Wrong bed, wrong ward

Kings Fund  December 6th 2012

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Overview

Acute care in crisis? The nature of the problem

Working towards solutions
Acute care in crisis?
The nature of the problem
Hospitals struggling to cope...

• Feedback from patients, RCP fellows and members

• Francis inquiry
  ‘insufficient care for patients’ dignity’ … ‘degrading conditions’… ‘horrific experiences’
  ‘a consultant body that disassociated itself from management and often adopted a fatalistic
  approach to management issues and plans.’

• NCEPOD reports
  ‘Routine daily input from medicine for the care of older people should be available to
  elderly patients undergoing surgery and is integral to inpatient care pathways in this
  population.’

• Temple report on impact of EWTD
  ‘Despite significant consultant expansion, trainees are still responsible for initiating and
  frequently delivering the majority of out of hours service, often with limited supervision.’

• Kings Fund report continuity of care
  ‘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.’
What patients tell us they want

• Dignity and privacy
• Kindness
• Not to be moved around “like a parcel”
• Joined up care
• Someone in charge who knows what is going on
• (Safe effective care)
What RCP fellows and members say:

Rate your hospital’s ability to deliver:

• continuity of care as norm – 24% (**poor or very poor**)

• stable medical teams for care and education – 23%

• discharge arrangements that realistically allocate responsibility for further action – 17%

• high-quality care, 24/7 – 13%

• balance of care between specialists and generalists – 13%

• effective relationships between medical & other teams – 10%

*(RCP survey, January 2012)*
What RCP fellows and members say:

One in ten doctors would not recommend their hospital to a family member or friend as a high-quality place to receive treatment and care, and nearly one in four were not sure.

(RCP survey, August 2012)
Hospitals on the edge?
The time for action

A report by the Royal College of Physicians
September 2012
Five key challenges

• Increasing clinical demand
• Changing patients, changing needs
• Fractured care
• Out-of-hours care breakdown
• Looming medical workforce crisis
Increasing clinical demand

- Third fewer acute beds than 25 years ago
- Third more emergency admissions over last decade
- Fall in length of stay flattening, even increasing for over 85s
- 59% of consultants report working more hours than three years ago, and three quarters report being under more pressure
- ‘Consultants felt that the supervision that they can offer to trainees is inadequate due to pressure of clinical work and a fragmented team structure.’
- The hospital door is always open...
Changing patients, changing needs

- Two thirds of people admitted are over 65
- Quarter have diagnosis of dementia
- People over 85 account for 25% of beds days – an increase of 22% over the past ten years
- Yet the system continues to treat older patients as a surprise, at best, or unwelcome, at worse
- ‘A significant percentage of patients seen are over 80 yet those caring from them often have no geriatric training.’ *(Regional conversation)*
Changing patients, changing needs

![Graph showing changes in acute beds, emergency admissions, and length of stay over years. The graph indicates an increase in emergency admissions and a decrease in length of stay. The labels for the axes are Acute beds, Emergency admissions, and Length of stay.]
Fractured care

A quarter of hospital doctors rate their hospital’s ability to deliver continuity of care as poor.

Conversations with doctors

- It is ‘common for patients to move four or five times during their stay’, ‘particularly afflicting elderly patients moved to outlying wards during the night’
- Decisions are often ‘made by bed managers’
- Patient care is ‘often transferred to a new consultant without any formal handover’
- Patients who do not fall neatly into an organ-based specialty remit may become ‘lost’ in the system or ‘neglected’

Every ward move puts one day on length of stay
Continuity of care for older people

12 patients with ‘complex medical problems’

Average transfers between medical teams = three per patient

10 out of 12 moved after 8pm

(Kings Fund 2012)
“Out-of-hours” care breakdown

At weekends:
- Patients do not get diagnostic tests as quickly
- Number of procedures, including emergency procedures, falls
- Fewer people are discharged
- Studies suggest 10% increase in mortality
- Access to primary care is fragmented and patchy

Conversations with doctors
- ‘All present were concerned that the trust does not function well at night.’
- ‘Often feel relieved on Monday that nothing catastrophic has happened over the weekend.’
- ‘Would like to see a 7 day week but believe that this would require more consultant cover and support services.’
Gastrointestinal bleeding in Wales

24,291 admissions 1999-2007

30 day deaths

Admissions on:

Weekday: 18,285 9.8% fatality
Sat/Sun: 5,686 10.6% (OR 1.13)
Public holidays: 450 12.9% (OR 1.41)

Fewer endoscopies Fri/Sat

Looming workforce crisis

- Difficulty recruiting to emergency and general medicine posts
- Application rates to training schemes with a general medicine commitment are declining
- Over a quarter of medical registrars are concerned their workload is unmanageable*
- 5.3% of FT2s and CMTs thought medical registrars had an ‘excellent’ work-life balance, compared to 88.5% for GP registrars*

We risk losing the pool of general medical skills essential to the provision of holistic care

*RCP (forthcoming) ‘The Future of the Registrar’ study, 2011/2
Fit for the future?
Dr Foster Hospital Guide
2012
Why highlight these challenges?

• Professional responsibility to improve care for all patients

• Need recognition of issues at highest level, including politicians

• Radical change, difficult decisions and leadership – the status quo is not an option

• Multi-factorial problem – no single solution

• Need consensus, collaboration and shared solutions
What is the Commission?

- Set up by the RCP
- Reports to RCP president and Council
- Chaired by Professor Sir Michael Rawlins
- Multi-professional steering group
- Range of additional stakeholders
- Due to report in March 2013
- Set longer-term programme of work for RCP (focusing on implementation of recommendations, including use of pilot sites)
Purpose and scope

Identify a system in which safe, effective and compassionate medical care can be delivered to all who need it as hospital inpatients.

Make sure hospitals in future are based around the needs of patients and can deliver:

• high quality care 24 hours per day, seven days a week
• continuity of care for patients
• stable medical teams for patient care and education
• effective relationships between medical and other teams
• appropriate balance between specialist and general care
• discharge/transfer arrangements that realistically allocate responsibility for further action.
Emerging themes: Patients and compassion

*These themes are intended to generate discussion, they are not recommendations and have not been approved by Commissioners at this stage – we need your views!*
Overall approach

• Patient experience matters as much as clinical outcomes

• Is it good for patients?

• Have we listened to what patients are telling us?

• Have we tried to find out what they think?

• If we take this seriously, then we will change how we do things
Key issues to patients

• Continuity of care

• ‘Wrong patient on wrong ward’ means lower standard of care

• Communication

• Involvement of families and carers

• Joined up care

• Dignity, compassion and respect –treated as a human being (Human Rights agenda)
12 principles of care

1. Good communication is essential between medical and ward teams if a patient moves, and must be improved.

2. Once a patient has reached a ward after assessment in the acute medical unit, they should not move again, unless there are exceptional circumstances.

3. More beds should be designated as general/older people’s beds and less as speciality beds.

4. A named consultant should be designated on each ward to liaise with the ward manager on basic standards of care for all patients on that ward.

5. The hospital environment needs to be designed for the needs of the frail older patient with dementia, whilst considering the needs of other specific groups such as young people.
12 principles of care

6. Patients and their families should be involved in discharge planning.

7. Medical staff need more training in motivational interviewing techniques (to support self care) and in recognition of the dying patient.

8. Advanced care planning for people with end stage disease needs to be done before hospital admission.

9. Values should be incorporated into appraisals and staff survey results recognised. Appraisals should be less punitive and more supportive.

10. Time for staff support, development and reflective practice should be built into working patterns.

11. Recruitment of staff should take attitudes and values into account.

12. Doctors and nurses in all specialties need to have basic training in cognitive impairment, acute confusional state and dementia.
Moving beds: Our commitment to patients

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 immediately and 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, where appropriate, why you are there.
Emerging themes: Place and process

These themes are intended to generate discussion, they are not recommendations and have not been approved by Commissioners at this stage – we need your views!
Principles: continuity of care

Care for patients admitted as an emergency should be organised so:

- the consultant team involved in care on the day of admission delivers care the following day
- (as far as possible) the same consultant team provides care throughout admission

Applicable patients on specialty pathways
Continuity of care at the front door (1)

• Transfers out of AMU: currently, AMU size mandates ward transfer of short stay patients (24–72 hrs) not requiring specialty pathway
• Transfers associated with added risk, need for handover, distress for patient
• Lose momentum towards discharge: adds one to two days to length of stay
Design care and facilities (co-located) around the needs of patients: **Acute Care Directorate**.

- **AMU + short stay** - capacity manage to discharge with single consultant team
- **Stable front door team** - focus on discharge (including ambulatory care)
- **Benefits**: patient safety, handover, supervision, feedback
- **Consultant staff blocks** of dedicated time acute care

Continuity of care at the front door (2)
Acute care directorate?

Co-locate with:

- **Ambulatory care**: patients discharged from AMU follow up with same consultant on ambulatory care unit
- **Augmented care area**: level 1–2 beds, located on AMU with staff competencies to provide care acutely ill
- **ITU, HDU** – close working – benefit from proximity
- **Emergency department**

Benefits of single acute care hub: unity of purpose staffing ‘esprit de corps’, clinical, administrative, accounting
Seven day working – consultant duty patterns and patient outcomes

- Consultant on site at least 12/24, 7 days
- No other duties scheduled
- Consultants conducting at least two ward rounds per day on AMU
- Consultant on-call blocks >1 day, <7 days

- Lower 28/7 re-admissions rate
- Lower adjusted case fatality rate
- Lower adjusted mortality in patients with a length of stay of >7 days
- Lower overall week-end mortality

*Evaluation of consultant input into acute medical admissions, RCP 2012*
Expert clinical care by a team that meets patients’ needs

Conflict:

• Aging population, increased frailty and co-morbidity
• Acute hospital care built on the idea of single system illness
• Relative oversupply of single system specialists?
• Specialty pathways for defined conditions leads to better outcomes (less evidence older cohorts)
• Most patients may now benefit from continuing care from specialists in general medicine – subspecialists consulting and intervention role
Debate: Continuity and a new kind of hospital physician?

Is it time for a new kind of hospital physician?
The changing demography requires current models of inpatient care to evolve

R M Temple acute care fellow, V Kirthi clinical fellow to the president, L J Patterson clinical vice president

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Today’s consultant physician manages inpatients who are older and have more comorbidities and a greater complexity of acute illness than in the past. Since the inception of the NHS in 1948, life expectancy in the United Kingdom has increased by 18% and 16.7% for men and women, respectively.¹ Half of those

In 2019, 60.5% of doctors from the six major medical subspecialties practised general internal medicine, down from 76.1% in 2002.² Currently 3838 (54.4%) medical registrars are registered for dual accreditation in general internal medicine and a subspecialty, but of these only 1597 would wish to practise
What is the right balance?

• Specialists who also do GIM on intake and look after those patients on the wards
• Acute Physicians – intake and ? 24-48 hours post admission
• Geriatricians – specialists who are expert in care of older people
• Specialists
• (probably not hospitalists as in USA)
The general physician

- High demand if we are to achieve seven-day AMU and post AMU consultant working
- Flight to specialties: less than 25% choose GIM post CCT
- How to reinvigorate?
  - Expand training/redeploy
  - Shared workload between specialties, eg emergency care, acute internal medicine
  - Curriculum revision
Balance between geriatricians and general physicians

‘We’re not worried about the patients you’re looking after, we’re concerned about the ones you’re not’ – Quotation from FHC participant

Workforce being pulled in all directions:
• Geriatricians at the hospital ‘front door’
• In-reach to Acute Medical Units
• Liaison with surgical wards, etc
• Community, post-discharge and prevention

What’s the answer?
• More geriatricians (and doing what)?
• More geriatric medicine beds?
• More training and skills (eg dementia and delirium) across medical workforce?
Models of geriatric care include

- Geriatricians responsible for acute stroke and rehabilitation
- Geriatricians as part of the hospital wide on call rota
- Community geriatrics
- Front door admission avoidance schemes
- Supported discharge teams
- Delayed discharge units
- Care home support scheme
- Separate acute frailty ‘take’ running in parallel to the general take
Get involved

Get engaged in the debate:

- Suggestions, comments, evidence and examples of good and innovative practice to:
  futurehospital@rcplondon.ac.uk.

Find out more: www.rcplondon.ac.uk/futurehospital
Thank you.