NHS Futures Scenario: The Future Hospital

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Executive Summary

In March 2012 the Royal College of Physicians (RCP) established the Future Hospital Commission. Its final report, Future Hospital: caring for medical patients, was published in September 2013 and sets out the Commission’s vision for hospital services structured around the needs of patients, now and in the future.

The report’s recommendations are drawn from the very best of our hospital services, taking examples of existing innovative, patient-centred services to develop a comprehensive model of hospital care that meets the needs of patients, now and in the future.

This submission to the NHS Futures Summit is based on the research and recommendations of the Future Hospital Commission. Our submission focuses on the role of the hospital in particular, but this does not mean that we see the hospital in isolation – on the contrary, ours is a radical new vision of care that re-imagines the role of hospital across a holistic system of primary, secondary and social care that is always centred around the patient.

We envisage a system of care that is designed and delivered to meet the needs of patients. We envisage a system of care that puts patients first. This will mean specialist teams working out into the community; it will mean using real-time patient experience data to inform care planning and service delivery; it will mean fast-tracking patients with specialist needs directly to expert clinical care from the community; and it will mean that older patients with multiple, complex conditions – those who make-up the substantial majority of hospital inpatients – will received coordinated care that promotes independence rather than exacerbating frailty, enabling more patients to return to their own homes when they leave the hospital ward.

Put simply, our vision is one of a system of care that is based on the needs of patients, and delivered across a range of care settings, by a range of professionals, all working in collaboration.

This is a brief overview of how we believe the system of care could be re-framed in order to deliver better quality patient care and patient experience in ten years’ time. We encourage readers to find out more by accessing the full Future Hospital Commission report and associated resources at www.rcplondon.ac.uk/projects/future-hospital-commission.

We welcome readers’ views on our vision and what we can do to help ensure its realisation in practice. Please share your views, suggestions, questions and ideas by emailing futurehospital@rcplondon.ac.uk.
About the authors:

*Professor Timothy Evans* has lead the RCP’s work looking at the overall design and delivery of inpatient hospital care. This role includes coordinating the RCP’s work around the Future Hospital Commission, which aims to address growing concerns about the standards of care currently seen in hospitals, and to make recommendations to provide patients with the safe, high-quality, sustainable care that they deserve. He is also currently vice dean of the Faculty of Intensive Care Medicine and medical director of the Royal Brompton and Harefield NHS Foundation Trust.

*Dr Mark Newbold* chairs the NHS Confederation’s Hospitals Forum and is chief executive of the Heart of England Foundation Trust, a large foundation trust running three acute hospitals and community services in the midlands. He originally qualified as a doctor and practised as a Consultant Histopathologist for 16 years. Mark is interested in new models for creating viable and sustainable acute hospitals, and believes that acute organisations have a greater role to play in improving the public health. He is passionate about developing a more open, accessible and collaborative leadership style within the NHS, and using the new social media channels to support this.
1. What is the case for change?

1.1 All patients deserve to receive safe, high-quality, sustainable care centred around their needs and delivered in an appropriate setting by respectful, compassionate, expert health professionals. Staff working in the NHS want to provide good care for their patients, and many patients experience excellent care.

1.2 However, recent reports of the care – or lack of – received by some patients makes for harrowing reading. As described in detail in the Royal College of Physicians’ 2012 report *Hospitals on the Edge?*, for example, healthcare staff and the hospitals in which they work face substantial and complex challenges to their ability to deliver high-quality care, whilst Robert Francis QC’s inquiry into Mid Staffordshire Foundation Trust has described vividly the unacceptable failings in patient care that can occur as a result. The existing system of care is struggling to cope with the challenges posed by an ageing population, increased hospital admissions, and its failure to meet the needs of the most vulnerable patients.

1.3 Compared to when the NHS was founded in 1948, patients are much more likely to be older, have multiple health problems, and a far greater complexity of illness. Nearly two-thirds of patients admitted to hospital are over 65 years old and around 25% of hospital inpatients have a diagnosis of dementia. Emergency admissions to hospital have increased by 37% in the last decade alone.

1.4 Our existing service structures, designed to focus on managing single diseases with little coordination across the different parts of the care system – or even across different parts of the hospital – are therefore often ill-equipped to meet the needs of patients today and in the future.

1.5 These challenges mean that we currently face:

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

1.6 This means that we need to take action now. We believe that those working in the NHS have a responsibility and an opportunity to lead this change. Doctors, nurses, politicians, hospitals, national bodies and others involved in health and social care must be prepared to make difficult decisions and implement radical change where this will improve patient care.

1.7 This is not inherently about systems and structures; redesigned systems and structures are not outcomes in the own right. Rather, our goal is to put patients at the heart of the health and care system, with systems and structures that are designed to enable this, and designed with a commitment to positive patient experience and clinical outcomes at their very core.
2. Our vision: the Future Hospital

2.1 Our vision is one of a new model of care which is centred around the patient. Our vision is of a model of care designed to encourage collective responsibility for the care of patients across professions and healthcare teams.

2.2 We envisage new ways of working across the hospital and between hospitals and the community, supported by financial and management arrangements that give greater priority to caring for patients with urgent medical needs. This means aligning funding and incentives across the health economy to ensure that acute services are appropriately supported. It means delivering patient-centred care, with the hospital operating at the centre of a coordinated, collaborative system of care which enables:

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

2.3 This vision recognises that illness can occur at any time, so care services need to be accessible seven days a week both in the hospital and in the community. The most acutely ill patients will require access to specialist, diagnostic and laboratory services 24 hours a day, 7 days a week.

2.4 We envisage a system of care that values patient experience as much as clinical effectiveness. We envisage a system which measures patients’ experience of care and deploys this data to drive improvement in the quality of care, supported by a Citizenship Charter drawn-up with patients and which puts patients at the centre of care.

2.5 We envisage care being delivered in whichever setting enables the patient’s clinical, care and wider support needs to be met best – whether this is in the hospital or in the community. We envisage smooth, timely and coordinated transfer of care between different settings when the patients’ care needs necessitate it, rather than when administrative or budgeting divisions allow it.

2.6 Put simply, our vision is one of a system of care that it based on the needs of patients, and delivered across a range of care settings, by a range of professionals, all working in collaboration.

2.7 In the hospital of the future:

- fundamental standards of care must always be met
- patient experience is valued as much as clinical effectiveness
- responsibility for each patient’s care is clear and communicated
• patients have effective and timely access to care, including appointments, tests, treatments and moves out of hospital
• patients do not move wards unless this is necessary for their clinical care
• robust arrangements for transferring of care are in place
• good communication with and about patients in the norm
• care is designed to facilitate self-care and health promotion
• services are tailored to meet the needs of individual patients, including vulnerable patients
• all patients have a care plan that reflects their individual clinical and support needs
• staff are support to deliver safe, compassionate care, and committed to improving quality.

2.8 Achieving this vision will require radical change to the structure of hospitals, the way they operate as part of a wider system of care, and the way that staff and systems work on a day-to-day basis.

3. How the Future Hospital will operate

3.1 The Future Hospital will operate at the core of a wider health economy, providing services that meet the needs of patients in the hospital and in the community. It will be part of a whole system of collaborative care incorporating GPs, social care and mental health, through which patients’ experience of care will be seamless and coordinated along care pathways.

3.2 When patients leave hospital, they will not simply be discharged into the community. Rather, responsibility for their care will transfer smoothly from one part of the system to another, with care provided as close as possible to patients’ homes.

3.3 Care will be centred around patients, not the other way around. Patients, staff and managers will work together to design a Citizenship Charter that puts patients at the core of everything the Future Hospital does, and which embeds in practice a culture of care.

3.4 In the Future Hospital, new senior operational roles will have been established to focus on the prioritisation of medical care which is coordinated across care settings. This includes a chief of medicine who sets the standard and direction of medical services, an acute care coordinator providing operational oversight and coordination of clinical care, and a chief resident to lead liaison between junior doctors and senior medical staff and management, including planning service redesign and delivery in relation to junior medical staff deployment, rotas, workload and duties.

3.5 The structure and operation of the hospital of the future will also be configured differently to enable patient-centred care that is coordinated across the hospital and community. This will mean a new configuration of the hospital itself and its interface with the wider system of care (see figs. 1 and 4, below).

3.6 Whilst all hospitals and health economies are underpinned by common principles, there is no single, optimal approach to designing and delivering services that is applicable and appropriate to all health economies. Our vision, therefore, would need to be adapted to the needs of the patients in each local health economy – from the isolated rural populations of West Wales or Cumbria to the diverse urban communities of larger cities like Birmingham or London. There are already many existing examples of
local good practice which goes some way towards creating a holistic, patient-centred vision for the hospital and the wider health economy, some of which is referenced in this paper and described in greater detail in the Future Hospital Commission report. Indeed, this good practice not only helped shape our vision of the Future Hospital, but also demonstrates the creativity of local health professionals in leading innovation in patient care.

3.7 Through the many and varied ways our vision will be tailored to reflect local circumstances, the overriding objective will always be to place patients and their physical, psychological and social needs at the very heart of the healthcare system.

The form and function of the hospital in the wider system of care

3.8 This shift will require new structures within the hospital and between the hospital and other parts of the care system (see fig. 1, below).

Fig 1. The Medical Division remit: circle of patient-centred care.

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<tr>
<th>Hospital-based</th>
<th>Shared responsibility</th>
<th>Community-based</th>
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<td>Clinical Coordination Centre</td>
<td>Coordinated community services</td>
<td>Medical Division in the community</td>
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<td>Hospital-based Medical Division</td>
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<td>Emergency department</td>
<td>Intermediate care / enhanced discharge</td>
<td>Mental health trusts</td>
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<td>Acute medical unit</td>
<td>Orthopaedic patients requiring physicians’ care</td>
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<td>Ambulatory emergency care</td>
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<td>Enhanced care / intensive therapy unit</td>
<td>Internal medicine wards</td>
<td>Integrated care specialist care in the community</td>
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<td>Medical Division</td>
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Medical Division

3.9 We envisage that this will include a single unified Medical Division sitting at the centre of the delivery of hospital-initiated and hospital-based care, which itself will sit at the core of a wider system of care that includes home and community care settings (see fig. 1, above).
3.10 The Medical Division will be responsible for all medical services across the hospital – from the emergency department and acute and intensive care beds, through to general and specialist wards. Although it will be physically located on an acute hospital site, the Medical Division’s clinical responsibility will extend beyond the physical boundaries of the hospital and into the wider health system through, for example, community-based intermediate care services, or home-based rehabilitation services. It will work closely with partners in primary and social care to meet the needs of all patients who would benefit from secondary care medical services, whether or not they are hospital inpatients.

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

Acute Care Hub

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

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

Clinical Coordination Centre

3.14 The Clinical Coordination Centre will be the operational command centre for the hospital site and the wider health economy. It will be the physical site from which all hospital and associated community care is coordinated for all patients with active clinical needs.

3.15 The Clinical Coordination Centre will provide healthcare staff with the information they need to care for patients effectively. It will hold detailed, real-time information on patients’ care needs and clinical status, enabling staff and services to be coordinated and deployed responsively and collaboratively to meet patients’ needs as they change and develop. Ultimately, the Clinical Coordination Centre will also include information from primary and community care, mental health and social care, through a single electronic patient record, developed to common standards.

3.16 The Clinical Coordination Centre will support coordinated and informed transfer of care between the hospital and community. Staffed seven days a week and linked, where appropriate, with other parts of the wider health economy, it will enabled shared responsibility for care through a continuous virtual dialogue between patients and practitioners in primary and secondary care and across the wider health and care system.

3.17 This structural shift in the form and function of hospitals is, of course, only part of the change necessary to deliver our vision of the Future Hospital. No less important are the changes in culture, relationships and ways of working which are fundamental to the delivery of coordinated care that meets the needs of patients.
Culture and ways of working

3.18 In the Future Hospital, services will be organised so that clinical staff and diagnostic and support services are readily available seven days a week. There will be a consultant presence on hospital wards seven days a week, and staff rotas will be designed on a seven-day basis, coordinated so that medical teams work together as a team from one day to the next. Wherever possible, each hospital inpatient will be under the care of a single consultant-led team, drawing on input from specialist teams when patients’ clinical needs require it.

3.19 Patients will be admitted to hospital only if their clinical needs require it, with ambulatory care units providing a rapid turnaround of diagnostic investigations and treatments for patients who could return home the same day, freeing up hospital beds for those patients whose clinical needs necessitate admission to hospital. There are already examples of emerging good practice in this area, such as the work of Nottingham Queen’s Medical Centre, where the consultant-led ambulatory care unit has enabled 30-40% of patients referred by a GP to be discharged on the same day after an average hospital stay of only four hours. (For more information please visit www.rcplondon.ac.uk/projects/case-study-ambulatory-emergency-care).

3.20 If admitted, patients will not move beds unless their clinical needs demand it. Early assessment by a senior doctor will enable this, ensuring that patients are allocated a care pathway that best meets their clinical needs – whether this means being cared for on a specialist ward or being cared for in the community. Sheffield Hospital is already making progress towards this vision by re-designing geriatric services to enable immediate access from GP and Emergency Department referrals to a specialist geriatrician and expert team. The results have yielded dramatic reductions in length of stay and in hospital mortality. (For more information please visit www.rcplondon.ac.uk/projects/case-study-early-geriatric-assessment).

3.21 Specialist medical care will not be confined to inside the hospital walls. Physicians will play a wider role that extends their leadership and clinical skills into the community (see fig 4, below). Medical teams will work closely with GPs and social care in an integrated manner to ensure that patients can access specialist care when they need it, where they need it – including in or close to their homes. Hospital doctors and specialist medical teams will spend part of their time working in the community, caring particularly for those patients who have long-term conditions to help manage their illnesses effectively and prevent acute health problems from arising or deteriorating.
3.22 Patients presenting acutely will be assessed by the clinician best able to evaluate their clinical needs and make immediate decisions about their care according to the unique needs of each patient. For example, patients aged over 80 will receive early, comprehensive assessment by a geriatric specialist. This means that physicians, including specialists, will work seamlessly across the emergency department and other parts of the hospital without artificial barriers between teams, enabling rapid patient care and smooth transfer of care between different parts of the hospital and different parts of the wider system of care beyond the hospital walls.

3.23 Care will focus on recovery and enabling patients to leave hospital as soon as their clinical needs allow. Planning the transition from the hospital to the community will begin as soon as patients are admitted, and will be incorporated into the daily review process and ward rounds. Services like the Countess of Chester Hospital’s rapid response and enhanced discharge scheme will be the norm, enabling patients to avoid hospital admissions or reduce their length of stay in hospital by providing responsive rehab, social care and short-term medical care in the community. (For more information please visit www.rcplondon.ac.uk/sites/default/files/countess-of-chester-hospital.pdf).

3.24 The Future Hospital will take seriously patients’ experience of care, measuring and evaluating the care experience to drive improvement. Good practice in this field can already been seen in the NHS, such as in Northumbria Healthcare NHS Foundation Trust’s patient experience programme, which collects feedback from 20,000 patients every year to build a comprehensive picture of patient experience. This, along with an exit survey conducted with patients’ friends and families, gives a real-time snapshot of patient experience which is used to appraise individual consultants, challenge wards which drop below 90% on key domains such as respect and dignity, and promote innovative practices that support a better experience of care overall. For more information please visit www.rcplondon.ac.uk/sites/default/files/northumbria-healthcare-nhs-foundation-trust.pdf).
3.25 In the Future Hospital, inpatient stays will be regarded as just one part of a longer care pathway that is coordinated and continuous, from and back to the patient’s home or usual place of residence. Patients who are well enough to leave hospital, but whose clinical needs require further diagnostic monitoring and medical review, can still access hospital-based services without needing to remain in hospital as an inpatient, enabling them to return home as soon as their clinical needs allow.

3.26 We will no longer talk about ‘discharging’ patients from hospital, but of transferring responsibility for their care between the hospital and the community. Arrangements for patients leaving hospital will operate on a seven-day basis, with health and social care services organised to enable patients to move out of hospital on the day they no longer require an acute hospital bed, whatever day of the week it is.

3.27 This will enable an integrated experience of care across different parts of the health and care system. The health and social care landscape will experience free movement of information and expertise across the entire system. Whilst the precise configuration of this integration will be tailored to meet the local circumstances and local health structures of different areas, it will enable the provision of safe, high-quality health and social care in all locations in order to meet the clinical, psychological and social needs of all patients. A series of simple questions will be used to identify which care setting is most appropriate for each patient (see fig 3, below).

3.28 Doctors will continue to be a critically important part of the healthcare workforce. They will receive the education and training necessary to diagnose, manage and coordinate continuing care for the increasing number of patients with multiple and complex conditions, with a greater proportion of doctors trained and deployed to deliver expert general internal medicine. Specialist expertise will be drawn in as patients’ clinical needs require, and specialist teams will contribute to generalist care.
Funding and measuring care

3.29 These new ways of working, new structures and new approaches will be supported by a funding regime and a performance measurement framework that enables the holistic care of patients’ clinical, psychological and social care needs across the health economy.

3.30 In our vision for the NHS, resource allocation will prioritise non-elective and urgent care. Unlike the current system, funding frameworks will not favour elective care and procedural services to the detriment of urgent care, but will support hospitals and other care providers to prioritise the treatment of the most urgent care needs. This is fundamental to any system of care which puts patients’ needs first.

3.31 Care will be measured not via outputs or process-driven targets, but by the quality of patients’ experience of care, and by the clinical outcomes they achieve across the whole pathway of care. Effective collaboration will be incentivised across different care settings in the hospital and the community through common goals and shared outcomes which emphasise the efficacy and experience of care throughout the whole care pathway. Monitoring regimes will be centred around the factors that matter most to patients, and will be informed by what patients tell us about their experience of care.

4. What does this mean for patients?

4.1 Patients are at the very core of our vision. Indeed, every aspect of our vision has been crafted to reflect what evidence and patient feedback tell us will deliver better patient experience and better patient outcomes.

4.2 For most patients, our vision of the Future Hospital will mean fewer admissions, shorter stays, and a seamless experience of care between the community and the hospital ward. Whilst in hospital, patients will receive care that responds to their unique needs and which genuinely values patient experience as well as clinical effectiveness.

4.3 For patients with specialist needs or a rare condition: Patients who have a single clinical problem will receive an early assessment by the most appropriate specialist, enabling these patients to be fast-tracked to specialist care in the most appropriate setting. This could mean, for example, being admitted to a specialist ward directly from the community.

4.4 For older patients who are frail: Whilst some older people may have straightforward single clinical problems, many others have multiple, complex, interacting problems, with exacerbations of chronic conditions and an increased likelihood of comorbidities including dementia. When these patients arrive at the Future Hospital, they will receive a comprehensive geriatric assessment wherever possible – an approach which has been shown to increase the likelihood that patients will survive and move back to their own homes after leaving hospital. This assessment will lead to a multifaceted therapeutic plan to enhance recovery and promote independence, taking in to account each patient’s wider support needs beyond the hospital walls.

4.5 For patients with an urgent or emergency care need: These patients will be assessed in the Acute Care Hub, where they will receive early assessment by a senior clinician, followed by treatment which seeks to minimise the length of their inpatient stay and which plans from the outset to enable recovery and transfer of care back into the community. Consultant-led emergency and urgent care will be available seven days a week, supported by access to the diagnostic and support services necessary across the hospital and wider local health and care system.
Box 1: a patient’s perspective:

“I am delighted to read the recommendations from the Future Hospital Commission report Future Hospital: Caring for medical patients. This is a life changing initiative and one that puts patients at the centre. The vision of the future hospital created in this report commits to giving patients what they deserve - high quality care centred based on their needs, in the right place at the right time by compassionate, respectful and highly trained health professions. No more being moved beds multiple times during the night, not knowing where I am, what is happening to me or who is ultimately responsible for my care”

50-year-old patient with Systemic Lupus Erythematosus, Leeds

5. What might be some of the barriers to achieving our vision and how might these be overcome?

Existing monitoring and incentives system

5.1 Too often in the current system, process-driven targets designed to promote better care for patients can inadvertently create perverse incentives that produce undesirable consequences and reinforce a fragmented system of primary, secondary and social care.

5.2 For example, the achievement of the 4-hour wait standard for patients being admitted to hospital through emergency departments and the 18-week referral to definitive treatment standard remain key focus areas for hospital management teams, particularly as these measures are often used as key indicators of the success of a hospital. This can produce an overriding drive to move patients out of emergency departments and into any available bed. This may not be the most appropriate bed for their clinical needs, and often results in specialist opinion being delayed, ward procedures which are not best suited to the patient’s needs, and an increase in the length of inpatient stay (as well as the accompanying increased risks of frailty and hospital-acquired infection, for example). This further exacerbates pressure on the availability of hospital beds and, therefore, on the ability to move other patients out of the emergency department and into an appropriate bed. In turn, this can affect the availability of beds for non-elective surgical admissions and jeopardise the 18-week standard.

5.3 The Future Hospital will require, at the very least, a ‘whole-hospital’ approach to setting standards and measuring success, with a clear focus on patient outcomes rather than hospital process. This will enable teams to work collaboratively, across and beyond the hospital, in pursuit of shared, patient-centred outcomes. Ultimately, standards will be set, measured and incentivised across the system of care, and will be designed to reflect the importance of patient experience as well as clinical effectiveness.

Existing funding system

5.4 The focus on elective care within the current system has meant that not enough attention has been given to emergency care. Funding models which are structured around what happens in elective care do not work well for emergency care and, as a result, emergency care has effectively been chronically underfunded in relation to elective care. This means that we need to rebalance resource allocation to prioritise non-elective and urgent care and – to be sustainable – this will need to be accompanied by the development of new funding models that do not favour elective and procedural services at the expense of urgent care.

5.5 Different contexts, services and conditions require different payment approaches. For example, in England, Payment by Results (PbR) has been found to be more applicable to elective care and less suited to acute care or complex emergency patients with multiple conditions. This sort of payment system
tends to increase the fragmentation of care and increase costs. At hospital trust level, a mitigating measure could be to opt for a different apportionment of resources internally. Systems must also be flexible and adjusted in the light of experience of their impact, changing objectives according to the context in which they operate. Further developments in payment approaches will need to be supported by high-quality data and analysis in order to avoid a system that lacks compliance or which might generate unintended and unwanted consequences across different parts of the system.

5.6 Funding mechanisms need be tailored and flexible in response to the different types and combinations of care required by patients with different needs. Some current examples being developed in the NHS include the so-called Year of Care Funding Model which aims to deliver integrated health and social care for people with long-term conditions by providing budget based on each patient’s level of need over a period of 12 months. By contrast, the Pathway Funding Model sets prices in relation to a bundle of services covering an episode of care involving a number of providers (e.g. maternity pathway).

Changing the existing infrastructure

5.7 The current structures of the health and care system would need to be re-framed in order to deliver our vision of the Future Hospital. For example, the current purchaser-provider split in England has undermined more joined-up working between different parts of the health economy and reinforced silos across the system of care.

5.8 Structural changes will also need to occur in the acute landscape at local level. The creation of a comprehensive acute care hub may be difficult to achieve in units with a smaller staff base, and this could, therefore, result in a network of fewer, larger, acute centres. Furthermore, as a consequence of resources being diverted to non-elective work, capacity for elective and specialised services will diminish. This will reinforce the choice of operating a network of fewer sites, which in turn requires appropriate recognition of this new reality, along with the necessary planning, engagement and communication with staff and the public.

5.9 Change requires flexibility between and across organisations, staff teams and leaders in the health and care sectors. It should be built around clear communication with patients, the public and the healthcare workforce, making clear the imperative and rationale for reconfiguration and built around the authentic involvement of these groups. It requires strong clinical leadership, underpinned by meaningful public engagement.

Existing work patterns

5.10 Although illness can arise at any time, neither the hospital nor the primary care environment is at present configured to deliver effective, accessible patient care seven days per week. As a norm, rotas are designed on a five-day basis, as are the wider diagnostic and support services across the health economy.

5.11 To make the Future Hospital a reality, working patterns will need to be designed around a seven-day rota. This doesn’t mean that hospital staff will work a seven-day week, but that services will be designed to ensure that an appropriate consultant physician is on-site every day of the week, supported by a wider team and with access to the diagnostic and support services to enable early assessment and appropriate treatment. As well as enabling safe admission and treatment in hospital, this will also help enable patients to leave hospital as soon as they are well enough to do so – irrespective of the day of the week.

5.12 The new, flexible workforce will need to stretch, and go beyond, the traditional cultural boundaries of the medical profession. Physician specialists could use their expertise much more to maintain health,
as well as to treat those who are acutely sick. Joint teams of specialists and general practitioners could work together, in hospital and non-hospital sectors, around patient pathways and across specialties. This will imply re-defining identities, and adopted roles, as well as securing buy-in from commissioners, who might have different views on how effectively general practitioners and the acute sector in general can be coordinating the delivery of more integrated care.

**Informatics**

5.13 Clinical records should also be patient-focused, with inputs generated in partnership with patients and carers, and a single electronic patient record should be viewable in the hospital and in community care settings to ensure that all parts of the team supporting the patient has the information necessary to deliver high-quality, joined-up care. The individual patient must be the primary focus of every electronic patient record – not their disease, intervention or the context in which they are seen – and records should be validated by and accessible to patients. Data must be used in a way which values patient experience as well as clinical efficacy, driving up standards of both.

5.14 At present there is inadequate alignment between clinical data collection and its potential uses. Information generated through routine clinical activity is not harnessed appropriately and the precision and quality of recorded data are often not fit for purpose. In many organisations, and across different organisations, information about a single patient is held in multiple different systems and structures, using different definitions. As a result, multiple, separate and time-consuming data collection exercises are often undertaken for each patient, leading to inefficiency and errors.

5.15 To address the challenges these problems pose, systems for collecting, recording and accessing data should be electronic, using a standardised structure so that the same set of records can be accessed across different care settings. The RCP’s Health Informatics Unit has led the development of standards for the structure and content of clinical records, which were approved by 50 organisations representing healthcare professionals. These standards should be adopted as a requirement for the procurement of electronic health records.

**Social care capacity**

5.16 Our vision of coordinated care centred around patients’ needs is predicated on there being sufficient capacity and expertise in other parts of the health and care system. At present, social care in particular is facing considerable challenges including low workforce morale, very high caseloads and other service pressures resulting from increasing demand for their services alongside substantial reductions in funding to local authorities.

5.17 Effective, proactive and collaborative social care services are vital to the delivery of good quality patient care and patient experience. The system of care needs to be designed and resourced with a holistic perspective across different care settings and whole care pathways in a way which recognises how changes in one part of the system will impact on other parts of the system (e.g. see 5.1-5.6, above). Only through this coordinated approach can we ensure that social care capacity needs are identified and resourced appropriately.

6. **Where next?**

6.1 Our vision, and the Future Hospital Commission’s recommendations more broadly, are just the first steps in a longer programme of activity designed to achieve real change across hospitals and the wider
health and social care economy. Whilst setting out the vision is key, we recognise that it is through implementation in practice that the greatest impact can be achieved.

6.2 Through the NHS Futures Summit, and through the RCP’s wider programme of engagement with patients, staff and policy-makers across the system of care, these recommendations will be translated into practical action and progress towards our vision, starting with pilot sites where hospitals will be transforming their current practice to better meet the needs of their medical patients.

6.3 From further work that reflects the Francis Inquiry’s call for better standards of care, to ongoing work to enable the medical workforce to be trained and deployed in a way that is fit for the Future Hospital, the RCP will be working with national bodies, patients, healthcare staff, commissioners, providers and academic partners to develop and trial new approaches to care that put patients at their core.

6.4 Just some of the first steps we will take to make our vision a reality include:

- Identify pilot sites to develop and trial new ways of delivering patient care, supporting clinicians and managers to deliver local approaches tailored to local circumstances
- Work with academic partners to lead research and evaluation of implementation, enabling learning to be shared and standards improved across the system
- Continue engagement with patients, carers and staff across the system of care at every stage of the journey towards the Future Hospital, ensuring their voices and experience meaningfully shape implementation
- Work with partners across the system of care at both a local and national level to develop a clear route map to new structures and support mechanisms that will enable the Future Hospital to be delivered.

Box 2: a hospital Chief Executive’s perspective on implementation of the Future Hospital Commission recommendations:

“The Future Hospital Commission report provides critical recommendations for dignified, patient-centred medical services, with hospitals becoming hubs for integrated, whole-system care. It will further stimulate the debate on new, more sustainable, models of healthcare provision, but we urgently need to implement practical changes in the way we supply the most vital of services. The Future Hospital Commission is to be commended for producing guidance that is based on the best interest for patients and constructively challenges not only physicians, but also hospitals and the wider health system. We can and should take on these challenges but, if we are to succeed, we must create a narrative for medical staff and the public that builds support for both the changes themselves and for those that will arise as a consequence”
Dr Mark Newbold, Chief Executive, The Heart of England NHS Foundation Trust

6.5 We welcome readers’ views on our vision and what we can do to help ensure its realisation in practice. Please share your views, suggestions, questions and ideas by emailing futurehospital@rcplondon.ac.uk.