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Reflecting back – 10 years of the Future Hospital Programme

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ABSTRACT

A decade ago, The Future Hospital Programme was created following the publication of the Future Hospital Commission (FHC), to demonstrate how Future Hospital (FH) principles could be implemented and embedded within the NHS. Ten years on, we reflect back on each of the development sites and the programme itself. What were the successes and what are the current challenges? Indeed, in the current NHS, is it feasible to deliver in 'real world environments' the FH principles and make sure that patient care is safe and effective? The last decade has seen financial constraints and inevitable (albeit often short-term) changes to manage the COVID pandemic. How have these affected each of the development sites and what else do we need to do to ensure that we get care right for our patients within our future hospitals?

Introduction

Ten years ago, the Future Hospital Programme (FHP) was created following the publication of the Future Hospital Commission (FHC) report, which made recommendations for providing patients with safe, high-quality, sustainable care that they deserve. There had been growing concerns about the standards of care and it was seen that change needed to occur. The FHP aimed to demonstrate how these recommendations could be implemented within the NHS. The Royal College of Physicians (RCP) embarked on a collaboration with eight Future Hospital (FH) development sites. Four sites were focusing on improving the care of frail and older people and the other four on integrated care models to a varied cohort of patients (Fig. 1).

So 10 years on, we ask ourselves 'What made the FHP a success?' Or are we deluded? Did the eight FH development sites have any impact in our ever-pressurised NHS? Was it the enthusiasm and commitment of the eight teams from remarkably diverse geographical areas and clinical backgrounds? Was it the extensive support, the quality improvement coaching, wellbeing and RCP technical support and backing? Or was it the fact that integral and embedded in all of our teams was the voice and contribution of the patient and the carer?

Improvement is 20% technical and 80% human, according to the work of the Sheffield Flow Academy.[1] We cannot stress how important the human aspect of this programme was. Yes, we learnt the technical stuff – Pareto, run charts, PDSA cycles etc[2] – and used data to demonstrate change and improvement. But, each team having a patient/carer representative to advise and be a critical friend influenced how we approached our projects, made us focus on putting the patient at the centre of everything that we did. 'With us, not for us' – the basis of co-production, which 10 years ago was in its infancy in the UK[3] – is now *de rigueur* but not well adopted.[4]

The FHP underwent an independent evaluation,[5] which concluded that the vision of the FHC[6] to deliver in 'real world environments' was attainable. No one could have predicted what the last 7 years following the end of the FHP within the NHS would bring in terms of financial constraints and inevitable (albeit often short-term) changes to manage the COVID pandemic.

It is with this in mind that each of the development sites was contacted and asked to reflect on their journey over the past decade. During this process, it again became crystal clear that each and every clinician continued to want the same – the best for the patients they serve. Each site has been on a different journey, but do all of the key successes and challenges still fit within the six requirements set out in the 'Delivering the Future Hospital' report,[7] the evaluation of the programme (Box 1) while also thinking about the 11 principles of care set out by the FHC (Fig. 2)?

This article reflects the opinions of the author(s) and should not be taken to represent the policy of the Royal College of Physicians unless specifically stated.

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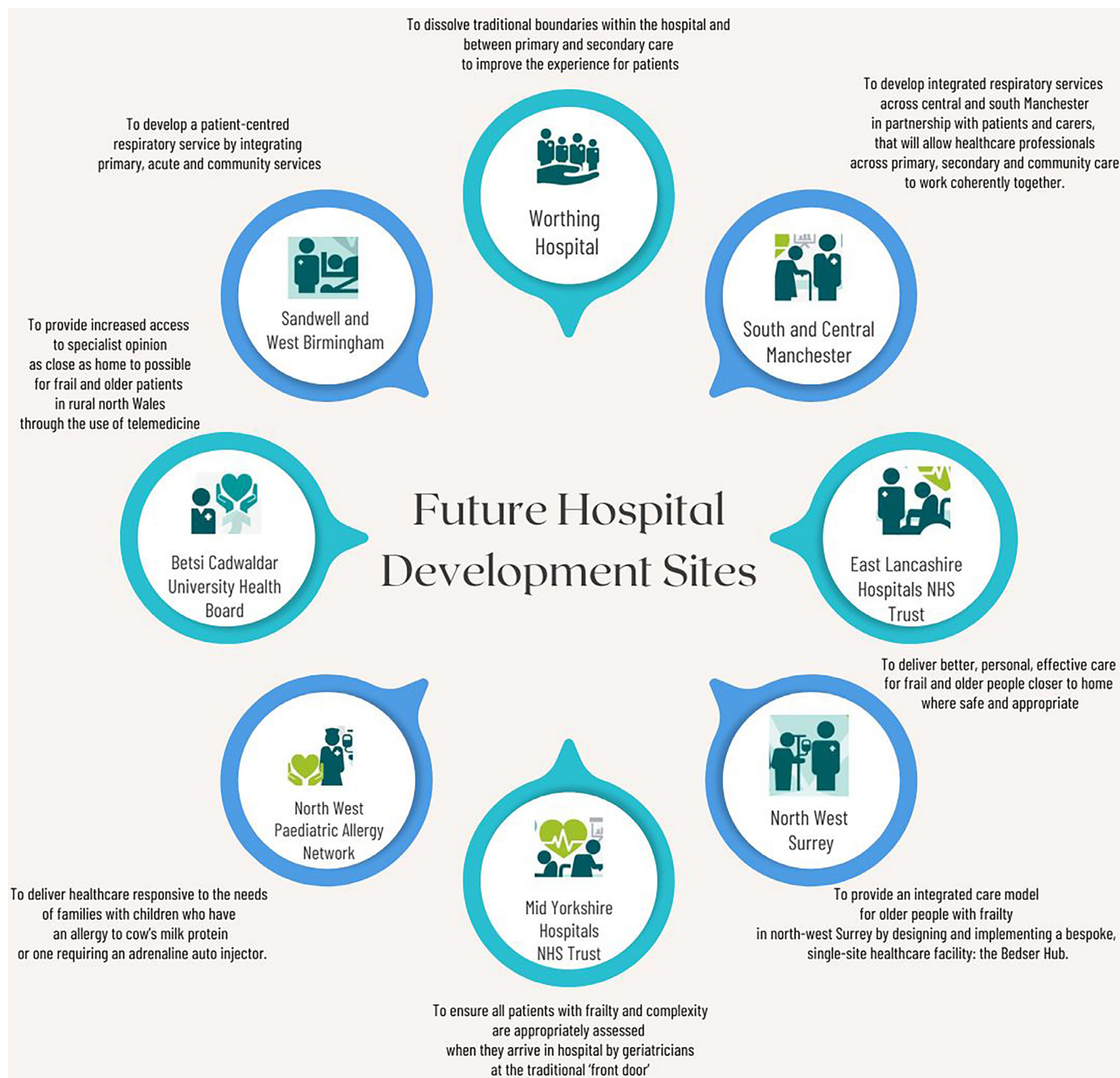

Fig. 1. The FH development sites and their aims.

Box 1. The six requirements identified within the 'Delivering the Future Hospital' report.

1. Ensure patients and carers are at the centre of healthcare design and delivery
2. Provide local support for teams to improve patient care in a financially constrained, politically exposed healthcare system.
3. Develop a collaborative learning structure to enable healthcare teams to successfully implement improvement projects
4. Collect and analyse data to support ongoing improvements to patient care
5. Develop future clinical leaders
6. Partnership working between the RCP and local teams is an effective model for improving aspects of patient care

Ensuring patient and carer involvement

The FHP enabled each site to have support from the RCP Patient and Carer Network (PCN), which empowered all the programmes to have patient and carers at the frontline with clinicians to work together to make improvement that is meaningful for the populations we serve.[8]

As time had gone by, there has been an increase in the number of patients and carers sitting in various committees; within virtual meetings of our clinical services; however, this has not yet become the norm. In embracing the new world of the Patient Safety Incident Response Framework (PSIRF), which encourages patients and their relatives to be part of the patient safety journey, it is certain that patient experience will be seen to be as important as clinical outcomes.[9] Reassuringly, within the FH development sites, this continues to be common in improving quality of care, so that the care provided is patient centred and takes into account what is important for patients. In fact, in South and Central Manchester the original patient representative remains involved in the 'Healthy Lungs' steering group, which evolved from the original FHP steering group.

Sandwell and West Birmingham Hospitals have embedded patient experience champions since involvement of the FHP and the trust has rolled out training, so patients and carers feel they are actively able to participate in the business of the trust. This enables care to be more patient centred and volunteers are supported to be truly part of the team

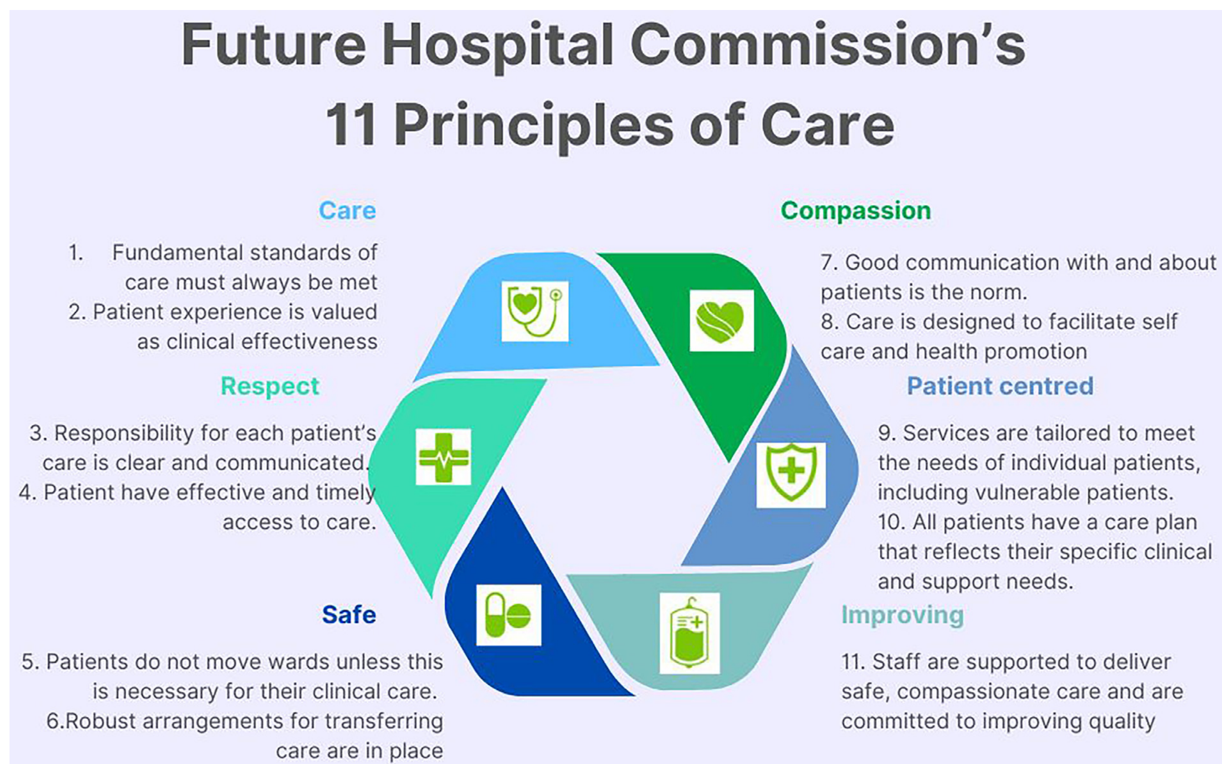

Fig. 2. The future hospital commission's principles of care.

and equal to any member of the multidisciplinary team in making improvements.

Other sites have embraced the use of ongoing patient feedback above and beyond friends and family, where the feedback actively helps ongoing design and delivery of programmes, whether in locality hubs or growth of new pathways. Thanks to such feedback, gaps in service have been able to be identified, such as mental health services in North–West Surrey Locality Hubs[10] and enhancing the transition of respiratory patients from diagnosis, disease management to palliative care so that patients within South and Central Manchester truly feel that care is joined up. By focusing on goals and priorities of care, it is possible to provide truly patient-centred care. This surely is a testament to the fact that patient and carer involvement remains valued and an integral part of integrated care. It also enables communication to be improved and guarantees that services are tailored to meet the needs of individuals, especially those who are vulnerable.

Support of local teams

Over the past decade, many clinical areas have seen improvements in terms of national guidelines and the recommendations of Getting It Right First Time (GIRFT), which have made a huge impact on the delivery of services, especially within frailty. In reflecting back at the development sites, it is clear that most of the services have grown either in size or in terms of the population they serve. Not in every case has this been funded with more injection of capital, but embedding the core principles at the start of the FHP has enabled teams to remain driven on service improvement. This is demonstrated by the changes Worthing Hospital has made to its Emergency Floor, which has seen a shift from zone-based working to a more heterogeneous patient model across the Emergency Floor. The main facilitator of this has been the development and integration of medical and nursing teams and a true desire to ensure that even the most complex, frail patients are able to be discharged within 72 hours of their admission.[11]

The power of enthusiasm and a common purpose of local teams can also be appreciated by the success and expansion of the North-West Paediatric Allergy Network. The Network, by developing a vibrant and active atmosphere for its healthcare professionals, has seen its expansion. The Network now has members in 20 district general hospitals within three Integrated Care Boards, one Health Board in North Wales and reaches out to 700 GP practices. The connections formed using technology during the COVID pandemic have meant increased connectivity and collaboration, so local teams truly feel supported and valued.

There has been also better integration of community and acute delivery of care supported by both health and social care services. East Lancashire successes are a key demonstrator of this: the Intensive Home Support Service and the Intermediate Care Allocation Team are now running 24 hours a day, 7 days a week and incorporated 2-hour emergency community response, virtual wards and hospital at home.[12] Such improvements are possible through great leadership and support of the local teams, starting from executives within an organisation and other stakeholders invested into making a real and meaningful difference.

Not every programme survived the 10 years; during COVID due to re-deployment of staff, the Betsi Cadwaladr University Health Board FH development site ceased to run their virtual outpatient clinics. However, many of the principles that they established help shape other services within the Health Board. From the start the staff had resilience training, which proved especially useful during the pandemic and the lessons learnt have been shared to the benefit of other teams, for example embracing telemedicine and newer technological advances. The lack of sustainability of the programme was due to a lack of buy-in and therefore despite support of the programme by innovative clinicians, it is hard to keep a dream alive even when it has meaningful impacts on patients. This demonstrates why, despite a hunger for improvement and empowerment of forward-facing clinical teams, support of the teams remains as important today as it did a decade ago.

Developing a collaborative learning structure

For some, success is measured by legacy and how something can helped spark future innovation. The FHP certainly achieved this by bringing together engaged and motivated clinicians who collaborated

actively, shared ideas and were willing to rally their energies around a large, generous idea of health and its provision. This led to collaborative learning environments being created and encouraging others to visit other development sites. Betsi Cadwaladr University Health Board hosted one of the first quality improvement study days and went on to develop quality improvement strategies, as did other development sites.

In other areas, the learning gained through feedback has led to the creation of specific training to help stimulate growth and address challenges, such as the employment in East Lancashire of an advanced communication skills trainer to truly improve levels of communication. Inspiring future generations by creating a collaborative learning structure is also vital in an NHS where high levels of burnout and dissatisfaction are common. This is why, 10 years on, it is encouraging to learn that Worthing Hospital continues to demonstrate that the Emergency Floor provides an exciting opportunity for staff. Those juniors who have the opportunity to take part in the 'Acute Care Foundation Block' continue to give positive feedback and many have come back for subsequent years of training, highlighting the effectiveness of a supportive clinical environment where trainees can learn the art of medicine.

There have also been developments within trusts which have helped to secure better education programmes. For example, Mid Yorkshire Teaching Trust has now achieved teaching hospital status by demonstrating improvements in undergraduate education and is now in the process of exploring the feasibility of a frailty academy with potential for a patient university. Within the North-West Paediatric Allergy Network, learning has been the focus throughout. By embedding a learning structure, the confidence of parents and professionals has increased. The network provides a plethora of study days and subgroup meetings. The creation of such an education-rich environment ensures that patient needs are set out and the FH principles are in the forefront of each clinician's mind.

Developing future clinical leaders and partnership working with the RCP

Within all the sites, clinical leaders were established. These innovations and improvements were physician led. In some places, the development site outcomes created new leadership posts; for example, Clinical Directors for Frailty in North-West Surrey, and the creation of an Associate Medical Directors position in Mid Yorkshire with a focus on System Collaboration for frail and older people. The sparks created for innovation of the FHP also have led the workforce challenges to be explored in different ways by the creation of hospital-based training posts to help individuals through the CESR route such as in East Lancashire. The Chief Registrar Programme run by the RCP also validates the importance of preparing future leaders to drive improvements and the acquisition of non-clinical skills, which will continue to shape the future of healthcare.

The FHP acted as a catalyst for individuals to work more closely with and in the RCP by understanding the power that the college itself holds in terms of improving patient care. Indeed, thanks to the success of partnership working with the RCP, the quality improvement hub was created and continues to drive quality improvement. Quality improvement continues within the development sites to support transformation and reconfiguration of services. The RCP acts as an inspiration platform for its members and fellows and this is one of the reasons why the FH principles still resonate with the development sites and the wider NHS community.

The provision of an FHP Network also provided a platform to showcase innovation and learning. This enabled stories to be told of taking specialist medical care beyond the hospital walls and showing real life examples where FH principles made positive changes to the lives of staff and patients. The value of such sharing is often underestimated, but makes individuals believe in the art of the possible where patient-centred innovation has to be part of our future. It is by understanding the challenges and seeking solutions that the FHP and the FH principles will have continued successes.

Challenges over the past 10 years

Throughout the past 10 years, a number of challenges (Table 1) have halted progress or resulted in changes at some of the development sites. The main issue for many of the development sites has been in recruiting nursing and medical staff with advanced skills. This has been made more difficult by the COVID pandemic, which saw the creation of alternative pathways of admission to keep safe. For other development sites, this acts as a catalyst where change had to happen at an accelerated rate. Furthermore, those development sites where patients were been managed for their respiratory problems or those who were older and frailer, thus being more susceptible to contracting and being very unwell due to COVID. Services adapted to the need of their patients in a time of crisis.[13] The way that each development site rose to the challenges this created was a testament to the flexibility and resilience of the teams having made large-scale change as part of the FHP. Key in everyone's mind was the FH principles, to which clinicians still aspire.

Funding continues to be a problem given the financial constraints within NHS trusts. This is exacerbated by the fact many of the development sites were modelled on prediction for the next 5 years. Seven years on, it is becoming increasingly clear that the ongoing increase in the population we serve coupled with the fact that primary care is less able to provide proactive services. This has been seen by the lack of spaces in community hubs and by the decrease in acute trusts achieving the emergency care standards within our emergency departments. The reduction in bed capacity has become our Achilles heel. Most importantly, though, this results in an experience for patients that is so far from what we set to deliver. This inevitably leaves everyone with the heavy weight of moral injury and wishing things were different.

So realistically, do the FH principles remain true and relevant in a world which is under more and more pressure, where patients have to be our priority? Of course they do, but sometimes navigating healthcare improvement is fraught with successes and challenges. This does not mean through the last decade that the FHP failed in its aims. On the contrary, it demonstrates that, united by common goals and principles, quality improvement remains at the heart of all we do.

Final reflections

In reflecting back on the past 10 years, it is clear that we still all strive for the principles set within the FHC. No physician would not want the best care for the patient they are caring for. Key successes can be mapped across the development sites to each and every principle. It is clear that every principle in every development site is not yet achievable, despite the efforts of the multidisciplinary teams. Quality improvement continues and grows stronger, which enables further developments to flourish. By remembering the key messages within the FHP (Fig. 3), quality improvement will remain at the heart of all we do.

By looking back over the last 10 years, it is clear that the FH principles are still relevant. Some are easier than others to achieve. The hardest of these at present seems to be that patients do not move wards unless this is necessary, alongside the achievability of timely access to care given the long waits being seen in our emergency departments. The issue that we face as the population we serve grows is that innovation alongside investment is key to sustainable futures. In an NHS environment, with high levels of stress and burnout, in order to continue to innovate and achieve meaningful quality improvements we must reinvigorate the FH principles to remind each and every clinician. Reinvigoration will undoubtedly reignite the spark, passion and dedication of those who have been at the forefront of development of services, especially those who have lost their sparkle due to moral injury and burnout. We have to remain optimistic as through adversity we will see more than one phoenix rise from the ashes and inspire future generations of clinicians. The fact that the services have continued to develop, expand and link with Hospital at Home Schemes, virtual wards[14] and integrated neighbourhood teams make the future look bright. If we as clinicians

Table 1
The key ongoing successes and challenges of the FH development sites.

Development site	Successes	Challenges
Betsi Cadwaladr University Health Board	Shared learning which during COVID was vital. Resilience in team members who have continued to innovate.	Executive support – programme has folded.
Mid Yorkshire Teaching NHS Trust	Ongoing collaborative working across the acute hospital and community, including creation of frailty virtual ward and integrated neighbourhood teams. Innovation and leadership leading to improvements in patient care and a drive to keep patients safe and cared for.	Workforce recruitment, sustainability and issues with resilience due to workforce challenges. Financial pressures, especially within the Division of Medicine.
East Lancashire Hospitals NHS Trust	7 days a week, 12 hours per day Older People's Rapid Assessment 24/7 community response. Quality improvement approach embedded in the organisation.	Workforce recruitment. Working across the boundaries into communities is constrained by acute hospital demand.
Worthing Hospital	Average length of stay for frail patients able to be discharged home sits at 56–72 hours Process of referral, the processes for admission, the data collection, integration with the Patient Administration Systems and associated IT (information technology) systems have all been improved.	Imbalance in demand and capacity for social care. Staffing across the MDT.
North West Surrey	Two new Hubs opened to cover the whole North West Surrey population. Development of Integrated Frailty Service across acute and community with Frailty front door, UCR, Hub teams, Frailty virtual ward plus Integrated Neighbourhood Teams with Hub team support being piloted.	Nursing staff are generally in short supply for the hub matron role as it requires a broad range of skills. Links to general practice are not as strong as originally hoped.
North West Paediatric Allergy Network	HCP Network created with members in 20 District General Hospitals within three North West of England Integrated Care Boards and one Health Board for North Wales, providing allergy care for children. This network services approximately 700 GP practices.	Changes in national and regional policies, including statements by the RCPCH, to acknowledge potential conflicts of interest between HCPs and the pharmaceutical industry has led to reduced advertising and access to professionals by pharma companies supplying alternative infant milk formula.
Central and South Manchester	The original Future Hospital Programme steering group became a formal committee when the CCGs and Manchester hospitals merged and has since become the 'Healthy Lungs' steering group, which still includes the original patient representative. A reduction in hospital admissions for COPD through collaborative system working achieved (pre-pandemic), and ongoing large programme of work through a 'cradle to grave' approach to population health.	Large-scale organisational structural and commissioning changes, pandemic impact on respiratory services.
Sandwell and Birmingham Hospitals NHS Trust.	Successful business plan led to establishment of 42 MDT clinics and 42 educational sessions a year. Post inpatient stay follow-ups almost exclusively delivered using virtual clinic models	Trust is in the final phase of the Transformational program of reconfiguration of services and a move to a new build – The Midland Metropolitan University Hospital EPR (Electronic Patient Records) system deployed but optimisation was interrupted by pandemic

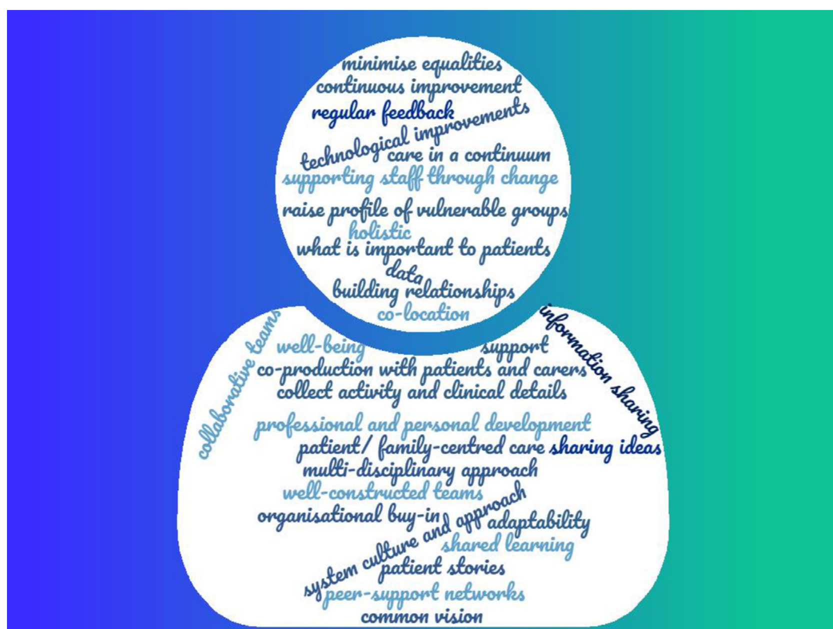

Fig. 3. Word cloud of key messages from the FHP.

Table 2
List of Development Site Contributors.

Development site	Contributing individuals
Betsi Cadwaladr University Health Board	Chris Subbe – c.subbe@bangor.ac.uk Olwen Williams – olwen.williams7@wales.nhs.uk
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North-West Paediatric Allergy Network	Peter Arkwright – peter.arkwright@nhs.net
Central and South Manchester	Binita Kane – binita.kane@mft.nhs.uk
Sandwell and Birmingham Hospitals NHS Trust	Arvind Rajasekaran – arvind.rajasekaran@nhs.net

aspire to the FH principles, we can drive improvement for the good of those we serve while maintaining staff morale and ensure that medicine remains brilliant #medicineisbrilliant.

Special thanks to each of the leads of each of the development sites (Table 2) who have provided their insights, which have been used to shape this article.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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