



**Current issues in the delivery of health care
in NW London**

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Summary

1. The original analysis on which SaHF was based failed to take adequate account of likely increases in population over time. The current population is already greater than SaHF had estimated for 2022, and SOC1 projects it will grow by 14% by 2026.
2. NW London has a different pattern of use of emergency services with greater use of minor A&E units than other parts of London, and the rest of England. Attendances at acute A&E units have fallen by 16.5% since 2011/12 compared with an increase in the rest of London of 10.5%, and in England of 8.8%. However attendances at minor A&Es have increased dramatically, so that taking all attendances together there has been an increase of 12.2% compared with 3.5% in the rest of London and 7.7% in England.
3. There is no evidence that NW London uses more A&E emergency services than other parts of England, or London. The level of emergency admissions through A&E in NW London has fallen between 2011/12 and 2016/17. But this was more than compensated by a dramatic rise in the number of emergency admissions taken through alternative routes, eg direct admission by GPs, which went from over 12,000 to over 29,000 over the same period. This translates into a small rise of just over 8% in total emergency admissions; at the same time, emergency admissions in England as a whole increased by almost 14% and in the rest of London by 16%.
4. There has been a considerable deterioration in A&E performance measured as the proportion of people attending A&E who are not dealt with within four hours. NW London, in the first quarter of 2011/12, was better than the rest of England and London, and well within the margin of the government target of 5%. However, more recent performance and in particular since the closure of two A&E units in NW London (on 10 September 2014) shows a considerable deterioration, and now performance in NW London is consistently poorer than elsewhere in England or London.
5. Another measure of A&E quality is how long it takes a patient to be admitted to a bed once the decision has been made to do so. In many cases this can take up to 12 hours, and increasingly over 12 hours. Performance in NW London has deteriorated sharply since the closure of two A&Es. In the third quarter of 2017/18, 5.3% of patients in NW London A&Es waited up to 12 hours for admission, 2.7% in other parts of London, and 4.1% in the rest of England.

6. Throughout January and February 2018, the Imperial Trust sites: St Mary's and Charing Cross, have been experiencing severe pressure and have had to declare black alerts on almost all days, indicating severe bed shortages and an inability to cope. Over the winter of 2018 LNWHT and Hillingdon trusts consistently had ambulances waiting longer than is appropriate to discharge patients into the care of the hospital, and sometimes twice as long as the England or London average. One in five ambulance patients in NW London waited more than 30 minutes.
7. Acute bed capacity has fallen in NW London by 270 beds between 2009/10 and 2017/18. SaHF indicated that over 1,000 beds would eventually be closed. At the same time NW London hospitals have a lower LOS than the England average, possibly indicating that they are already operating more efficiently than elsewhere. In the winter of 2017 they also had very high bed occupancy levels, upwards of 95%, indicating extreme pressure on the system.
8. There is no evidence that there has been a successful diversion of hospital activity into out-of-hospital facilities although SOC1 still claims the intended hubs will result in a reduction of 22,000 emergency admissions.
9. Partial implementation of a programme of closures of acute services before an adequate business case was produced, has increased the pressure on the health system and had a detrimental effect on the delivery of services in NW London. It is becoming almost impossible to run the system due to a lack of financial resources combined with a lack of acute bed facilities shortfalls in staffing throughout the area.
10. The deterioration in A&E services suggests that any plans for further closures of acute services at Charing Cross and Ealing are ill-founded. These should be halted and sufficient resources made available to retain existing services and staff.

Introduction

This paper is intended to reflect how well the health system is performing, and what the evidence is that hospital services are under pressure; with some comparisons over time where possible.

We do this by bringing together data and information from a number of sources and analysing these to produce what we hope is a coherent picture. Our analysis is designed to consider demand, supply and performance in the acute sector with a focus on the following key areas:

- Has demand for acute care increased and how does it compare with London and England?
- Have resources increased or decreased, again taking a comparative perspective?
- What has been the impact on performance measures, especially on quality of care delivered?
- What evidence is there that there have been improvements or increases in the provision of out-of-hospital care, and that these changes have had an impact on the demand for care, especially in acute settings?

Demand, supply and performance in the acute sector

In this section we build upon our earlier work for LB H&F (1), (2). We look at three aspects: how demand has changed, how resources have changed; and the impact on quality of care, in particular relating to emergency care.

Demand for care

Using ONS data, the population of NW London continues to grow, and will increase by around 11% overall in NW London between 2016 and 2026¹, and by much more for older people – by almost 32% in the ≥85-yrs age-group, to over 184,000 people. However, SOC1 is based on assumptions of even greater population growth² of almost 14% between 2016 and 2026 (p98), and growth in activity (if there are no changes to the system) of between 35-45% (p100). But at the same time, it assumes there will be a reduction in the demand for acute hospital services due to a number of factors, primarily diversion to other locations.

¹ Based on our analysis of the latest ONS population data.

² This estimate is based on GLA data and data relating to housing developments in each borough.

The latest estimate of the population in NW London by borough (mid-year 2016 estimates) suggests there are 2.08 million people: SaHF’s early population estimates look outdated (growth ‘in the next ten years’, which we interpreted at the time as until 2022, of 5.9% to 2 million people), although as we say, SOC1 used more recent figures.

Table 1: Projected growth in population, eight NW London boroughs, between 2016 and 2026

Borough	Projected growth
Hillingdon	14.9%
Westminster	10.7%
Hounslow	13.6%
Brent	10.6%
Harrow	11.7%
Ealing	8.8%
Hammersmith and Fulham	6.5%
Kensington and Chelsea	2.9%
NW London	10.5%

Source: Our analysis of ONS data.

Table 1 shows the projected population growth in the eight NW London boroughs, between 2016 and 2026: it is significant and comes to an average of 10.5% across all of NW London.

Demand for acute hospital services

SOC1 addresses four main types of acute hospital activity: A&E attendances; non-elective admissions³; outpatient attendances; and, elective admissions. Key to the argument about whether A&E departments should close is the projected demand for emergency care as reflected in A&E attendances and in emergency admissions to hospital. We examine each of these in turn.

There are three types of immediate emergency response: that provided by acute A&E departments and designated as Type 1 in Department of Health terminology; that provided by specialist A&E departments and designated as Type 2; and that designated as Type 3 which is provided by a range of centres that are characterised by having more limited access to testing facilities, tend to be run by nurses or GPs, and often are not open 24 hours a day. This last category encompasses Urgent Care Centres (UCC), Minor Injury Units (MIU) and Walk-in Centres (WiC), as well as services provided directly by some GP practices. Facilities in this last category were designed to deal with less serious health issues; there was a considerable expansion in their numbers in England as a whole after 2004 when UCCs were introduced in an

³ Non-elective is primarily emergency but also includes maternity admissions.

effort to divert activity away from acute A&Es, but there has recently been a reduction in their numbers. In this paper, we shall call these 3 types: acute, specialist and minor for ease of reference.

Use of emergency services

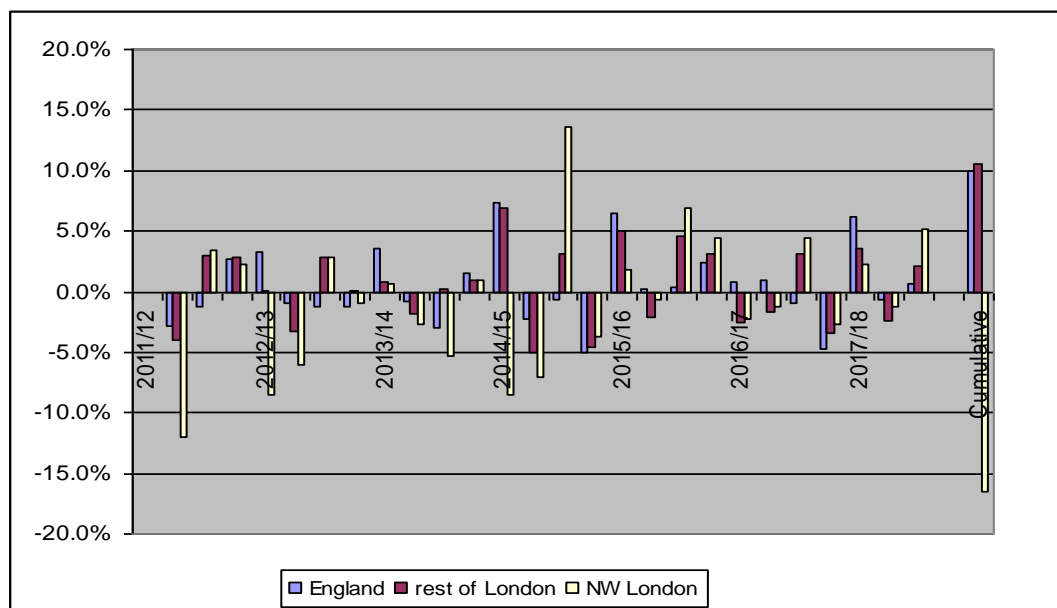
First we look at the number of A&E attendances in NW London, how many of these become admissions as emergencies, and how this profile has changed in the recent past. We then look at performance as measured by the NHS in terms of numbers of people attending A&E who are dealt with in less than four hours. For each of these indicators, we consider performance in NW London compared with the rest of London, and England.

NW London has a very different pattern of use of A&E services compared to the rest of the country and to the rest of London. There is a much larger proportion of attendance at non-acute centres (minor) and this has been growing in recent years. So we find that in 2011/12 some 65% of A&E activity in England was acute whereas in NW London the figure was just 49%; by the third quarter of 2017/18 the England figure remained at 65% whereas in NW London it fell rapidly to just 37% of attendances. For the rest of London the figure has increased slightly from 67% to 69%.

So patients in NW London appear to be able to distinguish very clearly their need for urgent care with now just over a third of them attending A&E departments when they perceive they have an urgent need for care. Patients in the rest of England, as in London, are being encouraged to behave like this, but there is no evidence of changes in patterns of demand. There has been no change in behaviour elsewhere over the last six years whereas NW London has witnessed a significant change.

Figure 1 presents percentage change in acute A&E attendances comparing England (excluding NW London), London (excluding NW London), and NW London. Data are provided on a quarterly basis and the final bar on the right-hand side is the cumulative change over this period.

Figure 1: Percentage quarterly changes in acute A&E attendances, April 2011 – Dec 2017



Source: Our analysis based on NHS England data

These data reflect the position up to the end of December 2017, and hence include over three years since September 2014 when Central Middlesex and Hammersmith A&Es were closed. Data are presented for all quarters from 2011/12 to 2017/18, and the cumulative effect over the whole period.

There has been a cumulative increase in acute A&E attendances in the rest of England over this period of 8.8%, and in London of 10.5% whereas in NW London there was a reduction of 16.5%. This represents a fall in annual attendances of approaching 100,000 in NW London hospitals over this period, although there is evidence of an increase in the last two years.

However, the growth in the use of urgent care centres in NW London would seem to provide most of the explanation for this fall in acute attendances. Thus we find that in July 2011, acute attendances were 49% of total acute and minor taken together, but by the end of December 2017, this proportion had fallen to 39%.

If we look instead at total A&E attendances including UCCs and specialist units we find a different picture. Attendances in NW London have increased by 12.2%, and in England by 7.7%, and in the rest of London by 3.5%.

Taking a population view, we compare use per 1,000 population. We find that in England, utilisation of acute A&E services has gone up marginally between 2011/12 and 2016/17, from 264 to 274 per 1,000 resident population; in NW London on the other hand utilisation has fallen from 304 (when it was above the England average) to 242 (now well below the England average). The rest of London exhibits greater

use of acute A&E services and this has increased, from 342 in 2011/12 to 352 in 2016/17, above both England and NW London figures.

On the other hand we find that NW London residents make considerably more use of UCCs and WiCs, between two and three times as much as England or the rest of London, and this has increased over these six years, from 295 to 394 attendances per 1,000 population: the equivalent figures for England are 129 and 134, and for the rest of London, 140 and 131.

This provides a fascinating insight into the use of services in NW London. Certainly NW London residents are not over-using acute A&E services when compared with residents of the other London boroughs, or indeed with the rest of England. So this cannot be used as an argument for removing services or closing down A&E units. Utilisation was falling before the closure of Central Middlesex and Hammersmith A&Es, and has continued to fall since.

On the other hand, NW London residents are making considerably more use of UCCs and the like, around three times as much usage as England in 2016/17. This could be a sign that the message has got through to NW London residents in a way that it has not in other parts of the country, that A&E departments should only be used in an emergency. It may also indicate a paucity of GP services, or poor quality services that cause residents to go to UCCs as an alternative to primary care. As one medical director in NW London said in an interview, for a younger more mobile population, UCCs may be a sensible alternative to the traditional GP practice.

So we have a situation in NW London where total attendances have been increasing but acute A&E attendances have fallen over the last five years.

Conversion from A&E to emergency admission

An indicator of the potential pressure on emergency capacity is the conversion rate between A&E attendances and emergency admissions to hospital ie the proportion of patients who attend A&E who have a condition that is serious enough to warrant admission to an acute bed.

The rate in NW London hospitals has changed over the last five years, most probably due to the shift between attendance at acute and minor A&Es. Looking first at England we find the conversion rate increased from 25% to almost 29% considering just acute A&E attendances. But if we look at NW London we find that this rate has increased from 24% to 32%. There is considerable variation between hospitals.

We can only speculate as to what is happening but given the observed shift from acute attendances to minor, it would appear that those patients attending acute A&E are more acutely ill as a group than was the case previously. This would seem to

be confirmed by the fact that taking all attendances at all types of A&E we find the proportion in NW London admitted has fallen slightly from 13% to 12% whereas in England it has increased from 16% to 19%. In London (not including NW London) the conversion rate for acute A&E has increased from 21% to 24% during this period while the rate for all A&E attendances has gone from around 14% to 16%.

Emergency admissions

We now look at the level of emergency admissions in NW London hospitals and how this has been changing over time. In absolute terms, between 2011/12 and 2016/17, the number of emergency admissions each year, through A&E, fell from 162,370 to 159,799 at a time when the number of acute A&E attendances had fallen by close to 100,000. However, this was more than compensated by a dramatic rise in the number of emergency admissions not taken through A&E, which went from 12,261 to 29,222 over the same period⁴. This translates into a small rise, just over 8%, in total emergency admissions over this 5-year period, from 174,631 to 189,021 admissions. At the same time, emergency admissions in England as a whole increased by almost 14% and in the rest of London by 16%.

It does not seem to be an increase in demand on acute A&E facilities that is causing pressure in the system; it is more likely to be a reduction in resources that is making it difficult for the emergency system in NW London to cope, especially with the closure of two A&Es in 2014. Of course, there is variation throughout the year and indeed in any particular week, and this can also cause problems for hospitals. Some slack in the system is required. Also, these figures reflect an average over the whole area, but individual trusts may be struggling.

Some analysis of the position with respect to the length of time patients spend in hospital, average length of stay (ALOS), and the level of bed occupancy in hospitals, is provided later in the paper when we discuss resources, and in particular, availability of acute beds.

Changes in the quality of care

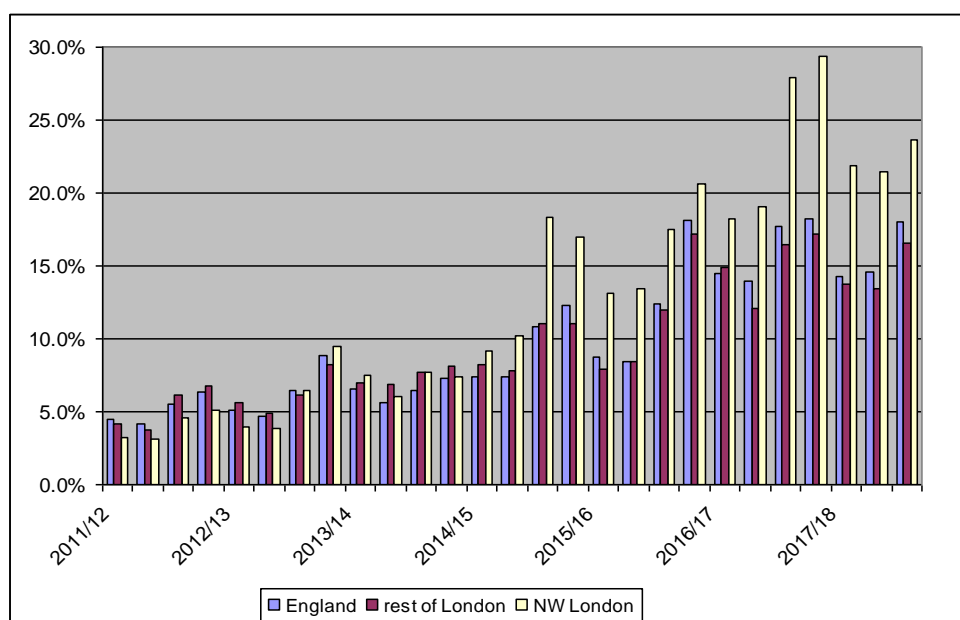
There are several aspects to the quality of care. Our focus in this section is on acute care. There seems little doubt that there has been increased pressure on hospital services in NW London since 2014 as reflected in A&E performance and ambulance performance.

⁴ For example, patients can be directly admitted by GPs, by consultants in outpatient clinics, from the A&E of another hospital, or from another hospital if an emergency arises. The number of these seems to be increasing.

A&E performance

Several indicators are used to measure A&E performance. In an earlier report in 2015 (1) our focus was on the proportion of people attending A&E who are not dealt with within four hours, and we found that there had been a considerable deterioration in performance on this measure. NW London, in the first quarter of 2011/12, was better than the rest of England and the rest of London, and at just over 3% was well within the margin of the target of 5% set by the government⁵. However the position gradually worsened during this period when attendances were in fact falling so that by the last quarter of 2013/14, NW London was worse than the rest of England and almost as bad as the rest of London: in the final quarter 7.4% of people were not seen within four hours.

Figure 2: Proportion of patients not seen at acute A&E within 4 hours, April 2011 – December 2017



Source: Our analysis based on NHS England data.

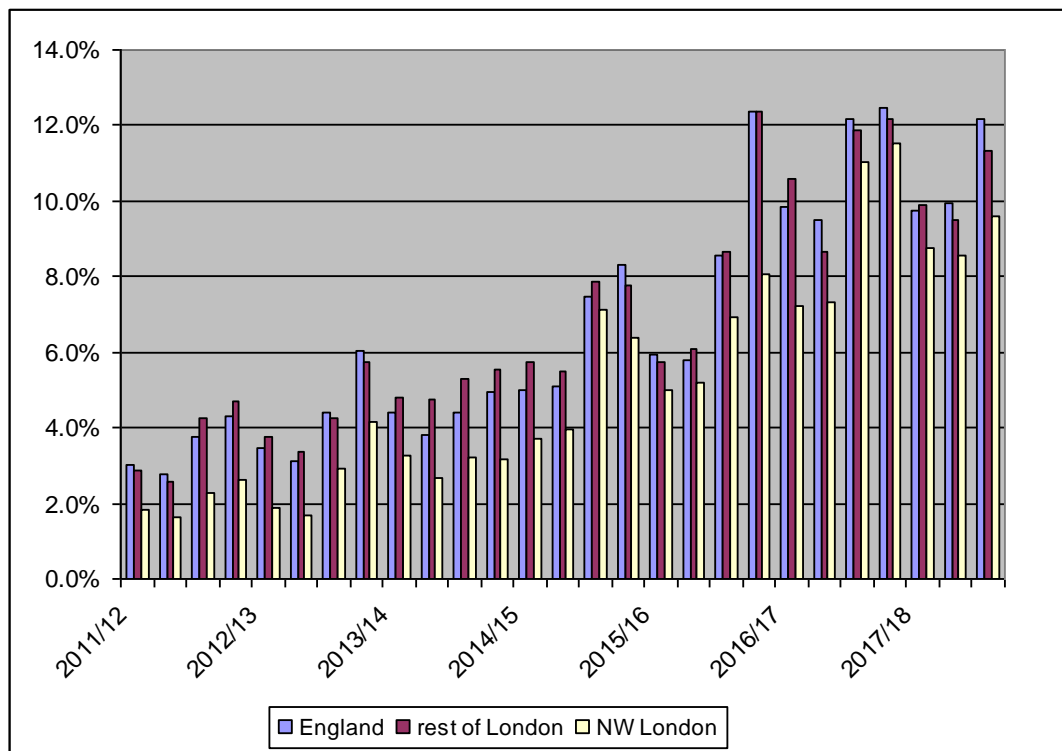
However when we look at more recent performance and in particular since the closure of two A&E units in NW London (on 10 September 2014) there has been a considerable deterioration in performance. Figure 2 compares the position in NW London with the rest of London and the rest of England for acute A&E attendances. In the third quarter of 2014/15 the figures were 18.3%, 11.1% and 11.1% respectively. There was a dramatic deterioration in performance between October and December 2014 (just after the closure of two A&Es) when the proportion failing to meet the target increased from 10.2% to 18.3%.

⁵ This refers to attendances at acute or Type 1 facilities.

While there has been some variation in how badly NW London performs relative to the rest of London or to England, it is fair to say that since the closure of two A&Es in September 2014, performance in NW London has consistently been poorer than elsewhere. Indeed there are very few places in England performing as badly. Moreover, as noted earlier, there are fewer A&E attendances in NW London with much greater use being made of minor A&E sites. Those people attending acute A&Es in NW London are therefore likely to have greater needs than elsewhere in the country.

If we include all A&E attendances (acute, specialist and minor), Figure 3 shows that NW London performs better than the rest of London and the rest of England, and has done so throughout this period, although performance has deteriorated across the country. In the last seven quarters, even on this measure NW London has failed to achieve the 95% target for the last three years.

Figure 3: % of patients seen at all types of A&E within 4 hours, April 2011 – December 2017



Source: Our analysis based on NHS England data.

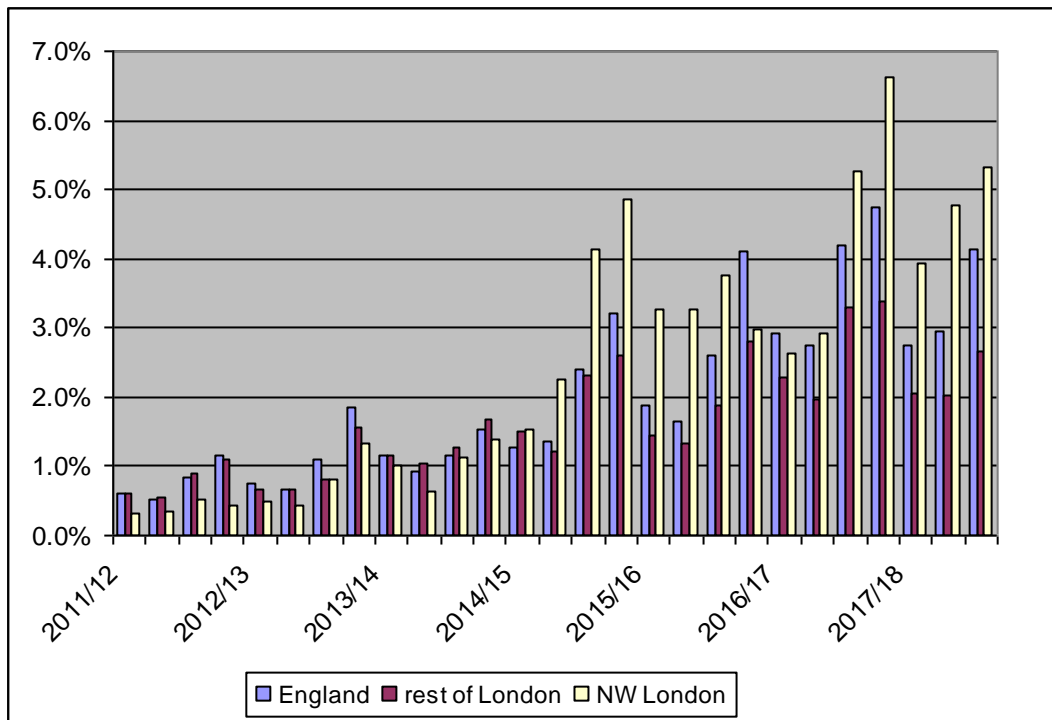
Confusion has been introduced by the way in which minor A&E services are often referred to as A&E services, both in national and local documents, and in the press. This can sometimes lead to apparently contradictory statements if a system is able to meet targets across all types of service but fails on the key service, acute A&E, which is what most clinicians and members of the public would regard as key to a well-functioning emergency service. It is the inability to meet the target for acute A&E services that is of most concern.

Time from decision to admit to admission

Another measure of quality in the A&E department is how long it takes a patient to be admitted to a bed once the decision has been made to do so. In many cases this can take up to 12 hours, and increasingly over 12 hours.

As Figure 4 shows, once again we find performance in NW London has deteriorated sharply since the closure of two A&Es in September 2014. Nationally and in the rest of London the picture is poor, but NW London is worse. In the third quarter of 2017/18, 5.3% of patients in NW London A&Es waited up to 12 hours for admission, 2.7% in other parts of London, and 4.1% in the rest of England.

Figure 4: Proportion of patients who spent >4 hours but <12 hours from decision to admit until admission, April 2011 – December 2017



Source: Our analysis based on NHS England data.

Measuring pressure on the emergency system: black alerts

Nationally the NHS operates a scheme to measure the pressure that local A&E services are experiencing (3). This is known as the Operational Pressures Escalation Levels (OPEL) framework, and provides a way of hospitals indicating how much pressure they are under on any particular day. These range from levels OPEL1 (the local system is coping) to OPEL4 (where the hospital can declare its A&E closed and patients must be diverted to other hospitals).

NHS England publishes a record of cases, on a day-to-day basis where A&Es close or diversions occur. This would seem to only happen when level 4 is reached. However,

hospitals are under severe pressure even at level 2 or 3, and these levels are referred to locally as black alerts.

Throughout January and February 2018, the Imperial Trust sites: St Mary's and Charing Cross, have been experiencing severe pressure and have had to declare black alerts on almost all days. Chelsea & Westminster has usually not had the same problems although it did declare a black alert on 30 January 2018, for example, at the same time that St Mary's and Charing Cross were also on black alert.

Trusts also indicate how many patients are admitted and waiting for beds at the beginning of a day. These are classed as a negative bed balance. For example, on 6 February 2018, St Mary's had -26 beds, Charing Cross had -28; on 13 February, St Mary's had -16 beds, Charing Cross had -12; on 19 February, St Mary's had -27 beds, Charing Cross had -46; on 20 February, St Mary's had -22 beds, Charing Cross had -33.

These are just examples of the pressure local hospitals have been under throughout January and February, based on locally reported information. We are not able to compare this with the situation in other parts of England, or London, as these data are not collated and published in this way by the NHS. However, anecdotally, and from press reports, we know that other regions have also been under extreme pressure.

NHS national data (known as Sitreps) show there was just one day when there was an A&E closure in the period between 20 November 2017 and 25 February 2018. Over the same period there were 353 instances where ambulances were diverted from an A&E. Just one of these occurred at a London NW Healthcare site. However, this does not correspond with the level of pressure in local hospitals we described above, and we are therefore somewhat wary of the usefulness of this nationally published data.

Ambulance delays

The NHS sitrep data also record ambulance delays at individual trusts on a daily basis. These delays occur when ambulances arrive at the trust but are waiting to deliver the patient into the care of the A&E unit, and the back-up in A&E is such that the care of the patient is not able to be transferred. Two levels of delay are reported, >30 minutes but < 60 minutes, and >60 minutes. The majority of patients are transferred within 30 minutes but as pressure increases in a hospital this proportion falls. We report below the position in NW London over the winter of 2018, from the week beginning 20 November 2017 until that beginning 5 February 2018.

Table 2: Max % ambulance delay >30 mins & <60 mins, 20 Nov 2017 – 5 Feb 2018

Chelsea And Westminster Hospital NHS Trust	2.8%
Imperial College Healthcare NHS Trust	7.4%
London North West Healthcare NHS Trust	24.2%
Hillingdon Hospitals NHS Foundation Trust	25.4%
NW London	14.1%
London	10.2%
England	12.4%

Based on our analysis of NHS data.

We find that over this period LNWHT and Hillingdon trusts consistently had ambulances waiting longer than is appropriate, and sometimes twice as long as the England or London average. Chelsea & Westminster and Imperial, on the other hand, appear better than average on this measure, as Table 2 shows. Overall, adding those patients who waited more than an hour to those waiting between 30 minutes and an hour, one in five patients attending NW London A&Es by ambulance, were detained by more than 30 minutes before being admitted into the care of the A&E unit.

Bed resources in the acute sector

In recent years acute trusts have combined in NW London so that there are now only four individual trusts: Imperial (St Mary's, Charing Cross and Hammersmith hospital sites); London North West Healthcare (Northwick Park & St Mark's, Central Middlesex and Ealing sites); Chelsea & Westminster (Chelsea & Westminster and West Middlesex sites); and Hillingdon (the only one on one main site). This can make some comparisons difficult as the original SaHF document was couched in terms of changes at nine hospital sites (which have been combined into these four trusts).

Nevertheless we know the number of acute beds (termed General & Acute) available in hospitals has been falling across England since 2009 – by 17.5% up to September 2017⁶; the same applies to London and NW London although to a lesser extent – 12.1% and 6.3%. The number of maternity beds has also been in decline across England, has remained static in the rest of London, but has witnessed an increase in NW London – by almost 28%⁷.

The number of beds for mental health has also declined, again more quickly in England as a whole and in the rest of London – by 28% and by 34.3% – but still by 9% in NW London (see Tables 3 and 4).

⁶ This is from a low base: England already has less acute beds per capita than comparable countries.

⁷ It was noted in an NHS review of the relocation of maternity beds from Ealing hospital that too much capacity was re-provided.

Table 3: Bed availability, 2009/10

	General & Acute	Mental Illness	Maternity
NW London	4,302	1,371	361
London	17,926	5,373	1,526
Rest of London	13,624	4,002	1,165
England	121,756	25,503	8,392

Source: Our analysis of NHS England data.

Table 4: Bed availability, 2nd quarter, 2017/18

	General & Acute	Mental Illness	Maternity
NW London	4,032	1,492	461
London	15,756	4,120	1,617
Rest of London	11,724	2,627	1,156
England	100,466	18,353	7,696

Source: Our analysis of NHS England data.

Analysing national bed data from the NHS we produced Table 5 showing the latest position in NW London by hospital trust: data are not provided at the individual site level. The actual number in the second quarter of 2017/18 is given alongside the base line from SaHF in parentheses although this is not strictly comparable as SaHF treated maternity and paediatrics as one, and separate from acute. However, the base level for bed availability under SaHF is not much more than current availability, and if paediatrics is included it may well be more. A considerable reduction in bed numbers is required by the full implementation of SaHF.

Table 5: Bed availability, NW London acute trusts, 2nd quarter, 2017/18

	General & Acute	Maternity
Imperial Hospitals	1,002 (1,276)	142
<i>St Mary's</i>		
<i>Hammersmith</i>		
<i>Charing Cross</i>		
C&W Hospital Trust	725 (717)	182
<i>Chelsea & Westminster</i>		
<i>West Middlesex</i>		
London North West	1,221 (1,130)	69
<i>Ealing</i>		
<i>Central Middlesex</i>		
<i>Northwick Park & St Mark's</i>		
Hillingdon	414 (326)	68
Total	3,362 (3,449)	461

Source: Our analysis of NHS England data.

Table 6 shows there are more beds per head of population in NW London than in England as a whole – looking in more detail, there are 7% more general & acute beds; and there are nearly 60% more maternity beds. The rest of London has less general & acute beds than England as a whole.

Table 6: Bed availability per 1,000 resident population, 2nd quarter, 2017/18

	General & Acute	Mental Illness	Maternity
NW London	1.94	0.72	0.22
London	1.79	0.47	0.18
Rest of London	1.75	0.39	0.17
England	1.82	0.33	0.14

Source: Based on our analysis of NHS England data plus population estimates from ONS.

The issue is how NW London compares with the rest of the country. A key question is whether areas where NW London is in excess of average requirements merely reflect their different status as centres for specialist care and for training and research, or whether it does indicate overprovision of local services for local people. It is well known that London hospitals provide specialist services to patients from all over England. Previous reports have shown that this can amount to as much as 15% of beds used (4). There are three specialist hospitals in NW London: the Royal Brompton, the Royal Marsden and the RNOH, which between them have 568 beds: this is over 14% of the total in NW London. If we remove these hospitals from our bed calculation above we find that NW London actually has less beds than the rest of the country.

Length of stay

NHS provider data for 2016/17 reveal that the average length of stay for all episodes of care in England as a whole was 4.9 days. No data are recorded in the national data set for Hillingdon hospital but the other three NW London hospitals have a length of stay less than the England average: Chelsea & Westminster 3.6; Imperial 4.1; and, London North West Healthcare 4.4.

In passing we should mention that a large proportion of these episodes have zero length of stay, and this contributes to lower overall lengths of stay. Thus, we find that in England as a whole 30.5% of emergency admissions actually do not result in an overnight stay. In Chelsea & Westminster the figure is 40%, in Imperial 24.8%, and, in London North West Healthcare 30.7%. This surely goes some way to explain the low length of stay in Chelsea & Westminster, although the other two trusts are at or below the England average. Their averages therefore may represent some measure of good performance.

Bed occupancy

Levels of bed occupancy are frequently used as an indicator of pressure on a health system. There has been much reporting in the media of problems with high levels of occupancy in individual trusts.

Looking at the four NW London trusts, and comparing with the reported position in England, we find that, in the second quarter of 2017/18 (July - October 2017), overall the level of acute bed occupancy in NW London was 88.9%; however, Hillingdon, and Chelsea & Westminster, were at 92.9% and 92.2% respectively, and London North West Healthcare was fractionally under 90%. While these are not the worst in the country, they are greater than the England average of 88.9%. Surprisingly, given anecdotal evidence of extreme pressures at some Imperial sites, it has an occupancy rate of just 82.8%.

But if we look at data from the winter of 2017, we perhaps get a better picture of the degree of pressure local hospitals are under. We find, in the last quarter of 2016/17 (Jan - March 2017), overall the level of acute bed occupancy in NW London was 92%, and Hillingdon, Chelsea & Westminster and London North West Healthcare were at 94.4%, 98% and 93.6% respectively. The England average was then 91.4%. Again Imperial is under less pressure with an occupancy rate of just 85%. However these are averages over the quarter, and on some days rates may go up to 100% creating major operational issues. It is generally accepted that an average occupancy level of 85% is appropriate for delivering safe patient care.

Staffing in NW London

We have also looked briefly at staffing levels in NW London hospitals⁸ and how these have changed since SaHF was published in 2012. Taking just the four existing hospital trusts, we find that in the five years since November 2012, there has been a 13% increase in WTE hospital staff – this covers all staff – with a range between 17.4% in Imperial, 15.1% in Chelsea & Westminster, 11.5% in Hillingdon, and 7.1% in London North West Healthcare. Over the same period there was an 8.3% increase in England as a whole. However, of the NW London trusts, London North West Healthcare has seen a decline over the last two years, and Hillingdon over the last year. The former may reflect the disruption experienced as a result of plans to close most of Ealing acute hospital.

It has proved difficult from readily available NHS sources to make similar comparisons over time for different staff groups, eg doctors, nurses, although it is clear this could prove insightful.

⁸ We analysed NHS Digital staffing data from February 2018.

Changes in out-of-hospital care

It was our intention to discuss in this section any independent evidence on improvements in the quality, or increases in the provision of, out-of-hospital care in NW London, and the impact on the demand for care, especially in acute settings. However, most of what we have found has been speculative, and not of the quality of the data on acute services.

Thus, the NW London Collaboration of CCGs presented evidence at the JHOSC meeting in December 2017 that the national Vanguard initiatives (the 50 sites across the country developing accountable care systems) had achieved overall in the last 12-month period a reduction in per capita emergency admission growth rates from the national growth rate of 3.2% to between 1.1 to 1.6% although individual vanguards had actually shown reductions in admissions. The paper went on to claim, as SOC1 does, that the intended hubs in NW London will result in a reduction in admissions of 22,000. However we have no evidence to provide either way to support this.

Our analysis of changes to A&E admissions in NW London in recent years does point to a possibility that demand for acute A&E can be diverted to minor A&E units, but having made major inroads already, it might seem unlikely that further diversion can take place. At the same time, while emergency admissions from A&E seem to have fallen in recent years, this has been more than overtaken by admissions from other sources such as patients admitted directly from GPs.

Discussion - what evidence implies for plans to close acute hospitals

An NAO report in February 2018, *Reducing Emergency Admissions* (5), suggests that out-of-hospital developments are no guarantee that demand for acute services will be reduced to a level where capacity can be taken out of the acute hospital system. Thus it states (pp25-28, paragraphs 2.10 to 2.17),

While the rate of growth in emergency admissions has slowed slightly, there is limited evidence to show that NHS England's programmes have brought about that slow-down. There is disagreement among clinicians, other practitioners and evaluators about the effectiveness of some of the interventions within the programmes.

On the Better Care Fund, data for 2017-18 are not available, and 2016-17 data show limited progress, with only 32% of local areas reporting they had met their local target to reduce emergency admissions. NHS England is currently unable to demonstrate that the interventions now in place in the urgent and emergency care programme have led to the slight slow-down in growth in emergency admissions seen in 2016-17; further work is underway by NHS

England and NHS Improvement to evaluate interventions. Some new care models have had slower increases in the rate of emergency admissions than other areas in England as of June 2017. However, there is considerable variability in performance, with results ranging from a reduction in emergency admissions of 7.4% to increases of 11.4% for multi-speciality community providers.

SOC1 and the original SaHF documents planned to close up to 1,000 acute beds as well as four A&Es, two of which have already closed, in our view prematurely. We have presented evidence of severe pressure on the acute system already, and we have not been able to find any evidence consistent with changes in out-of-hospital care producing the level of reductions in demand that are required. The figures presented earlier in this paper indicate somewhere in the order of 270 beds have been closed already.

We have shown that demand for acute A&E attendances in NW London is already low compared with elsewhere, and therefore unlikely to be forced to even lower levels. This coupled with the evidence gap for the effectiveness of OOH strategies, implies that the plans have no sound basis, and should be abandoned forthwith.

Conclusion

The original analysis on which SaHF was based failed to take adequate account of likely increases in population over time. This was apparently rectified in SOC1 but strangely has had little impact on the overall plan to close acute hospitals.

NW London has a different pattern of use of emergency services with greater use of minor A&E units than other parts of London, and the rest of England. There is no evidence that NW London uses more A&E emergency services than other parts of England, or London.

Partial implementation of a programme of closures of acute services before an adequate business case has been produced, has increased the pressure on the health system and had a detrimental effect on the delivery of services in NW London. It is becoming almost impossible to run the system due to a lack of financial resources combined with a lack of acute bed facilities and a shortfall in staffing throughout the area.

The deterioration in A&E services suggest that any plans for further closures of acute services at Charing Cross and Ealing are ill-founded. These should be halted and sufficient resources made available to retain existing services and staff.

Recommendations

Recommendation 1: The Council should continue to monitor NHS plans, and to insist that these are subject to the full scrutiny of the Council. Future demand projections and evidence for the success of out-of-hospital services and new models of care continue to be updated and although there is evidence that acute A&E attendances may indeed have fallen across NW London, this has not resulted from the SaHF plans presented now. In our view the introduction of minor A&Es has had the biggest influence. Moreover the level of emergency admissions has risen by 8% since 2012, not decreased as SaHF would have projected.

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