Local General Hospital Meeting **Charter House** **15th May 2007**

Jackie Bunce – PCT – works on Acute Services Review with Gareth Jones
Nicky Poulain – PCT
Mary Quinn – PCT
Jean Cobb – PCT
Moira McGrath – PCT
Suzanne Novak – PCT
Graham Bell – PCT
Richard Walker – DacCom
Mary McMinn – DacCom

Acute Services Review
The consultation is progressing. The business case has been 'gatewayed' on for checking that the reconfiguration proposals are fit for purpose. It will go to the SHA for approval. The ASR will be a public document supported by the Business Case (also a public document). It will set out the case for the change to one acute site in either side of Herts. In E&N Herts it will be either the QE2 or Lister. The Lister is the preferred option for clinical and financial reasons. Therefore QE2 will become a local hospital. Compare the Watford/Hemel debate.

LGH concept
What would a local hospital look like, including an Urgent Care Centre? The exact plan is for each Locality to commission and shape. For most patients the only thing that will be changing is the inpatient activity. JB needs to produce a business case for a generic model of a local general hospital. The capital cost will be based on the affordable square footage. There is national guidance as to costs. 4,150 sq m will deliver services to a 70,000 population. She has produced a menu of suggested services *(see diagram)*. There will be no beds. Considering the Hemel site, Verulam wing is 12,000 sq m. Its capital charges cannot be blocked off.

Services in the LGH
JB says that the PCT needs to hold the reins as commissioners. She believes that the PCT should hold the head lease and commission services out of the LGH. PBC "is given the commissioning intentions" (sic). 4th wave LIFT projects have been told that they can provide clinical services.

RW mentioned the political imperative for a local identifiable building. JB commented that a Hemel LGH would need 3,000 sq m. NP said that her approach would be to ask 'what is the mortgage costing?', so as to determine what services the PCT can fit in to the site to maximise the benefits. RW told us that he wrote a paper 3 years ago about "The New Dacorum Hospital"!

How to take the outline business case forward
It will take 2 to 3 years to get an LGH business case signed off and ensure procurement. It has to be fleshed out to determine what population it will serve and which services will be in it. What do we want to deliver for whom? What are the demographics over the next 10 years? Consultants looking after patients with long term conditions need to come out of OPD to deliver services in the community.

NP said that information about square footage and patient travel times was needed. SN mentioned the need for a plurality of models and different providers, with various options for patients. JB said that an UCC would be needed and we then need to look at what else we want.

RW reiterated that Dacorum must have a hospital. It is a matter of civic pride. There has to be a building which we can call "a hospital". He mentioned the need for the additional services which I have noted on the diagram. MMcG apparently knows the volumes of diagnostics going through Hemel (WHHT would **not** give this information to DacCom). E&N Herts information suggests that "30,000 ultrasounds a year equates to one sonographer" – RW commented that this would mean a sonographer was doing ~ 100 ultrasounds a day!

JB said that it will take 5 years to get the LGH up and running. It is difficult to know how the market is going to develop.

Next steps
There is to be a baseline assessment of Primary Care facilities – their capacity, quality of building, and opening hours. This will include GP surgeries and Health Centres and other possible 'health type' centres. (BUPA are to divest themselves of their hospitals and sell them off). JB and G Bell are to do this audit for the whole of Hertfordshire.

RW said that there should be an Intermediate Care service with beds (or access to beds). A long discussion followed. Clare Hawkins came to talk to the GPs in E&N Herts about such a service.

Attendees have been charged with talking to people in their Localities about their views and a follow-up meeting is planned for 6 to 8 weeks' time.

Other information
The work involved in this project will be needed for the SSDP (Strategic Service Delivery Plan). This plan is to produce commissioning intention between now and 2012. What are commissioners going to shift out, on a year by year basis?

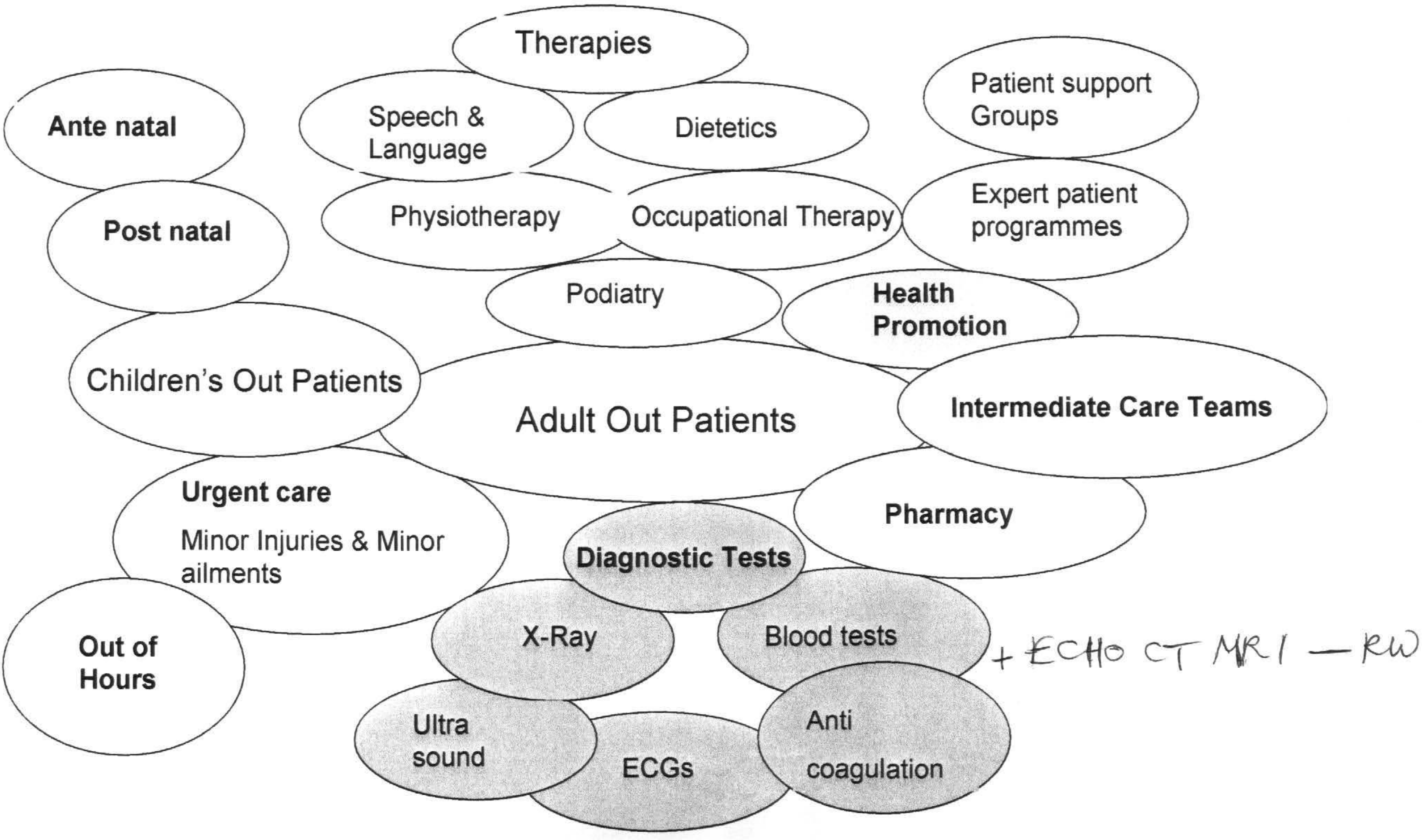
JB gave the following information about OPD attendances:

- 10% do not need to be commissioned at all
- 10 – 15% can be seen by a GPSI in primary care or non-secondary care facilities
- ~ 12% are core specialist OPD (e.g. nuclear medicine and cardiac)

The capitalised cost of developing a large LGH on each site needs to be considered. An alternative would be a smaller LGH with peripheral facilities.

Plus ça change…

Mary McMinn


A Local General Hospital
Therapies
Ante natal
Speech & Language
Dietetics
Patient support Groups
Post natal
Physiotherapy
Occupational Therapy
Expert patient programmes
Podiatry
Health Promotion
Children's Out Patients
Adult Out Patients
Intermediate Care Teams
Urgent care
Minor Injuries & Minor ailments
Pharmacy
Diagnostic Tests
Out of Hours
X-Ray
Blood tests
+ ECHO CT MRI — RW
Ultra sound
ECGs
Anti coagulation