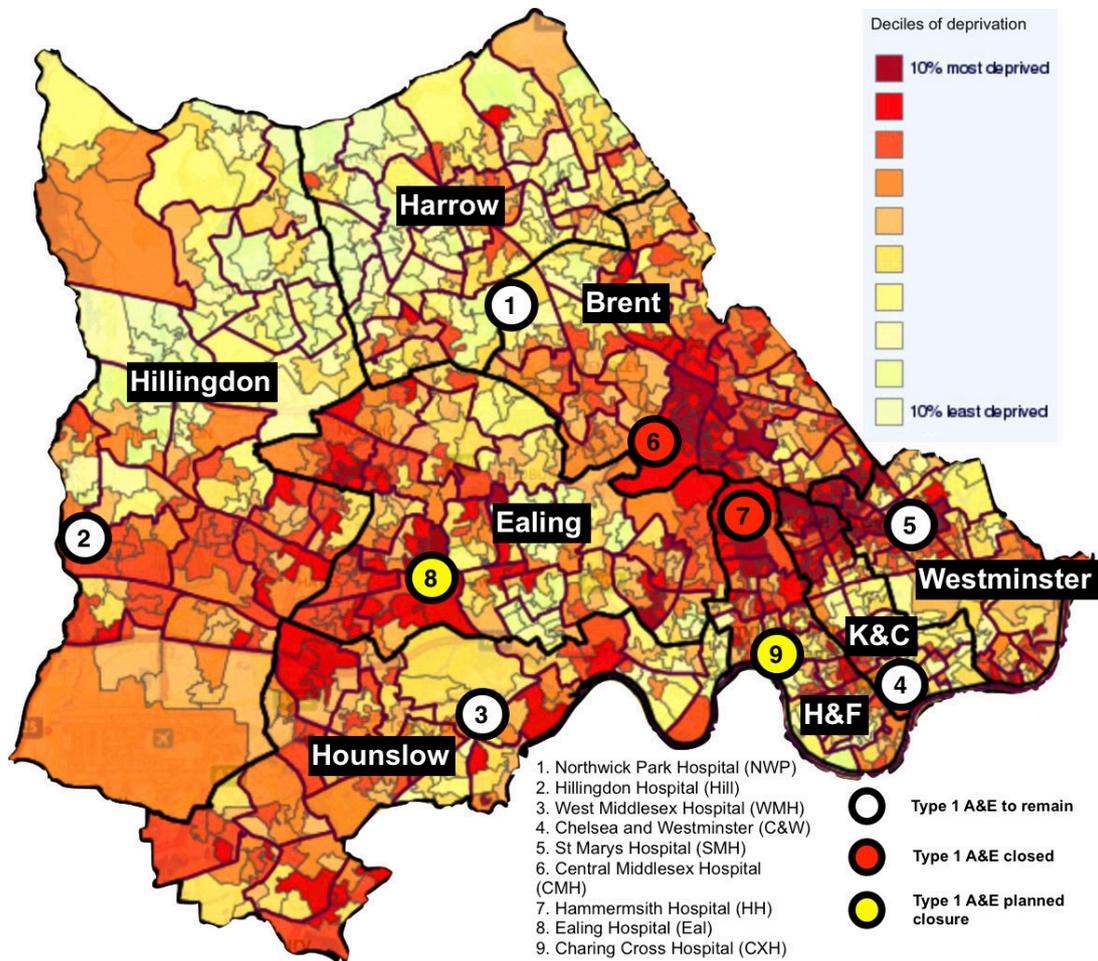


# Can we afford to close any more A&E departments? Evidence from North West London.

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## About the author

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Dr Gurjinder Singh Sandhu is a Consultant Physician specializing in Infectious Diseases and Acute Medicine. He has a specialist interest in Tuberculosis, Poverty and Health Inequalities. He was awarded a Wellcome Trust Tropical Fellowship and completed his PhD in 2010, studying Tuberculosis in resource poor countries. Dr Sandhu currently works in Acute Medicine and is developing an interest in health inequalities in elderly care medicine. Dr Sandhu is an active member of Ealing Save Our NHS.

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## Introduction

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1. Sustainability and Transformation plans (STP) are proposing the downgrading or closure of up to 24 emergency departments in England.<sup>1</sup> STPs rely on the assumption that large numbers of patients can be kept out of hospital and cared for in the community, or will attend urgent care centres with minor conditions.

2. In line with this, and predating STPs by four years, a programme called *Shaping a Healthier Future* (SaHF) was initiated in North West London in 2012, which plans to consolidate the provision of acute services from nine down to five hospitals, downgrading the remaining four hospitals into local hospitals – i.e. an urgent care centre, outpatient and diagnostic services. To date this programme has led to the closures of the emergency departments at both Central Middlesex and Hammersmith Hospitals (September 2014), the maternity unit at Ealing Hospital (July 2015) and the paediatric unit at Ealing Hospital (July 2016). An independent commission led by Sir Michael Mansfield in 2015 described how these NHS facilities had been closed without adequate alternatives in place, and called for a halt to the programme pending an immediate financial assessment by the National Audit Office and an equality impact assessment.<sup>2</sup>

3. Nevertheless the SaHF programme has been resurrected in the form of the North West London STP. Despite a sharp deterioration in A&E performance in North West London following the closures already made, the STP envisages closing the A&E at Ealing hospital by 2021 and closing the A&E at Charing Cross Hospital at some point after that. The STP also proposes to consolidate acute services from nine onto five sites in North West London.<sup>3</sup>

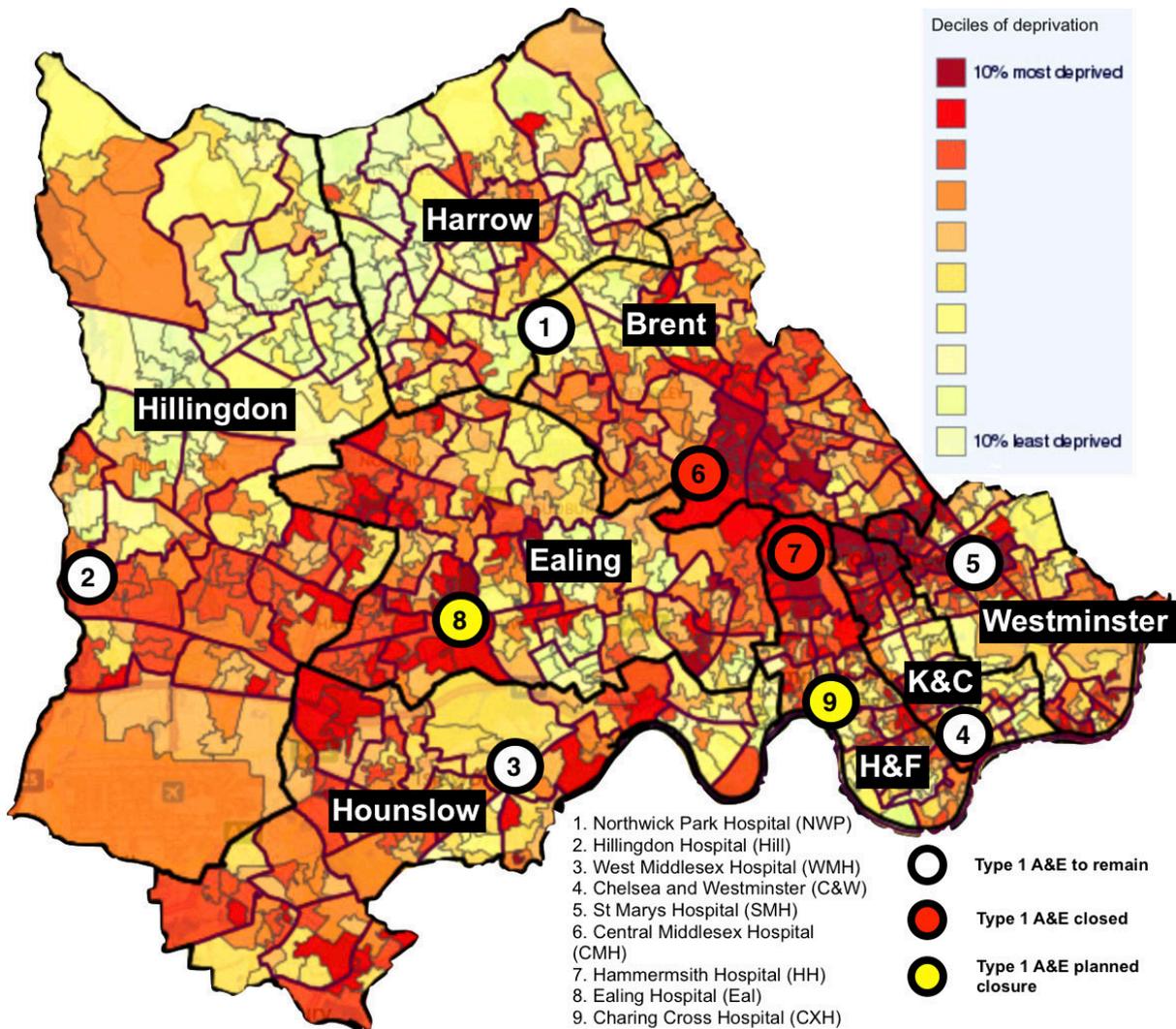
4. In this respect North West London is further down the STP pathway than any other region in England and there are important lessons to learn. One is that in these high-density city areas the closures aggravate already existing health inequalities. Another is that the overall quality of emergency care, which is already deteriorating nationally, will be pushed to danger point and beyond if further closures such as those planned for North West London are proceeded with.

### The local area and its demographics

5. North West London comprises 8 boroughs: Hillingdon, Hounslow, Harrow, Ealing, Brent, Kensington & Chelsea (K&C), Hammersmith & Fulham (H&F), and Westminster. *London's Poverty Profile 2015* showed that none of the inner west London boroughs (K&C, H&F and Westminster) are in the bottom half of the range for poverty.<sup>4</sup>

6. The poverty profile of outer west London, however, has changed in recent years: Brent and Ealing are now two of the four poorest boroughs in London, with high levels of unemployment, low pay and homelessness, as well as high rates of tuberculosis.

Figure 1. Emergency provision and relative deprivation in North West London

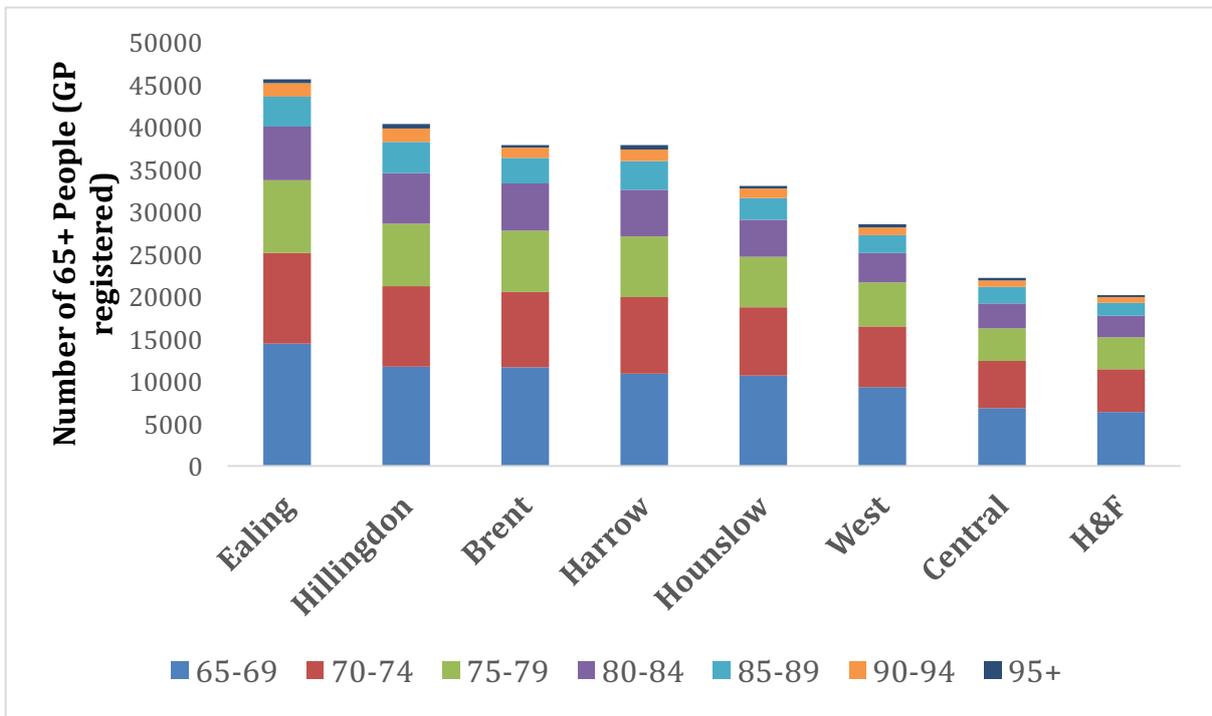


Source: 2015 English IMD explorer

7. Despite this inequality Figure 1 shows that the risk of emergency departments being downgraded – those in hospitals coloured red and yellow – directly correlates with levels of deprivation. It is in the areas with high prevalence of population, poverty and disease burden that hospital services have been, or are destined to be, downgraded, leaving the most vulnerable residents who are least able to afford it to travel the furthest for hospital treatment, while the sites that are destined to remain as major acute hospitals are in less deprived areas – i.e. St. Mary’s, Chelsea and Westminster, West Middlesex, Northwick Park and Hillingdon Hospitals.

8. As well as having the poorest patients, the outer North West London boroughs also have the highest population and a higher proportion of elderly patients (Figure 2).

**Figure 2. Number of 65 + people (GP-registered) in North West London**



9. The population of North West London is also predicted to increase rapidly over the ten years from 2014 to 2024, and the likely addition of a third runway at Heathrow and the completion of Crossrail can be expected to raise still further the predicted rates of growth in outer North West London, shown in Table 1.

**Table 1. Population (2015) and Projected growth in population, eight North West London boroughs, between 2014 and 2024**

<b>Borough</b>	<b>Population 2015</b>	<b>Projected Growth by 2024</b>
Hillingdon	297,735	16.1%
Westminster	242,299	15.6%
Hounslow	268,770	13.9%
Brent	324,012	11.4%
Harrow	247,130	10.7%
Ealing	343,059	7.9%
Hammersmith and Fulham	179,410	6.5%
Kensington and Chelsea	157,711	2.8%
North West London	2,060,126	11.1%

Source: UK National statistics and ONS Subpopulation projections (Web)

## *A&E department performance: the impact of A&E closures*

10. Before the closures of Central Middlesex A&E and Hammersmith A&E, the performance of Type 1 A&E departments across North West London hospitals met the 4-hour target between 78% and 95% of the time during the winter months. Immediately following the A&E closures this fell to between 60% and 80% - in other words up to 40% of patients needing serious emergency treatment had to wait more than four hours to be assessed and admitted into an appropriate bed. Whilst the majority of hospitals recovered from this low level of performance, Northwick Park Hospital did not and has subsequently experienced a summer crisis as well as winter one.

11. Since September 2015 Hillingdon Hospital has seen a dramatic downturn in its A&E performance. Hillingdon Hospital has the worst Type 1 performance of all 140 Type 1 trusts in the country; one year ago it was number 92 in the rankings.

London North West Healthcare NHS Trust (Northwick Park and Ealing Hospitals) has the second worst performing A&E in the country, although this position interchanges with Hillingdon hospital. Imperial College NHS Trust Hospitals (Charing Cross and St Mary's Hospitals) - have shown a similar

nosedive in performance, and importantly in 2016 they have not had the resilience to recover from poor performance.

### **Definitions:**

#### **Type 1 Emergency Department:**

A Type 1 emergency department is a Consultant-led 24-hour service with full resuscitation facilities and designated accommodation for accident and emergency patients.

#### **Type 2 Emergency Department:**

A Type 2 emergency department is Consultant led mono specialty accident and emergency service (e.g. ophthalmology, dental).

#### **Type 3 Emergency Department:**

A Type 3 unit can be nurse- or doctor-led. It is only capable of treating minor injuries and illnesses without an appointment. An 'Urgent Care Centre' is a Type 3 Emergency Department.

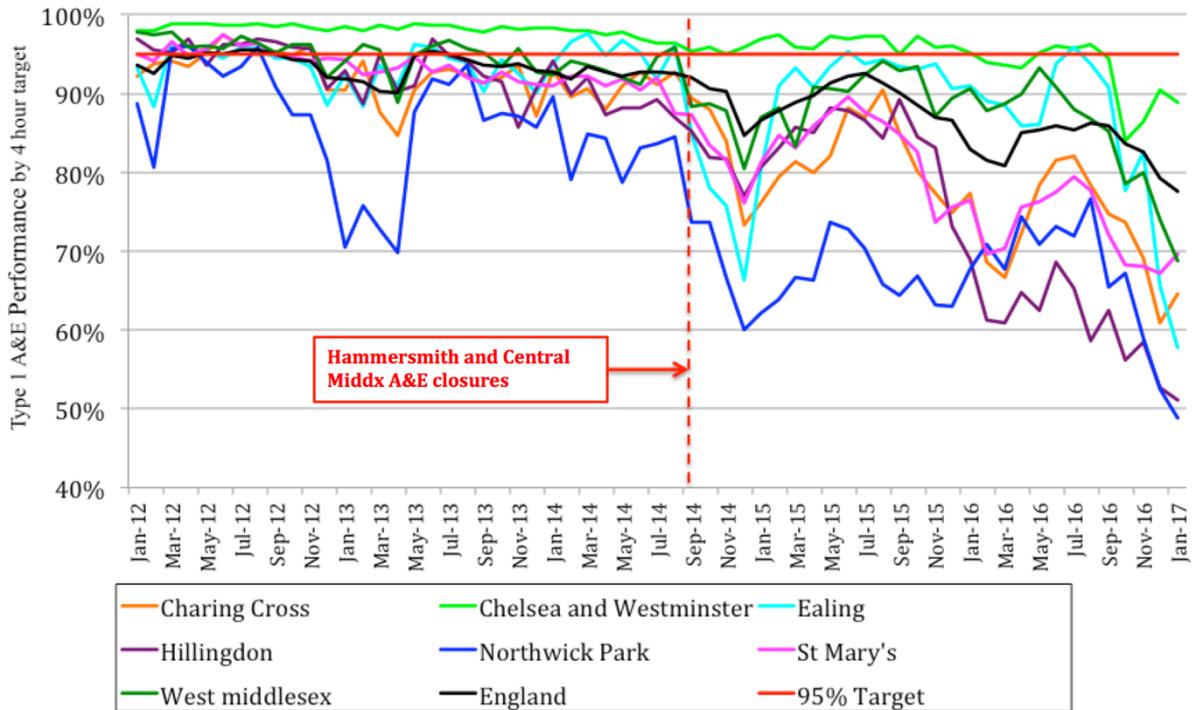
#### **4 hour target:**

At least 95% of patients attending the A&E department must be seen, treated and admitted or discharged in under 4 hours. This target is more important for Type 1 than Type 3 A&E departments, as this is where speed can be critical to preventing significant patient harm. A&E performance data are often presented as 'all Type' data, in which excellent performance with stable Type 2 and 3 patients can obscure poor performance in treating the sickest (Type 1) patients. Most Type 3 performance is excellent rarely dropping below 99%. The Western Eye Hospital is the only Type 2 Unit in North West London, with excellent performance and stable attendances.

#### **A&E closures:**

Where reference is made to A&E closures this means the closure or planned closure of a Type 1 A&E unit. Once a Type 1 A&E unit has been closed no blue light ambulances will come to the site and there will be no ability to admit patients to medical, surgical, paediatric or obstetric wards. There will be no Intensive Therapy Unit or High Dependency Unit and it is debatable whether the remaining facility can be called an A&E.

**Figure 3: Decline in performance of remaining emergency departments following A&E closures at Central Middlesex and Hammersmith Hospitals**



Source: North West London Collaboration of CCGs Performance data

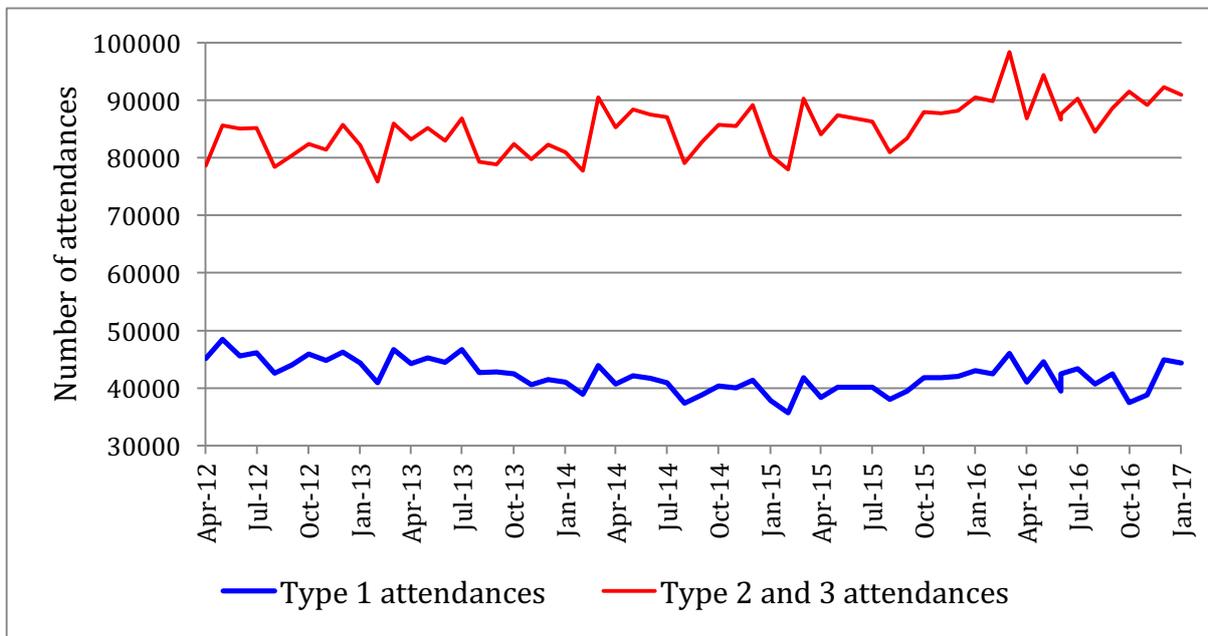
12. Whilst hospitals in the centre and south east of the sector, such as Ealing, Chelsea & Westminster and West Middlesex hospitals, have managed to maintain their performance at the English average, in September 2016 there was once again a very dramatic downturn in the performance in all three, with only Chelsea and Westminster hospital managing to stay above the England average.

13. Type 1 performance has been deteriorating nationally, although only to 78% at its worst, whereas the figures in North West London have fallen as low as 49%; the fact that performance has declined elsewhere does not change the fact that it is much worse in North West London, particularly after September 2014 when the closures took place. Two out of the four NHS trusts in North West London are consistently in the bottom two for Type 1 Performance (Hillingdon Hospital NHS Trust and London North West Healthcare Trust) in the country. Imperial College Healthcare NHS Trust is consistently in the bottom fifteen.

**A&E attendances: does diverting less ill patients from A&E reduce the need for Type 1 facilities?**

14. Plans to cut the provision of Type 1 emergency services rely on various studies which have estimated that anything from 15% to 50% of people who attend A&E departments do not need to, and could be managed in less acute settings. Since the closure of the Type 1 A&E units at Central Middlesex and Hammersmith hospitals in September 2014, all 9 sites in NW London have continued to offer Type 3 Emergency Care in the form of 24/7 Urgent Care Centres. Walk-in patients are triaged at the Urgent Care Centre, determining whether they need to attend the Type 1 or a Type 3 facility. In the last year (2016) there has been a steady increase in Type 3 attendances in NW London, but Type 1 attendances have remained largely unchanged, with intermittent surges in attendance.

**Figure 4: Emergency attendances in North West London 2012-16**



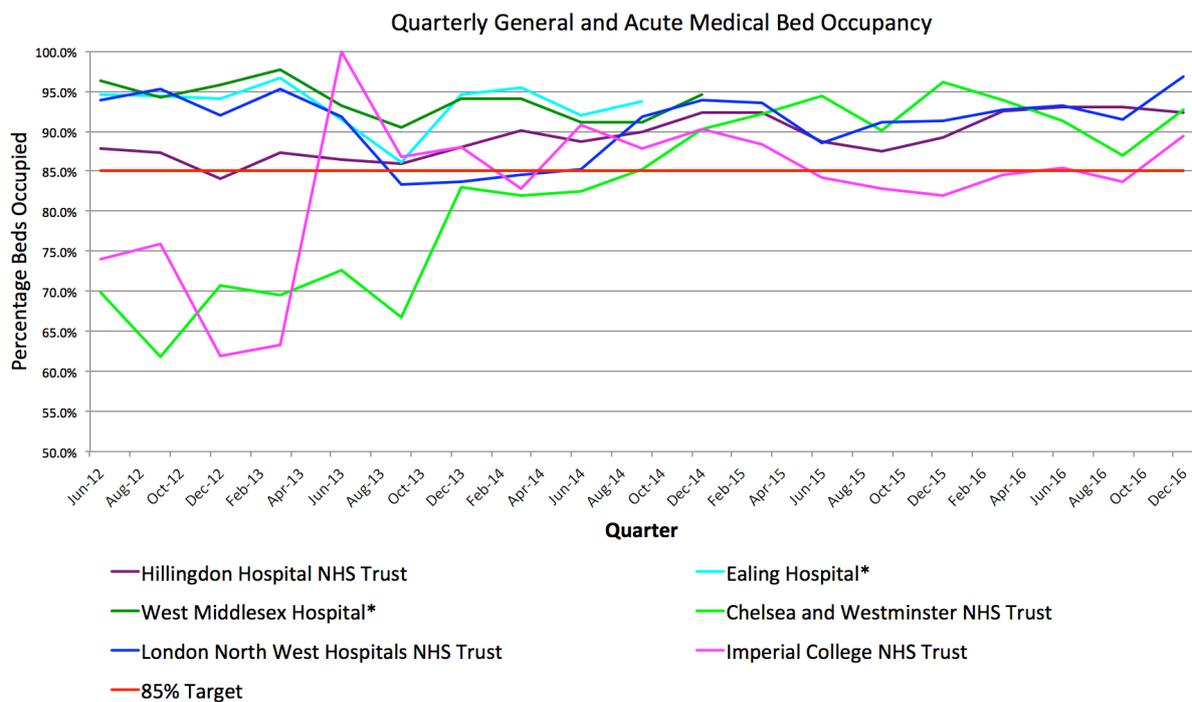
Source: North West London Collaboration of CCGs

15. In North West London about a third of people attending A&E are triaged to Type 1 Acute A&E departments while the other two-thirds are directed to Type 3 Urgent Care Centres. This split allows for a good proportion of the 15-50% “unnecessary attendances” to be triaged away from Type 1 units. Despite this, admissions to Type 1 care have remained unchanged, and with fewer facilities A&E performance in NW London is now amongst the worst in the country.

### Bed Occupancy: the impact of A&E closures

16. The safe level of bed occupancy as defined by the Royal College of Physicians is 85%; anything above 85% pushes the healthcare system and increases infection control risks.

**Figure 5: The impact of A&E closures on bed occupancy**



Source: NHS England Statistics, Statistical Work Areas, Bed Availability and Occupancy, 2017 \*Note Ealing hospital merged with London North West Healthcare Trust and West Middlesex Hospital merged with Chelsea and Westminster Trust. Although this may impact subsequent bed occupancy figures, both Trusts were showing an upward trend in bed occupancy prior to the mergers.

17. In North West London, prior to September 2014, only two hospital Trusts were meeting the 85% safe bed occupancy levels. These were Chelsea & Westminster Foundation Trust and Imperial College Healthcare Trust. More recently all hospitals in North West London have failed to meet this target. Hillingdon and London North West Hospitals NHS Trusts have shown a steady upward trend since 2014.

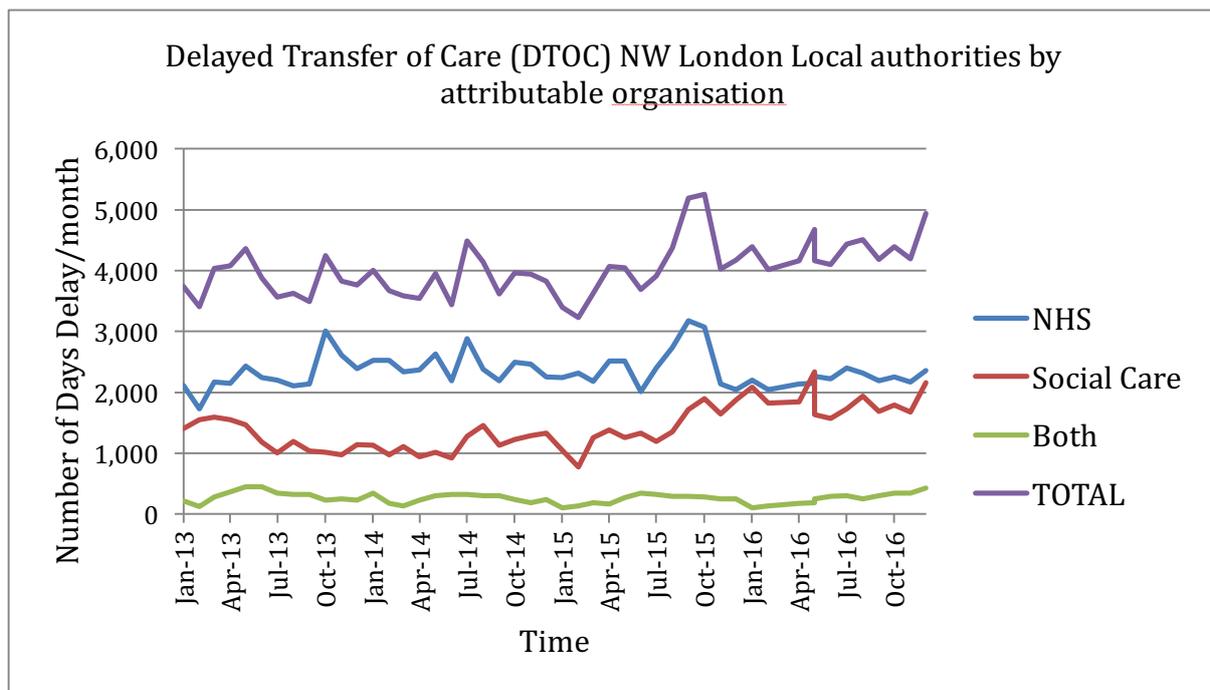
18. With high levels of bed occupancy the capacity of the system to deal with hot or cold weather, or influenza outbreaks, has become very weak. In the winter 'escalation' wards are opened, and patients are bedded in temporary areas such as theatre recovery, cardiac cath. labs, endoscopy suites or day surgery wards staffed by temporary staff. These temporary clinical environments can compromise patient safety and the quality of clinical care. High levels of bed occupancy, as well as

patient movement through multiple wards, increase infection control risks and wards have been closed due to norovirus and influenza outbreaks.

*How the underfunding of social care affects emergency care*

19. It is important to note that the social care crisis has contributed significantly to the A&E crisis. A ‘delayed transfer of care’ (DTC) occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care, but is prevented from doing so. These patients are often waiting for social care packages, or nursing/residential home placements. Six out of the eight boroughs in North West London are above the average for the city for delayed transfers from hospitals per 100,000 population. Particular hotspots for delayed transfer of care are in Ealing and Brent.

**Figure 6: The impact on emergency services of the unavailability of social care**

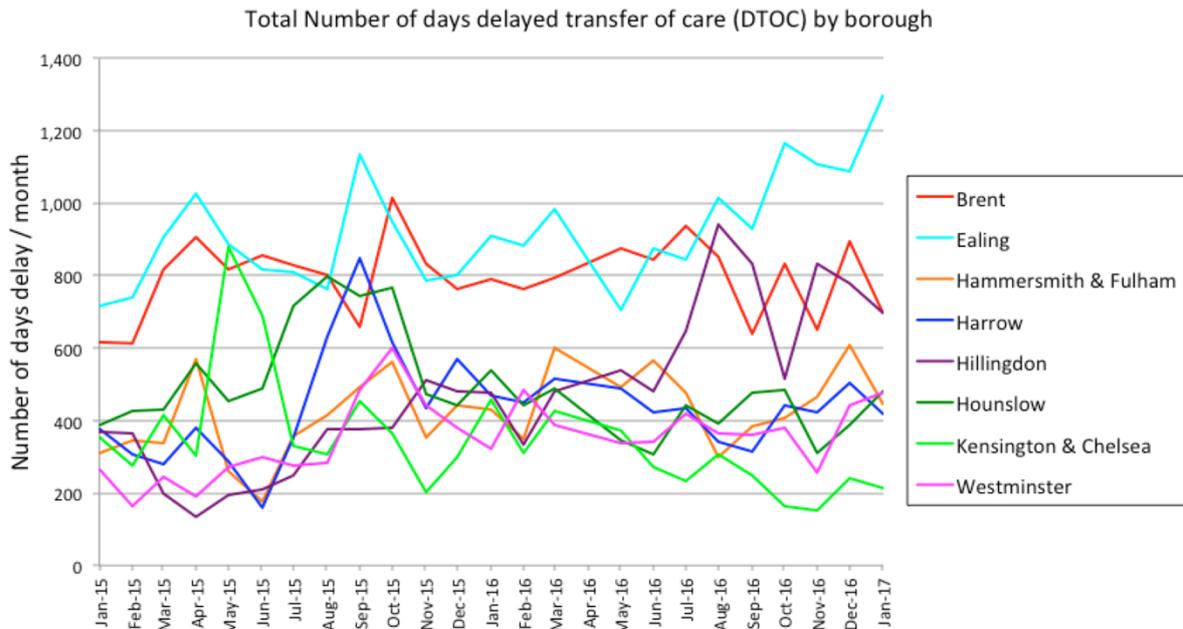


Source: NHS England Statistics, Statistical Work Areas, Delayed Transfers of Care, 2017

20. The reason for a DTC can be attributable to NHS factors (such as completion of therapy assessments in the hospital), social care factors (lack of available placements or home care packages) or a combination of the two. Figure 6 shows the total number of days per month lost to DTC in North West London boroughs by the organization responsible for them. In the past the NHS has been responsible for the bulk of these delays, but since mid-2015 the contribution to the problem by social care has doubled – a rise of 1000 days of delay per month. Delays due to lack of social care facilities now almost equal NHS-caused delays. Figure 7 further

highlights how those local authorities identified earlier as having a higher elderly population – Ealing, Brent and Hillingdon – have the highest DTOC bed days lost, as well as the worst-performing Type 1 A&Es in January 2017. Worryingly Ealing, which is next in line to have an emergency department closed, has the highest number of delayed transfer days.

**Figure 7: Delayed transfer of care by NW London local authority**



Source: NHS England Statistics, Statistical Work Areas, Delayed Transfers of Care, 2017

21. Patients trapped in acute hospital beds due to shortages of social care provision have an important impact on hospital capacity, patient flow and the ability of staff to admit new patients, including emergency patients, further compounding the A&E crisis. Yet a key assumption on which emergency departments were closed, and on which STPs envisage closing more of them, is that large numbers of patients can be kept out of hospital and cared for in the community.

## Conclusions

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22. Since the closure of Emergency Departments in North West London in September 2014, each successive winter has seen deterioration in Type 1 A&E Performance. For some hospitals there has been no recovery over the summer months and emergency care has been in a perpetual state of crisis. Ambulance response times are deteriorating, A&E units are unable to offload ambulances, and patients are waiting longer on emergency department trolleys to be assessed, treated and bedded where necessary. For time-sensitive conditions such as sepsis, respiratory failure, kidney failure and the unconscious patient, all this lost time equates to cellular death and eventually patient deaths. A lack of critical care and high dependency unit beds for the sickest patients is the greatest cause for concern.

23. In North West London A&E closures have also had significant effects on the performance of neighbouring A&E departments. STP footprints are not isolated: the STP for South West London also proposes to downgrade one of five A&Es, which will have a knock-on effect on North West London, and vice versa.

24. There has been a lack of equality impact assessment on the effects on deprived communities and the elderly in the NW London STP plan. Poverty is shifting from the centre of London to the outskirts, yet across London it is in these areas that clinical networks between a hospital, GPs and social care are being dismantled.

25. Whilst isolated deaths due to pressures on the emergency system have been reported by the media, disinvestment in NHS and social care services has been explored in one recent study as a factor contributing to nearly 30,000 extra annual deaths in 2015.<sup>5</sup> The authors expressed significant concerns that a pattern of rising mortality each year is emerging and called for further in-depth scrutiny of what caused this marked increase in mortality. Despite a dangerous deterioration in A&E performance since the closure of two local A&E Departments, the North West London STP still envisages closing a further two A&E units at some point in the future. Future planning needs to learn lessons from the reconfigurations that have already taken place and not continue with A&E closures based on assumptions which have not been borne out in reality.

## References

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