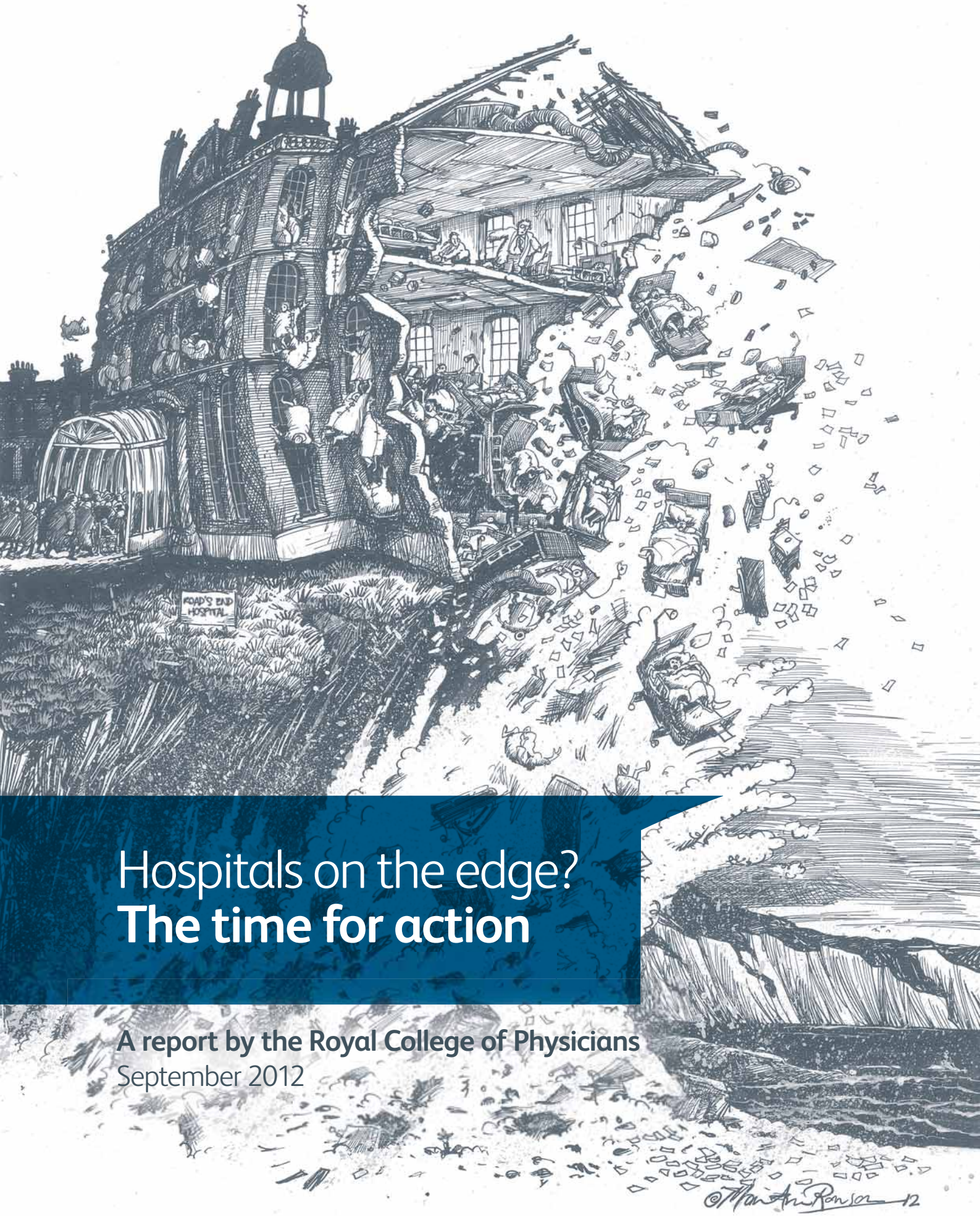
Royal College of Physicians

Setting higher standards



Hospitals on the edge?
The time for action

A report by the Royal College of Physicians

September 2012

Introduction

All hospital inpatients deserve to receive safe, high-quality, sustainable care centred around their needs and delivered in an appropriate setting by respectful, compassionate, expert health professionals. Yet it is increasingly clear that our hospitals are struggling to cope with the challenge of an ageing population and increasing hospital admissions.

The consequences of failing to meet these challenges are clear. The unnecessary pain, indignity and distress suffered by older patients in NHS facilities have been hauntingly documented by the Parliamentary and Health Service Ombudsman[1] and the inquiry into care at Mid Staffordshire NHS Foundation Trust. The independent public inquiry, chaired by Robert Francis QC, found that for many the most basic elements of healthcare were neglected and staff displayed 'insufficient care for patients' dignity with some left in degrading conditions and others inadequately dressed'. This inadequacy resulted in 'horrific experiences that will haunt them and their loved ones for the rest of their lives'.[2] The Inquiry's second report will have ramifications across the NHS, but, as we await its publication towards the end of 2012, the pressures on acute services continue to rise.

The RCP's *Hospitals on the edge?* report sets out the magnitude of the challenges facing acute care services. It is a call to action for all involved in the design and delivery of health services. It is increasingly clear that we must radically review the organisation of hospital care if the health service is to meet the needs of patients. We must act now and we must act collaboratively if we are to ensure patients receive the care they deserve now and in the future.

Overview of challenges facing acute hospitals

The pressures on the acute service are relentless and intense:

- **Increasing clinical demand.** There are a third fewer general and acute beds now than there were 25 years ago,[3] but the last decade alone has seen a 37% increase in emergency admissions.[4] Hospitals have coped with this increase by reducing the average length of stay for patients. However, this fall in length of stay has flattened and in the past three years it has started to rise for patients over 85.
- **Changing patients, changing needs.** Nearly two thirds (65%) of people admitted to hospital are over 65 years old,[5] and an increasing number are frail or have a diagnosis of dementia. However, all too often hospital buildings, services and staff are not equipped to deal with the people who have multiple, complex needs including dementia.
- **Fractured care.** Hospital doctors have reported the lack of continuity of care as their biggest concern about the current health service.[6] It is not uncommon for patients, particularly older patients, to be moved four or five times during a hospital stay, often with incomplete notes and no formal handover.[5,7] Every ward move puts at least one day on a length of stay and has a detrimental impact on patient experience.
- **Out-of-hours care breakdown.** Emergency admissions activity at weekends is around a quarter lower than the rest of the week, with fewer procedures and diagnostic tests.[8] Studies also show a 10% increase in mortality at weekends when there are fewer senior staff on site.[9]
- **Looming workforce crisis in the medical workforce.** Three quarters of hospital consultants reported being under more pressure now than three years ago[10] and over a quarter (26.9%) of medical registrars report an unmanageable workload.[11] Recruitment into emergency medicine is becoming increasingly difficult, with gaps in training schemes, an increasing reliance on locums, and unfilled consultant posts. Application rates into training schemes involving general medicine are also declining.[10] It is clear that if we do not act, we risk losing the pool of generalist skills so essential to the effective provision of holistic care to patients. ■

About the Royal College of Physicians

The Royal College of Physicians (RCP) plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians across 30 medical specialties, including geriatric medicine, with education, training and support throughout their careers. As an independent body representing over 27,500 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

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Changing patients, changing needs

The population of Great Britain has changed substantially since the inception of the NHS in 1948. There are 12 million more of us now and we are living longer, with life expectancy at birth around 12 years longer. People aged 60 or over make up nearly a quarter of Britain's population,[12] and half of those aged over 60 years have at least one chronic illness.

Unsurprisingly, the demographic of hospital inpatients has also changed substantially in the 64 years since the NHS was created. An increasing number of patients are older and frail, and around 25% of inpatients have a diagnosis of dementia. The reality of care in our hospitals has changed considerably. Nearly two thirds (65%) of people admitted to hospital are over 65 years old. People over 65 occupy more than 51,000 acute care beds at any one time, accounting for 70% of bed days.[5,3] Hospital Episode Statistics (HES) show a 65% increase in secondary care episodes for those over 75 during the past 10 years, compared with 31% for those aged 15–59.[4]

People over 85 years old account for 25% of bed days – increased from 22% over the past 10 years. This equates to more than five bed days per annum, compared to only one fifth of a bed day each year for those under 65.[5] People over 85 tend to spend around eight days longer in hospital than those under 65 – 11 days compared to three.[3]

Despite patients over 65 making up the larger share of the hospital population, the system continues to treat older patients as a surprise, at best, or unwelcome, at worst. Much more can be done to prevent unnecessary hospital admission and readmission, shorten length of stay and ensure the smooth and effective transfer of care for patients ready to leave hospital. Areas with integrated services for older people have lower rates of bed use; these hospitals also tend to have lower admission rates and deliver good patient experience.[3]

However, there will always be a cohort of patients with acute medical illnesses requiring admission to hospital. Hospitals, and those who work in them, have a responsibility to ensure that the needs of these patients are met. Research shows that medical and nursing staff often feel that older patients 'shouldn't be there'. Being perceived as the 'wrong patient on the wrong ward' has been shown to reduce the quality of care, building attitudes of resentment from both medical and nursing staff.[13] Older people must have equal access to healthcare services; it is not acceptable to view older people in hospital as being in the 'wrong place'. Hospital services must adapt to ensure that older patients, including those who are frail and have a diagnosis of dementia, have access to safe, high-quality care in settings that meet their needs. ■

Increasing clinical demand

The number of general and acute beds has decreased by a third in the past 25 years,[3] yet during the past 10 years there has been a 37% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75 in the same period (compared with 31% increase for those aged 15–59).[4]

Emergency hospital admissions account for over a third (35%) of all hospital admissions.[14] Hospitals have coped with this increase by reducing length of stay over the past 10 years. However, this fall in length of stay has begun to flatten, and has slightly risen for over 85s, as the numbers of admissions have continued to rise.

In 2010–11, 3.6 million (21.9%) of people who attended accident and emergency departments (A&E) required hospital admission. 57.4% (9.3 million) of people who attended A&E were discharged and required either no follow up or follow up from their GP.[15] Addressing the unrelenting rise in emergency hospital admissions is one of the major challenges facing the NHS.

Despite the high cost of hospitalisation, the NHS has been slow to develop comprehensive, effective alternatives to admission. Although patients become acutely ill 24 hours per day, seven days per week, the current drive to seven-day working in secondary care is not matched in the community. Out-of-hours GP coverage has become more fragmented and is supplied by agencies more commonly since the introduction of the new contract in 2004.[16] This compromises efforts to avoid out-of-hours hospital admissions and prolongs the length of stay for inpatients unable to access pathways out of hospital seven days per week, disrupting the capacity to manage new admissions. Integration of primary and social care and primary and secondary care have both been shown to reduce hospital admissions.[16]

Increased public expectation leading to more self-referral to NHS care is a possible explanation of the increasing admissions, as are changes in clinical-decision making and 'defensive' medicine. In support of this contention, the majority of additional A&E attendances are for minor conditions.[12]

Changing demographics make new demands on staff. This in turn affects the staffing ratios that are needed in order to deliver effective, safe care. It also affects the skills, knowledge and experience that staff need. However, many healthcare professionals working with patients over 80 will not have had geriatric training, despite the significant percentage of these patients in hospitals. ■

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Fractured care

Hospital doctors ranked continuity of care as their greatest concern in the current health landscape.[6] A quarter of RCP fellows and members rated their hospital's ability to deliver continuity of care as poor or very poor.[17]

Continuity of care

Lack of clinical continuity detracts from the overall quality of care experienced in hospital, particularly in patients aged 70 and over with multiple health problems. A report from The King's Fund shows that older patients are more likely than others to be readmitted to hospital within a short time of discharge and are often moved around in hospital.[5] Conversations with hospital doctors reveal a worrying picture:

- 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'.
- Many patients on specialty wards may be 'inappropriate' general medical admissions who are 'often moved between wards during their admission with no consultant taking overall responsibility for their care'.
- Patients can be 'moved four times because of the need for a bed in a particular specialty'.
- Decisions are often 'made by bed managers' and patient care is 'often transferred to a new consultant without any formal handover'.
- Patients who do not fall neatly into any organ-based specialist remit may become 'lost' in the system or at least 'neglected'.[7]

It is common for patients, particularly older patients who do not fit neatly into a specialty, to be moved multiple times during a hospital stay, each time changing their ward nursing team and often their medical team.[5] This is not good care. It also lengthens hospital stays: studies show that every ward move puts at least one day on a length of stay. Patients rate continuity of care highly.

Holistic and appropriate care for patients

Increasing specialisation in medicine has contributed to increasing survival rates for single conditions. However, the fragmentation of acute care services (eg stroke, acute myocardial infarction, respiratory failure) has removed many consultants from the general medical admitting role and certain specialties (eg neurology, dermatology) effectively provide no junior- or consultant-level staffing for this activity in the majority of hospitals. Only 19% of consultants reported having a formalised acute team in their hospital.[18]

There has been increasing specialisation in medicine and nursing with a proliferation of disease and organ based specialties. There are 61 approved medical specialties in the UK compared to 30 in Norway, which has also rendered the provision of continuity of care increasingly difficult.[19] While specialisation can undoubtedly improve clinical quality and safety, it has negative consequences when the care from specialists is poorly coordinated. This is particularly apparent for older people with complex and multiple needs.

Leadership is needed to clarify the roles and inputs to the team of each individual in order to coordinate the contributions of different healthcare professionals involved in the care of the patient. There must be clarity around who is accountable. There must also be the ability to assemble reliable information, provide good records and transfer care rapidly but safely (clinical functional integration). This problem is equally apparent on medical and surgical wards. A National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, concerning elective and emergency surgery in the elderly, indicated that routine daily input from medicine for the care of older people should be available to elderly patients undergoing surgery and is integral to the patient care pathways in this population.[20]

Studies suggest that as many as 40% of patients who die in hospital do not have the medical needs that require them to be there.[21,22] Less than 20% of people die in their own homes even though most people would prefer to do so.[22] It is clear that we must review the mechanisms for admitting patients, and the organisation of care for those that would be better served by care in alternative settings. ■

'An elderly, confused patient in her pyjamas was wheeled by a porter from her treatment to the entrance door, and left there. She was waiting for transport but obviously in dire need of care. She wore an incontinence pad that was saturated and the chair was also saturated with urine. She would get up and walk for a bit and then go back to the chair. No one spoke to her or tried to help her. She was just ignored. Was no one responsible for her care?' Patient story.

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'My trust does not function well at night and I am relieved on Monday that nothing catastrophic has happened over the weekend' Hospital doctor

Out-of-hours care breakdown

Emergency admissions activity at the weekend is around a quarter lower than during the rest of the week.[8] Patients admitted at the weekend do not get diagnostic tests as quickly as those admitted during the week, there are significant falls in the number of procedures performed at the weekend, including emergency procedures and fewer people are discharged. This suggests that patients are being 'pushed' into the following week. Analysis of 'system stress' (when admission to hospital exceeds discharge) shows a progressive rise from Sunday to Wednesday and 'recovery' (discharges exceeding admissions) from Thursday to Saturday.

Mortality for acutely ill patients is higher for those admitted at nights and at weekends, when less experienced doctors are on site. Studies suggest mortality is often 10% higher among patients admitted at weekends, although whether this is due to changes in case mix severity, clinical staffing or other organisational factors is unclear.[9]

RCP standards indicate that a consultant physician should always be available 'on call' and should be on site at least 12 hours per day, seven days per week with no concurrent duties except the delivery of care to acute admissions.[23] A consultant presence on the AMU for more than four hours per day, seven days per week, is associated with a reduced 28-day readmission rate.[16] Hospitals employing consultants with twice daily ward rounds in the AMU and no other routine duties have a lower mortality rate.[18]

However, around half of trusts had an on-take consultant with other routine duties to accommodate, and many do not provide twice-daily reviews of all acute medical admissions.[10] The introduction of an acute medical assessment unit may speed access to acute medical services and reduce cost.[24,25]

Consultants have a crucial role to play in ensuring effective clinical decision-making and communication. An NCEPOD report found that the care of patients who underwent resuscitation following in-hospital cardiopulmonary arrest to be 'less than good' in 70% of cases. Deficiencies were noted in consultant involvement, particularly in decision making for cardiopulmonary resuscitation (CPR) status. It is equally important that decision making about CPR is communicated consistently and effectively and performed only on patients who are likely to benefit.[20] The demands of discussing interventions such as CPR with each individual patient in a way that is deemed to be appropriate are significant.[26] Recent publications suggest that between 10 and 15 minutes is spent in discussion with the patient, but this is highly variable.[24,25] ■

Looming crisis in the medical workforce

The reduced working hours of junior doctors imposed by the New Deal and the European Working Time Directive has seen many specialties move to shift-pattern working, potentially impacting adversely on continuity of care.[27] Shift patterns may have decreased quality of life as work periods, although shorter, are more frequent, less regular and more anti-social. Training opportunities and trainee/trainer interaction have been reduced. Trainees working at night may not be able to undertake planned training during daylight hours due to enforced compensatory rest periods. Problems in recruitment attributable to changes in immigration law have compounded the difficulty in filling gaps in resident shift rota systems.

The reduction in junior doctors hours has also negated the expansion seen in consultant numbers over the past 10 years. The RCP's census in 2011 indicated that:

- 59% of consultants report working more hours than three years ago.
- Three quarters of consultants report being under more pressure than three years ago.
- Around half of consultants report spending less time with their trainees than three years ago.[10]

The supervision that consultants can offer to trainees is often inadequate due to the pressure of clinical work and a fragmented team structure. Nearly a quarter of RCP fellows and members rated their hospitals' ability to deliver stable teams for patient care and education as poor or very poor.[17]

Current policy is to reduce hospital training numbers and increase GP training numbers. This may be appropriate if GPs reduce hospital admissions or staff (additional) community-based care facilities. There is no evidence that this is likely to happen. >>>

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<<< There is a crisis in recruitment into emergency medicine and general medicine at both training and consultant levels. There were 0.8 applicants for every specialty training year 4 (ST4) post in 2011, compared with 5.0 for general surgery and 3.7 for geriatric medicine, resulting in partially filled training schemes. Numerous gaps have begun to appear in medical training programmes nationally and rota gaps are being plugged by locum staff on a regular basis.[28] In addition, there are large numbers of unfilled consultant posts in emergency medicine.[10]

Application rates into training schemes involving a general medicine commitment are also declining. Evidence suggests that the burdens associated with the role of the 'on-take' general medical registrar are responsible. An RCP survey of medical trainees – foundation year 2 (FT2s) and core medical trainees (CMTs) and medical registrars indicates that:

- The workload of the general medical registrar was perceived to be greater than that of their contemporaries in other specialties.
- Around 38% of FT2s and CMTs considered the workload of the medical registrar to be 'unmanageable'.
- Over a quarter (26.9%) of medical registrars considered their workload unmanageable.
- Only 5.3% of FT2s and CMTs thought medical registrars had an 'excellent' work–life balance, while 88.5% felt GP registrars had an 'excellent' work–life balance.
- Nearly 50% of medical registrars reported that they enjoyed their work 'not very much' or 'not at all'.[11]

It is clear that we risk losing the pool of generalist skills that is so essential to the effective provision of holistic care to patients. ■

'Medical registrars are overworked, with huge pressures from across the hospital, managers and A&E'
Core medical trainee, year 1

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Hospitals at a glance

How many beds are there in acute hospitals?

> 107,444 hospital beds are provided for general and acute services in England each year (April 2011–March 2012).[15] The number of general and acute beds has decreased by a third in the past 25 years.[3]

> There are 2.4 acute beds per 1,000 people in the UK (2010). This is below the Organisation for Economic Co-operation and Development (OECD) average of 3.4 beds per 1,000 population, but broadly equivalent to the US (2.6 beds per 1,000 in 2009).[29]

Who is in hospital?

> Nearly two thirds (65%) of people admitted to hospital are over 65 years old.[5] People over 65 occupy more than 51,000 acute care beds at any one time.[3]

> People over 85 years old account for 25% of bed days – this has increased from 22% over the past 10 years.[5]

> Over the past 10 years there has been a 65% increase in secondary care episodes for those over 75, compared with 31% for those aged 15–59.[4]

How long do people stay in hospital?

> The average length of stay for acute care in UK hospitals in 2010 was 7.7 days, higher than the OECD average of 7.1 days and significantly in excess of averages in Australia (5.1), Netherlands (5.8) and USA (4.9).[29]

> People over 85 tend to spend around eight days longer in hospital than those under 65 – 11 days compared to three.[3]

How many people attend A&E departments?

> In the three months between July and September 2011, there were 5,389,265 attendances at A&Es in England (5,213,362 first attendances, with 175,902 follow-ups).[15]

How many people get admitted to hospital?

> In 2010–11, 3.6 million people who attended A&E were then admitted to hospital.[15]

> There has been a 37% increase in emergency hospital admissions in the past 10 years.[4]

> Emergency hospital admissions account for over a third (35%) of all hospital admissions, costing an estimated £11 billion per year.[14]

> There are more than two million unplanned hospital admissions for people over 65.[3]

> Mortality rates for emergency admissions after 30 days of discharge is 3.6%, compared with 0.7% for elective admissions.[4]

How many patients do doctors look after?

> A snapshot survey of doctors in England and Wales in 2010 found that doctors were responsible for an average of 61 patients at night. However, this varied from 1 to 400 patients.[28]

Are services the same at the weekend?

> Emergency admissions activity at the weekends is around 25% lower than during the rest of the week.[8]

> The largest volume of hospital-based clinical activity at the weekend is that associated with emergency medical admissions.[30]

> Each year, there are 0.5 million outpatient appointments at the weekend, compared to around 14 million during the week.[8]

> International studies suggest an increase in mortality of around 10% among patients admitted at weekends. It is not clear whether this is due to changes in casemix severity, clinical staffing or other organisational factors.[9]

Who is in charge at night?

> On the night of the RCP's snapshot survey in 2010, 63 medical teams in England and Wales reported that the most senior medical cover was a junior doctor in their first two years of training.[28]

> Consultants were involved in the direct delivery of overnight care in only 6% of teams.[28]

The time for action

It is increasingly clear that hospital care must be radically reviewed if the health service is to meet the needs of patients now and in the future. Hospital services are one aspect of a continuum of care, involving general practice, social care, mental health services and the voluntary sector, among others. If we are to meet the challenges ahead, we must work collaboratively to revolutionise the way we organise and deliver care.

10 priority areas for action

Transforming the care that patients receive can only be achieved by challenging existing practice. Organisations involved in health and social care, including governments, employers and medical royal colleges, must be prepared to make difficult decisions and implement radical change where this will improve care. The RCP has identified 10 priority areas for action:

> **We must promote dignity and patient-centred care**
We must make sure patients are at the heart of service design and clinical practice. Hospitals must be a safe place in which all patients are treated with dignity and respect, including those with dementia. All health professionals have a duty to ensure patient needs are met, working together as a team to deliver the best possible care. Health professionals must be supported to care for patients, with appropriate staffing ratios and time to communicate, diagnose and treat. Hospitals under pressure must find ways of meeting the challenges without sacrificing the patient experience of care.

> **We must redesign services**
We must make difficult decisions about the design of services where this will improve patient care. In some areas, this will require service reconfiguration. Decisions about service redesign must be clinically led and clinicians must be prepared to challenge the way services – including their own service – are organised. We must better communicate the need for change to individuals and communities.

> **We must change the way we organise hospital care**
We must reorganise hospital care so that patients have access to efficient, high-quality, expert care regardless of their age or day of the week. This is likely to involve changes to working patterns and the way we organise wards and deploy physicians in hospitals and the community. Patients and their carers must know who to talk to about their care and be supported to make informed decisions.

> **We must review medical education and training**
We must consider whether the way we educate, train and deploy physicians ensures the right balance of general and specialist skills to deliver expert, holistic care for current and future patients. It is vital that all medical professionals have the skills and knowledge they need to care for older patients with complex conditions, frailty and dementia.

> **We must ensure the right mix of medical skills**
We need to make sure that medicine, including emergency and general medicine, remains an attractive career option. The burden of service delivery must not fall disproportionately on one profession, career grade or specialty. It is equally important that consultants and trainees have the skills, knowledge and time they need to make clinically appropriate decisions and communicate with patients.

> **We must renegotiate the New Deal**
We must renegotiate the New Deal to ensure time for training and a fair deal for doctors and patients.

> **We must improve the availability of primary care**
We must ensure the availability of primary care services whenever they are needed, including at the weekend and at night.

> **We must revolutionise the way we use information**
We must create pathways in which information moves with patients across the system in real-time. We must enhance electronic patient records and promote common record standards. Information and systems need to support clinical decision-making, reflective practice, quality improvement and meaningful patient choice.

> **We must embed quality improvement across the system**
We must ensure systems deliver continuous quality improvement, including commissioning structures. Tools such as clinical audits and service accreditation schemes have an important role to play.

> **We must show national leadership**
We must be prepared to make national recommendations and implement national standards and systems where this is in the interest of patient care. Organisations that do not apply national recommendations must be able to demonstrate legitimate reasons for their approach. ■

Join the debate

To address these issues, the RCP has launched the Future Hospital Commission. The Commission will undertake a radical review of the organisation of hospital services, releasing its recommendations in spring 2013.

Join the future hospital debate

> Online at www.rcplondon.ac.uk/futurehospital

> Email comments, suggestions and examples of good and innovative practice to futurehospital@rcplondon.ac.uk

Royal College of Physicians