Royal College of Physicians | Future Hospital

Future Hospital Commission report: case studies from the front line

The following stories were collected for the Future Hospital Commission report.

Key words: renal, acute medicine, geriatric medicine, patient involvement, patient safety, telemedicine, quality improvement

Contents

Brighton and Sussex University Hospitals Trust 3
Countess of Chester Hospital 4
Guy's and St Thomas' NHS Foundation Trust 5
Leeds Teaching Hospitals NHS Trust..... 7
Lewisham University Hospital 8
London Acute Kidney injury (AKI) Network 9
Northumbria Healthcare NHS Foundation Trust 10
Nottingham University Hospitals NHS Trust 11
Poole Hospital Foundation Trust 12
Portsmouth Hospitals NHS Trust 13
Renal patient view..... 14
Royal Brompton and Harefield Hospital 14
Queen Elizabeth Hospital Gateshead 16
University Hospitals Birmingham NHS Foundation Trust 17
University Hospitals Nottingham..... 17
Future Hospital Commission interviews 18

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Brighton and Sussex University Hospitals Trust

Role of a chief of medicine

Dr Lawrence Goldberg, chief of medicine and consultant nephrologist, talks about the role of a chief of medicine at Brighton and Sussex University Hospitals Trust (BSUH).

- **Local context**: BSUH is an acute teaching trust on two main sites (following a previous merger), with an increasing number of tertiary services. The Brighton and Sussex Medical School opened for medical undergraduates in 2003.
- **Structure**: Four divisions (surgery, medicine, women and children, and specialised services).
- **Leadership**: Each division is headed by a clinical chief, an associate director of operations, and an associate chief nurse. The clinical chief is professionally accountable to the medical director, and operationally to the chief executive and the director of operations.
- **Support team**: Each clinical service within the division has a clinical lead, a service manager and a matron. There is an associate chief of medicine who has responsibility for medical trainees, and deputises in the chief's absence.
- **Job planning**: The chief of medicine role has a dedicated 20 hours a week (1 programmed acitivity (PA) within SPA time, and 4 additional duties PAs).

The chief of medicine has to have an overarching knowledge of the division's and trust's services, and be very aware of the trust's internal and external environment, so that you can advise, be an effective leader and represent your services. Your knowledge of the services internally will help in sense-checking and refining the trust's clinical strategies and developments. At the same time you have to maintain your clinical credibility with colleagues, and ensure that you do enough clinical work to maintain clinical competence. Currently, it's a very vertical kind of clinical management pyramid when all the clinical leads feed directly to the chief of medicine. It's easy to get bogged down in far too much detail and reactive operational issues, as well as job planning, which take you away from the strategic work you need to be doing. I should be externally facing, talking more to our partners as we evolve integrated pathways of care with our community, and managing our external relationships. So, depending on how big your Division of Medicine is, you need a tier of people (eg clinical directors) who are responsible for managing the services and overseeing performance. I intend to set up a clinical forum for the divisional clinical leads so we can meet up regularly to share knowledge and build relationships, and provide mutual support.

The chief of medicine, along with the other clinical chiefs, has responsibility for ever-improving efficiencies, financial balance and cost-improvement plans, as well as ensuring the delivery of a safe and high-quality service. The balancing act between being a mini chief executive for the division, and the division's medical director, is constantly challenging.

With responsibility for A&E and the medical urgent care pathways, and their associated high-profile performance targets, I have a very wide remit and particular challenges that I know are shared in many trusts. We have benefited from the input of the emergency care intensive support team whom we invited in to advise us on our pathways after a difficult winter. It's been very useful in structuring our approach to improving A&E performance, length of stay and the patient experience. We have set up an Urgent Care Implementation Board, which I chair, and have set up five work streams to address the pathways within the hospital, from assessment in A&E to discharge from the wards. It needs a lot of clinical leadership, from consultants and junior doctors, which I am best placed to front and coordinate.

I am convinced that someone taking on the role of a chief or a clinical director does need formal leadership and management training. This is not something you should or can acquire just through trial and error, osmosis and experience. There is so much theory, practice and understanding about good

leadership and management skills that if you take on one of these roles you really should aim to get formal development in this area. I personally took a 4-week King's Fund 'Leadership for senior managers' course, funded by the trust, and it has proved invaluable.

As a clinician, I am able to have conversations with my clinical colleagues that wouldn't be possible as a non-clinical leader.

Finally, clinical leadership is strongly embedded here, which gives the organisation high-level clinical input and influence on hospital strategy and operations, though this influence needs constant protecting and nurturing and, critically, the support of a chief executive who truly values it, which we continue to have.

Countess of Chester Hospital

Rapid response and enhanced discharge scheme

The Future Hospital Commission interviewed Dr Frank Joseph, consultant endocrinologist and general medicine.

- **Hospital size**: 600 beds. Acute take 30–50 patients/24 hours.
- **Challenge faced**: High bed occupancy with 89% of patients over 65 remaining in an acute bed when medically stable (from audit data).
- **Solution**: Combined enhanced supported discharge service and admission avoidance for older patients. Provides bridging social care, therapy at home, short-term medical care at home, 7 days a week. Service is hospital supervised, taking referrals from primary care, ED and medical wards. Serves up to 70 patients a week.
- **Partners**: Countess of Chester Hospital Foundation Trust, Cheshire West and Chester Council, Cheshire and Wirral Partnership Community Foundation Trust, Hospital at Home. Teams delivering different elements of the pathway unified and enhanced with some additional funding.
- **Local context**: 21 unplanned adult care services available in West Cheshire.
- **Staffing**: Initial service delivered by 0.6 whole-time equivalent (WTE) band 6 nurse, 1.0 WTE band 5 nurse, 7 WTE band 3 nurses, 0.7 WTE social care assessor, 1 WTE band 6 physiotherapist and 1 WTE band 6 occupational therapist.
- **Outcome**: The scheme is planning to expand to take on more work, take referrals 7 days a week and include mental health support.

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

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

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

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

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

Guy's and St Thomas' NHS Foundation Trust

Improving patient experience

Eileen Sills has been working at Guy's and St Thomas' NHS Foundation Trust as chief nurse since 2005 and there are two particular measures she has implemented to improve the quality of care in the hospital.

- **Size of hospital**: Guy's and St Thomas' NHS Foundation Trust is a 1,100-bedded integrated community teaching hospital.
- **Challenge**: To improve the quality of care for patients.
- **Solution**: Two measures in particular were used: (1) 'Clinical Fridays' when senior nurses spend 1 day a week working with junior staff and patients in their departments. Patient harm events are also monitored and addressed regularly. (2) 'Barbara's story', a video about a patient with dementia and her experience of hospital, has been shown to staff to highlight the point of view of the patient. The video is supplemented by a pack on dementia and a discussion about the video. This led to changes in staff behaviour, which is monitored using standard measures.
- **Staffing**: 12,500 staff. 10,000 staff have attended the video and discussion.
- **Outcome**: 77% of staff would recommend the hospital as a place to work. 94% of patients have said they would recommend the hospital to a friend.

Clinical Fridays

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

Although this was accepted, there were initial anxieties about whether this was manageable in the context of their workload, and also what exactly senior nurses would be asked and expected to do clinically. All the obstacles were overcome and they now all work at least one day a week in a clinical environment. The senior nurses choose what they will do; they may observe care, work alongside a junior colleague, care for their own group of patients; or just sit and talk and listen to patients tell them about their experiences. If working clinically, they all work within their scope of clinical competence. As Eileen puts it, 'You have to go and see what it's really like if you are going to effectively lead and be a voice for your staff and your patients'. She says that the initiative has led to very high levels of visibility of senior staff within the hospital, which patients and other staff welcome. Also, it helps the senior management to pick up departmental issues more quickly.

Extending this, on Friday afternoons, the senior nursing workforce all attend a one-hour meeting to discuss the previous week's clinical indicators and patient experience, known as the 'safe in our hands' briefing. This drop-in session is open to all staff and is attended by members of the general management

team and medical consultants too. In a typical meeting, they begin by looking at the overall activity indicators, such as the number of elective and emergency admissions. They then go on to discuss the number of emergency department (ED) 4-hour target breaches and theatre cancellations.

They also specifically look at patient harm events. The number of patients at risk of falls, the number that have falls and the number sustaining injuries are all scrutinised with data broken down by ward. Similarly, the incidence of pressure ulcers, medication errors, MRSA bacteraemia, and Clostridium difficile infections are all assessed. Ward sisters and matrons often attend to present about a particular issue and whether any learning from the incident has happened and can be shared.Another part of the meeting looks at patient feedback using the newly launched NHS Friends and Family Test. Currently the focus is on obtaining a response rate of at least 20% – from July 2013 the government will make results public and has asked for a minimum response rate of 15%.

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

Barbara's Story

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

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

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

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

The impact in the organisation has been very humbling, with staff doing little things differently, and the level of awareness is outstanding. Following a successful bid to the Burdett Trust there are now six

further episodes being filmed which will follow Barbara's journey through different clinical scenarios. The film is also being formally evaluated by London South Bank University.

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

Leeds Teaching Hospitals NHS Trust

Acute neurology service

Future Hospital Commission interview with Dr Edward Dunn, consultant neurologist.

- **Hospital size**: 1,500 beds; 70 admissions every 24 hours.
- **Challenge faced**: Patients attending the AMU had limited access to neurology opinion and often waited up to a week to see a specialty trainee on a general medicine ward.
- **Solution**: Alternate-day acute neurology clinic accepted referrals from ED and AMU. A consultant neurologist was present on AMU on alternate days. Telephone advice from neurology registrar or consultant was available 7 days a week.
- **Local context**: Trust split over two sites with neurology inpatient care provided in only one centre. Partners: ED, AMU, neurology department.
- **Staffing**: One consultant neurologist doing six programmed activities per week.
- **Outcome**: Earlier diagnosis, reduction in length of stay for patients with neurological symptoms. Better targeted magnetic resonance imaging requests and other further investigations such as electroencephalography (EEG), electromyography (EMG) and lumbar puncture.

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

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

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

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

I think the important thing is first of all to listen to what the physicians want. What input is needed does vary and in general in-reach works very well, but it's making sure that you have got that balance right between also taking over the patients that shouldn't be sitting in acute medicine. If you start from the

viewpoint that this replaced the specialist care, well it doesn't. But then there's an awful lot of patients that I think aren't even being discussed with a specialist and leave hospital having had tests done but are none the wiser as to their diagnosis. That is where a liaison service is particularly good and undoubtedly is better patient care.

Lewisham University Hospital

Clinical assessment service

In this Future Hospital Commission case study Dr Elizabeth Aitken, consultant geriatrician at Lewisham University Hospital, talks about setting up a clinical assessment service.

- **Hospital size**: 450 beds. Acute take 25–40 patients/24 hours.
- **Challenge faced**: Increasing older patients presenting to ED, with potentially prolonged stays exacerbated by hospitalisation.
- **Solution**: Clinical assessment service based in ED. Front-door geriatric assessment for ED and community referrals (planning to expand to GP). Multidisciplinary team with occupational therapist, physiotherapist, social worker, nurses who rotate through front door and community services. Provide access to 72-hour community tariff beds, step-up beds and short-term enhanced home care. Supervised by same team.
- **Local context**: Trust is combined acute and community trust.
- **Staffing**: 2 whole-time equivalent (WTE) occupational therapists, 2 WTE physiotherapists, 1.5 band 6 nurse, 0.3 WTE consultant geriatrician, 2 WTE social assessors.
- **Outcome**: For May–Sept 2012, an average reduction in hospital admissions of 30 patients per month.

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

Mainly our service takes referrals from ED, although the community teams will now phoneme and say, 'I'm not sure about this patient', so I will suggest, 'Well bring them in and we can assess them'. The team will also go to the 11ampost-take general medicine multidisciplinary team meeting for everyone admitted in the previous 24 hours and identify patients whom we think we can transfer back home or support in the community. I hope this promotes the service and shares learning. Direct GP referral is a big element that is missing and that's our next step.

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

For example, there was somebody I saw on the Bank Holiday weekend. It was all very non-specific so initially the thought from ED was 'send her home'. However, talking to her and to her family it was clear that she wasn't coping as well at home; she wasn't doing as much as she could and there had been are cent decline in function. We saw her and she had a marked postural drop so I reviewed her antihypertensive medication and because we didn't have a community bed at the time she went to one

of our intermediate care beds. I saw her again yesterday – her mobility has improved, she is doing better and she will be going home with ongoing rehab in the community.

London Acute Kidney injury (AKI) Network

Coordinated care for kidney patients with swift access to tertiary centres

The Future Hospital Commission interviewed Dr Chris Laing, consultant nephrologist, Royal Free Hospital.

- **Population served**: Estimated 9–10 million people.
- **Challenge faced**: Acute kidney injury (AKI) represents around 10% of acute hospital admissions. Patients in London with AKI receive variable care, with mortality approaching 10% for stage 3 disease in some sites. A small minority of the acute hospitals have an on-site renal service.
- **Solution**: A pan-London network producing a harmonised guideline, standardised procedures for assessment, referral and transfer of patients with AKI.
- **Local context**: Seven tertiary renal units across London linked to 30 hospital trusts.
- **Partners**: NHS Kidney Care and now NHS England (London Region).
- **Outcome**: A harmonised pan-London pathway. 50% improvement in proportion of patients transferred to tertiary care in less than 48 hours. 50% of AKI presentations across London trigger an electronic alert; pan-baseline London audits of AKI care completed. Subjective reporting of a more consistent approach to managing early AKI and increased satisfaction with advice and support available from tertiary centres.

It had been on our radar that there were problems with delivering the acute kidney injury (AKI) pathway and the main concerns seemed to be the quality of basic ward management and then timely and safe transfer into tertiary centres for the appropriate patients. There seemed to be a regional problem that required a regional solution.

We started discussions in North London in 2009 and formally launched in 2010. This was a multidisciplinary approach with acute medicine and intensive therapy unit (ITU) representatives from the hospitals in the sector which decided to move forward and agree policies together via a regional committee. Nephrology led on the process, but the emphasis was on collaboration. We also had some patient representation on the committee which was very influential. I think the patient involvement was critical to add some perspective and to get clinicians to work together and focus on clinical priorities.

We have got a harmonised guideline based on the national evidence where possible and adapted locally; it has been operationalised into manuals, a website and mobile app that's now live across most of London. In 50% of trusts the pathology system will alert and automatically direct to the electronic guideline. We are aiming for 100% coverage. This has happened in tandem with collaborative audit, education and awareness initiatives.

The key to it has been the multidisciplinary approach and crucially the involvement of clinicians who manage these patients on the shop-floor. Most of them are comfortable with early stage AKI management. They do want some guidance about when we (nephrologists) would like to be called, what we can provide and what the expectations are from us in terms of delivering it in relation to transfer times, etc. One per cent of hospital admissions have severe AKI. Many of these need specialist management for supportive care or disease-specific therapy.

The acute medical and critical care teams are given guidance and we have educational programmes now to educate staff on who they should refer. Then we simplify the pathway for communication by providing them with a direct phone number, usually a mobile. Then they get phone advice. At the specialist end, registrars are also coached on how to respond and what to consider before transfer.

The other aspect has been around transfer safety, because we have agreed policies with local critical care units, which means we are not making up policy on a patient-by- patient basis. There are some clear standards and guidelines as to who should be transferred and who should be stabilised and resuscitated or get renal support on site. That makes it safer for patients.

In North London we are going to go up to the point of releasing a consultant hotline number to the networks. Going forward, more formal telemedicine and electronic referral systems is clearly an area for development. One thing we've been piloting, which Kent have also been doing superb work on, is critical care outreach to AKI stage 3. In the Royal Free, University College Hospital London and Barnet, the biochemistry alert prompts a biochemist to call the critical care outreach team and they go and assess the patient. They then stream the patient either to supported ward management, critical care admission or a phone call to the renal team, as appropriate. They have actually arrived to find some quite unwell patients who for some reason or other had not come to their attention via the physiological alerting systems. So the whole issue of pathology result alerting, as well as physical observation alerting (eg national early warning system) is quite a hot topic – AKI is very much in the middle of this. The mortality for AKI stage 3 is high, so early intervention may make a real difference.

Key clinicians meeting at the local AKI committee meetings on a regular basis, talking and ironing out clinical problems together, has been very important. We now have clarity on expectations and a team of senior clinicians who will contact each other preemptively if there are any concerns regarding delivering the pathway for an individual patient. That's purely about defining responsibilities, communicating and acknowledging that, though we work for different organisations, we are working together to deliver quality care at all times.

We have completed a tranche of pan-London audits. This has included basic ward care, critical care occupancy of patients awaiting renal unit beds, outcomes of patients transferred to renal units for AKI dialysis, and transfer times into the renal unit. We are benchmarking and making this data publically available. This will provide transparency on what's actually happening. The initiative has been effective in clarifying that tertiary services need to deliver AKI care in a timely way and has been influential in informing new national commissioning standards on this. Locally there has been a doubling of the number of patients requiring transfer to a renal unit achieving transfer in less than 48 hours.

Getting clinical engagement is never a problem if clinicians see a clinical problem and a common-sense solution. Our network members give their own free time to the project and we've been very grateful for the enthusiasm they've put behind this. Our network has now been formalised within the NHS England (London Region) Strategic Clinical Networks and we are delighted with this development.

We now hope to embed measurement of clinical performance in the clinical workflow. This is very challenging given that AKI patients may present virtually anywhere in the healthcare system, but it must be done. Going forward, we hope to use our strong clinical engagement to develop collaborative research studies with other groups in the UK.

Northumbria Healthcare NHS Foundation Trust

Consultant recruitment process

The Future Hospital Commission met with Dr David Evans, medical director and Dr Colin Doig, consultant cardiologist.

- **Population served**: 500,000 people.

- **Challenge faced**: The trust needs to maintain a shared culture amongst all staff, including 535 doctors, spread over multiple sites. It is keen to attract the best staff as they will be one of its most important assets.
- **Solution**: An extensive consultant selection process, spread over 2 days, involving members of the MDT and management with explicit reference to the organisation's value charter.
- **Local context**: Combined acute and community trust, combining three acute hospitals and six community facilities.
- **Partners**: The trust initially contacted an external agency but now runs the process itself.
- **Outcome**: Strong organisational culture, high levels of staff retention.

The trust depends on strong clinical leadership in every department and every site. It is always possible to improve practice to enhance patient care and experience, and the staff are the best placed both to recognise where those changes are needed and effect appropriate change. For staff to have faith in the system of using feedback, setting a priority agenda and delivering it, the leadership need to have a common vision. One of the ways of achieving this has been through a rigorous consultant recruitment process that not only selects new consultants on the basis of their 'fit' within the organisation as a whole and the specific departmental team they are joining, but also permits the trust to offer support and guidance tailored to that individual from the day they sign a contract.

The selection process occurs over 2 days. Prospective consultants are invited to attend a series of informal meetings with various professional groups – ward staff, allied healthcare professionals, business unit managerial staff, consultant colleagues etc, and these staff feed back to the executive team. The candidates are asked to take part in a simulated consultation most appropriate to their field (which may be a multidisciplinary team meeting, telephone consultation or clinical assessment). They also undergo rigorous personality assessments using validated tools. There is an opportunity to discuss their desired career plan and working patterns. The trust value charter is explicitly discussed. Consultant contracts are trust wide, and most consultants are expected to spend at least 30% of their annualised job plan delivering care outside their base site. Flexibility is encouraged to support regular 'out-of-hours' working, or evening/weekend clinics at the request of staff.

The process is completed by a lengthy interview where the panel have all the feedback and assessment information at their disposal. This means that they are able to form a more detailed judgment on the candidate's abilities and suitability to join the organisation. This information is also used for a successful candidate to formulate their first appraisal and identify areas where support and additional training would be welcome. One new consultant commented that when offered posts in two trusts she chose Northumbria based in part on their selection process, knowing she would be valued as they had taken so much time and energy from the whole team to choose her.

Nottingham University Hospitals NHS Trust

Hospitals@Night nerve centre

In this Future Hospital Commission case study, Dr Dominick Shaw, associate clinical professor and honorary consultant at Nottingham University Hospitals NHS Trust, describes using technology to improve out-of-hours care, reduce untoward incidents and length of stay, and make efficiency savings.

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

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

Poole Hospital Foundation Trust

Two stable admissions teams

Here, Dr Mike Masding, consultant physician and head of Wessex Foundation School, describes developing two stable admissions teams to reduce length of stay and improve trainee satisfaction.

- **Hospital size**: 500 beds, 60 medical admissions/ 24 hours on average.
- **Challenge faced**: High numbers of admissions; challenge meeting training needs with ETWD.
- **Solution**: Two 'on take' teams per day, one general medicine (adult) and one elderly care.
  - Locally agreed criteria for specialty management.
  - Admitting team remains responsible for non-specialty patients until discharge.
  - Medical leadership for junior doctors' rota.
- **Local context**: High proportion of elderly in the population. Three medical wards (1 admissions unit and two general wards), 6 elderly care wards (1 dedicated elderly care admission unit, 1 integrated stroke unit and 4 general wards) in the medical division.
- **Outcome**: Shorter length of stay than in surrounding trusts and higher trainee satisfaction.

Working in stable teams is a priority for us, and we are determined to find ways to create and maintain teams. I think it actually boils down to real commitment from our consultant staff that it's what we want. Also, the added element is that we control it. Our rota is written by one of the acute physicians.

We have a completely separate elderly care take. So if we look at say, 9pm, there would be four medics and three elderly care people. Rather than just having one massive team of seven people, we have two separate teams of four and three. And two completely separate takes with separate admission units. So we've got an elderly care admissions unit, run by an excellent team of dedicated elderly care physicians, who are expert at assessing and appropriately managing elderly patients with multiple morbidities – I would never claim to be expert in that. This is important because down here on the south coast, we have lots of elderly people. We still have 60 patients coming in a day, but each team is only seeing 30. So they're not inundated with patients. The patients get a better service. The junior doctors are happy. When they're doing elderly care, they're doing elderly care. When they're doing general medicine, they're doing general medicine and they are not the same. I am always on call with my team. I think the juniors appreciate that as well. They know if they're going to do a post-take ward round, it's going to be with a consultant they know. They know how to handle us! It works well.

Our acute medical unit (AMU) is staffed by acute physicians who take referrals between 8.30am and 7pm, so because senior doctors look for alternative ways of managing the patient, 25% of referrals don't even come into hospital. There is an acute medicine specialty registrar learning about ambulatory care, and the senior house officers rotate through AMU for a week block, the foundation year 1 doctors for a month block. They like it. They say after a month they have seen it all and start to get bored!

So if you get admitted with say, a severe exacerbation of COPD that needed non-invasive ventilation, they'd be admitted by the acute team and then they'd be handed over to the respiratory team because they need respiratory care.

On the other hand, if I admitted somebody with very mild COPD but the main problem is they're just off their legs a bit, we wouldn't hand them back to respiratory – I would carry on looking after them. I think the advantage of that is the continuity of care, where the junior doctors continue to see the patients

they've admitted and see the improvement in them. I am sure it's better for the patient because they see a familiar face every morning.

Every year we have an away day, where we get away from work, to have some space to bash everything out for the next year really. So there will be gastroenterologists, respiratory guys, cardiologists, ourselves, acute physicians, acute senior nurses and everyone in the room to really work on how we are going to work it, the referral guidelines and everything. I think that that cohesiveness is crucially important – this culture at Poole is what makes it a special place to work.

Portsmouth Hospitals NHS Trust

Increased research and patient participation

In this Future Hospital Commission case study, Dr Anoop Chauhan (director of research at Portsmouth Hospitals NHS Trust) describes developing a 5-year research strategy to increase research at the trust and improve patient participation.

- **Hospital size**: 1,200 beds
- **Challenge faced**: Pockets of research were carried out, but there was no research strategy.
- **Solution**: A 5-year research strategy was approved by the trust board, with funding from other organisations. Patients and clinicians were made aware of trials that could benefit patients. An online forum for research nurses was set up to share best practice and information on recruiting patients.
- **Outcome**: There has been a five-fold increase in the number of studies since 2009 (40 to 200), and a four-fold increase in the number of patients recruited (901 to 3,840).

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

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

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

In 2009, the trust board approved a 5-year research strategy at this trust. They initially obtained increased funding and support from commercial organisations and the National Institute for Health Research (NIHR), which was used to increase the size of the research office with more facilitators and research nurses. They then looked at the patient journey to identify where the opportunities were to engage with patients. One of the aims was to ensure that the right patient would know about the right trials within the trust and to foster this. Colleagues are now aware of other ongoing research and enrol patients on to those studies too. They also introduced clinical trials software and restructured their approval process. These measures have led to a five-fold increase in the number of studies since 2009 (40 to 200), and a four-fold increase in the number of patients recruited (901 to 3,840). They also now take less than 30 days to approve a study and are the best in the region, compared to 66 days before 2009.

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

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

Renal patient view

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

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

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

- This service only costs £3.50 per patient per year and has 17,000 registered users, including the vast majority of people with end-stage kidney failure.
- An evaluation carried out in 2012, by Dr Felix Mukoro on behalf of NHS Kidney Care, reported that patients found it valuable in managing their condition.

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

Royal Brompton and Harefield Hospital

Telecraft

A Future Hospital Commission case study exploring telecraft - telemonitoring for heart failure and COPD/chronic respiratory disease patients

- **Challenge faced**: Patients with severe cardiac or respiratory disease are troubled with frequent exacerbations, often requiring hospitalisation.
- **Solution:** The study is designed to see how best to use telemonitoring technology and the challenges of doing so.
- **Partners:** This is an NIHR CLAHRC funded study, in collaboration with West Middlesex University hospital and St George's University Hospital.

- **Staffing:** Four members of the respiratory MDT are trained to read and respond to the monitoring. One consultant physician provides medical support
- **Outcomes:** The study has finished recruiting and results will be available from the end of 2013. The main outcomes include time to first exacerbation. Secondary outcomes include GP and ED visits, self-efficacy, compliance, and quality of life.

People use telemedicine, telehealth, telemonitoring, interchangeably. There is no point in just monitoring someone. Someone has to look at that data, understand it in the context of that patient, and advise them to complete the loop. We've been doing telehealth – using telemonitoring to provide remote consultation services.

We did a cross-over trial, 6 months in random order: telemonitoring or follow-up. The cross-over answers different questions because in the group that were controlled first, you have a good comparative period for 6 months and then you see the impact that telemonitoring has on a known baseline. For the other group that had telemonitoring first, I was very interested to see, having had telemonitoring for 6 months and taking it away, whether that enabled that group to identify their exacerbations earlier and had an educational benefit. That might apply especially perhaps when they are unstable or discharged from hospital and then you take it away and you give it to someone else and that could have a lot of economies of scale.

I think some misperceptions about telemonitoring are that it's complicated and patients will be worried by it, which might make them more aware of their own problems. I don't think that came across at all. Although the average age of patients is into their 70s, providing it's explained at the beginning patients get along fine. Some of the more socially isolated ones really quite liked having something there. If you have got a nice neighbour who looks after you, or a wife who prompts you by saying, 'I think you should start taking those antibiotics' and you have a network who support you, then that's all going to help reduce your admissions and make sure you're not lonely. But if you're isolated, you have high anxiety levels, and you panic when things are not right. Then it may be more helpful for you to have telemonitoring.

Most of the systems pose questions to the patient. You can have it through your mobile phone. We had a broadband system that just came to their television set. So all they have to do is turn on their television and it asks them a series of questions and they answer via their remote control. For example, for chronic obstructive pulmonary disease (COPD): 'Are you more breathless? Are you producing sputum? What colour is it?' You can see them change their medicines. We had oximetry for respiratory patients and for heart failure patients the weight, blood pressure and heart rate, which is more useful. The bigger barrier was actually the staff and worries about workload. The person who looks at that data and their knowledge of the patient are important. It's also how the patient is reacting to the person who deals with them. They're our patients shared with the GP, so it's a remote consultation, a tertiary model. How you present the data to the person who is scanning it in the morning is important. Our system is a kind of traffic light approach. For individual patients you enter normal bands of their fluctuation; if they are outside the normal bands it triggers and someone can just glance through, see the red light and go to that patient. If the patient didn't have the telemonitoring, they would have to decide whether to call the GP or not themselves. What we're sometimes doing is giving an extra level of care: 'You know you just said to me that you wanted to see how it went over the weekend and then maybe go and see the GP Monday, but I really think you need to see them today.' Or 'You know your GP gave you those medicines, well I think you should start them now.'

The advantage would be that, as a community matron or a respiratory nurse specialist responsible for 60 patients, if you had data on them and you just saw when you went in on a Monday morning that you had red lights on three, then they would be your priority that day. Having said that, one should caution that it may be that specific targeting of telehealth is required rather than assuming it will benefit most patients with chronic disorders. Although the Whole Systems Demonstrator trial showed a reduction in

emergency admissions and mortality, recent large multicentre trials in heart failure patients have not reproduced earlier findings of decreased admissions, and there is the risk of large volumes of data generating increased healthcare activity. In order to explore these aspects further we are about to start a sleep apnoea telemonitoring study. I am thinking we could get patients started on continuous positive airway pressure, follow them from the beginning, and when they are settled we take the telemonitoring off and give it to other people. You start to think of other groups where it would be particularly relevant. I'm thinking about our motor neurone disease patients. As they get more poorly and housebound and weak, the less likely they are to come up to the clinic but that's where clinically telehealth would be quite relevant.

Queen Elizabeth Hospital Gateshead

Dual care ward

A Future Health Commission interview with consultant psychiatrist Dr Catherine Kirkley, about dual care wards.

- **Hospital size**: 500 beds
- **Solution**: Dual care ward, initially staffed by RMNs and RGNs , now mainly RGNs with specific skills. Joint psychiatric and geriatric input.
- **Local context**: Older people's mental health services are part of the acute trust.
- **Partners**: Community mental health team, mental health team supporting nursing homes.
- **Staffing**: 1.5 whole time equivalent (WTE) geriatricians. 0.7 WTE consultant psychiatrist. Two band 6 and two band 7 psychiatric nurse specialists as part of the psychiatric liaison service 7 days a week (not exclusively for the dual care ward).
- **Outcome**: Minimal resort to artificial feeding or hydration. Calm management of agitation and aggression in patients with dementia and delirium. Better care options for patients who are physically unwell and have severe mental illness.

One of the key things is having staff with the right attitude. The staff on the dual-care ward see people with mental health problems as their kind of person – that's who they're there to look after. They think that these patients shouldn't be moved somewhere else. I think that's the real strength of the ward. Initially we had a more even mixture of (registered general nurses (RGNs) and registered mental health nurses (RMNs) but recruitment of RMNs was difficult. So now we have mainly RGNs. However, we are aiming for dual care nurses. We start with RGNs with the right attitude, and then build in mental health training. The mental health liaison team has a big presence on the ward so at least one of us is there every day assessing patients and supporting the team. The nurses do a fantastic job and a job that's a lot harder than I think it is on a lot of other wards. It should be recognised that they're a specialist service doing a specialist, difficult job.

They focus on nutrition. The basic care is fantastic. The housekeepers are amazing. One of them comes in early every day to make sure that she knows what everybody will eat. The hospital stopped providing cooked breakfast a little while ago, but the ward manager noticed that is the meal that most patients always seem to eat, so they got it restarted. The nurses and healthcare assistants make sure that everyone who needs help with eating is given it. Sometimes I'll move a patient from another ward who is not eating, because I'll know the staff on this ward will make sure that they'll eat. We very rarely need to use other methods just because of the skills of the staff.

Patients are allowed to wander freely around the ward; they aren't told to sit down all the time. It helps to reduce the triggers for aggression and it feels calmer. With elderly mental health services being in the same trust we've got great connections with our geriatricians which is a real bonus. This also means that we can move patients quite freely between mental health beds and the dual care ward.

We don't just take patients with dementia. We have looked after patients with severe mental health issues who have become physically unwell to ensure they get access to both skill sets. For example, when we have had patients who had had very disturbed behaviour on the mental health wards, and become physically unwell, we can bring them up to our ward and, despite the challenging behaviour, we can cope with that and look after them.

The older people's psychiatric liaison team have recently started working 7 days a week which can be challenging with the numbers of staff that we have got, but it has meant that we have been able to identify patients most suitable for the dual care ward. We're also doing a lot of work on dementia in the hospital. All wards need to be able to manage straightforward dementia and delirium in patients who are physically unwell. The dual care ward should be for the patients who are more agitated, who are very complex and physically unwell or patients with severe mental health needs who have specific needs. I think it's really good that we haven't got strict admission criteria and we have that flexibility to have different kinds of patients there, depending on what they need.

University Hospitals Birmingham NHS Foundation Trust

Performance monitoring on wards

Patient Information and Communications System (PICS), was developed in-house at the University Hospitals Birmingham NHS Foundations Trust and is now available on every inpatient ward.

- **Challenge faced**: to find a means of monitoring patient care that will flag up problems early.
- **Solution**: Patient Information and Communications System (PICS) monitors measures like infection levels after surgery; falls; drug doses; bedsores. A traffic light system shows improvements or falls in performance levels.
- **Outcome**: PICS is available on every ward at the trust and enables senior managers to address problems quickly.

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

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

University Hospitals Nottingham

Acute medical geriatrician

This Future Hospital Commission case study interview is with Dr David Seddon, consultant geriatrician at University Hospitals Nottingham.

- **Hospital size**: Acute take 100 patients a day.
- **Challenge** faced: Large unselected medical takes with increasing numbers of frail older people.
- **Solution**: Consultant geriatrician review for identified frail older people admitted, to facilitate discharge and formulate a rapid admission plan.
- **Local context**: The geriatric department provides input on 2 sites, with all beds on 1 site and includes 2 community geriatricians.

- **Staffing**: 20 hours of consultant geriatrician time (planning to expand to 40 hours). Strong support from the integrated discharge team (whole time equivalent band 7 nurse).
- **Outcome**: From a local audit of 1 month's activity: 159 medications stopped; 260 bed days saved; 6 unsafe transfers prevented; care plans altered. Patients most in need of healthcare for elderly services identified.

One of the key things is that the service has raised the standard of care for these frail older patients in all sorts of ways. Medications that are inappropriate have been discontinued; medications that are indicated are prescribed; and we've given attention to appropriate prescribing. We also attend to advanced care planning. In some instances that is simply a matter of a phone call to a family to ask, 'Are you aware your Gran is very ill? Have you talked about the immediate future for her?' Contact with a consultant, even over the phone, is an extraordinarily powerful thing for relatives. We also perform a thorough assessment of cognition, obtaining a collateral history from the family about the duration of memory loss and consideration of alternative explanations, whether memory loss is acute, and therefore we diagnose lots of dementia. Having a consultant, rather than a trainee, documenting a clear differential diagnosis list and a care plan in the notes improves quality of care. The patient arrives on the ward and if I have made two or three entries in the notes the nurses go, 'Oh, that's good. We know exactly what we are doing. Let's get the physios to see the patient, get him up and moving and home in 36 hours'. Another aspect worth commenting on is preventing unsafe ward transfers or discharges, and ensuring that the patients who will benefit most in wards for the care of older people are triaged to go there.

Older frailer patients take time and you simply can't do them justice on an acute take round. It was nice to hear one of our colleagues describing the acute geriatrician as decompressing the take. Our specialty colleagues acknowledge that we do have a skill set and a range of experience that is more suited to looking after frailer older people.

We are also able to expedite discharges for up to 30% of frailer older people. This is partly due to the continuity we provide by seeing the patient every day. Also, we are in a strong position to put in a lot of community services, some accessible from the front door. We have community matrons, community geriatricians, our proactive intermediate care team and a crisis team who provide 6 weeks extra support. It's a team effort: the ward manager who can point you in the direction of patients likely to be able to be discharged, the geriatricians themselves, and the interdisciplinary team with their contacts and knowledge of the services available.

Future Hospital Commission interviews

A number of interviews for the future Hospital Commission were recorded.

Nottingham Queen's Medical Centre

- An interview with Dr Jack Hawkins

Sheffield Hospital: Geriatric medicine redesign at the front door

- An interview with Professor Tom Downes

University Hospitals Birmingham: Complex discharge ward

- An interview with Dr Zoe Wyrko

Whittington Hospital: Respiratory integrated care

- How is it set up?
- What does it mean for patients?
- What does it mean for staff?