THE FUTURE HOSPITAL – IMPLICATIONS FOR ACUTE MEDICINE

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Acute care toolkit 9: Sepsis September 2014

Staff working in acute medical units (AMUs) should be familiar with the significant morbidity and mortality associated with sepsis. The AMU should provide a key role in identifying patients with sepsis, stratifying risk, determining appropriate levels of care, and continuing the resuscitation of patients identified with sepsis prior to AMU admission. Sepsis responds well to early intervention and, if required, rapid escalation of therapy. All staff working in AMUs need to possess the knowledge and skills to identify sepsis and initiate resuscitation if appropriate.

Acute care toolkit 10: Ambulatory emergency care October 2014

Across the UK, emergency systems are under considerable pressure, with emergency department (ED) attendances and the conversion rate to hospital admission both rising. Some clinical teams across England have recognised that a new approach is needed, and have successfully redesigned their systems to manage demand by implementing ambulatory emergency care (AEC) as part of the solution. AEC has the potential to have a similar impact on emergency care as day surgery has had on planned care.
Context for FHC

65% increase admissions age >75
Age >65 = 70% of bed days
25% of all in patients have dementia

[31% age 18-59]
LOS age > 85 4x that of <65
RCP Health Bill survey
All members & fellows - March 2012

Top 5 Concerns:
1. Lack continuity of care
2. Efficiency savings/funding
3. Clinical staff shortages
4. Health reforms
5. Education training research

RCP Members & Fellows survey:
recommend hospital to Family?
- 1:10 No  1:4 Not sure

Continuity of care the norm?
- 42% average, 25% poor
Crisis: Hospitals on the edge - RCP

Clinical demand
- 37% ↑ admissions (10yr)
- 33% ↓ acute beds (25yr)

Changing pts changing needs
- ↑ Age, co-morbidity & expectation complex care

Workforce
- 27% SpRs workload “unmanageable”
- Crisis recruitment: EM, EC

Fractured care
- Inadequate handover
- multiple bed / team moves

- OOH care breakdown
- ↑ mortality admit w/e

- NCEPOD – high quality = consultant delivered care (time to intervene DNAR)

- Francis: Systematic failure care
- NHS financial climate
Mid Staffs Public Enquiry “Francis 2”- Feb 2013
7 months prior to FHC Report

290 recommendations

- “What is required now is a real change in culture a refocusing & recommitment of all who work in the NHS – from top to bottom of the system – on putting the patient first”

- Previous enquiries after initial courtesy of welcome .. implementation .. slow or non existent – this subject too important to suffer same fate..
What does the FHC report cover?

5 work streams 184pp 23 case studies best practice (print, on line, video)

- **Organisation of medical care and teams**
  Care organised around the needs of patients
  Care close to home – specialist care beyond hospital walls
  Continuity of care. Value the generalist as much as the specialist

- **Education, training, deployment of medical staff**
  Medical staff with skills & expertise to meet needs of pts

- **Building a culture of compassion and respect**
  Value patient experience as much as outcome.
  Support staff to deliver compassionate care.
  Fundamental standards of care.

- **Management, economics and leadership**
  Rebalance finances prioritise acute & complex care
  Promote clinical leadership

- **Information systems**:
  Facilitate patient-centred care across settings & support quality improvement
Principles underpinning the future hospital

1. Fundamental standards of care must always be met.
2. Patients with care plan reflecting their individual needs
3. Staff trained and supported to provide safe compassionate care
4. Patient experience as important as clinical effectiveness
5. Responsibility for each pt care clear and communicated
6. (Ward, hospital) transfer only for necessary clinical care
5. Pts have timely access to care including leaving hospital
6. Robust arrangements for transferring of care - in place
9. Good communication with/ about patients is the norm.
10. Care designed to facilitate self-care & health promotion
11. Services tailored to meet needs of individual patients
FHC Overview
Services designed to deliver:

Provision of care that is

- Organised around patient need
  care comes to pt – community /hospital – avoid multiple moves
  Safe, high quality
- Sustainable 7 days / week
- Focused on continuity
- Joined up - not discharge but “transfer of care”
- Comprehensive, effective focus: vulnerable, dementia
- Supported by IT

Features relating to staff

- Patient at centre of healthcare - patterns of staff working to fit
  - partnership working
- Stable medical teams
  Deliver continuity
  Training environment – feedback & safety
- Balance specialist & generalist (Internal Medicine) care: co-ordinated holistically to meet need
- Train staff to support pt needs
  - Care close to home
  - Elderly care expertise for all
From FHC reaction – to development sites

THE LANCET
‘Most important statement about the future of British medicine for a generation’

The King’s Fund
‘the result could be a step change in the quality of care’

The INDEPENDENT
Welcome to the hospital of the future
‘...bold and refreshing’

THE TIMES
‘Doctors propose cure for failures on wards’
Future Hospital Programme workstreams

- Education and training
- Organisational development
- Patient-centred care
- Academic medicine
- Development sites
- Workforce
- Future Hospital Journal
- Quality standards
- Partners network
- Information and data
FH Implementation:
Development sites + Commissioned “in house”

Patient centred care
• Shared decision-making & support for self-management HF, RCP Pt & carer network
• Transition of care young adults/adolescents 16-24

Information and data
• Develop informatics for ambulatory emergency care
HIU, AEC Network, IT Swansea

Academia & Research
• Review: integrated care models
• Organisation change to align staff priorities to pt need - integrated Diabetes care
Education/training (SoT)
- Dual training / demonstrate specialty 7/7 engagement in acute care
- 7 yrs (as now), 4 yr IM
- Enhance EC training for all
- Enhance status IM

Workforce
- Develop chief registrar post – 50% time out of clinical duties ST 7
- Chief Physician post
- Expand Physicians Associate workforce (Faculty hosted by RCP)
FH Development sites - objectives

Taking FHC from “page to practice”

• Show: how recommendations translate into practice
  – What works/doesn’t – what needs to be refined
• Demonstrate service change is possible
  – With enthusiasm, commitment, expert support
• Identify & promote existing good practice
• Develop (practical) recommendations/priorities for change
• Share learning, stimulate debate & champion FH
Application process:
Development sites - principles

• Not prescriptive re topic – capture enthusiasm!
• RCP supported application:
  – Application process not arduous
  – Focus: idea & impact on patient care
  – Explicit RCP support: QI Methodology, Evaluation, Access experts
• Not about winners and losers
  – 3-4 sites in Phase 1 (2014 start)
  – Recognise some applicants will “go it alone”
  – Partners network, FHJ: share learning positive & negative
  – Link to expert partners, funding, AHSN – option of Phase 2
Development sites – what makes a FH project?

• Aligned with principles of FHC
• The patient at centre of project:
  – Planning, implementation, impact of service change
  – Patient experience at core of evaluation - “as important as outcome”
• Collaborative partnership with RCP and others
• Commitment from site: share learning – partners network/FHJ/RCP events
• Commitment from RCP:
  – QI methodology & evaluation, access experts
  – Promote sites and their projects, champion FH
Steps towards selection development sites

- Post FHC: 40 unsolicited expressions of interest
- February: FH workshop - 20 hospitals, 84 delegates
- May: Call for applications – 20 received
- July: Applications scored by 4 reviewers (RCP) – set criteria – 4 sites selected
- August:
  - Sites informed, project initiation, feedback strengths/tweaks
  - Feedback other applicants + invite to join partners network
- September: launch of development sites
Site 1: Betsi Cadwaladr University Hospital

• **Lead & Project:** Olwen Williams. CARTREF - CARe delivered Telemedicine to support Rural Elderly and Frail pts.

• **Objectives:** Use of Telehealth & triage algorithms to identify risks in frail elderly in community - improving access to specialist care including palliative care.

• **Evaluation:** Impact on requirements for transport, acute admission, community hospital beds, OP consultations and pt satisfaction.

• **Strengths:** Existing team with Funded telehealth, 3 X Shine QI grants, identified metrics:
  – frailty / predictor of admission
  – Risk prediction for patients (with UCLP)
Site 2: Mid Yorks. Hospitals: Wakefield, Dewsbury & Pontefract

- **Lead & Project**: Dinesh Nagi. Development of older people assessment unit supporting patients with fragility syndrome within acute care hub.

- **Objectives**: Model 20 bed OPA. Frailty assessment by COE teams commencing within 2 hours of admission.

- **Evaluation**: Patient functional status, QoL, LOS and re-admission rates. KPIs under development and request for RCP to assist.

- **Strengths**: Completed pilot: COE team in-reach to AMU and impact on LOS. Defined service change, dedicated new unit. Recognition that evaluation needs strengthening.
**Site 3: Royal Blackburn (East Lancashire hospitals Trust)**

- **Lead & Project:** John Dean. Specialist service support for communities of Pennine Lancashire. Improve quality of services for frail elderly – integrated community teams. Partnership 1o community & social care, MH, leadership & outreach from CoE

- **Objectives:** Safe compassionate care for frail older people using an integrated care pathway. Self care, health promotion and effective timely access to healthcare through integrated teams. Emphasis on co-ordination, communication and tailored case management.

- **Evaluation:** Assessment of organisational, pt/carer perception of integration timeliness and quality of care. Assessment of admissions, occupancy, LOS, readmission, pt experience and total care costs.

- **Strengths:** Lead is IHI/HF QI Fellow. Project built on 2 year programme of partnership working & developments : intermediate care & community beds. Co-ordination hub under development. Commitment to improve acute services and listen to staff and patients.
Site 4: Worthing Hospital (West Sussex Hospitals Trust)

• **Lead & Project**: Roger Duckitt. Delivering the Worthing Emergency floor – realising the FHC Acute Care Hub.

• **Objectives**: Co-location of admissions & assessment pathways – medical, frailty and surgical - to ensure rapid access to diagnostic and treatment interventions to improve outcomes, patient experience, ambulatory care opportunities and safe discharge. New ways of working between 3 distinct clinical teams.

• **Evaluation**: Specific performance indicators (under development) and qualitative feedback. Assessment of impact on team working, education and training. RCP support sought.

• **Strengths**: Evolution of development of frailty Unit alongside AMU in a dedicated new build. New collaborative working with surgical teams to improve access to multidisciplinary teams, ambulatory care and co-ordinated discharge.
Development sites – common themes

• Acute services under pressure, seeking to avoid default admission
• Enhance care of frail elderly – throughout pathway
• Focus early expert assessment/care & how this can make an impact throughout acute illness pathway home - community service – AEC - AMU - OPA

[No FH Site applications from large tertiary centres]
Future Hospital & acute medicine

Opportunities to be involved:

• Contribute to ideas & debate:
  - FH Journal, RCP publications & meetings
  - Generalism & specialism, enhancing status of IM, SoT

• Share your innovations & best practice

• Phase 2 development sites (Spring 2015)

• Evaluation of FH projects –
  – AEC informatics, Chief Registrar, Handover