

Future Hospital Commission:

the time for action

Our hospitals are struggling to cope with the challenges of an ageing population, increasing hospital admissions, and a failure to provide coordinated, patient-centred care; added to a looming crisis in the medical workforce, and the need to find £20 billion efficiency savings by 2015. It is clear that radical steps need to be taken if we are to be able to provide high quality medical care.

In March 2012 the Royal College of Physicians established an independent Future Hospital Commission with the aim of addressing these challenges. The Commission, chaired by Sir Michael Rawlins, brought together patients and healthcare experts from many disciplines including general practice, to build a vision of what comprehensive high quality medical care for patients could look like. Its report *Future Hospital: Caring for Medical Patients*,¹ published on 12 September, sets out the Commission's vision for hospital services structured around the needs of patients, now and in the future. It focuses not only on the care of acutely ill medical patients, but also the organisation of general and elective medical services, and the role of physicians and doctors in training across the medical specialties in England and Wales. People's needs are often complex, and hospital services must be organised to respond to all aspects of physical health (including multiple acute and chronic conditions), mental health and wellbeing, and social and support needs. Importantly, the Commission decided its recommendations must be cost neutral, bearing in mind the need for financial stringency.

PRINCIPLES OF PATIENT CARE

The report envisions principles of patient care that place as much value on the experience and compassion as clinical effectiveness. They major on dignity, compassion, confidentiality, and privacy, food and nutrition, responsibility for care including a named consultant, transfer arrangements and care plans. Together, they underpin all the other recommendations in the report.

CREATING THE FUTURE HOSPITAL

The Commission also sets out a radical new model of care designed to encourage collective responsibility for the care of patients across professions and healthcare teams. It recommends new ways of

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working between hospital and community, supported by financial and management arrangements that give greater priority to caring for patients with urgent medical needs. This will mean aligning financial streams and incentives, both externally and internally, to ensure that acute services are appropriately supported, and set within a comprehensive healthcare system. Thus, care should come to patients and be coordinated around their medical and support needs, wherever they are, obviating the tendency for patients, particularly older people, to move beds several times during a single hospital stay. This is known to result in poor care, impaired patient experience and to increase length of stay. In the future hospital, moves between beds and wards will be minimised and only happen when necessary for clinical care. Delivery of specialist medical care, such as cardiology and neurology services, will not be limited to patients in specialist wards or to those who present at hospital. Specialist medical teams will work across the system 7 days a week.

The design and delivery of services will also consider the specific needs of older patients with cognitive impairment, and those known to have poor levels of access and outcomes, for example, those with mental health conditions and or who are homeless. To coordinate care, the Commission recommends that each hospital establish the following new structures.

Medical Division

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 (including surgical) wards. Medical teams across the Division will work together to meet the needs of patients, and coordinate care, including for those with complex conditions and multiple comorbidities. The Division will work closely with partners in primary, community, and social care services to deliver specialist medical services across the health economy.

Acute Care Hub

The Acute Care Hub will bring together the clinical areas of the Medical Division that focus on the initial assessment and stabilisation of acutely ill medical patients. These include the acute medical unit, ambulatory care centre, short-stay beds, intensive care unit and, depending on local circumstances, the emergency department. The Acute Care Hub will focus on patients likely to stay in hospital for less than 48 hours, and patients in need of enhanced, high dependency, or intensive care. An acute care coordinator will provide operational oversight to the Acute Care Hub, supported by a Clinical Coordination Centre, liaising with the community-based parts of the system as needed.

Clinical Coordination Centre

The Clinical Coordination Centre will be

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the operational command centre for the hospital site and Medical Division, including medical teams working into the community. It 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, and coordinate staff and services so that they can be met. In the longer-term, this would evolve to include information from primary and community care, mental health, and social care. This information would be held in a single electronic patient record, developed to common standards.

SEVEN-DAY CARE, DELIVERED WHERE PATIENTS NEED IT

We must bring the advances in medical care to all patients, whenever they need it, whatever their additional needs and wherever they are in hospital or the community. This means specialist medical teams will work, not only in specialist wards, but across the hospital. Care for patients with multiple conditions will be coordinated by a single named consultant, with input from a range of specialist teams when their clinical needs require it. The remit and capacity of medical teams will extend to adult inpatients with medical problems across the hospital, including those on 'non-medical' wards (such as surgical patients).

Once admitted to hospital, patients will not move beds unless their clinical needs demand it. They will receive a single initial assessment and ongoing care by a single team. In order to achieve this, care will be organised so that patients are reviewed by a senior doctor as soon as possible after arriving at hospital. Specialist medical teams will work together with emergency and acute medicine consultants to diagnose patients swiftly, allow them to leave hospital if they do not need to be admitted, and plan the most appropriate care pathway if they do. Patients whose needs would best be met on a specialist ward will be identified swiftly so that they can be 'fast-tracked'; in some cases directly from the community, bypassing accident and emergency.

For many patients with chronic conditions, acute exacerbations are common. Ongoing monitoring and care provided by primary care and specialist medical teams seek to reduce the frequency and acuity of these acute exacerbations. For these patients, the Medical Division of the future hospital will need to facilitate community access to the specialist teams to support patient-centred management. Therefore the

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specialties will support, 7 days a week, community services for home-based or self-management of chronic conditions, rapid access 'hot' clinics or 'frailty' units for immediate investigation and review, including exclusion of conditions, fast track pathways for proven intervention and aftercare services, and in-reach services to all medical wards including the Acute Care Hub for agreed pathways. The concept of discharge will therefore go: patients will be cared for in different parts of the integrated healthcare system.

We know it will be difficult to deliver such radical change, and the way hospitals implement the proposals will depend on local circumstances, size and staffing. However, we must show leadership in redeveloping services without boundaries across primary, secondary and community care, to deliver the seamless high quality medical care that our patients deserve.

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Provenance

Commissioned; not externally peer reviewed.

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REFERENCE

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.