The Future Hospital Commission of the Royal College of Physicians

Professor TW Evans DSc.FRCP. FRCA.FMedSci. Lead Fellow, Future Hospital Commission
The Acute Care Pathway, UK 2011

- 34654 WTE consultants (30 September 2009)
- 7583 WTE physicians, 5238 anaesthetists [1675 FFICM, 04.12]
The Hospital of the Future & the Future Hospital Commission

• The health service of the future:
  – *Financial & physical resources*
  – Human resources; political imperatives & challenges
• The patient of the future:
  – Case mix differences; complexity & specialisation
• The hospital of the future:
  – Compassion above all
  – Organisation & process: the home of the generalist?
  – Workforce & the numbers game
  – Data and IT
• Political engagement & leadership
Health reform: Honey we shrunk the hospital:
The next big row about the NHS

- £20bn to be saved from health budget by 2014
- King’s Fund: Specialist services better on fewer sites
- NHS CEO arguing for big reduction in hospital numbers
- Acute care now delivered in < 200 hospitals
- Fewer, better hospitals with competition and changed business models the way forward
Average number of daily hospital beds, England 1987-1988 to 2009-2010

Source: Department of Health, Hospital Activity Statistics
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• Political engagement & leadership
An acute problem (NCEPOD report, 2005)

Consultant physicians should see acutely ill:

‘Consultants' reliance on junior doctors in managing the acutely ill may be contributing to patient deaths, a report warns…..’
NCEPOD 2012: Cardiac arrest, time to intervene

Patient population, initial assessment and first consultant review:

- Timely escalation to more senior doctors was lacking in 62/347 (18%)
- Initial assessment (up to first consultant review or first 24 hours if consultant review could not be identified) was considered to be deficient in 230/483 (48%) of cases
- Deficiencies were present in many domains but by far the greatest number of concerns were raised about decisions regarding CPR status (107 cases)
‘Inside your hospital’

Mortality ratio compared to senior staff/bed ratio

- Lower quartile: Senior staff per 100 beds = 0.8
- Upper quartile: Senior staff per 100 beds = 4.1

Dr Foster Hospital Guide 2011.

Royal College of Physicians
Setting higher standards
Mortality rate by hospital & day of admission: Wales*

<table>
<thead>
<tr>
<th>Admitting Hospital</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Hazard Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronglais General Hospital</td>
<td>4.99%</td>
<td>5.59%</td>
<td>4.41%</td>
<td>7.86%</td>
<td>6.53%</td>
<td>6.72%</td>
<td>4.15%</td>
<td>1.89</td>
</tr>
<tr>
<td>Ysbyty Glan Clwyd</td>
<td>6.13%</td>
<td>6.10%</td>
<td>6.26%</td>
<td>5.87%</td>
<td>5.30%</td>
<td>6.03%</td>
<td>6.39%</td>
<td>1.21</td>
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<tr>
<td>West Wales General Hospital</td>
<td>5.63%</td>
<td>5.15%</td>
<td>5.67%</td>
<td>4.92%</td>
<td>5.75%</td>
<td>6.94%</td>
<td>6.00%</td>
<td>1.41</td>
</tr>
<tr>
<td>Morriston Hospital</td>
<td>4.62%</td>
<td>5.13%</td>
<td>5.41%</td>
<td>4.93%</td>
<td>5.93%</td>
<td>5.23%</td>
<td>6.00%</td>
<td>1.30</td>
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<tr>
<td>Nevill Hall Hospital</td>
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<td>4.51%</td>
<td>4.32%</td>
<td>5.15%</td>
<td>5.73%</td>
<td>5.00%</td>
<td>6.86%</td>
<td>1.59</td>
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<tr>
<td>Prince Charles Hospital</td>
<td>5.50%</td>
<td>4.69%</td>
<td>4.97%</td>
<td>4.58%</td>
<td>5.36%</td>
<td>5.24%</td>
<td>6.48%</td>
<td>1.42</td>
</tr>
<tr>
<td>Princess of Wales Hospital</td>
<td>7.60%</td>
<td>7.06%</td>
<td>6.82%</td>
<td>8.06%</td>
<td>7.18%</td>
<td>8.41%</td>
<td>8.06%</td>
<td>1.23</td>
</tr>
<tr>
<td>The Royal Glamorgan Hospital</td>
<td>6.00%</td>
<td>6.32%</td>
<td>5.94%</td>
<td>6.75%</td>
<td>5.41%</td>
<td>7.21%</td>
<td>7.68%</td>
<td>1.42</td>
</tr>
<tr>
<td>Royal Gwent Hospital</td>
<td>3.97%</td>
<td>4.50%</td>
<td>4.82%</td>
<td>4.85%</td>
<td>4.36%</td>
<td>5.56%</td>
<td>5.65%</td>
<td>1.42</td>
</tr>
<tr>
<td>University Hospital of Wales</td>
<td>5.56%</td>
<td>5.56%</td>
<td>5.21%</td>
<td>5.55%</td>
<td>6.13%</td>
<td>5.02%</td>
<td>5.90%</td>
<td>1.22</td>
</tr>
<tr>
<td>Withybush General Hospital</td>
<td>5.63%</td>
<td>5.88%</td>
<td>5.19%</td>
<td>6.66%</td>
<td>5.56%</td>
<td>7.25%</td>
<td>6.63%</td>
<td>1.40</td>
</tr>
<tr>
<td>Wrexham Maelor Hospital</td>
<td>4.71%</td>
<td>5.28%</td>
<td>5.15%</td>
<td>5.53%</td>
<td>5.37%</td>
<td>5.86%</td>
<td>6.01%</td>
<td>1.28</td>
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<tr>
<td>Ysbyty Gwynedd</td>
<td>6.44%</td>
<td>5.59%</td>
<td>5.29%</td>
<td>4.79%</td>
<td>4.86%</td>
<td>4.97%</td>
<td>4.80%</td>
<td>1.34</td>
</tr>
</tbody>
</table>

Notes: Data relates to discharges between September 2010 and August 2011 inclusive.

Source: NWIS

The best configuration of hospital services for Wales: a review of the evidence.
Welsh Institute for Health and Social Care * excl paediatrics and obstetrics & gynae
Working practices of the future

RCP Workshop on 7 day working, July 2010

‘....all the doctors were consultant level....there were no trainees. These staff were obliged to work... six to eight 24 hour shifts per month.’

Elective report of Christopher Hall, RCP-sponsored final year medical student, Dept of Intensive Care Medicine, Ajaccio, Corsica.
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• Political engagement & leadership
Caring to the end (NCEPOD report, 2009)

Health status on admission

<table>
<thead>
<tr>
<th>Health status on admission</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A normal healthy patient</td>
<td>52</td>
<td>1.7</td>
</tr>
<tr>
<td>A patient with mild systemic disease</td>
<td>244</td>
<td>8.0</td>
</tr>
<tr>
<td>A patient with severe systemic disease</td>
<td>743</td>
<td>24.2</td>
</tr>
<tr>
<td>A patient with incapacitating systemic disease</td>
<td>1368</td>
<td>44.6</td>
</tr>
<tr>
<td>A moribund patient</td>
<td>657</td>
<td>21.4</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>3064</td>
<td></td>
</tr>
<tr>
<td><strong>Not answered</strong></td>
<td>89</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>3153</td>
<td></td>
</tr>
</tbody>
</table>
## Comparison of medical admissions to ICU in the USA and the UK

<table>
<thead>
<tr>
<th>Comparison</th>
<th>US</th>
<th>UK</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>University affiliated ICU, %</td>
<td>56.4</td>
<td>17.2</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Number of ICU beds. median (IQR)</td>
<td>15 (12-20)</td>
<td>7 (6-9)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Source of admission to ICU, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room</td>
<td>58.0</td>
<td>33.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospital floor</td>
<td><strong>17.5</strong></td>
<td><strong>36.9</strong></td>
<td></td>
</tr>
<tr>
<td>Other hospital, ICU</td>
<td>1.8</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>22.7</td>
<td>23.6</td>
<td></td>
</tr>
<tr>
<td>Hospital length of stay prior to ICU, median (IQR)</td>
<td>0 (0-1)</td>
<td>0 (0-2)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospital length of stay prior to ICU, mean (±sd)</td>
<td>1.0 ±3.6</td>
<td>2.6 ±8.2</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Chronic Medical Conditions (any), %</td>
<td>25.9</td>
<td>14.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CPR in 24 hours prior to admission, %</td>
<td>4.4</td>
<td>10.4</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Changing patients, changing needs: RCP data and conversations:

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

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

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

We risk losing the pool of general medical skills essential to the provision of holistic care
In the October 2012 issue of Commentary we published ‘Confessions of a foundation doctor. Why I don’t want to be a medical registrar’, which provoked a supportive response from our readers. Here, we publish a letter from one reader who looks at the issues raised from both sides of the coin.

Dear Commentary,

Having recently completed my dual accreditation in general internal medicine (GIM) and rheumatology, I can see both sides of the coin. In the current system, where time for training is limited – due to the European Working Time Directive (EWTD) and shorter training programmes – junior doctors are exposed to a high-intensity medicine early in their careers. Breaking down of traditional firm-based care (where looking after the juniors’ needs were engrained in the firm’s ethos) leaves the trainee with limited opportunities to interact with their seniors in the medical hierarchy. This is made worse by the current medical rotas with weeks of night and day on calls, annual leave and study leave.
Hospitals on the edge?

A report by the Royal College of Physicians
September 2012
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• Political engagement & leadership
Aim: ‘Identify the optimal care pathway for the adult inpatient with medical illness, with specific reference to organisation, processes and standards of care.’

Journey: Hospitals serve the needs of patients and can deliver:

• High quality care 24 hours per day, seven days a week
• Continuity of care for patients delivered with compassion
• Stable medical teams for patient care and education
• Effective relationships between medical teams & community
• Appropriate balance between specialist and general care
• Transfer realistically allocating responsibility for further action
• A new care system the aim
What does the report cover?

Organisation of medical care and teams:
• From the emergency department, to wards and into the community: The Medical Division

Education, training and deployment of medical staff:
• Medical staff with the skills and expertise to meet the needs of patients: Re-emergence of the generalist

Building a culture of compassion and respect:
• Valuing patient experience & support staff to care with compassion: The Citizenship Charter

Management, economics and leadership:
• Rebalancing finances to acute care; promoting clinical leadership: The Chief of Medicine

Information systems:
• Facilitating patient-centred care and audit across a health care system: Patient empowerment

Steering group - experts across health and social care – used recommendations based on existing examples of good practice.
Hospital of the future - compassionate, patient-centred care

- Responding to patient needs
  *Personalised care that recognises individual patient needs*

- Communicating with patients and carers
  *Enhanced communication with patients, families & carers*

- More shared decision-making and self care
  *Promote shared decision-making and self-management*

- Advance care planning
  *Improve recognition of dying patient, ensure appropriate care planning (including decisions about care ceiling, preferred place and DNR)*

- Developing a caring workforce
  *Support staff to provide compassionate and dignified care*

- Caring specifically for patients with dementia and delirium
  *Ensure staff are adequately skilled and compassionate*

- Measurement
  *Rapid experience feedback: the Patient Council (see Chief of Medicine)*
Hospital of the future: changes in community care

Existing examples of good practice - secondary care in the community

- Shared decision-making schemes [Year of Care]
- Integrated care for long term conditions [Whittington respiratory service]
- Intensive support in high risk cases [North West London integrated care pilots for diabetes and heart failure]
- Nursing home support services [Nottingham]
- Community secondary care specialists [eg: community geriatricians; palliative care teams]

Community care: A revolution needed

- Seven day working in general practice
- Downward integration from hospital: the enhanced care centre
- Targeted and preventative: the Miami DC model
- A new manifesto for Care Homes
A new model of hospital care

**Medical Division**
- Covers all medical services and teams
- Remit from hospital into community
- Led by Chief of Medicine

**Acute Care Hub**
- Part of Medical Division
- Covers assessment and initial management of acutely ill patients (focus: first 48 hours)
- Overseen by Acute Care Coordinator

**Clinical Coordination Centre**
- Operational control centre for medical services
- All data on patients needs (RT monitoring)
- All data on capacity and resources

Fig 1. The Medical Division remit: circle of patient-centred care. Directional arrows (in the hospital-based Medical Division) denote areas of the future hospital where patients may be referred on to tertiary specialist care.
Medical staff (generalists)

Nursing staff (generalists)

AHPs (generalists)

Early postgraduate trainees (pre specialisation, or not)

Level II and III beds (n=40)

Level 1 beds (n=X)

Support services (labs, radiology etc);

IT and EPR

MAU, day hospital, urgent referral

General Clinics, Ed & T and outreach

Specialist advice (clinicians, nurses, AHPs) 24/7

Specialist Clinics, Procedures, Ed & T and research

Specialist outreach

A solution [3 & 3a]

Setting higher standards
FHC: Based on existing good practice

Case study: Ambulatory emergency care

In their own words: In the summer of 2010, capacity for our emergency patients was posing difficulties. Through our performance data, we found that 50% of acute medical patients were discharged within 15 hours, suggesting that some patients could be treated without requiring a bedded admission. It was clear that with appropriate systems change we could improve our service. The NHS Institute’s suggestions for ambulatory emergency care (AEC) complemented our vision. Having demonstrated an improvement in pilots we set up a new clinical area.

Our starting vision is: everyone is ambulatory until proven otherwise. The majority of patients are referred to our AEC via their GP. We were keen not to detract from the excellent ambulatory care that already happens naturally in the emergency department (ED) into a transfer process that would prove inefficient for the service and patients. We could have opted for more limited staffing but in practice most patients are actually clerked and assessed within AEC so we now have two consultants, three nurses and a clinical support worker. We have the same laboratory response times as ED for blood test results.

We don’t offer return appointments but rely on our communication system with the GPs. All discharge summaries are emailed immediately to the patient’s GP.

Having the support of the chief executive is essential. Ambulatory care is largely consultant delivered, and performing investigations rapidly is expensive. But you have to consider the wider implications of not having such a service, such as cancellation of important elective care, for example. At Nottingham University Hospitals having a team of acute physicians and acute medical nursing expertise has been important in introducing this change, as has the analysis of our performance data to identify areas for improvement. Having a clearly identifiable clinical area with seating has been crucial to our success, as has support from the other specialties with whom we work closely.

For example, I discharged two patients yesterday who had had blood tests, chest X-rays and ECGs as well as clinical assessment within 90 minutes of arrival. The patients were discharged with reassurance. There may be improvements to be made in managing some of these patients in the community, but having come to hospital they received a rapid, safe and excellent service.

FHC interviewed Dr Jack Hawkins, consultant in acute medicine

See also an online video with further information about this AEC service (www.rcplondon.ac.uk/fh-case-studies)
NWL 20% of patients drive 80% of health & social care expenditure

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Derived Population, 000</th>
<th>Average Cost per Capita, £</th>
<th>Social Care, % of Total Costs</th>
<th>Total Spend, £m</th>
<th>NEL LOS, Per Admission</th>
<th>Bed Days Per '000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high risk</td>
<td>4,757</td>
<td>24,752</td>
<td>54</td>
<td>117.7</td>
<td>3.68</td>
<td>11,591</td>
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<tr>
<td>High risk</td>
<td>41,675</td>
<td>7,857</td>
<td>40</td>
<td>327.4</td>
<td>2.48</td>
<td>2,468</td>
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<tr>
<td>Moderate risk</td>
<td>142,773</td>
<td>2,477</td>
<td>13</td>
<td>353.6</td>
<td>1.20</td>
<td>504</td>
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<tr>
<td>Low risk</td>
<td>322,609</td>
<td>575</td>
<td>14</td>
<td>185.6</td>
<td>1.17</td>
<td>186</td>
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<tr>
<td>Very low risk</td>
<td>378,020</td>
<td>275</td>
<td>9</td>
<td>104.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>In focus</td>
<td>889,833</td>
<td>1,223</td>
<td>25%</td>
<td>1088.5</td>
<td>1.95</td>
<td>264</td>
</tr>
</tbody>
</table>

Total spend, £m

2010/11; CWHH

Average cost per capita, £

Social care, % of total costs

Total spend, £m

NEL LOS, Per admission

Bed days Per '000

Setting higher standards
Achieving the future hospital vision: IT

Information used to support care & measure success:

• Clinical records will be patient-focused
• Linked to explanatory information
• Information in a single EPR
• Accessible from anywhere
• Common record standards; reminders by text
• Ability to record experience/feedback
• Information common across ‘system’
Immediate, post launch activity

- Up to 11 September: pre-briefings
- 11 September: Press conference (under embargo)
- 12 September: Launch of report
- 24 September: Council – discuss RCP response and workplan
- Mid-November: Parliamentary event to launch RCP response
- 2013-16: Taking forward recommendations for RCP

Plus:
- Party conference activity
- RCP committees; Other RCs
- Speaking engagements
- Journal articles
- Work with NHS Confederation, Monitor, HEE, CQC and other relevant agencies
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We propose there should be five major hospitals

<table>
<thead>
<tr>
<th></th>
<th>Three major hospitals</th>
<th>Four major hospitals</th>
<th>Five major hospitals</th>
</tr>
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<tbody>
<tr>
<td>Northwick Park</td>
<td></td>
<td></td>
<td>576</td>
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<tr>
<td>Charing Cross</td>
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<td>Hillingdon</td>
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<td>Hammersmith</td>
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<td>St Marys</td>
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<td>Ealing</td>
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<tr>
<td>West Middlesex</td>
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<td>323</td>
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<tr>
<td>Chelsea and Westminster</td>
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<tr>
<td>Central Middlesex</td>
<td></td>
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SUPPORTING INFORMATION – Consultant-delivered care: core standards

<table>
<thead>
<tr>
<th>Standard 1</th>
<th>Surgery, Medicine, Both</th>
<th>Adapted from source:</th>
</tr>
</thead>
</table>
| All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital. | Both | - NCEPOD (2007) Emergency admissions: A journey in the right direction?  
- RCP (2007) The right person in the right setting – first time  
- RCS (2011) Emergency Surgery Standards for unscheduled care |

**Adult emergency services:**

**Acute medicine and emergency general surgery**

Commissioning standards – supporting information
You must stop A&E cuts

Minister: The stinging letter of protest

Many professionals and patients over the serious risk these A&E reforms pose to people’s health. Not only do many people in some of the country’s most deprived areas face longer journeys to hospital, but those in rural areas face longer waiting times for ambulances and crowded A&E units when they arrive. We have yet to see the evidence that such changes are beneficial for patients.

In our view, the idea of slashing huge numbers of A&E units without significantly increasing resources for ambulance services (which hospitals taking up the strain or improving access to GPs will place the lives of vulnerable members of society at risk.

It is not only A&E that is suffering. As part of the same drive towards centralisation of services, the spokesman for the Future Hospital Commission at the Royal College of Physicians last month suggested that shutting a third of hospitals would improve patient care. This figure is not a hard fact but one person’s opinion, and there needs to be an urgent debate about its validity.

There has been only perfunctory consultation on these changes and many people feel they have not been adequately informed of the extent of the reforms. We ask that no further change takes place without full independent consultation and the approval of residents.

for a full list of signatories, visit mailonsunday.co.uk/doctors

Three minutes from casualty, but he died waiting for medics

CYCLIST Robert Tyler died in a road accident three minutes away from an A&E unit - while waiting for an ambulance that took almost 45 minutes to arrive.

Bystanders, including an off-duty police officer, desperately tried to keep him alive at the roadside until help arrived. But it took 25 minutes for the first paramedic to arrive on the scene and 90 minutes until he was dead.

Mr Tyler’s brother Keith Facey said: ‘It’s shocking. He was still alive 20 to 25 minutes after and if the ambulance had arrived sooner he might still be alive.’

Car was not dispatched from an ambulance station until 7.31pm, taking two minutes to arrive, by which time, 7.33pm, Mr Tyler had died. The ambulance did not show up until a further 19 minutes later at 7.52pm - 44 minutes after the original call.

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They could have got there.
The Hospital of the Future & the Future Hospital Commission

• The health service of the future:
  – Financial, human & physical resources limited
  – Political imperatives & challenges increasing

• The patient of the future:
  – Increased complexity & specialisation
  – Moves along an integrated care pathway

• The hospital of the future:
  – Compassion, coordinated and focused above all
  – Organisation & process: role of the generalist?
  – Data and IT crucial
  – Community integration essential

• Requires political engagement & clinical leadership