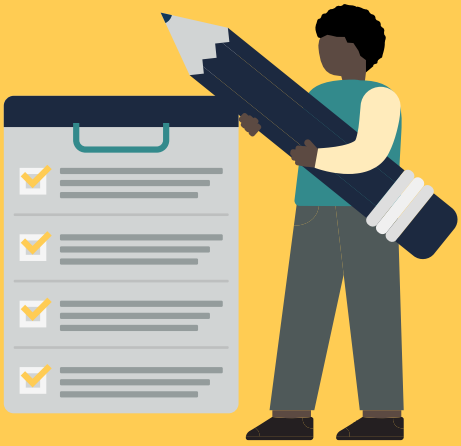
Royal College of Physicians

# Time to focus on the blue dots

## Designing care around people, not buildings: **an RCP toolkit**



On 16 April 2025, the Royal College of Physicians (RCP) brought together clinicians, patients, educators, and health leaders to discuss the UK government's proposed 'left shift' from hospital to community.

The event quickly evolved into a conversation about how we can empower patients and communities by investing in integrated, people-centred care systems.

'The most underused resource in our healthcare system are the people who use it. If you bring into your mind's eye a sheet of paper full of blue dots, except for one solitary red dot. The blue dots represent the hours in the year a patient has to manage their condition themselves. The red dot represents the time they interface with health professionals. Yet 99.99% of our time, effort, resource and management is on the red dot. Perhaps it's time we focused on the blue dots'

– Sir John Oldham, GP and strategic adviser to the secretary of state for health and social care

# Five core principles for 'blue dot' care

1 **Person-centred:** start with what matters to patients, not just what's the matter with them.

2 **Integrated:** care should flow across settings and sectors.

3 **Preventative:** focus on maintaining health, not just treating disease.

4 **Collaborative:** generalist and specialist medicine should be equal partners.

5 **Connected:** building relationships and trust should be a key priority.

# Three questions to ask your patients

1 **Personal:** what matters to you?

2 **Supportive:** how can we make your journey through the NHS easier?

3 **Empowering:** how can we support you to stay as healthy as possible in your daily life?

# Five barriers to change

1 **Disjointed:** data fragmentation and poor information sharing between care settings.

2 **Siloed:** workforce silos and role boundaries that prevent flexible team-based working.

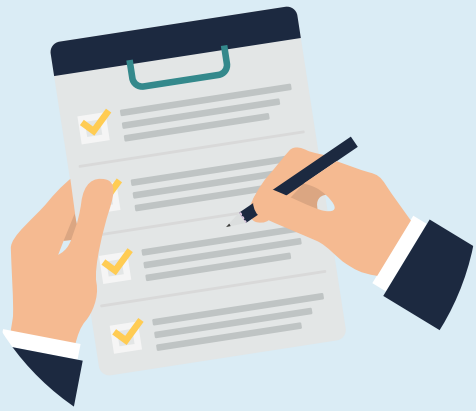
3 **Unclear:** inconsistent patient communication and lack of public awareness.

4 **Entrenched:** cultural attachment to hospitals as the 'default' for expertise.

5 **Inflexible:** professional and structural resistance to shifting models.

# A checklist for change:

## reimagining people-centred care



This checklist is intended to support clinicians, managers and NHS leaders to think about how they could develop and implement people-centred care in their local area by shifting resource from hospital to community.

**What are the things you should think about?**

### 1 Funding and resources

- Use funding models that prioritise integrated care.
- Develop social care provision that enables timely discharge and prevents admissions.
- Align shared metrics to support a system-wide 'left shift' and reward prevention.
- Put in place a staffing model with the right skill mix and sufficient numbers.

### 2 Leadership, governance and culture

- Establish visible leadership across primary, secondary, and community care.
- Develop shared service models and improve clinical accountability.
- Be willing to decommission outdated service models and shift resources.
- Align job planning with new models of care delivery.
- Ensure indemnity, escalation policies, and standard operating procedures (SOPs) are appropriate and in place.
- Use metrics that reflect patient value, not just service activity.

### 3 Training and workforce development

- Train future physicians in generalist, community and integrated roles.
- Protect time for MDT working, supervision, and relationship-building.
- Embed community-based experience across all stages of medical training.
- Build shared decision-making, co-production and person-centred care into training curricula.

### 4 Communication and continuity of care

- Communicate clearly using jargon-free, patient-friendly language.
- Support patient understanding of team roles and responsibilities.
- Build trust between GPs, physicians, and community services.
- Implement shared care plans.
- Include patients and families in multidisciplinary team (MDT) meetings where appropriate.
- Use the NHS app (or local equivalents) to increase transparency and engagement.

## 5 Patient engagement and support

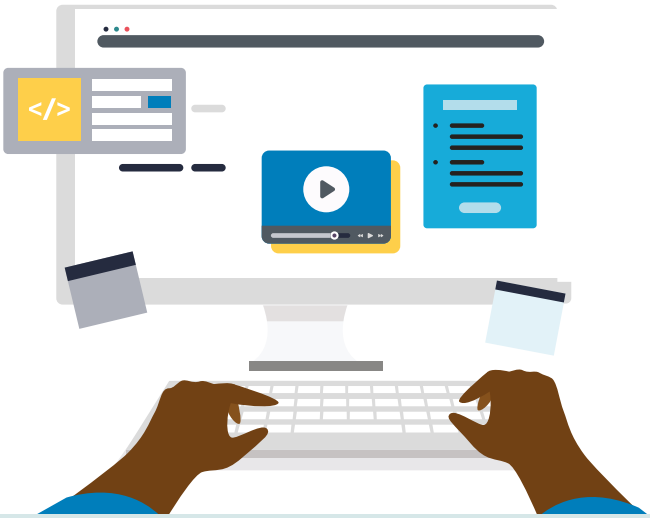
- Be transparent in discussing risks and benefits.
- Acknowledge when quality of life is the priority.
- Embed shared decision-making tools and empower patients to actively participate in their care.
- Co-produce care pathways and services with patients and communities.
- Offer access to patient-facing tools, apps and clear guidance.
- Proactively identify and support older patients at risk of fragmented care, particularly those living in care or nursing homes, to avoid them being lost in the system.
- Train resident doctors to handle sensitive conversations effectively.

## 6 Integration and pathway design

- Build mutual understanding of roles across the system.
- Hold regular MDTs that include primary, secondary and social care professionals.
- Define clear care pathways with roles, escalation points and handovers.
- Ensure effective interface between general, specialist and community care.
- Fully integrate community diagnostic services.
- Specific pathways should be developed to reduce unnecessary waits for older people and those living with frailty, with access to acute and community-based rehabilitation at all stages to prevent deconditioning and support timely transfers from acute beds to community settings or care homes.
- Build stronger links with voluntary and community sector organisations.
- Develop place-based models of care that reflect local population needs.
- Use advice and guidance (A&G) effectively.

## 7 Data, digital and technology

- Ensure interoperable IT systems link primary, secondary, community and social care.
- Use digital tools for asynchronous consultation, virtual monitoring and triage.
- Leverage population health data for proactive and preventative care.
- Improve outpatient coding and structured data collection.
- Continue investing in digital platforms like the NHS app.
- Use AI tools to reduce admin burden and enhance patient empowerment.
- Provide training for staff on efficient use of digital systems.




This toolkit was developed following an RCP workshop on the shift from hospital to community care. Our checklist for change is based on the input of more than 40 workshop participants, including patients, clinicians and representatives from specialist societies, national charities, royal colleges and the Department of Health and Social Care.

Case studies will be published on our quality improvement hub, Medical Care – driving change.

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