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The Future Hospital

caring for medical patients

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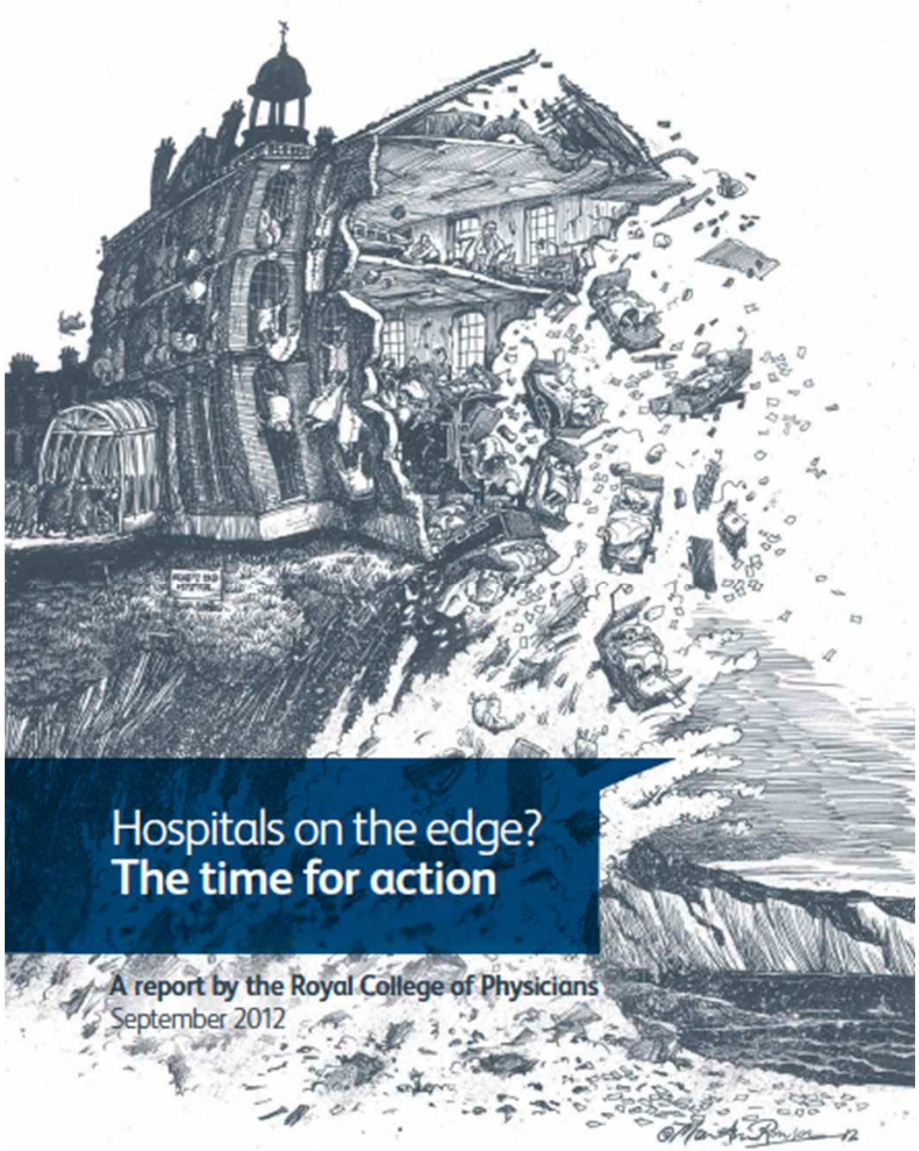
The UK's National Health Service

Principles (since 1948):

- Care that is "necessary and appropriate"
- Free at the point of need
- Funded from general taxation

Organisational network:

- Primary care (general practice/family medicine)
- Secondary care (outpatients and inpatients)
- Tertiary care (outpatients and inpatients)



Hospitals on the edge?
The time for action

A report by the Royal College of Physicians
September 2012

Hospitals on the Edge

1. Rising clinical demands
2. Changing patient needs
3. Fragmented clinical care
4. Breakdown in out-of-hours care
5. Medical workforce crisis

Rising clinical demand

1. 37% increase in emergency medical admissions (1987-2012)

2. 30% reduction in general and acute medical beds (1987-2012)

3. Hospitals have reduced the average length of stay for patients (<85 years)

4. But this has now flattened (2009-2012)

Changing patient needs

1. 65% of patients admitted to hospital are aged > 65 years old

2. 68% of patients admitted to hospital have two or more co-morbidities

3. An increasing number are frail and/or have a diagnosis dementia.

Fragmented clinical care

1. Lack of continuity of care

2. Not uncommon for patients, particularly older patients, to be moved 4-5 times during a hospital stay

3. Each ward move adds at least one day onto the length of stay

Breakdown in out-of-hours care

1. Patients admitted at weekends have 24% higher hospital mortality

2. An association between weekend mortality and weekend staffing ratios

3. Hospital activity at weekends is about 25% lower than the rest of the week (especially procedures and diagnostic tests).

Medical workforce crisis (1)

Recent surveys of senior staff show that (compared to 3 years ago):

- 75% feel under more pressure
- 59% are working more hours than three years ago.
- 48% spending less time with their trainees

Medical workforce crisis (2)

Surveys of trainees show that (compared to 3 years ago):

- Reduced working hours (EWT Directive) has seen moves to shift working
- Shift patterns decrease quality of life and training opportunities
- General medicine unpopular as a career


Future Hospital Commission
Future hospital:
Caring for medical patients
A report from the Future Hospital Commission to the Royal College of Physicians
September 2013

Future Hospital Commission

Membership included:

- Physicians (general and specialist)
- Trainee physicians (general and specialist)
- Surgeons
- General practitioners (family doctors)
- Patient representatives

Work streams

1. People
2. Place and Process
3. Data for Improvement
4. Planning and Infrastructure
5. Patients and Compassion

What does the report cover?

1. Organisation of medical care and teams
2. Education, training and deployment of medical staff
3. Building a culture of compassion and respect
4. Management, economics and leadership
5. Information systems

Proposals

1. Care is as important as treatment
2. A new model of care based on:
    - Division of Medicine
    - Chief of Medicine
    - Clinical Co-ordination Centre
    - Seven day working
3. All senior physicians should be trained in – *and practising* – general medicine
4. Integration of care – hospital and community
5. Consequential changes (IT, training, research)

Importance of Care

1. Fundamental standards must always be met.
2. Patient experience should be valued as much as clinical effectiveness.
3. Patients should have a care plan that reflects their needs
4. Patients should not move wards unless it is essential for clinical care.
5. Staff are supported delivering safe, effective and compassionate care

New model of care (1)

1. Individual patients' care coordinated by a single named senior physician
2. Input (as needed) from a range of specialist teams
2. All medical specialists undertake general medicine alongside their specialty
5. Hospital medical teams working in the community
6. Arrangements for patients leaving hospital that work on a 7-day basis.

New ways of working (2)

1. Named senior physician ultimately responsible for each individual patient
2. Doctors assume clinical leadership for safety, clinical outcomes and patient experience.
3. Consultant presence on wards over 7 days
4. Staff rotas designed on a 7-day basis.

New ways of working (3)

Medical Division – should be responsible for:

- Clinical care, management and budgets of all medical patients
- All specialty medical services
- Integrating care in the community (with GPs)
- Management of the Acute Care Hub

New ways of Working (4)

Chief of Medicine:

- Head of the Medical Division
- Reporting directly to the hospital's medical director
- Monitoring the workload and performance of all Divisional medical staff (seniors and trainees)
- Provided with appropriate support from
  - Acute care co-ordinator
  - Nursing and allied health professional staff
  - Chief clinical information officer
  - Director of medical education
  - Chief resident

New ways of working (4)

Chief resident:

- Senior medical trainee
- Providing liaison between medical trainees and the Chief of Medicine
- Planning trainees' deployment, rotas, workload, duties
- Contribute to trainees' educational programme
- Have allocated time to fulfill the role

New ways of working (6)

Seven day working requires:

- Senior staff present (and working) at weekends
- Trainees present (and working) at weekends
- Full laboratory and imaging services at weekends
- Discharge arrangements possible at the weekends (including social care and ambulances)

Generalists versus Specialists

1. In the UK some “specialists” commonly undertake general internal medicine:
   - Geriatricians
   - Cardiologists
   - Respiratory physicians
   - Clinical pharmacologists
2. Some “specialists” rarely undertake general medicine
   - Dermatologists
   - Neurologists
   - Medical oncologists

Specialists versus generalists

1. Specialists make very substantial contributions in their specialty
2. In future all medical specialists will combine their specialty with general internal medicine
3. All medical trainees will be dually trained in their specialty – and – in general internal medicine

Integrated care

1. Delivery of specialist and general medical care should not be confined to hospitals
2. Optimising care particularly for patients with long term conditions
3. Focus needed to be given to:
   - Early supportive discharge
   - Day case care
   - Nursing home care
   - Specialist clinics in the community
   - Preventing hospital admission

Consequential changes (1)

Information technology:

1. All clinical data should be recorded electronically
2. All clinical data should be recorded to national standards
3. Data in electronic health records (EHRs) to be validated by thr clinician and the patient
4. Interoperability of EHRs – between primary, secondary and tertiary care – essential.

Consequential changes (2)

Training:

1. All medical trainees to develop skills in general internal medicine (GIM) as well as in a specialty.
2. Better training modules for GIM need to be developed
3. Promote and develop GIM as a specialty of equal standing to all other medical specialties.
4. Appoint a Chief Resident in all acute hospitals

Consequential changes (3)

Research:

1. General internal medicine has its own research agenda
2. Time for research should be available in the work plans of all senior staff
3. Trainees should be encouraged to undertake primary and/or research
4. A Director of Research should be appointed by all acute hospitals

Implementation

1. Hospitals will implement the Commission's proposals in different ways and at varying speeds
2. The Report includes case studies of institutions where many aspects have already been piloted.
3. The *Future Hospital Journal* was launched this year.

Reactions?

Politicians?

- Plaudits from across the political spectrum

Healthcare managers?

- Enthusiasm

The professions?

- Mainly enthusiastic (surgeons, general practitioners)
- Some unease by some specialists

The professional press?

- The Lancet *"The Commission has produced the most important statement about the future of British medicine for a generation".*

The Lancet's Highlights (1-5)

1 Hospitals must offer *"seven-day care, delivered where patients need it".*

2 It's time to build a new movement for generalism, not specialism. "Generalists are the undervalued champions of the acute hospital service".

3 Hospitals need *"a single unified Medical Division…[with] clinical, managerial, and budgetary responsibility for all inpatient beds".*

4 A Chief of Medicine will lead the Division and will be responsible for monitoring performance, safety, and quality improvement.

5 A Chief Resident, a *"designated junior doctor"*, will assist and report to the Chief of Medicine, planning service delivery and redesign with a special emphasis on junior medical staff to continuously improve training.

The Lancet's Highlights (6-10)

6. Each hospital will have a Director of Medical Education
7. A new Director of Clinical Information will ensure that information, including patient-reported outcome measures, will be used to support care and measure success.
8. Technology—email, texts, and video conferencing—will be used to communicate between patient and doctor, support self-management for those with long-term conditions, and conduct virtual clinics and ward rounds.
9. An Executive Director for Research should be responsible for promoting research within each hospital
10. Finally, the hospital must tear down its walls: *"the concept of the hospital needs to change radically*", integrating the management of chronic disease with general practice in the community.