Future Hospital Commission

Future hospital: Caring for medical patients

Executive summary and full recommendations

September 2013

Executive summary and recommendations

'The patient must be the first priority in all of what the NHS does. Within available resources they must receive effective services from caring compassionate and committed staff working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.'

(Robert Francis QC)[1]

'Patient safety should be the ever-present concern of every person working in or affecting NHS-funded care. The quality of patient care should come before all other considerations in leadership and conduct of the NHS, and patient safety is the keystone dimension of quality.'

(Don Berwick, 2013)[2]

This is the executive summary, the vision, principles and recommendations of *Future hospital: caring for medical patients*,[3] published in September 2013.

Executive summary

In March 2012 the Royal College of Physicians (RCP) established the Future Hospital Commission. *Future hospital: caring for medical patients*[3] 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.

Future hospital: caring for medical patients focuses on the care of acutely ill medical patients, the organisation of medical services, and the role of physicians and doctors in training across the medical specialties in England and Wales. However, 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 well-being, and social and support needs.

The report's recommendations are centred on the need to design hospital services based on the needs of patients, and that deliver:

1 safe, effective and compassionate medical care for all who need it as hospital inpatients
2 high-quality care sustainable 24 hours a day, 7 days a week
3 continuity of care as the norm, with seamless care for all patients
4 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
5 effective relationships between medical and other health and social care teams
6 an appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs
7 transfer of care arrangements that realistically allocate responsibility for further action when patients move from one care setting to another.

Care, treatment and support services need to be delivered in a range of ways, across a range of settings and by a range of professionals, all working in collaboration. 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.

Patients have been involved across the breadth of the Future Hospital Commission's work, informing and developing its recommendations. Experts from across health and social care have also participated in developing this vision for the future hospital. It was clear from patients and existing examples of good practice that hospital services in the future should be designed around 11 core principles.

In the hospital of the future:

1 Fundamental standards of care must always be met.[1]
2 Patient experience is valued as much as clinical effectiveness.
3 Responsibility for each patient's care is clear and communicated.
4 Patients have effective and timely access to care, including appointments, tests, treatment and moves out of hospital.
5 Patients do not move wards unless this is necessary for their clinical care.
6 Robust arrangements for transferring of care are in place.
7 Good communication with and about patients is the norm.
8 Care is designed to facilitate self-care and health promotion.
9 Services are tailored to meet the needs of individual patients, including vulnerable patients.
10 All patients have a care plan that reflects their individual clinical and support needs.
11 Staff are supported to deliver safe, compassionate care, and committed to improving quality.

Future hospital: caring for medical patients sets out a vision for collaborative, coordinated and patient-centred care. Achieving this vision will require radical changes to the structure of our hospitals and ways of working for staff. The recommendations in the report must be the first step in a longer programme of activity designed to achieve real change across hospitals and the wider health and social care economy.

The case for change

> *'Continuity of care cannot be achieved without fundamental change in the way that the NHS as a whole thinks about the role and priorities of the Acute General Hospital and how it is run.'*
>
> (King's Fund)[4]

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 in our hospitals every day. However, recent reports of the care – or lack of care – received by some patients in our hospitals makes harrowing reading.[1,5–9]

Our hospitals are struggling to cope with the challenge of an ageing population and increasing hospital admissions. All too often our most vulnerable patients – those who are old, who are frail or who have dementia – are failed by a system ill-equipped and seemingly unwilling to meet their needs. The Royal College of Physician's report *Hospitals on the edge?*[10] set out the magnitude and complexity of the challenges facing healthcare staff and the hospitals in which they work – and the potentially catastrophic impact this can have on patient care. It described:

1 a health system ill-equipped to cope with the needs of an aging population with increasingly complex clinical, care and support needs
2 hospitals struggling to cope with an increase in clinical demand
3 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
4 services that struggle to deliver high-quality services across 7 days, particularly at weekends
5 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.[10]

The need for change is clear. The time has come to take action. Those working in the NHS have a responsibility to lead this change, supported by the organisations that represent them and empowered by national policy-makers. Organisations and professionals involved in health and social care – including doctors, nurses, politicians, hospitals and national bodies – must be prepared to make difficult decisions and implement radical change where this will improve patient care.

It was against this backdrop that the RCP established the Future Hospital Commission, an independent group tasked with identifying how hospital services can adapt to meet the needs of patients, now and in the future. Its report, *Future hospital: caring for medical patients*, sets out this vision.

Creating the future hospital

'I don't want to be passed round the wards: I'm a person, not a parcel.'
(Patient, Royal College of Physicians' Patient and Carer Network)

1 A new principle of care

The Future Hospital Commission 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 working across the hospital and between hospital and the 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.

Care should come to patients and be coordinated around their medical and support needs. However, it is not unusual for patients – particularly older people[4] – to move beds several times during a single hospital stay. This results in poor care, poor patient experience and increases length of stay. In the future hospital, moves between beds and wards will be minimised and only happen when this is 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 whole hospital and out into the community across 7 days.

Effective care for older patients with dementia will help set a standard of care of universal relevance to vulnerable adults. The design and delivery of services will also consider the specific needs of the most vulnerable patients and those known to have poorer levels of access and outcomes, eg patients with mental health conditions and patients who are homeless.

2 A new model of care

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

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 interests of patients.

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, 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 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.

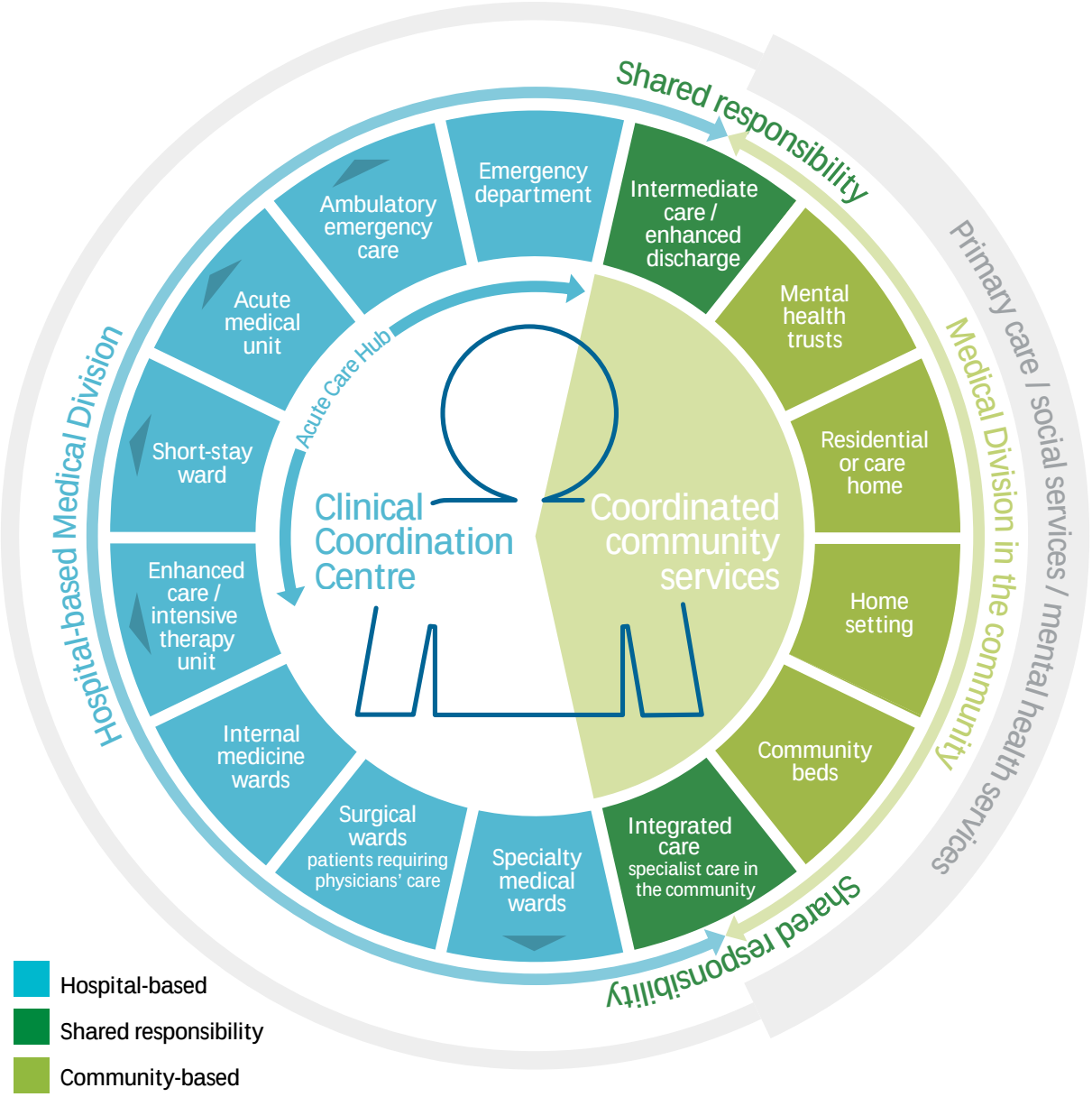
Clinical Coordination Centre

The Clinical Coordination Centre will be 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.

Further detail about these new structures is in chapter 3 of the main report.[3]

3 Seven-day care, delivered where patients need it

Advances in medical science mean that outcomes for many patients with a single medical condition have never been better. However, an increasing number of patients present at hospital, not with a single medical problem, but with multiple illnesses and a range of support needs due to conditions like dementia. Our hospitals are often ill-equipped to care for these patients.



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

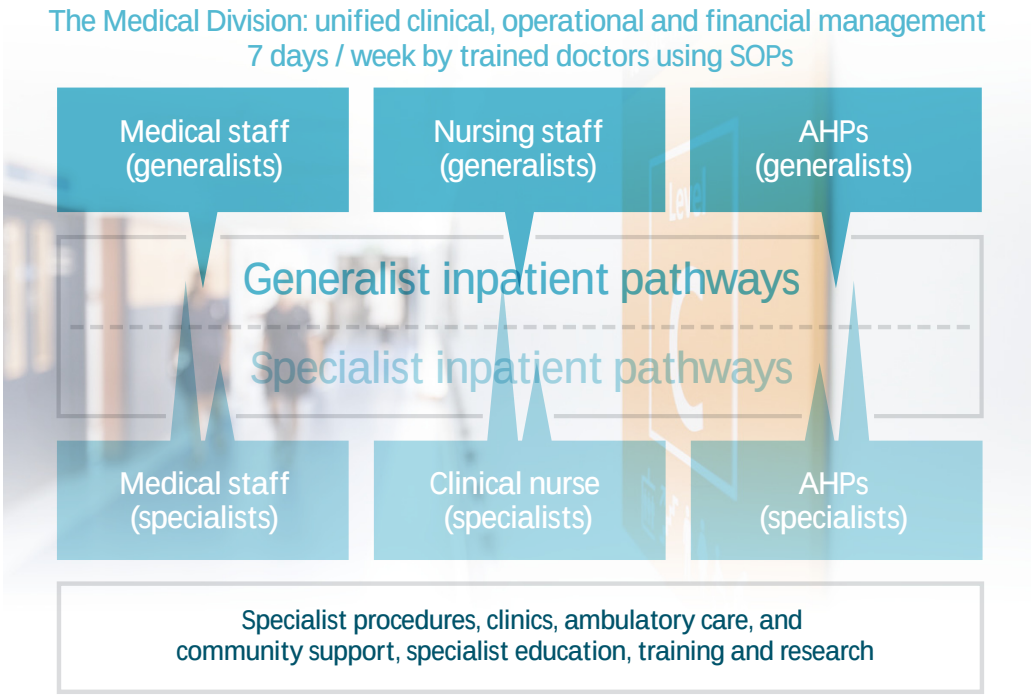
Directional arrows (in the hospital-based Medical Division) denote areas of the future hospital where patients may be referred on to tertiary specialist care.

We must bring the advances in medical care to *all* patients, 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 patients' 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 (eg surgical patients).

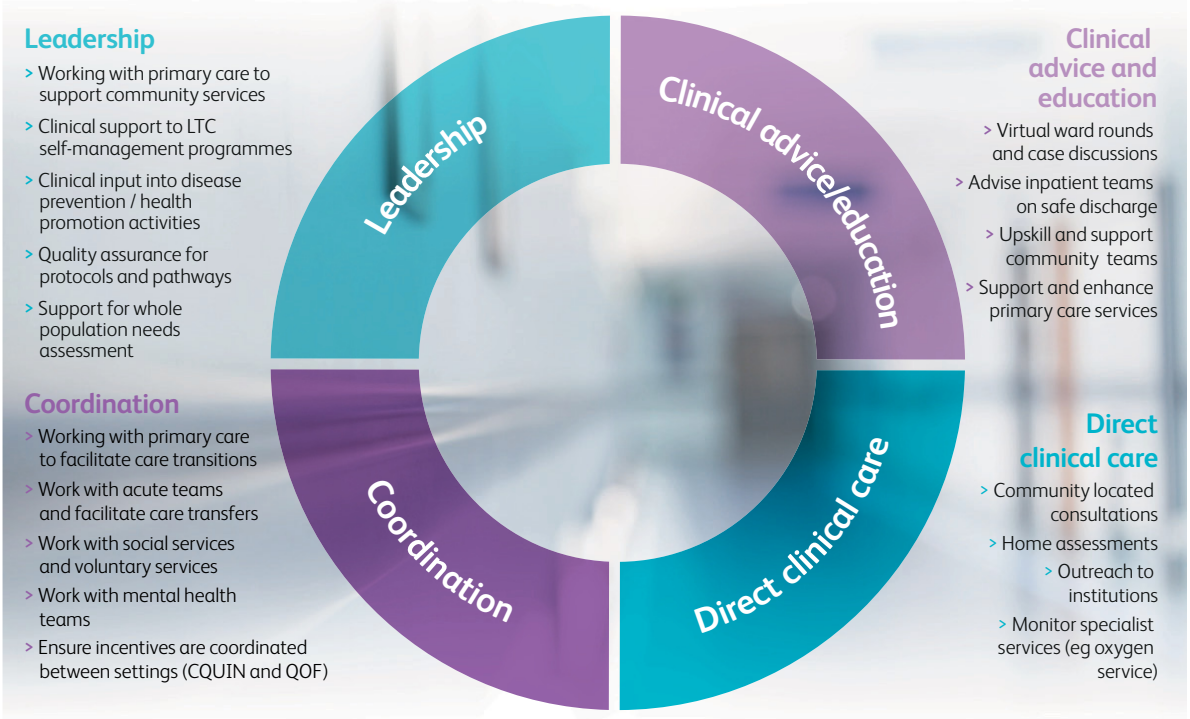
Once admitted to hospital, patients will not move beds unless their clinical needs demand it. Patients should receive a single initial assessment and ongoing care by a single team. In order to achieve this, care will be organised so that patients are reviewed by a senior doctor as soon as possible after 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.

When a patient is cared for by a new team or moved to a new setting, there will be rigorous arrangements for transferring their care (through 'handover'). This process will be prioritised by staff and supported by information captured in an electronic patient record that contains high-quality information about patients' clinical and care needs.

Specialist medical care will not be confined to inside the hospital walls. Medical teams will work closely with GPs and those working in social care to make sure that patients have swift access to specialist care when they need it, wherever they need it. Much specialised care will be delivered in or close to the patient's home. Physicians and specialist medical teams will expect to spend part of their time working in the community, with a particular focus on caring for patients with long-term conditions and preventing crises.



Generalist and specialist care in the future hospital. Generalist care includes acute medicine, internal medicine, enhanced care and intensive care (excluding child health, obstetrics). Specialist components of care will be delivered by a specialist team who may also contribute to generalist care.
AHP = allied health professional; SOP = standard operating procedure.



Integrated care in practice: extended roles for physicians in the community.
CQIN = Commissioning for Quality and Innovation; LTC = long-term conditions; MDT = multidisciplinary team; QOF = quality outcome framework.

To support this way of working, the performance of specialist medical teams will be assessed according to how well they meet the needs of patients with specified conditions across the hospital and health economy, not just those located on specialist wards.

Acutely ill medical patients in hospital should have the same access to medical care on the weekend as on a week day. Services should be organised so that clinical staff and diagnostic and support services are readily available on a 7-day basis. The level of care available in hospitals must reflect a patient's severity of illness. In order to meet the increasingly complex needs of patients – including those who have dementia or are frail – there will be more beds with access to higher intensity care, including nursing numbers that match patient requirements.

There will be a consultant presence on wards over 7 days, with ward care prioritised in doctors' job plans. Where possible, patients will spend their time in hospital under the care of a single consultant-led team. Rotas for staff will be designed on a 7-day basis, and coordinated so that medical teams work together as a team from one day to the next.

Care for patients should focus on their recovery and enabling them to leave hospital as soon as their clinical needs allow. This will be planned from when the patient is admitted to hospital and reviewed throughout their hospital stay. Arrangements for patients leaving hospital will operate on a 7-day basis. Health and social care services in the community will be organised and integrated to enable patients to move out of hospital on the day they no longer require an acute hospital bed.

Patients can be empowered to prevent and recover from ill health through effective communication, shared decision-making and self-management. Clinicians and patients will work together to select tests, treatments or management plans based on clinical evidence and the patient's informed preferences.

Patients should only be admitted to hospital if their clinical needs require it. For many, admission to hospital is the most effective way to set them on the road to recovery. However, it can be disorientating and disruptive. In the future, hospitals will promote ways of working that allow emergency patients to leave hospital on the same day, with medical support provided outside hospital if they need it.

Doctors will assume clinical leadership for safety, clinical outcomes and patient experience. This includes responsibility to raise questions and take action when there are concerns about care standards, and collaborate with other teams and professions to make sure that patients receive effective care throughout the hospital and wider health and care system.

There will always be a named consultant responsible for the standard of care delivered to each patient. Patients will know who is responsible for their care and how they can be contacted. The consultant will be in charge of coordinating care for all patients on the ward, supported by a team. The consultant and ward manager will assume joint responsibility for ensuring that basic standards of care are delivered, and that patients are treated with dignity and respect. Nurse leadership and the role of the ward manager will be developed and promoted.

There will be mechanisms for measuring patients' experience of care. This information will be used by hospitals, clinical teams and clinicians to reflect on their practice and drive improvement. A Citzenship Charter that puts the patient at the centre of everything the hospital does should be developed with patients, staff and managers. This should be based on the NHS Constitution and embed in practice the principles of care set out by the Future Hospital Commission.

4 Education, training and deployment of doctors

Medical education and training will develop doctors with the knowledge and skills to manage the current and future demographic of patients. We need a cadre of doctors with the knowledge and expertise necessary to diagnose, manage and coordinate continuing care for the increasing number of patients with multiple and complex conditions. This includes the expertise to manage older patients with frailty and dementia. Across the overall physician workforce there will be the skills mix to deliver appropriate:

1 specialistion of care – access to sufficient specialty expertise to deliver diagnosis, treatment and care appropriate to the specific hospital setting
2 intensity of care – access to sufficient expertise to manage, coordinate and deliver enhanced care to patients with critical illness
3 coordination of care – access to sufficient expertise to coordinate care for patients with complex and multiple comorbidity.

In order to achieve the mix of skills that delivers for patients, a greater proportion of doctors will be trained and deployed to deliver expert (general) internal medicine care. The importance of acute and (general) internal medicine must be emphasised from undergraduate training onwards, participation in (general) internal medicine training will be mandatory for those training in all medical specialties, and a more structured training programme for (general) internal medicine will be developed.

The contribution of medical registrars will be valued and supported by increased participation in acute services and ward-level care across all medical trainees and consultants, and enhanced consultant presence across 7 days.

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Future hospital principles, vision, recommendations and commitments to patients

Principles underpinning the future hospital

Principles for patient care

Hospitals and health professionals must provide patients with high-quality, compassionate care that meets their clinical and support needs. To achieve this, hospitals and other health services must in the future be designed around 11 principles of care. These principles are at the core of the Future Hospital Commission's work and underpin each of the recommendations in *Future hospital: caring for medical patients*.[1]

Care for patients – core principles

1 Fundamental standards of care must always be met[2]

Patients must:

i be treated with kindness, respect and dignity, respecting privacy and confidentiality
ii receive physical comfort including effective pain management
iii receive proper food and nutrition and appropriate help with activities of daily living
iv be in clean and comfortable surroundings
v receive emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on themselves, their families and their finances.

2 Patient experience is valued as much as clinical effectiveness

Patient experience must be valued as much as clinical effectiveness. Patient experience must be measured, fed back to ward and board level and the findings acted on.

3 Responsibility for each patient's care is clear and communicated

There must be clear and communicated lines of responsibility for each patient's care, led by a named consultant working with a (nurse) ward manager. Consultants may fill this role for a period of time on a rotating basis.

4 Patients have effective and timely access to care

Time waiting for appointments, tests, hospital admission and moves out of hospital is minimised.

5 Patients do not move wards unless this is necessary for their clinical care

Patients should not move wards unless this is necessary for their clinical care. Care, including the professionals that deliver it, should come to patients.

6 Robust arrangements for transferring of care are in place

There must be robust arrangements for the transfer of care:

i between teams when a patient moves within the hospital
ii between teams when staff shifts change
iii between the hospital and the community.

7 Good communication with and about patients is the norm
Communication with patients is a fundamental element of medical professionalism. There must be good communication with and about the patient, with appropriate sharing of information with relatives and carers. Medical and other staff must be trained in communication with patients and their families, including diagnosis and management of dementia and delirium.

8 Care is designed to facilitate self-care and health promotion
Working with, and empowering, patients is a fundamental aspect of medical professionalism. Shared decision-making should be the norm. Patients should have access to information, expert advice and education concerning their clinical status, progress and prognosis. Care should be designed to facilitate autonomy, self-care and health promotion. Medical staff must acquire skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk).

9 Services are tailored to meet the needs of individual patients, including vulnerable patients
Services must be tailored to the needs of individual patients, including older patients who are frail, patients with cognitive impairment, patients with sensory impairments, young people, patients who are homeless and patients who have mental health conditions. The physical environment should be suitable for all patients (eg those with dementia). Services will be culturally sensitive and responsive to multiple support needs.

10 All patients have a care plan that reflects their specific clinical and support needs
Patients must be involved in planning for their care. Patients' care preferences are checked and measures taken to optimise symptom management. Patients and their families must be supported in a manner that enhances dignity and comfort, including for patients in the remaining days of life.

11 Staff are supported to deliver safe, compassionate care and are committed to improving quality
Hospitals will support staff to collectively and individually take ownership of the care of individual patients and their own contribution to the overall standard of care delivered in the health system in which they work. Doctors will be supported to embed the principles of medical professionalism in their practice. Staff well-being and engagement will be a priority, in order to promote good outcomes for patients.

Responsibilities for the care of patients must extend beyond traditional ward or team boundaries. Hospitals should look to develop and promote a 'citizenship charter' based on the NHS Constitution, the principles of care articulated by the Future Hospital Commission (above), and the 'Commitments to patients' set out at the end of this document. This should be developed in collaboration with staff, senior managers, hospital chairs and boards, patients and carers, and the wider community.

Principles of medical professionalism

Doctors must expect to provide clinical leadership for the whole care of the patient, working individually and at the system level. All physicians should feel responsible for the quality of basic care provided to patients, and take action whenever they become aware of this being inadequate, regardless of whether the patient is 'under their care' or not. This is at the heart of medical professionalism.

Medical professionalism – core principles and values[3]

1 Medicine is a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This aim is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability. Doctors are committed to:

i integrity
ii compassion
iii altruism
iv continuous improvement
v excellence
vi working in partnership with members of the wider healthcare team.

2 Professional values must express the need:

i for clinical leadership for the whole care of the patient, working at direct patient care and at system level to organise care for all patients. The 'whole care of patients' covers the care patients receive across specialties, across settings and all domains of quality (eg safety, outcomes and experience). This includes responsibility to raise questions and take actions when they have concerns about care standards.
ii to communicate effectively with patients, their families and carers. Medical and other staff must be trained in communication methods with patients and their families, including the diagnosis and management of dementia and delirium.
iii to empower patients through effective collaboration. Medical staff must acquire skills for shared decision-making and encouraging better self-management by patients (eg motivational interviewing techniques, explanation of risk).
iv to collaborate with other teams and professions. Medical staff have a responsibility to communicate and collaborate with other teams and professionals to make sure patients receive smooth and effective care throughout the health and social care system.

The Commission's vision for the future hospital

The Future Hospital Commission aims to develop a new model of care that delivers safe, high-quality care for patients across 7 days. In the future, hospital services must be designed to deliver continuity of care as the norm for all patients, including those with multiple and complex conditions. This means delivering specialist and general medical care that is coordinated to meet the clinical, care and support needs of all patients, with clear arrangements for providing ongoing care for patients when they need to move from one place of care to another, including when they leave hospital.

Evolution to this new model of care will involve a range of changes to the way we plan, design, deliver and support hospital services. The focus must be on how hospitals and professionals can build a patient-centred culture in which all are treated with compassion and respect. Current and future patient needs must underpin all aspects of service design: from the way medical professionals train and work, to how information is gathered, used and shared; from managerial and financial structures, to the way staff are supported to deliver the standard of care all patients deserve.

The Commission's overarching vision for the future hospital articulates key components of hospital services in the future.

A new model of clinical care

1 **Hospital services that operate across the health economy:** Hospitals will be responsible for delivering specialist medical services (including internal medicine) for patients across the health economy, not only for patients that present to the hospital. Integrated working, shared outcomes and real-time communication of information with health and social care partners across traditional hospital and community boundaries will be the norm.

2 **Seven-day services in hospital:** Acutely ill patients in hospital will have the same access to medical care on Saturdays, Sundays and bank holidays as on a week day. Services will be organised so that consultant review, clinical staff (eg allied health professionals and specialist nurses), and diagnostic and support services are readily available on a 7-day basis.

3 **Seven-day services in the community:** Health and social care services in the community will be organised and integrated to enable patients to move out of hospital on the day they no longer require an acute hospital bed. Hospital procedures for transferring patient care to a new setting operate on a 7-day basis, with 7-day support from services in the community.

4 **Continuity of care as the norm:** Care will be organised to maximise the continuity of care provided by the individual consultant physician and key members of clinical team, with staff rotas organised to deliver this. Once assessed in hospital, patients will not move beds unless their clinical needs demand it. When a patient is cared for by a new team or in a new setting, arrangements for transferring care (through handover) will be prioritised by staff supported by direct contact between staff and information captured in the electronic patient record. Physicians will provide continuity not only during the hospital admission, but also embed this into follow-up consultations and arrangements.

5 **Stable medical teams in all acute and ward settings, focused on the whole care of patients:** A greater number of medical and non-medical staff (including consultant physicians and trainees) will participate in the provision of acute services and general ward care, ensuring a balanced workload across medical services and career grades. There will be a consultant presence on wards over 7 days, with ward care prioritised in medical job plans. This will be supported by a longer-term programme to promote internal medicine and increase internal medicine skills and deployment across the medical workforce.

6 **Access to coordinated specialist care for all patients:** Patients will receive the best specialist care wherever they are in hospital. For patients with multiple and/or complex conditions, there will be input from a range of specialist teams according to clinical need, with a single named consultant responsible for coordinating care. Care will be organised so that there are clear arrangements for the delivery of specialty-specific care to patients wherever they are in hospital, with criteria that allow easy, rapid identification of patients requiring specialist care. Performance of specialist medical teams will be assessed according to how well they meet the needs of patients with specified condition/s across the hospital and health economy.

7 **Early senior review across medical specialties:** Patients will have access to early consultant review, which has been shown to improve outcomes for patients. This will include early senior review by specialist teams at 'the front door'. This will help prevent delays in obtaining specialist medical review in patients with conditions known to benefit such a review 7 days a week. For example, older patients with multiple comorbidities presenting as a medical emergency will have early access to comprehensive geriatric assessment, which is known to improve experience, outcomes and efficiency.

8 **Intensity of care that meets patients' clinical and support needs:** The level of care available in hospitals will reflect the acuity and complexity of illness experienced by the current demographic of patients. There will be more enhanced care beds (level 1) relative to acute medical beds (level 0). Nurse staff ratios will match patient requirements for higher intensity monitoring and treatment, including for those with cognitive impairment and/ or frailty.

9 **Medical support for all hospital inpatients:** 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. There will be 'buddy' arrangements between consultant physician teams and designated surgical wards to ensure reliable access to a consultant physician opinion 7 days a week.

10 **Focus on alternatives to acute admission and supporting patients to leave hospital:** Care will be organised so that ambulatory ('day case') emergency care is the default position for emergency patients, unless their clinical needs require admission. Systems will ensure ambulatory care patients continue to receive prompt specialist care aligned to their needs, maximising alternatives to acute hospital admission, and improving safety, outcomes and experience of patients. Early senior assessment will support a focus on advanced care planning, with planning for recovery / movement out of hospital starting from the point of first assessment.

11 **Care delivered by specialist medical teams in community settings:** Much specialised care will be delivered in or close to the patient's home. Physicians and specialist medical teams will expect to spend part of their time working in the community, providing care integrated with primary, community and social care services with a particular focus on optimising the care of patients with long-term conditions and preventing crises.

12 **Holistic care for vulnerable patients:** There will be high-quality, seamless care for patients with dementia. Effective care for this group of patients will help set a standard of care of universal relevance to vulnerable adults. The design and delivery of services will also consider the specific needs of the most vulnerable patients and those known to have poorer levels of access and outcomes, eg patients with mental health conditions and patients who are homeless. The provision of holistic care that meets patients' needs should be the responsibility of all staff. This will be embedded in a hospital-level citizenship charter, based on the NHS Constitution.

Evolution to the future hospital vision of care

13 **The medical workforce meets the needs of patients across the system:** Medical education and training will develop doctors with the knowledge and skills to manage the current and future demographic of patients. This includes the expertise to manage older patients with frailty and dementia, and lead and coordinate the 'whole care' of patients in hospital and into the community. Across the overall physician

workforce there will be the skills mix to deliver appropriate: specialisation of care (ie access to sufficient specialty expertise to deliver diagnosis, treatment and care appropriate to the specific hospital setting); intensity of care (ie access to sufficient expertise to manage, coordinate and deliver enhanced care to patients with critical illness); and coordination of care (ie access to sufficient expertise to coordinate care for patients with complex and multiple comorbidity). Most physicians, whatever their specialty, will possess and deploy a combination of these skills across their careers.

14 **Internal medicine is valued and promoted:** The importance of acute and (general) internal medicine is emphasised from undergraduate training onwards, and acute and (general) internal medicine is attractive to doctors at all stages of their careers. A greater proportion of doctors are trained and deployed to deliver expert (general) internal medicine care, developing the knowledge and expertise necessary to diagnosis, manage and coordinate continuing care for the increasing number of patients with multiple and complex conditions. The contribution of medical registrars is valued, and they are supported by structured training in (general) internal medicine, increased participation in acute services and ward-level care by all medical trainees and consultants, and enhanced consultant presence across 7 days.

15 **Clinical workloads are regularly reviewed:** Workforce planning is undertaken with an appreciation of clinical demand and the professional skills mix required to meet this demand. Attention is paid to variation in demand and peak time of day to ensure staffing can adequately meet the demand. The organisation of workloads and allocation of tasks is underpinned by a clear understanding of professional roles and responsibilities.

16 **Non-elective medical care is prioritised:** Management structures, financial models and leadership roles will be designed to support and enhance the delivery of high-quality non-elective and urgent care, and embed strong clinical leadership.

17 **Information is used to support care and measure success:** Clinical records will be patient-focused and contain accurate, high-quality information on patients' clinical and care needs. Information will be held in a single electronic patient record, developed to common standards and viewable in both the hospital and community in order to support the coordination of care.

18 **Hospitals and the healthcare system are innovative and research-driven:** Research – and staff involvement in research – is valued and supported at the highest level in the hospital, and the opportunity to participate is promoted to patients.

19 **Fundamental standards of patient care will always be met:** The principles of basic patient care will underpin the design and delivery of all hospital services and professional practice. Patients will always:

i be treated with kindness, respect and dignity, respecting privacy and confidentiality
ii receive physical comfort including effective pain management
iii receive proper food and nutrition and appropriate help with activities of daily living
iv be in clean and comfortable surroundings
v receive emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on themselves, their families and their finances.

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

20 **A patient-centred culture will operate, delivering compassion and respect for all patients:** Hospital services and professional practice will be based around ten core principles:

i **Patient experience is valued as much as clinical effectiveness.** Patient experience is measured, fed back to ward and board level and findings acted on.
ii **Responsibility for each patient's care is clear and communicated.** This is led by a named consultant working with a (nurse) ward manager.
iii **Patients will have effective and timely access to care.** Time waiting for appointments, tests, hospital admission and move from hospital will be minimised.
iv **Patients will not move wards unless this is necessary for their clinical care.** Care, including the professionals who deliver it, will come to patients.
v **Robust arrangements for transfers of care will be in place.** These arrangements will operate between teams when a patient moves within the hospital, between teams when staff shifts change, and between the hospital and the community.
vi **Good communication with and about patients will be the norm.** This will include appropriate sharing of information with relatives and carers.
vii **Care will be designed to facilitate self-care and health promotion.** Patients will have access to information, expert advice and education, and will be empowered to manage their care by trained staff.
viii **Services will be tailored to meet the needs of individual patients, including vulnerable patients.** The physical environment will be suitable for all patients (eg those with dementia); services will be culturally sensitive and responsive to multiple support needs.
ix **All patients will have a care plan that reflects their specific clinical and support needs.** Patients will be involved in planning their care. Patients, their families and carers will be supported by expert staff in a manner that enhances dignity and comfort.
x **Staff will be supported to deliver safe, compassionate care and will be committed to improving quality.** Hospitals will support staff to take individual and collective ownership of the care of individual patients and their contribution to the overall standard of care delivered in the health system in which they work.

21 **Doctors will embed the principles of medical professionalism in their daily practice:** Medical professionals are committed to integrity, compassion, altruism, continuous improvement, excellence and working in partnership with members of the wider healthcare team (RCP's *Doctors in society*, 2005). Doctors assume clinical leadership (at individual patient and system level) for the care patients receive across specialties, across settings and across all domains of quality, eg safety, clinical outcomes and patient experience. This includes responsibility to raise questions and take action when there are concerns about care standards; communicate effectively with patients, their families and carers, and empower them through effective collaboration; and collaborate with other teams and professions to make sure patients receive smooth and effective care throughout the health and social care system.

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.

What's next?

'We need to take responsibility for every patient that comes through the hospital door. Consultants need to reclaim responsibility for all aspects of medical care, whatever their specialty.'

(Hospital consultant)

The Future Hospital Commission was established by the RCP in March 2012. *Future hospital: caring for medical patients*[1] is a report from the chair of the Future Hospital Commission, Professor Sir Michael Rawlins, to the RCP. The RCP is an independent body representing 28,500 fellows and members, mostly doctors working in the UK's hospitals. The RCP will respond to the report in autumn 2013.

The Future Hospital Commission's recommendations are just the first step in a longer programme of activity designed to achieve real change across hospitals and the wider health and social care economy in which they operate. In its response to the Commission's report, the RCP will set out how it will take this work forward and continue to drive improvement in hospital services across England and Wales.

You can inform the RCP's response and next stage work by sending us your comments, ideas and examples of good practice. On the RCP website, you can read about existing examples of innovative practice and listen to doctors talking about how they achieved change in their hospital.

Get involved

To get involved in the ongoing debate and help shape the future of our hospitals:

Visit the website: www.rcplondon.ac.uk/futurehospital

Or send an email: futurehospital@rcplondon.ac.uk

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