Graham Ramsey
WHHT Service Plans

Phase 1 – September 10th 2007
Shifting of large bulk of elective work to St Albans
3 operating sessions daily not 2
Vast majority of orthopaedic work etc
Screen patients for MRSA
No cancellations (running at 80 per month at present)
Trauma → Watford

Phase 2 – redevelopment of Watford
Another CT and MRI scanner
2nd new catheter lab – cost £36 million
The business case is with the SHA at present
Good case → financially viable
October 2007 → August 2008
Acute admission unit – physicians
Consultant-led, 24 hours/day
More rapid diagnosis and treatment
Remove the need for 66 beds
Improve quality of care

Phase 3 – Watford Health campus
This won't be developed unless it is financially viable – this depends on:

Commissioning certainty
He joined WHHT in May 2006
By Sept 2006, he still did not know what SLAs had been let for 2006/07
This year, the SLAs were signed by the beginning of the year
4 PBC groups may be destabilising
Sudden changes in commissioning will be disastrous
No problem moving work into primary care
But need to know well in advance of the moves

Intermediate Care
By this, the PCT means 'admission avoidance'
WHHT means 'step-down care'
Repatriate a fractured neck of femur patient to Hemel in 3 days
No doctors / few nurses / HCAs
Get patients out
Because there will be 120 fewer beds in September

Urgent Care Centre
This should have started by now
When he worked in the Netherlands, there were 26,000 A&E attendances pa for a population of 450,000
There are 120,000 for Hemel now
The difference was that there was an OOH GP service in Holland

WHHT needs to know if the UCC will lead to a dramatic decrease
It needs to know because of its financial stability
Are there going to be GPs or nurses in the UCC?
Need to let them know

Outpatient new/follow-up ratios
Of 33,000 attendances in the first 2 months of this financial year, 7,300 will not be paid for by the PCT
This equates to 50,000 OPD attendances per year that will be re-directed back to GPs – are GPs ready?
Is it cheaper for patients to come to hospital appointments?
Need to get the pathways that were signed off a year ago implemented
Need to provide management support

Other points
Laparoscopic cholecystectomy – throughput time is 66 days
In the Netherlands this was reduced to 14 days by training 2 GPs in a transmural ultrasound service, using hospital-based equipment

Colorectal cancers – 93 days throughput
This can be reduced to 12 days by talking to GPs and direct access to colonoscopy

18 week targets could become 2 weeks once a second MRI scanner has been installed

Business case for second catheter lab – 2 more consultants
PCT doesn't pay twice – 460 unnecessary ambulance journeys avoided
But PCT must repatriate the work

Also for Hepatitis C

Trust willing to look differently at providing services
Can move some services out of hospital but not if expensive equipment is involved
Consultants and GPs can provide services from pathways

RW – arguments for disseminated care are weaker because the distances are less
LM – distances are moveable – do care where best placed to do it

Alison Davies – pathways don't sit with Choose & Book
Significant incidents – need to feed these back

SBJ – how does this fit in with Any Willing Provider model
LM – curious paradox in system
In a private system would be seen as caballing
Get on and make it as tight as can
Providers need the certainty

GR – step-down care essential to lose 120 beds
ME – unbundled tariff
GR – do step-care in tariff
LM – different kinds of care in community settings