Title of report	North West London strategy for provision of acute beds
Author (name and role)	Toby Lambert, Executive Director of Strategy and Population Health

North West London Strategy for provision of acute beds

JHOSC has asked for a report detailing the North West London ICS' Strategy for the provision of acute beds across North West London. The report should also focus on the potential impact of the government's recent decision to postpose the delivery of three 'new' hospitals across the ICS on the North West London's strategy for the provision of acute beds across North West London.

Background/ context

For the purposes of this report, we have assumed that JHOSC is interested in somatic, rather than psychiatric, beds (i.e., beds primarily used for those with physical health conditions, rather than mental health conditions) and for curative care, rather than rehabilitation, long term care or palliative care. By curative care, we mean beds accommodating patients where the principal clinical intent is to do one or more of the following:

- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care); reduce severity of illness or injury, protect against exacerbation and/or complication of illness and/or injury which could threaten life or normal functions; and/ or
- perform diagnostic or therapeutic procedures.

There are live discussions on proposals for mental health care which have been covered in depth elsewhere. The ICS has commenced work on the strategy for mental health, building on 2015's Like Minded – The North West London Mental Health and Wellbeing Strategy, which will come to North West London's Integrated Care Partnership in due course.

Residents in North West London have access to a wide range of clinical expertise delivered by our hospitals, with access routinely coordinated by a patient's own General Practitioner (GP).

There are 11 acute hospital sites in North West London, organised into four Trusts (Imperial Hospitals NHS Trust, Chelsea and Westminster NHS Foundation Trust, London North West University Hospitals NHS Trust and Hillingdon NHS Foundation Trust).

Combined, each year these sites deliver over 500,000 urgent and emergency contacts, 152,000 emergency admissions, 2.7m specialist outpatient appointments, 246,000 diagnostic imaging tests and 17,800 elective surgeries (as day cases and as inpatient cases). At present there are 3,150 such beds across North West London, broken down as follows:

Trust/Site	Borough location	Boroughs which account for 10% or more of bed use	Ave. Open Beds Jan to Jun 2023	Ave. Open Beds 2019/20
Chelsea and Westminster Hospital NHS Foundation Trust			**712**	**689**
Chelsea & Westminster Hospital	Kensington & Chelsea	West London, Hammersmith & Fulham	314	308
West Middlesex Hospital	Hounslow	Hounslow, Ealing	398	381
Imperial College Healthcare NHS Trust			**1,058**	**1,034**
Charing Cross Hospital	Hammersmith & Fulham	Hammersmith & Fulham, Ealing	421	413
Hammersmith Hospital	Hammersmith & Fulham	Hammersmith & Fulham	294	266
St Mary's Hospital	Kensington & Chelsea	Westminster, Kensington & Chelsea, Brent	343	344
Western Eye Hospital	Westminster	All North West London boroughs	0	11
London North West University Healthcare NHS Trust			**1,012**	**1,098**
Central Middlesex Hospital	Brent	Brent, Ealing	79	107
Ealing Hospital	Ealing	Ealing	267	281
Northwick Park Hospital	Brent	Brent, Harrow	666	710
The Hillingdon Hospitals NHS Foundation Trust			**367**	**422**
Hillingdon Hospital	Hillingdon	Hillingdon, Ealing	367	422*
Mount Vernon Hospital	Hillingdon		0	
Total			**3,150**	**3,242**

***Please note that the way in which bed numbers are calculated has changed since 2019/20, with rehab beds no longer included in the total. The comparable number for Hillingdon in 2019/20 is 365.**

For the purposes of the table, Queen Charlotte's and Chelsea hospital is treated as part of the Hammersmith. A standard approach to counting and classifying beds has not been in place in previous years and work is under way with Trusts to put a consistent approach in place. Consequently, the figures above do not give a like with like comparison between the two periods. The national focus for this year is for Trusts to achieve a maximum bed

occupancy of 92%. Delivery of this standard will be supported by more accurate counting of beds, which has previously over stated the number of beds that are open and available for use.

Records prior to 2019 capture acute beds by trust, rather than by site. We have indicated which borough the beds are located in, though as many residents attend or are admitted to a site outside their borough of residence this does not reflect the usage of beds by residents of each borough.

Looking forward, there are a number of trends that affect the overall number of beds required. These include:

- Population changes. Both changes in the overall number of residents in NWL, and in the demographic breakdown of that population (e.g., all other things being equal, older residents require more hospital care) affect the number of beds required.
- Managing patients in the least intensive setting appropriate for their care;
- New treatments and new technology;
- Ensuring that only those residents that require an inpatient stay receive an inpatient stay;
- Ensuring that residents requiring inpatient care are treated and discharged in a timely fashion;
- The number of people waiting for treatment.

Population change

There are many population projections available from the Office for National Statistics and the Greater London Authority. Generally, projections differ in their assumptions on birth rates, death rates and migration (both within the UK, and from/ to abroad). North West London uses the GLA's identified capacity housing-led projections for its central population forecast, as this best captures local developments.

Using this projection, and adjusting for ageing within the population as well as overall population growth, we would anticipate an increase of 15-20% in hospital activity from 2019 to 2035, or around 1% per year. This is consistent with the activity projections in the business cases for the St Mary's, Charing Cross, Hammersmith and Hillingdon hospitals.

New treatments

As technology advances, new treatments become available. Some treatments support shorter lengths of stay or remove the need for it entirely (for example, in the late 1980s hospitals routinely had dedicated HIV wards; the advent of antiretroviral treatments has both improved outcomes for those living with HIV and almost entirely removed the need for beds); some treatments prolong the life of those that otherwise would have died/ would not have been treatable. The rise of remote monitoring may support the expansion of efficacy of 'hospitals at home' or virtual wards, allowing residents to be treated and home and thereby reduce the need for inpatient beds. Often new treatments start with a longer length of stay that shortens over time (coronary artery disease was initially treated with open heart surgery, but can now often be treated with key hole surgery).

Least intensive setting appropriate for their care

There has been a long term shift to less intensive settings – planned treatments that originally required an overnight stay can now be performed as day cases; treatments that were carried out as day cases can now be performed in outpatient settings. Similarly, some emergency treatments that would routinely have led to an overnight stay are now performed as Same Day Emergency Care. This provides a multi-disciplinary clinical service that can give more clinical input and diagnostics than patients would ordinarily receive in Emergency Departments, substitutes for hospital stays and hence decreases the beds required.

Ensuring that only those residents that require an inpatient stay receive an inpatient stay

For many residents, inpatient hospital care is absolutely the most appropriate place for them to be. However, we know that there are a considerable number of admissions for conditions where alternatives should be available. These include admissions for ear/nose/throat infections, kidney/urinary tract infections, angina, diabetes, epilepsy and high blood pressure. These equate to approximately 16,000 admissions annually.

Design and implementation of standardised frailty pathways are underway across the sector. These will link with the virtual ward and acute front door frailty models, ensuring that where possible, frail patients can be treated in alternative settings to hospital beds. This will be aligned with improved resources for care homes, supporting them to manage patients in the home and avoid preventable ambulance conveyances to emergency departments.

Another focus is on end of life care pathways, increasing the use of Advanced Care Planning and use of the London Urgent Care Plan, which will allow services to access information about patients assessed as being in their last year of life. Emergency Departments are increasing the use of these plans, assisting with the co-ordination of patients by services across healthcare settings so that they are supported outside of hospital rather than admitted.

Likewise, a hospital at home service for children is in place across the sector, which since being implemented has been able to demonstrate a reduction in hospital admissions and emergency department attendances. It is absolutely right that many residents have an inpatient stay, however, we know that prolonged inpatient stays beyond the curative are often damaging to patients with significant impacts that can increase their length of stay in hospital and increase the challenges when returning home. This includes physical deconditioning such as loss of muscle tone, greater confusion and vulnerability with a prolonged stay in an unsuitable environment and exposure to hospital acquired infections.

Ensuring that residents are discharged in a timely fashion

Inpatient admissions, while often appropriate, can nonetheless be disruptive for individuals. Prolonged stays in particular can make it harder for residents to return home. For example, prolonged bed rest can result in a loss of muscle tone, and/or increase confusion among those already experiencing cognitive decline.

According to acute data, since April this year between 12%-14% of acute beds across NWL are taken up with residents that do not meet the criteria to reside.

The number of people waiting for treatment

Insufficient capacity leads to an increase in those waiting – in emergency departments, in the time ambulances spend waiting outside emergency departments to handover patients, and for planned care. This has been exacerbated by the rebound in care following the pandemic, and by industrial action by some of the clinical and/ or professional groups staffing our hospitals.

North West London routinely increases bed capacity during winter to meet the pressures that increased demand and clinical acuity bring. To increase ongoing resilience at particularly challenged hospital sites NHS England has released £26m capital funding for new wards in North West London, 28 beds at West Middlesex and 34 beds at Northwick Park. This will enable the sector to move towards achieving a bed occupancy of 92% during winter 2023/24.

This in turn will reduce the waits that patients experience in emergency departments, enable ambulances to offload more swiftly and get back on the road with the impact that patients will spend less time waiting for an ambulance in the community.

The majority of those waiting for planned care, however, are waiting for outpatient treatments; and of those waiting for planned inpatient treatment, the majority are for day case care. The backlog in specialties requiring significant numbers of overnight beds is being address through elective centres (e.g., the elective orthopaedic centre at Central Middlesex for hip and knee replacements).

Conclusion

In terms of number of beds required, these factors push in different directions. Population growth and aging increase the demand for beds; technology and new treatments can do either, but generally push downwards; less intensive settings, alternatives to admission and ensuring residents return home swiftly reduce the demand. The strategy addresses how we can meet the challenges, and ensure that our acute bed provision remains fit for purpose.

ICS Strategy

Although significant progress has been made in addressing the challenges in the acute hospital system following the pandemic, we know that our residents don't always have an optimal experience of care when they need it. They don't always find it easy to access timely clinical advice, whether for an urgent or non-urgent need, and waiting times for elective services remain long. Elective services describe those hospital services where a referral is made, either by a healthcare professional or yourself. Significant volumes of patients are waiting over 52 weeks to be seen; this can result in people suffering a deterioration in their health and quality of life and can place additional pressure on the primary care system. Residents don't always feel that their care is joined up; some hospital visits could be avoided, opportunities for residents to take control of their own follow-up care are not always available, and integration of specialist advice into primary care is not always consistent. This leads to variation in the quality of care and clinical outcomes experienced across our sector.

Our aim is to deliver consistently high-quality care, on a par with the best cities globally, for residents of North West London and to deliver the best hospital care in the UK by ensuring that we meet the following key objectives:

- Ensuring that residents have routine access to specialist expertise
- Significantly improving access to surgery (inpatient and day cases) to reduce waiting lists
- Ensuring that residents have convenient, effective and timely access to diagnostics
- Significantly improving urgent and emergency care to reduce delays
- Ensuring that residents experience the same quality of care regardless of where they receive it, by identifying and reducing the causes of any varied experience
- Ensuring the appropriate reprovision of acute estate, starting with the four hospital sites in the national New Hospitals Programme.

Routine access to specialist expertise

Traditionally, the first non-emergency contacts a resident has with the hospital is through an outpatient appointment. The pandemic demonstrated different ways of delivering these services, whether by telephone, video call or by providing specialist advice to a GP. We will develop this further, focusing on ensuring rapid access to specialist advice and support regardless of where this is delivered. This may take the form of:

- direct GP and patient communication via email
- a virtual appointment or
- an in-person appointment which could be delivered in a community setting as well as in a hospital.

This will significantly shorten the time taken for patients to be seen, reducing waiting lists and ensuring a much quicker resolution of any condition or ongoing treatment.

North West London ICS is developing the use of digital tools to support more effective and efficient delivery of care. In dermatology we are piloting the use of digital image recognition to support the rapid identification of patients who may have skin cancer which, if successful, will release clinician time to support treatment. Across all our outpatient services we are also piloting the use of technology to automate manual administrative processes which, if successful, should improve our patient-facing services around booking and rebooking of appointments.

North West London ICS has rolled out an Advice and Guidance system for many of our hospital services, connecting GPs with specialists directly. There is scope to significantly expand this to a wider range of specialists and geographies. For some patients this may mean that a specialist can virtually ‘join’ an appointment with their GP (for example through a video link), or it may mean the GP and specialist work together to agree the plan to support a patient.

In other instances, routine specialist care may be delivered away from the traditional outpatient building in a hospital and make use of local care hubs.

Some services require very specialist equipment or teams, and these are likely to remain in traditional hospital settings.

We will work with patients to develop new ways of communicating and working with users. We will do this by developing effective digital tools that support reliable, accurate and timely communication, whilst ensuring that residents who are unable to use digital tools are provided with equivalent support.

Improving access to elective surgery – day cases and inpatient cases

The COVID-19 pandemic has had a significant impact upon the residents of North West London and our hospitals, with waiting times remaining significantly increased since it began.

Across North West London the four acute Trusts are working together to identify where theatres and staff can be used more effectively e.g. by reducing cancellations on the day of surgery, by using data and analytics to optimise scheduling, by reducing length of stay, and by sharing resources and expertise across sites.

As highlighted by the national Getting It Right First Time (GIRFT) programme, there are three key steps to improve quality and productivity for high volume, low complexity surgery. These are:

- separating elective and non-elective surgery
- increasing day case surgery rates
- improving the utilisation of asset such as operating theatres, x-ray equipment and other complex equipment, increasing theatre productivity and creating more efficient care pathways.

Separating elective and emergency work reduces the risk of cancellations and the risks of infection.

For example, we are currently developing an elective orthopaedic centre, which will bring together patients and specialists from across North West London in a purpose-designed centre with the goal of delivering rapid access and world-class clinical outcomes.

The elective orthopaedic centre will be part of an improved end-to-end pathway for musculoskeletal disorders. This draws upon best practice from other parts of England where the establishment of dedicated elective orthopaedic centres has led to improved clinical outcomes and has enabled more orthopaedic activity to be undertaken throughout the year, helping to reduce waiting times for life-changing joint replacements.

Convenient, effective, and timely access to diagnostics

Timely access to appropriate diagnostic tests is key to ensuring that any treatments can happen as quickly as possible, or any problems can be excluded. Improvements can be made in several places:

- Starting in primary care, GPs will be supported with Clinical Decision Support (CDS) electronic tools that help direct referrals to the most appropriate place and ensure that results are rapidly available to both GPs and patients.
- Once referred for diagnostics, electronic systems such as Swiftqueue allow patients to organise and modify their own appointments online at their convenience. They also support electronic scheduling systems to improve the use of diagnostic equipment. Again, cross-North West London working in hospitals allows for patients to receive care

as quickly as possible, ensures that there is no unnecessary duplication of tests and cuts out unnecessary travel for patients.

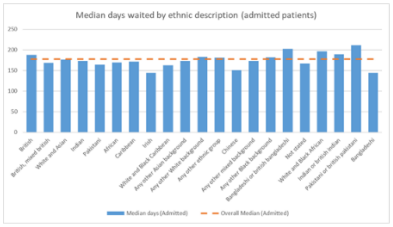
- We will continue to explore the use Artificial Intelligence (AI) tools to support diagnostics and ensure that specialist staff capacity is used effectively. To help achieve this, an AI strategy is being formulated and pilot initiatives rolled out.

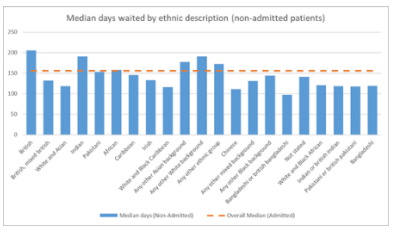
In liaison with specialist cancer providers (see below) delivery of the Cancer Faster Diagnostic Standard (FDS) through improving care pathways will be prioritised.

Community Diagnostics Centres (CDCs) are being established to provide additional capacity and more accessible diagnostics in Wembley, Willesden, and Ealing (all areas of high health need).

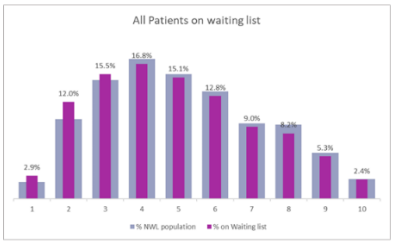
Improving quality of care and reducing variations in quality across North West London hospitals

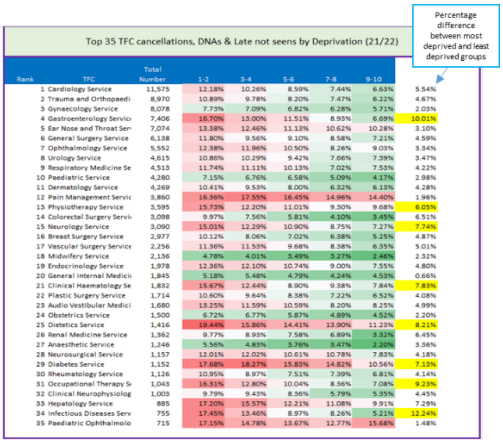
We will continue to work together to review and monitor data about access to care (including waiting times) and quality of care. Our aim is to achieve consistent standards in quality of and access to care across our population, regardless of where an individual lives or their background. An example of how we are doing this is set out below.





Data shows that there is no significant difference in waiting times for elective care across different ethnic groups. There is slight disproportionality in the percentage of patients on the waiting list in North West London from deprivation deciles 1-3 compared with the total population accounted for by this group of patients…





…However, we have identified variation in attendance at appointments between different ethnicity and deprivation groups, and we are now seeking to develop interventions that will better support our population to access elective services.

Today, we can view a single waiting list for North West London and ensure that patients are offered equitable treatment, including offering earlier appointments at other hospitals, where this is clinically appropriate.

We have established clinical networks and communities of professionals to share information and best practice across North West London, and to develop new, more collaborative ways of delivering care. We will continue to work with our local universities and researchers to build upon North West London's esteemed position in research and development.

Across our acute system, we will have a consistent and standardised approach to our digital infrastructure to allow for seamless end-to-end care for our patients and sharing of information. All our hospitals will have a common electronic patient record by the end of 2023 providing a solid building block for this. We will look at ways of harnessing digital

and technological developments and innovations to improve systems and processes within hospitals.

Always here for you in an emergency

The current urgent and emergency care system is clearly under pressure with very long waits for patients in primary care, at urgent care centres and in A&E departments. Reasons for this include:

- delays in discharging people from hospital beds who need social care and ongoing support
- internal hospital systems which add to delays e.g. not discharging people until later in the day, difficulties in patients receiving their drugs to take home, not planning for discharge early enough
- blockages in A&E due to the above which then lead to delays in ambulances offloading patients
- people with severe mental health problems being cared for in an A&E department rather than a dedicated mental health facility
- delays in ambulance staff being able to contact other services who could look after people at home rather than taking them to hospital
- large numbers of people attending urgent care centres and A&Es due to difficulty accessing a GP appointment
- lack of sufficient support for older and frail people to be cared for in their own home/care home rather than taken to hospital
- a plethora of choices for different types of services. This can be confusing to people who need care but lack the information or time to identify the best place to go.

We are currently seeking to invest resources to address these challenges, but we also need to undertake a holistic review to ensure we are making the best use of facilities and staff, and supporting systems to better respond to urgent and emergency care needs. Services will have sufficient capacity to meet with demand, along with a commitment to efficient working and high clinical standards to reduce the time that patients spend on each stage of their urgent care journey.

Urgent and emergency care services must work closely with other services, such as primary care, mental health care, community healthcare and social care, to ensure that urgent care is delivered in the most appropriate way possible.

This could be through A& E, for patients who need specialist services or inpatient care. For patients who require more extensive investigation and treatment but not necessarily admission to hospital, same day emergency care departments are able to carry out a range of diagnostics, bring in specialist support and, if required, review patients at the same time for multiple conditions. North West London ICS are extending these services, allowing them to treat more people, take on different conditions and open for longer hours, taking pressure from hospital emergency departments.

Options will be available for patients not in an emergency but requiring prompt support. This could be through an urgent care centre where GPs and nurses can provide primary

care for minor illnesses and injuries or it could be through a primary care centre, bringing together GPs and expertise from district nurses, physiotherapists and pharmacists.

We are working closely with the London Ambulance Service (LAS) to ensure that 999 calls are answered quickly and that patients who require an ambulance receive one promptly. North West London ICS will work with the LAS to ensure that options are available to people who require care but don't need to be taken to A&E.

The 111 service provides advice to people over the phone, making appointments in primary care and booking patients into an urgent treatment centre. 111 can also make referrals to other services such as community nursing.

Patients with mental health conditions will receive prompt assistance from specialist services. Dedicated service models are being developed for babies, children and young people, older people, and those on end of life care pathways.

North West London ICS is committed to learning from the best examples of care, nationally and internationally. It will work with all urgent emergency care (UEC) providers to achieve a consistent and high level of service so patients, wherever they are, will be met with the care that they need.

Ensuring the appropriate reprovision of acute estate, and the impact of the government's decision to postpone work at St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital

Four of London's acute hospital sites are part of the national New Hospitals Programme – Hillingdon Hospital, St Mary's Hospital near Paddington, and both Charing Cross Hospital and the Hammersmith Hospital in Hammersmith & Fulham. We are in the process of developing and securing approval for the business cases for each of these sites. A separate PowerPoint covers the response from the trusts.