1. Introduction

This report presents that outcomes of a 100 day review undertaken by the Trust following centralisation of services in March 2009. It highlights the key issues that have arisen during this initial period of transition and the recommendations that are being taken forward to further improve services.

2. Background

Following the decision to reconfigure services, as approved by the Trust Board in November 2003, a detailed plan and process was put in place to effect the move of services between the three hospital sites. These included the increased use of St Albans City Hospital for elective surgery, the move of A&E and in-patient services from Hemel Hempstead to Watford, the establishment of a new Intermediate care service at Hemel Hempstead and the development of a new Acute Admissions Unit at Watford. The service reconfiguration was completed in March 2009, on time and in line with the overall plan.

As part of the planning process it was agreed that, given the nature of the significant changes to service delivery, a review of how the new AAU was operating would be undertaken 100 days from the day of its opening. The outcomes of centralisation will continue to be evaluated over time, with further reviews being undertaken at 6 months and 12-18 months. The latter will be a full benefits realisation report.

3. Purpose and Overview of The Report

The centralisation of acute services and the opening of the acute assessment unit were successfully implemented on March 11th 2009. The transition was extremely smooth with no adverse outcomes and only a very small number of patients required transfer. This report provides the board with the key outcomes from the first 3 months of operation and a summary of the post project evaluation; the 100-day review

The 100 day review covers the following areas:

- Patient care
- Staff
- Finance
- Environment
- Performance
- The wider NHS

Each section of the report sets out what the required outcome was, the actual outcomes and the recommendations arising form the outcomes.

The key outcomes from the review indicate that:
• Lengths of stay – reduced from 7.3 to 5.4 days (average)- subject to validation
• Reduced readmission rates- now 4.2% (peer group 6.5%)
• Key performance measures maintained and in some cases improved
• Staff turnover reduced (16.3% to 12.8%)
• Complaint numbers reduced
• Emergency admissions – 10% increase
• Emergency attendances – 4% reduction
• Standardised Mortality Ratio- further fall to only 69

The following information is provided in appendices.

• Appendix I - a summary of Acute Admissions Unit patient feedback from follow up phone call.
• Appendix 2 - a letter from Sir Bruce Keogh
• Appendix 3 - a letter from a patient
• Appendix 4 - illustrates the continued reduction in Hospital Acquired Infections- MRSA and Clostridium Difficile Infections
• Appendix 5a - allegations made by DHAG (patient identifiable information removed)
• Appendix 5b - response to above
4. Patient Care

Required Outcome:

- The centralisation of acute services does not have any adverse patient impact.

Actual Outcomes:

- The transition of acute services from Hemel Hempstead Hospital to Watford General Hospital was completed smoothly, with no adverse incidents. All patients requiring to be transferred between HHGH and WGH were properly assessed prior to transfer and all patient journeys were completed successfully. In the lead up to the final moves significant efforts were made by Trust staff and staff in other agencies to ensure that patients who could be discharged were appropriately placed outside of hospital or where non acute care was still required, were able to receive this within those services that remained on the HHGH site. The role of Adult Care Services and the East of England Ambulance Trust in supporting this must be recognised.

- Significant changes to clinical support services and to the Hemel Hempstead site, to support the centralisation of acute care at Watford were delivered ensuring the establishment of additional and enhanced services which have been able to deliver significant improvements to patients.

- Infection control performance has been maintained during the transitional period and has shown a further improvement overall since the beginning of this financial year. The last quarter performance is the best ever achieved by the Trust.

- There has been one reported Serious Untoward Incident on the AAU since it opened. Whilst this was a tragic case the nature of the incident was not related to the services provided following centralisation and has not resulted in changes to the clinical model being provided.

- Since the transfer of services our standardised mortality ratio has fallen further to 69. This demonstrates that the services provided are safe with fewer people than would be expected from the case mix seen dying as a consequence of their illness.

- Although there was an increase in the level of incidents reported on the Trust’s risk-reporting system in relation to the lack of staff availability (medical division) and bed capacity (surgical division) which reflected concerns prevalent at the time across the Trust, the new model of care provided following centralisation and the focus that has been given to staff recruitment and bed management has seen these reduce over recent months. Further work is on going to ensure that staffing levels remain appropriate and that bed availability is able to meet the service needs.

- The number of patient complaints and enquiries via the Patient Advice and Liaison Service (PALS) increased slightly during the transition period when compared to the previous quarter, though this was a
particularly busy winter and the key complaint themes do not relate specifically to the centralisation of acute care services

- Towards the end of the 100 day period the Trust received a copy of a report written by the Dacorum Hospital Action Group in which a number of patient related concerns about the centralisation of services were raised. A detailed analysis by the Trust of this report has concluded that, overall, the issues raised are not consistent with feedback received by those patients and visitors that have been contacted directly by the Trust or who have written to express their positive views on the care provided. This report also contradicts the feedback received by Sir Bruce Keogh, NHS Medical Director following a recent visit to the AAU

Recommendations:

- Continue to monitor standardised mortality ratio, infection control rates and incidents to assess the impact of the changed service model on patient care in this post-transition phase.
- Continue current mechanisms to gain patient feedback and monitor patient complaints / PALS enquiries regarding the new model of care.

What follows is the detailed supporting data from which the outcomes above were derived. To give a sense of the scale of the task completed, Table I summarises all the service moves that were required for the centralisation of acute services and the dates on which they were planned and completed.

**Table I: Summary of Transition Service Changes**

<table>
<thead>
<tr>
<th>Transition Key Change Summary</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cassio Moves into AAU L1</td>
<td>04-Feb-09</td>
</tr>
<tr>
<td>AAU Plain Film X-ray opens</td>
<td>04-Feb-09</td>
</tr>
<tr>
<td>HH Cath Lab Closes and transfer to WGH commences</td>
<td>07-Feb-09</td>
</tr>
<tr>
<td>All STEMI patients taken to other providers</td>
<td>07-Feb-09</td>
</tr>
<tr>
<td>HH Cardiac Pacing clinic undertakes move to WGH</td>
<td>09-Feb-09</td>
</tr>
<tr>
<td>AAU pharmacy dispensary opens</td>
<td>09-Feb-09</td>
</tr>
<tr>
<td>WGH Cath Lab 1 open to inpatients only</td>
<td>16-Feb-09</td>
</tr>
<tr>
<td>Cardiac Pacing clinic at WGH opens to inpatients</td>
<td>16-Feb-09</td>
</tr>
<tr>
<td>HH York ward starts to winds down and patients nursed in side rooms.</td>
<td>18-Feb-09</td>
</tr>
<tr>
<td>HH Aragon ward merges with HH Boleyn ward</td>
<td>23-Feb-09</td>
</tr>
<tr>
<td>WGH Cath Lab 1 fully operational</td>
<td>23-Feb-09</td>
</tr>
<tr>
<td>STEMI patients now seen at WGH (Mon - Fri, 8.30 - 4.30)</td>
<td>23-Feb-09</td>
</tr>
<tr>
<td>WGH CCU move into extended area at WGH</td>
<td>23-Feb-09</td>
</tr>
<tr>
<td>All chest pain patients, both ambulance &amp; GP heralded now taken to WGH</td>
<td>24-Feb-09</td>
</tr>
<tr>
<td>WGH stroke move into extended areas at WGH</td>
<td>24-Feb-09</td>
</tr>
<tr>
<td>HH CCU transfers to WGH</td>
<td>24-Feb-09</td>
</tr>
</tbody>
</table>
Each individual service move constituted a major project in its own right for which the patient, staff, equipment and activity implications needed to be fully considered and detailed planning completed. It is a credit to the dedication of WHHT frontline staff that the centralisation of acute services was effected so smoothly, with no adverse incidents. The transition ran entirely according to plan with no major changes to the dates of service moves from those that had been anticipated. The only minor change was that the switch of Letchmore ward beds from surgery to medicine was delayed slightly, due to problems with recruitment of acute medical nurses.

To assess the impact of the many service moves and changes listed in Table 1 on patient care and experiences, the following indicators have been used:

1.1 Standardised Mortality Ratio
1.2 Infection Control Performance
1.3 Incidents
1.4 Patient Feedback

Standardised Mortality Ratio

Early indicators are that WHHT’s standardised mortality rate has continued its downwards trajectory during the reconfiguration of acute services as shown by Graph 1. This will be subject to continuing scrutiny to assess the impact of the new model of care. In order to satisfy ourselves that the number of deaths that occurred on the AAU in the first few months were consistent with expectations based on case mix and due to the significant change in delivering emergency care, an audit of deaths was undertaken which did not show any adverse outcomes. No changes were considered necessary to the clinical model.

![Graph 1: WHHT Risk - Adjusted Mortality Ratio](image)

Infection Control Performance

Another key indicator as to the quality of our care is our rate of hospital-acquired infections. Continued improvement in performance has been seen during the period of transition, which has seen many services having to move or be affected by building works. Graphs 2 and 3 provide the data to show this. The last quarter performance is the best ever achieved by the Trust.

---

1 Data Source for Graph 1: CHKS
2 Data Source for Graphs 2 and 3: WHHT Trust Data (As Validated Nationally)
Incidents

During the transition period from February to March 2009, there were no Serious Untoward Incidents (SUIs) related to the move of services. The total number of reported incidents of all severities did not increase outside of normal variation during the transition period as shown by Graph 4 below:

---

3 An SUI is any major or catastrophic incident with the potential to cause serious harm and/or likely to attract public and media interest. This may be because it involves large numbers of patients, there is a question of poor clinical or management judgment, a service has failed or a patient has died under unusual circumstances. In these instances the SUI is reported to the Strategic Health Authority.

4 Data Source for Graph 4: WHHT 'DATIX' Incident Reporting System
Graph 4: WHHT Monthly Number of Incidents

[Graph showing monthly number of incidents from October 2007 to June 2009, with data points for each month and control limits indicated.]
Patient Feedback

The number of patient complaints and enquiries via the Patient Advice and Liaison Service (PALS) increased slightly during the transition period when compared to the previous quarter, as shown by Graphs 6 and 7. However, the nature of complaints received have remained consistent with the main themes being those seen in trend analysis provided by the complaints department i.e. poor communication, poor staff attitude, delays in assessment and treatment.

Graph 6: WHHT Monthly Number of Complaints

Data Source for Graphs 6 and 7: WHHT ‘DATIX‘ Incident Reporting System
Graph 7: WHHT Monthly Number of PALS Enquiries

Oct-07  102  100  120  140
Nov-07  59   69   85   100
Dec-07  51   59   64   82
Jan-08  47   50   73   87
Feb-08  50   62   72   94
Mar-08  68   69   84   96
Apr-08  73   72   64   87
May-08  85   84   61   82
Jun-08  87   87   82   94
However, the percentage of patients that have formally complained following their experiences at WHHT has remained constant as shown by Graph 8:

![Graph 8: % of WHHT Patients That Formally Complain](image)

Irrespective of the above graph, the Trust is keen to do all it can to heed what our patients are telling us about their care. Given the scale of the change, an analysis of formal complaints received by the Trust between 1st February and 30th June 2009 has been completed which concluded that the issues raised regarding emergency care were no different to those normally received by the Trust. None of the 172 complaints received during the period commented adversely about the move of services from Hemel Hempstead to Watford. Only one complaint made reference to being disappointed with the service in the AAU given that it was a new unit, which it was felt should have been running more efficiently. Table 2 summarises the key complaint themes relating to emergency care from the 40 complaints that referred specifically to A&E and the AAU.

---

*Source Data for Graph 8: WHHT Complaints Database*
Table 2: WHHT Main AAU and A&E Complaint Themes from 1 February – 30 June 2009

<table>
<thead>
<tr>
<th>Complaint Theme</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor A&amp;E experience (compared with total attendance for period of 49,837)</td>
<td>16</td>
</tr>
<tr>
<td>Communication/Attitude</td>
<td>13</td>
</tr>
<tr>
<td>Poor clinical care</td>
<td>8</td>
</tr>
<tr>
<td>Food and environment</td>
<td>7</td>
</tr>
<tr>
<td>Delays in assessment and investigations</td>
<td>5</td>
</tr>
<tr>
<td>Inappropriate or poor discharge</td>
<td>5</td>
</tr>
<tr>
<td>Delayed transfer from AAU to PMOK</td>
<td>3</td>
</tr>
<tr>
<td>No transport available on discharge</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
</tbody>
</table>

In order to gain more detailed feedback on the new emergency model of care, a programme has also been put in place to contact AAU patients 48 hours after their discharge to gain their feedback and address and outstanding queries or concerns. Though it is still early days, this exercise has provided rich feedback and the first report is included as Appendix I. This report shows that there were 24 negative comments received and indicates the actions that have been taken to address those concerns. Importantly the report indicates that 27 positive comments were received with very clear indications that the services being provided were very good, with many comments highlighting the staff, the environment and the level of care provided.

During the transition, a detailed log of issues identified by Trust staff was maintained. Table 3 shows the main issues that staff were concerned about when the AAU first opened and the mitigating action that has been put in place:

Table 3: WHHT Initial AAU Issues Identified by Staff and Mitigating Actions

<table>
<thead>
<tr>
<th>Initial AAU Issue</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAU nursing levels initially insufficient.</td>
<td>Approval given immediately to fund additional staff and recruitment underway.</td>
</tr>
<tr>
<td>Patient feedback that soup and sandwich meals were insufficient for patients staying on AAU level 1.</td>
<td>‘Steamplicity’ meals now available to all AAU patients, both level 1 and level 3.</td>
</tr>
</tbody>
</table>

7 Source Data for Table 2: WHHT Complaints Database
8 The number in this column is greater than the total number of complaints reviewed as in some instances complainants identified more than one issue.
9 Source Data for Table 3: DaHF Transition Issue Log NB: Any remaining service issues are now being managed via the Trust’s DATIX system and the DaHF Transition Issue Log will be closed by 31 July 09.
<table>
<thead>
<tr>
<th>AAU nurse-call bell system not loud enough.</th>
<th>Contractors have resolved problem and increased volume of call.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff feedback that further training was needed on the new patient monitors purchased as part of the DaHF programme.</td>
<td>Further training package put in place.</td>
</tr>
<tr>
<td>Inter-site transport and parking at Watford Hospital.</td>
<td>Raised as concern during transition and a number of measures now in place, including an additional 300 car parking spaces and a free shuttle bus service between sites for patients, visitors and staff.</td>
</tr>
</tbody>
</table>

Towards the end of the 100 day period the Trust received a copy of a report written by the Dacorum Hospital Action Group in which a number of patient related concerns about the centralisation of services were raised. This report raised specific concerns in respect of the new Urgent Care Centre in Hemel Hempstead, the Helen Donald Unit, transport and access and a number of one off individual cases that the trust was unable to investigate as they were anonymised. A detailed analysis by the Trust of this report has concluded that, overall, the issues raised are not consistent with feedback received by those patients and visitors that have been contacted directly by the Trust or who have written to express their positive views on the care provided. This report also contradicts the feedback received by Sir Bruce Keogh, NHS Medical Director following a recent visit to the AAU.
5. Workforce

Required outcome:

- Staff are engaged with the reconfiguration and feel valued throughout the process

Actual Outcomes:

- Staff turnover rates at WHHT have traditionally been high. This peaked at 16.3% in March 2008, after the plan to proceed with the centralisation of emergency services was formally approved, but decreased during the actual transition of services and is currently 12.6%
- Out of 500 staff, less than 10 were not able to move to one of their two preferred roles
- There are still some staff areas that carry a high vacancy factor, due both to national patterns of staff shortages and where there had been an increase of establishments to deliver the changed models of care. However, recruitment has continued to move forward with the number of vacancies beginning to reduce
- A local staff survey indicated many positive aspects of the reconfiguration however, some staff commented that they did not feel valued throughout the change process, or that the change was fully communicated and that service benefits have yet to be realised. Recent feedback from staff working in the AAU has demonstrated a very positive attitude to the model of care and the benefits it has to patients

Recommendations:

- Report on staff turnover and sickness rates following the transition as part of the ‘Operations Review’ to assess staff movement following reconfiguration in more detail
- Continue to recruit to vacancies, with specific focus on those staff groups where recruitment is proving difficult
- Undertake a further staff survey prior to the ‘Operations Review’ to assess their views as to service delivery and the impact of the reconfiguration on their working lives once services have had greater opportunity to ‘bed-in’

What follows is the detailed supporting data from which the outcomes above were derived.
Of ç500 staff moving site less than 10 were unable to slot into one of their 2 preferred posts and we retained our staff during the period of intense change in late 2008 / early 2009 as shown by Graph 9:

Graph 9: % of WHHT Staff Leaving the Trust Each Month

However, this only forms part of the picture. The biggest impact on staffs’ working lives is often the number of vacancies within their department. Vacancy rates at WHHT are traditionally high given our proximity to London Trusts and we currently have particularly high vacancy factors amongst the following groups of staff:

- Pharmacists
- ITU nurses
- Theatre nurses
- Cardiac Catheter laboratory staff
- Occupational therapists
- Midwives

In the case of pharmacy, the high vacancy levels are due to the enlarged pharmacy establishment needed to deliver the new model of care. Pharmacists are being actively recruited, with full staffing anticipated in the autumn. In the meantime the service is being as flexible as possible in order to meet demands of the new models of service.

Source Data for Graph 9: WHHT Workforce Database
For other services, our staff shortages are in line with areas of national staff shortages. We still need to recruit our third and final Acute Physician, given their central importance to the AAU model of care. A revised job description has recently been completed with the aim of attracting a good field of candidates when the post is re-advertised.

A staff survey completed by the WHHT workforce department shortly following the reconfiguration. The outcomes of this indicated many positive aspects of the service reconfiguration. However, some staff commented that they did not feel valued throughout the change process, or that the change was fully communicated and that service benefits have yet to be realised. Recent feedback from staff working in the AAU has demonstrated a very positive attitude to the model of care and the benefits it has to patients.
6. Environment

Required outcome:

- Capital work to support the centralisation of acute services was completed on time and Watford environment is fit for purpose

Actual Outcomes

- The AAU and other associated building work at Watford was delivered on time and within budget
- Due to significant time pressures and operational constraints, a non-traditional modular design solution was adopted for the AAU, which reduced the construction programme timescale and minimised disruption to the site
- The pharmacy manufacturing unit is the only capital development planned as part of the centralisation of acute services that has still to complete. External inspection of the finished unit is planned for August 2009
- There are still some outstanding latent defects and Estates issues that need to be resolved, particularly within the AAU itself

Recommendation

- Finalise remaining latent defects and Estates issues as a matter of urgency

What follows is the detailed supporting data from which the outcomes above were derived.

The centralisation of acute services has required a significant improvement in our Estate and was delivered both on time and within budget. The scope of the programme included:

- Construction of a new 120-bedded Acute Admissions Unit (AAU), including 2 cardiac catheter laboratories, a CT scanner and pharmacy robot and standard diagnostics.
- Expansion of our Children's Emergency Department.
- Refurbishment and enlargement of our ICU unit.
- Refurbishment of the 'Front of House’ area at WGH
- Works to our existing wards at Watford overseen by our own Estates team
- Works to the Hemel Hempstead site to reflect the new range of services

It is anticipated that the final cost of the programme will be less than expected but this will not be determined until the pharmacy manufacturing unit is complete. Once this is known a calculation can be made, based on the Project 21 gain-sharing agreement, as to how much the Trust will be able to retain to contribute to reducing the Trust's overall 2009-10 capital programme.
Whilst the extensive building programme has completed on time and received positive feedback from both staff and patients, there are still several ‘latent defects’ that need resolving. The WHHT Estates team is in continued discussion with the building contractors to ensure that outstanding defects are resolved as a matter of urgency. A full list of outstanding latent defects is available on request from the Estates Division, however those that are thought to present the greatest potential service implications are summarised in Table 4 below:

**Table 4**: Summary of Key Latent Defects Remaining From DaHF Phase 2

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description of Latent Defect</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAU-General-1</td>
<td>The fire alarm sounder pitch / tone as currently installed under the contract causes interfere with the AAU telephone system.</td>
</tr>
<tr>
<td>AAU-EXT-0003</td>
<td>There are several sections of the revised southerly cladding where the bottom has become detached and part of the cladding itself is loose. This is an H&amp;S issue.</td>
</tr>
</tbody>
</table>
| AAU-General-0008 AAU-General-0016 AAU-Level 2 - 0002 | AAU flooring defects:  
1) It has been reported that various welded seams in the vinyl flooring are separating.  
2) During a routine check it has been noted on several stair risers the vinyl is detaching itself from the riser backing.  
3) During operation of the AAU it has been noted that in the pantry [Room 2.48] the vinyl flooring has developed a noticeable ripple. |
| AAU-General-0009             | It has been reported that the “wet” shower areas cause a water slip hazard in the adjoining areas. It had been thought that this was due to a lack of shower curtains. Following installation of curtains / further review there appears to be an issue. Inspection has confirmed that this is a problem on floors 1 and 3 of the AAU. |
| AAU-General-0014             | On more than one occasion since handover both lifts 1 & 2 within the AAU have overheated causing them to stop operating. The lifts then require time to cool down before they will begin operating again. Apollo have been called when this occurs. This has now become a “defect” as this has occurred on at least three occasions. The fitting of fire shutters without revisions to the ventilation may be a contributory factor. This is a clinical and operational risk |
| AAU-Level 1-0001             | Water Storage Tank Room: The floor is not laid to suitable falls to the drain shown on the layout drawings and the drain is not suitably constructed to allow water to drain away. The result of this defect is to allow water pooling on the floor with the resultant slip / fall risk. In addition the water has entered the structure and is evidencing on the inner wall skin of the MGPS backup cylinder area and the MGPS plantroom. |
| AAU - 2 - 0001               | During operational “run up” it was noted that the control room temperatures in the CT suite were excessive and, despite efforts by EST to control the temperature we have, to date not achieved a suitable temperature. This is an operational issue which may well affect the departmental operation as the general temperatures rise during the summer and a safety issue should staff become unwell due to the heat or equipment fail. |

*Source Data for Table 4: Provided by WHHT Estates Team*
<table>
<thead>
<tr>
<th>Reference</th>
<th>Description of Latent Defect</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMoK – Level 6 - 0002</td>
<td>Estates were called to a leaking toilet in the Female changing Area of ICU. The staff attending were unable to readily access the bottom of the cistern to correct the leak. Various waste connections were also found loose. MO were requested to resolve a leak to the shower tray outlet several months ago. It was noted during our attendance that the EST “out of use” notice is still there from the original report in March.</td>
</tr>
</tbody>
</table>

A further environmental measure that it was agreed needed to be reviewed after 100-days was access to parking for staff and patients, given the strength of concerns regarding this issue during the transitional period. A number of measures are now in place, including an additional 300 car parking spaces and a free shuttle bus service between the hospitals for patients, visitors and staff.
The photographs below show the newly refurbished areas that have enabled emergency services to transfer from Hemel Hempstead to Watford hospital.
7. Finance

Required Outcome:

- Transition costs stay within budget

Actual Outcomes:

- The service centralisation was delivered within budget with no adverse impact on the Trust’s end of year position. The Trust delivered the new service model and maintained its financial target for the year

Recommendations:

- Agreement should be reached with the West Hertfordshire Primary Care Trust on the appropriate tariff for the new service model in order to ensure that the model of care remains financially viable
8. Performance

Required Outcome:

- The Trust maintains performance against its key performance targets

Actual Outcomes:

- The Trust maintained its performance against key performance targets and is continuing to do so
- The number of patients awaiting a transfer of care to social services or intermediate care was at its lowest for years during the transitional period thanks to the multi-agency approach
- Services that have transferred to Watford are generally running well, though the AAU model of care is not yet matching that originally planned as lengths of stay before patients are transferred out of the unit are longer than originally envisaged. This is not adversely affecting the services provided to patients, rather it creates challenges for the bed managers in respect of bed allocations which they continue to respond to extremely well
- Bed availability in both AAU and the general wards in Watford are mutually dependent. Early indicators are that our already low length of stay for emergency patients has decreased by a further 1.5 days on average and that the number of patients discharged within 24 hours has also increased by 5%. However, capacity on the Watford site is tight at peak periods, particularly at the start of the week. This is not unique to West Hertfordshire Hospitals Trust and was also the case under the old service configuration
- Underlying administrative systems and processes at Watford need to be revised to support the swift assessment of patients within the AAU

Recommendations:

- Keep under review the AAU model of care to ensure that it continues to maintain a positive contribution to improved patient care and delivery of national targets
- Review the bed allocation arrangements within WGH to ensure that there is constant availability of beds in the right locations in order to avoid any delays in transferring patients into the most appropriate location in the hospital
- Continue service improvement work with intermediate care and social services to ensure that patients are discharged as soon as it is no longer in their best clinical interests to remain in an acute care bed and complete review of WHHT internal processes, with a particular focus on the role of therapy services
- Institute a programme of service redesign to review underlying systems and processes and ensure smooth-running of the Watford site. Key amongst these are: medical record availability; appointment booking;
completion of discharge summaries; results reporting; and use of information technology

What follows is the detailed supporting data from which the outcomes above were derived.

Achievement of Key Performance Targets During Reconfiguration

A&E Performance:
We have consistently ensured that patients attending A&E are seen and treated quickly, even in the midst of significant change to our emergency model of care. We assumed that performance might drop slightly during the transition and given that 2008-09 saw the NHS nationally experience the worst winter for decades, this assumption proved correct. The key to achieving the Emergency Care target was therefore forward planning. It was crucial that we achieved at over 98% every week earlier in the year to provide us with capacity during the most intense change period to still achieve the 98% target overall as shown by Graph 10\(^\text{12}\):

---

\(^\text{12}\) Source Data for Graph 10: Department of Health Quarterly Monitoring Return for A&E
18-Week Referral to Treatment Time Performance:
We also maintained our target of ensuring that planned patients are seen and treated within 18 weeks of their referral as shown by Graph 11.\(^\text{13}\):

\(^{13}\) Source Data for Graph 10: Department of Health Quarterly Monitoring Return for 18-Week Waiting Time
Delayed Transfers of Care:
During the transition itself, every effort was made by the Trust, intermediate care and social care to minimise the number of patients awaiting transfer of care and thus reduce the number of patients that would need to be transferred across sites when ward areas transferred to Watford. The impact of this close partnership working for the transition continued beyond March 2009 and the number of patients awaiting a transfer of care to social services or intermediate care initially remained at its lowest for years as shown by Graph 12, though recently the number of patients awaiting social care has increased. Service improvement work with intermediate care and social services must be continued to ensure that patients are discharged as soon as it is no longer in their best clinical interests to remain in an acute care bed. A review of internal processes to assess improvements that can be made by WHHT to ensure patients are not retained in hospital when it is no longer in their best interests also needs to be undertaken, with a particular focus on therapy services.

Graph 12: WHHT Delayed Transfers of Care

![Graph 12: WHHT Delayed Transfers of Care](image)

Early Indicators for New Model of Emergency Care
The opening of the largest Acute Admissions Unit in the country has provided an innovative way of managing the assessment and admissions of acute patients. Clinical skills to support the rapid assessment of patients are concentrated in the unit, over an extended working day. This model of care was predicated upon a radical change to the way our doctors, nurses and clinical support staff work and many stakeholders are keen to see what the outcomes on our service delivery have been. Though the original plans anticipated a possible reduction in activity as a result of the reconfiguration,

14 Source Data for Graph 12: WHHT Chief Executive’s Report
the number of patients that we are admitting has remained constant as shown by table 5.

Table 5: WHHT No of Admitted Spells

<table>
<thead>
<tr>
<th>Admission Type</th>
<th>Apr 08</th>
<th>May 08</th>
<th>Jun 08</th>
<th>Jul 08</th>
<th>Aug 08</th>
<th>Sep 08</th>
<th>Oct 08</th>
<th>Nov 08</th>
<th>Dec 08</th>
<th>Jan 09</th>
<th>Feb 09</th>
<th>Mar 09</th>
<th>Apr 09</th>
<th>May 09</th>
<th>Jun 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>3053</td>
<td>3131</td>
<td>3021</td>
<td>3012</td>
<td>2899</td>
<td>3020</td>
<td>3087</td>
<td>2865</td>
<td>3043</td>
<td>2827</td>
<td>2633</td>
<td>3239</td>
<td>3524</td>
<td>3309</td>
<td>2086</td>
</tr>
<tr>
<td>Emergency</td>
<td>842</td>
<td>808</td>
<td>707</td>
<td>722</td>
<td>685</td>
<td>655</td>
<td>747</td>
<td>781</td>
<td>634</td>
<td>688</td>
<td>584</td>
<td>706</td>
<td>712</td>
<td>757</td>
<td>471</td>
</tr>
<tr>
<td>Inpatient</td>
<td>2295</td>
<td>2072</td>
<td>2118</td>
<td>2222</td>
<td>1986</td>
<td>2161</td>
<td>2396</td>
<td>2397</td>
<td>2106</td>
<td>2449</td>
<td>2048</td>
<td>2279</td>
<td>2154</td>
<td>2550</td>
<td>1734</td>
</tr>
<tr>
<td>Elective</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>420</td>
</tr>
<tr>
<td>Daycase</td>
<td>2295</td>
<td>2072</td>
<td>2118</td>
<td>2222</td>
<td>1986</td>
<td>2161</td>
<td>2396</td>
<td>2397</td>
<td>2106</td>
<td>2449</td>
<td>2048</td>
<td>2279</td>
<td>2154</td>
<td>2550</td>
<td>1734</td>
</tr>
</tbody>
</table>

Graph 14 shows the number of attendances to our A&E department as remaining constant, indicating that our threshold for admission has not altered, particularly as the changed pathway of care means that GP-heralded patients are now seen initially in the AAU rather than A&E and so are not included in the A&E attendance figures as of March 2009. GP heralded admissions direct to AAU are currently 700 per month.

15 Source Data for table 5: Which Doctor
16 Source Data for Graph 14: ‘Which Doctor’ Database
Graph 15\textsuperscript{17} shows how our emergency length of stay has reduced to enable us to continue to see this increased volume of patients in our reduced bed-base. Given the limited amount of data points available for analysis so soon after the centralisation of acute services, it is too early to form robust conclusions as to the true scale and sustainability of any reduction in length of stay. However, an initial ‘statistical process control chart’ analysis shows that even with the limited data available, our emergency length of stay has reduced beyond natural variation by 1.5 days since the time of the original planning assumptions. Further figures and analysis will be available as part of the ‘Operations Review’.

\textsuperscript{17} Source Data for Graph 15: ‘Which Doctor’ Database
As Graph 16\textsuperscript{18} shows, our re-admission rates have remained constant, and we continue to outperform our peer group trusts (according to CHKS) in re-admitting fewer patients within 14 days. We can be confident that our new model of care has not impacted on the quality of care we provide, although it is important that this early this will continue to be monitored closely:

\begin{center}
\textbf{Graph 16: % of Medical and Surgical Patients Readmitted within 28 Days of Discharge}
\end{center}

\textsuperscript{18} Source Data for Graph 16: CHKS
9. Wider NHS Issues

Required Outcome:

- Initial achievements and lessons learnt are captured and disseminated within the wider NHS

Actual Outcome:

- A ‘lessons learnt’ survey has been completed and a workshop held to gather further feedback.
- A conference was held on 14 July 09 to share the experiences of WHHT with the wider NHS

Recommendation:

- Plan journal submissions to share learning more widely

The Trust is keen to ensure that the vast experience it has gained in delivering the centralisation of acute services be shared with the wider NHS. A programme of work is already well underway to ensure that key lessons learnt are captured and widely disseminated. The conference held on 14 July 09 provided further opportunity to share lessons learnt and the feedback from attendees regarding the recent achievements at WHHT was extremely positive.