

## **Review of the Implementation of North West London A&E Changes**

### **1. Introduction**

This paper is NHS England London Region's report on the independent review of the impact of the closure of Central Middlesex and Hammersmith Hospitals Accident and Emergency (A&E) departments on performance against the A&E targets. It covers the background to the changes, key aspects of the implementation, the independent review and key conclusions from it.

### **2. Background**

In February 2013, the Joint Committee of North West London PCTs (JCPCT) decided on a reconfiguration of acute services in NW London following public consultation. In making this decision they received written support for the decision from the emerging CCGs in NW London. The decision was referred to the Secretary of State who asked the Independent Reconfiguration Panel (IRP) to undertake a review in line with standard practice. Their report, and the Secretary of State's decisions based on it, was published in October 2013. One of the IRP's recommendations, based on the clinical and other evidence they received was:

*"As part of a staged approach for implementing Shaping a Healthier Future, the proposals for A&E services at Hammersmith and Central Middlesex hospitals should proceed as soon as practicable"<sup>1</sup>*

In support of this recommendation, the IRP report states:

*"5.5.12 With regard to the existing A&E at Hammersmith Hospital, the Panel found that, while residents considered it to be a valuable service, the range of conditions able to be treated is constrained by the absence of relevant back up services such as emergency surgery. Both the commissioners and provider of this service agree that better care could be provided by concentrating A&E resources at St Mary's Hospital linked to a 24-hour urgent care centre at Hammersmith Hospital.*

*5.5.13 The A&E service at Central Middlesex Hospital is also limited in the range of conditions able to be treated. It is currently open for 12 hours a day. Whilst this service provides some capacity to the A&E system in North West London, the panel accepts that a more effective option is to concentrate A&E resources at Northwick Park linked to a 24-hour urgent care at Central Middlesex Hospital"*

Subsequently, Imperial Healthcare Trust (which is responsible for the Hammersmith Hospital) and North West London Hospital Trust (Central Middlesex) again raised concerns with local CCGs regarding their ability to run safe Accident and Emergency services on these sites in the light of on-going staffing challenges. Central Middlesex's A&E had a 60% vacancy rate for nursing and medical staff rising to 85% at weekends which required extensive use of locums and agency staff resulting in poor continuity of care. Northwick Park also had a 43% locum rate which merging the departments' staffing was expected to improve. The College of Emergency Medicine removed accreditation of Hammersmith A&E over ten years ago and since then the A&E service had been provided by consultant physicians. Hammersmith Hospital also had a locum rate of up to 60% with increasing difficulty in covering out of hours shifts leading to some overnight shifts being staffed by general medicine specialist registrars (SpR).

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<sup>1</sup> 'Advice on Shaping a Healthier Future Proposals for Changes to NHS Services in North West London', IRP 13 September 2013.

### 3. Preparations for Closures

Trusts worked with the 'Shaping a Healthier Future' (SaHF) programme to agree when would be 'as soon as practicable'. They recommended the two units should close simultaneously to simplify communication with the public and to avoid some patient flows displacing to a unit scheduled for closure. It was agreed to close both units on 10 September 2014 to allow time for all the necessary preparation and for new patient pathways to 'bed-in' before Winter.

The overall design was to:

- Close Emergency capacity at the two sites and reprovide that capacity at receiving sites (mainly Northwick Park and St Mary's Hospitals).
- Improve the quality of care at receiving sites by redeploying clinical staff to them from the closing A&Es
- Increase urgent care capacity by providing 24/7 urgent care centres (UCCs) at both sites operating to an improved specification.

It should be noted the changes were not predicated on delivering more care in primary and community care settings which is a longer term aim of the SaHF programme. The intention was reprovide at least the same level of A&E capacity at the receiving sites as previously available at the closing sites as well as increased urgent care capacity at the closing sites.

The planning for the operational delivery of the programme was undertaken by:

- Project teams for Hammersmith and St Mary's Hospitals and Central Middlesex and Northwick Park Hospitals with clinical leadership/ membership reporting to their Trust Boards and the SaHF Implementation Board
- Oversight by Trust Boards who received regular papers
- The Shaping a Healthier Future Implementation Board which was responsible for assurance and coordination
- An Operations Executive comprising Operational managers from all hospital Trust and London Ambulance.

Internal assurance was undertaken by Trust Boards, the SaHF Implementation Board, NHS England (NHSE) with the Trust Development Authority (TDA) and relevant Clinical Commissioning Groups (CCG) Governing Bodies.

External assurance was undertaken by NHS England, the Trust Development Authority and Monitor ('the Tri-Partite').

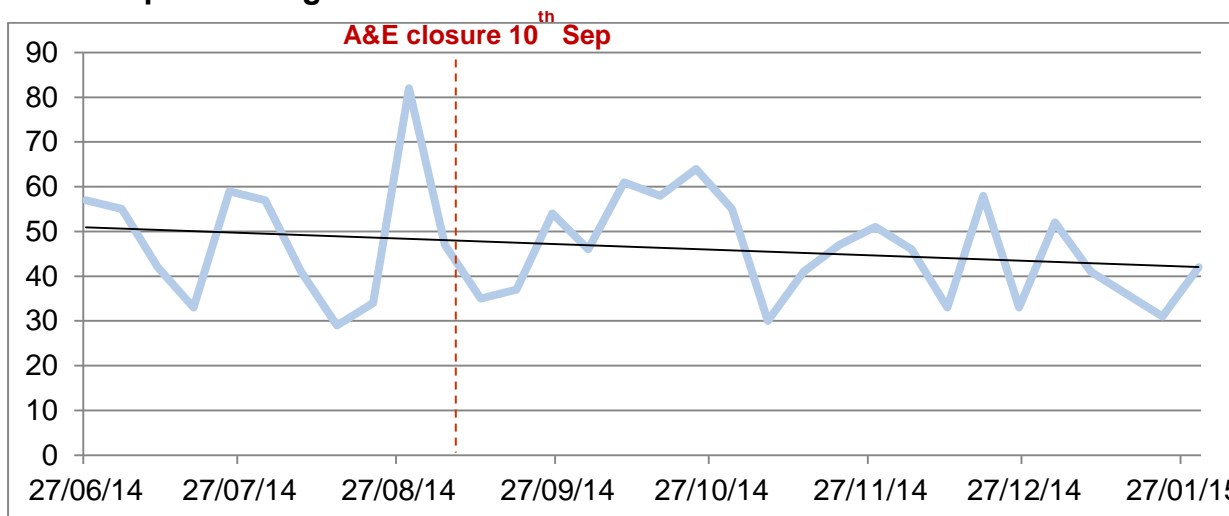
### 4. Safety

Evidence suggests the A&E changes were implemented safely and led to improved staffing. A&E incidents<sup>2</sup> had been reducing across NW London and this trend was not affected by the A&E changes.

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<sup>2</sup> An 'incident' defined by the National Patient Safety Agency (NPSA) as 'any unintended or unexpected incident which could or did lead to harm for one or more patients....'

**Graph showing reduction in A&E incidents across NWL**



The potential impact of the changes on ambulance travel times from scene of incident to A&E was highlighted through engagement prior to the changes. Data from London Ambulance Service (LAS)<sup>3</sup> shows that the increase in travel times to A&E has been smaller than expected.

A&E Site	Difference average scene to hospital (mm:ss)
Northwick Park Hospital	+00:47
Hillingdon Hospital	+00:22
Ealing Hospital	+01:04
West Middlesex Hospital	+00:27
St Mary's Hospital	+01:25
Chelsea & Westminster	+00:25
Charing Cross Hospital	+01:03

## 5. Independent Review of A&E Performance

### Introduction

NHS England commissioned an independent review of A&E performance on behalf of the Tripartite.

The reviewers were asked to:

- Review A&E performance at all North West London urgent and emergency care sites

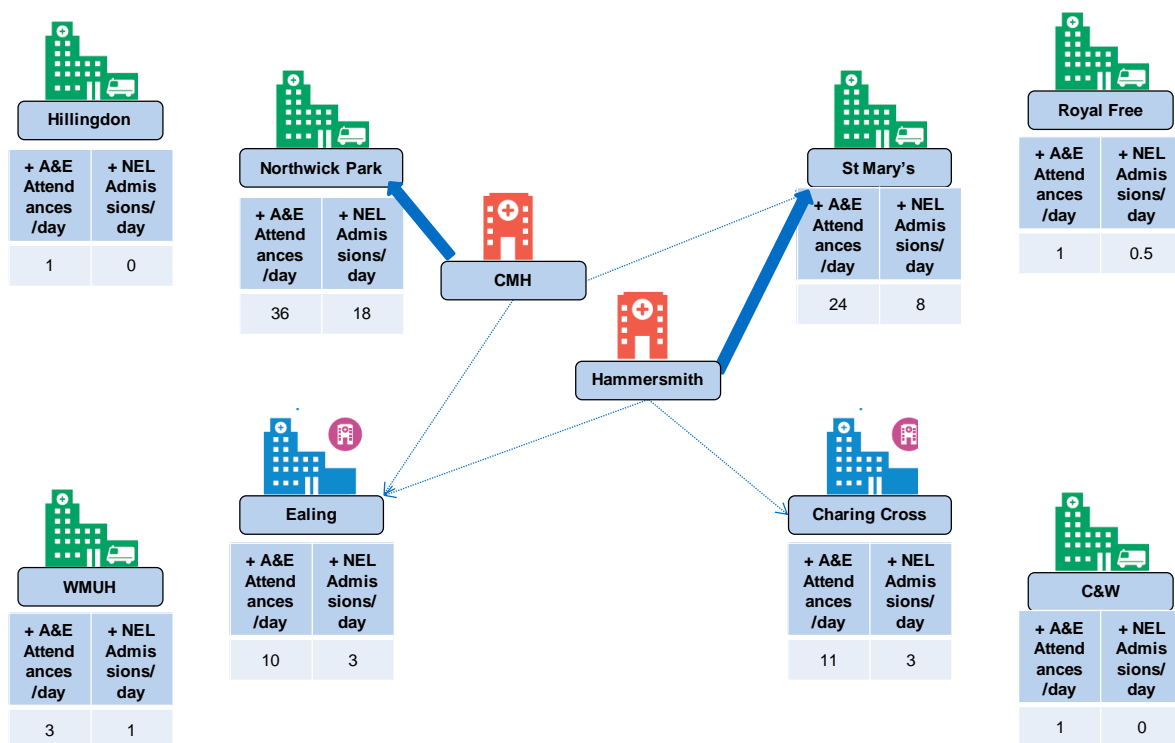
<sup>3</sup> LAS evidence to NW London JHOSC, 3 March 2015

- Investigate links between performance and the A&E changes. We agreed with the reviewers that their main analysis should compare October 2014 (the first whole month post-implementation) with October 2013.
- Make recommendations regarding any lessons that should be learnt regarding the planning for and implementation of, the changes.

## A&E Performance

In order to prepare for the transition, the SaHF programme undertook detailed modelling to predict the redistribution of patients attending and requiring admission by site. The diagram below shows this modelling at a high level to show the general expected patient flows.

### Modelled Anticipated Patient Activity Flows



The review found the actual redistribution of patient activity from Central Middlesex and Hammersmith Hospitals to receiving sites was in line with, or lower than, the SaHF modelling predicted. The October 2013 v 2014 comparison showed overall emergency admissions in NW London were lower in 2014.

However, the review found significant variances in demand unrelated to the closures which led to local performance issues. Hillingdon and Harrow CCGs saw month versus month increases of 7% and 6% respectively which impacted their local A&Es of Hillingdon and Northwick Park.

The review did not find evidence of 'overflow' from the new receiving sites to other NW London sites. For example, in view of travel times, SaHF predicted no impact on Hillingdon and the review found this was true in October. Hillingdon Hospital did however experience an increase of 8 admissions per day due to the local increase in demand from Hillingdon CCG (referred to above), with consequent impact on its performance.

A&E performance is measured against the 4 hour A&E target, which is that 95% of patients should be seen, treated, admitted or discharged in under four hours. There was deterioration in A&E performance in NW London A&E sites during and after the A&E transition. However, this deterioration was in line with deterioration across London and England and the review found it was not related to the A&E changes. For example, for the quarter October – December 2014, as a whole, NW London's 'all type' A&E performance fell to 92.9% (compared with 96.1% the previous quarter). However, the all London performance fell to 92.4% and NW London had the best performance of the three London sectors. In the quarter January – March 2015, NW London achieved 93.6% (London 92.6%). Currently NW London is achieving 94.7% (London 94.2%).

As referred to above, the SaHF programme modelled predicted attendances and admissions at receiving A&Es and hospitals and actual activity aligned well with this modelling. Individual Trusts were responsible for modelling the impact of this activity on their facilities and the provision of additional capacity, including A&E, beds and staff. The SaHF and Trust modelling was subject to assurance by NHS NW London Clinical and Implementation Boards and the regional Tripartite.

In general, Trust modelling also proved accurate, however, the independent investigation found an increase in the acuity of patients being treated in October 2014 (compared with 2013). In summary, whilst the total numbers of patients were accurately predicted, they were at the higher end of the acuity spectrum than normal. As an example of this increased acuity, the review found whilst ambulance conveyance to A&Es were actually 11% lower in October '14 compared with October '13, the absolute number of Category A arrivals (the most acute) rose by 3%. In October 2013, 217 of 472 patients were Category A. In October 2014 it was 225 of 418. The review found a rise in acuity in ambulances conveyances across London as a whole but the NW London rise was greater than other areas. The review confirmed the underlying cause for this increase in acuity could not have been linked to the A&E changes. There was a national increase in demand and acuity over the Winter of 2014/15. It is known that the 14/15 flu vaccination was ineffective against the main H3 flu strain (which is known to particularly affect the elderly) this Winter. Nationally, Public Health England observed excess deaths from respiratory illness, mainly flu, amongst the elderly from late September 2014 into January 2015<sup>4</sup>

This rise in acuity adversely impacted receiving hospitals' patient flow compared with their models. The biggest impact was at Northwick Park. SaHF predicted that Northwick Park Hospital would receive an additional 18 patients per day and the Trust opened an additional 29 beds to accommodate them. Of the 18, the Trust expected 12 patients would require admission and the remainder could be treated through an ambulatory pathway and not require hospital beds. In practice, 16 additional patients per day required admission. Similarly, the Trust expected the patients admitted to have a length of stay of 3.5 days whereas their actual length of stay was 4.5 days. The review shows the combination of 4 additional patients per day with a longer length of stay meant the hospital had an effective bed deficit of over 20 beds and this deficit drove the deterioration in the hospital's A&E performance. Subsequently further beds were commissioned and A&E performance improved.

### **Lessons to be learned**

The independent review concluded that the assurance processes used in preparation for the change were extensive. However, the assurance process should have undertaken further

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<sup>4</sup> Public Health England, Weekly All-cause Mortality Surveillance, 29 January 2015

testing of hospitals' key assumptions and further sensitivity testing. For future similar changes, the review recommends:

- Clear identification of key assumptions on which planning is based.
- Understanding the rationale for assumptions and the evidence upon which they're based
- Ensure sensitivity testing encompass the most significant potential variables.