UNIVERSITY OF LIVERPOOL

# Future Hospital Programme:

## An independent evaluation - Final Report

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# Contents



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# Abstract


## Background

Following the Future Hospital Commission report, the Royal College of Physicians (RCP) set up the Future Hospital Programme to put these visions into practice. The Future Hospital Programme had various foci of activity, this included providing support to eight development sites to implement projects surrounding the Future Hospital Commission report principles and engaging the health care community. The RCP sought an external group to undertake an independent evaluation. This report presents the findings of that external evaluation.

## Methods

A mixed methods approach was used. Opinions about the FHP were sought four main sources; the development site teams, the patient representatives from the development sites, personnel from the RCP both directly and indirectly involved with the programme, and the wider college membership. Activities involved focus groups, one-to-one interviews, a comprehensive documents review and web-based surveys.

## Key Findings

This evaluation has confirmed that the programme has had many successes and brought about real change; developed QI capacity directly within teams; and more widely across the RCP, and demonstrated it is possible for the vision of the Future Hospital Commission to be delivered within real world environments

It has demonstrated that colleges are well placed to lead on quality improvement work. The programme links well to future plans for the Quality Improvement Hub in the RCP, as well as the Chief Registrar scheme and the web-based 'Tell Us Your Story' initiative.

However, the Future Hospital Programme approach is not sustainable for the RCP to resource alone. Whilst it was effective pump-priming to deliver demonstration sites and shared evaluations, other approaches need to be explored to facilitate professional-led, 'bottom up' innovation, co-produced with patients working to RCP recommendations for quality improvement, evaluation and innovation. This requires a less formalised and high-investment environment for it to be sustainable in the longer-term.

# Background

The Future Hospital Commission report published in September 2013, described a new model of patient-centred care underpinned by a core set of 11 principles and new approaches to leadership and training (1).

The 11 Principles of the Future Hospital Commission:

1. Fundamental standards of care must always be met.
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.
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 specific clinical and support needs.
11. Staff are supported to deliver safe, compassionate care and are committed to improving quality.

In addition to these 11 principles, the Future Hospital Commission also made 50 recommendations.

The aim of the Future Hospital Programme was to put this vision into practice over a three-year period (2014-2017). The Future Hospital officer was appointed to guide the activities.

The Future Hospital Programme of activity included:

### Future Hospital development sites

The main work stream of the Future Hospital Programme was working with eight multidisciplinary teams on discrete projects aligned to the vision of the Future Hospital Commission. The sites were recruited in two phases. For phase 1 sites (recruited in October 2014) the topic was open. However, all four of the successful applications focused on improving care for frail older patients, reflecting the largest demographic of patients using NHS acute medical services. For phase 2 the call was specified as projects focusing on integrated care and four sites were recruited in March 2016.

*Phase 1*

**Worthing Hospital -** the emergency floor project brought acute medical, surgical and care of the elderly teams together with standardisation of clinical pathways for emergency admissions.

**East Lancashire Hospitals NHS Trust -** developed integrated community-based teams to support frail older people within their homes, either preventing admission to hospital or continuing care following assessment and care in hospital.

**Mid Yorkshire NHS Hospitals Trust** - the 'REACT' team is a dedicated team to ensure patients with frailty and complexity are appropriately assessed when they arrive at hospital, by geriatricians at the traditional 'front door' areas.

**Betsi Cadwaldr University Health Board -** the team increased access to specialist outpatient consultations through telemedicine for frail and older patients in rural north Wales, to ensure they took place as close to home as possible.

*Phase 2*

**Central and South Manchester -** the team integrated respiratory services across central and south Manchester.

**North-West Surrey -** by developing dedicated locality 'hubs', the North-West Surrey team aimed to deliver the best possible outcomes for the older population.

**North West Paediatric Allergy Network (NWPAN)** - working with all healthcare staff and families and the public, NWPAN aimed to deliver more effective and timely care for children with allergies.

**Sandwell and West Birmingham Hospitals -** developing and delivering physician-led integrated services for respiratory patients in Sandwell and West Birmingham.

Although the Future Hospital team worked in close partnership with clinical teams, no funding was provided by the RCP directly to partner healthcare organisations to bolster service provision.

## Future Hospital Chief Registrar scheme

Through the chief registrar scheme, looked to establish new, senior leadership roles for trainee physicians. The chief registrar pilot, run during 2016/17, determined the skills, protected time and training needed to support this new leadership position.

## Future Hospital Partners Network

An active and evolving community of people who are champions for the Future Hospital model. Many individual clinicians, NHS trusts and stakeholders from across the NHS expressed an interest in becoming involved in the work of the FHP.

### Tell Us Your Story

The Future Hospital Programme published online stories of clinically-led service improvement, examples of where the Future Hospital Commission principles had been effectively embedded into day-to-day practice in the NHS. The stories were grouped under five themes:

- 7-day services
- Integrated care
- Person-centred care
- Improving patient safety
- Developing the workforce

Stories are reviewed in a formal quality assurance process by Future Hospital officers. Submitted stories are assessed on their robustness and how easy it would be for someone to adopt similar principles in another hospital.

### Integrated diabetes care in Oxfordshire

The FHP supported a clinical and research team in developing and implementing an integrated service model for diabetes care in Oxfordshire.

The Future Hospital Programme also commissioned smaller discrete work packages:

### Review of integrated care

The Future Hospital Programme commissioned a review of current models of integrated diabetes care.

### Transition services for young adults and adolescents

The Future Hospital Programme commissioned a review of transition services within adult medical specialties, which resulted in the publication of an RCP toolkit raising awareness of the issues related to caring for young adults and adolescents with long-term, complex conditions.

The Future Hospital Journal (now the Future Healthcare Journal) was also developed following the Future Hospital Commission report. With the aim of providing a sustainable long-term forum for debate and innovation around the delivery of secondary healthcare, with a focus on improving patient care and management through process and system change. This was a separate entity to the Future Hospital Programme team but was used to communicate the activities relating to the programme to the RCP's wider membership.

## Evaluation

A team of academics from the Department of Health Services Research and the Management School at the University of Liverpool, applied to undertake the external evaluation of the Future Hospital Programme (FHP). The external evaluation supplements, and gives an overview of, the central internal evaluation of the pilots and local site evaluations, as per the supplied tender document. The evaluation team consisted of eight members, six senior academics from a variety of backgrounds and two

research assistants. The health professional groups represented within the team included; general practice, dentistry and orthoptics.

The aims of this evaluation were:

- To assess how the Future Hospital Programme has affected patients, professionals and processes.
- To assess whether the interpretations of the Future Hospital model are sustainable and more widely implementable.
- To provide an external assessment of the processes, findings and developmental phases of the Future Hospital Programme at both site and central project team levels.

# Methods

We used a mixed methods approach, in addition to monthly meetings with the Evaluation and project team from the Future Hospital Programme. This was supplemented by weekly telephone conversations to discuss progress with the Future Hospital Programme team, to support the evaluation team to access required documentation and personnel. We also attended the three learning events held during the period of our evaluation (December 2016 to August 2017).

We collected data regarding the Future Hospital Programme from a variety of perspectives, which included: the development site teams, the development site; patient representatives and Patient Carer Network (PCN) representatives; personnel from the RCP both directly and indirectly involved with the programme; and members and fellows of the RCP.

Ethical approval was granted by the University of Liverpool Institute of Psychology, Health and Society Research Ethics Committee (Reference: IPHS-1907) on 21st April 2017.

The following framework was used to guide all methods of data collection. This was informed by, and built upon, discussions with the Future Hospital Programme team about the aims, objectives and evaluation of the Future Hospital Programme and our application of relevant theories about change management, public involvement and co-production of innovation.

We identified three key elements of enquiry which formed the basis for each topic guide:

- Patients
    - What have been the challenges and barriers to collecting patient outcome data (or relevant proxies) or patient experience data?
    - How has patient participation/co-production/leadership been a part of the Future Hospital process in service redesign?
- Professionals
    - What is the impact of change on the multi-disciplinary team?
    - What is the impact of the multi-disciplinary team on change?
    - What role did clinical leadership play in the realisation of the Future Hospital model?
- Processes
    - What changes or improvements have been made to hospital, community or primary care processes as a result of future hospital work?
    - Have new pathways of care been identified and shown to be effective?
    - How has the Future Hospital Programme influenced change and the development of new processes?

## Data sources

### *Development Site Documentary Analysis*

A review of all development site documentation was conducted. Four hundred and seventy-one documents were reviewed, including: monthly, quarterly and annual reports, patient reports, learning event presentations, posters and feedback, monthly call notes, notes from site visits and personal

communications. A pre-designed data extraction form was used based on the above framework, collecting information on

- 'Why'; Was change needed within the service? What was the motivation for change?
- 'How'; What type of service redesign? What changes to working were made?
- 'Who'; Who was involved? What was the extent of patient input to co-design? What was the extent of NHS management support? What were the links across services?
- 'What'; What was the impact on patient experience and care? What metrics were collected and were the impact of these? What was the impact on staff well-being?
- 'When'; What is the context of the pilot site?
- 'What extra'; What did Future Hospital Programme provide? What were the impacts of what Future Hospital Programme provided?
- 'Challenges and barriers'
- 'Learning through being a development site'

### *Development Site Focus Groups*

Focus groups were conducted with six of the site teams attending the Future Hospital Programme learning event on 10th May 2017. The group sizes varied between two and five team members. All groups included the clinical lead and five out of the six groups included at least one patient representative. Other roles of individuals in the groups included project manager, nurse, lead general practitioner, data analyst and CCG manager. Time with each group was limited to 30 minutes due to the other activities planned during the learning event day. The two focus groups not possible on the day of the learning event due to time constraints were conducted via teleconference. The group sizes were three and six team members, both groups included a clinical lead and one included a patient representative. The topic guide followed the framework of patients, professionals and processes.

### *Development Site Survey*

A web-based questionnaire was also circulated to the development site team members including patient representatives giving another opportunity to share their opinions individually. The questionnaire used a combination of multiple choice and free text response options. The topics covered included; the sites achievements, impact on patient experience, support received from their organisation, motivation to be a part of the development site team, support provided by the Future Hospital Programme, recognition of the work, co-production, multi-disciplinary team working, learning, and asking them to rank the importance of the various elements provided by the Future Hospital Programme. The survey received 23 responses; this included at least one response from each of the eight development sites plus the Oxford project and from a mixture of patient representatives and clinicians.

### *Patient Representatives Focus Group*

A focus group was conducted with the local patient representatives and PCN representatives attending the Future Hospital Programme learning event on 10th May 2017. One hour was allocated to speak with the group of patient representatives separate from other members of their team. This

focus group included nine participants in total, seven of which were local patient representatives and two PCN representatives. Seven of the eight development sites were represented. Topics covered included role, successes, barriers, level of engagement, opportunities, support and training, lessons learnt and future recommendations.

Following this focus group some of the patient representatives requested to speak with the evaluation team on an individual basis. One-to-one interviews were offered to all local patient representatives and PCN representatives. Four one-to-one interviews were conducted via teleconference and one patient representative provided a written account. The same topic guide for the focus group described above was used.

### *Interviews with Personnel In and Around the Future Hospital Programme Team*

Key personnel from within and surrounding the Future Hospital Programme team, as well as senior members of the RCP were identified. One-to-one interviews were conducted with 17 individuals either face to face or via teleconference, six from within the Future Hospital Programme team and 11 involved in the mechanism surrounding the Future Hospital Programme team including three senior members of the RCP. The patients, professionals and processes topic guide was adapted depending on the role of the individual and their level of involvement with the Future Hospital Programme.

### *Royal College of Physicians' Members and Fellows Survey*

In order to seek the opinions from the wider RCP membership, a web-based survey was circulated by the RCP through a variety of channels. The survey maintained the University of Liverpool branding to highlight its independent nature. The questionnaire used mainly multiple choice response options. The topics covered included; awareness of the Future Hospital Programme, promotion of topics, application of the Future Hospital principles, improvement of own service, importance of quality improvement initiatives.

The survey received 138 responses; the majority of which were from practicing clinical physicians (85.3%) at consultant level (84.6%) and 26.5% held a medical management role.

## Data Exclusion

The research fellow involved with the 'implementing integrated diabetes care in Oxfordshire' was interviewed along with the personnel in and around the Future Hospital Programme team and completed the development site survey. Despite finding some interesting differences, these are not reported here, as anonymity could not be guaranteed.

## Data Analysis

All focus groups and interviews were audio-recorded with consent and transcribed verbatim. Two members of the evaluation team independently coded three transcripts from each of the following groups; development site teams, patient representatives and RCP personnel. The two sets of coding

were compared to identify variation, areas of disagreement/agreement in code allocation. This created a coding scheme which could be used for all transcripts and survey free text responses.

A thematic analysis approach was used for qualitative datasets (2). Codes were grouped for similar topics, which created sub-themes across the data, these defined the emerging themes presented in the report. Descriptive quantitative statistics were used to analyse the multiple-choice responses of the surveys.

Quotes have been included where they add context or for illustrative purpose. To maintain anonymity of all participants; development sites are referred to as DS1 to DS8 in no particular order, patient representatives are referred to as PR1 to PR5, plus the patient representatives focus group referred to as PRs and the personnel in and around the Future Hospital Programme team are referred to as RCP1 to RCP17.

All findings are based upon data collected during this evaluation and an audit trail is available. The findings are discussed in the following three sections:

1. Development Sites- a comparative analysis of experience
2. Engagement and Co-production- patient and public involvement
3. RCP as a lead organisation-strengths and limitations

# Development Sites- a comparative analysis of experience

In this first section, we report in more detail the experience of the eight development sites that participated in the Future Hospital Programme. We present findings from a comparative analysis by drawing on the eight focus group development site interviews and secondary data in the various site progress reports.

## Processes

### *Motivation to Becoming a Future Hospital Programme Development Site*

The analysis across the hospital sites of this phase of the selection process demonstrates mixed views. This suggests there were several motivators that shaped a sites decision to apply to become a Future Hospital Programme development site.

The first motivator relates to the need for change led by physicians, where agency of individuals and the relationship they have with their professional body to gain sponsorship momentum from their Trust was fundamental. This was especially apparent in DS1-3, 5 and 8 where staff gave this account:

> *"…from my perspective and the clinical team's perspective it was an amazing platform for us to gain a little bit of self-worth, and belief and kudos for an organisation that was actually struggling at that time. It was, you know it was going through a very difficult point and to some extent is that, that good news story was so important for the organisation."* (employee, DS1)

> *"exploring the possibility of a new way of working and the organisational changes that would be required to achieve this."* (DS2, document 7/8)

Balancing the kudos of the RCP with the development site aspirations for the Future Hospital Programme to become a vehicle that would contribute to driving through change they arrived at an alliance that would be perceived both internally and externally as offering expertise in change; thus gaining sponsorship momentum. Of the survey respondents, 77.3% reported their development site had recognition from internal and/or external sources. Overall, it was reported that the impact of this recognition had positive effects on the development site teams. This included a sense of *professional pride* working to provide better service across units, also exploiting benefits of multidisciplinary team working. The Future Hospital Programme team's contribution is that it provided the structure, such as systematic reporting processes and learning events and the infrastructure in terms of support and access to mentors to address local problems. This programme has without exception provided learning opportunities at individual and collective levels.

The second motivator for becoming a Future Hospital Programme development site was timeliness: the need to bring about patient-focused change, at the time of the applications call. Although effective health care development requires 'productive interaction', the practical processes to deliver such

change may not always follow that recommended model. Such inconsistencies include separating targets for different branches of service delivery which focuses effort in silos rather than cross systems coordination and collaboration (3).

> *"the, factors that led us towards special measures are constant and seemingly insurmountable pressure on beds kept on repeating themselves, it seemed to me that I would say it was my absolute conviction that the answer to this, lay in the appropriate management of frail older people … and it was, for me kind of, an opportunity … to marry in the developments in the community."* (employee, DS4)

> *"… at the timing of our experience is that we had already been going through a process of change, and our project had already evolved to the point of launch so FHC calls for applications were opened… The timing was perfect."* (employee DS3)

> *"it was quite a CCG driven project as part of their commissioning intentions around integrating health care across the system for frail older people."* (employee, DS8)

> *"Within my own specialty of geriatrics, we saw subspecialties like stroke, develop …but it seemed to me as a provider that the generality of …frail older patients, have not really been factored into the sort of strategic thinking of the organisation."* (employee, DS4)

Complexity based organisations theory recommends that system and pathways need to be considered as a whole rather than divided into segments, otherwise whilst each component may deliver on its own targets, the overall process may fail to do so, as the thinking about co-ordination and interactions between components of the whole is neglected (3).

### *Integrating Whole System Change with Patients at the Centre*

Combining targets and or budgets across whole systems also generates greater creativity and novel solutions (3). Within our analysis of the development sites, we looked for evidence of whole-system and creative thinking versus constraints compartmentalising into segments. In widening the focus to the whole system, the Future Hospital Programme was able to cross boundaries.

> *"The key issue for me has been getting the stakeholders engaged in this process. Certainly if your project is to do with integration, which is what we are trying to do so we are looking, we are having to speak with people whom we normally do not speak with, who are outside of our organisation, people who are you know governed by different organisations, have their own sort of frameworks and how to get them so that was an issue and that took us a long time to get them on board because we were, we understood the ethos of this project, but then to, to be able to convince the other stakeholders and to get their buy-in to subscribe to the same ethos and to get them on board it took us a considerable amount of time." (employee, DS2)*

> *"…we had taken on a range of new services through the Transforming Community Services programme so the organisation was already thinking about how it needed to engage*

*differently across the system… But we had also been through a very difficult time organisationally as an organisation in special measure, so …you know it was felt again we needed to drastically rethink the way we worked to address that." (employee, DS4)*

The above quotes show that in balancing the demands of the Future Hospital Programme: whole system change and the needs of patients, the development site project leads could call for their organisations to generate commitment in creating the culmination of health service providers and patients to partner in a viable sustainable service model. We note for example a propensity to use clinician-led change to bring about patient-led outcomes. There were several examples of sites that recognised the complexity in combining multiple stakeholders to reconfigure multiple services or sites and were committed to this path.

*"Frailty has been agreed as one of seven health improvement priorities, and work this year has established a Frailty Steering Group which is bringing together multiple strands of work. Considerable work has also been undertaken with the regulated care sector which includes nursing homes, care homes and domiciliary care as part of Together a Healthier Future." (DS4, document 75)*

A positive culture that promotes and enhances levels of medical engagement should be a key objective of medical leadership (4). The critical argument that underlies this proposition are that levels of medical engagement are strongly associated with organisational performance, including quality of care (4).

### *Organisational Leadership, Structure and Sponsorship*

Consistent leadership, senior management and sponsorship enables projects to thrive and the converse was also true. Fifty-five percent of respondents to the development site survey reported they received the support they required from their organisation.
Development site team changes created inconsistencies in the direction and momentum but could be managed and minimised.

*"*[Future Hospital Programme Officer has] *spoken a little bit about the rigour we have been through a Future Hospital process and I think it was clear that, in terms of that discipline ..you know it is a network, organisations and professionals so to actually form a specific project and take it through a defined process, with timescales and everything else, I think we recognised that that was something that was really valuable, and it was the most like… it was the most likely way in which we were able to achieve some of the kind of objectives that we would probably have struggled to achieve otherwise. Recognising it was going to be a challenge, to meet the capacity of that, it was going to stretch us."* (employee, DS7)

The above quote shows an example of one of the several projects which experienced challenges from internal organisational restructuring that include changes at the top of the trust leadership team and the consistency of the support offered by the Trusts. Several of the projects thrived under consistent leadership support and sponsorship. Attrition of development site management team members created inconsistencies in the direction and momentum of all of the projects. In some cases the

attrition was managed and the cascade of knowledge and skills well-orchestrated, thus minimising adverse impact on the projects. In other cases there was limited management of the attrition and this led to periods of either inertia, chaos or lack of direction before projects were refocused, rephrased and brought back into line.

## *The Internal Organisation of Work*

### *Building the Right Relationships*

Developing a new model of care involves establishing or strengthening relationships that span system boundaries. We found that the work conducted in many development sites was seen as having enabled conversations between providers that otherwise would not have happened. Examples of new alliances and relationships were given:

> *"As the PCN rep, I had access to RCP staff support at the start of the project. However, the remit for this role requires an ability to take the initiative to ensure relevant information is sought, and provided; that effective communication is maintained across all involved… with both the RCP and the patient representative and the FH development site team."* (patient representative, DS7)

> *"…. within our directorate and beyond our directorate… it has encouraged relationships in many respects…"* (employee, DS4)

We heard that several factors can facilitate the formation of these relationships, including direct communication, regular face-to-face meetings, co-location of integrated teams, and the alignment of strategic objectives. Some interviewees stressed the importance of having the leaders and patients 'around every table' in order to consistently keep patient-centric health on the agenda.

> *"[Our patient representative] is involved as part of the team and not someone that we have consulted with... Rather than just asking [our patient representative] what he thinks about x y and z, he has led that process, he has worked with clinicians, managers, corporate support services and he has very much felt like part of the team and he gives that patient perspective as to how we approach things…he very much informed that from a patient point of view.".* (employee, DS5)

### *Multi-Disciplinary and Multisite Working*

The Future Hospital Programme has facilitated the coming together of organisations that have traditionally operated in relative isolation from one another, particularly the combination of patient networks, NHS, social services and voluntary sector organisations. It is important to recognise that relationship-building takes time and may require cultural change within organisations (5). Achieving this was not without its challenges in the Future Hospital Programme though people involved recognised the benefits to the healthcare system, patients and staff.

> *"... I think it was challenging because we were doing it across two [hospitals]… and it was a single team."* (employee, DS6)

*"…voluntary sector was slow to engage due to increased demand being placed on their time and resources."* (patient representative, DS7)

It was reported by 86.4%, of respondents to the development site survey, that multi-disciplinary working has had a positive impact on their project.

## Tensions

The analysis across the hospital sites suggests that several tensions shaped their participation in the Future Hospital Programme. The first tension reveals typical organisational and management challenges; balancing workload demands within limited resources, with the challenge of project delivery to time and target (6). This was especially prominent in DS2 and DS4 where we note staff accounting for the difficulties in coordinating the demands of the project with their everyday workload.

*"…with all these kind of projects, there is that sort of conflict between doing the day job, and then actually to try and you know sort of measure, you know trying to achieve some kind of improvement, and I think what invariably happens is you won't get everybody there, all the way through the length of this project, you will have people who will be able to kind of do, some, maybe at the start, maybe the middle, maybe towards the end, and then there will be some people maybe be able to work all the way through it, you kind of have to be very kind of agile in your way of kind of managing these projects, in the sense that if you have got certain elements that you need, like a project manager, or an analyst or you know, you are going to have to get used to the fact that you are not going to get them for that length, so you are going to have to be very smart about how and when you are going to use them. And I think that is one of the key things in truth is that most sort of organisations don't have the resources to be able to put people full time onto this sort of these projects and there is a bit of kind of working sort of outside of normal hours…"* (employee, DS2)

*"Clinical and managerial staff are constantly challenged to balance day to operational and clinical elements of their role with strategic and quality improvement work. Although the organisation has had some very significant successes in quality improvement and service developments, protecting the time for these to progress remains a weekly challenge for all."* (DS4, document 75)

*"We are utilising existing staff to develop the work which is the best way to do it, but inevitably in a very, very busy Trust you get dragged particularly over the winter period and bank holiday period, into operational management. So, that is always a dilemma and that has been flagged up throughout the course of our pilot."* (employee, DS4)

### *Future Hospital Programme Plus Business as Usual*

On some sites the Future Hospital Programme was adopted within existing roles, others engineered workforce and process reconfiguration, which realigned existing resources. The majority of sites

reported the pressure of doing the Future Hospital Programme on top of existing workload was burdensome. The majority of the sites reported high attrition rates, consistent staff turnover and a need for capability building.

> *"we have been in a massive sea of change but actually being part of this process has ensured that we are continually on line and despite all these changes, the one consistent person is the chairman hasn't changed."* (employee, DS5)

> *"Further staff resignations. Staffing levels still variable. Nursing morale remains an issue." (DS3, document 10b)*

Balancing the demands of the development site project and day-to-day workload, they recognised the need to not undermine the quality of project progress when day-to-day issues took priority. This called for sites to generate commitment in creating the necessary additional resources. Prominent of these resources were time (i.e. extending the working day) and staff. The latter proved particularly significant because, it highlighted an emerging tension, that of balancing individual development and career progression among those contributing to the project and ensuring the necessary project continuity. This resulted in staff attrition both at the development site team level as well as, among patient representatives. On several sites the Future Hospital Programme projects fuelled individual career development. This was at the expense of needing increased contribution from other members of the team and disrupting the momentum of the project.

> *"…with all these kind of projects, there is that sort of conflict between doing the day job, and then actually to try and you know sort of measure, you know trying to achieve some kind of improvement…"* (employee, DS2)

> *"So he [previous Clinical Lead] is now a fellow [for a national body], my clinical academic lead and as a result of the work and working with the group he is now doing a project looking at patient inputted records. So he has gone off to do the sort of stuff that he has picked up from the patient reps and the network generally is around working more with patients and patients taking a control but that has come from the support he has had from our Patient Carers Network sort of thing. So, it has kind of done a lightbulb moment for him. But again it takes him away from the team."* (employee, DS1)

> *"She has used the work that she has done with us, to then move on to actually work with … government, in actually looking at developing the same project, for all of … region. So the big spin-off so there has been a big spin-off like that."* (employee, DS1)

> *"Throughout the course of the programme we have had a number of changes in key staff. In particular changes in available support from quality improvement, informatics, programme management, commissioning managers and patient experience team. Some staff leaving though now being replaced, with inherent delays this creates. In addition changes in clinical team members with different approaches to care for frail older people are shown to effect clinical decisions, this is particularly seen in the "front door team". We are therefore continually rebuilding the broader team."* (DS4, document 75)

The relative opportunities provided to individual members versus the collective benefits for the development site team can create interpersonal tensions in the form of potential 'professional jealousy'.

> *"I suppose one of our biggest problems was that the change happened, and when the change happened I would say, there is probably an element of professional jealousy gone on, there is this team, there was also this Future Hospital, oh we are doing that but they weren't, … now I have been asked to go and present stuff about Future Hospital to the new strategic group that are setting the strategy that has to be in place by next January."* (employee, DS1)

These interpersonal tensions across professional groups are not uncommon, and reflect findings in other social contexts, where social interactions reflect the dynamics governing the distribution and organisation of work across multiple professional groups (7). However, what the inter-professional tensions do expose aside from the internal dynamics of the Future Hospital Programme development site teams, is the scope to align different stakeholders on the same agenda. This would suggest that the service quality improvements and other outcomes achieved as a result of becoming a Future Hospital Programme development site, were accomplished amidst concurrent inter-professional tensions within the team, the hospital, the relationship with the Trust and senior management. Such tensions work against principles of collaborative and integrated modes of work that the Future Hospital Programme promotes, but even with RCP support, sites lack sufficient influence to deliver consistently.

### *Resources and Organisational Support*

Resource requirements were generally underestimated throughout the majority of the projects. Organisational dynamics to resource the changes were required for project delivery, reported as both a challenge and contribution to that delivery but were often paradoxically integrated. These ranged from identifying the team members, maintaining momentum of the individual projects, developing the project management skills needed and leadership capacity, developing the social and intellectual capital to maintain the project momentum.

> "*…I managed to get some money to actually do resilience and wellbeing and team building for the whole team at the time…"* (employee, DS1)

> *"Well it demanded people to be, sort of resourceful, to be able to contribute because they were doing this on top of what they were already doing."* (employee, DS2)

Several sites have made attempts to strengthen the competence, confidence and skills of their people – although there remains much more to be done to ensure that all professionals have the necessary skills, support, and at times mentoring, to develop resilience alongside capability. To redress this, wellbeing in the workforce should be a core objective for change projects be it new models of care or transforming services. Inter-professional approaches are considered as an effective way of improving skills across the workforce, but robust evidence for this remains patchy (8).

The fact that the Future Hospital Programme projects initiated in the various sites were clinician-led, was both one of the most important accomplishments in driving change, but it also present with difficulties in project managing if the resources were not available. The kind of resources that emerge as critical across hospital sites include predominantly: time and staff. However, another critical resource was the political support from the organisation at large. Without organisation buy in the chance of the Future Hospital Programme projects running smoothly were jeopardized. There is reference to funding issues but these are not seen critical to success. That said, the availability to resources in terms of expertise to draw on from the RCP was deemed valuable.

> *"I think what happened is it fell outside the organisation's priorities. Now, because it fell outside the organisations priorities as a service development it has never really had the support that it should have. We have the support from the medical director and the then chief exec."* (employee, DS1)

> *"The first 18 months went really well and I implemented several things that I am proud of. The second 18 months have been a disaster mainly as we had a complete management change and whilst I used all the leavers I had at my disposal, I failed to get the support we needed. Failure to be part of the organisations 'strategic plan' was my downfall."* (employee, DS1)

> *"…sharing some of our sort of frustrations if you want to call them and sharing that in a more sort of open environment, with the Future Hospital project in terms of ok how do we overcome that at the time… there is a way obviously of trying to accelerate that, earlier on and it could have been whatever level of support we needed at the time actually, what is your blocker locally, you know it is engaging or is it because you haven't got capacity, how do you fix that problem to move forward quicker. Sort that, sort of thing of actually trying to facilitate that independently."* (employee, DS2)

Even though engagement with the Future Hospital Programme increases workload, staff believe their investment of time is worthwhile.

> *"We want to do things, and we want to know if it works. Ok if it doesn't work, share it. If it works share it. Ok that is why, still people are in this project even though they don't have the time for it because they want to understand and make a real contribution, rather than just doing, because someone thinks."* (employee, DS2)

Fifty-nine percent of survey respondents reported feeling more engaged in their day-to-day role as a result of being part of a Future Hospital Programme development site team.

### *Staff Wellbeing*

Several development site team members reported that their own health and wellbeing was a cause for concern in the projects and they were running the project alongside existing roles and jobs of work. When events such increasing pressures from patient demand was experienced, there was limited support and flexibility to adapt so the pressure of work increased.

*"I think again it would have been useful to use the insight, from the project team, the Future Hospital project team to come and maybe advice us to do some support at the subgroup level as well."* (employee, DS2)

*Two staff surveys conducted – "shift towards a less optimistic position between the two surveys which we believe to be a response to the significant changes and winter pressures, compounded by staff shortages."* (DS3, document 16b)

*"Our consultant geriatrician has experienced GPs who are very anxious and overwhelmed start to now being much more confident…"* (employee, DS8)

### *Leadership Style*

The focus group comments suggested that a degree of consensus was emerging around the need for a more shared style of leadership. This challenges the existing NHS culture where the majority of leadership development still focuses on enhancing the skill set of the individual leader.

### *Building Longitudinal Resilience*

The development site teams had to sustain the 'team spirit' which fuelled the energy of delivering the project beyond content. This included sustaining confidence and guarding against obstacles that could demoralise the team if progress was not noted or things did not go to plan. Hence, a crucial input was emotional support such as 'having someone to talk to' and being a supportive critical friend. Another way of illustrating this may be 'mentorship' or 'coaching' as part of RCP skills provision in relation to the Future Hospital Programme site development.

*"[Our patient representative] has been fantastic, … in times when I could have quite easily just chucked everything in, because without her input there has been times…when I have had some supportive feedback, just a nudge..."* (employee, DS1)

*"I lost my mentor (mid project) ...so there was a whole thing about understanding the need for coaching and mentoring and emotional wellbeing through, that I have learnt so much about the emotional intelligence and resilience."* (employee, DS1)

*"I truly believe that being part of the programme has given us more resolve and understanding for the challenges and successes we experience."* (employee, DS8)

While the need for workforce development was referred to, so too were the barriers. Interviewees noted that workforce development was not a short-term process and that to embed this and translate it into changes in practice could take years. Barriers in workforce development were reported by some to be hindering the ambition of the Future Hospital Programme to accelerate integration.

*"The project isn't going to be complete for us in September 2017 because the frailty units will only just have been kicking into place in September. Ours is probably a longer-term scheme."* (employee, DS5)

### *Balance of Supporting Evidence*

The impact of a focus on statistical significance as to what matters to measure seemed to encourage a specific form of reporting that may not always do justice to the patient experience.

> *"the ethos of this project is very much you have got to be able to show some quantifiable tangible impact that you have done, you know try and improve it, with some real kind of proper data and that ethos has been brilliant because you don't often find that in some of these programmes."* (employee, DS2)

> *"they* [learning events] *have been wonderful and for me they have been subtended by the report writing, we have got together as a group, we have shared we have had a, we have had the kind of human and experiential connection but we have been required to share our experiences, numerically and in the narrative and but by doing that I mean we have you know we have had to grapple with these difficult things … the art and the science and the soul and the numbers they have to kind of find a balance."* (employee, DS3)

Whilst measures and metrics have been recognised as the 'expected' way of demonstrating proof of concept they adopted a more systematic and exploratory way of making these metrics and associated surveys and other ways of collecting data/evidence relevant.

> *"Speaking as somebody who is not in some cases the most disciplined it can be a bit challenging to be given time deadlines for things, that you weren't anticipating. So, that is just a personal view, that is a mild negative but actually applying a bit of discipline and getting things done within a time deadline is of course a good way to achieve things."* (employee, DS4)

## Inputs, Outcomes and Impacts

The analysis across the sites suggests that considering the 'inputs' that the Future Hospital Programme provided via the structure and guidelines guiding phase one and phase two projects, a range of 'outputs' have resulted that account for a range of tangible impacts. Improvements in a range of practices collectively affecting the patient experience. However, we identified a number of crucial but more subtle impacts.

The hospital sites participating in the Future Hospital Programme recognised the RCP's contribution by way of inputs in that it provided the structure (systematic reporting processes, learning events) and the infrastructure in terms of support and access to mentors to address local problems. Such infrastructure, also included a more systematic approach to accounting for the improvements in patient care. The outputs measured are driven by the metrics orientation instigated by the Future Hospital Programme design. This metrics orientation provides focus and develops a language of 'measures' that 'quantifies' patient care. Some of the reflections capturing how sites experienced the focus on metrics and measuring outputs are reflected in the following quotes:

> *"A lot of other projects in the past, have just kind of had a very woolly approach to proving that you have actually made an improvement whereas the ethos of this project is very*

*much you have got to be able to show some quantifiable tangible impact that you have done, you know try and improve it, with some real kind of proper data and that ethos has been brilliant because you don't often find that in some of these programmes."* (employee, DS2)

*"It is a very much evidenced approach, this is refreshing …, it is rather than saying you know somebody else has done it down the road and it will work here, but actually to test some of those assumptions locally."* (employee, DS2)

*"I mean we have demonstrated, we have made a change, we have made a difference, which has made a difference. And the difference is measurable in terms of numbers, and we exist in a world in which patient experience and outcome are to be considered at least equal, in the view of the Future Hospital report, you know that's how they want us to be thinking. We talk a lot about patient measures, but we do need to talk about hard measures because if you go to commissioners or if you go to the chief executive of an organisation… you need to go to them with more than a patient experience survey. You have to go with numbers." (employee, DS3)*

It is notable that the RCP instigated a systematic process of reporting progress and thus, where there was not sufficient progress providing the necessary support, and encouraging a 'proof of concept' orientation to claims of improvement. In many respects this is a more 'scientific' way but what the progress reports account for is the emerging development and learning that the Future Hospital Programme perhaps more fundamentally provided a basis for.

*"It [Future Hospital Programme] gave us deadlines to work towards, so that was really important. And because we were meeting up regularly we had to have something to say for those deadlines." (employee, DS7)*

The development sites could be assessed against their aims and objectives but the evaluation report suggests that there is evidence of perhaps more significant impacts that are more subtle and less easy to measure. Among the more subtle impacts of the Future Hospital Programme include:

- the mobilisation of individual and collective learning and development
- the sense of professional pride in making a difference to patience and health
- the visibility and recognition that raises profile of issues, hospital and participants
- the broadening of networks and fostering of new pathways for integrated care across professional groups.

The mobilisation of individual and collective learning and development has been reported as adding real value to participation in the Future Hospital Programme, particularly at the learning events.

*"I mean the learning events have been a real gelling process…. the people are always saying you know we can steal, there is so much here that we have learnt that you could steal, why doesn't the Trust steal some of it… it is that lovely little … booklet, or it is the … hospital I think their idea is brilliant … I mean that is probably at kind of a different level*

*to what you and I can immediately influence, in our smaller sort of things... you can plant little seeds can't you because unless you plant seeds trees can't grow."* (patient representative, DS3)

*"just learning a lot, … I think the opportunity for working has been really, really useful… I think being able to see that you are not the only one struggling is also useful as well because then you realise that it is not something that is, it is not that there is something wrong with you, it is just that it is something everyone has to find ways around the challenges. There have been some of the presentations that people have given really good advice on how to manage some of the challenges, how to get people on board, and things like that, how to deal with changes, within teams and within management and stuff like that. Different ways of looking at measurements, I think being part of, just being part being able to learn, from what other people are doing, and even to learn on the go because, even for me personally just looking at figures in a different way, looking at outcomes in a different way, thinking about what we are trying to measure, what we are trying to improve just changing the way I think about what we do really. So, for me I think that has just been the thing just learning in a very…. It has been a big learning experience for me."* (employee, DS4)

As has then learning from colleagues within site teams:

*"For the Future Hospital Programme we have therefore focused on measuring and learning from patient experience more effectively, and in collaboratively planning care for frail older people in their last 12 months of life…Our participation as a Future Hospital development site has brought considerable learning for us and for others. In aiming to improve care for frail older people, and creating a culture of continuous improvement, a continued focus on building, nurturing and sustaining cross organisational and multi-professional relationships is vital… Culturally we are moving to a much more whole system approach to improvement of services….This is now established in 'Together a Healthier Future'. Physicians and teams working on service improvement should ensure that their work is aligned and part of organisational and health and social care economy plans and delivery/improvement mechanisms."* (DS4, doc 75)

*"…I think one of the key things is that each professional brings certain skills and knowledge and experience, but a lone it is really not possible to achieve the outcomes of this project. So an example is, I may have the idea to change the … form, with colleagues in … and the GPs who I have met and the patients, it would not be possible to put that into practice."* (employee, DS7)

*"I think it has been a fantastic project, it has really sort of motivated us as a department to engage at a, at a different level. Because otherwise, we would not be having this conversation with our stakeholders like CCG, in the way we are doing it. So we have really put the spotlight on our department."* (employee, DS2)

The sense of professional pride in making a difference to patients and health was also often described as an important benefit for development site teams.

> *"Our organisation was and still is going through a difficult time. Being part of Future Hospital gave a sense of cohesiveness and pride. We have received more recognition from outside our organisation than from with in!"* (employee, DS1)

> *"Being an RCP Future Hospital development site has enabled us to get considerable support, inspiration, energy, examples and expertise from other sites and from the central team and wider faculty e.g. measurement and patient experience. It has supported our resilience in continuing to move the work forward for local people. In addition it has kept the improvement work for frail older people prominent within the Trust and with the health and social care economy."* (DS4, doc 75)

> *"…we believe that there is quite a strong legacy that we have left a very strong legacy…"* (employee, DS4)

As well as acting as a mechanism to enhance the visibility and recognition of the work, and through that also raised the profile of issues, hospitals and patient groups.

> *"News broadcast from the* [name of department] *as part of an in depth review of the services and future of the NHS." "Japanese film crew filming for Japanese TV series picking up on work which has been done on the floor relating to patients at risk of renal deterioration."* (DS3, documents 16a, 52a)

> *"it has given the work profile at board level. I think medicine for older people now is seen as one of the key elements of the organisation running right through the organisation, almost like the golden thread so I think it's just, I wouldn't say that wouldn't have happened anyway but I think the RCP has given it even more national recognition that is reflected locally if that makes sense."* (employee, DS4)

The broadening of networks and fostering of new pathways for integrated care across professional groups was frequently cited as another key positive outcome from these projects.

> *"It also raised the profile of the network within the host organisation to get that…That's the credibility…I think there is the credibility also within the number of organisations it put credibility to our network in an area that we weren't necessarily working with, so we work with tertiary centres, GPs, mainly district general hospitals it took that out wider into providers that provide health visiting, community services."* (employee, DS7)

> *"Oh it is invaluable because it is all about … communication, relationships understanding the challenges of interfacing and whether that is primary, secondary care thing or a patient carer interface or you know college district general interface it is about understanding the perspective of different sides in a highly stressed environment, which is what we work in. "* (employee, DS3)

*"Building relationships across the health and care community for joint work for these patients. Whilst this has started from a firm base of work in the previous few years it will require ongoing focus and leadership…We recognise that the barriers are not purely between organisations, but that even as an Integrated Care provider with an Integrated Care Division the shared understanding of hospital and community care options is limited, and the linkages between them are still developing. This is particularly with front line staff who may not have experience of delivering, planning or implementing care in other settings, and few staff that have worked in multiple care settings."* (DS4, documents 24a, 24g)

*"I do feel is that a number of these projects are much, much wider than just doctors and they all involve a range of professionals and the public engagement has been, I would say the public engagement is something without the RCP and the Future Hospital Programme I don't think there would have been as much emphasis on the public engagement. I think it did help drive it and it helped give the people who were involved in public engagement on the project a bit of ability to ensure that it got the correct attention."* (employee, DS8)

Taken together the outcomes of the Future Hospital Programme and its impacts range well beyond what the metrics seem to be able to account for. The more subtle impacts also reflect that outcomes are only as good as the inputs. In this respect the role of the RCP in the way it initiated and lead the Future Hospital Programme is itself a great contributor to the outcomes that participating hospital sites achieved.

Participating as a Future Hospital Programme development site was unanimously recognised as innovative and rewarding. The role of the RCP has also been recognised as fundamental to the experience of being a Future Hospital Programme site. There appears to be a recognition of the more formal structural aspects of the RCP's contribution in terms of a learning infrastructure.

*"Building a community of learning with the other Future Hospital development sites has broadened our view of what is possible, what challenges there are and how we can progress. It has strengthened our professional networks considerably, and will continue enable more rapid delivery of these and future changes."* (DS4, documents 24, 75)

# Engagement and Co-production- patient and public involvement

Patient and public involvement (PPI) was designed to be implemented from the start of the Future Hospital Programme development site projects. Each development site was expected to have at least one local PPI representative within their team. The aim of this was to ensure a patient perspective was present throughout the life of the project: being an integral part of decision making and being able to participate actively as the project evolved. There was also a focus on capturing 'patient experience' (of the service and service re-design) and this was often a role under taken by the PPI representative. This section largely concentrates on the role of the PPI representative rather than the patient experience data that were collected.

The PPI representatives were to work alongside a designated member of the RCP's Patient and Carer Network (PCN). The PCN played a key role in supporting work in the development sites, the responsibilities of the PCN representatives were set out in a guide: resource for PCN representatives involved in the Future Hospital Programme. This PCN was established in 2004 to give greater patient and carer input into the work of the RCP. This part of the Future Hospital Programme, involving local patients, local PPI representatives and PCN members in service design, monitoring and evaluation was a new learning experience for the RCP and the PCN.

This section includes data primarily from the focus group and interviews conducted with patient representatives. It also includes data from interviews with RCP staff and officers, and focus groups with the development site teams.

### Background – PPI and Co-production

PPI is well embedded in current health policy and legislation. Section 13Q of the NHS Act 2006 (as amended by the 2012 Act) put a legal duty to properly involve patients and the public in commissioning processes and decisions throughout the NHS; NHS Constitution (2015 latest update) states that the NHS belongs to us, 'of the people, by the people and for the people' (9, 10); The Five Year Forward View (2014), 'we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services' (11). And, NHS England – Patient & Public Participation Policy (2017), 'NHS England will work in partnership with patients and the public, to improve patient safety, patient experience and health outcomes' (12). Therefore, there is an expectation that new pathways of service delivery should always involve the public, and these decisions should not be taken by professionals alone.

There is no consensus over how PPI should be defined, this is partly as public participation in decisions in health spans a wide area and what constitutes 'involvement' is contested. Tritter defines it as, 'ways in which patients can draw on their experience and members of the public can apply their priorities to the evaluation, development, organization and delivery of health services' (13). INVOLVE defines public involvement in research as 'research being carried out 'with' or 'by' members of the public

rather than 'to', 'about' or 'for' them.' Here, PPI includes notions of active contribution, rather than just consulting or the passive receiving of information (14).

INVOLVE's definition of PPI moves towards co-production. 'Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, [research] development and evaluation' (14). (Coalition for Collaborative Care) NESTA outlines the following key principles of co-production (15):

1. Building on people's existing capabilities: altering the delivery model of public services to provide opportunities to grow people's capabilities and actively support them
2. Reciprocity and mutuality: offering people a range of incentives to engage which enable us to work in reciprocal relationships, mutual responsibilities and expectations.
3. Peer support networks: engaging peer and personal networks alongside professionals as the best way of transferring knowledge.
4. Blurring distinctions: removing the distinction between professionals and recipients, by reconfiguring the way services are developed and delivered.
5. Facilitating rather than delivering: enabling public service agencies to become catalysts and facilitators rather than central providers themselves.
6. Assets: transforming the perception of people from passive recipients of services into one where they are equal partners in designing and delivering services.

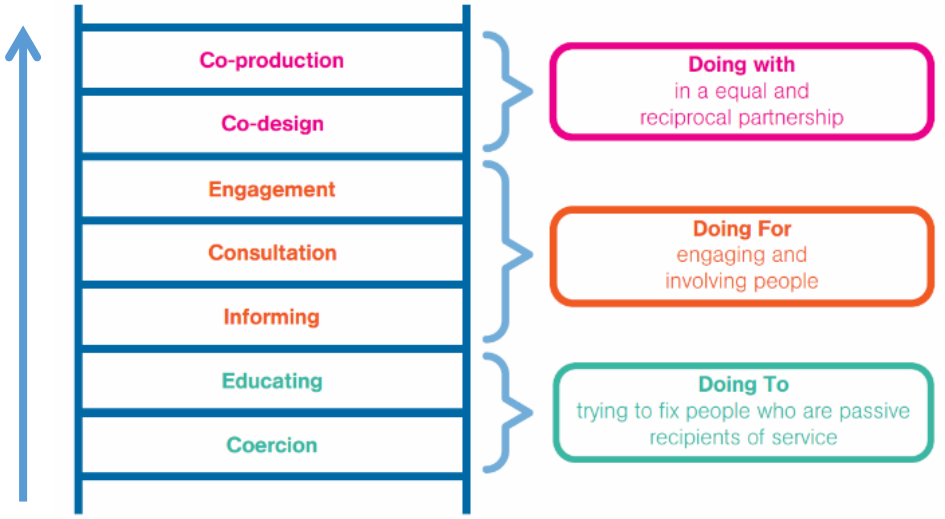


***Figure 1:*** From coercing to co-producing, the ladder of effective public engagement. Courtesy of the New Economics Foundation (16).

This can be illustrated by this diagram, that moves from a 'traditional' medical model of paternalism, through educating patients and ensuring fully informed consent, consulting with patients and engaging them in decision-making (for instance holding dissemination events), towards members of the public and patients being fully involved in the decision-making process – with as much influence as any other group in the process.

NHS England outline seven practical steps to make co-production happen in reality (17):

1. Establish leadership commitment to co-production.
2. Recruit and select diverse groups of citizens to support co-production activities, including perspectives which represent families and communities as well as the lived experience of individuals who use services.
3. Create systems to allow reward and recognition of the citizen contribution.
4. Develop a co-production strategy in discussion with citizens, explaining what coproduction means to the organization.
5. Work with citizens to strategically identify areas of work where co-production can have a genuine impact and get people involved at the earliest stages of development.
6. Provide training and development of staff and citizens to create an environment where co-production can thrive.
7. Regularly review and report back on progress – modelling co-production by moving from the "You said, we did" approach to a "we said, we did" approach.

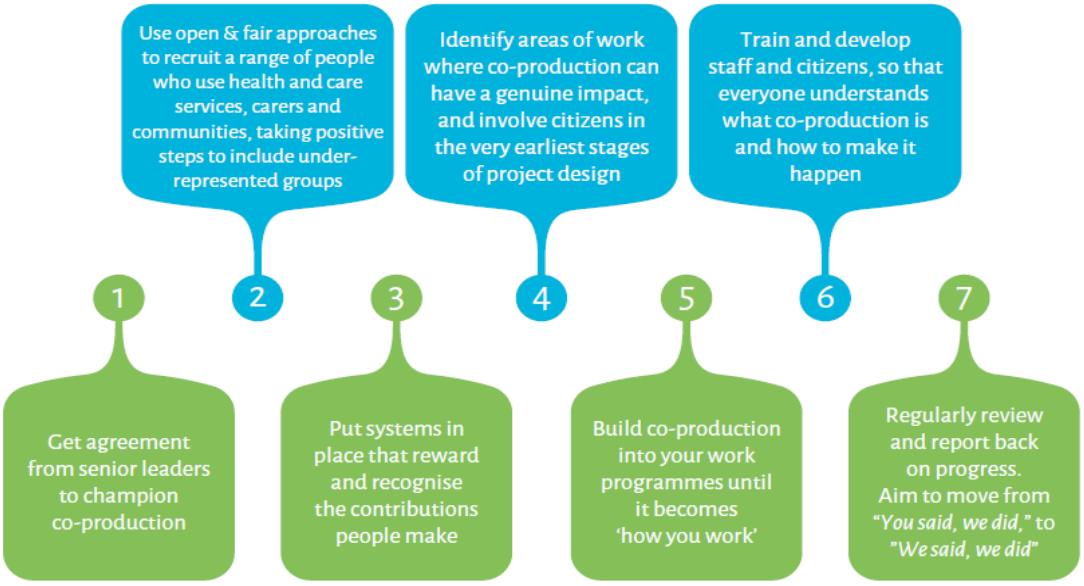


***Figure 2:*** Seven practical steps to make co-production happen in reality. Courtesy of the Coalition of Collaborative Care (17).

## PPI in the Future Hospital Programme

This section will consider the themes and issues that arose in the evaluation of the Future Hospital Programme related to PPI.

## What was Done

One of the main aims of the Future Hospital Programme was:

> *"to demonstrate how change could be done, and how we could put patients and clinicians together to lead change, so that we could almost demonstrate that this is how it should*

*be done. I am not sure we knew at the beginning how it should be done but the College* [RCP] *has learnt along the way, that it is important to make sure that patients are right at the front of everything."* (RCP4)

A key priority of the Future Hospital Programme was the patient experience and the way this can be enriched through greater public engagement in general but perhaps more critical embed patient involvement in the co-design of patient-centred care.

> *"We have workshops to discuss things where the patient reps go alongside, that actually any change the change is managed in a way which encourages everyone to be part."* (employee, DS5)

As a member of one of the hospital site teams put it:

> *"It was very clear that the patient was at the very centre of everything that we do, and we were actively seeking patients ideas starting from the very first day when we said, what do you want, it was patients idea which then led us onto define our aims of the project pretty much. So, so patient was the beginning of our journey really the Future Hospital project. … and the patients really, certainly the patient rep that we had, realised that he was a very eloquent, well-spoken person, and the person that we were given from the PCN also was a very astute… well-spoken person who was able to influence and certainly help me." (employee, DS2)*

And another hospital site participant added:

> *"…One of the feedbacks that we have had from managers has been this is one project I like coming to because here we are talking with patients, and talking about what matters to patients. So it is, so when you hear feedback like that I think it is only a good thing." (employee, DS2)*

Each development site had to show that they had a PPI strategy in place before being chosen, as one RCP staff member said:

> *"Yes, we made it very clear from the off that… in terms of our development sites,… we weren't, we wouldn't be selecting any of the sites without them having a really clear patient engagement strategy. So,… each development site has got its own patient representative, locally or more than one in some cases."* (RCP17)

In phase two this process became more formalised and sites had to have a PPI rep in place:

> *"For phase two having watched how the sort of organic coming together, people volunteering option in phase one for patient reps, hadn't really been as effective as I think we initially hoped and that, the rigours of doing FH alongside the day jobs for most of the consultants and the multi-disciplinary team involved in the FH project teams meant that patient recruitment was often low down on their list and sometimes it took them, a good*

*few months to recruit a patient rep and kind of withhold that patient rep as well. So for phase two we decided to do a more proactive recruitment campaign advertised….. So we learnt a lot from phase one, about how to take patient involvement and engagement in the development site teams from sort of tokenistic and leaving the teams to do it themselves, to really prescribing what we needed and to get the framework in place to."* (RCP6)

This theme of the development of the PPI representatives' role and the overall strategy and implementation over the two phases of the Future Hospital Programme is clearly outlined by this participant (who was part of the Future Hospital Programme team).

*"[PPI] reps were recruited through sort of a, a fairly formal interview process, they were given a job description so they, they entered the role with a much bigger,… much better view of what it was going to involve and I think the phase two sites had a better understanding of patient involvement. They realised that it wasn't just going to be about having a representative who could sit in their meetings and tick their boxes."* (RCP9)

The comparative analysis suggest that the majority of development sites recognised the importance of patient involvement and have taken active steps to create new mechanisms, roles and ways in which patients – via the volunteering representatives – can directly contributed to the efficiency and effectiveness of health services provided.

### What the Sites Did

The majority (63.6%) of respondents to the development site survey reported their project was partially co-produced with patients, and 27.3% reported full co-production.

A variety of activities of patient engagement have been noted including:

- A series of engagement events– 'Open Days' conducted by Trusts and hospital sites, promoting innovative approaches to health services delivery.
- Information leaflet distribution.
- Posters were designed including quotes from patient feedback to promote the service.
- Dialogue with the general public, councillors, Age Concern, locality GP clusters and other community groups was fostered.
- Patient advisory group setup.
- Set up of an operational mobilisation group that included PPI members.
- Regularly attending relevant public events and involving patients in more detailed work design via patient advisory group.
- Patient experience surveys conducted
- Development of electronic forms to capture time taken at pathway stages.
- Local celebrities engaged to educate the public about new choices offered in health care.

These varied activities signal overall a commitment to understand what matters to patients and account for some of the benefits to patients that the development site projects sought to deliver.

However, it was clear that there was not a universal experience of PPI:

> *"Patient experience across all eight has been varied but what has been similar and key is that there is a patient or a PCN representative in each team, providing a voice, a perspective and sometimes a check on what the consultants and the clinical teams are trying to do."* (RCP6)

Overall, we were not able to get detailed process or quantitative data on the activities undertaken by either the local or PCN patient representatives.

### Patient Representatives Being Able to Add Value through Their Contribution

Comparing the evidence in the various reports from each hospital site, we noted different levels of clarity of the voice of the patient representatives in with the development sites. For example, we noted that in some instances patient representatives are very actively involved and can steer some of the work by 'nudging' clinicians on what they need to do. In other instances we note that patient representation is present but in a more tokenistic form. Yet, also witnessing the interaction between the clinicians and the patient representatives in the focus groups and the learning events it was also clear that the relationships formed between them have a direct impact on the value added contribution that patient representatives are able to make. The sample of quotations below shows this variation and highlight some of the actual contributions and roles that patient representatives have performed in the course of the Future Hospital Programme project.

PPI representatives' chance to influence any elements of the service redesign was often limited and their engagement, and the timings and format of that involvement in the projects and evaluation varied. Some participants felt they were brought in after the main decisions were taken:

> *"It quite frankly is that you don't start off with asking the patients what they want, you start off usually with some enthusiastic usually a clinician, who has an idea about how things might be done better, and that idea is taken forward either by themselves with their own organisation or through some other organisation or whatever, and the patients are asked to contribute to the development of that idea."* (PR5)

> *"All you ever do is ask them to review what you have done rather than to input into it and you know there are these things where you go, hmm, this is not a co-production the patient is not at the heart of the process of the project."* (PRs)

PPI representative participants in the focus groups reported varied opinions on how much they had been involved in the Future Hospital Programme.

> *"Very involved. We meet monthly with the … team which is an opportunity to share and discuss ongoing proposals and ideas or implementation of new approaches to working. We also have regular contact with the staff medical and non-medical on the ward when we come in to conduct our face to face interviews, pick up questionnaires or conduct telephone follow calls after discharge, support colleagues in writing the quarterly reports*

*or simply to help with the retrieval of data for analysis. We have a very strong and collaboration with team members. The team is a very strong collaborative group who do obviously come across problems but are skilled in finding solutions. The patient reps are treated with courtesy and respect and are views are listened to and taken on board. We are considered to be an integral and vitally important part of the team."* (PR2)

*"And for me it is kind of like it is great I feel accepted by the team, I feel listened to etc but there is me, and you know and that is a challenge and you know there is, I don't know 18 other clinicians in the room and I am like I wonder if the tables were reversed when you have got 18 patients in the room and you asked one of them to be a clinical representative."* (PRs)

Others felt that they had not been involved sufficiently:

*"The meetings are oh wow, they are all clinical leads, they speak in those three letter acronyms you know them, and one of the people there really makes it pretty obvious that she thinks I should not be at the meeting. They sit there, on… Tuesday it was meant to finish at 1.15 it finished at 1.45 occasionally I am allowed to say things …. 1.45 we hadn't got through it, we had only got half way through, hadn't got to a patient experience section and we had to go out because we had already overrun our time by 15 minutes that was it."* (PR4)

The patient representatives have undoubtedly added value by offering directly a perspective that the paternalistic mode of care has not fully accounted for. The Future Hospital Programme has created a pragmatic platform for learning to develop a more 'interpretative' approach to health care delivery and for that it not just about having patients involved or indeed recognising that the patient experience is critical (18). It is about learning to speak the patient's language, from the patient's perspective. The latter is not clearly evident in the findings of this analysis and remains one of the most critical issues to address perhaps fuelling some of the wider tensions that the hospital sites participating in the Future Hospital Programme have experienced.

We note that there appears to be a tension in the alignment of patient representation and their genuine involvement. The latter could raise some potential doubts if what is measured and the metrics used to account for proof of concept are always accounting for the underpinning conditions that reflect and affect patient experience.

*"[Our patient representative] is involved as part of the team and not someone that we have consulted with, do you understand what I mean. Rather than just asking [our patient representative] what he thinks about x y and z that he has led that process he has worked with sort of clinicians, managers, corporate support services and he has very much felt like part of the team and he just, he just gives that patient perspective in himself as to how we approach things and he has already alluded to that in terms of you know how the story unfolded as to how we approached this. He very much informed that from a patient point of view."* (employee, DS4)

*"… For me another really key outcome of this process, has been having, how can I put it, to move from what I saw as a tokenistic patient involvement process prior to all this, to see the patients and relatives voices raised in a much more formal way within the organisation that has not always been a straight forward process, I know and it has taken a lot of persistence, and effort from* [our patient representative] *to do that, but for me that has been a real, plus of this process and one that I think will be an enduring legacy of it."* (employee, DS4)

PPI representatives reported that they felt they had had an influence on the development site projects, and this was particularly in being able to get and report back the feedback from the wider body of patients.

*"Whilst I know our patient data in the early stages was not as revealing as it is now starting to be I don't believe we would have as much detailed information as we are now gleaning. The new graded response questionnaire is proving to be accessible to patients to complete and the assistance of the Health workers in the team so ensure patients receive them has been a big help and boost to the number of returns."* (PR2)

*"Patients will speak more openly with us than perhaps they feel they can do with the medical or other members of the team."* (PR2)

*"We give patients a real 'voice' which we ensure is heard and that can make a difference."* (PR2)

This involvement and feedback was seen as important by members of the Future Hospital Programme team.

*"It has helped to keep the clinicians grounded, it has helped to keep the focus on patient experience."* (RCP12)

*"I think it keeps the work a bit more real world for the person going through the system, rather than like because you can get caught up I think in not seeing the woods for the trees. You know the system so well that you don't always know where the bits that are rubbish are."* (RCP1)

*"It just gives you the patients' perspective you know more than the clinicians' perspective and that is really important, so that's been a big success I think."* (RCP4)

A specific example of how the representatives inputted into the Future Hospital Programme was:

*"Project meetings, and the patient representatives would be involved in those and be able to take an active part rather than just sort of sit there and listen,… And, they designed a new leaflet… I think initially it was designed by kind of the project team, the project manager and the… and the clinical lead, but then feedback was sought from the*

*patient representatives and it was changed as a result. So they, they definitely made a difference to how that was developed and they have also been involved in the running of patient experience surveys both like literally in terms of delivering surveys but always giving feedback on to us as a Future Hospital Programme set of staff on how those are, you know how the methods of delivering the surveys are working."* (RCP9)

### Clarity over the Role of PPI Representatives

Some PPI representatives expressed their uncertainty over what their exact role was in the Future Hospital Programme.

*"The PCN has been very involved. What it didn't have was clarity about the roles of the people who were going to be actually involved in this specific initiative."* (PRs)

*"I think you had to develop your own role within the project - as far as you were allowed."* (PRs)

*"Well I have done very little. I have, I haven't had no idea what the patient rep was supposed to do. In my opinion I was merely a tick in a box that said you have to have a patient rep."* (PR4)

Part of this lack of clarity over their role, was ambiguity over what their purpose was and what they were meant to bring to the endeavour and issues of 'representativeness':

*"We are still talking about what in our patient advisory group what exactly is the purpose of this. And I am still talking to the joint management board, for the programme and saying what do you want, what do you expect and what is the purpose of me purporting to be representative which I am not, (laughs) what is the purpose of me being here at all, you know are you listening to me."* (PRs)

*"That's what I was saying I think, to me the process and the role is more probably about being the patient voice, rather than being the patient representative because you can only be representative of what you have experienced."* (PRs)

*"I am very much of the opinion that individual patients cannot represent patients as a whole unless it is very strange or peculiar circumstances. Probably, leaders of some patient organisation or something but even then it is a pretty poor sample, that they are likely to know. So, and this is one of the big problems about the whole issue of patient involvement, patient representation is so many people can only quote from their own experience and very few are either able or perhaps sometimes willing to look at it in a more generalised way, for patients more collectively."* (PR5)

*"But again you see you are talking about people who are willing and able to be involved, people who go to … groups, how typical are they of the patients on the whole probably the ones that are able and willing to participate. People who are more antisocial, more*

*disabled by their condition or some other condition… don't just join in with anything, won't go so… so it is all relative."* (PR5)

This uncertainty over the role of PPI representatives, was reiterated by one of the RCP team.

*"There is still quite a lot of uncertainty about what your [PPI representative] role is. Are you, are you giving a viewpoint as a patient who has experienced that service, so if you like common sense from an individual point of view or are you in a representative role are you trying to reflect a broader view of patients let's say who are acutely ill going in through a particular hospital. And, I that I think hasn't been worked out nationally we haven't really got a sort of sense of what the, what the major aspects of a patient representative role are."* (RCP12)

One member of the Future Hospital Programme team felt that some training was needed to enable PPI representatives to step outside of their own concerns to represent a wider group.

*"If you have a patient representative the… are they a representative of the wider population or are they just bringing their own baggage to it, that is a big question and it is a big, you almost have to train people not to bring their baggage to the table and that is not easy."* (RCP4)

## Views of the Future Hospital Programme Team on the Successes and Challenges of this Form of PPI

The value of including patient representatives and networks in integrated care teams was clear for the development site team members included in the focus groups. Clinicians reported that they found the contribution of patients extremely valuable. Adding extra in-house capacity and/or developing arrangements for closer working with other patient groups was seen as a high priority for future service improvement. In several sites, there was an ambition to increase the level of patient input over time, in recognition of the high levels of changing demand among the population groups served. The 'Choosing Wisely' initiative resonates with our interviewees' experiences; by improving the quality and value of care by reducing unnecessary interventions through the promotion of conversations between clinicians and patients (19).

The opportunity for patient representatives to voice what matters to patients generated a number of interesting dynamics in the hospital sites. On the one hand, we note that engaging and involving patient representatives, would require clinicians understanding how to listen to patient perspectives and reframe the clinical attitude as well as orientation of 'clinicians know better what is good for patients' akin to what Gawande (2014) calls, 'paternalistic' approach to health care provision. On the other hand, there was also a call on patient representatives being able to add value through their contribution. We examined this dynamic from each perspective to reveal some of the challenges that the orientation toward greater patient involvement entailed in practice.

From a Future Hospital Programme perspective, the process of the Future Hospital Programme and its approach to PPI was seen by one key figure in the Future Hospital Programme as an area where positive development had taken place.

*"But definitely an area I think where as a College we have grown, and hopefully an area where we have supported the sites to grow as well."* (RCP5)

Future Hospital Programme was seen by this participant as an area where PPI was particularly strong in comparison to other areas of college work.

*"unique to Future Hospital, in comparison to the other programmes of work. So there is lots of oh a patient was involved tick type activity, throughout the College* [RCP]*, and I think the difference particularly with the phase two sites is that there is proper co-production with the patients I hope that they feel that way, it certainly seems at least a big step along the route to co-production, than anything else that I have been involved with or seen or heard about so far."* (RCP1)

And more generally:

*"I think the, the patient involvement is probably the most, most crucial part of what makes Future Hospital different to anything else that is going on around the country right now."* (RCP4)

*"So I think that that is a really, really strong element and I am surprised that like our team and the policy team haven't picked up on that best practice, because I think we are slightly missing a trick and that we could have really made that space using FHP as our evidence for why it works."* (RCP16)

While members of the Future Hospital Programme team were justifiably proud of their attempts to embed PPI in the Future Hospital Programme, they highlighted a number key challenge that needed to be overcome, so that PPI could be fully utilised was ensuring the support of the clinicians.

*"Yes, so I think some of the challenges have been getting doctors particularly on board, so thinking about the development sites. I think it was that sort of level of patient involvement was quite alien to some of the doctors that were involved in those sites and I don't think that certainly at the outset they necessarily saw the value of that."* (RCP5)

### Clinicians Understanding How to Listen to Patient Perspectives

The analysis distils a number of valuable points about the implications for clinicians in engaging patients more actively in the design and delivery of health services. It is noted that the majority of clinicians involved in the Future Hospital Programme recognise and see the value of patient representatives and actively seek to involve them and draw on their contribution. We noted the following indicative responses towards patient representatives:

*"…what we actually did at the start of the project was have some forum of ideas as to what the project should actually achieve… We got everybody's ideas and the patients were key to that. We had five patients down on that day along with sort of representatives from the CCG, and our own Trust… their input was really invaluable because quite often the*

*perspective of people who work in Trusts or GPs will have a particular perspective on what they should be doing for the patient, and when you actually talk to the patient about what they actually want, they are not necessarily completely different but you do get a different perspective on it. So one of the things that we got out of that session was… you know some invaluable kind of at least anecdotally from patients about what they did or didn't like about their particular kind of pathways. And we used that to kind of you know, refine what our, what our aims would be for the project, but we did that at the very start. And that was crucial."* (employee, DS2)

A clinician, while supportive of having the patient voice involved questioned the utility of having to have a specific PPI representative:

*"You will never get true representation. You will just get me who will speak up and fight at every opportunity, for the patient. But you see that suggests that that is not what motivates everyone in the room which I think is not fair. Do you have time to do it? And I can speak up because I am a volunteer, and they can't sack me but I can goodbye, you have to be careful it is true. It is true. I can probably be far more forceful. That's what I feel that I said that to you, I am a little box… they ticked, they ticked the box."* (patient representative, DS3)

*"I think that the disappointing thing is that one considers patient experience, to be reflected by a patient representative. Because patient experience is so much more than just one person coming in and saying…I think the word representative is a very difficult word because I am not sure that* [our patient representative] *could truly represented patients other than having been one…we have 70,000 patients a year, so the question in my mind is, you know if we are trying to extrapolate a representation of their experience, then having one person who has their own carried experience representing them is difficult."* (employee, DS3)

*"… I started thinking very hard about patient experience and that, and then I sort of rebelled a bit because I thought well, patient experience is not what happens in the ward it is what happens right across the whole thing from when a patient falls down or has an attack whatever right to how they get on after hospital and discussed that with* [our patient representative] *and a presentation was done on it and that helped to develop us collecting the stories direct from the patient, which proved to be very valuable and supported a lot of the work that was going on you know."* (employee, DS4)

*"The patients' representatives' contribution directly impacted the service. [Our patient representative's] contribution was quite powerful actually and that has really shaped our mission statement."* (employee, DS6)

*"We actually go and invite the patients in, and get them to tell their story … and we don't ask them about particular bits of the service they just tell their story and from that comes the positives and the negatives, and from that it is like well what, how can we improve and what really matters to the patients because what really matters to the patients is similar*

*and overlapping but is not always aligned with what is important from a clinicians perspective."* (employee, DS7)

The ways in which patient engagement and patient experience has been interpreted in different hospital sites evidently in the above quotes reflects an equally varied way in the relationships that clinicians have sought to form with the patient representatives they more directly engaged. It is here that we also recognise a further variation in the value added contribution that patient representatives are able to make.

## Practical Ways to Improve PPI

### *Recruitment*

It was recognised that recruitment was key to good PPI:

*"The beginning of phase one there just wasn't the guidance there, I don't think there was the understanding from the programme team, or the site teams or like I say as kind of a national understanding of how patient involvement was going to work at the time, so there just wasn't that core, that kind of underlying planning for it. So when the patient representatives were recruited, they weren't necessarily the best people for the job."* (RCP9)

*"I think the starting point is just finding suitable people it is not easy you know. Especially if your service change is in a cohort of people who are elderly, and frail they are not all able to be active participants."* (RCP4)

*"Careful selection of volunteer patient reps would be helpful to look to see if they have experience/expertise that could be useful."* (PR2)

#### *Buddy System between PPI Representatives and PCN*

As part of the process of supporting the local patient representatives, they were given a buddy from the central PCN and this was seen as a useful form of support.

*"Invaluable and excellent. As the patient rep, … was not initially involved in the project until it had been running for six months. At that point [the PCN representative] and [local patient representative] joined the group meetings and I know that [the local patient representative] found [the PCN representative's] support helped to build her confidence. [The local patient representative] has been a volunteer in the hospital for many years but this was something completely new for her."* (PR2)

*"Definitely something that should be there. Patient reps need a mentor/liaison link to the team for guidance and support."* (PR2)

### *How to Engage the Patient Voice*

The location and timing of involvement was crucial, as pointed out in an interview with one of the Future Hospital Programme team members, when the patient group was parents of young children it was not possible for them to come into the hospital in working hours to attend a focus group:

> *"They engaged with the local … support group, and actually went along after hours for the consultant to a meeting that was happening anyway."* (RCP6)

### *Lessons for the Future*

Have a sufficient number of PPI representatives:

> *"I think for the continuation of the project it would be really helpful that, that there were two patient reps because they can at least support each other and bounce ideas off each other. And two is better than one I think I said that. But I also think that they need to have a link person, maybe you look at it in terms of a mentor or maybe you look at it just as in terms of a reference point in that are we doing the right things that you need and are we getting the right sort of information that you need."* (PR1)

> *"[Patient representatives] two are better than one and they need a mentor or link within the team if it's outside a project."* (PR2)

There is a need for clear guidance on role and what it means and entails:

> *"Clear guidance of expectation of the patient reps role and also guidance on what they should do if they hear or see an aspect which gives them concern."* (PR2)

> *"Clear consideration about how they will fit in with the rest of the team and that the team have to be willing and welcoming and see that the patient's reps' role is both essential, vital and informative."* (PR2)

Here the 'buy-in' of the team to the process is highlighted as key. Also a commitment of the team and organisation, to keep the momentum going, and really embed PPI and co-production.

> *"…the patient engagement piece is quite labour intensive, and whether without the Future Hospital Programme guiding it, … will providers prioritise it (patient engagement) in the same way they would without the Future Hospital chasing them and asking them what they are doing on a regular basis...". (employee, DS8 )*

People also highlighted the skills and experience that they thought a good PPI rep should have:

> *"Empathy - patient reps have to be able to put themselves into the patient's shoes."* (PR2)

> *"Experience of service or similar – either directly or through a relative or friend."* (PR2)

*"More strategic and I guess … her education background, has made a massive difference. But also the fact that she has two perspectives to give, she has a perspective of being a [daughter of someone] who has been in the system a couple of times under …[the Future Hospital Programme] but also having been the partner of a gentleman who came through the service and not necessarily through the whole …[the Future Hospital Programme] service"* (employee, DS5)

# RCP as a lead organisation-strengths and limitations

This section includes data primarily from the interviews conducted with RCP staff and officers, both internal and external to the Future Hospital Programme team. It also includes data from the survey of RCP Fellows and Members, the survey and focus groups with the development site teams.

### Learning from Experience and Essential Elements for Success in Future

The project evolved iteratively as the core team learnt from experience of what worked well, what needed more support and direction, which aspects became barriers rather than facilitators, what makes an effective development site, and how to best engage, and maintain drive and enthusiasm. The RCP also continues to reflect on its role and strategic direction, and where these sorts of projects and activities fit within that.

> *"Partly the aim of the Future Hospital Programme was to demonstrate how change could be done, and how we could put patients and clinicians together to lead change, so that we could almost demonstrate that this is how it should be done."* (RCP4)

#### *Building on the Future Hospital Commission*

Many referred to the importance of the Future Hospital Commission report and its 11 principles (1). The Future Hospital Commission was seen as key to underpinning the development of the Future Hospital Programme overall as well as the focus, aims and objectives of the pilot sites. More than this, pride was expressed as the Future Hospital Commission being a key development and highlight in recent RCP activity, as innovative, and a marker of excellence.

> *"The blueprint [Future Hospital Commission] has provided a set of principles which we have recruited against, and I sort of often said that if, if the going gets tough and it does get tough when you are in a busy hospital with the sort of growth in acute care that we are seeing, you know across the NHS, when things get tough we have got a template to fall back on. You know you can say what are we seeking to do, we are seeking to do a, b and c."* (RCP12)

> *"One of the key strands when developing the original Future Hospital Commission reports was to make sure that it was based on some case study examples of what was happening out there, in the system so we were reporting on existing good practice and obviously that is something that has continued through the current Future Hospital Programme both at the development sites but also with the Tell Us Your Story initiative."* (RCP5)

Seventy-six percent of RCP Members and Fellows surveyed were aware of the Future Hospital Commission with 44% of them both reporting awareness and application of the 11 principles. A larger percentage of 84% reported having heard of the Future Hospital Programme. These responses are outlined in Figure 3.

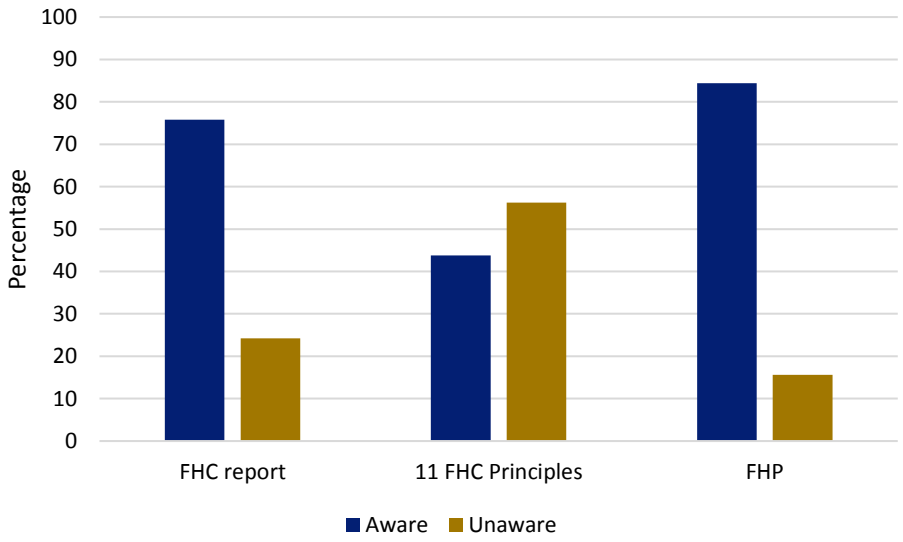


**Figure 3:** Members and fellows awareness of the Future Hospital Commission, its 11 principles and the Future Hospital Programme.

### *Phased changes*

There was widespread support for the changes in how sites were selected and supported during the application stage in phase two.

> *"The PCN had that chance to review the applications and the application pack and … make sure that as I say that the patient and public involvement was given a much stronger focus and emphasis within that."* (RCP3)

> *"Second time round there was a lot more space in the schedule for the interviews, for interviewing patient representatives, you know a double induction day, an induction day for patients and carers as well, which was fantastic"* (RCP17)

Opinions were mixed about whether the advantages of themed calls working on similar clinical topics, with the opportunity to share expertise on relatively specific areas outweighs the benefits of a theme of aspects of care to focus on such as integrated care. There is no 'right answer' to this, but there was consensus that a theme (whether pathway or condition focused) was better than a completely open call.

*"Not having the same topic made people focus more on the process of change and the quality improvement, whereas I think if you had teams who were focussed on the same clinical topic you might get dragged into the clinical change but not necessarily into the process of change. Whereas actually what you need is a balance between the two."* (RCP4)

*"So the cohort based learning is important, erm… I think if you facilitate it correctly it doesn't matter if the clinical topics are separate, erm… there are some advantages to the clinical topic being aligned. So if you had teams from four acute medical units or four geriatric units or four respiratory units you know you would learn from each other in a different way."* (RCP4)

*"…there was a theme* (in phase one)*, for the development like… share, learn and then reinvest that…. This was very powerful, because phase two have said they don't have the same shared focus."* (employee, DS3)

In terms of support it became clear that monthly reports were too onerous and repetitive, however monthly phone calls were helpful, and regular calls and written quarterly and annual reports helped maintain momentum, focus and energy to meet deadlines, as well as ensuring regular communication helping tailor timely support and advice for sites and the opportunity to deal with problems.

The adherence to timelines and reporting was variable and for some sites proved more difficult than others; hence the provision of central support and 'nagging' required also varied. Respondents commented on the number of sites that could be reasonably supported at the level designed for the Future Hospital Programme, and four seemed the maximum feasible for most, with perhaps six if shared learning from initial phases facilitated a lighter touch in the future.

*"Four I think works, could maybe do five, six, maybe seven or eight even eight might work but actually I think four to six is probably the maximum number of teams you can run in parallel because if you do the like, when all the eight sites come together it is great but it is a packed day you know and you don't get enough time to share and I think four to six is probably as much as you can squeeze in in terms of teams."* (RCP4)

*"I think we were able to build up a sort of personal relationship. I think we had a sort of continuity of that relationship and we deliberately didn't go for a large number of sites. So eight sites is a sort of modest number particularly compared to Vanguard for instance, but it made it manageable and it made our support quite tailored to those sites."* (RCP12)

Some talked of the benefit of recruiting sites that were ready to implement a new way of working that had been planned and negotiated. It was considered less effective and efficient, with greater risk if the projects were at a much earlier stage. However it's clear from other expectations of what needs to be in place to be true to the Future Hospital Commission principles that project teams would have been following the recommended pathways to reach that point, with genuine patient representation in the team etc.

*"It would be nice if people had kind of half way done their work ready to go and then we support the implementation phase. Whereas in some places it was kind of very nebulous they hadn't gotten to that stage of implementation and so, it took longer to get off the ground."* (RCP4)

### *High Points*

There was widespread acclaim for the Chief Registrar project with many hailing this as a great RCP success, and an excellent way to build future clinical leaders. Some suggested maintaining the link to the Future Hospital Commission through the Future Hospital Programme to bring together leadership training and a clinical/organisational focus for participants in the programme, based on core principles of excellence (20).

The annual reports were considered excellent, as was the overall impact of the innovations being tested in the development sites. However it was realised the time to demonstrate impact was too short for most, and tough to balance the resources required to maintain the intensity of this approach and deliver projects for long enough to show their impact, particularly when the NHS is under considerable pressure with rising demand anyway.

*"The first annual report and they were fantastic especially compared to kind of the dribs and drabs of monthly and quarterly reports ... they took their time over them, they were, it really made them kind of pull everything together, and it just made us think maybe we need to look at the way they are doing the other reports and have a kind of rethink about how it could be done better … monthly reports was a bit too short, not enough had happened and the emphasis on them wasn't quite right. So then we moved to suggest a monthly phone call instead, and keep a quarterly report but give it kind of a different structure."* (RCP9)

There was widespread support for the *'Tell Us Your Story'* project, some considering this more useful than the pilots. The argument being that this peer information sharing about what works and what doesn't is likely to have wider impact across the membership, being wider in scope and more accessible than formal evaluation reports. However others were concerned these reports are relatively light on detail and the key elements of evaluation that would be required for the results to be considered generalisable.

*"Tell Us Your Story … I think that has been really nicely done and I think that stands out as, as what, as a good model in terms of there is lots of great stuff going on out there, but erm… sharing in a way that is not kind of this is the way it should be done, rather than this is what we have tried and it has been successful for us"* (RCP14)

*"How well other than reading a story on a website, what I don't think we know is so how many people actually make contact with that site or that story teller to understand the*

*improvement and the lessons. We kind of don't know the next bit as to whether there is something about a story encourages people to look further or make contact."* (RCP15)

### *Elements Required for a Successful Programme*

Ninety-five percent (n=21) of respondents from the development site teams reported that the Future Hospital team had provided 'just the right amount of support'. The learning events were rated the most useful element, with 77.3% selecting either the 'very' or 'extremely' useful options. Other high ranking elements included site visits, having a named contact with the Future Hospital team and networking opportunities. The average rating on a scale of zero (not applicable) to five (extremely useful) for each element is outlined in Figure 4.

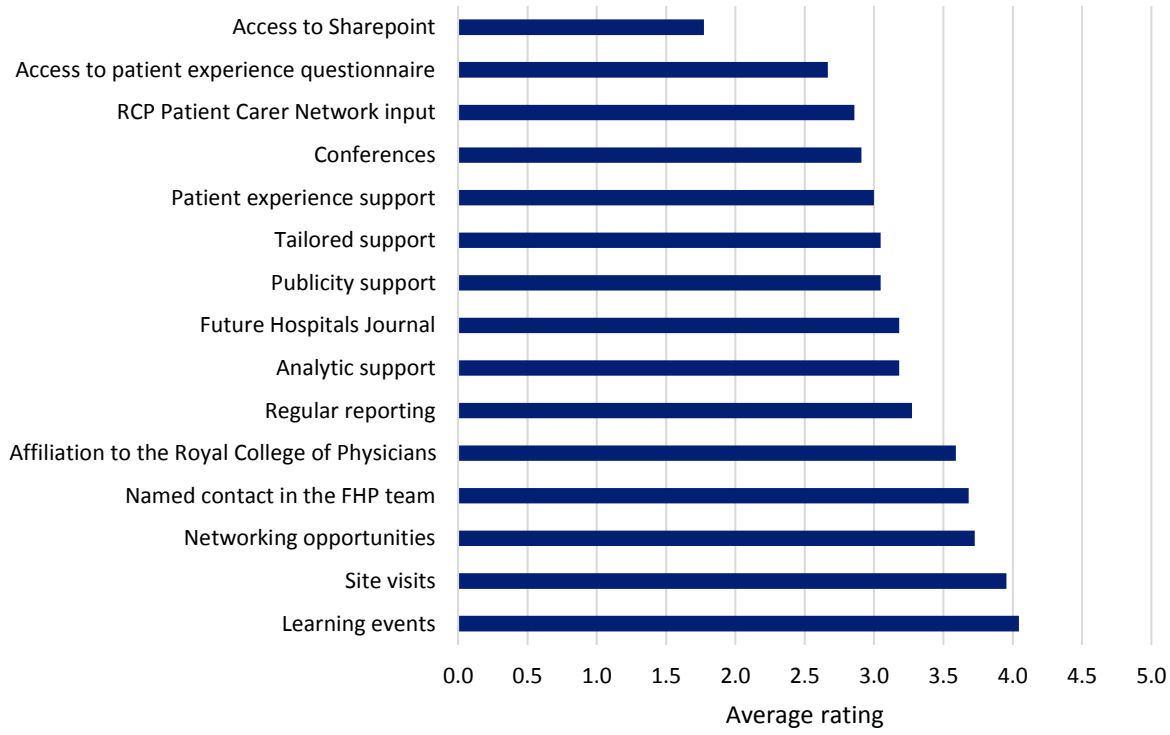


**Figure 4:** Average rating of the elements provided by the Future Hospital Programme on a 6-point rating scale ('0' = not applicable to '5' = extremely useful).

The elements ranked in the top six were also highly discussed within the focus groups with development site teams.

*"The learning events have been a real gelling process"* (DS3)

*"I have spoken a lot with* [other development sites leads]*, that support structure of clinicians but not only clinicians because I think you as patient reps and even the therapists have benefited from just discussing things say at learning events"* (DS5)

*"Highlights from me have been to visit different places, and to hear some of the other initiatives"* (DS3)

*"*[The Future Hospital Programme team have] *been our critical friend and I constantly use that phrase because they have given a level of scrutiny to what we are doing and, at times have been very, very challenging erm… and at times that has been quite hard to sometimes accept some of their criticisms but actually out of that has flourished better work."* (DS5)

*"I think the RCP has given it even more national recognition that is reflected locally if that makes sense. You know it has allowed us to go and talk to board and believe it or not, not many services get that opportunity to go and present this sort of work at board and you know the board were immensely impressed and proud of the work that the team has done, but I think it is that that it has added."* (DS4)

*"I just had my first experience of a monthly call yesterday and this whole approach to improving and trying to do new things which focusses on yes all the good stuff of which there is a lot, but also saying that you know we want to share this productively and also the challenges and the things that didn't go well we also need to talk about, be open about… and that is incredibly valuable for the learning."* (DS8)

### *Development sites and teams*

Teams benefited from the support of the Future Hospital Programme team, keeping them on task, providing training for quality improvement skills such as Plan-Do-Study-Act, data collection and management. It was suggested that this support is best delivered early, and needs both methodological expertise in project planning, evaluation and data to monitor process and impact. In addition, having senior clinicians in the support team, seen as being familiar with the challenges and realities of clinical work, developing and delivering change.

*"What was interesting was for the first four sites he [data analyst expert] met them once their projects were up and running. For phase two which is the second four sites, he was part of their induction so we sort of learnt that you have got to get the data collection right, you have got to get the data analysis right and so we had learnt that from phase one so we applied it to phase two. And the other thing about data analysis is that there are two sites in particular where they had their own in-house hospital based performance data analysis, people that were aligned with the project, and they have been invaluable because they have presented at our learning events and they have been strongly linked with clinicians, patients, and what they are trying to do on that site, and we see that as a model for further Future Hospital type development site type work where we would like to see patients, clinicians and analysts linked within a health care organisation."* (RCP12)

*"I think that was a key part for us was that making sure there was clinicians [RCP senior officers] supporting that change process who had been through change, who had dealt with change that sort of thing."* (RCP4)

*"I think just the access to expertise like [RCP senior officers] hugely helpful to them you know if they need something, quite often in fact it has been one of, what I think is one of the limitations to the approach because I think when we take that away, like can they carry on. Can they carry on without it that is almost one of my concerns is the sustainability of the approach because I think that we have spoon-fed to a large extent some of the teams and they come to us for everything and so now they need to stand on their own two-feet and hopefully they can do that."* (RCP1)

Teams access to data support varied, although this was considered essential. In phase two the expectations of team membership was expanded to include an on-site data analyst, a GP to represent primary care, and of course, patient representation.

"Sites that have had dedicated analytic support, have flourished." (RCP11)

"[Our Data Analyst] was an important member of the team emphasising that and talking about the aspects of quality improvement measurement." (employee, S8)

*"I think those, big days with [the Future Hospital Programme Data Analyst] were brilliant we laid the foundations but actually some support in data analysis and what have you because we just haven't had that locally.".* (employee, DS6)

The development site teams were very positive about the supportive role of the Future Hospital Programme team. The contribution was recognised as being practical, political and emotional.

*"…the support for me personally has been that I have had someone to go and have a discussion with when things are not going right. Had someone that has used their leverage and ability to you know maybe influence when I couldn't, has been significant."* (employee, DS1)

*"I was clear that RCP is keen to provide whatever support necessary to XX and team to maintain progress on FH project – in any way that would help."* (DS2, document 25)

*"from my perspective the College* [RCP] *has been a kind of supportive, a kind of, has kind of struck a good, I think on the whole a good balance between support and challenge in terms of what we have been required to do. … It has kept us accountable to them for the progress of the project and I think that's been very helpful."* (employee, DS4)

*"…[member of Future Hospital Programme team] is always approachable, … is always there, and if she can't answer the question she will always go and find you and she will always remind you what you have not done in a very helpful way."* (employee, DS7)

### *Support*

> *"It [the Future Hospital Programme] has to come to an end, because the, I mean as much as anything financially."* (RCP8)

Whilst it was clear the RCP could not financially sustain this type of project and support in the longer term, it was acknowledged that these types of innovation required a number of key elements. Senior management had to be supportive (and this was facilitated at times by letters from the RCP encouraging this), early, genuine patient involvement, support around data collection and evaluation planning following the quality improvement paradigm such as 'Plan, Do, Study, Act' cycles[10].

> *"FHP has been a little craft afloat in a sea of turbulence… RCP is sort of the an anchor in this that it has helped you to stay afloat, without that you would have drifted off."* (employee, DS1)

> *"…the RCP offers prestige… I had certainly read about the programme before because I am a member of the College* [RCP] *so I get the literature, and my feeling was the Trust viewed the project as predominantly a community project with Trust input, RCP helped with backup and support and interest…"* (employee, DS8)

> *"So when we are talking about the RCP serving as a mobilising force I completely agree with that, but to sustain that engagement from the local sites, local trust, they have no influence so the College* [RCP] *doesn't have an influence on the local politics, the local policy changes, beyond they are beyond their influence on the clinicians involved and the team that is involved and giving them more support and motivational support that will carry them to a certain extent. Beyond that there isn't any influence on the politics or the trust."* (employee, DS2)

A phased approach was recommended in collaboration with data experts from the trusts involved, who would be more familiar with the data currently collected and what would be feasible to add, and have the relevant analytical skills.

> *"We set timeframes for reporting and ensure teams work to meet those timeframes and deadlines. Erm… ensuring that there is a rationale behind each one and that we haven't just plucked it out of the air. Erm… we provide support for those reporting deadlines so for example, erm… templates for the quarterly reports, guidance for the annual reports, guidance for the shadow final report that is due to come, to ensure that we are not wasting team's time it is sort of what is the end goal, what do we want to know, and how best can they share this with us, that sort of stuff goes in the guidance. Erm… arranging, facilitating, visits and support from external experts like …* [data expert and patient experience expert] *erm… reactive stuff like employing the weight and seniority of senior officers at the College* [RCP] *where needs be, so message from the Chief Executives, and being that conduit going to the Chief Exec team at the RCP explaining*

*the situation for a particular site asking if he will support us, drafting the letter and then sending it off to the development site, chasing it up that sort of stuff. Erm… monthly phone calls to check that folks are on target and meeting their aims and objectives and their milestones, erm… and again offering support of the RCP communication teams, RCP design team when it comes to abstracts, posters etc, erm… supporting the sites when visits from MPs or other notables you know, we turn up and represent FH and are able to sort of represent the College* [RCP] *and explain between the work the team are doing on site in their Trust and the wider programme. Erm… coordinate communication opportunities so seeking out platforms so like talk at conferences, or meetings, erm… and linking them up with College events where possible. Erm… and just generally tapping into various experts and resources that we have in the College* [RCP] *to help the sites further if we can."* (RCP6)

## Inputs and Outputs

### *Inputs*

The pilot projects were diverse in many ways, looking at different solutions to common problems around frailty in phase one, with varying local environments and cultures. Nevertheless much was also common across projects and the team experiences, and these issues were successfully shared at the learning events. These events were considered successful for peer support, sharing progress, learning and bonding, but some respondents felt that too much was squeezed into each event.

*"The learning events engender a degree of professionalism because actually what tends to happen is the leads or the clinicians tend to congregate and feed off each other, in a positive way and it is not competitive you know because they work in different areas on their own projects and actually what they do is egg each other on so there is a degree of almost peer support which I think is also a very professional thing because actually how often in an organisation do we see professional jealousy, competition actually hold things back, whereas actually we have created an environment where actually everyone moves forward and I think that has been a very key part of what we do."* (RCP4)

*"There is always such a buzz at the learning events."* (RCP9)

The development sites clearly acknowledged this importance of the learning community which developed, facilitated by the conferences and networking events to share learning from the practices of other sites and to allow reflection on their own development site projects.

*"… it is part of actually working and networking and the excitement of actually reflecting and thinking can do it better together, than alone."* (employee, DS7)

*"…you can go to them* [learning events] *with issues around the project, but also things that are not in our* [department name] *so I have been to them with other pieces of work saying*

*do you know anybody doing this, so it has opened up those wider relationships." (employee, DS7)*

There are different elements to this however. If improved patient experience and pathways of care are at the core, then it is essential to incorporate patient expertise as early as possible in the planning when redesigning service pathways, intervention and evaluations to ensure what matters to patients is at the core of the process.

The workforce also varies, and many talked of the great contribution of diverse members of the workforce, some development site teams were more driven by charismatic leaders. Others spread the leadership more widely and at different times the leadership responsibility moved in emphasis across the team. This is a more sustainable model, and benefits capacity building and sustainability rather than over-reliance on a single leader or champion. Effective teams need the right skills and expertise at their core, and there was a link between an effective skill mix and delivering objectives.

Data needs to be built in from the outset, not bolted on, both having metrics that matter to patients and the NHS, as well as making data collection matter. Some data are already being collected, but it is likely some new data collection systems will need setting up and sustaining. Most teams will need to develop their quality improvement skills to deliver an evaluation that answers the questions posed. Whilst this expertise is in the RCP, teams would also be able to access that through other means, including in-house, NIHR infrastructure, Academic Health Science Networks etc.

Most survey respondents were involved in improving services, with over 80% interested in quality improvement. Figure 5 outlines elements with members and fellows would find helpful to support their improvement activities. Sixty-three percent of respondents reported they would be either likely (42%) or very likely (21%) to use such expertise if provided by the RCP.


**Figure 5:** What Members and Fellows report they would find helpful to support their quality improvement activities.

Only 5% of respondents felt Future Hospital Programme wasn't core business for the RCP with 80% giving it a top or important priority for RCP in the Members and Fellows survey. The full response regarding importance and priority are outlined in Figure 6.

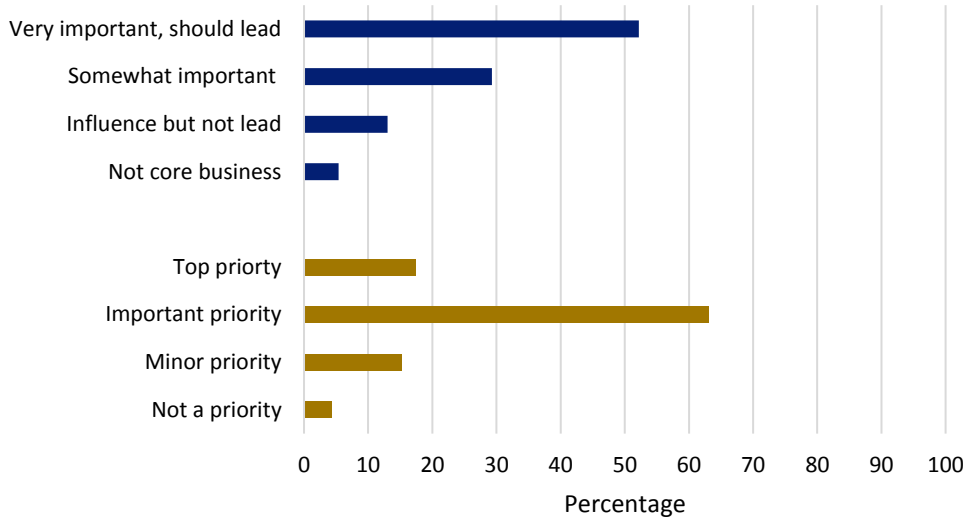


**Figure 6:** Members and Fellows view on the importance and priority for investment into future projects related to quality improvement, such as the Future Hospital Programme.

### *Outputs*

> *"In practice,… you know there wasn't a clear view, or a clear outcome that was expected other than learning, and there has certainly been a lot of learning."* (RCP7)

Communication and dissemination is a key to success, but there were differing opinions about the message, its timing, content and target audience. It was said that some in the RCP only consider something as evidence to change behaviour if it is from a randomised control trial, however the respondents were broadly in favour of the quality improvement approach using recognised approaches to service evaluation and re-design. There was widespread support for *Tell Us Your Story* and Partners' Network and some expressed regret that the Future Hospital Programme was too complex and costly and complicated, and a simpler way of sharing news about what works and what doesn't based upon brief reports from members would be more useful and affordable for the RCP.

> *"We got very much involved in the ins and outs of the eight projects,… and that was fine for those eight projects but what about everybody else?"* (RCP8)

Some considered *Tell Us Your Story* more useful than the development sites as sharing what works and what doesn't is likely to have wider impact across the membership, being wider in scope and more accessible than formal project reports. However, others were concerned these reports are relatively light on detail and the key elements of evaluation that would be required for the results to be considered generalisable.

*"I would do a much better job about the comms. Both getting the stories into quality improvement journals, getting them into conferences, abstracts, but getting them into a trade press you know like Health Service Journal, but also telling it, messaging it out to mainstream media I just think we have been too cautious about making a big splash."* (RCP2)

*"I know a lot of people in the Future Hospital Programme are fascinated by what is it that you have changed, and what result did it bring about. And actually that is of less importance to me, and I think to many of the readers of this document because … their systems are going to be slightly different, so what is more important is going about how did you engage with people, how did you trial and fail, how did you learn, how did you engage with people, how did you sustain and I think that is far more important messages."* (RCP11)

Of note in the membership survey, whilst 67% of respondents were aware of development sites only 43% were aware of *Tell Us Your Story* and 23% of the Partners' Network. The awareness of other elements of the Future Hospital Programme are outlined in Figure 7.

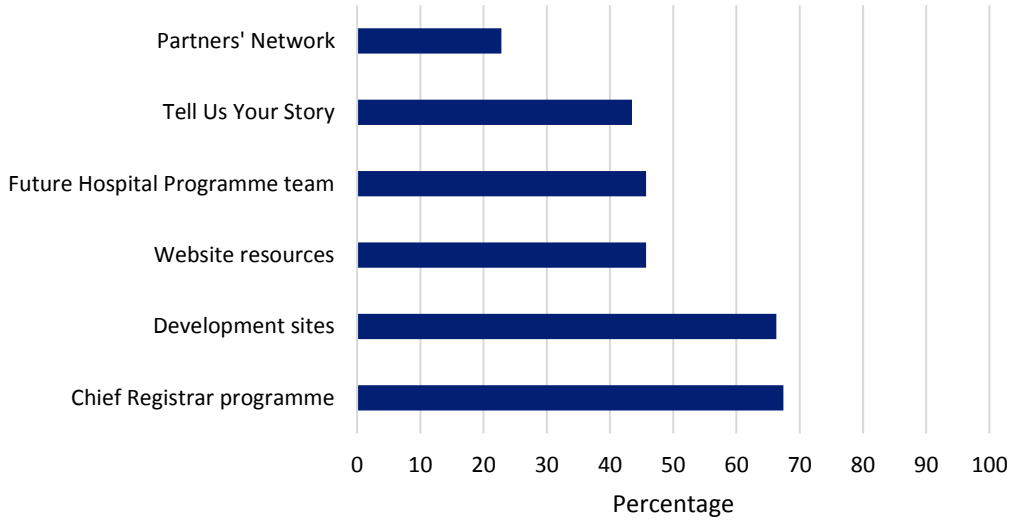


**Figure 7:** Member and fellow awareness of different components of the Future Hospital Programme

Dissemination was mentioned as having the potential to influence policy, NHS service redesign, investment and wider policy as well as the overall approach to delivering and designing care and cultural beliefs within the profession, putting the RCP at the core of influencing, and perhaps driving change.

*"Focus has been very positive and very good, for the college* [RCP] *because its put us on the map as people who can think up creative health policy and it was very well received by the government at the time and it had a lot of media coverage, the original*

*commission. And so the, the setting up of the next phase of the Future Hospital development sites was, was something that reflected well on us as an organisation"* (RCP8)

*"…the link between the [Royal] College of Physicians which obviously traditionally represents hospitals and hospital doctors with the community. …it has been a theme forever how we can collaborate and cooperate more effectively? So the fact that the College* [RCP] *has been seen to promote and support something that started off in the community …* producing, going to visit something in the *States and again developing this model, I think is quite a powerful statement."* (employee, DS8)

Royal College of Physicians staff are well placed to advise on communications, press releases, media management as well as writing research posters and papers for meetings and conferences. However, the informal, local routes are also important, as are the sharing of thoughts and findings amongst colleges, both directly and through discussion fora, websites and quality improvement programmes. Audiences include trainees, care teams, managers, NHS policy makers, politicians and patients.

*"It is just offering that, them that sort of, that sort of infrastructure we have at the College* [RCP] *and probably take for granted. You know we have got communication professionals, it is putting those opportunities out to sites because they don't have access to that, on the ward so we may as well give them a bit of a national, you know, boost if you like through our communications team and give them some profile."* (RCP17)

Some felt the programme was 'over-cautious' and it should be publicising the work and pilots earlier, others were concerned about the risk to reputation if findings were prematurely released and made claims that couldn't later be reliably substantiated. Nobody mentioned the potential for harm, but of course, this has to be considered; change can improve, worsen or have little or no real impact. The potential to encourage patient representatives to publish their work was mentioned as important and worthwhile as an outcome, which has been achieved.

*"They have always been very cautious about kind of selling in any of the data, or selling in any of the kind of recommendations that have come from it because they don't want to kind of say oh you know this has worked for six months so this is definitely going to work in ten years' time. So I think that has been quite difficult externally because you are trying to prove a concept that they have always been cautious to prove or disprove I think that has been a big challenge."* (RCP16)

*"I think that is where we have sort of missed some of the benefit of the FHP because I think we have always been slightly at conflict as to how we can share the messages because they don't want to share anything until it is rooted in like really robust QI methodology, and actually some of the principles is really helpful to everyone else."* (RCP16)

There is scope to provide opportunities and a feedback loop for development sites to shape the way Future Hospital Programme develops by identifying good practices and instigating these across development sites.

## Checks and Balances and the Tensions Between and Within

### *Royal College of Physicians Goals*

What is clear is that this project has had a high profile within the RCP, and has achieved its aim of translating aims and ideals into real delivery projects, showing the potential for the Future Hospital Commission approach to influence service redesign.

Interviewing RCP officers and staff highlights differences in the views of best strategy and priorities. Is this a college for members, focused on quality, standards and professionalism (the MRCP membership qualification and CPD), or a body supporting the cause of physicians, influencing government and policy and driving healthcare development, or all of the above? Respondents suggested the Future Hospital Commission and Future Hospital Programme were relevant for both the curriculum and discussing management of cases as well as contributing towards continuing professional development (CPD).

> *"I think, there is anecdotally there is probably been clear continuing professional development for the clinical leads, the project managers and the MDT involved in the development site project teams because with the assistance of say … the experts we have brought in on a consultancy basis, they have learnt the importance of data, they have learnt how to process their data, they have learnt how to … present their data in ways that demonstrate that they are making a change and so, from that point of view, and in evidencing their hard work the initiatives, their PDSA cycles, I would suggest that they are learning a lot there. Again no CPD formal structure attached to that either."* (RCP6)

> *"I would hope that clinicians whether it is doctors, nurses, or whoever has been involved, could articulate their involvement and their experience for the purpose of appraisal and revalidation. I don't know, that we have encouraged that or I think doctors and nurses just do this stuff because it is the right thing to do they don't really think, unless it is a certificate moving them into this was a great experience or you came to this learning event and if you just took some notes and articulated what you have learnt that might be really helpful. Erm… because they tend to focus on earning so many points, so I think that they could and should be recording their involvement for CPD but I think that's possibly a gap that we haven't encouraged them."* (RCP15)

More pragmatically does the RCP's focus belong with supporting the daily work of its members and their work to improve care? The latter was a focus for the wide support for *Tell Us Your Story*, Partners' Network and the Chief Registrar project, which perhaps speaks more to the concerns of the wider membership, continuous professional development (CPD) and quality improvement.

> *"Chief Registrar is a really, really important part of Future Hospital, that is because it looks forward to the next generation. … Tell Us Your Stories, I think was also very, very crucial … it allowed you to engage more people who were doing great stuff you know, a lot of people are doing what the Future Hospital wants them to do or the principles are being adhered to and met and implemented, they just don't brand it or don't know it."* (RCP4)

Other competing priorities are the need for more generalist physicians to meet the needs of increasing complexity and co-morbidity (21). There is also the goal of influencing international developments in care and innovative ways of working. Patient involvement is highly esteemed centrally, so would continue to be an expressed goal and expectation for ongoing work of this type, but the core Patient Carer Network group lacks the resources to support lots of similar schemes.

> *"The College* [RCP] *have policy and have set out in a whole load of campaigns and resources and documents, , about the need to revive generalism for instance, … we very much want to start being an organisation that is more relevant … it is all focussed on the exam and it is not always thinking about the frontline teams who have got real problems to solve, so I am hoping it is highly relevant to that agenda."* (RCP2)

### *What Constitutes Evidence?*

Quality Improvement is considered the right paradigm for these types of activities. The importance of quality improvement was recently highlighted by a senior officer of the RCP(22).

> *"At the moment the quality improvement implementation science movement can end up looking to other medics a bit like a cult with its own language and its own zealotry and I think, I think what we have to do is say it's a range of approaches to improving service and this is one of them, but just be clear about where it sits and why it should have equal weight."* (RCP2)

There are recommended methods for this type of approach and it is intended there would be guides within the quality improvement section of RCP referring to expert knowledge and more informal advice to mirror the support provided to development teams within the Future Hospital Programme.

Toolkits for project development and evaluation could be developed, and perhaps available through the RCP quality improvement team and web-pages, linked to *Tell Us Your Story*. Some of these exist already; Plan-Do-Study-Act (23), Logic Models (24), PESTLE analysis (25), Health Inequalities Assessment Toolkit (HIAT) (26), Experience Based Co-Design (27) for example, and were mentioned by different respondents as useful approaches and resources.

### *Royal College of Physicians Roles: Influencing Internal and External Policy and Change*

This links to the RCP goals, relating to prioritising the direct needs and expectations of the membership versus wider influencing of policy and delivery, and working in partnership with other organisations such as other Royal Colleges, for both doctors as well as nurses, allied health professionals, managers and commissioners. Some see the importance of demonstrating how to achieve change and new ways of working, keeping physicians in leadership roles, hence perhaps the wide support and acclamation of the Chief Registrar programme. This balancing act between the expectations of the RCP members to support their daily work and the wider role, lie at the heart of the diverse views. This is mirrored in the membership survey about what the role of the RCP is in larger headline programmes such as the Future Hospital Programme, and the levels of evidence of effectiveness that can be found through robust evaluation, versus a more informal *Tell Us Your Story* approach, which lacks the evidential rigour. Parallel dilemmas mentioned included the role for CPD linked to this type of work and whether it should be formal or informal; how prominently it should feature within the quality improvement team and work stream within the RCP, the role for the PCN in supporting patient involvement in projects in the future, and the capacity to do so, versus concerns about wide interpretation of what constitutes patient and public involvement in such initiatives and how to ensure the colleges championing of true involvement is upheld if these activities become less formal and more widespread.

The respondents to the members and fellows survey reported the Future Hospital Programme to have promoted: the need for change, quality improvement and clinical leadership with 71.1%, 64.4% and 61.5% voting they were either 'strongly' or 'very strongly' promoted respectively. The average rating on a 6-point scale of one (not promoted) to five (very strongly promoted) and zero (don't know) are outlined in Figure 8.


**Figure 8:** Average rating of what Members and Fellows felt the Future Hospital Programme has promoted on a 6-point rating scale ('1' = not promoted to '5' = very strongly promoted and '0' = don't know which was excluded from analysis).

### *'Top Down' versus 'Bottom Up'*

Another key dilemma is whether initiatives are best built up and sustained from a local, bottom up focus driving enthusiasm and ideas, supported by the centre, or the centre setting the focus and asking for volunteers to be supported and directed. The future probably lies between, but realistically although change can be initiated top down, the RCP's charitable status and finances cannot sustain that approach. Disseminating the benefits and supporting teams is likely to be the only sustainable way to roll the programme out more widely, providing key opinion leaders are convinced by the evidence that this is an important development worthy of the investment of staff time and resources. The goal of the Future Hospital Programme was to provide that evidence.

### *Sustainability and Future Funding*

> *"As a medical Royal College it is unsustainable for us to roll out all innovation in the NHS"* (RCP8)

Therefore, the funding and support for this programme and its legacy will need revising:

> *"I just hope that even outside of the formal programme we can maintain some sort of communication about what phase one and phase two programmes are still achieving in the next, because this won't stop obviously at the end of the programme, you know we will continue to develop the… pathway and we have got some really exciting … times ahead of us with joint work with the commissioners around what that might look like and it would be good to still be able to share that work with the other sites that you know are… a relationship and a network with.".* (employee, DS4)

None of the respondents expected that the project as currently delivered was sustainable with just RCP funding. As a charity, it was suggested the RCP could not continue to justify the level of investment in the Future Hospital Commission movement as had been committed to the current Future Hospital Programme.

> *"Because of it being so principle based it can link to everything so it is more of a, it is a way of thinking rather than just a set of activities. I suppose that's why we hope that it will continue beyond the length of a specific set of time for the programme because, it is more of a set of philosophies and ways of working."* (RCP9)

Therefore it looked to others to pick up resourcing these types of programmes going forward, specifically the Department of Health whether directly or devolved to NHS (England or Wales) nationally, or trusts/STPs locally perhaps using the RCP team to manage the programme in the future. It was suggested that this is distinct from Vanguards for example, but also very important to improvements in the effectiveness and quality of care. Some suggested a more regionalised approach to taking this model forward in collaborations, perhaps linked to the Sustainability and Transformation Plans (STPs) in England. Many considered that this programme now needs to build into the offer from the quality improvement department. Some expressed that it should focus on big messages and a less complex approach, highlighting the *Tell Us Your Story* element of the Future Hospital Programme, with a more local focus linked closely to the Chief Registrar programme.

*"Eight is not enough hospitals to work with, eight is enough to test something on and see if it works and take the learning from."* (RCP1)

*"What we need to do, is to create a sense of broader community around this piece of work, linked to the Future Hospital principles, and almost create that movement of this is the way we want to work, therefore this is how we are connecting, and this is how we are learning together… I think the next phase is really important I think it is erm.. it is a strong brand, it is really important that that brand isn't lost or that it is developed further and we are certainly you know in discussions about how that happens moving into QI hub."* (RCP7)

*"We can't continue doing exactly what you were doing, but we want you [programme team] to be part of something bigger and better and newer that is, has grown out of Future Hospital."* (RCP8)

# Discussion

This external independent evaluation has examined the Royal College of Physicians' Future Hospital Programme from four different perspectives; development site teams, patient representatives, RCP personnel and RCP members and fellows. We collected data from a thorough document review relating to sites and Future Hospital Programme evaluation team, observations of meetings, semi-structured interviews and focus groups.

It has been able to look at the experiences of each development site within the context of their own organisation, highlighted the benefits and barriers to PPI within these projects and explored the role of the RCP from internal and external viewpoints.

Throughout this evaluation, two themes have re-occurred across the different groups consulted; learning and tensions. Learning has been a process for each of the development sites as well as for the Future Hospital Programme team and the RCP. The Future Hospital Programme team conducted an internal evaluation following phase one and transferred the lessons learnt into the conduct of phase two. Tensions have been reported at all levels internal and external to the programme. A key tension for the RCP was how large innovative elements of their work such as the Future Hospital Commission can be demonstrated and rolled out more widely. It arguably demonstrates the importance of negotiating wider funding partnerships to sustain large initiatives outside the traditional core functions of a Royal College. Tensions for the teams are, as one might expect: workload and capacity demands; resource challenges; PPI engagement; and sustaining the project and evaluation together consistently.

Key lessons have been highlighted for future initiatives of this type, the challenges that can be anticipated, and potential solutions to overcome them.

Considering the learning that the Future Hospital Programme provided from the perspective of the development sites, we note unanimously a sense of appreciation that whilst the demands placed on participating sites were considerable there is notable development, improvement and change on a number of levels. The Future Hospital Programme acted as a catalyst for a clinician and patient led, programme of change in the hospitals participating.

Quality improvement projects within hospitals require adequate support from Trust management and other stakeholders. Liaising with key stakeholders, such as patient groups, Trust management, colleagues in primary, secondary and tertiary care, and commissioners from the outset, facilitates buy-in of all parties. Another crucial requirement is the identification of the correct experts, which may not be available within the Trust, to support the methods and process. The use of robust evaluation methods when carrying out quality improvement work, including the collection and analysis of metric and patient experience data, requires additional time and resources. Whenever possible however, it is important to identify relevant expertise, such as data management, from within the organisation, to facilitate shared learning and future sustainability. The development site teams reported this work improved their engagement in their day-to-day role and as a worthwhile investment of their time. Consideration of staff well-being must be made during periods of change, measures such as resilience training and mentoring can be used to support transition.

It was recognised by all parties in the Future Hospital Programme that 'doing' PPI is challenging. A key issue was that this kind of work needed funding so that the patients were not out of pocket, and staff resourcing so that patient representatives could have adequate support. This support could take the form of buddying, building a community of representatives, shadowing, exploring training needs, and support from the centre, i.e. the RCP's PCN. Consideration of what levels and types of core support should be provided, and ways to develop peer support for PPI representatives is needed, plus ways to support them between projects.

There was a dominant theme that the representatives wanted clear guidance on the roles and expectations that the RCP and the Future Hospital Programme had both for them individually and the process as a whole. How representatives were and should be recruited was important. There should be a formal process for recruiting the PPI representatives on the team, and their roles should cover a wider remit, not just advice on patient questionnaires and publicity. There was an issue of difficulty in recruiting due to the lack of capacity in PPI, and this needs to be addressed. To meaningfully embed PPI in the quality improvement projects, it cannot be a piecemeal approach, PPI needs to be sustained and sustainable, there needs to be support of the whole system – organisational buy in – so that it becomes a 'way of doing things' throughout the NHS.

# Conclusion

This evaluation has confirmed that the programme has had many successes, brought about real change; developed QI capacity directly within teams; and more widely across the RCP, and demonstrated a number of RCP policies and strategies in real world environments with clear evidence of achievements. This suggests that the approach of RCP driving and supporting local projects for service delivery innovation, that incorporating a structured evaluation of the implementations of the Future Hospital Commission principles was a successful strategy. It was demonstrated the impact and identified enablers and barriers to using this approach to improve patient care.

Furthermore the shared learning and central support has co-ordinated the development sites, ensured the momentum was maintained and kept projects to plan despite considerable workload pressures and tensions that could have derailed them locally. The project enabled synergistic development and improved patient engagement at the development sites.

The programme of Future Hospital development sites links well to future plans for the Quality Improvement Hub in the RCP, as well as the Chief Registrar scheme and the web-based Tell Us Your Story initiative.

However, the Future Hospital Programme approach is not sustainable for the RCP to resource alone. Whilst it was effective pump-priming to deliver demonstration sites and shared evaluations, other approaches need to be explored to facilitate professional-led, 'bottom up' innovation, co-produced with patients working to RCP recommendations for quality improvement, evaluation and innovation. This requires a less formalised and high-investment environment for it to be sustainable in the longer-term.

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