The Future Hospital Commission of the Royal College of Physicians

Professor Timothy W Evans DSc.FRCP.FRCA.FMedSci.FFICM.
Late, Lead Fellow, Future Hospital Commission
The Hospital of the Future & the Future Hospital Commission

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

• The patient of the future:
  – Case mix differences; complexity & specialisation

• The workforce of the future

• The Future Hospital Commission
  – Aim & guiding principles
  – Composition & Methods
  – Main results
  – What follows

• Political engagement & leadership
Average daily hospital beds, England 1987-1988 to 2009-2010

Source: Department of Health, Hospital Activity Statistics

- Acute care now delivered in < 200 acute trusts
- £20bn to be saved by 2014

Economist, October 2011
BUT: *Increasing* clinical demand

- One 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...
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…..’
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)
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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Royal College of Physicians
Setting higher standards
**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>Not answered</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>3153</td>
<td></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)
The Hospital of the Future & the Future Hospital Commission

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Workforce: A looming crisis

- 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; to 88.5% for GP registrars
Hospitals on the edge? July 2012
The Hospital of the Future & the Future Hospital Commission

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Aim: ‘Identify the optimal care pathway for the adult inpatient with medical illness, with specific reference to organisation, processes and standards of care.’

Guiding principles: Hospitals serve the needs of patients and must 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
Future Hospital Commission – composition & methods

- Independent of the Royal College of Physicians
- Commission Board, Chaired by Sir Michael Rawlins
  - Patient representatives
  - Royal Colleges & Faculties; professional societies
  - Health regulators, Healthcare think tank(s), CEOs
  - Academy of Medical Sciences
- Operational Steering Group, Chaired by Tim Evans
  - Patient representatives
  - Work stream (x 5) leads
  - Cross cutting theme (x 4) leads
- Infrastructure and support, lead by Gemma Cantelo
  - Site visits (40-50)
  - Case reports (19 included)
  - Stakeholder events (approx 20)
  - Electronic & oral evidence (> 650 pieces)
- Triangulation using existing material, identifying gaps
Main components of the report

Organisation of medical care and teams:
• Whole system care: Emergency department, wards and the community: The Medical Division, Chief of Medicine, Clinical Coordination Centre

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

Building a culture of compassion and respect:
• Valuing patients, care with compassion: The Citizenship Charter

Information systems:
• Facilitating patient-centred care and audit: Patient empowerment

Management, economics and leadership:
• Rebalancing finances, negotiating with commissioners
The Hospital of the Future: A system not a building

Fig 3. Considerations in the approach to care for patients with long-term conditions.
The Hospital of the Future: A system of care

Box 1. The Future Hospital Commission’s definition of ‘the hospital’.

The Future Hospital Commission developed its recommendations around the following definition of ‘the hospital’. The hospital:

- is not necessarily based on one physical site
- includes a broad mix of medical specialties, although not necessarily comprehensive at any one site
- may include a mix of acute and elective care
- is a fusion of micro-healthcare systems within a hospital, working collaboratively
- should not be constrained by macro-service organisation (e.g., trust boundaries)
- is part of the wider health economy, providing services to defined populations
- links with primary and community care, and this interface may be blurred
- may be involved in postgraduate education and research.

Royal College of Physicians

Setting higher standards
A system not a building
Medical Division: Patient Centred Care
Nottingham Queen’s Medical Centre

Hospital size: 1,300 beds. Acute medical take 100–130 every 24 hours.

Challenge faced: High demand for medical assessment and difficulty transferring patients from the acute medical ward to the main medical wards.

Local context: The Trust is based on two sites with key specialties (respiratory, renal, cardiology) based on another site.

Partners: NUHT ‘Better For You’ whole hospitals change programme.

Solution: Ambulatory emergency care (AEC) as default for all GP referrals to medicine. Consultant-led assessment with rapid access to diagnostics and specialist in-reach when required. Utilising reconfigured clinic space, redefining roles and providing this service 8am–10pm Monday–Friday.

Outcomes: 30–40% of GP referrals discharged the same day. Average AEC stay 4 hours.

- 50% of acute medical patients discharged within 15 hours
- ‘everyone is ambulatory until proved otherwise
- Enhanced senior staffing and lab services
- AEC default for GP referrals, ALOS 4 hrs
The Hospital of the Future & the Future Hospital Commission

The Medical Division: unified clinical, operational and financial management 7 days/week by trained doctors using SOPs.

- Medical staff (generalists)
- Nursing staff (generalists)
- AHPs (generalists)

Generalist inpatient pathways
Specialist inpatient pathways

- Medical staff (specialists)
- Clinical nurse (specialists)
- AHPs (specialists)

Specialist procedures, clinics, ambulatory care, and community support, specialist education, training and research.
Medical staff (generalists)
Nursing staff (generalists)
AHPs (generalists)

Early postgraduate trainees (pre specialisation, or not)

Level I, II and III beds

Clinical Coordination Centre

Support services (labs, radiology etc.);
IT and EPR

MAU, day hospital, ACC, urgent referral
Acute Care Hub
General Clinics, Ed & T and Outreach

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

Specialist Clinics, Procedures, Ed & T and research
Specialist outreach

Royal College of Physicians
Setting higher standards
Future Hospital Commission – The Medical Division

• **Chief of Medicine:**
  • Major supporting infrastructure; high prestige
  • Has administrative authority over all medical staff and trainees
  • Chief Resident

• **Acute care hub:**
  • Run by Acute Care Coordinator (for day/week)
  • Ambulatory care a priority
  • Access to enhanced/intensive care

• **Clinical coordination centre:**
  • Operational Command Centre: A data rich, IT-driven environment
  • Equipped with offices, teaching facilities
  • Accessed by GPs
  • Electronic displays for staffing
  • Handover centre twice per day, hospital at night hub

• **All medical [& surgical] wards:**
  • Responsible consultant acting as coordinator and generalist 7 days
  • Junior staff and multi disciplinary team allocated

• **Enhanced role for specialists**
• Split site trust, neurology on non AMU site
• Goes to AMU 3 times per week
• Sees inpatients of that day or previous day
• Casualty and GP referrals a priority
• Earlier diagnosis, reduced LOS; better use of MRI, EEG, lumbar puncture

**Medical Division: An enhanced role for specialists**
Box 6. British Geriatrics Society: the comprehensive geriatric assessment

Geriatricians have a unique role as the only specialty with a focus on acute illness and rehabilitation of frail older people. The evidence-based application of comprehensive geriatric assessment (CGA) is central to this specialist practice. There is strong evidence for specialist units (e.g., wards) for the post-acute optimisation of patients’ recovery, using a multidisciplinary CGA approach. There is no established ‘best model’ to bring multidisciplinary CGA expertise to all patients who need it at the ‘front door’ and onwards in the acute hospital medical service, but the key components are:

- assessment to target individuals into community-based services in lieu of hospital admission
- age-attuning acute medical admission units, with both the environment and processes of care
- early recognition and response to geriatric syndromes: delirium, falls, immobility, functional loss
- proactive identification of suitable patients for rapid follow-up in specialist clinics
- end-of-life care is a core medical skill but geriatricians can be expected to provide expert support
- multidisciplinary rehabilitation and expert discharge planning for patients with complex needs.
Box 2. The seven domains of quality.¹⁵

Patient experience: The patient should be the definitive focus of healthcare delivery. ‘Quality healthcare’ may not be the same for every patient.

Effectiveness: Healthcare should be underpinned by the deployment of beneficial interventions at the right time and to the right patients.

Efficiency: Healthcare must make best use of limited resources. Avoidance of waste should apply to material and abstract (e.g. time, ideas) resources.

Timeliness: Timeliness is key to avoiding waits and potentially harmful delays in the delivery of healthcare, incorporating the deployment of health interventions to anticipate and prevent illness.

Safety: While risk in healthcare cannot be reduced to zero it must be actively managed with the minimisation of harm a definite objective.

Equity: Healthcare must strive for a level playing field, in which patients determine their own high-quality care, and in which the needs of the many and the few are balanced.

Sustainability: Sustainability should be viewed as a characteristic of healthcare which must run through and moderate other domains. Healthcare should be considered not only in terms of what can be delivered to an individual today, but also to the population in general and the patients of the future.
Northumbria, close to real time patient feedback
The Hospital of the Future: No discharges, only transfers

Case study: Complex discharge ward

In their own words: The ward was set up in response to a winter bed crisis which persisted into the summer, and a large number of patients had completed their acute medical treatment but were waiting for social services’ input.

We started with nine beds, and we now have 31 on the unit. Bed occupancy ranges between 23 and 31 according to demand. The majority of patients are older people with frailty, and most have dementia. We do occasionally have some younger patients, but they still have complex physical and mental health needs.

To access the ward, a patient has to have completed their medical treatment, physiotherapy and occupational therapy, and be ‘as good as they’re going to be’; some patients are waiting for equipment to be delivered that is essential for discharge. All patient transfers have to be approved

University Hospital Birmingham

Challenge faced: Significant numbers of patients were awaiting care package organisation or transfer of care, prolonging their hospital stay.

Solution: A dedicated ward area with nurses attuned to the needs of frail patients, particularly those with dementia. Focus on hospital discharge organisation.

Local context: Acute trust

Staffing: Consultant with two programmed activities, one whole time equivalent junior doctor. Nursing staff and visiting members of a multidisciplinary team.

Outcome: From being a pilot this is now a permanently funded ward with an average length of stay of 7–10 days. Its hospital-acquired infection rates and falls rates are lower than the hospital average.
### 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
FHC: Management and financial negotiations in Sheffield

- Clinically efficiency might lead to financial penalty
- Negotiations with commissioners concerning financial structuring
- Improved service, no penalty
NWL 20% of patients drive 80% of health & social care expenditure

2010/11; CWHH

<table>
<thead>
<tr>
<th>In focus</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>
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<tbody>
<tr>
<td>Very high risk</td>
<td>14,757</td>
<td>24,752</td>
<td>54</td>
<td>117.7</td>
<td>3.68</td>
<td>11,591</td>
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<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>
</tr>
<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>Total</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>
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’
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The Lancet
‘Most important statement about the future of British medicine for a generation’

The Independent
Welcome to the hospital of the future

The King’s Fund
‘The result could be a step change in the quality of care’

The Times
‘Doctors propose cure for failures on wards’

...bold and refreshing
Hospital inpatients deserve to receive safe, high quality, sustainable care centred on their needs, which is delivered in an appropriate setting by respectful, compassionate, and expert health professionals. However, fewer hospital beds in the UK than 25 years ago must accommodate the 37% increase in emergency admissions seen over the past decade.¹ Although reduction of the average patient length of hospital stay has helped reconcile this imbalance, the fall has plateaued in the past 3 years, and has started to reverse for patients older than 85 years, who present frequently with multiple comorbidities including cognitive impairment and general frailty.¹ Although emergency admissions fall at weekends, findings from some studies show rises in out-of-hours mortality.² In the UK, recruitment into emergency medicine is becoming increasingly difficult, and trainee physicians are actively avoiding specialties that include duties as a general medical registrar.²³

The response of the Royal College of Physicians (RCP) to these problems was to establish an independent Future Hospital Commission in March, 2012, chaired

‘…the most significant piece of work from the College for a generation …….’
‘...the most significant piece of work from the College for a generation........’

- Daily Telegraph, 12\textsuperscript{th} September 2013
- Daily Mirror, 12\textsuperscript{th} September 2013
- Independent, 12\textsuperscript{th} September 2013
- Guardian, 12\textsuperscript{th} September 2013
- The Times, 12\textsuperscript{th} September 2013
- Daily Mail, 12\textsuperscript{th} September 2013
- BBC news, Daybreak, SkyNews, etc
The Hospital of the Future & the Future Hospital Commission: *Next steps*

- **September 2013:**
  - Launch, presentation to Council
  - RCP response to the report formulated and published
- **The Future Hospital Commission operational/implementation phase:**
  - Partners sought for pilot work
  - Appointment of operational group lead by FHC Fellow
  - Academic projects planned
  - Feed into other workstreams ongoing (Shape of Training Review)
- **The Future Hospital Journal:**
  - Looking at process
  - Launch April 2014
- **Political engagement & leadership**
<table>
<thead>
<tr>
<th>Job Reference:</th>
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<tbody>
<tr>
<td>Job Title:</td>
<td>Chief of Medicine - Birmingham Heartlands Hospital</td>
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<tr>
<td>Employer:</td>
<td>Heart of England NHS Foundation Trust</td>
</tr>
<tr>
<td>Location:</td>
<td>West Midlands</td>
</tr>
<tr>
<td>Salary:</td>
<td>Excellent package on offer - 12 PA's</td>
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</tbody>
</table>

**Job Type:** Permanent  ●  **Staff Group:** Medical & Dental  ●  **Pay Scheme:** Hospital Medical and Dental Staff  ●  **Pay Band:** Consultant
Realising the Future Hospital

Consult
Future Hospital partner sites
develop model
understand implications
identify barriers and changes
promote and mentor

Promote good practice - Future Hospital Journal
Influence - identify levers in new structures
Embed in existing RCP work
We propose there should be five major hospitals

<table>
<thead>
<tr>
<th>Number of Major Hospitals</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three</td>
<td>About 800 to 1,000</td>
</tr>
<tr>
<td>Four</td>
<td>About 600 to 700</td>
</tr>
<tr>
<td>Five</td>
<td>About 500 to 600</td>
</tr>
</tbody>
</table>

- Northwick Park: 576
- Charing Cross: 498
- Hillingdon: 408
- Hammersmith: 407
- St Marys: 399
- Ealing: 327
- West Middlesex: 323
- Chelsea and Westminster: 311
- Central Middlesex: 233
<table>
<thead>
<tr>
<th>Standard 1</th>
<th>Surgery, Medicine, Both</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Both</td>
<td>• NCEPOD (2007) Emergency admissions: A journey in the right direction?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• RCP (2007) The right person in the right setting – first time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• RCS (2011) Emergency Surgery Standards for unscheduled care</td>
</tr>
</tbody>
</table>
The views of healthcare leaders on the future of the NHS

Our 2015 Challenge brings into focus the scale and nature of change needed to ensure a sustainable healthcare system for the future. Here are the views of healthcare leaders from our national survey.

The main challenges facing the NHS

1. The effect of an ageing population
2. The effect of an increase in long-term conditions
3. Potential future budget cuts
4. Insufficient budget to meet current service requirements
5. Outdated or inappropriate service or workforce models

The case for change

51% of respondents believe...
"The NHS needs to make large scale changes to the way it currently operates and provides services in order to maintain current levels of care"

45% of respondents believe...
that even if the NHS makes large scale changes, "this alone will not ensure it can maintain current levels of care"

Plans for change

97% of respondents stated that plans are being made for service change within their own organisations

91% of respondents stated that joint plans are being made in collaboration with other local health and/or social care organisations
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The key enablers for change
1. Greater commitment to working collaboratively across organisations and boundaries
2. Clinical support for and involvement in changes
3. Open and honest public discussion on the need for large scale change and the costs and benefits involved
4. Greater involvement of frontline staff with strategic decision making
5. Good evidence base for benefits of change

The consequences of failing to achieve change
1. Local providers go into financial failure
2. Patients will experience a reduction in access to care
3. Providers will need to reduce the numbers of front-line staff
4. Patients will experience a reduction in the quality of care

Confidence in ability to change
While leaders recognise the need and are planning for change, 70% of respondents are not confident in their local health economy’s ability to achieve it.
The key enablers for change

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nhsconfed.org  @nhsconfed  #2015challenge
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 and 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, by which time he had died, and another 20 minutes until the ambulance showed up.

The 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.

Mr Tyler's brother Keith Pacey 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. 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 focussed above all
  – Organisation & process: role of the generalist?
  – Data and IT crucial
  – Community integration essential

• Requires political engagement & clinical leadership