver better care for patients by more motivated, engaged staff. The FHC vision of improving patient care through enhanced access to specialist medical care closer to home and earlier in hospital pathways was realised in part.

Development sites recruited in 2014 showed improvements in the care of frail older people in hospital and community settings. Development sites commencing their projects in 2016 highlighted the promise and initial impact of enhanced joint working across healthcare boundaries for respiratory, allergy and frail and older people services.

Patient involvement

Patient involvement helped to ensure that the improvements reported were meaningful to patients. Successful and effective patient involvement required careful planning and continuing support.

Team morale and resilience

Almost all development site projects were put at risk by relentless systemic pressures in their organisations, leading to staff redeployment and vacancies. Improvement requires resilience and flexibility; projects may evolve in directions that were not foreseen at their inception.

Collecting data for improvement

The IHI improvement methodology was utilised by all development site teams. Those teams with data analysts were able to apply this methodology most effectively. Data analysts should be embedded in front-line clinical teams seeking to improve care. This will ensure that the 'right' data are collected, analysed and appropriately interpreted.

Developing future leaders

The pilot of the role of chief registrar has been a notable success of the FHP. The evaluation from the University of Birmingham provides important insights into its implementation.² The achievements of the first chief registrars have been impressive, leading to wide support and a doubling of recruitment.



Improving future health and care

The findings and learning from the FHP confirm that the RCP is uniquely placed to support physicians to improve patient care through:

- > supporting patients and carers to be members of improvement teams
- > harnessing its national and international prestige to improve patient care
- > facilitating collaborative learning and networking opportunities with peers and experts
- > supporting the development of the next generation of clinical leaders and ensuring today's leaders are equipped with the skills to continuously improve patient care.

References

- 1 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.
- 2 Exworthy M and Snelling I. *Evaluation of the RCP's Chief Registrar programme: Final report*. Birmingham: University of Birmingham, 2017.

Background

Future Hospital Commission

[Hospitals on the edge? The time for action](#)¹ and the [Francis Inquiry report](#)² set out stark evidence of the critical pressures on acute medical services in the NHS. In response, the RCP set up the Future Hospital Commission (FHC) to address these concerns.

What emerged from the FHC was a compelling and ambitious report, [Future Hospital: caring for medical patients](#) (2013), which was welcomed across the professional, political and policy community and described by the editor of *The Lancet* as ‘the most important report in British medicine in a generation’.³

In its report, the FHC described a vision for comprehensive care for medical patients based on 11 principles of patient care, setting out a radical new model of care designed around the needs of patients, with clear lines of responsibility across professional and healthcare boundaries.

11 principles of patient care

The programme is underpinned by 11 principles of care around which healthcare should be designed:

- 1 Fundamental standards of care must always be met
- 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
- 5 Patients do not move wards unless this is necessary for their clinical care
- 6 Robust arrangements for the transfer 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 support needs
- 11 Staff are supported to deliver safe compassionate care and are committed to improving quality.

Despite its title, the FHC goes far beyond the hospital, considering how specialist medical care extends into the community and interfaces with primary, community and social care.

Innovation and changes to service delivery are familiar to all NHS staff, driven by rising demand and increasingly constrained resource. What set the FHC apart from other initiatives was its scope, comprehensive nature, and the willingness of an authoritative professional body to directly address multiple critical pressures compromising the medical care of acutely ill patients.

FHC: recommendations

The FHC made a total of 50 recommendations relating to the organisation of acute medical care. At its core, the FHC proposed:

- a comprehensive model of acute medical care underpinned by 11 principles of patient care
- patients and their medical and support needs must be at the centre of how services are organised and delivered
- patients must be involved in service design and delivery
- specialist medical care must be available to patients irrespective of where they are, either in hospital or in the community
- patient experience must be valued as much as other outcomes
- the measurement of patient outcomes, including patient experience of care, must be embedded into clinical practice and drive improvement initiatives
- a renewed emphasis on training and leadership, embodied in the post of chief registrar
- prioritisation of self-management and shared decision making
- special provision with services for vulnerable patients, including frail and older patients, and young adults and adolescents.

Principles of patient involvement and representation

Patients helped to shape the FHC report recommendations and, naturally, patient involvement is at the core of the Future Hospital Programme (FHP). Since its inception, the FHP has worked closely with the RCP's Patient and Carer Network (PCN) to realise its aims of ensuring patients are at the heart of healthcare services. The PCN's aim is to ensure that patients' and carers' voices are at the centre of all of the RCP's work.

Comprehensive patient involvement within the FHP is most apparent in the eight Future Hospital development site projects. Selected to work in collaboration with the FHP, the development site teams exemplify the FHP's commitment to promoting the message that patient experience is valued as much as clinical effectiveness, good communication with and about patients is the norm and services are tailor-made to meet the needs of individuals.

Future Hospital Programme

Establishment and funding

Following the publication of the FHC report, the RCP committed to testing the recommendations of the FHC and to fund this programme over a 3-year period. The cost of the programme to the RCP was just under £2 million.

In addition, grants were awarded from the Lord Leonard and Lady Estelle Wolfson Foundation to the integrated diabetes care project, and the transition services for young adults and adolescents project. The shared decision making project and the supported self-management projects were supported by grants from the Health Foundation.

Although the RCP worked in close partnership with clinical teams in England and Wales to implement new ways of delivering patient care, no funding by the RCP was provided directly to partner healthcare organisations to bolster service provision. Clinical sites that demonstrated improvements in the quality of care achieved this within existing NHS budgets. The costs to the RCP of this partnership working related to central project support, provision of expertise (eg data analysis) and activity related to collaborative learning, networking and peer support.

The Future Hospital Programme

The FHP was a multifaceted approach to implementing and evaluating the recommendations of the FHC report. This was achieved through the following workstreams.

1. Supporting local teams to deliver improvement

The FHP worked with eight **Future Hospital development sites** comprising multidisciplinary teams of physicians, nurses, managers, allied health professionals, social workers and patients on discrete projects aligned to the vision of the FHC. The sites were recruited in two phases: phase 1 in October 2014 and phase 2 in March 2016.

- **Phase 1** sites focused on improving the care of frail and older people.
- **Phase 2** sites focused on implementing integrated care models to support varied cohorts of patients.

The FHP also supported a clinical and research team in developing and implementing an **integrated service model for diabetes care in Oxfordshire**.

2. Developing future clinical leaders

Through the **Future Hospital chief registrar scheme**, the FHP implemented a key recommendation of the FHC: to establish new, senior leadership roles for trainee physicians. The chief registrar pilot, run during 2016/17, determined the skills, protected time and training needed to support this new leadership position.

3. Providing a platform to showcase innovation and learning

Future Hospital Partners Network: An active and evolving community of people who are champions for the Future Hospital model.

Tell us your story: Through the *Tell us your story* initiative, the FHP published online stories of clinically-led service improvement in the NHS.

Review of integrated care: The FHP commissioned a review of [current models of integrated diabetes care](#)⁴ – this was published in February 2016.

Shared decision making and support for self-management: In 2013, the RCP published a position statement and established a project to promote shared decision making and support for self-management. Subsequently, the FHP prioritised these recommendations in the development site projects.

Transition services for young adults and adolescents: The FHP commissioned a review of transition services within adult medical specialties which resulted in the publication of [an RCP toolkit](#) (*Acute care toolkit 13: Acute care for adolescents and young adults*)⁵ raising awareness of the issues related to caring for young adults and adolescents with long-term, complex conditions.

Patient involvement: learning

The FHP championed patient involvement in the design of services from the outset, advocating the inclusion of at least one, and ideally two, lay person representatives in the development site project teams. Local representatives were supported by a member of the PCN, who also acted as a link to the FHP team and the RCP.

Development sites were selected for involvement in the FHP, based on their ability to demonstrate existing and on-going commitment to patient involvement. Teams were also encouraged to consider when a larger cohort of patients was required to inform service design, for example through patient focus groups or co-production events.

Each development site involved patients in different ways and with varying levels of activity and output. Although patient involvement is widely advocated, several challenges characterise its effective implementation in clinical practice. Below are aspects of patient involvement successfully exemplified in practice by development sites and some of the challenges teams faced.

Successes

✓ **Co-designing services with patients**

Development sites sought to engage with public and patients at the outset, to ensure services were designed in line with patients' true needs.

The central and south Manchester development site held two co-design days that brought together multiprofessional teams alongside patients.

✓ **Giving patients a voice**

As equal members of project teams, patient representatives were encouraged to have an active and valued voice in decision making.

At the north-west Surrey site, patients played an important role in the implementation and management of the newly formed Patient Advisory Group. This group contributed to the development of the Bedser Hub; a bespoke, single-site healthcare facility.

✓ **Directly improving care for patients**

As patients and carers, lay representatives are aware, first-hand, of the changes needed to improve patient care and, in some cases, are well placed to coordinate the change.

In the North West Paediatric Allergy Network team, the local patient representative led the development of the new patient zone of the network's website. The patient representative and linked PCN member at Mid Yorkshire Hospitals were central to the production of a new patient information leaflet after identifying, from patient experience interviews, a lack of understanding by patients of who was responsible for their care.

✓ **Putting the FHC principles of patient care into practice**

Patient representatives and PCN members were encouraged to help ensure project teams were guided by the FHC principles for patient care.

As a result of patient involvement in the East Lancashire development site team, the project team now interview patients in their own homes to [collect patient experience stories](#). Clinical teams use the results to continue to learn and improve services.

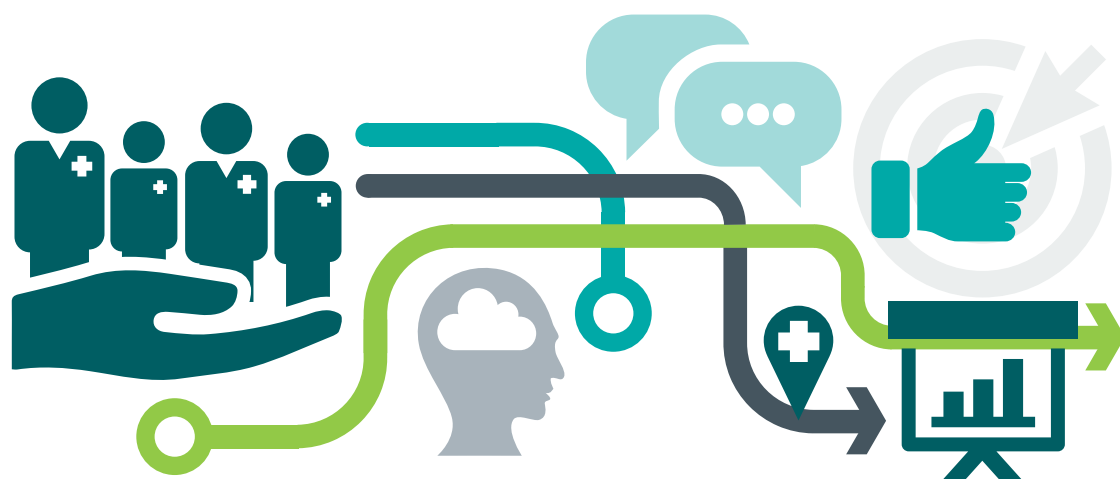
✓ **Recognition for patient representatives**

At Mid Yorkshire, the dedication of patient volunteers locally was recognised by the trust with a nomination in the annual 'Volunteer Team of the Year' awards. This has led to a greater awareness and recognition within the wider trust of how patients and carers are contributing to the provision of high-quality patient care.

- ✓ **Building an improvement network**
Patient representatives and PCN members are now part of a wider network of improvement advocates through their involvement in the FHP. Patients valued the opportunity to meet and connect with the wider Future Hospital development site network.

Challenges

- **Making patient involvement meaningful**
Achieving full integration and acceptance of patients as team members has not been easy. Setting up and maintaining effective patient involvement in a team requires a lot of work, attention and commitment. Even with strong support from the PCN and RCP, site teams achieved varying levels of success. For example, while clinical teams have multiple opportunities in the working day to meet and discuss project progress, patient representatives have to catch up more formally through scheduled meetings.
- **Involving patient champions**
A patient involvement champion (a member of staff) is essential to ensure that team decision making is fully inclusive. Without a person in the team and organisation who is a champion for active involvement of patients/carers, it is all too easy for patients to be kept out of the loop, albeit unintentionally.
- **Changes to project management and team structure**
Complex projects extending over several years need effective and consistent team membership and project management. Some of the greatest challenges teams faced were when the team structure and/or membership changed. In some instances this had a profound impact on local and PCN patient representatives who are not based in the hospital day-to-day.
- **Changes in patient representation**
Patients and clinicians worked on the FHP projects in addition to their other 'day' jobs and responsibilities. At times, patient/carer representatives were dealing with their own health issues or caring responsibilities which prevented their continuing involvement in the FHP. In recognition of this, it was recommended that each project included two patient representatives – both to share the burden of the role and provide mutual support.



Chapter 1

Supporting local teams to deliver improvement

The major clinical workstream of the FHP has been supporting local teams to deliver projects aligned to the vision and recommendations of the FHC. This chapter includes findings and learning from:

- > eight Future Hospital development sites: teams of allied health professionals, social care colleagues and patients leading local improvement projects
- > a project team in Oxfordshire, working to integrate diabetes services across the region.

Future Hospital development sites

The FHP set out to implement the FHC vision of improving care for acutely ill medical patients. Fundamental to this was organising services around the needs of patients and bringing specialist care closer to the patient, irrespective of where they are in hospital or in the community.

The RCP invited NHS-wide, clinically-led, multidisciplinary teams to apply to become FHP development sites, to implement the FHC recommendations that related directly to the provision of patient care. Applicants were required to:

- provide details of their projects and how these aligned with the 11 principles of the FHC
- demonstrate involvement of patient representatives in design and implementation
- have a local, board level executive sponsor.

For phase 1 sites (recruited in October 2014) the topic was open. However, all four of the successful applications focused on *improving care for frail and older patients*, reflecting the largest demographic of patients using NHS acute medical services. For phase 2 the call was specified as projects focusing on *integrated care* and four sites were recruited in March 2016.

Phase 1

- **Worthing Hospital**
The Worthing emergency floor project brought acute medical, surgical and care of the elderly teams together with standardisation of clinical pathways for emergency admissions.
- **East Lancashire Hospitals NHS Trust**
The East Lancashire team developed integrated community-based teams to support frail older people within their homes, either preventing admission to hospital or providing continuing care following assessment and care in hospital.
- **The Mid Yorkshire NHS Hospitals Trust**
Mid Yorkshire's 'REACT' team is dedicated to ensuring that patients with frailty and complexity are appropriately assessed when they arrive at hospital, by geriatricians at the traditional 'front door' areas.
- **Betsi Cadwaldr University Health Board**
Betsi increased access to specialist outpatient consultations through telemedicine for frail and older patients in rural north Wales, to ensure they took place as close to home as possible.

Phase 2

- **Central and south Manchester**
The team developed integrated respiratory services across central and south Manchester.
- **North-west Surrey**
By developing dedicated locality 'hubs', the north-west Surrey team aimed to deliver the best possible outcomes for the older population.
- **The North West Paediatric Allergy Network (NWPAN)**
Working with healthcare staff, families and the public, NWPAN aimed to deliver more effective and timely care for children with allergies.
- **Sandwell and West Birmingham**
Developing and delivering physician-led integrated services for respiratory patients in Sandwell and West Birmingham.

FHP support for the development sites

The FHP tailored its support to the needs of each development site. However, the following interventions were common to all.

- **Patient involvement**
The FHP supported sites in engaging local patient representatives in improvement projects.
- **RCP Patient and Carer Network (PCN)**
The PCN identified representatives to 'buddy' local patient representatives. PCN representatives supported the local patient representatives, many of whom were new to working with clinicians on projects and participating in project teams.
- **Clinical leadership**
Two Future Hospital officers (consultant physicians) provided support to site teams. Particular support was given to clinical leads who led FHP projects in addition to their existing acute service leadership roles.
- **Learning events**
At regular 'learning events', site teams were given space and time to network with and learn from each other, reflect on their progress, and set ambitions for the future. Learning events were attended by patient representatives and PCN 'buddies'.
- **Progress reporting**
Development sites submitted regular progress reports to the FHP team. The frequency of reporting was revised over time. Annual reports were prepared at the end of 2015 (phase 1 only), and 2016 (phases 1 and 2), with feedback provided by the central FHP team to provide encouragement, address concerns and focus the teams' priorities.
- **Data analysis advice and support**
Sites were supported in data collection, analysis and reporting. The FHP facilitated the support of a dedicated NHS analyst to help sites to use data for improvement.
- **QI methodologies**
Sites were supported by the FHP to lead service improvement projects using quality improvement (QI) methodologies. All sites collected patient experience outcomes data and received advice on how to obtain and use this.
- **Project management support from the FHP team**
Two FHP coordinators were responsible for supporting four development site projects each. They arranged monthly telephone calls with clinical leads and were in regular contact with patient representatives (local and PCN) to offer guidance in identifying and solving challenges.
- **Speaking, networking and collaboration opportunities**
The FHP identified speaking opportunities for development site teams at national and international conferences to raise the profile of their projects. The FHP also introduced site teams to other health organisations, for example NHS 111 (North West) and The Chartered Society of Physiotherapy.
- **Affiliation with RCP**
All development site projects were officially affiliated with the RCP. This status gave the teams credibility and prestige within and outside their organisations.



Worthing Hospital

Aim

To dissolve traditional boundaries within the hospital and between primary and secondary care to improve the experience for patients.

Outline

The Worthing emergency floor combines an acute medical unit, an acute frailty unit and a surgical assessment unit in a medium-sized district general hospital. The teams set out to:

- 1 improve patient flow and experience
- 2 reduce length of stay in hospital and limit readmissions rates
- 3 improve patient and staff satisfaction
- 4 improve the training environment for staff
- 5 increase the use of ambulatory care.

Key messages

- **Co-location of acute admission units** delivers significant benefits to patients and the system.
- Having all new **admissions in one area** makes transfers of care easier.
- **Regular feedback** to staff on patient experience is essential.
- Reporting on **waiting times** is helpful and reflects process, experience and outcomes.
- An organisational **culture of continuous improvement** is essential to achieving change.
- Regular **multidisciplinary team meetings** help to build new processes.

Methods

1. The emergency floor concept

The Worthing emergency floor project combined an acute medical unit and a surgical assessment unit and co-located them with an acute frailty unit in a medium-sized district general hospital. It focused care around the patient regardless of the route of access or specialty requirement of the patient.

2. Multidisciplinary working

- Daily emergency floor safety huddle.
- Daily 11am multidisciplinary team (MDT) board round.
- Daily ward input from physiotherapy, psychiatry, social work, intermediate care and dietitians.
- Daily specialist medical input from neurology, palliative care, oncology and cardiology.
- Regular multidisciplinary Emergency Floor Operational Group (EFOG) meetings.

3. Use of e-whiteboard

All patients arriving on the emergency floor are entered on an e-whiteboard. This electronic patient list allows data collection for tracking times, consultant review and location of patients.

4. Increased utilisation of Ambulatory Care Area (ACA)

Use of the ACA continues to expand, particularly for surgical care, posing some challenges to space and staff resource. The potential for over 30% of all attendances to be managed through ACA results in bed-saving.

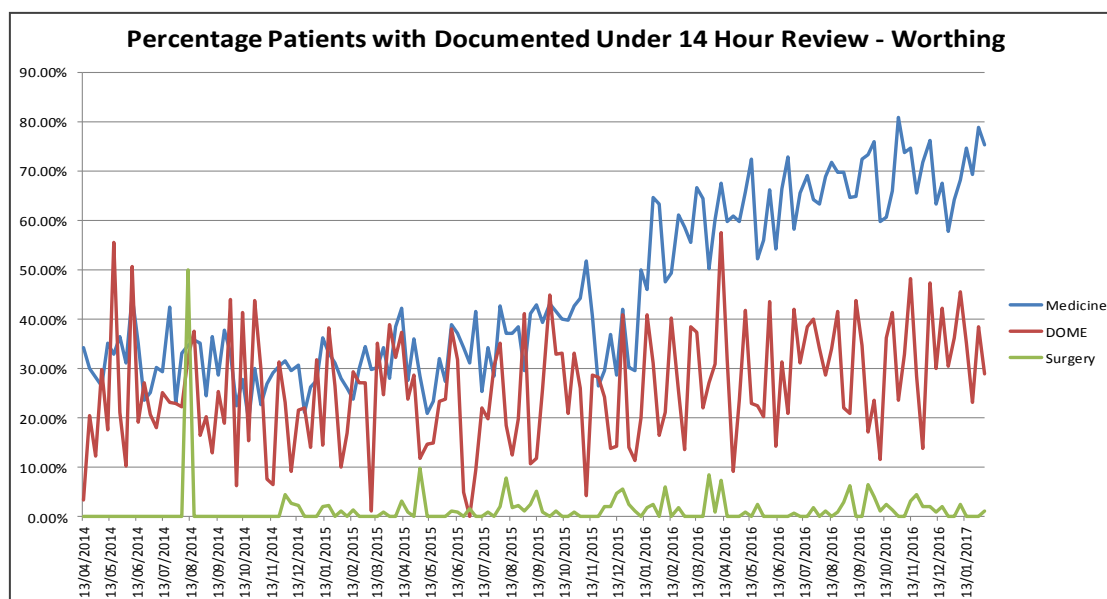
Milestones

- Sep 2014: Appointed as an FHP development site.
- Dec 2014: Worthing emergency floor opens.
- Apr 2015: Introduction of daily monitoring safety huddles.
- Aug 2015: Acute care foundation programme is launched.
- Oct 2015: Project manager leaves team: no replacement made.
- Dec 2015: Hosted a learning event for phase 1 sites.
- Jan 2016: Acute medicine consultant rota changed: 8am–7pm cover, 7 days a week.
- Apr 2016: Worthing Hospital awarded 'outstanding' rating in (Care Quality Commission) CQC inspection.

Outcomes

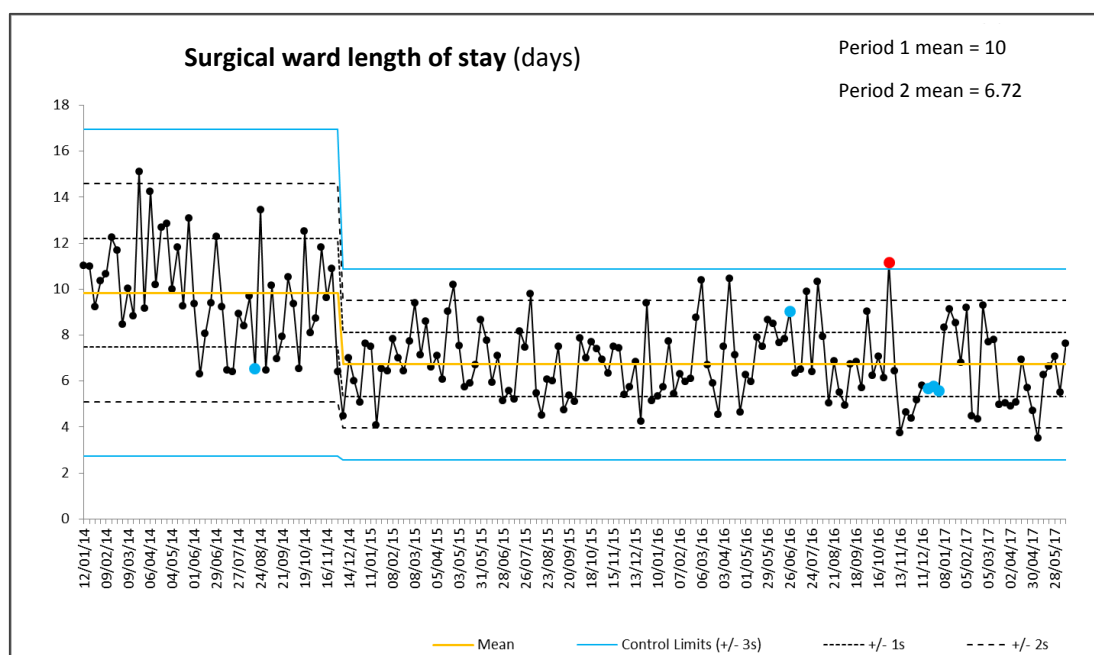
1. Time to review

The importance of rapid access to the 'right person,' helped to deliver **improvements to patient experience** in parallel with **improved clinical effectiveness**. The graph below reflects a change in the medical consultant rota and the fact that surgical teams have not been using the e-whiteboard to record these data.



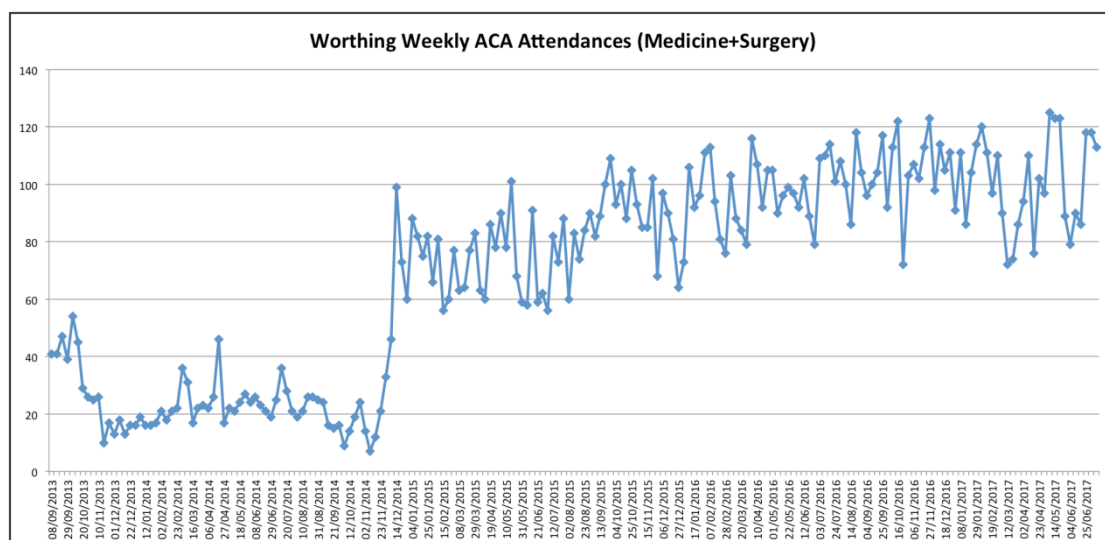
2. Length of stay

The most important measurable impact of this project has been on the pathway, process and flow for surgical patients. As soon as the ambulatory care area opened, it became clear that many patients previously admitted under surgical teams could be seen and cared for in the ambulatory setting.



3. Ambulatory care

The Ambulatory Care Area (ACA) has advanced significantly over the past 5 years and played a major role in the success of the emergency floor project. It is likely that this has been the single most important factor in **reducing admissions to the hospital** and particularly so for surgical patients.



Successes and challenges

Successes

- ✓ Decreased average length of stay, particularly for surgical patients.
- ✓ No increase in mortality or readmission rates.
- ✓ Good feedback from friends and family, despite significant service pressures.
- ✓ Excellent MDT community of hard-working and committed professionals who work together, with the common purpose of providing the absolute best experience and care for each patient.
- ✓ Cultural shift to a clear engagement with the process of improvement, learning, adapting and reviewing.
- ✓ Clinical outcomes and patient experience measured, evidenced and re-enforced regularly.
- ✓ Successes and failures demonstrated in regular reporting of an agreed set of metrics.
- ✓ Any patient on the emergency floor who requires a comprehensive geriatric assessment now has this on the day of admission.
- ✓ All foundation trainees rotate as an 'emergency floor doctor' in their first year; an excellent opportunity to develop a wide range of generalist and practical skills spanning medicine, surgery and care of older people.

Challenges

- Opening the emergency floor in the month of December (2014) was challenging; there was high demand and system-wide discharge challenges resulting in significant pressures.
- A planned patient forum was not set up due to lack of administrative resources.
- A change in the organisation of frailty nursing staff posed a challenge for coordinators who manage beds and liaise with the community services.
- The national shortage of nursing staff has been a significant challenge to recruitment.

Read the full report from Worthing's development site team at:

www.rcplondon.ac.uk/delivering-the-future-hospital

Contact: Dr Roger Duckitt, roger.duckitt@wsht.nhs.uk



East Lancashire Hospitals NHS Trust

Aim

To deliver better, personal, effective care for frail and older people closer to home where safe and appropriate.

Outline

The Future Hospital development site work at East Lancashire is a core component of the Pennine Lancashire Transformation Programme 'together a healthier future'. As one of six health improvement priorities and part of the trust's emergency care system transformation programme, the project team set out to:

- 1 develop integrated community care teams to support frail older people
- 2 implement a rapid frailty assessment for frail older people attending hospital as an emergency
- 3 embed holistic care planning for frail older people approaching the end of their lives
- 4 learn from the experiences of patients and families to improve services.

Key messages

- **Adaptability** to local changes, and embedding the work within them, has brought the current success, and set a platform for the future.
- The sense of being part of a **community of practice** that is testing the real world implementation of the Future Hospital principles has been both invigorating and created resilience in challenging times.
- Recognising that the prominent culture of **care is a continuum** that may include hospital care. This has been exemplified through this work and has influenced organisation and **system culture**.
- Establishing the measures for the process and outcomes of care at the start of the programme or project, alongside robust **project management**, may bring earlier results.
- Keeping **patients at the centre** and embedding your work in the organisation's everyday business.
- By **raising the profile of vulnerable patient groups**, multiprofessional staff are now better coordinated to meet families' needs, and improvements in care are progressing fast.

Methods

1. Developing integrated community-based teams

These teams were developed to support frail and older people within their homes, either preventing admission to hospital or provision of continuing care following initial assessment and care in hospital. This included the following:

- Integrated neighbourhood teams (INT): a case-management approach for high-need individuals, linked to multidisciplinary teams.
- Intensive home support service (IHSS): an urgent multiprofessional support at home to prevent or reduce hospitalisation.
- Intermediate care allocation team (ICAT): a multiprofessional team who coordinate referrals, care planning and packages and monitor service capacity.
- Integrated discharge service (IDS): to signpost, coordinate and progress throughout the patient discharge pathway, acting as a central point of referral, assessment and information, thereby actively reducing length of stay (LOS) in the acute setting.
- 'Home first': a discharge-to-assess approach which was piloted across Pennine Lancashire.

2. Rapid frailty assessment for older people attending hospital as an emergency

A frailty specialty doctor was appointed in August 2016 to lead and provide the medical input for rapid frailty assessment. The multiprofessional team assesses those patients highlighted by emergency department coordinators or who have been 'screened' in the department.

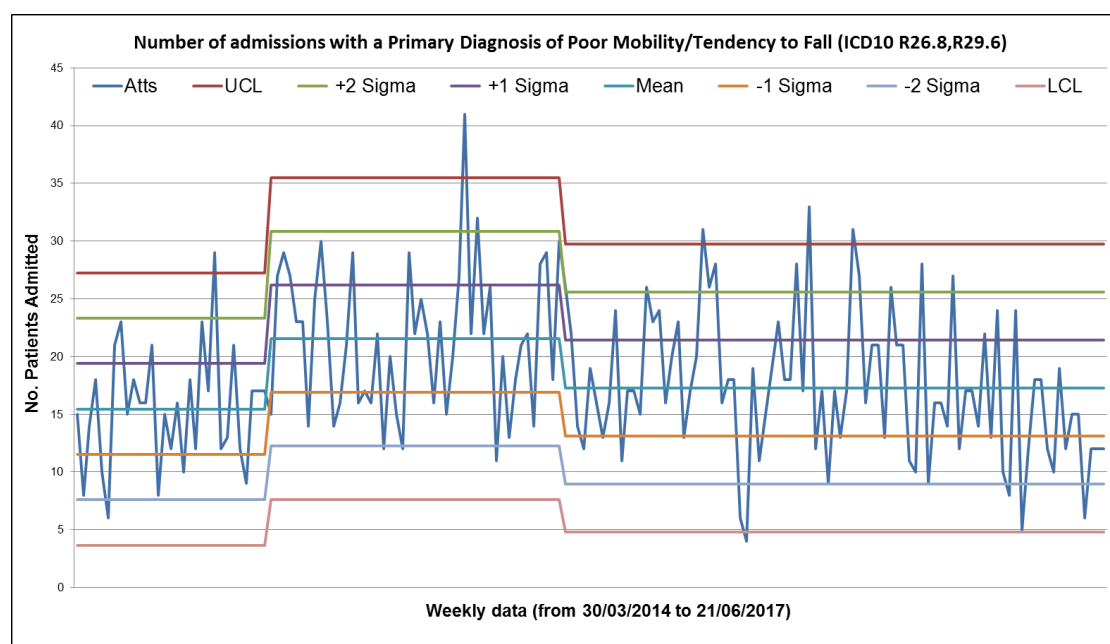
Milestones

- Jul 2013: East Lancashire Hospitals NHS Trust (ELHT) enters special measures.
- Jul 2014: ELHT taken out of special measures.
- Sep 2014: Appointed as an FHP development site.
- Feb 2015: Frailty MDT piloted in medical assessment unit.
- Oct 2015: Expansion of acute medical unit (AMU), to AMU A and AMU B with 82 beds.
- Dec 2015: IHSS and ICAT services commence.
- Feb 2016: IDS commences.
- Mar 2016: Hosted learning event for phase 1.
- Aug 2016: IHSS fully operational. Frailty specialty doctor appointed to lead rapid frailty assessment.
- Oct 2016: Specialty doctor begins working as part of the front door team in the emergency department at Royal Blackburn Hospital.
- Jan 2017: ELHT rated 'good' in Care Quality Commission (CQC) inspection.
- Mar 2017: Pilot of 'discharge to assess' system.

Outcomes

1. Admissions due to falls or poor mobility

There has been a **reduction in admissions to hospital** as a result of falls and poor mobility. This initially coincided with the development of IHSS and INTs, with a trend to further reduction since January 2017. The increase in November 2014 is thought to be due to changes in clinical coding.



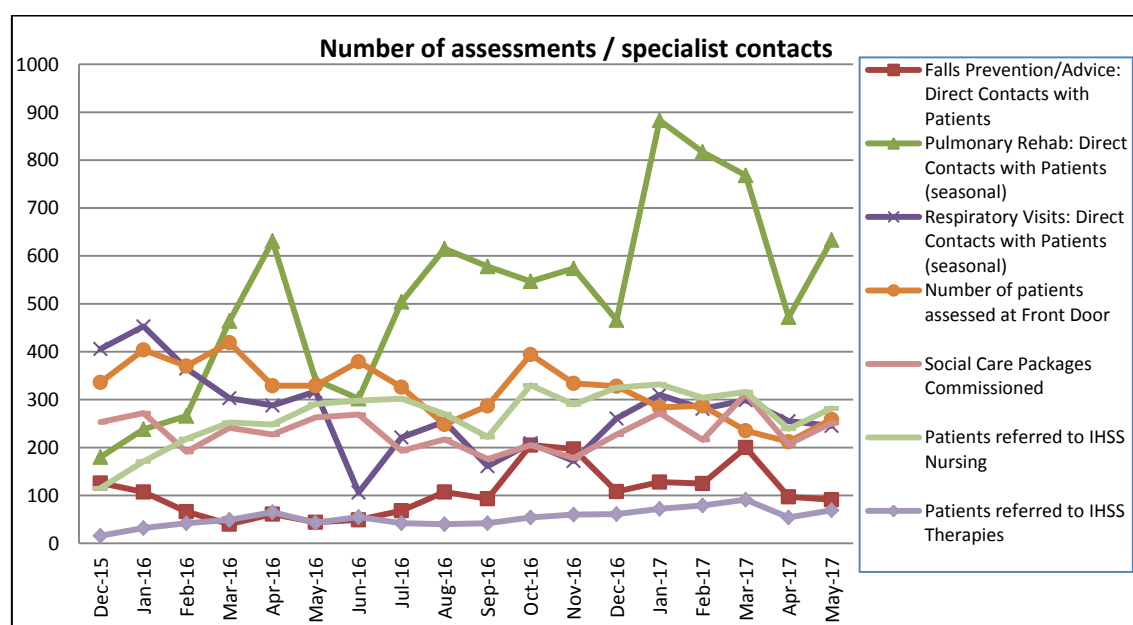
2. Patient experience

Strong themes that emerged from patient experience reporting have been:

- the need for improved information about what care to expect
- the need for greater involvement of families and carers in care
- the importance of other services, eg community pharmacy, ambulance services and voluntary sector
- the importance of good end-of-life care.

3. Impact on community services

Community services have responded to patients' needs, not only those referred from the emergency department, but also patients referred directly from community services, including INTs. A notable **increase in falls prevention advice** and input, together with **fewer but more complex assessments by the 'front door team'**, have been seen.



4. Staff engagement

The introduction of a frailty specialty doctor (FSD) to the front door team has had a **positive impact** on many staff in the emergency department.

- *'The FSD gives me confidence of a safe discharge. They have time to go into detail that I will never have. The team have a familiarity with support services.'*
Emergency department consultant
- *'The FSD gives us confidence to make higher risk decisions and a greater understanding of what can be treated at home. I am reassured that the patient is going to the right place. We now work in a less risk-averse way.'*
Occupational therapist

Successes and challenges

Successes

- ✓ A new approach to using patient experience through structured interviews about the whole experience of care.
- ✓ Standardised patient stories used by teams and leadership to guide and invigorate continuous improvement.
- ✓ Better conversations and care planning have been major outcomes.
- ✓ Improvements in care and experience for frail and older people in their own homes, when attending hospital and during and following a hospital admission.
- ✓ Reduced admission rates for people with mobility problems
- ✓ Consistent use of improvement methodology of small-scale testing and adaptation moving to wider scale implementation.
- ✓ CQUIN (quality funding incentive) negotiated, thanks to status as FHP development site.

Challenges

- Challenging to coordinate and involve multiple stakeholders working across a number of internal and external programmes of work.
- East Lancashire has a complex health and social care economy, with two clinical commissioning groups (CCGs), two community providers and two local authorities.
- Having the workforce resources to deliver the project was not always possible and at times it was demoralising.
- Difficult to retain volunteers to deliver the patient experience elements of the project.
- Issues around governance and competing priorities for the patient experience team and clinical and managerial leads.

Read the full report from East Lancashire's development site team at www.rcplondon.ac.uk/delivering-the-future-hospital

Contact: Dr Ray Hyatt, raymond.hyatt@elht.nhs.uk



Aim

Outline

Rapid, multidisciplinary assessment of those with frailty.

Ensuring patients are at the centre of everything we do.

Caring for and engaging with patients and members of the team.

Key messages

- Creating **collaborative teams** can make a real difference to the care of older people, especially those with frailty. A culture of openness enables problems to be addressed and create change.
- **Co-production with patients** to ensure true patient-centred care drives improvements and is at the heart of everything the team does. Putting patients and their families first is key.
- Working **holistically** is vital to ensure that frail older people have access to comprehensive geriatric assessment and to achieve excellent patient experience each and every time.
- Rolling out services trust-wide, creating two acute care assessment units (for older people), **minimises the inequalities** in healthcare provision.
- **Professional and personal development** helps to create new leaders and encourages staff engagement in improvement.
- Being involved in the FHP has ensured **shared learning** within the team, trust and region. This encourages networking within and beyond the community.

Methods

Clinical model

- The service operates 7 days a week.
- Opening hours of the service are continually reviewed for optimal benefit to patients.
- A clinical model was set up for patients aged 80+, and 65+ from nursing homes, with an understanding that patients who are otherwise frail over the age of 65 can be referred for rapid assessment on an individual basis to the acute geriatrician.
- In place in two sites: Pinderfields and Dewsbury Hospital.
- Assessment moved to a frailty-based service for those aged over 65 in 2017 at both sites. Dedicated telephone service with direct access to GPs, operational at both sites.
- A&E consultants can directly refer to the REACT team for advice and support.

Milestones

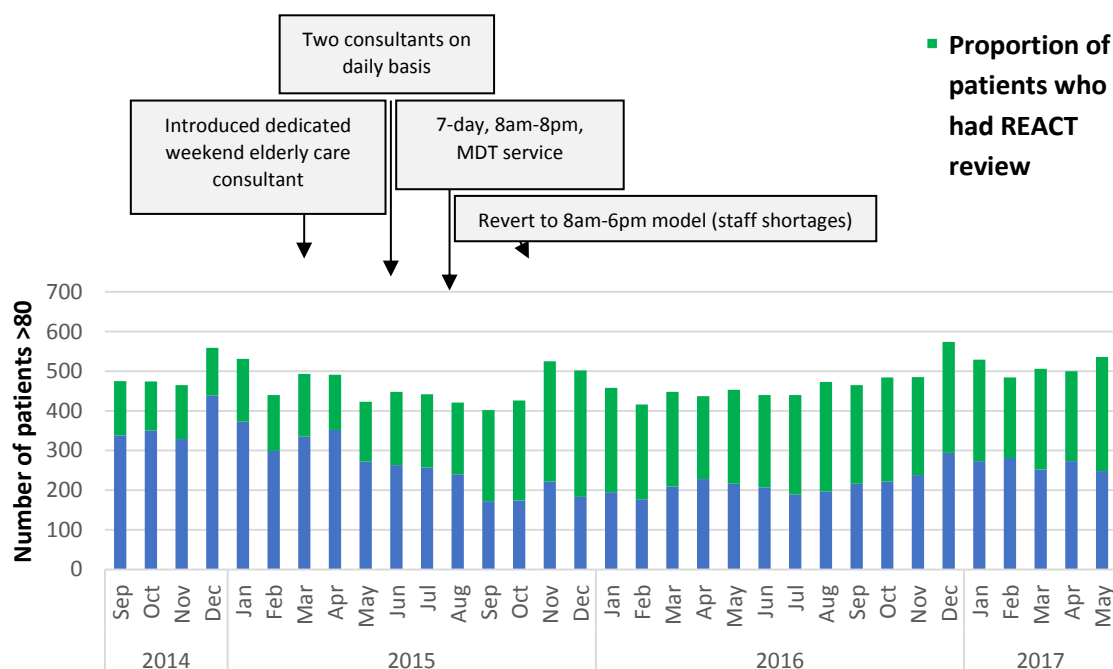
- Sep 2014: Appointed as an FHP development site.
- Apr 2015: Dedicated on-call geriatrician rota. Two ward rounds during weekdays and a weekend elderly care consultant.
- Jul 2015: Third consultant joins REACT team (part-time). Two consultants in team on daily basis.
- Jul 2015: RCP Patient and Carer Network (PCN) member and local patient representative join project team.
- Sep 2015: Move to 7-day service (8am–8pm) for patients aged 80+, or 65+ from nursing homes.
- Sep 2015: 7-day multidisciplinary team (MDT) service established.
- Oct 2015: Dedicated telephone service established. Patients admitted from A&E handover.
- Nov 2015: Service reverts to 8am–6pm model due to staffing constraints.
- Apr 2016: New chief executive appointed.
- Sep 2016: Shared competency model for occupational/physiotherapists and nurses.
- Sep 2016: Frailty champion appointed.
- Dec 2016: Shared competency model for nursing staff.
- Mar 2017: Fourth consultant appointed. Two consultants present on daily basis.
- Jul 2017: New acute care of the elderly pathway comes into use.
- Jul 2017: Acute care of the elderly assessment unit opens at Dewsbury and District Hospital.

Outcomes

1. Rapid assessment

More patients admitted acutely are seen by REACT, with increasing numbers presenting with frailty. Prior to the introduction of a weekend elderly care consultant rota, an average of 28.5% of patients over the age of 80 were identified for early discharge. The introduction of a dedicated geriatrician increased pick-up rates to 38%. The impact of a 7-day REACT service increased this further to 53.8%.

Increasing numbers of patients are identified by REACT, especially since moving to a 7-day service

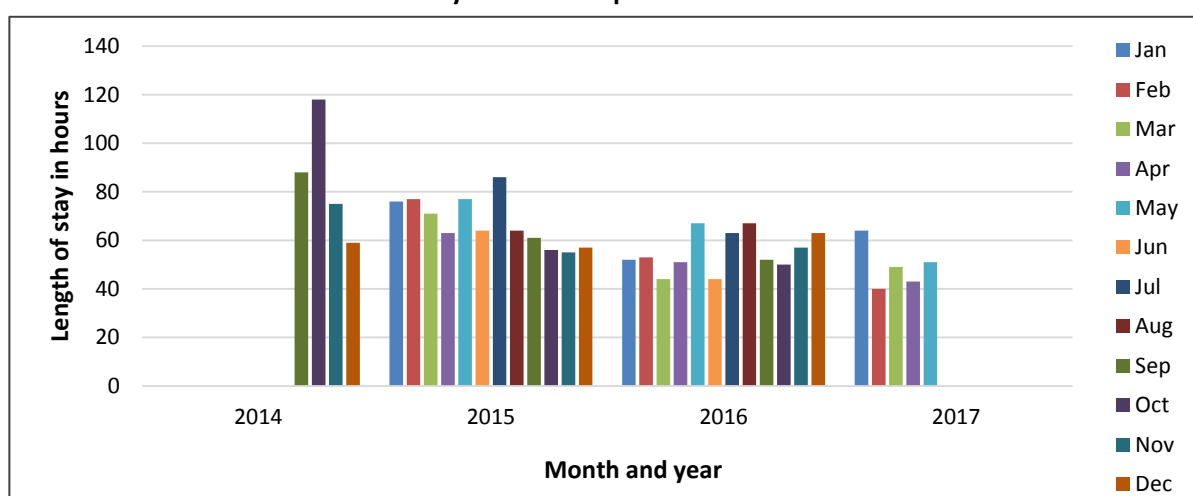


2. Reduced length of stay

The **overall length of stay of REACT patients has reduced** on a month by month comparison, except through the winter months. Year on year there has been a reduction in the length of stay of those admitted and discharged by REACT.

Prior to the introduction of a dedicated geriatrician, the length of stay was an average of 80.9 hours (Sept 2014–April 2015). Post-April 2015, after the introduction of a 7-day service, the average was 70.7 hours. This has fallen further to 55.7 hours in 2016 and 50.9 hours in 2017.

Length of stay has reduced since 2014 for those assessed by REACT, especially following the extension of the team to a 7-day service in September 2015

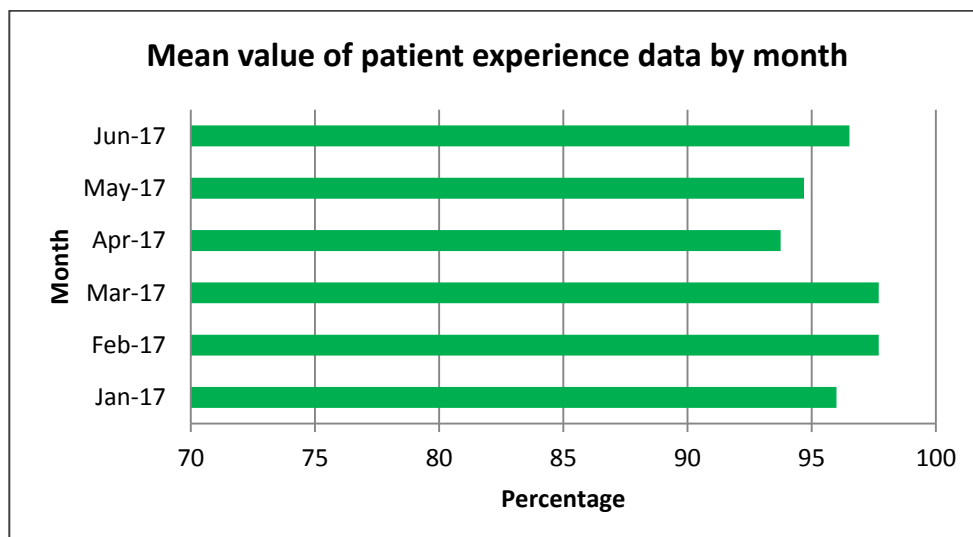


3. Patient experience

Patient-centred questionnaires have evolved over the course of the project, together with guidance for face-to-face interviews (minimum two sessions per month) to ensure consistency. In 2017, follow-up phone calls were arranged after discharge.

Low levels of complaints despite numbers assessed being high. There were six formal complaints out of 1,618 patients managed by the service between July and December 2016 (0.04%), of which two related to external agencies beyond the control of the team.

In the graph below: very satisfied = 70, highly satisfied = 100.



Successes and challenges

Successes

- ✓ The development of shared competencies and a revision of workload, therapists have maintained the service. (No extra physiotherapy / occupational therapy recruitment has been feasible due to freezes on funding.)
- ✓ All comprehensive geriatric assessments for older patients have been standardised.
- ✓ Staff have improved access to personal and professional development and there is a greater sense of loyalty/belonging.
- ✓ The whole department has been involved in frailty workshops and has a great reputation in the organisation, with 150 applications for two–three band 3 posts, and 15 for two band 6 posts.
- ✓ Patient involvement has been important throughout the project. The team has co-produced service developments with local patients and RCP PCN representatives, and benefited from the full support of two patient representatives from 2017.

Challenges

- There are high patient numbers and a constant stream of eligible patients who would benefit from comprehensive geriatric assessment.
- Increasing patient numbers have led to a higher risk of patients not being able to move through the care pathway. While demand is high, there is a continuing need to move to a frailty model which is also challenging in relation to available resource.
- The aim was for generic therapy skills to be shared with nursing staff. This has not been possible due to staffing numbers and other strains on resources.

Read the full report from Mid Yorkshire's development site team at www.rcplondon.ac.uk/delivering-the-future-hospital

Contact: Dr Zuzanna Sawicka, zuzanna.sawicka@midyorks.nhs.uk



Betsi Cadwaladr University Health Board

Aim

To provide increased access to specialist opinion as close as home to possible for frail and older patients in rural north Wales through the use of telemedicine.

Outline

Known as the CARTREF project – CARE delivered with Telemedicine to support Rural Elderly and Frail patients – the Betsi team set out to:

- 1 allow patients to have outpatient follow-up consultations closer to their home, reducing the need for patient travel and the burden on Welsh ambulance services
- 2 facilitate improved chronic disease management in primary care through access to specialist support, resulting in increased patient satisfaction
- 3 reduce waiting times in other outpatient clinics through releasing review appointment slots for specialty patients
- 4 ensure acceptability of telemedicine service model through co-production with patients and carers.

Key messages

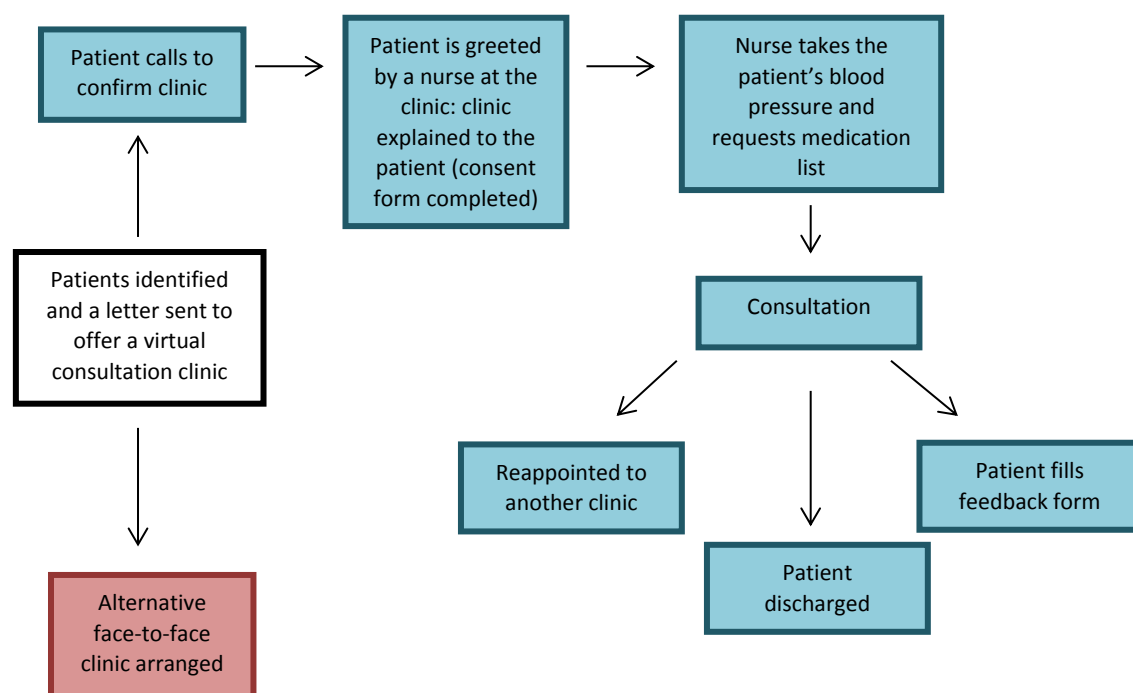
- **Co-production** is essential – virtual clinics have received positive feedback, which has been an enlightening experience for staff and has driven change.
- **Telemedicine** is a viable option for outpatient consultations in frail older individuals.
- **Patient stories** are powerful tools in diffusing clinician anxiety regarding adopting digital technology.
- **Organisational buy-in** and support are essential for delivery and success of a quality improvement project.
- **Supporting staff through change** is essential – coaching and mentoring help to build resilient teams.
- Relationship building and **sharing ideas** among the eight Future Hospital development sites have been powerful motivators to strive for excellence.

Methods

In order to provide increased access to specialist opinion as close to home as possible for frail and older patients in rural north Wales, the Future Hospital project team set up a range of telemedicine services.

1. Telemedicine clinic

Bimonthly virtual general medicine consultation clinics are facilitated by a consultant in the community hospital Ysbyty Bryn Beryl.



2. Engagement with primary care and community – digital inclusion officer role

The digital inclusion officer (DIO) provided essential patient advocacy and support throughout the project rollout, helping to inform the patients what the consultations entailed and the benefits, which in turn improved the patient experience. The DIO collected patient feedback via a patient questionnaire during this period.

3. Telemedicine clinics across other specialties

- Rheumatology consultations and Parkinson's clinics established between Ysbyty Llandudno and the community hospitals Ysbyty Bryn Beryl and Ysbyty Dolgellau.
- Gastroenterology services set up a telemedicine service.
- Neuroscience network are adopting telemedicine.
- The majority of specialties at Wrexham Maelor Hospital have elected to do telemedicine consultation follow-ups at HMP Berwyn – a prison with 2,000 men.

Milestones

- May 2014: Welsh Government Health Technology and Telehealth fund awarded.
- Sep 2014: Appointed as an FHP development site.
- Jan 2015: Video hardware installed. Trial consultations undertaken.
- Jun 2015: Betsi Cadwaladr University Health Board placed in special measures.
- Jul 2015: Virtual consultations are fully operational at Ysbyty Bryn Beryl community hospital.
- Jul 2015: Host learning event for phase 1 sites.
- Dec 2015: Local patient representative moves away – role unfilled.
- Feb 2016: Rheumatology consultations and Parkinson's clinics begin between Ysbyty Llandudno and the community hospitals Ysbyty Bryn Beryl and Ysbyty Dolgellau.
- Mar 2016: New patient representative joins the team.
- Jul 2016: Drop in number of virtual clinics due to fewer eligible patients
- Sep 2016: Telemedicine working group established.
- Nov 2016: New patient experience questionnaires are developed in collaboration with patient representatives.
- Mar 2017: Vaughan Gethin, Welsh cabinet secretary for health, visits Cartref team.

Outcomes

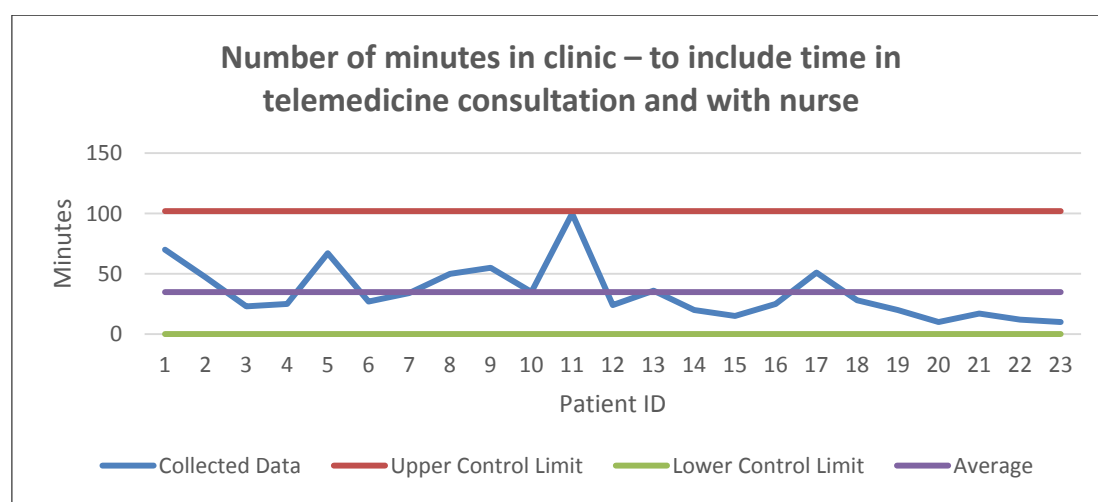
1. Impact on travel time and costs

Telemedicine clinics reduced travel, number of consultations per patient, movement of patient notes, and travel time for patients with associated costs saving. The service converted 20% of outpatient department follow-up contacts to telemedicine; a completely new way of working.

The impact on consultants was also significant. One reduced their travel time by 1.5 hours per clinic and mileage by 80 miles per clinic. This equates to £1,411 saving per annum (based on travel expenses being remunerated at 42p per mile).

2. Duration of consultations

Telemedicine clinics were associated with a shorter duration of consultation. The chart below shows the total amount of time spent in the clinic with doctors and nurses for 23 consecutive patients. At the outset, the allocated time with a consultant was 30 minutes, however, with growing confidence in the system, the time was reduced to, on average, 14 minutes compared with a conventional outpatient consultation of 20 minutes.



3. Patient experience

Detailed patient experience questionnaires were collected in a sample of 55 consecutive patients for 2015/16 and 33 for 2016/17. The age of patients ranged from 75 to 104 years.

- **88.6% (78/88) of patients would recommend the virtual consultations** to family and friends.
- **100% stated that they would prefer the telemedicine clinic** in comparison with travelling to the hospital clinic.

Successes and challenges

Successes

- ✓ Positive patient feedback.
- ✓ Maintaining staff wellbeing and resilience despite significant organisational pressures.
- ✓ Excellent support from patient representatives.
- ✓ Spread of telemedicine to additional specialties.
- ✓ Time and cost savings for patients and consultant staff.
- ✓ Significant forecasted savings could be made with scale-up of virtual outpatient services.
- ✓ 'Highly commended' for an HSJ Value Award 2016, category: telemedicine.
- ✓ Support from the cabinet secretary for health for Wales.

Challenges

- Project team changes due to the health board restructuring.
- Changes in the team led to a lack of continuity.
- Decrease in number of patients eligible for telemedicine.
- Unable to appoint a DIO after the initial set-up phase of project.
- Limitations around quantitative data collection to support qualitative data.

Read the full report from Betsi Cadwaldr's development site team at

www.rcplondon.ac.uk/delivering-the-future-hospital

Contact: Dr Olwen Williams, olwen.williams@wales.nhs.uk

Learning from the phase 1 development sites

The application and project management processes for development sites were considerably refined based on the experience of recruiting phase 1 and the teams' experiences of working with the FHP.

A uniting theme: integrated care

By coincidence, all four phase 1 development sites had a focus on improving care for frail and older patients. However, the call for applications for phase 2 was structured around the theme of integrated care. This fitted with the FHC vision and complemented the FHP's integrated care project in Oxfordshire and the FHP commissioned review on integrated care.

Application process

The application review panel was extended to include external assessors. A clear vision for patient involvement and representation was required from the outset. Shortlisted sites were interviewed at the RCP. The application process required sites to obtain support from a wide network of colleagues, lay representatives and senior management, including:

- lead clinician
- lead GP
- nurse or associated allied health professional lead
- project manager
- data manager
- lay representative
- executive (or non-executive at trust-board level) project sponsor.

Importance of patient involvement

The importance of patient involvement was emphasised from the outset for the phase 2 development sites. Some phase 1 sites lacked patient representation for periods of time or recruited individuals who had difficulties contributing in the role. Patient representatives were identified in the application and were integral to the interview process. The pairing with the PCN patient representative was formalised, and representatives were briefed on each site and on the scope of their project to match skillsets.

Progress reporting

In the first year, phase 1 sites submitted monthly written progress reports to the FHP. When four additional sites were recruited, this process was refined based on feedback from sites. Monthly written reports were arduous so the frequency of reporting was reduced to quarterly. In addition site leads had monthly telephone calls with the FHP team which were found to be extremely effective.

Joint learning events

All eight development sites came together twice at special joint learning events to foster a wider sharing and learning environment.

Delivery events

Learning events evolved with time. Sites were encouraged to take the lead in hosting and facilitating the events, rather than being led by the FHP team. Likewise, as sites became more familiar with each other's work and their projects matured, learning events became 'delivery events': opportunities to present team's successes, and challenges of implementing new ways of working in their organisations.

Data analysis support

A data analyst was to be named on each application to ensure a focus on data and metrics was set from the beginning.



Phase 2: Integrated care

Central and south Manchester

Aim

To develop integrated respiratory services across central and south Manchester in partnerships with patients and carers, that will allow healthcare professionals across primary, secondary and community care to work coherently together.

Outline

Historically, central and south Manchester had separate community respiratory services that operated within different clinical commissioning group (CCG) boundaries. The team set out to create a single, collaborative and integrated respiratory care service across Central Manchester Foundation Trust (CMFT), University Hospital South Manchester (UHSM) and central and south Manchester CCGs. The team's objectives were to:

- 1 break down geographical and organisational boundaries for patients
- 2 reduce variation in care and provide high-quality, standardised respiratory services
- 3 enhance patient experience by reducing fragmentation of care
- 4 gain greater efficiencies and value from current resources.

Key messages

- Encourage and nurture **self-care skills** among patients with long-term conditions.
- Developing **peer support networks** can help people with respiratory disease feel more knowledgeable about their condition, confident and less isolated.
- **Building relationships** and trust between individuals in different organisations at ground level is the foundation to integrating care.
- A **systems approach** is required to address the issue of recurrent hospital admissions.
- Measurement of change and organisational performance needs to reflect **what is important to patients**.
- **Data, data, data.** Prove the value of what you do.

Methods

1. Vertical integration in south Manchester

In order to align services with central Manchester who had a well-established community model, south Manchester made a number of changes and developments to the community team over 18 months, including: recruitment, re-defining roles, establishing regular team meetings with a respiratory consultant, an education programme, commencing a 'virtual clinic' model in primary care and a review of services provided.

2. Horizontal integration between CMFT and UHSM at the front line

Historically the UHSM and CMFT front-line community respiratory teams had a professional relationship but had never met face-to-face as there was no previous incentive from the organisations/system to do so. Joint team meetings between CMFT and UHSM were established on a monthly basis. Teams:

- explored the services each team offered
- identified the patient access routes
- established joint education sessions, including sharing of case studies
- used process mapping to identify different parts of the service and produce joint operating policies.

A shadowing programme was undertaken where staff within the teams gained experience of how the other team operates. This enhanced development of personal relationships and helped with the alignment of team policies.

3. Patient involvement

Patients were involved in the integrated steering group and in co-design events to ensure that service developments were patient-centred.

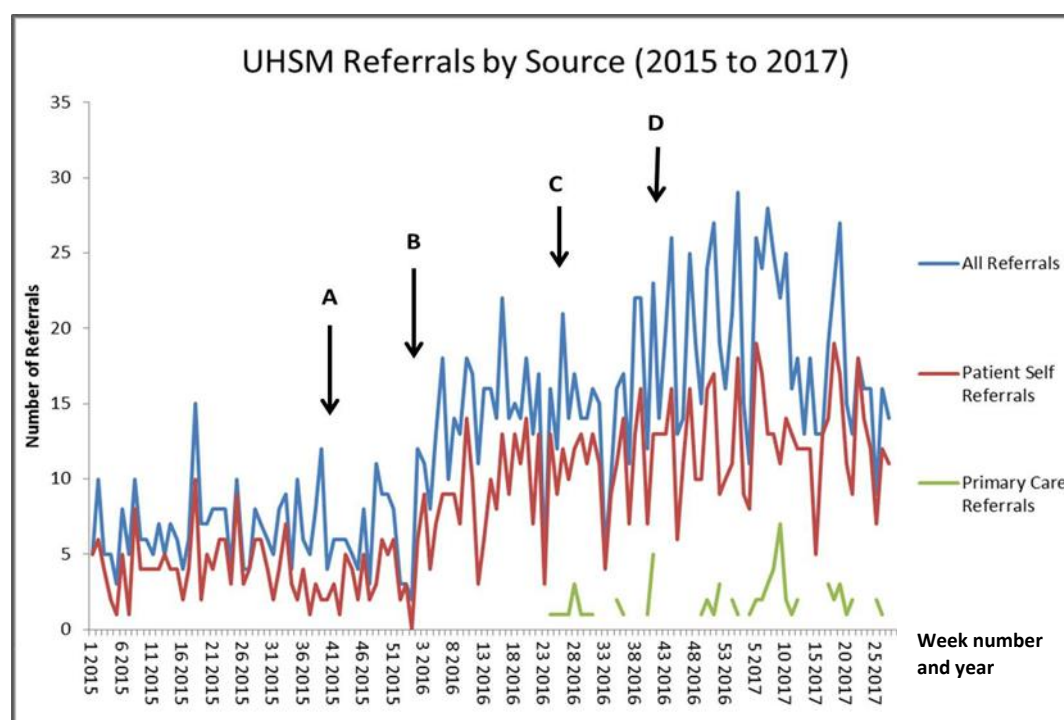
Milestones

- Jan 2016: Appointed as an FHP development site.
- Mar 2016: Multiple stakeholder co-design event: developing a pathway for the acutely unwell.
- Jun 2016: Multiple stakeholder co-design event: developing services to support chronic disease management.
- Dec 2016: Hosts of phase 2 learning event on the theme: commissioning.
- Apr 2017: North, south and central Manchester CCGs merge into one city-wide CCG.
- Jun 2017: Palliative care co-design event.
- Oct 2017: UHSM and CMFT merge into one acute trust.

Outcomes

1. Impact on patient care

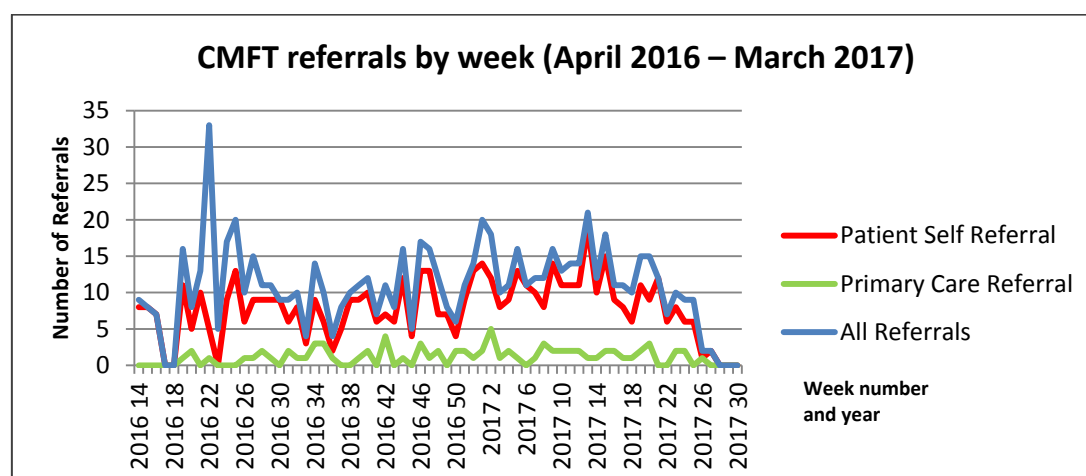
In south Manchester, patient self-referrals rose steadily in 2016 and primary care referrals started to grow from mid-2016. These data act as an indirect marker of **increased integration with primary care** and a shift to **more patients being seen in the community setting**.



Phased changes that were made to team working and structure

A	Decision for UHSM and CMFT to work together
B	Integrated steering group established Change in leadership for community team Community team roles reviewed and changed to become more community-focused Regular community team meeting established
C	Barriers for primary care to refer to team reviewed and removed Co-production days completed with system-wide engagement Specialist nurses assigned to GP practices to i-reach and provide support
D	Virtual clinic pilot in primary care

The graph below shows that in a similar period, referral numbers to the CMFT community respiratory team (CRT) did not change significantly. As mentioned previously, CMFT already had a fully integrated model, therefore significant changes to working practices were not made.



2. Impact on patient experience

A patient experience sub-group was established in 2016. It comprised three patient representatives, a representative from the British Lung Foundation and two members of clinical

staff. A specific objective was set to develop a set of measures for the 'acute' pathway (ie when a person with COPD becomes unwell) and to explore their experience of getting appropriate help and care. The following key issues and concerns were raised and discussed by the group:

- Patient representatives are not representative of 'most' patients and their contribution should be considered as a 'patient view' rather than representing the whole patient population.
- Metrics should reflect what is important to patients, such as 'living the life they want to live', rather than simply reflecting experience of a particular service or process.
- More should be done to support patients to provide honest feedback about their negative experiences of accessing care and treatment.
- Patients 'don't know what they don't know'; therefore satisfaction surveys or measures such as 'Friends and Family' are of limited benefit.
- More needs to be done to engage BME, LGBTQ and other minority groups.

3. Impact on workforce

Nine staff from the two teams (UHSM and CMFT) responded to a questionnaire on their views of the integration of the two services. There were four responses from UHSM and five responses from CMFT. Concerns included cross-site working, potential increased commute to work and the practicalities of how the teams would work.

A quote from the survey captured the positive effects: *'The joint working sessions have helped us to get to know the other team and experience a different way of working. Communication has definitely improved and it is easier to refer patients between us'.*

Successes and challenges

Successes

- ✓ The FHP was hailed a 'flagship' for joint-working by both executive boards, when UHSM and CMFT became one acute trust in October 2017.
- ✓ FHP clinical leads are integral to the citywide Manchester CCG Integrated Respiratory Steering Group, which is now shaping the future respiratory care for the city.
- ✓ The quality improvement support provided by the RCP has had a profound impact on how the team considers data and metrics that will now have influence at Manchester CCG level.
- ✓ The virtual clinic model is being considered by the Greater Manchester Transformation Team for roll-out across 500 Manchester GP practices.

Challenges

- Limited information-sharing across the system, which has been a barrier to progress.
- Enabling effective and diverse patient representation was challenging.
- The hierarchical process-driven culture in some departments and changing the mindset of those on the front line accustomed to working within single disciplines.
- The changing political landscape and turnover of staff across the system created uncertainty.
- Few additional resources were given to the project.
- Administrative support, project management, data retrieval and analysis were hugely challenging throughout.

Read the full report from central and south Manchester's development site team at www.rcplondon.ac.uk/delivering-the-future-hospital

Contact: Dr Binita Kane, binita.kane@mft.nhs.uk



Phase 2: Integrated care

North-west Surrey

Aim

To provide an integrated care model for older people with frailty in north-west Surrey by designing and implementing a bespoke, single-site healthcare facility: the Bedser Hub.

Outline

The Bedser Hub concept was developed in response to an ageing population and the challenges that arise from more people living longer and with more chronic conditions. Detailed analysis suggested there was a significant opportunity to reduce avoidable hospital admissions and length of stay and relieve stress on health services, which so often result in failure of quality standards and poorer patient care. The north-west Surrey team aimed to:

- 1 keep people independent for longer
- 2 improve patient experience and patient and carer satisfaction
- 3 reduce avoidable inpatient admissions and shorten acute length of stays
- 4 increase the throughput and optimal utilisation of acute inpatient capacity
- 5 increase the proportion of older people with frailty receiving planned and coordinated care with fewer unpredictable exacerbations of need
- 6 eliminate duplication, with more efficient use of resources across the health and social care system to meet the demographic challenges for frail older people.

Key messages

- Primary care engagement upfront is key – secure engagement of local practices in order to **deliver primary care leadership** with GP cover at all times.
- **Wellbeing coordinators** are invaluable for integrating health and social care – they provide named key workers for all patients, ensuring access to all relevant support within and beyond the Bedser Hub.
- The team initially **underestimated the culture change** required to work in this way.
- **Information sharing** across the health and social care network can be enabled by information governance (IG) support – embed this as early as possible in the project.
- EMIS was used to provide a **single care record** for each patient, which is available to all professionals in the Bedser Hub.
- Patient assessments took longer than originally anticipated, resulting in **increased impact** on Bedser Hub activity.

Methods

In order to support the frail and older population in north-west Surrey, the Future Hospital project team set up a locality hub: a **physical building that sits alongside a community hospital**.

1. Wellbeing coordinator

As part of the multidisciplinary team, the Bedser Hub is supported by a group of wellbeing coordinators (WBCs) who:

- are provided by Age UK Surrey to support patients in a holistic way
- offer patients hour-long appointments, allowing the Bedser Hub team to understand the whole person, their support network and their aims and preferences
- signpost patients to services, both within the hub and externally.

2. Primary care leadership for frailty

All locality general practices and their services operate in a network supported by diagnostics, pharmacy and transport. By connecting services across the region, the team hopes to expand their project by opening additional hubs across north-west Surrey. Patients from other practices have been drawn into a central location (not fragmented in each practice).

3. Improved efficiencies

Improving links between Ashford St Peter's Hospital and the Bedser Hub has enabled:

- patients to be followed up within 3 days at the hub for any urgent medical issues that previously relied on GPs
- hub patients are alerted on our AE patient centre when they arrive in hospital
- the hub is enabling the local 'discharge to assess' project, to provide a more efficient and effective delivery.

Milestones

- Jan 2016: Appointed FHP development site.
- Mar 2016: Bedser Hub open. Sessions: GP 4 days/week, consultant 2 days/week.
- Jul 2016: New GP lead appointed.
- Jul 2016: Host of first phase 2 learning event.
- Aug 2016: Delegation from Singapore visits Bedser Hub.
- Oct 2016: 1,500 patients. 15 GP sessions running per week.
- Jan 2017: Six GPs deliver 20 sessions per week.
- Mar 2017: 1,700 patients.
- May 2017: 1-day a week service delivered at other sites: Ashford and Weybridge.
- July 2017: After a fire at Weybridge Hospital, building of second hub at Ashford Hospital 'fast tracked'.

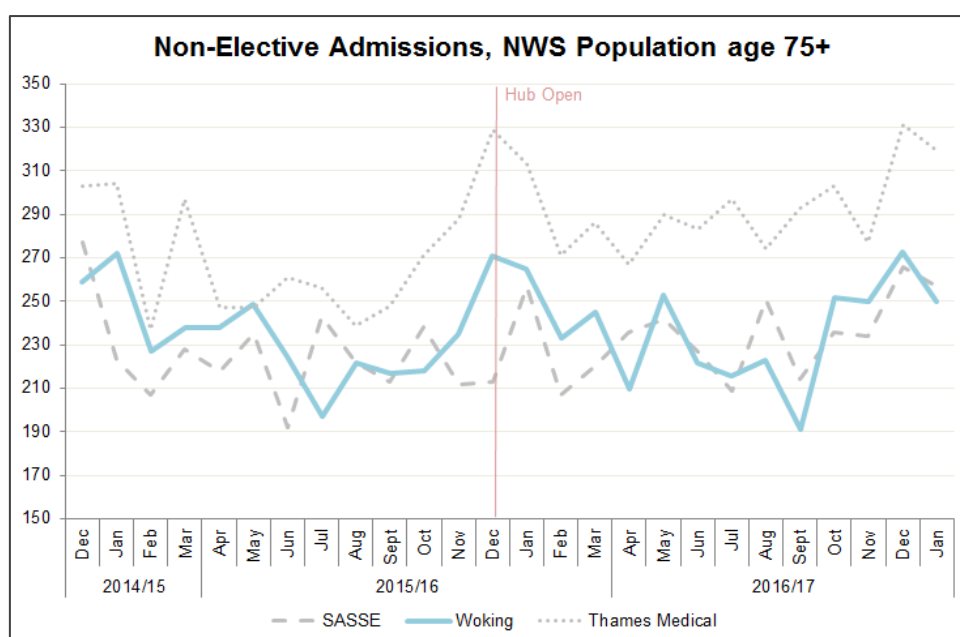
Outcomes

1. Hospital activity

The hub service is beginning to affect unplanned hospital activity. Inpatient admissions and A&E attendances appear to be reducing and planned outpatient attendances have slightly increased.

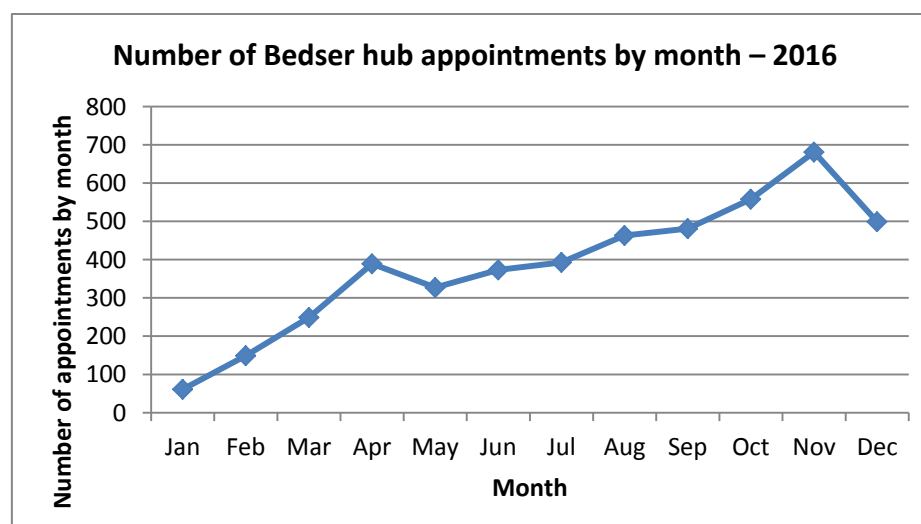
2. Non-elective admissions

From January to December 2016 there was an overall 1.1% reduction in non-elective admissions for the over 75 population in Woking, compared with the previous calendar year. This relates to a saving of approximately £90k. There was an increase in admissions for the same age group in Stanwell, Ashford, Staines, Shepperton, Egham (SASSE) and Thames Medical localities (+1.4% and +8.5%).



3. Bedser Hub activity

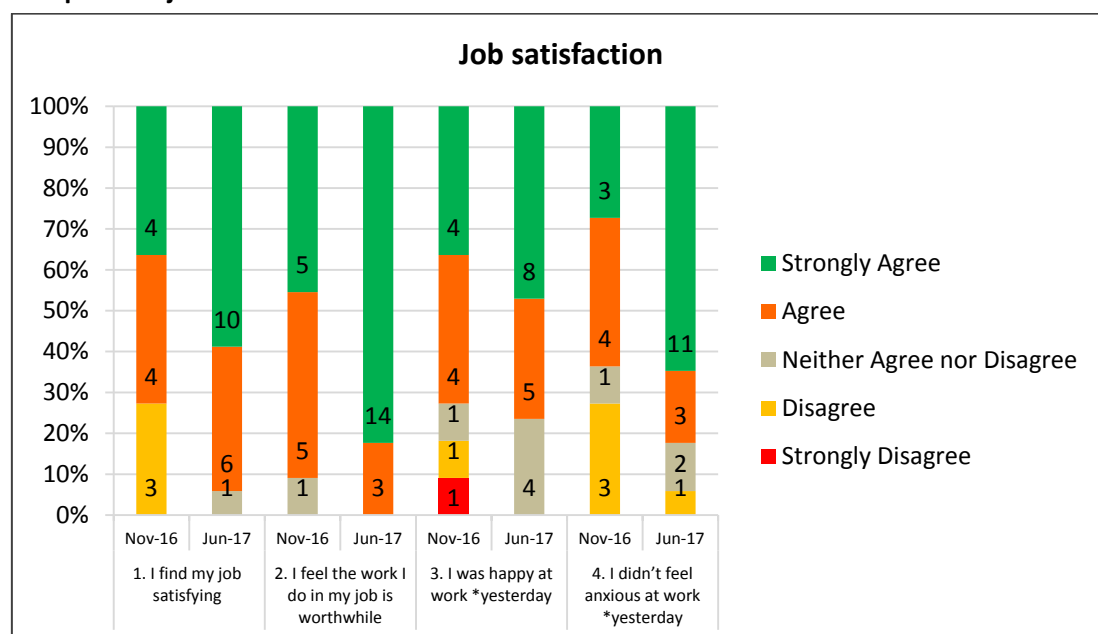
The Bedser Hub is well established (with the cohort increasing daily). The chart below details the number of appointments by month in 2016, with a peak of 700 patients in November.



4. Workforce satisfaction

Data from two recent staff surveys support the strong positive perceptions in the eight domains measured, including: customer service and job satisfaction. Perceptions have improved in spite of a recent transition to a new provider for many of the community staff (from April 2017).

Comparative job satisfaction of hub staff between Nov 16 and June 17



Successes and challenges

Successes

- ✓ Reduction in A&E attendances.
- ✓ Excellent patient feedback.
- ✓ Shared IT system established.
- ✓ Projected financial efficiencies are promising.
- ✓ National and international interest from improvement community and colleagues.

Challenges

- More time was needed to train all staff in the new IT system than estimated.
- Staff found it difficult to adjust to new roles.
- Point of care testing not yet in place.
- The hub is not yet able to provide patients with all services on one single visit.
- Patient assessments were slow initially, resulting in increased impact on Hub activity.
- There was a change in provider (From Virgin Health in April 2017).
- It was difficult to establish a process for collecting robust information for analysis.

Read the full report from North-west Surrey's development site team at www.rcplondon.ac.uk/delivering-the-future-hospital

Contact: Mr Neil Selby, neil.selby1@nhs.net



Phase 2: Integrated care

North West Paediatric Allergy Network

Aim

To deliver healthcare responsive to the needs of families with children who have an allergy to cow's milk protein or one requiring an adrenaline auto injector.

Objectives

There has been a dramatic increase in allergies in the developing world and it is estimated that 6–8% of children have a proven food allergy, while levels of perceived food allergy in communities are more than twice this number (NICE clinical guideline CG116: *Food allergy in under 19s: assessment and diagnosis*, 2011). The team set out to:

- 1 document current deficiencies and work to improve knowledge and confidence of GPs and other healthcare workers in diagnosing and managing non-complex milk allergies and children needing adrenaline auto-injectors
- 2 embed allergy templates within the electronic patient record system routinely used by GPs within the region, providing them with a checklist and clear management plan for children with these allergies
- 3 promote self-management and shared decision making between parents/carers and healthcare professionals for common food allergies
- 4 improve the public's knowledge and confidence of children's allergies and reduce their reliance on healthcare professionals for ongoing care.

Key messages

- Having a **common vision** and values has kept the group focused on delivering change through whatever challenges they faced.
- The support and input from our **families and charities** has been invaluable.
- Secondary care allergy activity is bundled into general paediatrics and hard to extract. The ability to **collect activity and clinical** detail was very challenging but vital.
- Increasing capacity in hospitals for when an infant first presents would not address the key areas needed for a **sustainable, family-centric approach** to managing allergy.
- **NHS 111** is a great support for families with children suffering from allergic symptoms out of hours.
- Using links with the Anaphylaxis Campaign and their local support groups to develop an approach to involve patients and learn from their experiences was vital.

Methods

1. Knowledge and confidence of GPs and health visitors in Oldham

The knowledge and confidence in both GPs and health visitors needed to be addressed. Educational packages and resources were developed to meet these needs, including:

- how to manage milk allergy
- the differences between replacement milk formulas.

2. Access to dietetic support for families, as outlined in NICE guidance

Access to dietitians was reported by families as a vital requirement, and is outlined in NICE guidance. The North West Paediatric Allergy Network (NWPAN) team developed group dietetic sessions to provide information and a forum for peer support.

3. Group dietetic sessions: peer support and reducing time to dietitian

Group dietetic sessions for infants with cow's milk protein allergy (CMPA) were developed. Five to ten families could come together with a dietitian with the support of a health visitor for both professional and peer support. This empowered families/carers to work to not only manage their infants CMPA, but also promoted tolerance and thus resolution of the disease in the quickest time, improving the family's overall quality of life, and reducing the workload of the dietitian and cost of replacement milk formulas to the NHS.

4. Patient records

The team developed electronic patient record templates to be embedded into EMIS (a leading electronic patient record system used in primary care). These are triggered when a milk formula or adrenaline auto-injector is prescribed, and when infants present with a potential milk allergy, for example infant feeding problem.

5. NHS 111

The team worked with NHS 111 (North West) to understand and support how children with allergies could be managed. Collaborations continue for managing the 85% of calls for rashes, which are currently directed to primary care.

Milestones

- Jan 2016: Appointed as a FHP development site.
- Feb 2016: GP competencies set. Baseline spend on milk products established.
- Apr 2016: Develop a decision tool that would be used by parents after consultation.
- May 2016: Decision tool used at educational event for 100 GPs.
- Jul 2016: Patient involvement event hosted in collaboration with Anaphylaxis Campaign Manchester Support Group.
- Sept 2016: Meeting with NHS 111 (North West) to discuss allergy pathway.
- Sept 2016: Patient engagement group meeting.
- Feb 2017: Hosts of phase 2 learning event.
- Mar 2017: Wythenshawe hospital: dietitians seeing more patients.

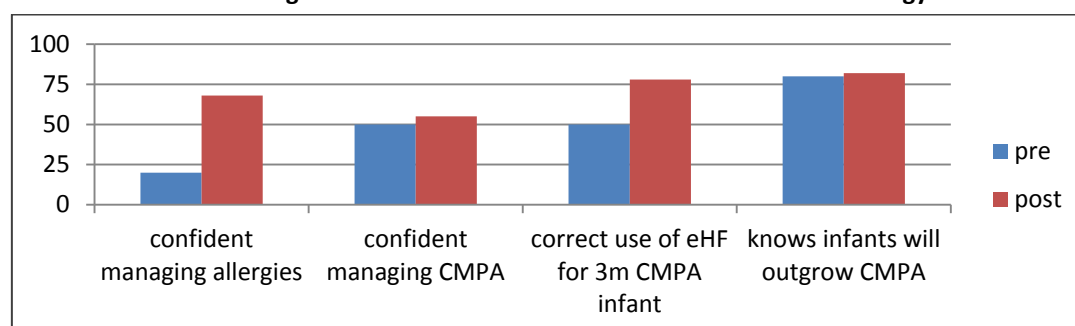
Outcomes

1. Experience and confidence of healthcare professionals in managing CMPA

GPs

Although 90% of GPs knew that most infants outgrew CMPA and 56% were confident in providing a general allergy advice, **only 40% were confident in providing specific advice on milk allergy**. Forty GPs filled out the survey before and after a 60-minute educational session on children's allergies.

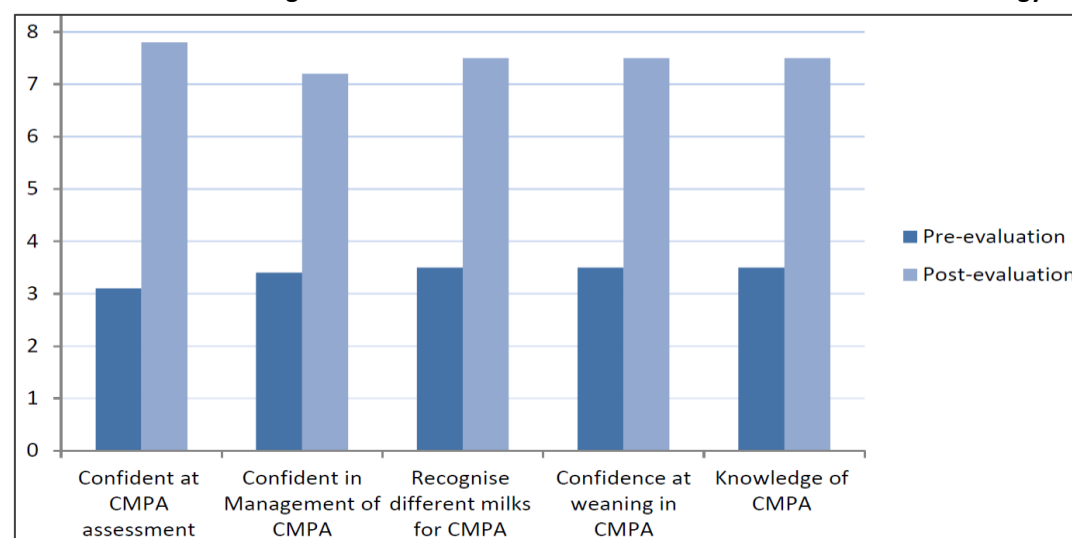
Confidence and knowledge of GPs before and after an education session on allergy



Health visitors

To provide knowledge and confidence to our health visitors, a 90-minute CMPA education session and an accompanying **resource pack** were developed and delivered.

Confidence and knowledge of health visitors before and after an education session on allergy



2. Prescribing of milk allergy formula

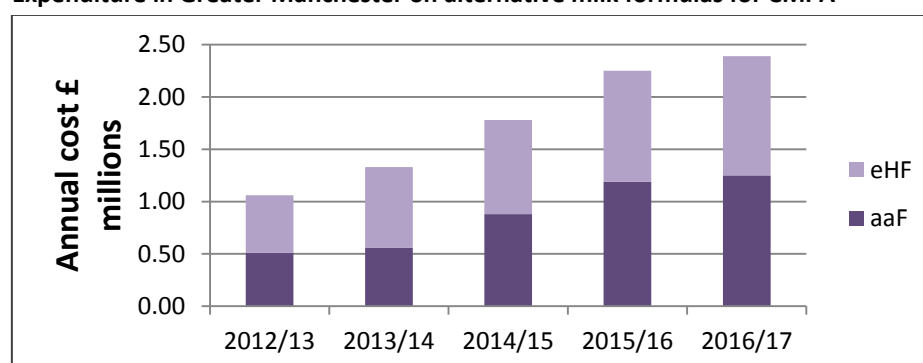
In view of the variability in GP prescribing, clinical records were reviewed in relation to prescribing of replacement milk formula for 40 infants in high prescribing practices. Key findings were:

- 62% of GPs prescribed formulas with no input from paediatricians; 50% had no input from dietitians
- 24% of children had no planned follow-up

- 64% of children were tolerating some dairy, suggesting that they could be on an extensively hydrolysed formula (eHF) rather than an amino acid formula (aaF) (saving £180 per infant per month)
- 8% of infants were tolerating fresh cow's milk and thus did not need to be on a replacement formula.

Our data shows that in the last 5 years there has been a doubling in the cost of prescriptions for both eHF and aaF by Greater Manchester CCGs (£1.1 million in 2012–13 to £2.4 million in 2016–17).

Expenditure in Greater Manchester on alternative milk formulas for CMPA



3. Web-based resources

The network launched its new website (www.allergynorthwest.nhs.uk) for professionals in March 2017, containing resources and patient information leaflets. Active interactions with the website were tracked and the average number of hits was 1,400 per week, with two peaks linked to educational events. Publicity will be vital to ensure that families are aware of this resource.

Successes and challenges

Successes

- ✓ Through strong teamwork, the network has maintained determination to deliver its aims.
- ✓ Widening of network: over time, there has been an increase in the number of organisations and professionals actively engaging and driving the network.
- ✓ Support of collaborators: the input, advice and support from families and charities have been invaluable.
- ✓ Strength of patient representation: the work and commitment of the patient and carer representatives has been exceptional.

Challenges

- Publication of national milk allergy protein (MAP) guidelines in 2013 has not been associated with a noticeable decrease in specialist milk formula prescribing in Greater Manchester; rather the opposite trend has occurred.
- The current level of referrals is not sustainable; referrals to secondary or tertiary services generate long waits for families, creating anxieties.

Read the full report from the North West Paediatric Allergy Network development site team at www.rcplondon.ac.uk/delivering-the-future-hospital

Contact: Dr Peter Arkwright, peter.arkwright@nhs.net



Phase 2: Integrated care

Sandwell and West Birmingham

Aim

To develop a patient-centred respiratory service by integrating primary, acute and community services.

Objectives

Sandwell and West Birmingham's care model centres around a multidisciplinary respiratory team, including primary care doctors, acute clinicians, consultants, nurses and allied health professionals. The team identified the following objectives:

- 1 to provide patients, carers and clinical staff easy and swift access to care, services and specialist advice at each point in the care pathway, incorporating modern methods of access
- 2 to establish 'joined up' care records, alleviating burden on patients to repeatedly relay their condition and history and enable quicker correct diagnosis and treatment
- 3 to provide consistently high standards of care and reduce variations in quality of care
- 4 to empower patients to manage their own condition with full understanding as to where and how support can be accessed.

Key messages

- To ensure the sustainability of objectives, design a model which addresses **all aspects of care** requirements of the respiratory patient.
- Identify the gap between what is expected and the resource available in order to produce **persuasive business cases**.
- Effective, **collaborative engagement** of clinicians, commissioners and the executives working in the primary and secondary care setting is paramount.
- A **well-constructed team** is key – involving hospital clinicians and managers, patient representatives, GPs, commissioners, nursing staff, community clinicians and, importantly, a data analyst and project manager.
- Bringing **specialist input** to the primary care setting improves patient care, patient experience, skills and knowledge of GP and practice nurses.
- Additional resources and different ways of working are needed not just for consultants but also the **wider multidisciplinary team (MDT)**.

Methods

The team led three workstreams to reflect patients' experience before, during and after a hospital visit.

1. Pre hospital

- Primary and secondary care: a respiratory consultant visited a GP practice for one morning session to work alongside GPs.
- Frequent attenders: patients were identified by cross-referencing those with frequent attendances and admissions across the emergency department, secondary care and a GP practice.

2. In hospital

- 'In Reach' care model: Patients attending the emergency department were promptly reviewed and diagnosed to allow a safe deflection or admission to the wards. This was led by the acute specialty clinical lead, in conjunction with the respiratory team and clinical nurse specialists.
- Back fill: to support a 7-day working pilot, all work was backfilled to ensure all clinicians and nurses were able to carry out daily ward rounds on the respiratory wards.
- Assessment: impact on length of stay, midnight free beds, junior doctor training opportunities and feedback from nursing staff were studied, along with other qualitative measures.

3. Post hospital

- Discharge from hospital: discharge plans were developed in combination with community respiratory services to decrease the frequency of admissions and reduce the length of stay for any necessary admissions to hospital.
- Integrated discharge: this workstream is jointly led by a clinical nurse specialist (CNS) and respiratory physician with input from the community respiratory services, a psychologist, GP and social worker as required.
- Virtual MDT: a virtual MDT was initially set up to adopt a holistic approach to frequent attending patients with long-term conditions.

Key milestones

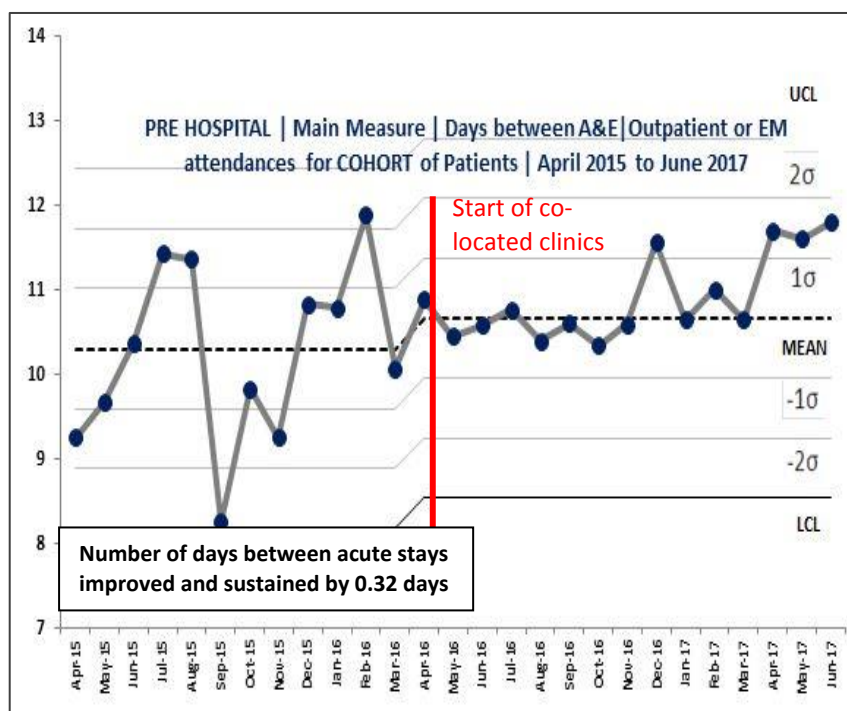
- Jan 2016: Appointed as an FHP development site.
- Mar 2016: Project launched to Sandwell and West Birmingham staff, patients and managers.
- Jun 2016: Organisational restructure resulting in redeployment of head of team, project manager and data analyst.
- Sep 2016: New project manager and divisional general manager appointed. Three workstreams defined.
- Jan 2017: Pilot model of reviewing referrals from assessment unit daily commences. Co-located respiratory clinics start.
- Feb 2017: Patient representative steps down from project.
- Jun 2017: New patient representative joins the project.

Outcomes

1. Patient outcomes

Pre hospital

Outcomes were measured for the workstream's ability to prevent unnecessary hospital visits for the cohort of patients seen within the pre-hospital clinics. **The number of days between acute stays improved by 0.32 days** balanced against **no discernible change in length of stay** for the same cohort. Patient satisfaction responses to the clinics were high.



Post hospital

Prevention of unnecessary emergency A&E attendances for patients seen within the post-hospital MDT clinics was measured for the post-hospital workstream. **The gap between A&E attendances lengthened by an average of 0.49 days** balanced against **no discernible change in emergency length of stay** for the same cohort. Patient satisfaction responses to the clinics were not undertaken. There was a positive return on investment as far as the reduction in A&E frequent attenders and some early evidence of follow-up outpatients.

2. Staff impact

Feedback from staff

A Likert scale entered by staff after they saw patients in the in-reach acute medical unit (AMU) clinic reported that staff agreed that the clinics facilitated service provision for acute respiratory medical patients, added educational value and personal development to them, and had a positive impact on their workload.

3. Patient experience

- **Integrated clinics:** Patients attending clinics ‘strongly agreed’ that there was value in a consultant being present and that they were able to discuss more about their conditions.
- **In reach model:** Patients seen by the In Reach Respiratory Team ‘strongly agreed’ that they were satisfied with the care of their condition and that care was timely and efficient.

Successes and challenges

Successes

- ✓ The team remained resilient through challenging times, which was the result of a shared vision and clinical engagement and distributive leadership.
- ✓ The pre-hospital workstream managed to reduce the frequency of combined attendances to either A&E, outpatient and emergency admissions by 0.32 days on average for the cohort of patients that were treated.
- ✓ By sharing knowledge between the respiratory consultant and general practice staff some early signs of improved practice and patient self-management were demonstrable through patient and staff feedback.
- ✓ The in-hospital workstream had a positive impact on the rhythm of the day for the specialist wards, improved training opportunities and positive feedback from nurses. There was no discernible impact on length of stay in the studied period.
- ✓ The post-hospital workstream managed to reduce the A&E arrivals by on average 0.49 days for the cohort of patients treated within the MDT clinics, by providing alternative avenues for these patients post-acute discharge, rather than re-attending as an emergency admission.

Challenges

- The two biggest challenges were the loss of two members of the improvement team and their change management experience. For example, the team lost its change project manager at an early stage and were without one for a period of time. Once the role was filled, the project resumed with great vigour.
- Experience in running PDSA cycles and driving improvement through data was limited among the clinical members of the team. At the critical time when posts were vacant, support was provided by unfunded work from the improvement analyst. With effective liaison with the executive team we managed to get back the same analyst to support the project.

Read the full report from Sandwell and West Birmingham’s development site team at www.rcplondon.ac.uk/delivering-the-future-hospital

Contact: Dr Arvind Rajasekaran, arvind.rajasekaran@nhs.net

Integrating diabetes care in Oxford

Integrated care is **seamless, coordinated and locally designed care** that **puts patients at the centre** of service organisation, considers their needs in a holistic way, and develops high-quality services that meet these needs **in settings that are accessible and convenient** for patients. The aim of integrating services has been on the national agenda for a number of years. RCP members and fellows however, regularly report the difficulties they face in making integrated care a reality.

Learning from a journey towards cross-organisational integration

The consultant clinical team in Oxfordshire had previously been successful in implementing a model of integrated care for diabetes in Derby using an innovative model⁶ (detailed in the review of integrated care). They were looking to take their learning and apply it in a different context to the whole health economy of Oxfordshire, spanning primary care, community services and an acute trust.

A qualitative researcher was embedded within the project to record and highlight the process of implementation. While there was not the same intensity or structure of project support, time with a dedicated data analyst or involvement in a network of peer support as that provided to the eight development site projects, the team remained in contact with the FHP through the Future Hospital officers and reported to the FHP Board.

Initially, the aim of the project was to commission one single diabetes service for the whole of the county. Leadership and management challenges meant it took much longer than expected to get the business case approved, and the commissioning process was halted twice. Eventually, it was agreed to pilot some elements of the integrated approach on a smaller scale (one primary care locality) before rolling out the new service across the county (six primary care localities).

Successes

- 1 **Governance:** A joint clinical board in each locality within the CCG responsible for delivery and governance of the service.
- 2 **Outcomes:** A suite of agreed shared outcome measures and a diabetes 'dashboard' that monitors variation in diabetes indicators between GP practices across the county.
- 3 **Service delivery:**
 - Twice-yearly GP practice visits by consultants, community diabetes specialist nurses, community Improving Access to Psychological Therapies (IAPT) service to improve service quality (eight key care processes and triple target of blood pressure, cholesterol and glycaemic control).
 - The introduction of virtual consultations using Skype for Business to increase the speed of decision making and encourage the sharing of clinical records between different providers.
 - Shared care plans developed for patients requiring additional support for their diabetes (educational, pharmacological, and psychological support). This was supported by money awarded from the National Diabetes Transformation Fund.
- 4 **STP:** Diabetes service changes were incorporated into the local sustainability and transformation plan.
- 5 **Culture:** Greater understanding of how to work collaboratively between primary and secondary care and with mental health services. Increased awareness of the challenges and resources available to address the needs of patients with diabetes type 1 and type 2 previously categorised as complex or disengaged.
- 6 **Dissemination:** A wealth of learning on the process of integration that has been shared through multiple channels, including the [RCP website](#).

Challenges

- 1 **Organisational:** the decision-making structure and leadership was not always clear within organisations and between organisations. In particular, working out which committees were responsible for agreeing cross-organisational collaboration made progress challenging.
- 2 **Leadership:** changes in primary care leadership within the CCG made it difficult to secure primary care commitment in the context of a variety of short-lived programmes as there was little continuity and learning between them.
- 3 **Team members:** there was uncertainty as to how service integration would affect individual healthcare professionals within each organisation.
- 4 **Patients and stakeholders:** engaging stakeholders and patients in a wide-ranging and complex project was variable and difficult to facilitate over a prolonged time.
- 5 **Technical:** costing the long-term outcomes of improved diabetes care against the cost of short-term changes.
- 6 **Resource:** there was an inability to release resources to enable work on the programme.

Facilitators of progress

- Appointment of committed GP champions to establish strong, cohesive, clinical leadership across organisations.
- Co-production with patients with long-term conditions to ensure that the service provided patient-centred care.
- Shared vision and common goals to agree the case for integration at all levels of the organisations involved.
- Recurrent and ongoing engagement with primary care through multidisciplinary team meetings to build mutual understanding of needs.
- Data on variation in care, local needs and feedback from patients to gain early consensus among clinicians.
- Focus on mini-transformations to support a bottom-up approach.
- IT infrastructure must be meaningful and timely to facilitate faster communication, enable service change and collect data for improvement.

Next steps

Following the pilot of the integrated diabetes service, the CCG, GP federations, community trust and acute hospital have committed to implementing a new integrated service in autumn 2018.

Acknowledgements

The Oxford integrated care project was run alongside the National Institute for Health Research Oxford Biomedical Research Centre.

Contact

To discuss the project, contact the team via Dr Rustam Rea, rustam.rea@nhs.net



Chapter 2

Developing future clinical leaders

This chapter covers the flagship Future Hospital chief registrar scheme

The Future Hospital chief registrar scheme

The [Future Hospital chief registrar scheme](#) provides a platform from which **positive change can be effected by junior doctors** who experience the challenges and pressures of life on the **medical frontline** every day.

The FHC recognised the pressures and constraints facing the medical workforce:

'[There is a] 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.'

- *Future hospital: Caring for medical patients*, September 2013⁷

The FHC recommended that a chief registrar be appointed in every acute hospital. The chief registrar role provides a bridge between the junior doctor workforce and senior clinical leaders and managers within their organisation.

Chief registrars are the NHS's future clinical leaders and take a leading role in developing innovative improvement projects that address key local challenges. Supported by a bespoke leadership and management development programme provided by the RCP, chief registrars positively influence patient outcomes, staff fulfilment and motivation, and organisational performance.

Chief registrar: benefits

For patient care and the organisation

Using their position, clinical judgement, knowledge of the clinical environment and new skills, **chief registrars develop initiatives that tackle their hospital's critical challenges**. By working across teams to address issues such as patient flow and patient safety, chief registrars deliver better outcomes for patients and contribute to improved organisational performance.

For the trainee workforce

The chief registrar scheme is **a tangible demonstration by an NHS organisation of its commitment to valuing and supporting trainees**. While the chief registrar is not a representative role, postholders provide a 'bridge' between their trainee peers, senior clinical leaders and managers, and improve medical engagement and morale.

For the individual

Unlike anything else in their clinical training, chief registrars gain **direct experience of senior management** and an **understanding of the wider NHS and care system**. The benefits to the chief registrar are multiple: individuals develop effective leadership and management skills; become confident leaders; and have the opportunity to put their skills into practice by delivering high-impact quality improvement projects in a supportive environment.

Chief registrar: local impact

Chief registrars work to address local problems in collaboration with clinical teams, managers and senior leaders. Chief registrars deliver a wide and diverse range of projects that reflect local circumstances, but some common themes have emerged.

✓ Service improvement

Chief registrars work with clinical teams to determine the areas most in need of improvement and ensure that the Future Hospital principles of patient care are at the heart of change. Protected time for developing and implementing quality improvement (QI) projects gives chief registrars the time and space to lead change to benefit their patients, colleagues and organisations.

✓ Workforce transformation

Chief registrars have oversight of service delivery in relation to junior medical staff deployment. Their role gives them an understanding of patterns of out-of-hours working, shift working, safe cover, handover and hospital at night. They work with senior colleagues and teams to ensure that medical skills are deployed where and when they are needed, ensuring that plans meet current and future patient needs.

✓ Engagement and morale

As a 'bridge' between the junior doctor workforce and senior leaders, chief registrars ensure that the trainee voice is heard at the highest level. Supporting and guiding other trainees to develop their own initiatives, chief registrars ensure that trainees have a forum to raise concerns and share ideas, and importantly, feel inspired and motivated to deliver change.

✓ Education and training

Chief registrars are in an ideal position to influence the training and education of junior doctors, ensuring that the skills being developed are fit for the modern medical environment and for future developments such as integrated care, digital technologies and the changing patient demographic.

The chief registrar role

- Minimum 12-month post
- 40–50% protected time for chief registrar initiatives
- 50–60% clinical practice
- ST4 and above
- In- or out-of-programme opportunity (training or experience)
- Ideally dual training in a medical specialty and general internal medicine
- Enrolment in RCP leadership and management development programme

Chief registrars: support from the RCP

During their time in post, chief registrars benefit from regular support from the RCP.

- *Leadership and management development programme*
 - The RCP development programme currently consists of four modules on topics including change management, quality improvement and team development, plus additional introductory and showcase events.
 - In addition to the development programme, chief registrars are signposted to leadership and management resources and events to further develop their knowledge and skills.

- *Clinical and management expertise*
 - Chief registrars have access to expertise within the RCP, including education, quality improvement and the FHP, and are linked into local RCP networks.
- *Networking*
 - Chief registrars have the opportunity to network with RCP senior officers, QI and education faculty, senior NHS leaders and innovative thinkers.
- *Chief registrar alumni network*
 - Chief registrars are enrolled into the chief registrar alumni network to foster sharing and learning beyond their immediate cohort.
- *Presentation opportunities*
 - Chief registrars are encouraged to share their learning at conferences and events in oral presentations or posters.

Growth of scheme

In its pilot year, **19 chief registrars** from **nine specialties** and **16 organisations** completed the chief registrar scheme. A [chief registrar alumni yearbook](#) documenting their achievements is available online.

In year 2, **37 trainees** from **36 NHS organisations** will join the development programme.

For more information, or to register your interest in joining the scheme, email chiefregistrar@rcplondon.ac.uk.

An external evaluation of the chief registrar scheme by the University of Birmingham

The Health Services Management Centre at the University of Birmingham was commissioned by the RCP in 2016 to [independently evaluate](#)⁸ the impact of the chief registrar pilot, looking in particular at patient care, organisational culture, professional development, support for junior doctors and allied health professionals, and acute care processes.

Key findings

Positive overall influence

Overall, the scheme had a positive impact upon chief registrars and the individuals they worked with.

Significant contributions to service improvement, education provision and trainee doctor engagement and involvement

Chief registrars implemented a diverse range of locally tailored initiatives that delivered positive outcomes, including: increased patient satisfaction; improved patient safety; reduced waiting times; and improved perception of training quality.

Strong evidence of personal development

Chief registrars developed leadership and management skills, particularly skills in negotiating, change management and leading quality improvement projects. Exposure to senior staff was also extremely beneficial in understanding organisational decision-making and governance. Chief registrars gained:

- greater self-awareness
- more confidence
- increased understanding of their role as a doctor and a medical leader
- direct experience of senior management activities.

Enhanced medical engagement

Chief registrars 'breathed life' into junior doctor engagement forums and improved overall medical engagement between junior doctors, senior clinical leaders and managers. The 'bridge' role allowed a two-way flow of information which was welcomed on all sides.

Increased engagement with, and facilitation of, QI across teams

Chief registrars became a generic source of QI advice and were involved in developing a 'QI culture' which will benefit their organisations in the long term.

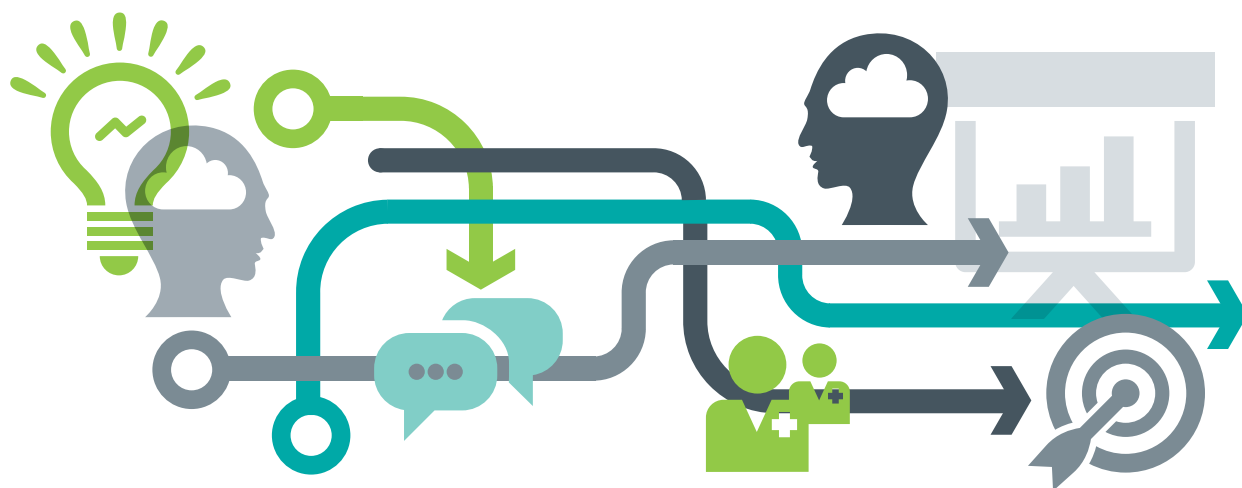
RCP leadership and management development programme

The RCP development programme was well-regarded by the chief registrars.

Cost benefits

Some chief registrar initiatives have had direct cost benefits. For example, a weekend discharge service which has been estimated to save the trust up to £200,000 per year, or a new papilloedema pathway that reduced duplicate and unnecessary scans and is projected to save up to £15,000 in bed days alone.⁹

The independent evaluation⁸ found that other projects are likely to have contributed to cost savings indirectly, by focusing on challenges such as improving flow, increasing patient safety and reducing rota gaps. Given the relatively low cost of a chief registrar role, the return on investment that is achieved directly and indirectly through their initiatives is significant.



Chapter 3

Providing a platform to showcase innovation and learning

This chapter explores how the FHP helped to build relationships and foster learning.

Future Hospital Partners Network

Through the Partners Network the FHP fostered a powerful learning community of people who champion the FHP and its 11 principles of patient care.

The FHP is committed to enabling system-wide improvements in the care of medical patients; yet it did not issue a set of defined instructions for how every hospital should change. Many individual clinicians, NHS trusts and stakeholders from across the NHS expressed an interest in becoming involved in the work of the FHP. This community of interest offers enormous potential to the FHP, in terms of both drawing on the expertise of this group, and also in supporting them to deliver the future hospital model and recommendations in their own areas.

A strategy for change

The FHP draws on the expertise, experience and enthusiasm of its Partners Network members to inspire a social movement that strives to realise the Future Hospital principles. The Partners Network:

- promotes innovative clinical practice
- upholds the principles of the FHC
- shares the experiences of those who have led improvement work
- hosts events to bring the Future Hospital community together
- provides members with information and resources to lead service improvements in their area.

Partners Network members

The Future Hospital Partners Network is made up of:

- clinicians
- hospital managers
- allied health professionals
- patients
- patient representatives
- policy officers
- chief registrars
- Future Hospital development site teams
- RCP colleagues.

Tell us your story

Tell us your story case studies are 'real world' examples of service improvement/redesign initiatives, exemplifying the very best of the NHS.

The FHP recognised there was a great interest in the recommendations identified by the FHC, but many people wanted to know where these principles had been effectively embedded into day-to-day practice in the NHS. Through the *Tell us your story* initiative, the FHP is collecting case studies from real-world improvement projects in the NHS. Stories are collected and disseminated by the FHP to members of the Partners Network, colleagues across the RCP and beyond.

Quality assurance

Stories are reviewed in a formal quality assurance process by Future Hospital officers. Submitted stories are assessed on their robustness and how easy it would be for someone to adopt similar principles in another hospital.

Categories

Stories are published online¹⁰ and organised into [five distinct categories](#):

- ✓ **7-day services**
Among the FHC's recommendations is the need to design hospital services that deliver high-quality care sustainable 24 hours a day, 7 days a week. These stories detail real-world examples of services running every day of the week, often finding creative solutions to operate within existing budgets.
- ✓ **Integrated care**
The FHC also advocated for 'integrated care'; that is for health and social care services to be joined up and unified. These varied case studies offer examples of effective and sustainable solutions for integration of services.
- ✓ **Person-centred care**
These *Tell us your story* case studies demonstrate one of the 11 principles of patient care in action: services should be tailored to meet the needs of individual patients.
- ✓ **Improving patient safety**
Through these interventions, clinical teams had the overarching aim of improving patient safety, both inside the hospital and in the community.
- ✓ **Developing the workforce**
These *Tell us your story* case studies highlight examples of new ways of working on an individual or team level.

Review of integrated care

What is integrated care?

Integrated care services:

- are seamless, coordinated and locally designed
- consider patients' needs in a holistic way and are organised around their needs
- meet patients' needs in settings that are accessible and convenient.

Taking specialist medical care beyond the hospital walls

Integrated care is a key priority for the NHS and for the RCP's FHP, as highlighted by the FHC. The FHP [reviewed current models of integrated diabetes care](#),⁴ exploring how outcomes are improved for patients by better working across care sectors.

Lay representatives, clinicians, allied health professionals and academics examined how the physician community, the FHP and other organisations can support, develop and deliver integrated care. The report, *Integrated care – taking specialist medical care beyond the hospital walls*, was published in collaboration with the RCP's PCN.

Priority areas for physicians

Based on examples of the very best of integrated services, the reviewers found five priority areas for physicians leading change in their locale.

- 1 Ensure that the patient's and carer's perspective is the organising principle of service delivery across organisations.
- 2 Support population health and wellbeing outside the hospital walls, while offering specialist care within the hospital and being an advocate for patients groups with specialist needs.
- 3 Evolve medical training and curricula to ensure that physicians of the future are equipped with the additional skills to deliver integrated services.
- 4 Ensure that organisations that deliver care support consultants with appropriate job plans, contracts, management structures, governance frameworks and information systems to deliver integrated care.
- 5 Evaluate the effects of health service redesign on patients' and populations' health and wellbeing.

Priority areas for patients

This report is a timely reminder for physicians to involve patients and people with long-term conditions in service development as the NHS faces so many challenges in terms of both workforce and resource.

- 1 Patients' needs should be central to the care that is provided, as outlined in the FHC.
- 2 For patients with long-term conditions and the frail and elderly, there is great value in a seamless, integrated approach to care; one which involves the patient and/or carer.
- 3 Care systems and approaches must be built to support the principles of integration and patient involvement.
- 4 Co-production – equal partnerships between patients and physicians in the design of health services – is integral to making integrated care a reality.
- 5 Patients should be equipped with the skills and access to technology to allow them to self-manage effectively and safely.

Shared decision making and support for self-management

Shared decision making (SDM) and support for self-management (SSM) refer to a set of attitudes, roles and skills, supported by tools and organisational systems, which put patients and carers into a full partnership relationship with clinicians in all clinical interactions.

Aims

Through the shared decision making and support for self-management project, the RCP set out to:

- **establish the readiness of the RCP** for SDM and SSM part of the routine practice of physicians
- **embed the principles** of SDM and SSM into the systems and structures of RCP policy and programmes
- **support and act as a resource** to clinicians to implement SDM and SSM into practice.

Methods

The RCP is committed to working in partnership with patients in clinical settings, and in developing policy and guidance.

- In 2013, the RCP adopted a [position statement](#) on SDM and SSM¹¹ that set out its support for partnership working between patients and clinicians.
- A SDM and SSM clinical fellow, was appointed to work across RCP departments to promote partnership working in practice.
- In 2014, the SDM and SSM project was adopted into the FHP.
- The FHP worked closely with the RCP PCN in pursuit of its aims to shift the culture and attitudes towards SDM and SSM.
- A series of workshops were conducted to raise the profile of issues and attitudes related to SDM and SSM among clinicians.
- The principles and practice of SDM and SSM were successfully incorporated into scenarios that feature in the RCP membership exam (PACES), as this is recognised as core learning for trainee physicians.

A special edition of the [Future Healthcare Journal](#) was published in June 2016 with half of the articles written by patients and patient representatives.

Key learning and recommendations: embedding the principles of SDM and SSM

- The process of reflection and change concerning SDM and SSM is only **likely to go forward at pace and scale if it is led by clinical peers**.
- The structures and programmes within the RCP lend themselves to **fostering the new partnership relationship between clinicians and people** that need their services.
- Especially important in this process are **relationships with service users**.
- The **RCP is able to act as a bridge between policy intent and clinical practice** and has a range of ways to do this.

Transition services for young adults and adolescents

The RCP's *Acute care toolkit 13: Acute care for adolescents and young adults*⁵ demonstrates the appropriate behaviours to effectively and compassionately manage young adults and adolescents (YAA) for physicians in acute medical units.

There is evidence that poorly planned transition may be linked with an increased risk of young people dropping out from medical care and poor health outcomes. There is also evidence, however, that age-appropriate adolescent services improve patient outcomes by improving attendance and retention of young people in clinical services.

- The **different social and emotional needs of YAA** mean that they often have different health needs. They are not always suitably addressed.
- **There is a growing problem:** between 1996 and 2010, emergency admissions among 16-to-19-year-olds increased by 43%. The number of 10-to-19-year-olds with a long-term condition has increased by 26% in 8 years, and there are growing rates of obesity and depression amongst YAA.¹²
- **Self-harm and suicides** are major causes of YAA morbidity and mortality.
- **Appropriate implementation of 'transition' is variable** and does not incorporate thought on young adults who find themselves acutely unwell for the first time.

Young adult and adolescent toolkit

- **Who?** The FHP published a report highlighting the issue of transition between hospital services for YAA). In particular YAA with **chronic disease** in the **16–25 year age group**.
- **When?** Secondary and tertiary healthcare provision changes from paediatric to adult services between the ages of 16 and 19 years old.
- **Why?** YAA with chronic disease need a **developmentally appropriate response from the health care service**. Scientific evidence tells us that their **brains are continuing to develop**: this patient group is not really mature until they're about 25 years old. Many **personal transitions** are also occurring in the lives of these young people, for example, leaving home for higher education or work.

Acute care toolkit: acute care for adolescents and young adults

Currently there are pockets of excellence for transition services for YAAs in some specialties and geographical areas. The RCP's *Acute care toolkit 13: Acute care for adolescents and young adults* provides knowledge and skills, and demonstrates the appropriate behaviours to effectively and compassionately manage YAA for physicians in acute medical units.

Findings

- Further concerted action is required to ensure healthcare provision is developmentally appropriate to the needs of YAAs.
- YAAs' needs should be identified and prioritised by providers, commissioners and policy makers as an essential element of an excellent, equitable healthcare system.

Conclusions: Delivering the future hospital

Improving future health and care

Following the acclaim for the FHC,³ the RCP was in a unique position to lead and fund a programme to test its recommendations in clinical practice. This was a challenging undertaking, ranging from new ways of delivering patient care to piloting a senior leadership post at a time when the NHS was striving to maintain services in the face of unprecedented demand and budget constraints.¹³

The FHP has demonstrated that a patient-centred approach to improving services can help to deliver better care for patients by more motivated, engaged staff. The FHC vision of enhanced access to specialist medical care closer to home, and earlier in hospital pathways, with potential reduced use of hospital resource was realised in part.

The FHP partnered with selected clinical teams recruited in two phases in 2014 and 2016. The former showed improvements in the care of frail older people in hospital and community settings, while the latter highlighted the promise and initial impact of enhanced joint working across healthcare boundaries. Embedding patients in the project teams helped ensure the improvements reported were meaningful to patients and appreciated by them. These improvements were achieved within existing budgets. This, and the associated enthusiasm of patients and staff bodes well for their sustainability.

The pilot of the new chief registrar post has been a notable success and the independent evaluation provides important insights into its implementation. Junior doctors have been consistently undervalued and their potential to lead change overlooked. The pilot started when junior doctor morale was at its lowest ebb and the achievements of the first chief registrars have been impressive, leading to wide support and doubling of recruitment.

The FHP was exposed to the rigour of independent review and reported a wealth of successes, challenges and learning. Careful planning and continuing support is required to successfully embed patient representatives as effective advocates in busy healthcare teams, with inbuilt relationships and hierarchies. Improving care in tandem with service delivery requires the repeated assessment of the impact of serial interventions – a requirement met by the use of [improvement methodology](#). This methodology has not been adopted widely in the NHS, despite this expertise being available in the many performance departments of NHS providers. Healthcare organisations seeking to improve services in the next decade need to release data analysts to work with front line clinical teams to ensure the right data is collated, and the right analysis and clinical interpretation is applied.

Almost all development site projects were put at risk by relentless systemic pressures in their organisations, which led to staff redeployment or vacancies. The variability of service and health economy priorities and instability of staff roles and organisational structures makes replication and scalability of proven service improvement extremely challenging.

FHP development site teams valued the expertise, influence and authority that working with the RCP brought. The teams reported that improvement requires resilience and flexibility, as projects may evolve in directions that were not foreseen. For some there is a sense that they have yet to achieve their aims, and recognition that improving care is an ongoing journey that takes time and commitment.

While the structured support to development site partners within the FHP has ceased, the FHP has revealed the need for the RCP to support service improvement led by physicians and their teams much more widely. To address this, the RCP has embarked on building a faculty drawn from both within and outside the FHP.

The RCP Quality Improvement Programme will build on the considerable learning of FHP, to support physicians and their teams to deliver improvements in services and the quality of patient care. Key factors to achieve this include facilitating collaborative learning, and supporting patients and carers to be effective members of improvement teams. The RCP will provide learning opportunities, networks and coaching by expert peers to deliver improvement. This will build existing expertise within the RCP including national clinical audit, accreditation, the publication of guidelines and the use of health informatics. There will also be an emphasis on the development of the next generation of clinical leaders through expansion and refinement of the chief registrar scheme. As the RCP approaches its 500-year anniversary in 2018, the FHP has confirmed that the RCP is uniquely placed to support physicians to lead improvements in the care of their patients.

An independent, external evaluation by the University of Liverpool – abstract

Background

Following the Future Hospital Commission report, the Royal College of Physicians (RCP) set up the Future Hospital Programme to put these visions into practice. The Future Hospital Programme had various foci of activity, this included providing support to eight development sites to implement projects surrounding the Future Hospital Commission report principles and engaging the health care community. The RCP sought an external group to undertake an independent evaluation. The full report presents the findings of that external evaluation.

Methods

A mixed methods approach was used. Opinions about the FHP were sought from four main sources; the development site teams, the patient representatives from the development sites, personnel from the RCP both directly and indirectly involved with the programme, and the wider college membership. Activities involved focus groups, one-to-one interviews, a comprehensive documents review and web-based surveys.

Key findings

This evaluation has confirmed that the programme has had many successes and brought about real change; developed QI capacity directly within teams; and more widely across the RCP, and demonstrated it is possible for the vision of the Future Hospital Commission to be delivered within real world environments.

It has demonstrated that colleges are well placed to lead on quality improvement work. The programme links well to future plans for the Quality Improvement Hub in the RCP, as well as the Chief Registrar scheme and the web-based *Tell Us Your Story* initiative.

However, the Future Hospital Programme approach is not sustainable for the RCP to resource alone. Whilst it was effective pump-priming to deliver demonstration sites and shared evaluations, other approaches need to be explored to facilitate professional-led, 'bottom up' innovation, co-produced with patients working to RCP recommendations for quality improvement, evaluation and innovation. This requires a less formalised and high-investment environment for it to be sustainable in the longer-term.

Contact the evaluation team via Professor Mark Gabbay, m.b.gabbay@liverpool.ac.uk

Read the evaluation report at:

www.rcplondon.ac.uk/delivering-the-future-hospital

Appendix 1: About the FHP

The Future Hospital Programme (FHP) was established by the Royal College of Physicians (RCP) in response to the seminal [Future Hospital Commission \(FHC\) report](#). The report described a new model of patient-centred care underpinned by a core set of principles and new approaches to leadership and training. The FHP put this vision into practice through a range of activities in order to evaluate the real-world impact of the FHC's recommendations.

FHP team

Nina Balachander
Hannah Bristow
Sarah Campbell
Caroline Cormack
Lindsay Dytham
Jessica Greenhalgh
Ella Jackson
Susie Jones
Dr Olga Kozłowska
Susan Latchem
Christopher Marot
Natalie Pink
Aimee Protheroe

Future Hospital officers

Professor Frank Joseph
Dr Mark Temple

RCP clinical vice presidents

Dr Anita Donley
Professor David Oliver (appointed July 2016)

Future Hospital fellows

Dr Nick Lewis-Barned, shared decision making and support for self-management
Dr Andrea Goddard, young adults and adolescents

Governance of the FHP

The FHP was overseen by a programme board, and reported to the Care Quality Improvement Department Board, which in turn is accountable to the trustees of the RCP. Overall clinical responsibility for the programme rests with the RCP clinical vice president who reported to the RCP Council.

Acknowledgements

The FHP was led by a dedicated project team at the Royal College of Physicians, London.

Many thanks to the people who have engaged with the FHP in different ways, including the eight Future Hospital development site teams, the Oxford integrated care team, chief registrars, members of the Future Hospital Partners Network, authors of *Tell us your story* case studies, RCP clinical officers, Future Hospital officers and the RCP's Patient and Carer Network.

Appendix 2: Glossary

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 as emergencies.

Acute trust: An NHS body that provides secondary care or hospital-based healthcare services from one or more hospital sites.

Allied health professionals: This term encompasses many different roles including therapists, dietitians, occupational therapists, paramedics, physiotherapists, radiographers, and speech and language therapists.

Chief registrar: A senior leadership role for doctors in training, with minimum 40% protected time for leadership and management.

Comprehensive geriatric assessment: The British Geriatric Society defines 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’.

End-of-life care: Care that helps people with advanced, progressive, incurable illness to live as well as possible until they die.

Frailty units: A specialist unit, led by the geriatric medicine team, focused on the needs of older patients with frailty conditions, including dementia.

General medicine: Diagnosis and management of inpatients with a variety of medical disorders both common and complex, in addition to patients with acute illness.

Generalist physician: A physician whose practice is not orientated in a specific medical specialty (eg an organ- or system-specific specialty, such as cardiology) but instead covers a variety of medical problems.

Integrated care: Free movement of information and expertise across the structural borders of primary, secondary, community-based and social care.

Outpatient: A patient who attends a hospital for treatment without staying there overnight.

Pathway of care: The route followed by the patient into, through and out of NHS and social care services.

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.

Specialty medicine: Care provided by a physician who is a specialist in internal medicine (trained in general internal medicine). 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.

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.

Appendix 3: References

- 1 Royal College of Physicians. *Hospitals on the edge? The time for change*. London: Royal College of Physicians, 2013.
- 2 Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: executive summary*. London: Stationery Office, 2013.
- 3 Horton R. Offline: Clinical leadership improves health outcomes. *The Lancet* 2013;382(9896):925. [www.doi.org/10.1016/S0140-6736\(13\)61866-8](http://www.doi.org/10.1016/S0140-6736(13)61866-8) [Accessed 14 November 2017].
- 4 Hussain S and Dornhorst A. *Integrated care – taking specialist medical care beyond the hospital walls* London: Royal College of Physicians, 2016. www.rcplondon.ac.uk/projects/outputs/review-integrated-care [Accessed 14 November 2017].
- 5 Royal College of Physicians. *Acute care toolkit 13: Acute care for adolescents and young adults* London: Royal College of Physicians, 2015. www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-13-acute-care-adolescents-and-young-adults [Accessed 14 November 2017].
- 6 Rea, R. *Integrating diabetes care in Derbyshire* (Video). www.kingsfund.org.uk/audio-video/rustam-rea-integrating-diabetes-care-derbyshire [Accessed 14 November 2017].
- 7 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.
- 8 Exworthy M and Snelling I. *Evaluation of the RCP's Chief Registrar programme: Final report*. University of Birmingham, 2017. www.rcplondon.ac.uk/projects/outputs/independent-evaluation-chief-registrar-scheme [Accessed 14 November 2017].
- 9 Royal College of Physicians. *Chief registrar alumni*. www.rcplondon.ac.uk/projects/outputs/chief-registrar-alumni [Accessed 14 November 2017].
- 10 Royal College of Physicians. *Future Hospital: Tell us your story*. www.rcplondon.ac.uk/projects/future-hospital-tell-us-your-story [Accessed 14 November 2017].
- 11 Future Hospital Partners Network. *Shared decision making and support for self-management*. www.rcplondon.ac.uk/projects/outputs/shared-decision-making-information-and-resources [Accessed 14 November 2017].
- 12 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: 69.
- 13 Royal College of Physicians. *Underfunded, underdoctored, overstretched: The NHS in 2016*. London: Royal College of Physicians, 2016.

Delivering the future hospital

Full report

This report is an account of the successes, challenges and learning from the FHP in the 3 years between 2014 and 2017. Its purpose is to report on the findings of the FHP and its partners.

This report is for healthcare professionals, patients and carers, commissioners and NHS managers.



Royal College
of Physicians



Future Hospital
Programme