Future Hospital Commission

Future hospital: Caring for medical patients

Extract: Recommendations

Achieving the future hospital vision – 50 recommendations

The recommendations from *Future hospital: caring for medical patients*[1] set out a 'road map' for achieving the vision of a future hospital in which all patients receive safe, high-quality care coordinated to meet their clinical and support needs across 7 days. The Commission's recommendations are drawn from the very best of our hospital services, taking examples of the innovative, patient-centred services that exist now to develop a comprehensive model of hospital care fit for the future.

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

A new organisational approach (chapter 3)

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

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

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

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

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

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

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

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

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

Staffing the Medical Division (chapter 4)

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

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

6 Organise care to focus on consistent early consultant review.

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

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

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

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

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

The hospital–community interface (chapter 5)

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

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

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

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

i Develop clinical criteria that define which patients require specialty consultation, advice or management on a specific pathway. This will be supported by clearly defined specialist services available to provide rapid assessment in 'front door' areas to facilitate fast-track referral to specialty pathways.
ii Patients assessed as likely to have a stay in hospital of less than 48 hours will usually be admitted to the acute medical unit unless their requirements for rehabilitation are likely to mandate care on a specialist or internal medicine ward. Protocols for routes of admission should be developed.
iii Patients admitted to the acute medical unit should be under the care of a single consultant-led team. The same should apply to patients for whom ambulatory care is deemed appropriate. This

will mean designing rotas that allow the consultant reviewing the patient on admission to review the patient the next day. Arrangements must be in place to ensure that specialty care is accessible to patients in all locations across the hospital.

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

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

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

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

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

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

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

This can be supported by the development of:

i Shared referral pathways and care protocols across the system to support integrated working with health and social care partners. This would be underpinned by rapid, relevant sharing of information, mechanisms for rapid admission and referral, and effective arrangements for enabling patients to leave hospital with support where necessary.
ii Information systems that bring together all relevant clinical information, including that from primary and community care, mental health, social and hospital services in one electronic patient record (EPR). Immediate access to this comprehensive EPR is particularly important in the assessment of patients presenting as a medical emergency. (See chapter 9 for further recommendations on the use of information.)

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

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

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

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

It is recommended that:

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

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

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

The changing workforce (chapter 7)

Short term (0–6 months)

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

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

Medium term (6–24 months)

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

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

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

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

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

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

Longer term (2–5 years)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Research and development (chapter 10)

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

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

38 Clinical and research commitments of staff must be integrated.

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

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

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

Building a culture of compassion and respect (chapter 11)

41 Design healthcare services around the 'seven domains of quality'.

The seven domains of quality are defined as:

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

42 Embed patient experience in service design and delivery.

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

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

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

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

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

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

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

46 Coordinate ward rounds between medical and nursing staff.

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

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

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

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

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

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

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

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

enable staff from all disciplines and all levels to discuss difficult emotional and social issues arising from patient care (eg Schwartz Center Rounds©).

50 Hospitals should make staff well-being and engagement a priority to ensure high-quality 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. www.rcplondon.ac.uk/futurehospital [accessed 4 September 2013].

2 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chaired by Robert Francis QC. London: Stationery Office, 2013.

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

Future hospital: Our commitments to patients

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

Our commitment to patients – moving beds

1 We will only move you on the basis of your needs.
2 We will explain to you where you are moving to and why. Where possible, we will tell you how long you are moving for.
3 We will not move you at night unless your needs urgently require it.
4 We will make sure you know who to speak to about your needs, treatment and care.
5 We will make sure your family know where you are and why you are there (unless there are circumstances that mean this is not appropriate).

Our commitment to patients – communication

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

Our commitment to patients – leaving hospital

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

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