NORTH WEST LONDON HEALTHCARE COMMISSION

PROCEEDINGS

at a

REVIEW OF THE NORTH WEST LONDON HEALTH ECONOMY

arising from the

IMPLEMENTATION OF SHAPING A HEALTHIER FUTURE

held at

HAMMERSMITH & FULHAM TOWN HALL,
KING STREET, HAMMERSMITH, W6 9JU

on

SATURDAY 14 MARCH 2015

Before:

Mr Michael Mansfield QC **In the Chair**
Dr Stephen Hirst
Dr John Lister

Ms Katy Rensten, Counsel to the Inquiry, instructed by Birnberg Peirce & Partners

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THE CHAIRMAN: Good morning. May I introduce myself, first of all. I am Michael Mansfield and I am chairing the first session of four sessions of the independent Healthcare Commission for North West London. May I also introduce the two extra judges, as it were, on the panel: to my right is Dr John Lister and to my left Dr Stephen Hirst. They are doctors in different fields, as you may be already aware.

Just introducing the other personnel who are in front of me. To my right standing up is Katy Rensten. She is in fact counsel to the inquiry. It is not the normal way in which proceedings go. May I say straightaway these are quasi judicial proceedings. Obviously, we have not been imbued with the usual statutory authorities but, nevertheless, we are going to conduct ourselves as if we were a judicial inquiry. Katy Rensten will be introducing the witnesses and also introducing their evidence, although they will be giving it from just in front of me. To her left is Maria Willis Stewart from the solicitors Birnberg's who instruct Katy. We are independent of the Councils who have set this up. There would be no point in us just being mouthpieces for them and we have a very specific task to do. Just before Katy introduces the session today, we have got a timetable. We are starting a few minutes late to give people grace to get into the building and find this particular chamber. We are going through until 12.30 lunch time. We have a lot to get through. We will have a mid-morning break. We may have to judge it in terms of if we appear or you appear as if you need one and then obviously we will take five or ten minutes. The questioning will not only be led by Katy Rensten, but, obviously, we may have extra questions and there will be time for us to ask those and they will be asked directly.

Finally this, it was clear to me when I was approached to do this particular job that if we are going to be independent we ought to stand back a little bit and there were three things, and they are rather obvious questions, that need to be asked, and I am certainly focusing on these questions. More detailed material clearly will come to light, but if you stand back, the three priorities seem to me to be we need to identify, I am going to call it the constituency, I do not mean the political constituency, I mean the demographic constituency of these particular boroughs because they are all different, so we need to identify who constitutes that hinterland in each of those areas because they are different. Secondly, what are the needs of the people who live in that particular constituency, because again they will differ. The third question is how are they best met. Of course that involves asking are they being met at the moment; will they be met by, for example, *Shaping a healthier future*. So that is how we are approaching the task, but each of the three of us will probably have very different perspectives on the questions we want to ask.

Having said that, may I call upon counsel to make some introductory remarks.

MS RENSTEN: Today's hearing and those which will follow form part of the Commission of Inquiry that had been jointly commissioned by the London Boroughs of Brent, Ealing, Hounslow and Hammersmith & Fulham. The focus of these hearings, as you have heard, and of the Commission as a whole, will be the long-term as well as the immediate impact of the *Shaping a healthier future* programme for the provision of health services which is currently underway in North West London.

The background to this is that in 2009 work began on a programme, the purpose of which was intended to shape a strategy to provide sustainable, high-quality health services

throughout the region. The premise upon which this work was commenced was that there was a pressing need for change based on the increasing healthcare demands of a rising and ageing population and that there was unacceptable variation in levels of service across and within the region's hospitals and other facilities. It was said that to do nothing was not an option.

In late 2011, this work evolved into the *Shaping a healthier future* programme. There then ensued a pre-consultation phase, during the course of which the bodies involved in the process gathered information and arrived at a series of what they considered to be the possible options for change. These were then whittled down to three potential options which became the subject of a public consultation in July 2012.

The broad thrust of the proposals presented for consultation was that whilst five of the nine hospitals in the region were to continue to provide the full range of services, including accident and emergency facilities, the remaining four were to adopt reduced or more specialist roles. The changes to acute hospital services were to be offset by the development of enhanced out of hospital provision and other associated services. The three options presented for consultation were all variations of this plan with the stated benefits envisaged being those of increased quality of care, improved access to care and cost benefits.

In February 2013, the decision-making business plan setting out the projected costs and the cost-benefits of the proposal was published and the Joint Committee of Primary Care Trusts, which was the then decision-making body, approved the programme.

Over the course of the consultation and following the adoption of the proposal subsequently chosen there ensued a considerable degree of controversy which generated a number of reviews and reports in which divergent views were expressed about both the decision-making process and the substance of the programme itself.

Following a formal referral by the Adult Services arm of the London Borough of Ealing in March 2013, a review was undertaken by the Independent Reconfiguration Panel at the behest of the Secretary of State. Although identifying some areas of uncertainty and making some recommendations, the Reconfiguration Panel broadly endorsed the proposals for change. Implementation of the proposals then began and has since mid-2014 been in the process of being rolled out across the region.

By December 2014, when this Commission was established, a number of key events, including the closure of the accident and emergency departments at Hammersmith and Central Middlesex Hospitals, the opening of the new accident and emergency facilities at Northwick Park Hospital and the merger of the North West London and Ealing Hospital Trusts had taken place. Further significant changes are taking place on a continuing basis, with perhaps the most obvious current issue being the planned closure of the maternity facilities at Ealing Hospital, a decision about which until very recently we understood was to be taken this week. That has now been subject to further delay.

The purpose of this Commission is to engage in a transparent, open-minded exchange with all interested parties to examine the decisions made thus far and to look afresh at whether those decisions and the plans arising from them are indeed those that are best

able to provide the optimum available healthcare and linked social care services for the residents of this region, or if, upon fresh examination, there are other alternatives which might be as good or better and which merit exploration.

Given that the implementation of *Shaping a healthier future* is well underway and that many of the planned changes are already in mid-stream, the emphasis of these hearings will be on the aspects identified by the commissioning boroughs as being of the most immediate and most critical importance to the residents of the region.

It will surprise no-one that chief amongst these are the changes to A&E and acute services, the closure of the maternity unit in Ealing, the perceived lack of progress in the provision of out of hospital services and the financing of the programme. The Commissioners are, as you have heard, keen that the voices of as many of the individuals or organisations that wish to be heard in the process can be.

So with that in mind and with the permission of the Commissioners, may I now call Mr Andy Slaughter as the first witness.

Witness: MR ANDY SLAUGHTER, Member of Parliament for Hammersmith

Examined by MS RENSTEN

Q. MS RENSTEN: Could I ask you please, first of all, to give your full name and professional address to the Commissioners.
A. (Mr Slaughter): My name is Andy Slaughter. I am the Labour MP for Hammersmith and therefore my business address is House of Commons, London SW1A 0AA.

Q. You should have in front of you right at the bottom of that pile of ring binders a bundle labelled Volume 5 and the very last document in that bundle at page 1741 should be your submission.
A. Yes.

THE CHAIRMAN: Could I just ask if you could kindly keep your voice up. The acoustics are not bad but you are quite softly spoken on occasion. I do not know whether the microphone is working.

Q. MS RENSTEN: Nobody is quite sure whether the mic works to amplify or record.
A. I will speak loudly in any event.

Q. Is that statement true to the best of your knowledge and understanding?
A. It is.

Q. And do you wish it to stand as your evidence to the Commission?
A. I do.

Q. I would like to ask you first very briefly about the consultation phase. You were the MP at the point the consultation was taking place. If we turn please to paragraph 8 of your statement, what you say there is that in your view there was no genuine attempt to engage with the public. How would you characterise the consultation process?

A. I think the process here is quite revealing about the substantive proposals as well and I will try not to take too long, but if I could perhaps briefly set out my experience because I have obviously been following this from June/July 2012 when the original proposals were published. They clearly had, and you mentioned in opening that there had been a pre-consultation phase, but I think that had been relatively low key and I think it was a surprise when the McKinsey documents, which were only made available on the day they were published, and these were several very large volumes, at the meeting of what was then the Joint Committee of Primary Care Trusts at Central Hall Westminster, took many people by surprise because of the radical nature of the proposals. There then followed between then and February 2013 what purported to be a public consultation process but which, on reflection, I think the general view, certainly of my constituents and in my own experience it was a box-ticking exercise which did its best to minimise the opposition, and that ranged from, and I had my own experience, being quoted as saying that I had myself been consulted at an early stage and had given an opinion through another MP at a meeting which I did not attend, which was completely false, to the fact that petitions with several thousands, I think in some cases several tens of thousands of signatures opposing significant parts of the proposal *Shaping a healthier future* were treated as one representation so they would have counted alongside one person who had filled in the standard questionnaire even though there might be 20,000 or 30,000 people had signed that petition. One of the reasons why people preferred to sign petitions or to write their own letters or to sign their own petitions was because the questionnaires and the way the process was carried out was seen to be biased. It was seen to push people towards a particular view.

Q. Can I ask you then to encapsulate whether or not you were able to form a view as to whether information about the proposals and the consultation reached all groups of your constituents?

A. No, there was an original promise, I think, that all households, and we are here talking about I am not quite sure how many households but we are talking about two million people within the catchment area of nine hospitals, would receive a leaflet of some kind through the door. Without informing anyone that a change had been made, it was then decided by I think it was still the Joint Committee of PCTs that that would be too expensive to do and therefore that was not done, and therefore the only way that constituents were informed, unless they were informed by campaigning groups, was through on-line methods or through advertisements in local papers which do not have a very high circulation.

Q. Are there any particular groups of constituents that, in your view, news of the consultation did not reach?

A. The reality is, and it may sound surprising, it reached very few constituents and I think it took well beyond the close of the public consultation process, probably into late 2013/early 2014, before there was a general awareness amongst the population, and I can only really speak for Hammersmith here, but it may well be true elsewhere, who understood the magnitude or the nature of the proposals. However, I think to answer your question more directly, those groups who did not have on-line access, who were not receiving perhaps communications or were not sufficiently computer literate to do that, those groups who would find it difficult to understand information because perhaps they had English as a second language, perhaps were elderly, were more likely, in my experience, not to have understood what was happening, but it was a general malaise.

Q. Just moving on please, to paragraph 9, you refer there to constituents frequently mentioning to you feelings of being disregarded. Can I ask you whether that comment relates just to the consultation period or is that something which is still continuing?

A. I have to say part of that experience is not just my ordinary job as an MP, which obviously brings me into contact with constituents on a daily basis, but through actively participating in the campaigns which meant certainly up until very recently spending a couple of hours every Saturday talking to constituents in Central Hammersmith about this as part of the awareness-raising exercise that Save Our Hospitals has done. People felt the decisions had been made and that their opinions, it was almost not worth bothering because the decisions had been made and they were going to go ahead and hospitals were going to close or services were going to shut down and there was little that could be done about it.

Q. I want to move on to consider Hammersmith Hospital. Of course the accident and emergency was shut on 10 September 2014. You will see Volume 2 in front of you and what I am going to take you to is a letter from Dr Tim Spicer, who is the Chair of the Hammersmith & Fulham Clinical Commissioning Group. I am just going to ask you to comment with your views on some of the things that are said in that letter, if you would not mind. It is page 585 of that bundle. If you turn on to page 589, what you can see there is Dr Spicer is setting out the reasons for the closure of the A&E department at Hammersmith Hospital and what he says in brief terms is that the emergency department was small, there were not enough senior clinicians and there were difficulties in recruitment and, in essence, he says it was unsafe. That is reiterated elsewhere, and I will not take you to it, but what he says is that because of that it took priority over the original plans to keep Hammersmith A&E open until the out of hospital services had been put in place. Can I ask you please to comment on that analysis as to whether or not the safety issue was in fact correct?

A. That is an argument that was raised both in relation to Hammersmith and the Central Middlesex and indeed the Central Middlesex A&E became not a 24-hour service, it was a daytime only service and that was the reason that was given. Various explanations were given as to either the level of cover, the ability to recruit staff or the level of not competence but level of qualification of staff at Hammersmith and Central Middlesex. That seemed often to be a self-fulfilling prophecy and the same fears which surrounded Hammersmith and Central Middlesex now surround Charing Cross, which is to say that the certainty with which it was stated from day one and the *Shaping a healthier future* programme that these A&E departments would be closing meant that it became obviously more difficult to recruit staff, that the organisations saw less reason to invest in them in that way and, therefore, I do not feel I have the clinical knowledge to say on a day-to-day basis what was the level of competence or staffing at a particular A&E department but I think it is indicative of the poor way in which the process has been handled that, by Dr Spicer's own admission, closures were happening earlier than was desirable because, in their own terms, services were not up to scratch. I have to say my own constituents' experience is that they value the services at Hammersmith Hospital. It serves one of the poorest communities in the country and I have had very few, if any, complaints about the service there.

Q. I also want to ask you about another issue which he raises. He states that there is a 24-hour Emergency Care Centre now open at Hammersmith Hospital and that there is a

route for transferring any emergency treatment which cannot be handled there at either St Mary's or Charing Cross or Chelsea & Westminster. First of all, can you help us with what, if any, information you have got about the operation of that Urgent Care Centre, what does it do and what are your constituents saying about it, briefly if you will, only because of the time pressure.

A. It is slightly more complicated than that because there are emergency cardiac facilities at Hammersmith and indeed blue light emergencies are still diverted there. So it is slightly more complicated and part of the confusion of people still not knowing what services are available at what hospital includes road signs being still up after the closure of the A&E saying there was an A&E there and the way that the public relations exercise around the closure went which refused to use the word "closure" and just said that "services are changing" means that there is no certainty among people as to where to go for care. My understanding is clear, that the Urgent Care Centre there does not any have emergency consultant cover. It has either GP or nursing cover and it effectively provides the same services as urgent care or walk-in centres anywhere else.

Q. That being the case, do you have an understanding about there being any transfer arrangements in place for patients who need to move on to A&E?

A. All I can say about that is that clearly, as it is a 24-hour service, if someone arrived at any point, and I say that advisedly because I know that elsewhere there have been tragedies where individuals have gone to A&E or urgent care centres which were not 24 hours and there has been a delay in transfer, I am assuming as a simple administrative process that if someone arrives and is unable to be treated there then an ambulance will be called and they will taken probably to St Mary's, but I do not know any process beyond that.

Q. Finally on that, can I ask you to comment on the conclusion that Dr Spicer draws that the changes at Hammersmith Hospital have resulted in a safer sustainable urgent care centre for local residents"?

A. I am talking on a daily/weekly basis with residents in the Old Oak/White City areas who are the immediate catchment area for the hospital. They are not just extremely unhappy. They are extremely worried that they no longer have emergency services, they no longer have an A&E which is accessible to them. There is very low car ownership and very high levels of chronic illness and disability in that area. I find that an extraordinarily complacent statement. I think he should also look at what the knock-on effect has been to the surrounding A&Es including Charing Cross post the closure on 10 September.

Q. Can we in fact now turn to Charing Cross. Obviously there is a plan to reconfigure the Charing Cross site. Can you help us with your view about whether the demolition of the existing buildings is necessary or not?

A. The buildings, which I well remember being built some 40 years ago, there have from time to time been statements about what remedial work will need to be done, and it may well be that that is the case in relation to a building that is 40 years old. But it is purpose-built hospital. It is one of the largest hospitals in London. It is 40 years old. As far as I am aware, other than what is in *Shaping a healthier future*, ie the plan for the reconfiguration of services, there is no reason to demolish that building. Indeed, it formed part of the assessment part of the options as to whether that building could be retained, albeit to provide only the primary and other care services which *Shaping a healthier future* envisages.

Q. In relation to the facilities which are said to be put in place, can you briefly give us your view of the impact of the reduction in beds proposed?
A. The impact on in-patient beds, there are other beds, but in-patient beds, which is a primary concern is of over 90%. There will be some increase of beds, we understand, at Chelsea & Westminster and St Mary's but there will still be a net loss of several hundred beds.

Q. And in relation to the loss of the hyper-acute stroke unit which is moving to St Mary's?
A. Which has been rated the best in the country which works very well on that location, and it is a good location in the catchment area it serves, going way up into West London which in terms of travel time is important. If it moves to St Mary's, even assuming there is no loss of service there, it still is greatly to the detriment of those who live in my constituency and further out.

Q. And in relation to the closure of Charing Cross Accident& Emergency in its current form, whether it is consultant-led or GP-led, if it becomes an urgent care centre is it your view that it will fulfil the need of local residents?
A. Absolutely not. This is the crucial point and the obfuscation around this point I think is one of the most troubling aspects. That goes right up to the Secretary of State and beyond in terms of using phrases such as "A&E" albeit of a different shape or size. It is very clear from the proposals put forward at the moment that, whatever it is called, whether it is called an emergency department, a Type 3 A&E or an urgent care centre that there is no emergency consultant cover on site and, specifically, when I asked the question what differences could there be between the emergency department on the Charing Cross site under the *Shaping a healthier future* and an urgent care centre I was given only three differences. One is that there would be 24-hour GP cover (because 24-hour GP cover is not guaranteed at urgent care centres) and there would be x-ray facilities there and there would be some, although I think this is a particular feature of the Charing Cross site, there will be some recuperation beds, so that if elderly people came and were treated for effectively outpatient treatment they could stay in for a day or two rather than going home, not features of ordinary urgent care centres, but, beyond that, there is nothing which will associate this with what an A&E department will do.

Q. Very briefly, thinking about the financial implications, the suggestion is that there are financial benefits to be gained from the sale of the freed-up land. What is your view of the benefit that that will bring, presuming that that funding goes back to Imperial College Healthcare Trust and the NHS?
A. This is a material aspect in which the plans have changed and on which there has been no further consultation. The original plan was to clear the entire site of Charing Cross, as I understand it, save for possibly some query over the buildings that Imperial do not own. Now part of the land will be retained to build new primary care and other facilities and the additional capital receipt will come from the sale of 50% of the St Mary's site. Some estimate has been made of what that receipt will be and they are substantial sums of money, although they do seem to me, knowing the property market locally, on the low side. Clearly, that is an important part of Imperial Healthcare Trust's development strategy, their site strategy. It was a significant change that was never consulted on, never advertised between the publication in February 2013 of the proposals for the future of the

Charing Cross site which were in the hands of the CCG and what effectively happened thereafter which is that Imperial took over and its blueprint for the site is now what is going forward. They both involved the loss of emergency consultant services but the actual land use and configuration of what goes on the sites is very different and that has never been consulted on.

Q. I just want to look at the other side of the coin very briefly because the other side of the coin to the reduction of acute services is the improvement of provision of new primary services. On the information you have can you give us in a nutshell what you think the state of the GP services in your constituency is at the moment?
A. We have very good GPs in the constituency. Traditionally, we have the problem that there are a number of older premises and sole practitioners and we have tried slowly and gradually to move towards larger units like the new Parkview Centre that has opened, like the Park Medical Centre and so on and so forth. However, those services are under severe pressure, as they are elsewhere, and waiting times for appointments are substantial and there are substantial additional pressures and they may come from nursing homes, they may come from the elderly population, they may come from the fact there are very strong ill-health indicators in the population here and they are unable to cope.

Q. What would your view be of the impact of them taking on an increased role?
A. I just do not think and I am not even sure that the Health Service claims that they are able to do that. The only change there has been in recent months is, I think, four surgeries are now offering late evening or weekend appointments. That has been introduced at short notice in response to the closure of Hammersmith and Central Middlesex. Of course it is to be welcomed, we welcome any increased hours GPs are open, but it is a fire-fighting operation.

Q. I want to ask you about that because in fact Dr Spicer, and this is at page 586 of the bundle there talks about investment in primary care as being in the sum of £4.45 million, setting up a seven-day a week GP surgeries, organising access to clinical specialists and investing in mental health services and integrated health and social care initiatives and I wondered if you were able to comment briefly, and I think you have already started to in some ways, on whether or not on the ground you have seen any changes as a result of those initiatives?
A. I welcome those improvements, but they are pretty *de minimis* compared with the proposals that are being taken forward. They are only happening now after some closures have already taken place, and I think that would be conceded, that this is all happening rather late in the day and they do not address the central concerns which is that the capacity needed for A&E services is there, the problems with personal and social care are there, and the pressures on GP services are there, and none of those matters is being addressed. It is a moot point as to whether even if all those issues were addressed you would still be able to go ahead with the degree of reduction in A&E services. I do not think you would and I think that is a view that has expressed by the College of Emergency Medicine. I think the model we have here which is that you have GPs, urgent care and Type 1 A&E co-located at Charing Cross is the best model to use and the primary problem is one of capacity.

Q. Finally can I just ask you, what is your view about what should happen now?
A. I wish I could press a button and *Shaping a Healthier Future* would disappear entirely

because I believe it is an entirely faulted process that that has been partly cost-driven, and certainly is based on very shaky clinical evidence and has disregarded public opinion throughout, and indeed other opinion. We are where we are. At a minimum, what I would ask for is a full independent clinical review of the process and a proper public consultation. Neither of those I would have thought essential facts have taken place throughout this period. That makes it in the end an entirely faulted process. We have now reached a stage where, and the General Election is very close too, really it is impossible to get answers from anybody up to and including Government level. We are still awaiting the NHS England inquiry into the closures that took place in September. We are still awaiting part two of Keogh, which was supposed to justify the *Shaping a healthier future* model for the whole country. I think in the absence of a sound clinical methodology that it is dangerous, and quite wrong, to push ahead with these proposals. It is simply treating my constituents as guinea pigs.

MS RENSTEN: Would you like to wait there, there may be questions from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Can I thank you very much for your presentation. I have a number of questions which we are never going get in in the next six minutes. The first one is an observation that I would like to make on behalf of the Commission in relation to something you have just said, namely, I think we are extremely concerned about the fact that it appears that the run-up to an Election is making it difficult to obtain material, documents and answers to questions that we are asking. We do not wish to be in a position at the end of the day when we issue a report that we are going to be told, "Oh well, you didn't have all the information." The answer to that is we are not being given all the information, so we are very concerned about that. I would just on behalf of the Commission issue an urgent request to those who know please to provide material so that the public may know what it is we are basing our opinions on. That is just an observation.

The second observation is I did not at the beginning make it obvious but it probably is, that as Commissioners we do have reports and statements from all witnesses including this one, some of which obviously we will not be able to hear and we will just read. But my main question relates to paragraph number 11 in your statement. I am going read just this sentence in case others have not got it although these all be will made available. This is how you put it: "We are trying to implement major change on a system that is currently broken, and on organisations which, in many cases, have gone through repeated management change, and which suffer from high staff turnover and low staff morale. So the question is this and it relates to that part of the observation about a system that is currently broken. I think one of the observations put in the opening was "doing nothing is not an option", so really if the system is broken, for whatever reason in the past, how is it going to be mended? Is it yet more consultation, as you have suggested, or is there something beyond the consultation which you see should be the objective here?

A. Absolutely right, I would just say that I do preface that paragraph by praising the job that the staff are doing. I want to put that on record because I make no criticism of the nursing and other clinical staff who are coping, I think, with an extraordinarily difficult situation. To answer your question, there is an agreement, I think, between all parties that

A a number of the proposals that are in *Shaping a healthier future*, or which are implied by that, are sound principles. Integration of health and social care, the ability to try and end - a terrible term - bed-blocking; the ability to try and triage better so that people go to the appropriate type of emergency service in that way, and a lot of good work is done on that. The difficulty is that the way that *Shaping a healthier future* is being implemented militates against that in many respects. For example, the loss of the majority of in-patient beds at Charing Cross is clearly not going to help the situation with A&E services because a large part of the problems with A&E is people who have to be admitted but there are no beds available to go into. Equally, some, as I say, "fire-fighting" increases in GP services are not going to provide the alternative in so far as it is applicable in primary care services. I think there are two things happening with *Shaping a healthier future*. Firstly, insofar as it is right, it is not doing what it says it should do. Also the elephant in the room really is its basic premise, which is that you can have this huge reduction in A&E services and this huge centralisation in A&E services, which is not in any way proven and therefore that is what we have to look at again and what we are going to come up with, I think, at the end of that is yes, an increase in community services, yes, an integration of health and social care and, yes, hopefully a better integration of primary and hospital services, but still maintaining a sufficiency, both geographically and in terms of capacity of A&E services. .

D Q. I have another one I am afraid. It relates to triage in a sense. If I am a member of the public and I have an urgent situation in the middle of the night, this is related to urgent care centres, are there some kind of standard criteria? What is an urgent care centre? How do I know where I have got to go and who is going to be there and what are the criteria? It seems very fluid.

A. That is why I gave some of the anecdotal stories about road signs and notice of the consultation process. It is a huge problem. There have been significant changes before, for example paediatric emergency care was moved from Hammersmith Hospital to St Mary's about 15 years ago, and I still find people who are just getting used to that as a change. Changes of that kind take a long time to bed in. The terms of art or sometimes the terms of public relations that are used by the Health Service bodies do not mean anything to people, which is why people at the moment do not know where to go and therefore they will, to a large extent, continue to go where they have always gone. So people who have serious, whether it be chronic or acute conditions, will still walk into the urgent care centre at Hammersmith, and I worry about the level of care that people will receive as a consequence of that. That is not to be rude to people who run urgent care centres, but they do not have the same resources and same degree of qualification as those who are available in A&E departments. I think the bottom line is that people are going to get a second-class service, particularly poorer people, particularly people who are less mobile because they will not think, "Right, what I need to do now is get a taxi or get on a bus or couple of buses and go to St Mary's because then I will get the full range of treatment. I am just going to go to Hammersmith Hospital as I have always done and see what happens."

Q. DR LISTER: Just one thing. Right at the beginning you were talking about access to information about this in terms of the consultation. I do seem to recall some specific points were made about the availability of translations of the proposals and the extent to which the full details of the proposals were translated and made available to minorities. Would you like to add something on that?

A. Only to say I think that the point I made about the failure to inform all households - this is described by the NHS themselves as the biggest ever re-organisation programme in the history of the NHS - the idea that you do not inform the people who use those services, even basically by putting a leaflet through people's doors explaining how people, it may be people with a disability or people with English as a second language, if they cannot access that information, how they then access it, I just found extraordinary. I think it said a lot about the fact that decisions had already been made and opinions were not really being sought.

Q. THE CHAIRMAN: I have got one final question, I am sorry we are over-running by a little bit but we started later. One of the things I am interested in and I think we are all interested in, and you would be in a prime position to help, if one looked at your constituency, and I mean in that sense your political constituency as well as medical, how would you describe the needs of that constituency? I know this is a global question, but what type of constituency is it and what is it that needs to be met in that constituency?

A. Perhaps the defining point for the purposes of today is the fact that almost 50% of my constituents were born outside the UK. Although it has very wealthy pockets, it also has some of the most deprived area of the UK contained within it. It has high levels in the Census data of chronic illnesses, things like diabetes and HIV. It has a lot of people with what I would call multiple health problems who need a lot of attention and often attention that can only be provided at consultant level, which is not to say that lots of GPs do not do a very good job, but there are acute health needs there. The other significant factor is there is a turnover of various estimates of between a quarter and a third of the population a year, which means that people, far more so than other parts of the country, even other parts of London, are not registered with GPs. If they do fall ill their point of recourse is the accident and emergency department. That is one of the reasons why urgent care and indeed GP services are available at the accident and emergency department (or were until they were closed) because we are trying to anticipate that problem. There is nothing you can do about that. You cannot stop that population mobility. A lot of it will be, for example, poorer people, people seeking low-paid jobs, migrant communities. Their healthcare needs must be met and it is both more expensive and it requires a different type of response to a very stable community where people will go through a more orthodox process of simply going to their GP and being referred on.

THE CHAIRMAN: Thank you.

MS RENSTEN: Thank you, I am very grateful.

<u>The Witness Withdrew</u>

MS RENSTEN: The next witnesses we are due to hear from are from the Royal College of Nursing. I do not know if we have those people present, Sharon Bissessar and Laura Flanagan.

Witnesses: MS SHARON BISSESSAR, Senior RCN Officer and MS NORA FLANAGAN, RCN London Operational Manager, Royal College of Nursing

Examined by MS RENSTEN

Q. MS RENSTEN: Because there are two of you, please do feel free to answer the questions depending on who you feel you wish to answer the questions. Could I ask you first of all, please, if we start with the lady on the left, your name and your professional address and your current post held.
A. (Ms Flanagan): My name is Laura Flanagan and I am the Operational Manager for the Royal College of Nursing for London. My address is 20 Cavendish Square, London.
A. (Ms Bissessar): My name is Sharon Bissessar. I am a Senior Regional Officer from North West London for the Royal College of Nursing and my professional address is 20 Cavendish Square.

Q. In front of you, you should have a bundle labelled Volume 1. If you could please look at pages 3 to 6 and confirm that those are your submissions. Can you confirm please that that submission is true and accurate to the best of your knowledge and understanding? I think one confirmation will do.
A. (Ms Bissessar): Yes, it is.

Q. And that you wish it to stand as your evidence for the Commission?
A. (Ms Bissessar): Yes, we do.

Q. I just want to ask you first very briefly about your membership and the responses that they gave. Were the responses that you had received from nurses who were practising throughout the North West London region or from any particular area?
A. (Ms Bissessar): The responses we received both verbally and written were from nurses working across North West London in the community and in the acute settings, in some of the trusts affected as well as some of the surrounding trusts.

Q. So were they practitioners based in the full range of healthcare environments?
A. (Ms Bissessar): Yes, I would say so.

Q. And with differing levels of experience and expertise?
A. (Ms Bissessar): Yes, our membership covers a broad range of experience from healthcare assistants, who are unqualified, to very senior nurses working within North West London.

Q. So would you consider the responses as providing an accurate reflection of the views of nurse professionals in the relevant area?
A. (Ms Bissessar): Yes.

Q. I wanted to ask you first of all about the acute hospital environment. At page 4 of your submission, you set out details of the overstretching of accident and emergency over winter period and that Northwick Park has been on divert numerous times over that period. I wonder if you can help us. Can you expand for us on what happens to a patient when the site is on divert and how is a divert managed, please?

A. (Ms Bissessar): I would be happy to answer that. My professional background as a registered nurse is actually in accident and emergency and I have worked in four accident and emergency departments in North West London. Just to explain what a divert is. A divert is a request from a receiving trust for ambulances to avoid approaching the trust with a patient, and that is purely on the basis of capacity, whether it be through an emergency situation or not. So a patient has already called for an ambulance and that ambulance is told to go elsewhere. The issue within North West London is we found that the majority of accident and emergency departments are running at full capacity and some of them are over-capacity, so there is no real release valve for that ambulance, anywhere for that ambulance to go. What seems to happen now is that ambulances just queue outside with sick patients, vulnerable and very ill patients sometimes, sitting in the back of the vehicle and they are unable to bring that patient into the hospital for proper care and treatment.

Q. Can I just clarify, are you saying that rather than actually going on divert when a divert happens, they no longer divert, they simply wait?
A. (Ms Bissessar): Sometimes the divert as it is supposed to happen does not happen because there is no capacity for that ambulance to divert to.

Q. What is the impact on nursing staff at the site when a divert is taking place?
A. (Ms Bissessar): Generally when a divert is taking a place that department is already very, very busy. They are already running to full capacity and, as I have already mentioned, sometimes over-capacity. Our members have been reporting to us increasing levels of stress, of work-related stress, of concerns about professional standards and the care that they are able to provide. One of the senior nurses from Northwick Park actually mentioned that she is having sleepless nights now worried about the patient care she has delivered during the day because she is not able to deliver the high standard that she would like to on occasions when diverts are happening.

Q. What, if you could sum you please for us in your view, are the causes of that situation, diverts being put on?
A. (Ms Bissessar): The causes are generally due to lack of bed capacity within the system, so if a patient arrives at A&E, they are generally assessed, treated and discharged or assessed, treated and admitted to hospital for further treatment. If the patient has to be admitted to hospital and there are not the full capacity of beds for that patient to go to because of patients already there, then there is a blockage in the system and that blockage always backs up in accident and emergency, so if the beds are not available within that hospital unit there is nowhere for that patient to go.

Q. Your submission is dated, I think, 27 January. Are you able to assist with whether the pressures that you talked about at that stage have changed in any way since then?
A. (Ms Bissessar): My understanding from speaking to some at the trusts is that it changes on a daily basis. The trusts are generally working very hard to find capacity, discharge patients earlier than they might have discharged them before, to free beds for patients in accident and emergency to be able to move into.

Q. Are you able to say whether in fact the situation has got better, got worse or is more or less the same?
A. (Ms Bissessar): It is more or less the same.

Q. Thinking about the proposed plans for Ealing Hospital and Charing Cross Hospital, can you encapsulate for us your view of the impact that that will have first of all on patients. I am thinking specifically about the A&E departments; what impact will there be for Ealing patients?

A. (Ms Bissessar): Ealing A&E department is already very, very busy. The nurses have told me that the patients were already worrying about what is going to happen and the department has not shut yet. Those patients, if they become unwell or they suffer an emergency or an accident, they will have to make a decision as to where to travel to. There is a high level of concern about transport links and the lack of direct transport links to local hospitals. Patients already within the borough are confused as to whether to go to the urgent care centre at Ealing or whether they should go to the A&E department or whether they should go to another A&E department. There is so much confusion already. The staff are already concerned about this.

Q. What about what impact on nurses in that situation?

A. (Ms Bissessar): It is the same. The nurses have very serious concerns now about vulnerable and elderly patients actually staying at home and not looking to access care because they just do not know where to go or, if they do know, they cannot get there because some of the surrounding accident and emergency departments are quite hard to get to if you do not have a car, so if you need to take public transport and you cannot afford a taxi, they are very likely not going to go and then we will find sicker people at home rather than in hospital.

Q. I wanted to ask you in fact a little bit about the linked issues of the transport element of things and the urgent care centres. Can you help with your members' experience of patients arriving at an urgent care centre who then need onward transfer? Is that something which you know to be happening frequently or is it rare or what?

A. (Ms Bissessar): The units that I cover said that happens on a daily basis, and it does happen quite frequently. Sometimes the patients refuse assistance with transport to another hospital. I can give you a very personal example of my mother. She went to an urgent care centre in North West London and was requiring a 999 ambulance to be taken to an accident and emergency unit because they were so concerned about her and she refused. I had to go in the car.

Q. Can you help us with how the transfer is supposed to done between UCCs and A&Es?

A. (Ms Bissessar): UCCs historically were always meant to be nearby to an A&E department so the patients could walk over or there would be a wheelchair, but at the moment there is no formal system in place to enable patients to transfer directly from the UCC to an A&E. There is no taxi there. There is no ambulance sitting there waiting to take people. It is on a case-by-case basis. Some patients require a 999 ambulance and some do not.

Q. What happens if a patient arrives and is found to need A&E and it is not on the same site, is there a back-up plan if there is no ambulance available?

A. (Ms Bissessar): The urgent care centre that my mother went to, there was no back-up plan. There were no medics available on site at all so no senior doctors would be available to help my mother if she deteriorated.

Q. Can I just ask you because I wanted to see if something chimes with what you have said or not. There is a Volume 4 bundle in front of you. It is literally the fourth one down and I would just ask you to look, please, if you could turn to page 1239. That document is an anonymised document from an emergency nurse practitioner. If you flip over the page, about three-quarters of the way down the nurse practitioner is talking about being in a care centre and nurses sometimes paying for taxis for patients to have onward care. It is the paragraph just below the one your finger is on. Do you have that? Do you see that?

A. (Ms Bissessar): I have not come across that myself.

Q. I was going to ask whether that is something you have ever come across?

A. (Ms Bissessar): No, nothing I have come across.

Q. Does it surprise you?

A. (Ms Bissessar) It does not actually. It is quite desperate, is it not?

Q. Thinking about the transport difficulties, what is your view then about the need for accident and emergency units and urgent care centres to be co-located?

A. (Ms Bissessar): My view is that it is the most sensible option and it avoids disruption for patients who do not get it right. Patients do not know whether they have an emergency situation sometimes, the doctors do not know even when they arrive, so from my perspective they need to be nearby, co-located even on the same site to avoid any further disruption to patients.

Q. Although this may elicit an obvious answer, what are the risks if they are not?

A. (Ms Bissessar): They are life-threatening risks potentially.

Q. What are your members saying about the public's understanding of the difference between A&E and urgent care centres?

A. (Ms Bissessar): There is a lot of confusion out there. Some members of the public are very well informed, but for the majority of the boroughs that I cover the nurses are reporting that the public just do not understand.

Q. And in your view, are the difficulties in public understanding teething problems or more systemic?

A. (Ms Bissessar): I think it is more systemic than that. Many people in the public have received documentation through the letter box, there have been posters up at bus stops, all requiring good reading skills and a good command of English, and our members are saying that when patients arrive in A&E or in the urgent care centres they still do not understand where they should have gone; they have just taken pot luck.

Q. I wanted to ask a little now about the community and primary care settings which you say in your submission are also under strain. What do you say needs to be done in terms of resources and staffing levels to reduce that strain?

A. (Ms Bissessar): Increase it number one. The community areas that we cover are suffering high sickness rates, high staff turnover rates. I spoke to a very senior manager within the Ealing Borough two weeks ago who told me she had serious concerns about the vacancy rates for community nurses and for health visitors and the fact that she did not have enough permanent members of staff to care for patients on their current

workload.

Q. So the impact on nurses who are working in this environment is what?
A. (Ms Bissessar): It is quite negative to the nurses, but what they are concerned about is trying to ensure that patients receive adequate care. At the moment they explained that they do not believe that they have been resourced properly or invested in for at least ten years within that particular borough but yet their workload has gone up, they have to see more patients on a daily basis and because they have got more patients on their workload, they are spending less time, so there is possibly 15, minutes or ten minutes to a patient visit. How much quality time is that with a patient? They actually want to give more to people but they cannot do it.

Q. What, in your view, would the likely effect be if the GP services to which some of these nurses are allied were expanded to seven days a week?
A. (Ms Bissessar): The likely impact will be there will more people and more patients requiring community nursing services and at the moment those services are not there on a full capacity nine to five, Monday to Friday. We understand that some GP services within the patch have increased their working on a Saturday for example. Our practice nurses are reporting that they are having to increase their hours and some of them are working excess hours that are unpaid to meet the demand but that there is no back-up service within the community to provide, for example, dressings to elderly patients and injections and treatments to vulnerable patients or people who have mobility problems. It is just not there, so at the moment the impact is on patients having to be further inconvenienced, leave their houses and go back to accident and emergency or an urgent care centre to receive those treatments.

Q. Just thinking about the out of hospital services, within your knowledge and awareness, what new or enhanced services in the borough do you know of, in the region in fact?
A. (Ms Bissessar): There is one specific service that I understand has happened within Hammersmith & Fulham. In the community they have started to look at the community as a "virtual ward" and they have put into post new care co-ordinators, who are people who co-ordinate this virtual ward, so if you imagine a patient at home is a bed on the ward and that is how they are trying to co-ordinate that particular area. I do not know of any other new initiatives across North West London and I cover Hounslow & Richmond, Ealing, Brent, Harrow. I part cover Hillingdon. I do not know of any new initiatives in those boroughs.

Q. Bearing in mind that position, do you consider that it is currently safe or unsafe to reduce acute facilities?
A. (Ms Bissessar): At this current time I believe it is unsafe to reduce those acute facilities?

Q. What would need to be in place to achieve that aim safely?
A. (Ms Bissessar): We would like to see proper investment in community services. We would like to see proper testing of some of these new community services that we have been told about. There is no data at present to support that patients have received a benefit from any of changes so far, and we would like to see some of that data. We would also like to see the professional organisations around the table with the people

running the project to talk about the clinical impact on patients of these changes within the patch.

Q. Finally, I just want to ask you about Ealing Maternity Hospital. It seems now that the decision which was to have been taken on 18 March has now been put back again to May. Can you assist with what effect the delay rather than the decision itself is having on the nursing staff who are working there?

A. (Ms Bissessar): We have a good proportion of Royal College of Nursing members working in that unit and the delays have had such a dreadful impact on their morale. We have seen midwives actually leave the NHS to join agencies because then they feel they will have a bit more security working with an agency. Can you believe it? The staff there are working under pressure already. They are quite short-staffed. They are absolutely devastated with this and they have reported that to the RCN.

Q. Again in terms of the delay are you able to help with what the effect is on the women who are using this service?

A. (Ms Bissessar): We now understand that patients have been contacting Ealing asking why they cannot have their babies at Ealing. Women are wanting to have their live births at Ealing but because they were aware that the closure was going to happen, they were already making plans to go to some of the receiving trusts and they do not want to do that. We have been told by senior nurses at Ealing that the patients are very unhappy that they are not getting their choices.

MS RENSTEN: If you wait there, there may be questions from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much again for your presentation. I have a question which I know there is further evidence to come from other witnesses about this, but I would like your help. In other words, standing back and looking at the population that is being served, the first question is: is there a correlation between numbers? In other words, the percentage of a population can be related to the number of A&E facilities that are required. Is there an optimum number that you need to have? 200,000 comes to mind because I know that is a figure that comes up later. Does that make any sense? In other words, you could have a smaller population with a bigger need or a bigger population with a lesser need. In other words, how does this work? Am I right in thinking there is more than one type of A&E at the moment which the public may not be fully aware what the types of A&E are? That is the second part of this. Do any of the urgent care centres by definition equate with any of the types of A&E that you have at the moment? I am sorry, it is a three-part question. Have you followed all right or have I gone too fast?

A. (Ms Flanagan): We usually hear that the population is about 250,000 or around that amount for a fully functioning A&E department.

Q. Can I just interrupt. How do they calculate that?

A. (Ms Flanagan): Population status and the demands of the population.

Q. So it is worked out on demand?

A. (Ms Flanagan): Yes, I think so. The second question was the types of A&E?

A. (Ms Bissessar): The types of A&E and I cannot remember the question, to be honest,

but my understanding is that the public do not realise that some A&Es have a different level of service to others. So for example in North West London you would imagine that every A&E would offer the same back-up service to patients but we know about specialist centres that are currently running, so, for example, we have stroke units in some hospitals to back up their A&E, and not in others. If you are having a stroke and you go to A&E (because that is the right place to go) you are very often transferred by 999 ambulance to another A&E. That is the answer to that.

Q. You have not quite answered it. So you do not know how many different types of A&E there are at the moment?
A. (Ms Bissessar): A&E is A&E so accident and emergency departments are supposed to provide front-line, first-line care to patients in an accident or an emergency. It is more about the back-up services within the building within that trust as to what the A&E will offer, so if the trust does not have a stoke unit, I am giving that as a broad example, if it does not have a stroke unit, and many of our trusts in North West London do not, and a patient has presented with a stroke, they have to be transferred away from that A&E to an A&E that has a stroke unit to support it.

Q. Sorry, I am just trying to follow this through practically speaking in terms of an urgent care centre, if this is going to be the model for the future. If you are going in the middle of the night with something that presents or may present as a stroke or some cardiac problem, then who is making the decision? Is the ambulance crew deciding we will take them there or is it a hospital saying you have got to go over there?
A. (Ms Bissessar): It is a combination, so the Ambulance Service provide quite strict protocols and if the patient fits the protocol and they suspect that there is a stroke happening or a cardiac event happening then they automatically will take that patient to a hospital that they know has that receiving specialist unit to support the A&E department.

Q. As a follow-up question, would you say that in fact what should be happening is that all hospitals that have an A&E facility for the 250,000 population should be able to cope with all the necessary ailments that may come into the category of emergency? In other words, whether it is a stroke or whether it is a breathing problem, whatever it happens to be, acute problem, each A&E hospital should have the same standardised facilities? Do you believe that is an important follow-up?
A. (Ms Bissessar): That, in my view, is ideal. If you are going to offer that A&E department service then you should have the support behind it.

Q. DR LISTER: I would like to take you back to the concept of Hammersmith & Fulham as a virtual ward. Someone said to me recently if you are going to have a virtual ward then you have to staff it like a ward. I would like you to go in a little bit further as to the various professional skills and staff that would be needed and what your idea might be of adequate staffing of a virtual ward the size of Hammersmith & Fulham? What would you need and how many, let's guess, for a 200,000 population?
A. (Ms Flanagan): It is very difficult to actually say those numbers because there would be a number of people within the virtual ward and I think staffing for the ward would be maybe similar to what it would be within a hospital ward. However, maybe you have got 20 patients/28 patients in the community, you will need different skills because the nurses do not have the next colleague to consult, they have to be more skilled up, with more district nurses available and more people working on an independent basis to be able to

make those decisions, do a full clinical assessment of the patient and then call in the therapists that they need to be able to allow the patient to stay at home. Those people need to be experienced because they need to be able to make that decision: is this person safe in their bed at home.

Q. So, in other words, in order to make that a reality rather than simply a virtual idea, you would need to put a certain component of staff who would need to available in a properly organised unit to do that?
A. (Ms Flanagan): In a properly organised base or two bases within the borough.

Q. Is there any sign of that actually emerging in Hammersmith & Fulham?
A. (Ms Bissessar): I understand that they have started some work on that. It is not fully developed, but they have started.

Q. THE CHAIRMAN: What does that mean?
A. (Ms Bissessar): They have employed two new members of staff. They are calling them care co-ordinators and their role is to create this virtual ward and to manage it, set up systems and processes that are safe for patients to be cared for at a home, so it is a new initiative.

Q. So it is not really off the ground practically speaking?
A. (Ms Bissessar) Not fully running, no.

Q. DR HIRST: Can I explore that a little bit further. I am particularly interested in what your thoughts are about how far the out of hospital services have gone in preparation for whatever changes might come. So, for example, I have here a list of 15 proposals from the Hounslow CCG which I think it is piloting in Chiswick, my old stomping ground actually, and there are 15 proposals here. I can quickly run through them: ambulatory blood pressure monitoring, two levels of anti-coagulation, case finding, care planning and case monitoring, Co-ordinate My Care; two levels of diabetes care, ECGs, homelessness, phlebotomy, ring pessaries, spirometry and two levels of wound care. My old practice used to do most of these anyway. I am trying to find out how would their proposals prevent admissions. I am interested in that respect and in respect of case finding, care planning and case monitoring and Co-ordinate My Care. You have mentioned Co-ordinate My Care, although I am not certain how that would prevent admissions. Do you know anything about case finding, care planning and case monitoring in respect of preventing admissions? For example, I know conducting ring pessaries is not going to prevent an admission and measuring spirometry is not. Complex wound care might but then we used to do that anyway in the treatment room. Can you explore and tell me how you think any of those might prevent an admission?
A. (Ms Bissessar): We understand from our members that the theory is about preventative medicine so it is about health screening, trying to identify when abnormalities are about to occur and getting some treatment for that patient in the community. It is questionable about whether that will actually have the effect of prevention of admissions to hospital. I do not know if there is any data available to support whether it prevents admissions. I have not seen any of it.

Q. But certainly you and your colleagues have been doing complex wound care for years have you not?

A. (Ms Bissessar): We have, yes.

Q. That is not a new thing, is it?
A. (Ms Bissessar): No, certainly not. We are the experts on wound care.

DR HIRST: As I know and thank you for your help over the years.

MS RENSTEN: Thank you very much for your evidence.

The Witnesses Withdrew

THE CHAIRMAN: I believe there is a switch in order?

MS RENSTEN: Yes, I am told next witness is Cllr Andrew Brown.

Witness: CLLR ANDREW BROWN, Hammersmith & Fulham Conservative Group

Examined by MS RENSTEN

Q. MS RENSTEN: Could you give the Commission your full name and professional address and current post held?
A. (Cllr Andrew Brown): Good morning. My name is Cllr Andrew Brown. My address is Hammersmith Town Hall, King Street. My current post is Opposition Health & Adult Social Care Spokesman.

Q. In front of you, you will see a number of volumes. If you could pick out Volume 2, please. The very first item in Volume 2 starting at page 369, can you confirm that those are your submissions and they are true to the best of your knowledge and understanding?
A. That is right.

Q. And that you wish them to stand as your evidence to the Commission?
A. That's correct.

Q. I wanted to ask you first of all about some of the issues you raised on the second page of your submission. You were talking about work relationships between the local authority and health professionals being in difficulties and I wondered if you could assist with the specifics of where that information came from?
A. That information has come following meetings of the Health, Adult Social Care and Social Inclusion PAC where I have talked to numerous local NHS doctors and managers as well as at meetings I have had with certain professionals within the NHS, both at the CCG level and at Trust level.

Q. Could you just expand a little on what they were saying to you?
A. A lot of it is taken from my perception of the meetings and how especially senior members of the Council have been behaving towards NHS staff and then comments made by individuals following those meetings in which they expressed significant unhappiness at the way that they were treated.

Q. I do not know if you can help with this but is that something which is documented

anywhere and, if so, where could we find it?
A. No, I do not believe it would be something that would be documented. However, I am sure you will be speaking with members of the NHS.

Q. I wanted to ask you, in fact, about that. Do you consider that it is important for this Commission to hear views from all side of this debate?
A. Absolutely.

Q. And does that include hearing evidence from the NHS bodies that you suggest may have been subjected to unfair criticism?
A. Of course. I think the NHS are probably the most important people to give evidence.

Q. So it is really important that they attend?
A. Of course.

Q. Thank you. I wanted to ask you also about this. You say that you think things have sometimes gone beyond legitimate scrutiny. What impact do you think that that has had on the process so far?
A. I think the key part of the *Shaping a healthier* future proposal and any changes to the provision of healthcare in this borough and across North West London are about better integration of health and social care. The working relationships between the NHS and councils across North West London, who obviously have a very important role in providing social care, public health and that integration of health and social care through the health and well-being boards, through the Better Care Fund and all those different aspects, I think that is fundamentally important to the success of *Shaping a healthier future*. If that is not able to take place then it surely puts into doubt whether some of the significant changes to acute hospital trusts can take place. However, one thing that I want to state and just going on from some of your questions that I heard a few moments ago, I reject the concept that the A&E at Charing Cross and also Ealing are not going to be A&Es. That is something that we reject and has been guaranteed by the Secretary of State for Health and by the Prime Minister. I know there is uncertainty over how those A&Es will be. A lot of that is related to the Keogh review into emergency medicine. However, the Conservative Group and my support for any changes to acute trusts in North West London is for the A&E at Charing Cross (and also Ealing but I am speaking primarily for this borough) to remain recognisably an A&E and to remain with consultant leadership.

Q. Can I ask you about that. That is one of the topics I obviously wanted to cover with you. Is it your understanding that the, call it what you will, emergency service, for want of a better phrase, at Charing Cross Hospital is going to have consultant-led arrangements or GP-led arrangements?
A. We have been told at many meetings since May that the leadership of the A&E at Charing Cross and Ealing will be consultant-led. However, the slight uncertainty about that is over the Keogh review. These changes are looking forward five years up to 2020 and beyond, but, as far as I am aware, and as far as I have been told, the leadership of the A&Es will be consultant-led.

Q. Do you know whether that means that there will be consultants on site 24/7 or not?
A. Again, it is not something that I can know for certain. However, I have been told and

A I would believe and I do believe that it should have consultants on site 24/7. Consultants currently are not on site 24 hours a day seven days a week and one of the documents that I have referred to is that seven-day consultant-present care, and I think it is important that NHS trusts move towards much greater coverage of consultants present 24 hours a day seven days a week. Since the change specifically to the Hammersmith A&E, the coverage of consultants across the Imperial NHS Trust has been augmented by the recruitment of additional emergency medicine consultants and that has increased the B amount of time that they are present in the A&Es.

Q. Could I just ask you to pause there because I wanted to ask specifically about that. I was going to ask you whether that drive for recruitment has borne fruit. Do you know the extent to which that has happened?
A. We have asked questions relating to that at the PAC, the Health and Adult Social Care Policy & Accountability Committee. I was not at the last one because I am on paternity C leave and my wife has recently had a baby.

Q. Congratulations of course!
A. So I do not know whether that has been clarified. However, I do believe that they have now recruited some additional emergency medicine consultants from what I have been told and that hopefully six or eight new posts have been created and they will D hopefully all be filled very soon.

Q. Is it correct, have I understood you correctly that your support for the plans for the emergency care centre at both CCH and Ealing is predicated on it being consultant-led?
A. Absolutely.

Q. And there being good or better coverage than now?
E A. Absolutely.

Q. And upon those units being able to admit ambulances where appropriate?
A. I think the point with regards to admitting ambulances is important. I think that the term "blue light" is very misleading because I think the public and many of us in this room would consider any ambulance to be blue light whereas the NHS and the Ambulance Service consider a very small proportion of ambulance journeys to be blue F light admissions.

Q. Can you clarify for the Commission please whether your support is in relation to whether blue light ambulances must be admitted or other ambulances? Can you help us with what exactly you are saying about which ambulances are appropriate?
A. Of course. The very specifics of this question is something that is probably best answered by the Ambulance Service and by the NHS ---
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Q. Just as far as you are able to, of course.
A. In my opinion, I believe that certain blue light ambulances should still be appropriate for Charing Cross. However, ones, for example such as major trauma, as currently is the case, should go to St Mary's, where they have some of the best trauma mortality rates in the world. For cardiac care they should go to the Hammersmith where they are a centre of excellence for heart attacks and other cardiac treatments. Currently, the stroke centre H is based at Charing Cross, but, as part of the changes, that is being moved to St Mary's, so

those patients would go to St Mary's in the future, but for other blue light cases where it is clinically appropriate and safe to do so then they should still continue to go to Charing Cross.

Q. So do I have this right, where there is a specific specialist unit dedicated to a particular condition the blue light ambulance should go there, but, otherwise, the blue light ambulance should continue to be able to go to Charing Cross or Ealing A&E?
A. I believe so, yes. Just to pick up on something that a previous person giving evidence mentioned regarding whether every A&E should have the back-up of a stroke unit or other specialist services, I disagree with her point, especially with regards to stroke. The centralisation of stroke units across North West London has saved thousands of lives and reduced disabilities from stroke for thousands of patients and this part of London and London as a whole has some of the best stroke outcomes in the country. That is because London was at the forefront of centralising these hyper-acute services.

Q. Do you have a view about the move from Charing Cross to St Mary's of the hyper-acute stroke unit and whether that was or was not appropriate?
A. Speaking as a councillor for this borough, it is to my mind a shame that the stroke service is moving because obviously it is a service that is exceptional, it is right on our doorstep and from that local perspective in many ways I wish it could stay. However, from what we have been told by the local clinicians and the local NHS, they believe that having a stroke unit at the St Mary's site, where it has a co-location with the major trauma unit and with additional intensive care facilities, that that would provide even better patient outcomes. So from a very local perspective, in many ways I would like the stroke unit to stay. However, the clinical expertise is saying that more lives will be saved by transferring that unit to St Mary's. Of course, people are concerned about ambulance journey times and that is something that obviously has to be worked into the plans extremely thoroughly. In other parts of Europe and other parts of the world, many of the treatments and the diagnoses of stroke takes place by paramedics in the ambulance and treatment can start before a patient even gets to hospital. This is something that needs to be built in further down the line before these changes take place.

Q. Just lastly on that point, are you able to help with what your constituents are saying about the move of that unit?
A. Obviously, I have spoken to many constituents about the changes to local healthcare services. A lot of that was prior to May but there have been many conversations since May as well. It is something that is brought up by some people, but a small proportion compared to the bigger concern which is the A&E services.

Q. Just turning back to the A&E services, we know of course that there were closures at Central Middlesex and at Hammersmith and you have set out that your view is that that was necessary on safety grounds. We know though, do we not, that those closures took place in a way that was not following the original plan and I think you have said that more should have been done to prevent that. What should have been done?
A. I think the question is conflating two issues.

Q. Yes.
A. The first is the Independent Review Panel recommended the closure of the A&Es at Hammersmith and Central Middlesex were brought forward, and that is why that decision

and the plan to do so happened in September rather than I believe later in 2014 or 2015 (I am not 100% sure on the exact original timings that were proposed). My knowledge is better regarding Hammersmith Hospital for obvious reasons and that was due to the fact that for many, many years, I think up to ten or even 15 years from what we have been told by local doctors, there have not been emergency medicine consultants at Hammersmith. That is not because of funding or anything like that. It is because the caseload at Hammersmith has changed to such an extent that because of its specialisation as a cardiac centre, it was staffed extremely well by cardiologists and also renal physicians, but it was not suitable to train A&E emergency medicine doctors. That meant that the posts for consultants could not be emergency medicine consultants. That then meant that the A&E was staffed by locums, both at consultant and at a junior doctor level. That, for very many reasons, creates a situation which for patients is potentially very unsafe, where there is not that continuity of clinical leadership, where there is not that ability as a team working together to build on national and local strategies through improved patient care, so I think that is the reason why - and I do not know about Central Middlesex specifically but for Hammersmith that is why the staffing was unsafe.

Q. What you say is that you were told at the time that those unplanned, brought forward closures would not create a reduction of service quality?
A. We were told that, yes.

Q. You said you were given those assurances.
A. We were given those assurances both at the Policy & Accountability Committee and I also attended the CCG meeting which was in St Paul's Church in Hammersmith. I think that was around late May or maybe June where they went in-depth through their planning for the changes to the A&E facilities. There are two big problems with regard to what has happened since then. The first is unfortunately out of anyone's hands really and that is the mutation of the strain of the influenza virus which was the primary virus used in the influenza vaccine. That has created nationally a much greater pressure this winter on A&E services in England, Wales Scotland and Northern Ireland and then locally. Also, I think it is very regrettable that the new A&E facilities at Northwick Park were not completed on schedule.

Q. Is it of concern to you that the information that you were given that gave you those reassurances turned out to be inaccurate?
A. Yes. I guess in many ways it is a concern that the A&E facilities at Northwick Park were not completed on time. That is something where I do not want to speak ill of areas of London that are not part of this immediate borough, but that is something that is a question for both the Trust at Northwick Park and also the CCG covering that area. With regards to what has happened locally in Hammersmith & Fulham with regard to the changing demands on A&E both at St Mary's and Charing Cross, I think that is explained more by increasing demand on A&E services on a regional and national basis and also perhaps some knock-on effect from the difficulties experienced at Northwick Park.

Q. Specifically though, does the fact that the information that you were given was not correct give you any cause for concern in relation to other assurances or information which you are currently being given?
A. I think any plan from any organisation, especially the NHS and healthcare with such complicated systems and such a complicated area of expertise, that any plans obviously

become relatively out-of-date as soon as they are started to be implemented and people have to react to those plans as quickly and efficiently and effectively as possible. And from what myself and other councillor colleagues have heard from Imperial relating to their A&E waiting times, they have plans in place to improve their waiting times. However, I think that with regards to the plans for *Shaping a healthier future*, specifically answering your question about whether I have concerns about that, I think it is sensible to have more contingency in the plans, especially with regards to bed numbers. The original proposals for *Shaping a healthier future* specifically relating to the Charing Cross site had much fewer bed numbers than is currently proposed. I would personally like to see more contingency built into their planning for what will happen if - and we hope this will not be the case - their out of hospital plans working with the Council and other providers do not bear fruit by way of the reduction in demand that they are calculating.

Q. So there is a degree of uncertainty there?
A. Of course there is a degree of uncertainty in any plan that goes five or more years into the future. One particular area of uncertainty that perhaps the NHS needs to take better consideration over is the proposed increase in population in North West London, in particular relating to the redevelopment of the Old Oak area relating to the HS2 interchange as that, potentially, will add tens of thousands of new homes.

Q. When you say needs to take more notice of, does that suggest that you are aware of any problems with the statistical analysis thus far in terms of population?
A. I think the NHS has used, I am sure it must have used very tried and tested means of predicting population growth and growth in demand for services. That is something that they must be extremely capable and experienced in doing. However, I think the potential growth of population in that area specifically, and in North West London as a whole, may be out of the ordinary and may not be fully factored into their calculations.

Q. I just wondered if you could expand very briefly, you talked about the flexibility that you called for in terms of bed space at Charing Cross Hospital. I wonder if you could just give us a little more detail about what you were envisaging in terms of the scope because of course we have a very small number of in-patient beds proposed. What is it you are saying in terms of number?
A. I obviously cannot give the numbers. I am not a NHS manager nor do I have the facts and figures.

Q. A broad brush.
A. The current proposals are for around 150 beds of which a small proportion are acute beds. I think there needs to be greater flexibility in the number that is available for acute medicine if required and I think that perhaps there should be some - and this all comes round to contingency planning and how they design the proposed new facility at Charing Cross - some flexibility in how they design that building, so if it is necessary in 2020/2025/2050, whenever it may be, as was done with Chelsea & Westminster when they built their building, that flexibility is built into that structure so we do not end up with a situation that we have with the current Charing Cross building which was in difficulties from a maintenance and structural perspective not many years after it was first built and it was not very adaptable. I think what I am trying to say is that there needs to be from an architectural and management and process design perspective a flexibility in the Charing Cross site. I think it important for us to also recognise that the NHS is

proposing a £150 to £200 million investment in the Charing Cross site as part of a £1 billion capital investment across North West London, and that is something which will significantly improve provision of healthcare services in this part of London.

Q. I wanted to ask you about that. You say you welcome obviously the extra investment and you said that there will be more probably when all facilities are agreed. Does the fact that the full scope of what there is actually going to be at Charing Cross Hospital seems still to be something that is up in the air, does that give rise to any concern?

A. I think when we talk about the NHS, we perhaps fall into the trap of thinking of it as the NHS. It is not as simple as that; it is not one organisation. It is a very complicated group of different providers, people who manage and run the NHS such as NHS England and the Care Quality Commission, all these different organisations, the commissioners at CCG level and also the commissioners at NHS England, and the providers, so there are lots of different organisations each with their own leadership and boards and each with their own ideas of how they want to drive forward change. That inevitably, and with any planning over five/ten years or more, creates uncertainty. However, I would like to see at Charing Cross as many services as possible to provide even better healthcare for the residents of Hammersmith & Fulham that is clinically safe and supported by the expert clinicians at Imperial and beyond. With regard to what I specifically said in our submission, I think one of the question marks is over the elective surgery facility for part of North West London. From a parochial perspective, I would like that to be in Charing Cross. I would like that to be in this borough and I believe that because of some of the services that we are being asked to give up that there should be something that we get in return, but, ultimately, the most important factor is the outcomes and the mortality for patients across North West London and also this borough and I think it is important that we recognise that the proposals estimate that they will save up to 300 lives a year.

Q. Just thinking - and sorry to come back to the grubby subject of money again - a little bit about what is going to happen on that site, would it be better, given that we are not quite sure, to wait until we know exactly what facilities are going to be there before embarking on the sale of land or the demolition of buildings or indeed any other irreversible step? Are we at that point yet where we can safely do it?

A. I absolutely believe that there should be no demolition of buildings at Charing Cross, with the exception perhaps of some minor non-clinical buildings, before the final new building at Charing Cross is built. The last thing we would want is a situation where they have started knocking down parts of the Charing Cross building and they are still building the new facility. We have been told by the NHS that the new facility will be built and operational before any changes to the existing main clinical buildings at the Charing Cross site take place. Again, I put it in my submission but I think it is important to recognise that a significant amount of the Charing Cross site is not used by the NHS clinically. A lot of it is used by the Imperial College Faculty of Medicine, both for academia and also teaching medicine. A large proportion of the site is ground storey car parking so there is room on the site for a new facility to be developed.

Q. But should there be a sell-off before we know the scope of what is going to be on the new site?

A. Okay, on the specific point of sell-off, my apologies for not answering that.

Q. It is all right; it was a two-part question.

A. I think there has to be a great deal of further clarity before that would take place. However, I do not think it is any time soon that they would be proposing doing that and I do not think there would be any development of any part of the site until after the clinical buildings are developed. As these plans are for up to 2020 and beyond, I think we are many years away from that scenario taking place.

Q. Finally, I just want to ask you a little bit about something you raised at the outset of your presentation in relation to social care. You set out some of your concerns about the current situation. What is it that you say would be needed to ensure that additional services are in place so that the emphasis can shift towards community care? What needs to happen first?

A. I think this all comes around the Better Care Fund and I think the Better Care Fund in this part of London is one of the leading areas with regard to the amount of money and services that are part of the Better Care Fund. It is incredibly important that the integration of health and social care is improved. We all know that it is nowhere as good as it should be. Anyone working in a healthcare setting will know that there are frustrations between the NHS and social care and vice versa when there is a patient who is clinically fit to be discharged but cannot be discharged because the social care is not ready or there is a patient who is being looked after by social care and the NHS is not working in a joined-up way to provide the services, the diagnostics, the treatment, the review, whatever it may be, in a streamlined fashion so that patient ends up having to go back into acute care. So I think it is clear that in the integration of health and social care we are towards the beginning of that journey and there is so much more that can and should be done on that.

Q. So the infrastructure now is not currently robust enough?

A. I think the infrastructure is improving. This area is a forerunner of improving that structure and the NHS is investing a lot money in the Council's social care services to enable that out of hospital model, that virtual ward to be in place. However, I think it would be wrong, I do not think anyone would claim that that is fully in place, and that needs to be in place before further changes to acute trusts can take place.

Q. Just very briefly on that, what would you think would be the impact on residents if further changes were made to the acute structure before there is more development of the out of hospital services?

A. I do not think that will happen but, if it did, then obviously it would have worse outcomes for patients because there would be a gap in provision of care whether in acute trusts or within the community. So, I do not think it is possible for that change to happen without there being adequate and well-performing and assured care in the community working at a better level. Just to add, it is not just about social care. I think what we need to do a lot more in this area, but I am not singling out this area, across the country, we need to be much better at preventative medicine, we need to be much better at public health and not just communicable diseases and vaccination but preventing long-term chronic diseases such as diabetes, hypertension, all these different long-term diseases that have become much more prevalent in the last 20 or 30 years than when the NHS was first developed. That is why the NHS, both with that and an ageing population, is under the pressure that it currently is.

MS RENSTEN: If you would like to wait there, there may be questions from the

Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much for that presentation. I have got a number of questions, I think we all have, and I will be focused. I pick up on one point you made about population increase not being taken account of. If you can give us some help as to what is the population increase as you see it and what sort of proportion? Is it going to change the nature of the North West's needs and so on? That is the first question. The second question is do you think it is remotely sensible to be closing facilities before you have in place adequate alternative equivalent provision? So those are the two questions if you can answer them.

A. Of course. I cannot give you an exact percentage or a number for the population growth due to the redevelopment of Old Oak and that entire part of London because it is at an early stage. This is something I believe is going to be managed by the Mayoral Development Corporation (I think that is the right term) and who knows how many properties and residents that will result in an increase of. However, we know it is going to be very, very significant. Because there is uncertainty, I do not know and I do not think anyone knows for sure how that will play out through the planning process and the development process. The NHS has to take into account that degree of uncertainty. The way the NHS works is they are planning for what they envisage the situation to be now and a reasonable extrapolation of that into the future. And then if increased demand comes from a development such as this or just general developments in North West London as a whole, they will then react appropriately. They would argue that this is five years or more into the future and they would have adequate time to do that, but as an elected councillor in this borough, I would like to see more contingency and more planning being put in place to take into account those proposed changes and any other large developments in London. It is not North West London but there is a very large development at the Battersea Power Station, for example. Could you just remind me of the second part of the question?

Q. Yes, is it sensible to be closing facilities before you have in place an alternative equivalent?

A. In a perfect world, no, of course it is not advisable to be closing any facilities until you are absolutely sure that the replacement services are operational and are running well and are better than what is being proposed for closure. It is clear that there was a failure in that regard at Northwick Park. With regard to the Hammersmith and the changes to the emergency provision there, I think from a clinical perspective, from the recommendations of the Independent Review Panel and a situation that had a developed by accident in many ways, not by design, the provision of emergency medicine, because of the lack of emergency consultants, was becoming clinically unsafe. I think that was the situation and the leading emergency medicine consultants at Imperial will tell you that was a situation where they were feeling was unsafe and that it was going to potentially put patients' lives at risk and also reduce the quality of the outcomes that they would receive, so I think from that perspective there is a strong clinical justification for the changes at the Hammersmith.

Q. DR HIRST: I hesitate to ask you questions because I imagine you are quite sleep-deprived from your baby!

A. If there is anything I do not have a specific answer to, I am happy to write to the Commission.

Q. I just want to pick up on a few lines in your submission which is: "It is crucial that the Medical School, such an important part of the character of the area, is accommodated and provided with new improved facilities that will help Imperial College to continue to train some of the country's best doctors." I am thinking from the view of Hammersmith and also having been a junior doctor at Hammersmith, and I did my final exams in that building in Charing Cross that is meant to be falling down, from a Hammersmith point of view, obviously it was painful to see the Kennedy Unit go to Oxford, a unit which I thought would have made the name Hammersmith to be heard throughout the world. I just wondered if, as you say, facilities are to be withdrawn, I cannot see any medical students getting adequate training on the Charing Cross site, especially if the non-NHS buildings are to go, and moreover being again a GP who was trained at the Charing Cross vocational training scheme, any GPs wanting to be trained being able to be trained at Charing Cross. Of course, it is how I came to be in Hounslow, as it so happens, because I trained at the Charing Cross scheme and young doctors tend to stay where they train, as my own daughter has in Manchester. My first point was referring to that, and I would like to hear what you say. The other thing is that you mention that you were sad to lose the hyper-acute stroke unit (HASU I should say) to St Mary's but you understood that it was because, as we have been told, it had to be near a trauma unit, but if the HASU, which is very much a Charing Cross thing and by the way it was being thought of and acted on 30 years ago, goes to St Mary's where there is a trauma unit, it is only half a mile down the road from UCH where there is another HASU with no trauma unit. How do you cope with that from the view of a Hammersmith councillor?

A. Firstly, I will declare an interest. I studied medicine at Imperial and the reason why I live where I live and the reason why I have grown my family in this area is because I went to the Medical School at Imperial, so obviously it is very close to my heart. I am going to touch on the stroke unit first and then come back to that. The clinical arguments for whether a stroke unit is co-located with a trauma unit and the other hyper-dependency facilities is something that I am not qualified enough to give an expert opinion on. That is a question for clinicians and for the NHS. However, I can understand the logic and I am sure you can understand the logic behind it. The questions for UCH and that part of London, that is something that they have answer and whether they will change their services I do not know. However, as I believe it, the changes relating to the stroke unit when they were first established, it was always in my understanding envisaged that the stroke unit would ultimately end up at St Mary's. I do not think that is an integral part of the *Shaping a healthier future* proposals. My understanding is that was part of the original proposals with regard to the hyper-acute stroke unit which has been so incredibly successful in saving lives and reducing disability. Coming back to the training of doctors at Imperial and in this part of London, obviously the Imperial College Faculty of Medicine is extremely important for training world-class doctors and its operations are not just restricted to North West London nor are they just restricted to the Imperial College NHS Trust. They have major sites across North West London and beyond. They send people to all the hospitals in North West London. They send them to Kingston. I was even sent to Boston, Lincolnshire on one rotation, so their reach is extremely wide. However, there is clearly a demand especially at the junior end of the Medical School for there to be a site for the Medical School, whether it is at Charing Cross or whether Imperial uses some of its facilities at South Kensington or whether it uses some of its

facilities at the lecture theatres, for dissection labs, for those non-clinical aspects of medical training. That is obviously something that has to be considered. I think you rightly address the clinical aspects of ward rotations and gaining experience clinically in training GPs, training junior doctors and ultimately training consultants. So I think there is a big question over healthcare education, but that is something that only the Faculty of Medicine and the NHS Trust and the wider people who organise medical training can answer.

Q. DR LISTER: One short one and one longer one because you did say that after the closure of Hammersmith A&E that Imperial Trust is now recruiting additional emergency medicine consultants. Could they not have tried to recruit them to actually staff the Hammersmith unit in the first place? The second question is you mentioned £1 billion of capital investment, which obviously sounds very enticing, but is that contingent on making a £1 billion of savings first in order to raise that money or where else is that money going to come from?

A. With regard to the question of staffing the Hammersmith, it was not a question of funding. I think I have already covered this. It is the fact that because the Hammersmith specialised towards cardiology and renal medicine it no longer had the caseload to enable emergency medicine consultants and emergency medicine junior doctors and the rotations needed for those people to train in that facility to enable it to continue to staff with emergency consultants. It is not just a matter of funding a consultant post. There have to be the cases there for the consultants to continue their learning, to continue improving their knowledge, keeping up their skills and their improvement, I think that is why the centralisation of certain hyper-acute services have proven to be so successful at reducing mortality and improving outcomes because it creates a concentration of cases where instead of two or three emergency clinicians or two or three stroke physicians or radiologists who specialise in removing blood clots or whatever it may be, it creates that concentration where clinical excellence is allowed to flourish by four, five, six, seven, eight consultants in one specialty, working with each other, talking to each other about new techniques and new practices and that is why it is the accepted practice in the academic theory of providing acute health care. If you refer to the work of the Academy of Medical Royal Colleges and the Royal College of Physicians - and I hope they are giving evidence to this Commission - that is the kind thing they are talking about to improve patient care. The other part of your question was?

Q. Billion pound of capital investment, where would it come from?

A. It would come from the Treasury I assume, who will underwrite that investment. Obviously ---

Q. Obviously?

A. No hold on, I have not finished. "Obviously" was what is about to follow. Obviously, there will have to be some form of land sale at sites across North West London to partially fund some of that capital investment. I think in many ways, although people do not like the idea of that, from a healthcare perspective where you can provide better healthcare facilities and at the same time better make use of your sites, then it is incredibly sensible for organisations like that to do so, as long as it is done in a responsible manner. So obviously to fully summarise the answer, it is going to be a combination of write-off from the Treasury and funding from central Government combined with some later money coming in from other sources.

Q. I suppose what I was getting at is yesterday a contract to build a new Papworth Hospital was signed off at £140 million under a private finance initiative. Would you anticipate a PFI being used here?
A. From what I have been told this is not proposed to be done by PFI and I would be very, very sceptical and wary of PFI being used because of the problems that we associate with PFI from the last Government.

Q. And this Government ---
A. Just to finish that point, I do not think necessarily PFI in itself is a bad idea, but I think where the scrutinisation and the contracting of PFI is not done rigorously enough - and there are examples in North West London where PFI-funded and managed hospitals are creating a significant problem - I would not want any redevelopment in this borough to be linked with PFI.

THE CHAIRMAN: Pressures of time, I am afraid. Thank you very much indeed for coming particularly in your domestic situation. .

The Witness Withdrew

THE CHAIRMAN: I am going to take an executive decision to carry on unless anybody is desperate for a break because there is so much material here. Unless there is a protest, we will carry on with the next witnesses.

MS RENSTEN: The next witnesses are from Hammersmith & Fulham Council.

Witnesses: CLLR STEPHEN COWAN, Leader, CLLR VIVIENNE LUKEY, Cabinet Member for Health and Adult Social Care, and CLLR RORY VAUGHAN, Chair, Health, Equalities and Social Inclusion Policy & Accountability Committee, Hammersmith & Fulham Council

Examined by MS RENSTEN

Q. MS RENSTEN: As we have the benefit of three of you, if we can take it one at a time, starting on the left, could you please all give your names, professional addresses and current posts held.
A. (Cllr Lukey): I am Cllr Vivienne Lukey, I am the Cabinet Member for Health and Adult Social Care. My professional address is Hammersmith Town Hall.
A. (Cllr Cowan): I am Stephen Cowan, I am the Leader of Hammersmith & Fulham Council and my professional address is Hammersmith Town Hall.
A. (Cllr Vaughan): I am Rory Vaughan. I am Chair of the Health, Adult Social Care and Social Inclusion Policy & Accountability Committee and my professional address is also Hammersmith Town Hall.

Q. If you look in the bundle in front of you at Volume 1, pages 9 to 20, you should find the submission jointly prepared. Can I ask one of you to indicate whether that submission is true and accurate to the best of your knowledge and understanding and do you wish it to stand as your evidence to the Commission?
A. (Cllr Cowan): Yes it is and yes we do.

Q. I wanted to ask you first about some matters you raise in terms of assumptions. At paragraph 2.3 on page 10 in your opening paragraphs you talk about the modified business case being based on some "unrealistic assumptions" and you talk later on at paragraph 3.1 about "over provision of A&Es" and then about the population issues. Can you help us with what you say the assumptions are that have been relied upon and how they may be in error if they are not correct?

A. (Cllr Cowan): Yes, and my colleagues will add to this. The assumptions were that they would make significant headway on treating a greater number of people in the community and that would be able to reduce the amount of demand really, and that tied in with improvements in GP services as well as adult social care, as the Commission has already heard. So they are the assumptions and they are flawed for a number of reasons that we can go into, but not least because they are based on a variety of incorrect information. If you take the population figures, the population figures were primarily done by the Office of National Statistics' analysis which occurred some time ago, mostly based on the last Census, and it was topped up with extra information from the GLA, but what it does not take into account is that there is a £35 billion development happening in College Park and Old Oak which will add at least 70,000 in population. There is a £12 billion development taking place on Earl's Court which will add well over 10,000 in population and indeed we are in talks with the GLA about sinking the Hammersmith Flyover and replacing that with housing and a park. TfL have also opened up talks about the Hammersmith Gyratory, so there is significant development going to be happening in the centre of Hammersmith which will add significant extra population. None of that has been taken into account in *Shaping a healthier future*.

Q. Could you also just clarify whether in addition to the future population you say the figures for the existing population are correct or incorrect?

A. (Cllr Cowan): We believe those figures are inaccurate as we detail in our document. While we do not think that is deliberately so, it certainly is the case that relying on the ONS figures does seem to be unwise and possibly a touch reckless given that they are so out-of-date and London is such a fast-changing city when it comes to population numbers.

Q. If the assumptions are flawed, what effect does that have on the business case for reconfiguration?

A. (Cllr Cowan): We appreciate making such assumptions is difficult, but it is certainly the case that if you have drastically under-estimated the population and you have under-estimated the traffic then the figures, for example, for taking someone from Fulham Reach ward, which is the ward that Charing Cross Hospital is currently in, and driving them at blue light to St Mary's within, they argue, 14 minutes that clearly is difficult on the traffic alone. The fact that they then argue that the A&E at St Mary's will be fit for purpose with this increased population going through St Mary's, then I believe the calculations on the number of consultants and number of acute care beds needed, all of that does not marry to the size of population. I do not know if my colleagues would like to add anything.

Q. I wanted to turn to the issues in terms of the acute A&E situation and start first with Hammersmith Hospital. Your submission sets out that the closure has had a severe impact. Can you provide any further details and the very up-to-date position in relation to

first of all waiting times, the number of patients being sent on to other accident and emergencies and journey times?
A. (Cllr Lukey): Yes, we can because this is something that is mapped on a very regular basis. We are looking overall at pressures on Charing Cross ---

Q. I am asking about the most up-to-date figures that you have, if possible?
A. (Cllr Lukey): The most up-to-date no, I will pass on that.

Q. What about the most recent that you do have available?
A. (Cllr Vaughan): Can I just interject on the journey times. I am a member of the Joint Health Overview and Scrutiny Committee that covers the whole of North West London. We met last week to talk to the London Ambulance Service and they gave us some figures at that meeting which show that average ambulance journey times to hospital have been increasing. In terms of the averages they are giving they are spread across thousands of ambulance journeys, but there are clearly extra minutes being added or certainly halves of minutes being added to ambulance journey times, potentially as a result of the recent closures back in September. But similarly, they are clear that they are not meeting their target journey times at the moment even with just two closures having taken place. They presented those statistics to the Joint Health Overview and Scrutiny Committee not this week but the week before.

Q. One of the views that has been suggested is the difficulties in the local hospitals - I should not say local hospitals because it has probably the wrong meaning - in the hospitals in the locality have been caused by teething troubles exacerbated by winter problems rather than failings which are causally linked to the closures of either Hammersmith or Central Middlesex Hospital. Can you comment on that?
A. (Cllr Cowan): Yes, it is worth going back to the board meeting that I think took place on 6 September at Imperial, but when the decision was made to close Hammersmith's A&E, what was interesting, if you look at the board papers, is that no questions were asked by the board. If they had asked questions, what they should have asked about was the fact that the paper said that all the A&Es were acting at full capacity and that there was no possibility of increasing capacity. What we went on to see was the chaos in Northwick Park. We saw the CQC recently fail St Mary's on their ability to manage their A&E and we have seen problems at Chelsea & Westminster. So it seems worth investigation of the loss of capacity to deal with A&E when it is accepted that all hospitals are currently acting at full capacity and struggling to increase.

Q. I just wanted to ask you a little bit about Charing Cross Hospital. If Charing Cross Hospital loses full blue light capacity for its accident and emergency, what do you say is going to be the likely impact on the population?
A. (Cllr Cowan): We have already seen a chaotic approach to this, so whilst I have sympathy, what you have is a number of different organisations, you have Imperial, you have the foundation trusts, Chelsea & Westminster, you have other hospital groups within North West London, the CQCs, and it is slightly chaotic in the way that they organise the responses to these scenarios or indeed the information that they have, but what is undoubted, so the first conclusion is there is a lot, I hate to quote Donald Rumsfeld, but there are "known unknowns" and there are "unknown unknowns", and I would suspect, if you were able to interview the health officials making the decisions, there are too many unknown unknowns around this. What is absolutely clear in the closure of Charing Cross

is if you already have other hospitals operating at capacity then what you will see is what you currently see in Northwick Park with people waiting up to an hour in ambulances. When I talk to doctors who work in A&E in Northwick Park and I say to them, "Well, how do you know who is in the ambulance and what particular emergency you are dealing with?" the very simple answer is we do not. So you could be having a cardiac arrest in the back of an ambulance or a stroke in the back of an ambulance and not being treated in what is often referred to as the "golden hour". That situation would increase if Charing Cross were allowed to go at the current time.

Q. I assume that is partly linked to journey times as well. Can you help with what, if anything, is being done in Hammersmith & Fulham to ensure that the transport routes and the links are aligned to a positioning of the new configuration of accident and emergency units?

A. (Cllr Cowan): As I said, there is a degree of chaos, so what the Health Service is not aware of, and you will have seen recent media reports, we are in conversations with the Mayor of London about sinking the A4 and getting rid of the Flyover. I met with Transport for London officials last week and one of the complexities was the level of increased traffic and what is going to happen to it. There is nowhere for that traffic to go along the River or into Hammersmith, so if you are in a blue light scenario coming from, again let's use the ward where Charing Cross is currently based, you may well find yourself stuck in very serious traffic. So the situation has got worse. What is absolutely clear is there is no link-up between the work TfL are doing and the work health professionals are doing and the Government is doing in instituting *Shaping a healthier future* so it has got worse - much worse - since *Shaping a healthier future* was written.

Q. Just thinking about those journey times still, are there any particular communities or areas within the borough that you feel are likely to be more affected than others?

(Cllr Cowan): When they presented *Shaping a healthier future* to our council policy committees and our select committees have in the past used anecdotal evidence so if you take a resident living in Ashcroft Square who thinks they are having a heart attack and decides to self-diagnose, then they would go to Charing Cross. If you are coming from the third or seventh or tenth floor of a housing estate and making your own way, to self-diagnose, because you think there is an A&E still is it existence, not only have you gone to the wrong place because they want to downgrade it and still call it an A&E, you would put your life at risk if you are indeed having a heart attack. The second point looking at the state of council estate lifts and consistent problems for as long as I have been an elected representative, which is 17 years, someone living on the seventh floor of a council block calling an ambulance because of a serious emergency is going to find themselves at greater risk than someone living on a street property with full normal access to the highway.

A. (Cllr Vaughan): One thing I wanted to add was in the initial proposals there had not been (at least upfront) an initial equalities impact assessment done on the changes, so for example that was not done, initially at least, for the Hammersmith Hospital A&E changes and as you probably know Hammersmith Hospital is actually sited in a more deprived area of the borough, particularly the College Park and Old Oak and Wormholt and White City wards, which are some of the most deprived certainly in the borough and probably across London, so it was interesting to note on that case that that had not properly been taken into account, at least in the initial proposals. I think a subsequent equalities impact assessment was done to look at those issues, but it was a significant error I think not to

A have done that upfront.

Q. I just wanted to touch on urgent care centres. First of all, with regard to the definition of an urgent care centre, you set out, and I think it is on page 14 and it is paragraph 3.21 that Imperial Healthcare Trust are awaiting the outcome of the Keogh urgent and emergency care review before committing to a definition of what an urgent care centre is. Are you able to assist with whether that holding position, does that still remain the case?

B A. (Cllr Vaughan): Yes, that is right.

Q. What implications do you say might flow from urgent care centres which are already up and running?

A. (Cllr Vaughan): I think the difficulty here is that we understand urgent care centres in the borough have been co-located with A&Es, so in the case of Hammersmith and in the case of Charing Cross you have been able, if you have got a health emergency, to walk

C through the front door of what you see to be the A&E at Charing Cross or Hammersmith until recently, you are then triaged and they can then decide whether to push you through the A&E route and therefore have the emergency access to hospital that is needed or people can be taken into the urgent care centre. The problem for urgent care centres is going to be people not having that one-stop shop. People may turn up at urgent care centres and then need to be taken to an A&E because that is not the appropriate place to

D treat them, so there is a real problem for patients attending an urgent care centre getting the access to the right emergency medical help at that time, which is potentially either going to mean that people automatically go to where they know a full A&E is and leave the urgent care centres not doing the work they ought to be doing or people turning up at an urgent care centre and needing to then be redirected to an A&E in another location.

A. (Cllr Cowan): If I could just add, on 29 July we put this question to a variety of health professionals when they came the Policy & Accountability Committee and indeed I think

E it was Dr Spencer who said that people do not know the difference between an A&E and an urgent care clinic. The reason for that is, as you would have once seen on the NHS England website, that class 1, 2 and 3 A&Es were listed. A class 3 A&E is the same as an urgent care clinic and it is so confusing that actually the language got mixed up on the website initially, sometimes referring to an A&E as a class 3 A&E and sometimes as an urgent care clinic. That is the type of problem that you have. If the health professionals are honest, and they certainly told us, they think that is a problem with the current

F structure, calling everything an A&E. It just causes confusion and it does allow for people to come with a self-diagnosis to the wrong place and does put their lives at risk.

Q. Just in terms of public confusion, even if there was a definitive definition of a UCC, in terms of the public understanding of that, what do you say it would take and over what period would it take for that information to become embedded?

A. (Cllr Cowan): I hate to use a marketing term but I think it should say on the tin what

G it is and the fact is if something is an A&E it should be called an A&E. If it is not an A&E they should find another name and it strikes me "urgent care clinic" is exactly the right thing to call a class 3 A&E.

Q. How long do you think it would take in terms of the public understanding the differences? How long will it take for a local authority to be able to convey that message?

H A. (Cllr Cowan): If I could add to the confusion, this is what the council was putting out

this time last year, which I should point out was before our watch, when there were quite a lot quite of controversies. This is a Council magazine which says "A&E retained at Charing Cross".

THE CHAIRMAN: Could we see the cover, please?

Q. MS RENSTEN: Could we hand that up, please?

A. (Cllr Cowan): It says "A&E retained". When I spoke to the communications professional, who later worked for us, about why they had put that, because clearly an urgent care clinic or class 3 A&E was the deal that had been done, he argued that his great success was getting the quotation marks because that is what Jeremy Hunt had said in the Houses of Parliament. I think there is an awful lot of vested interest in trying to tell the public that nothing is changing, A&Es are being retained and it is all fine, where, in reality, what we see is a significant change for accident and emergency care in England and there is too much spin, possibly for political reasons, which is done I think to disguise the true nature of it, but in the process is confusing the public. In terms of how do you correct that, I think we have to have very clear usage of language otherwise people will be going to the wrong places at the wrong times.

A. (Cllr Lukey): May I also add to that. Obviously we do have the experience of the attempts to educate the public about what services remain at the Hammersmith Hospital, and, despite a vast amount of expenditure by the CCG and Imperial Trust, that turned out to be a very flawed exercise, partly because they did not inform us strategically in the first place. Secondly, we heard about it when they asked the people in charge of highways for a list of roads in our borough, which did not really seem the most appropriate way to go about it. We have also heard this morning about mobility in the borough and the diversity of our population, the number of languages spoken and people who do not have English as a first language, and obviously a number of people who have difficulties in communication because of their ill-health problems, so obviously the most vulnerable people that you would want to target in the first place, and the means of communication were obviously leaflets through letter boxes which looked like pizza leaflets, text messages which you got if you are actually registered with a GP, and of course we know in our borough we have so many people who are not registered with GPs which is why they go to A&Es in the first place. We have heard recently at a scrutiny committee about the surge at 4 o'clock after school finishes of parents taking their children to A&E. There are a lot of people who are excluded from the information about Hammersmith A&E and so I think it would be a major challenge to communicate to people and you can only communicate clearly if you know what the product is and if you are working closely in partnership with the community leaders in the Council and the voluntary sector, and that simply did not happen.

A. (Cllr Vaughan): Could I just add on that. To answer your question, I think it will take many years to educate even the population that is resident over a longer period of time as to how to use the NHS in the event that we have a fragmented service which has blue light A&Es, urgent care centres and GPs as to when there is a health emergency which they should use, given the fact that the out of hospital service strategy is meant to take some of the pressure off, seemingly, hospitals of one sort or another, so getting people to understand, even those who are long-term residents of the borough, how that fragmentation works and in which circumstances they should go to which type of health facility will be a long-term issue and, as Cllr Lukey has said, the fact that this is a very high turnover borough means that we would need to keep re-educating on a consistent

basis people moving in and out of the borough as to the services that are available and when they should use them. The problem I feel with the whole of this of course is that it does mean that people need to do self-diagnosis which could lead to them gambling as to whether they go to their GP, urgent care centre or a full-scale A&E when they have got a health emergency, and educating people about how to do that would be a particularly tough task.

Q. I am conscious of the time pressure so could we take the next bit at something of a gallop if you would not mind. I just want to ask you very briefly about bed spaces. If the reduction takes place as proposed and demand does not fall in the way that *Shaping a healthie*r future projections envisage, what is your understanding of where the patients will go if they can no longer be at Charing Cross Hospital?

A. (Cllr Lukey): We have been told that St Mary's will obviously be the key hospital for this area, the major acute hospital. Our experience obviously over the winter period and since the closure of Hammersmith A&E is that we have had a net over-demand so that they have not had the capacity at St Mary's and they have had to open more beds. We have also seen the same picture at Charing Cross - that demand has outstripped capacity.

Q. So if there is no capacity in the hospitals that they are supposed to go to, are you aware of any plan B that exists?

A. (Cllr Lukey): We have not seen a proactive plan B. We have seen a reactive experience over the winter where non-elective admissions have increased, elective surgery has dropped, those plans have had to be scrapped and people have been moved around local hospitals so they might be admitted to one, say St Mary's, but end up somewhere else, so it does not seem a very robust plan that we can deal with, and that is obviously over a few short months.

A. (Cllr Cowan): I think we have some monitoring information that we should like to submit to the Commission at some point on bed usage and it does indicate ---

Q: Is that something that could be submitted in writing and very briefly dealt with here?

A. (Cllr Cowan): Yes. It is a complex table, as you can see, so we will just give that to you for further analysis, but, actually, what you see at the moment is that all the hospitals are at full capacity and the health professionals have to react rather than pre-plan. That is a critical point about acute care beds is the loss of those at the moment is just completely unsustainable and will be for many years to come because of the failure to be able to move to care in the community which the NHS argues is underway, but there is plenty of evidence to the suggest the alternative.

Q. I want to ask about primary care services. Are the GP services in the borough able to cope with current demand?

A. (Cllr Vaughan): Speaking anecdotally, I think it is in our submission as well, there is a problem of coping with demand at the moment. In fact, I was talking to a resident only the other night who was telling me that she was not able to get a GP appointment within two weeks at her surgery, so certainly residents in the borough are finding it difficult in a number of cases to access GPs within the time.

A. (Cllr Cowan): Just added to that, on 29 July 2014, we managed to question on precisely that question about how many people do the NHS professionals believe will be treated now in the community by either GPs or adult social care compared to currently going to A&E because a significant proportion are still going to A&E. What is

interesting is we had people there from the CCGs for Ealing and Hammersmith & Fulham, we had Imperial there, we had advisers from what had been known as NHS North West London. There were about 20 health professionals in the room and about eight on the panel, and I do urge the Commission to view this video, and not one of them could answer how many people would now be treated in the community compared to currently being treated in A&E, so it adds to my view that there is a lack of planning to a larger degree of chaos and a lack of understanding of the consequences of some of the critical decisions that they are making on reducing A&Es and acute bed care.

A. (Cllr Lukey): Just to add to that, at a recent Health and Wellbeing Board I was able to have a debate with NHS England who are responsible for commissioning GP services locally. We talked about the population increases and I asked them what their plans were to commission additional GP surgeries and they said there was none. And this is when we have 7 am queues at Shepherd's Bush outside some of our surgeries to get an appointment for that day.

Q. I just wanted to ask you very briefly about the investment. You set this out and it is at page 18, paragraph 3.38, the planned investment in primary care between £6-8 million and you say it is "not sufficient to accommodate the diminution of service". What would your view be about that figure of £6-8 million if it was decoupled from the reductions in the acute service?

A. (Cllr Lukey): It is not sufficient for the reasons we have discussed. How can any model developed some time ago take into account the population increases and where we will be? We already are two and a bit years on from the original *Shaping a healthier future* plans. We are behind schedule and we do not have those out of hospital services in place, so I think it is very difficult to actually predict and be confident that the money on the table at the moment could possibly meet changing demands.

A. (Cllr Cowan): I think the problem is if the answer is £6-8 million then what is the equation that lies before it? Given that *Shaping a healthier future* was put together on the premise that there need to be changes in acute and accident and emergency care and more of that needed to happen in the community, if you have got every single person in the room responsible for *Shaping a healthier future* together and none of them can answer a simple question of what percentage of people will be treated in the community now compared to currently going to A&E and into hospitals, if none of them knew, as you will see if the Commission looks at the video, then you have to ask how can you therefore conclude £6-8 million is exactly the figure you need to actually provide adequate care? The only possible conclusion of those two things together is that people are plucking figures out of the air and hoping it will be enough to get along. What the Commission should see as it carries on its investigation is that happens more often than not on very, very critical points of change in *Shaping a healthier future*.

Q. Just thinking about the social care element, which is perhaps more traditionally provided by local authorities, can you help us with what input the relevant arms of your authority had into this process and if you are satisfied or unsatisfied with that?

A. (Cllr Lukey): There is some good news and bad news. The good news is that we have been working well together on the ground to develop some better arrangements for out of hospital care. They are at a very early stage and there is uncertainty because some of the pilots that we do have in place only have one year of funding, so we are hoping for some good outcomes over this financial year, but we have no guarantees for the future. The bad news is, and very disappointing for me as a newly elected councillor and taking on

this cabinet role, is that there is no seat at the table, there is no behind-the-scenes sharing of information about what is happening and what the thinking is. There is no opportunity to shape some of the thinking. If the worst-case scenario takes place and we are left with only a few beds on that site and an urgent care centre, at least I want to be in a position where I can be trying to negotiate the best deal for our residents, but all of that is going on behind closed doors. I have no idea what is in the outline business case and even the structures where we do have representation, the local CCG board meeting, our Director and Deputy Director of Public Health were asked to leave the meeting at the stage when they discussed this because they work for the local authority and it was deemed there might be a conflict of interest rather than a congruence of interest. How can we work together when we are not at the table?

Q. How heavily do you consider the success of the out of hospital plans depend on provisions that are coming from the local authority rather than from health?

A. (Cllr Lukey): In terms of workforce and day-to-day contact with people, then I think the new service that we are developing in terms of home care will be very key in reablement and getting people moved on to less intensive forms of support at home, but, however good our home carers are, they are not community nurses and they are not GPs and we will be doing this work in the context of an above-average vacancy level in community nursing locally and, with our local community health trust needing to go later this year to the Philippines and to Portugal to try and recruit to those posts, it is a very, very challenging prospect.

A. (Cllr Cowan): Even though we disagree with what looks like the chaotic *Shaping a healthier future* and the plans around it, what should be happening is we should be sharing information and making objective decisions. What I do know is our Executive Director of Adult Social Care did that when she worked in the Greater Manchester area and said they had a seamless relationship with local health providers. Here it is very hard to get any information out. There is a culture around presentation and spin and indeed even around this Commission where we are interested in getting to the bottom of it, they are hiring a spin doctor in John Underwood in order to try and manage the information that the Commission has.

Q: Can you pause a minute. When you say "they" can you explain who you mean by "they"?

A. (Cllr Cowan): I think you will have seen that there is a letter that has come from the Director of the CCG saying that no-one in North West London will be submitting information prior to the Election and makes a series of other requests and indeed they argue that their main point person will be a spin doctor in John Underwood. That is exactly the process that we have experienced for a number of years whereas what we should be seeing is objective information on numbers of patients, on population projections and travel times. Instead what we are getting is an emphasis on presentation, and our Director of Health tells us that is in complete contrast to what she experienced in the Greater Manchester area.

MS RENSTEN: Thank you, I am grateful. Would you wait there, there may be questions from the Commission.

Examined by THE COMMISSION

Q. THE CHAIRMAN: I am conscious of the time because there is another important area of evidence to come. However, I just wanted to ask one question at this stage. I am trying to stand back from it all and look at what the underlying forces or dynamics are. One of the things that has concerned me so far today is listening to what I call the fragmentation of the National Health Service. It is a National Health Service where we now have such fragmentation in terms of providers wherever you look that that results in a trickle-down effect in which the criteria they will be using are different, the motivations are different and have we departed from the original concept? It is a big question and hopefully a small answer.

A. (Cllr Cowan): Maybe we could all give an answer. That is absolutely where we are at. If you look at the consultation as an example, Chelsea & Westminster Hospital was able to put leaflets out around the area asking people to sign and to send submissions in because they are a foundation hospital and they had a vested interest in protecting their hospital. Imperial is not a foundation trust and was unable to do the same and meanwhile Imperial wants to sell off Charing Cross in order to build up St Mary's and has an interest in that. Then you have the PFI hospital in West Middlesex. So when *Shaping a healthier future* was being put together you had a variety of competing interests. It looked like the court of Henry VIII in some of the politics that went on in putting this together and reaching the conclusions that have come about. That is in absolute contrast to the original idea that universal health care would be managed in a way focused on the needs of the population and would be handed out equitably on that basis. There is a lack of objectivity, I think, and that is currently structured into the system.

A. (Cllr Lukey): If I could add to that. We heard earlier about the effects of flu and flu immunisation locally. We as a Council through scrutiny and through the Health and Wellbeing Board have been trying to increase the rates of immunisation particularly for children over the winter and trying to find the people to hold to account for this within the NHS. It is not the CCG. Although you go to your doctors' surgery, it is not them. It is NHS England, but they never come to the meetings. Then of course there is the community trust, the nurses there and the health centres where you might go and try and get your immunisation. Then there are the pharmacists and that is without beginning to talk about privatisation and the many private interests who are part of our so-called health community locally. So it is a real challenge, even with the best will, to try and get a comprehensive approach to anything.

A. (Cllr Vaughan): I would just reiterate the point I made earlier which is that we should look at this in some ways from the patients' perspective and in breaking up the system potentially of GPs and hospitals so where does a patient attend for their healthcare, they know how to use GPs,. To a certain extent, they know they ought to go to A&E when they need urgent attention and it is not clear to me that the system that is proposed is going to help patients navigate the system in an appropriate way, and it will take much effort from perhaps ourselves as a local authority, the NHS and others to re-educate people about how to use the NHS in this potentially fragmented system.

THE CHAIRMAN: I am going to ask the stenographer whether we can carry on to do the last witness. May I thank all three of you very much indeed.

The Witnesses Withdrew

THE CHAIRMAN: Just so that everybody is clear. This contributor was intended to have half an hour and I think he should have half an hour so we will go on until five to one and have lunch after that.

Witness: CLLR ROBERT FREEMAN, Chairman, Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington & Chelsea

Examined by MS RENSTEN

Q. MS RENSTEN: Could you give the Commission your full name and professional address, please.
A. (Cllr Freeman): I am Robert Freeman, I am a Councillor at Kensington & Chelsea. My address is Town Hall, Hornton Street, London W8.

Q. If you turn to Volume 1, which should be in front of you, and if you look to page 359 to 366, it is the last document in that volume.
A. That's mine.

Q. That is your submission. Is it true to the best of your knowledge and understanding and do you wish it to stand as your evidence to the Commission?
A. Yes, I do.

Q. I wanted to ask you first a little bit about the consultation phase. Do you have any view about whether the proposals which were put to consultation were adequate?
A. I think that is a very difficult question. I sometimes had the feeling that there was an answer waiting to be given and that answer was expected of us rather than it was a completely open consultation.

Q. So was it your view that starting from a reduction of nine to five major hospitals was an adequate consultation or perhaps too circumscribed?
A. I would not say circumscribed. I think there was a certain expectation that the proposal would be approved.

Q. What level of awareness in your locality was there amongst members of the public about these proposals?
A. I think very little.

Q. Could and should more have been done to engage the public and, if so, what?
A. It is always very difficult. You can always do more, but I think the reality is that the public do not look at the fundamentals of healthcare. They look at their own needs in terms of, "If I'm ill, how can I be treated and where can I go?" They do not actually say, "If there are closures, how is that going to affect me." And to carry on, if I may, we are different from Westminster, we are different from Hammersmith & Fulham because Imperial, although it is a major provider for our residents, there is no actual Imperial facility within the Royal Borough.

Q. In your submission you say you are standing back from voicing views about individual hospitals, but I wonder if you are able to clarify your Committee's position on the baseline proposition that the reconfiguration should involve a reduction from nine

major to five major hospitals.
A. The reduction that really concerns our residents more than anything else is any possible downgrading of Charing Cross Hospital. Our residents in terms of general acute care, if one can use that term, as opposed to specialist acute care, are served mainly by St Mary's and the Chelsea & Westminster and to some extent Charing Cross and particularly for emergency care in terms of stroke, cardiac and some elective procedures such as cancer, the Marsden obviously is the major cancer provider together with the Brompton in terms of thoracic and lung cancer, but the two major hospitals for us are St Mary's and the Chelsea & Westminster.

Q. So is it the case then that it was not something that your Committee considered whether or not the baseline proposition of from nine to five was appropriate or not?
A. I think what concerned us more than anything else was how St Mary's and Chelsea & Westminster would cope with the additional burden, and I think we were particularly concerned with the effect of the closure of the hyper-acute stroke unit at Charing Cross and the move to St Mary's. We were also concerned by the poor state of Imperial at St Mary's and to a lesser extent the Western Eye Hospital (although the Western Eye Hospital is likely to close anyway and for the specialist departments there to move to St Mary's), but the difficulty we had was understanding where the funding was going to come from to make a major change to St Mary's Hospital which would be essential in order to provide for the closure of Charing Cross, but so far as closing or downgrading Charing Cross and moving to St Mary's, it was not a major concern for us as such provided that the new St Mary's, if I could use that term, was able to cope with the additional burden put upon it.

Q. You have raised the issue of finances and in your submission you have raised some of Imperial's problems. It is at paragraph 2.2 at the bottom of 359 and 360 where you suggest that there will be a need for substantial funding. Can you help with your understanding of where that substantial funding is to come from?
A. I have discussed it with Imperial and to my view the only reasonable solution is the money comes from a Treasury loan because in terms of PFI, I have had a fair amount of experience of PFI hospitals, they can work, and the largest one I think going on at the moment is the Royal Liverpool University Hospital which is something like half a billion pounds. But I do not think that would be a good model for St Mary's. I think St Mary's needs to get Treasury funding probably by loan in order to carry that out.

Q. What, if anything, is the relevance do you think of the sale of the land on Charing Cross, the proposed Charing Cross land sale?
A. I have no idea how much it can raise. Obviously it is a very large area, but you have the problem that you would need to bridge it in any event because you would have to keep Charing Cross Hospital open for quite some time while you were upgrading the estate at St Mary's.

Q. So a degree of uncertainty?
A. A high degree of uncertainty. Imperial is not a foundation trust. Obviously since the CQC report it has put back its plans to become a foundation trust and, although the financial position there has strengthened considerably from two or three years ago, it still is not a strong financial trust. Mind you, what a strong financial trust is these days is hard to say. Most of them are facing considerable problems with the tariff and with earning

enough money to build up reserves.

Q. Just thinking a little bit about the impact on Chelsea & Westminster and St Mary's of the closures at Central Middlesex and Hammersmith Hospital. You say you know that both St Mary's and Chelsea & Westminster were assessed as needing improvement by the CQC. In your view, was the poor assessment of the CQC in any way related to the impact of an additional influx of patients from the closure of the two accident and emergency wards?
A. I think it is always very hard to say what the causes are, but we have been through the CQC report action plans carefully, both ourselves and also with the trusts concerned, and I do not think there has been an appreciable increase in the accident and emergency waiting times or referral times to treatment from the closure of Hammersmith A&E. I do not think that is a major factor.

Q. Is there a risk if there are further closures, albeit slightly further afield, that more pressure will be put on those services?
A. Yes, of course, but Chelsea & Westminster is undergoing a major refurbishment and increase in capacity of its A&E department which I hope would help to cope with that. At St Mary's, the A&E department is very near capacity and I would be concerned that without more investment that that could be a problem.

Q. And in terms of the move of the hyper-acute stroke unit, you say that you and your Committee questioned the decision-making about placing it at Charing Cross for such a short time. Can you expand please on exactly what you mean by that?
A. If we said that I do not think that was what I meant to say. We are concerned with the decision to open a hyper-acute stroke unit at Charing Cross which is now faced with the possibility of the closure in order to gain proximity from the major trauma unit at St Mary's and what we are questioning is whether the decision was right in the first place to have the hyper-acute stroke unit at Charing Cross rather than at St Mary's. I have been at the hyper-acute stroke unit as a patient. It is an outstanding facility and one that plays a major part in ensuring the health of patients within this area.

Q. Do you have any comment on the move to St Mary's in terms of the impact it may have on residents who live further out in the borough and region?
A. My strong belief is geographical proximity is not nearly as important as an ability to offer high-grade patient care. Everybody who is interested is now well aware that your blue light ambulance will avoid one particular hospital and go to one a little further away because the patient care there for the particular requirement is to so much higher.

Q. Does it follow therefore that efficient transport routes are a priority?
A. Efficient transport routes are a priority. An efficient ambulance service is a priority. The London Ambulance Service has suffered very badly from a leakage of highly skilled paramedics. They are conducting a campaign at the moment in Australia to try and encourage more paramedics to come to London, but clearly that is not going to solve the problem immediately.

Q. You raise in your submission as well a number of areas where you say you would have liked to have more information or detail and these are broadly a clear outline about the effects on people's co-morbidities, future plans for specialist services at Charing

Cross and plans for the site, the need for an examination of the allocation of funding to midwifery, a commitment to appropriate expenditure and more detail on the out of hospital improvement works. Looking at those together, while those questions remain unresolved, does that give rise to any degree of uncertainty about whether the decisions that are currently being taken are correct?

A. I would say there really are two factors that worry me particularly, in a way possibly more than that. First is the uncertainty as to exactly what an urgent care centre is. I think we need to educate people on how to use health services. We need a stronger signposting which has to come through the GP surgeries. I am concerned about the smooth working together of adult social care and acute trusts. I am worried about the discharge process. I am worried about our own ability as a local authority to provide good home care reablement to people coming out of hospital. Unless you can deal with those, then I think you have got problems, but they are not just problems that arise from the closure of any particular hospital. I am also concerned about the equalities aspects of this. Many of our residents have poor English and I think we will need to educate them very carefully about how the system works now and how it will work.

Q. Would it be better to have more complete information, if possible, on these kinds of things before taking any irreversible steps?

A. I think it is essential.

Q. I just want to ask you very briefly about the maternity aspects because you commented on the omission of factoring in free-standing midwifery services. How serious, in your view, an omission is that?

A. I think it is a serious omission, but my view is what we really need to do is to improve in-hospital midwifery services. I think that is the need. In fact, with the CQC report the midwifery services at Imperial were rated "Good", which I think is very encouraging.

Q. I wonder even though it is not in your borough do you have a view about the planned closure of the Ealing maternity unit?

A. No, I have no view on that. It is really outside our realm or knowledge.

Q. Finally, I just wanted to ask you about the social care end of things, if I can call it that. If that is not fully financed and functioning and up and running, what are the implications for the increasing use of primary care?

A. I think it is absolutely vital, and I am disappointed because I had thought the Better Care Fund was going to be used for linking up hospital-discharged patients with social care, but the emphasis now seems to be far more on reducing hospital admissions. My view is that is the wrong end. It should be used for better discharge rather than decreasing hospital admissions. A good quality social care service is essential, in my view, to alleviating some of the problems that we see in the National Health Service. We cannot afford to have patients who can be home and should be home and would be far happier at home still in hospital because there is no way of allowing them to go into a home that is unsuitable for them.

Q. Assuming that some of those services will come from the local authority, what further information do you need on the financing of those social care services to be able to assess the implications of the services provided by the LBK&C?

A. I think we have got a pretty good handle on it. What I would hate to see is further

A cuts in funding from central government that make our task more difficult. One point you have not talked about which concerns me enormously is the provision for mental health and particularly acute mental health, and I think that is a problem which will not go away and it is something that we really do have to address locally and nationally.

Q. What effect do you say - my omission - but the omission of that from the *Shaping a healthier future* programme have on the ability of the programme as a whole?

B A. We are treating more of our mental health patients in an acute setting and I think this is not desirable. We are sending, so I gather, although I have asked for a report on it, more patients who are sent to a place of safety under sections 135 and 136 of the Mental Health Act to an acute setting. I think that is extremely undesirable. We have 72 hours in order to treat a patient like that and I think that wasting time in an acute setting is appalling.

C Q. Is it safe to further cut or reconfigurate acute services whilst the financing and the arrangements for out of hospital care remain unclear?

A. I think you cannot reconfigure until you know first that that reconfiguration is practical and secondly that that reconfiguration is possible. It is only possible if you have the estate in terms of land and you have the money to provide the physical estate. You cannot possibly safely close highly specialised, effective and safe units unless you know

D that those can be reconfigured elsewhere.

MS RENSTEN: I have no more questions but if you would like to wait there, there may be questions from the Commissioners.

Examined by THE COMMISSION

E Q. THE CHAIRMAN: I have a simple, straightforward question, I hope. Is the plan safe? In other words, the plan for out of hospital care in the community and so forth, is this safe at the moment because it happening right now, apparently? Is it safe?

A. It could be safe but it is not safe and it can only be safe if we know how it is going to be implemented. You cannot have a plan unless that plan includes an implementation strategy and I do not believe we have that at the moment.

F Q. DR LISTER: I just wonder if you could say a little bit more about the mental health point that you made because you talk about people being sent to the wrong type of unit, to an acute unit, and presumably this is again a question of provision of these services in the community, more community-based mental health?

A. I think this is a very big subject and, I am sorry, I probably started a hare running which maybe I should not, but it is much more complicated than that. It involves clearly the police, who are the force that intervenes when people require to be taken to a place of

G safety. I believe the police in our borough are extremely good about taking people to a suitable place, but we need to establish that always happens. Certainly to take a 135/136 patient to an acute setting or, worse still, to a police station, is appalling.

Q. Are you working with local trusts in order to tackle that, particularly in West London?

A. Certainly our own social workers we put a very high priority on this. We had a working party on it which some people call a task and finish group, I prefer a working

H party. We looked at it in depth. We looked at it with the police, with the local mental

health trust and with our own social workers. It is something which I think is vitally important.

Q. Do you feel that this is sufficiently recognised as a priority when talking about the broader questions of the re-organisation?
A. It is where we live. It is in Westminster, Kensington & Chelsea and Hammersmith & Fulham. I cannot really say what happens elsewhere but in some parts of the country, not in this part of London, it is an appalling state of affairs, but I think we are coping here.

Q. DR HIRST: Just a comment about the working relationships. We heard from Cllr Lukey the difficulty she had working with the Imperial Trust. You mentioned that following the CQC report you worked closely with the trust (the CQC report presumably on St Mary's A&E). What kind of working relationship do you have with the providers?
A. You mean with Imperial or Chelsea?

Q. Just generally.
A. We have excellent working relations with the trusts. We talk to them. We have frank discussions with them. We have been through the action plans with them with the CCG and we have commented and suggested alterations to those action plans, and I am satisfied that our concerns have been listened to, are listened to and that we can work together in order to make the health provision in the secondary and tertiary sector very much better.

Q. That was precipitated by the CQC report. How closely have you discussed *Shaping a healthier future*?
A. Of course we are responsible as local authorities for looking at reconfigurations of the Health Service, but our main role as a local authority, I believe, is to be the patients' voice. Post-Francis it is something that we have taken extremely seriously. We have had public meetings with Imperial, with Chelsea & Westminster and with the Royal Marsden and I believe we have a very good working relationship with them. We have councillors who are actually on the Council of Governors at Chelsea & Westminster. I am on the Council of Governors at the Royal Marsden, another councillor at the Brompton. We take an extremely keen interest in what goes on. We do not with Imperial for two reasons. First of all, Imperial comes under the Trust Development Authority not Monitor, so we do not have representatives there and again we are not host to one of their facilities, but we talk regularly to Imperial. They came to our last Scrutiny Committee a week ago and I go and see them and talk to them and so does the cabinet member. I think we do watch very carefully. We also analyse patients' complaints, which I think is a vital part of being the patients' voice. We look at the way the complaints system is organised and I feel we do help to shape the way that they operate. If the question is how far have I felt engaged in *Shaping a healthier future*, I do not feel terribly engaged in that. I feel in a way it had a momentum which we probably had inadequate input into how it was going to go forward.

DR HIRST: Thank you.

Q. DR LISTER: You say you did not feel particularly engaged with the *Shaping a healthier future* but you also previously interestingly raised the question of the Better Care Fund, where clearly you are supposed to be more engaged, but you talked pretty

much as if it had been steered in a direction that you do not agree with. You think, and I think you are probably right, that it should be focusing more on discharging patients with support into community settings, in the home or whatever, rather than stopping or reducing the number of emergency admissions. Do you feel it has now been effectively steered in that other direction?
A. Far be it for me to get involved in political points.

Q. I was not making a political point.
A. I am a very low-grade politician. I had always been under the impression that the Better Care Fund was to be used to integrate or join-up - awful word - the way that the acute trusts worked with particularly adult social care. It seems to have been steered away by central Government far more and, understandably, if you look at the pressure points on the Health Service, towards decreasing hospital admissions, and there are incentives in order to see that done. My personal opinion is that is unfortunate.

Q. THE CHAIRMAN: Thank you. I am looking at the time slightly, quite a lot in fact, and I am sorry we have over run. Before I let you leave the building, in view of your very good working relationship with providers, could I urge you, on our behalf, to go to those providers and ask them in the next few weeks if they would closely co-operate with us because we are having difficulty getting documentation and answers. Is that something I can ask you to do?
A. I will try but I think you over-estimate my ability to influence them, but I will certainly try.

Q. Judging from you today, I do not think so. Thank you very much.
A. Thank you, Sir.

The Witness Withdrew

THE CHAIRMAN: We will re-convene at 1.45 for this afternoon's session.

After the luncheon adjournment

THE CHAIRMAN: May I welcome you all back to this afternoon's session of this hearing and we are going to be begin with a witness right now.

Witness: MS ELIZABETH BALSOM, Putney resident

Examined by MS RENSTEN

Q. MS RENSTEN: Ms Balsom, could you please first of all give the Commission your full name and address.
A. (Ms Balsom): My name is Elizabeth Mary Balsom and I live 16 Coalecroft Road, Putney, London SW15 6LP.

Q. In front of you, you will see a number of documents to your right. You should see something there headed Volume 4, which logically is the fourth volume down, but I am not sure if it still is. If you look at page 131, that should be the opening page of your submission. I am not sure you are in the right volume. That is your submission?

A. Yes, it is.

Q. Can you confirm that it is true and accurate to the best of your knowledge and belief?
A. Yes, it looks just like the piece of paper I have brought with me.

Q. And you would like it to stand as your evidence to the Commission?
A. Yes.

Q. There is another letter which you submitted after the bundles were concluded and it is a letter dated February 2013?
A. Yes, I found that when I was trawling through my computer.

Q. Pause there a moment. Is that something you would also like to stand as your evidence to the Commission?
A. Yes, I think so, yes.

Q. What I would like to ask you first of all is about the consultation phase. You live in Putney, that is correct, is it not?
A. Yes.

Q. Did you know about the proposed changes to the hospital services?
A. I am trying to remember that because I think I might have responded to the original *Shaping a healthier future* thing which the Imperial Board was sending out because I am a patient at Charing Cross Hospital, so I was going there fairly frequently and I think I probably picked up some information about it there.

Q. Are you able to help with whether or not in your area, the West Putney area, the changes were adequately publicised?
A. Absolutely not. I remember I would go to the patient participation group at my local surgery and had mentioned it there. There is a community website as there are in many areas and I have mentioned it there. I did go along, as I say somewhere here, a sparsely attended meeting at Wandsworth Town Hall it must be two years ago now, but it was not publicised at all. I just happened to know because I was having to trail to Charing Cross hospital very frequently.

Q. What else do you think should have been done about publicising the changes in the West Putney area?
A. I do not know whether GP surgeries were consulted because quite a lot of people do come to Charing Cross. A number of my neighbours have been treated at the hospital and when I was diagnosed with breast cancer five years ago I do not know how I knew that Charing Cross was going to be --- I had once been there to A&E and I asked to be treated at Charing Cross because it is so much more convenient to get there.

Q. Could you pause there. Could you explain to the Commission how you came to be and why you were treated at Charing Cross rather than St George's in Tooting?
A. I asked to be treated there because for me to get to St George's from where I live in West Putney is a nightmare journey whereas to get to Charing Cross I just hop on the 430 bus and in about half an hour I am there.

Q. What do you think the impact upon you in terms of your emotional and physical wellbeing would have been if you had had to have cancer treatment elsewhere?
A. If I had had to go to St George's, I think I say in the letter to Justine, I would have as soon got on the plane to Zurich. I just cannot imagine having to take so many changes of bus or get on a train or do this that and the other. This week I just looked up on the Transport for London website putting in my postcode and St George's and they just send you on this nightmare journey of going to Putney Station - it is so crazy - getting a train to Clapham Junction, getting a train to Balham, getting out at Balham Train Station, walking to Balham Tube Station, an eight-minute walk, going to Tooting Broadway Tube Station and then walking to the hospital. That would just be totally impossible.

Q. Pausing there for a moment. You have talked about your journey times and your experience briefly. Can you assist with whether or not the same applies, to your knowledge, to other people in your area?
A. It would do, yes.

Q. Do you have personal knowledge of other people, I think you are saying who are treated in Charing Cross for the same reasons or not?
A. Yes, I know a couple of people in my road who have been treated in Charing Cross. There seems now to be a policy that if you are, say like a friend of mine who had a heart attack, she was taken on a blue light to St George's.

Q. If the Charing Cross Hospital facility were no longer available to you, having reached the stage of treatment you are at, what do you think the impact would be upon you?
A. I do not know that at this stage because I do not know how much further treatment I might need or whether the cancer will return. I just do not know. On occasions when I have been there over the past couple of years for follow-up appointments I have said, "What is going to happen?" and all the doctors will say, "We don't know."

Q. So you have made enquiries?
A. I have made enquiries.

Q. Of whom apart from your treating physicians?
A. Nobody. Whom is there to ask?

Q. Do your treating physicians know what the future for their service is?
A. Not as far as I am aware.

Q. In addition, you had some treatment from the haematology department?
A. Yes, that's right.

Q. Again the same question: have you made enquiries about whether this is going to stay at Charing Cross or whether it will go?
A. No, I have not because I managed to escape their clutches during that year, because one thing I would say is that I did have to go to the Hammersmith for a bone marrow biopsy. That was utterly painless because I was very frightened about that and I thought it might be painful and so I phoned up and said, "What's going to happen?" and they said, "Oh, we're wonderful here, people come from all over the world to have their bone marrow aspirations and biopsies done", and, as I say, it did not hurt at all. I just went on a

number 72 bus that time rather than the 430.

Q. In terms of the uncertainty about where these services are going to be located, does that have an impact on you?
A. Yes, it does. I do wonder what will happen and various records of mine are at Charing Cross Hospital and yes, I do wonder what will happen.

Q. You also made mention of eye care services you had received?
A. Yes, indeed.

Q. Again, can you help the Commission by explaining what your concerns about those services are?
A. Yes, just by chance about 20 years ago I was a patient at the Western Ophthalmic for about ten years, but I am now a patient at Moorfields. That is so over crowded, I would say if you stand up somebody pinches your seat, and I think it is well-known if you look at things like the Macular Society or the International Glaucoma Association, any of those support groups will say that eye services are under immense pressure. If you take out the Western Ophthalmic, I do not know what Imperial's plans are to deal with the patients they have there but I just do not see how you can take out an eye hospital in London when the demands are horrendous.

Q. Just very briefly in relation to the letter that you have written, is there anything you want the Commission to know in relation to that letter? It is to your MP Justine Greening.
A. It is such a long time ago. I only found the letter when I was going through my computer yesterday seeing what I said at various times. I cannot remember if Justine replied to me, I do know her slightly, and I do not know if it was referred to Jeremy Hunt or what Jeremy Hunt has done on this whole matter, if he has been involved at all.

Q. Broadly speaking, in terms of the reconfiguration of hospitals, and particularly thinking about Charing Cross Hospital, what is your view about the proposed reforms?
A. I think they are misguided. Personally I would like the hospital to stay there because I have been well treated there and it is a very easy hospital for me to reach, so, selfishly, I want it to stay there. On a broader consideration, I just do not understand how you can take out that number of hospital beds because I believe, and I do not have the figures in my head but, say, the number of hospital beds per whatever it is of population, 100,000 of population, we are quite low in this country compared, say, to other European countries, so there is that. I just do not see how you can take out that number of beds and still provide an adequate service because the day I wrote the letter to this Commission, which was 5 January I think, as I mention, the headline in the *Evening Standard* was "London's population is soaring".

Q. So what do you say to the Commission should happen now in relation to the proposed reforms?
A. I would like to see a rethink of the proposed reforms. I would like to see them scrapped. I am not a health economist, but I just cannot see how you can serve the population of West London under what their proposals are and I would like the Commission to emphasise that people south of the River, which is not taken into account in this, do have an interest and a stake in what happens to the hospitals north of the River.

MS RENSTEN: Thank you. If you wait there, there may be some questions from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Yes, thank you very much for your presentation. I am just trying to pick up something I may have misheard. Can I just check everybody can hear all right at the moment? Did you say you are a health economist?
A. No, I said I am not a health economist because I wanted that figure of how many beds per, do they say 10,000 people or 1,000 people, but we are very low in the ratio of beds to population. It is not very good in this country.

THE CHAIRMAN: I have to declare an interest because I have lived in Putney a long time and I attend the same hospital. Any other questions? (Negative) It was very clear.

MS RENSTEN: Thank you so much for coming give your evidence.

Witness: MR JOHN McNEILL, regular NHS service user, Board member, Healthwatch Ealing

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your full name and your address?
A. (Mr McNeill): My full name is John Beresford McNeill. My full address is 14 Hopley House, Bayham Road, London W13 0TU.

Q. Can you please turn in bundle 4, which should be in front of you, to page 1223. Is that your submission?
A. That is my written submission.

Q. Is it true to the best of your knowledge and understanding and do you wish it to stand as your evidence to the Commission?
A. Yes, it is and I wish it to stand.

Q. I want to ask you first very briefly about the consultation process. Very simply, in your view, was it a fair process?
A. In my view, it was not a fair process.

Q. Can you explain why not?
A. Yes, I can. When the process first started I went to a public meeting at Ealing Town Hall in I think it was 2011 and I was assured by one of the senior representatives of NHS North West London (as it then was) that this was to be a proper consultation and that no decisions would be taken without the consultation and consent of the local people.

Q. Could you pause there for a moment. It is entirely my fault, I forgot to ask you, you are, I believe, a board member of Healthwatch Ealing, is that correct?
A. I am a board member and trustee, yes.

Q. Please do go on. You were telling us about why you felt the consultation was unfair?
A. Basically because the reassurances I was given at that stage did not come to fruition. I saw very little difference, if any difference between what was initially proposed and what finally came from the resulting consultation. So I am sorry, but I was not particularly happy with the result and I do not believe it took into account a lot of the evidence that had been given.

Q. In terms of the publicity given to the consultation process and its accessibility by members of the public, was that done correctly or not?
A. I would not say it was done incorrectly. I would say it might have been done better. There was a provision for written submissions to be made and I presume in that case it probably was done reasonably correctly.

Q. Are you able to help with whether or not it reached all sectors of the population?
A. I very much doubt it.

Q. Are you able to help - you may not be, I do not know - with which sectors of the population it did not reach?
A. I do not think it would have reached people who live in places where I now have to live in sheltered accommodation where very little information gets through to the elderly and disabled in the borough. Unless they actually get the local paper or try and find out themselves, there is very little information that comes through.

Q. I want to ask you about the impact of the closures so far. We know of course that Central Middlesex and Hammersmith have had their A&E departments closed. Can you help us with your view on what impact that has had on you personally and on people in the locality that you know?
A. The impact on me personally is that I have witnessed at Ealing Hospital A&E a large growth in attendance and lots more pressure on staff. I had to attend there, unfortunately, in October of last year. I spent most of the night there and I could see the pressure that everyone was under and I can presume that a lot of that is down to the fact that people cannot go to places that have been closed.

Q. Had you used that facility previously?
A. Yes, I had.

Q. Before the closures?
A. Yes, I had.

Q. And was it the same or different?
A. It was more busy this time.

Q. So what do you say the likely impact or in fact the impact thus far of the closures of the other A&Es has had an Ealing?
A. I think it has had a very detrimental effect. I have been advised by staff at Ealing Hospital now that if I was to be taken ill at my home in Ealing or if I was to be involved in a serious road traffic accident in Ealing, my chances of getting treatment quickly and locally are much reduced.

Q. And is that predicated on the basis that Ealing's A&E department is to be closed or changed in structure?
A. I am very wary of that happening.

Q. Tell us what you think the impact will be if that department closes or is downgraded?
A. To me it will be a nightmare because we also have the news coming through that Ealing Hospital itself may well be down for closure and that will mean there will be no in-patient beds left in the whole of the London Borough of Ealing and patients will have to travel a long way or be taken a long way in order to get treatment. And on top of that their friends and families will have to make some very difficult journeys in order to go and see their families.

Q. What is your understanding of where patients will go in those circumstances?
A. My understanding is that Northwick Park either has been or is due to be expanded in some way. Northwick Park is a long way away. It could take up to an hour in the rush hour to get there from where I live. I also have been told that there might be other expansions, I think Hillingdon was mentioned. Again, that is a long way away.

Q. You raised concerns about fragmentation of services?
A. Yes.

Q. And about the possibility of records not being properly shared between different treating clinicians. Is that something from your own personal knowledge?
A. It is from my own very recent personal experience only in the last couple of weeks.

Q. Is that something you would be prepared to share with the Commission?
A. Yes, of course.

Q. Please do.
A. I was referred by the consultant neurologist at Ealing Hospital for tests and a second opinion at Charing Cross Hospital. I attended to see the consultant at Charing Cross who then made the appointment for me to attend again for some tests to be carried out and I spent most of the day there. When I had my follow-up consultation at Ealing, the consultant at Ealing had no access at all to the results of those tests that were carried out at Charing Cross. That was over period of about a month.

Q. You may or may not be able to help with this. To your knowledge, is that something that you just know about in terms of yourself or are you aware of this happening to other people?
A. I have not discussed it with other people.

Q. You have a particular interest, you say, in transport?
A. Yes, I do.

Q. Can you help us with your view of the Transport Advisory Groups that have been set up? Do you know what their role is and whether or not they are effective?
A. I have heard little or nothing about them. I really do not know much about them at all.

Q. On the ground in terms of transport between hospitals are you able to help with what actually happens now? Perhaps if we take it in two stages. In terms of a non-emergency situation that requires some form of hospital transport, what is it that you say happens?
A. Well, my experience is non-emergency. Although I have had emergency transport in the past, my main concern is on non-emergency transport. I have to attend at the moment three different locations, Ealing, Charing Cross and Clayponds in Ealing and I now use patient transport non-emergency for all of the appointments that I have. And at the moment I am roughly running at about one every week to ten days to any of those.

Q. Is patient transport provided when it is needed?
A. It is provided. My concern is the style of transport, the qualification of the staff who run the transport and the timing of the transport. Those are my three key areas where it goes wrong.

Q. Perhaps if we take them each in turn. Start with the first one and tell us what your concerns are about that?
A. My concern for the vehicles provided, albeit manned by private sector people, if it is an NHS-branded patient transport purpose-built vehicle, then that seems to be okay, but on many occasions my hospital transport is passed out to a local minicab firm which for me being partially disabled is very difficult when their main priority, their drivers' priority is to get the job done and be back on the road as quickly as possible. So patience can run thin with the driver if I have difficulties. They are not kitted out like a proper passenger ambulance. The drivers are not trained so how they would deal with anything urgent or emergency in transit I really do not know. I am sure they do not. And for timing it is a matter of whether you get to your appointment on time or not. I have had several cases where I have been picked up late, I always have to be ready two hours prior to my appointment, which I always am, I am always ready in time, but if I am not picked up until about the time of my appointment I could be half an hour three-quarters of an hour late getting to the hospital or to the clinic. There was one occasion where I arrived after the clinic had closed so I could not be seen that day and had to be sent home again.

Q. Do you know who decides, who makes the decision about whether a particular patient is to be sent in hospital transport or contracted out minicabs?
A. Hospital transport initially is arranged via my GP. If I have to attend a new clinic for the first time that has to be organised via the GP and the GP contacts the hospital transport people and it is fixed up from there. If it is for a repeat appointment with the same clinic, I can just book that or it should be with the hospital transport people automatically anyway.

Q. But in terms of whether what is sent to you is an in-house vehicle or a private vehicle?
A. I really do not know. I have no control. I said in my submission that I find hospital transport a lottery, and I chose that word very carefully because in a lottery you can win, you can have a very good experience, but also you can have a very bad experience.

Q. Just thinking about the way things have evolved over time, are you able to say whether the transportation system is the same as it used to be, better, worse? What direction are things moving in?
A. It is getting worse. Most of the hospital transport, in fact almost all hospital transport

now, I believe, even if the vehicles carry the NHS logo, are run by private companies and on that basis, I am afraid, it seems that finance comes before patient care.

Q. Are you concerned, do you have concerns about the risk involved?
A. I have concerns about the risk involved when there are non-trained drivers in minicabs. If I can give you one example where there was a severe risk quite recently.

Q. Please do.
A: I had been to Charing Cross for an appointment. For transport home I was put in a normal saloon car from a cab company with my walking frame, which they had great difficult finding room for in the vehicle. I was then joined by two other patients both with large sets of crutches. One of the patients had just been discharged after a knee operation and there was just no room in the vehicle for her to be comfortable stretching her leg. There was no room for the seat to be moved because the three of us were packed in the back of this vehicle. I am sorry but that to me is a big risk.

Q. I wanted to ask you now a little bit about your role with Healthwatch Ealing. There is another bundle there and it is headed Volume 2. I wonder if you could please turn to page 673. My understanding of that document from 675 is that is a submission from Healthwatch Ealing. If you just turn over to 675, you will see it is signed by somebody called Carmel Cahill.
A. I know Carmel, yes.

Q. Chair of Healthcare Ealing. What I wanted to ask about is what is your role first of all as a board member on that body?
A. It is a double role firstly as a board member and secondly as a trustee. As a board member it is to receive reports, discuss the operation of Healthwatch Ealing, make decisions at board meetings, which happen every couple of months, about policy, staffing, those sorts of issues, and on the trustees' side is to keep an eye to make sure that the operation is actually running according to the right rules for that sort of organisation. It is a statutory body.

Q. Can I ask you is this a document that you have seen before?
A. I have not seen this before, no.

Q. We can go through it together, but is this a document, is it a submission to this Commission from a body of which you are a board member signed by the Chair?
A. Yes.

Q. Is it a document that you would have expected to have seen before?
A. Yes, I would have expected to have seen it.

Q. Does it give you any concern, we will come to the contents later, that it has been submitted without your knowledge as a board member?
A. Yes, I am concerned about that. There is a board meeting next week and I will be raising that issue at the board meeting that I was not given foresight of this document.

Q. Can we turn to the contents? If you have not seen it before, we need to take it fairly slowly. What this document suggests - this is at page 673, paragraph 1 - it talks about

Healthwatch Ealing having been involved in the facilitation of publication and publicity about the consultation and it refers to having published and cascaded proposals, facilitated communications, promoted public attendance, held a number of discussions, hosted consultation events and hosted public meetings where various bodies including the CCG and the hospital trusts were present. Does that chime with your understanding and knowledge of what has gone on?
A. Not particularly. Not in that detail. I was aware that there has been a reference to the Commission in the documentation, but I have not been aware of anything more than that.

Q. Perhaps if we can turn over the page to 674, what it says you will see paragraph 3 on the side, it is headed "A&E Closures". What it says there is that "although only a small number of Ealing residents are directly affected by this change", can I invite you to comment on that, is that a view you share?
A. No, it is not a view I share. If I had seen that before it was submitted I would have challenged it.

Q. What do you say in terms of the true number or the true percentage if you like of Ealing residents who are directly affected by these changes?
A. I would suggest it would be more than 50%. If we are looking at A&E closures and hospital closures that are planned, the effect will be on the majority of patients in Ealing and their families and friends.

Q. The document just in the sentence below goes on to say this: "Although only a small number of Ealing residents are directly affected by this change we monitored the implementation through our involvement in the TAG." That is the Travel Advisory Group. You said earlier that you had had no information from the Travel Advisory Group.
A. Correct.

Q. Can you help us with that submission how that comes to be then if you as a board member have not had involvement? Where does that come from, do you think?
A. I can only presume it has come from the paid staff of Healthwatch Ealing. I have not seen this as a board member before today.

Q. Does that not accord then with your understanding of what has been going on between Healthwatch Ealing and the Travel Advisory Group?
A. I have no knowledge of what has been going on with the Travel Advisory Group.

Q. Is that no knowledge or are you able to say whether that is correct or not?
A. I do not know what involvement staff at Healthwatch Ealing might or might not have had.

Q. Moving on, still on the same page, Ealing Maternity, what it says is this: "Members of Healthwatch Ealing have been much more involved in the development of these plans and have been successful in adding additional engagement and research undertaken during the early phases of this project. This work led to a remodelling of the numbers of women, who would go where. We have been involved in the communications workstream and have been successful in having copy amended to make it clearer and more accessible. We have championed more in-depth engagement with local women and have been part of the

SaHF internal assurance group which has visited all maternity units." Are you able to help with what that actually means?
A. I am afraid I am not, and, again, if I had seen this before today I may well have commented on it to Healthwatch Ealing. I know there have been discussions with mothers in Ealing about the proposals. That is what Healthwatch is there for and that is what the staff do. I as a board member have not been particularly involved or advised in terms of the Ealing maternity arrangements, just only been kept aware that it was happening.

Q. Are you able to say what the view of Ealing Healthwatch is - and you may not, it may simply not be your remit - whether or not they do support the closure of the maternity unit.
A. I think I would rather leave that to ---

Q. That is absolutely fair.
A. --- Healthwatch Ealing to speak for themselves. I have made my views clear to local groups but, no, I am sorry, I would not like to continue with that.

Q. Finally just to clarify, if this is a document that you have not seen and it does not accord with your views, and I think you have made that clear?
A. Yes.

Q. If I am paraphrasing too far do stop me ---
A. --- In parts.

Q. There are elements of this that you are not in accordance with?
A. Yes.

Q. Does that give you concern about whether this is or is not an accurate reflection about what other members at Healthwatch Ealing might actually think?
A. It does give me concern and, as I have said, there is a board meeting next week and I shall be raising this exact issue at the board meeting and I shall also then be able to ascertain the views of other board members.

Q. Are there any other issues in relation to either this or in relation to your personal experiences of healthcare that you feel would be of assistance to the Commission?
A. My main reason, two reasons for putting in my written submission in the first place was for me to be able to comment on the actual plan for *Shaping a healthier future* which I found to be not at all a good path forward. I think it has been used to cover up cuts and closures. And, secondly, I wanted to get my views across on the patient transport situation because with hospitals closing that is going to mean longer journeys for patients to get to and from appointments and admissions. It is going to mean a lot of inconvenience for friends and families. I cannot see the way patient transport is currently run in North West London and my experience of it that the extra work that is going to be entailed for patient transport taking people for longer journeys can even start to work.

MS RENSTEN: Thank you. I have no more questions. If you would like to wait there, there may be some from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: I have three questions. The first one relates to the consultation you have described in the written document as "a sham". What I really wanted to know is you had a meeting, I think you said, and what I want to know is what was your input which you feel has really been sidelined because it is a *fait accompli*? What did you provide for them?

A. I did not actually provide anything. I attended a public meeting, a public exhibition, which was held in Ealing in order to describe the services and I was pointed to a particular person who was a lead in the *Shaping a healthier* future plan. I spoke to him personally and he assured me that everything would be taken into account and nothing would happen without the agreement of local people. That did not happen.

Q. I want to get to the point. Were they provided with reasoned opposition to the plans which they overlooked?

A. There was plenty of opposition from local groups, some of which I have attended meetings of, who put in quite severe criticism and questioning of *Shaping a Healthier Future*.

Q. Second question: related to urgent care centres and should they appear, as far as you are personally concerned, would they be a satisfactory alternative?

A. I would say not. Working on the basis of my experience in A&E and talking to staff, the shortage there is undoubtedly going to be of in-patient beds and is going to put absolutely unnecessary stress on promoting A&E services. The question of bed-blocking comes into this as well that if we have got a much fewer number of beds available then without the social care aspect, community care and in response to the A&E closures I can only foresee a very, very bad future for patients in Ealing.

Q. The third question relates to an organisation of which you are a member, the Council for Restorative Justice, which is dealing with young offenders and various mental problems and so on. How does this impact this whole programme of reconfiguration? How does it impact in that area, if you are able to help on that?

A. My experience of working with young offenders is that at the moment they get minimal help if they present with mental health problems or addiction problems. There are things that can happen, people for them to see, but then it is a matter of what happens after that for the availability of back-up services for them then to be passed on to, and all I can see is if we are going to finish up with fewer facilities in North West London generally, which appears to be the case, then that will reduce the option for young offenders to get access to services.

THE CHAIRMAN: Thank you.

Q. DR LISTER: I wonder if I could take you back to the issue of Healthwatch Ealing. This is a latest incarnation of what in years gone by used to be community health councils, and community health councils varied in the quality of what they did, but I suppose I am going to ask you, to what extent is this actually a replication of that because I note in the final paragraph of this letter it says: "We believe that out of hospital plans are developing well in Ealing." That does not correspond with what we have heard in other areas in terms of the implementation of the SaHF proposals and it does raise a question of

whether they regard themselves as a voice of patients or information bodies for those promoting these changes. It does look from this letter as if it is the second that is the case. Do you feel from your point of view that it is an effective body representing consumers in Ealing, which I thought it was supposed to do?
A. It was about a year to 18 months ago I was sent an application form to become a board member of Healthwatch Ealing. I thought this would be a good idea, a good way to get patients' views heard and so on and so forth. When I joined and I realised that basically it was just a communication channel and not a lot more, I asked about do we actually campaign on local issues, do we get involved, and I was told no, statutorily we are not allowed to campaign, and so my experience of Healthwatch has not particularly been good and I am currently considering my position with Healthwatch.

Q. DR HIRST: From that, I gather there is not much "watch" in "Healthwatch"?
A. I think there is "watch" in terms of receiving communications from patients who want to raise issues that can then be communicated onwards, but when it comes to being active as an organisation that is where it does not seem to be doing a great deal.

Q. Can I ask, an already recurring theme is how much the out of hospital services are going to prevent admissions because that is one of the bases on which SaHF and H&F hope to facilitate the reduction in beds. You are, unfortunately, I can see, what is called a "service user", we used to call them patients.
A. You can call me what you like!

Q. Have you been aware yet, personally for example or through friends, of coming into contact with any of the new developments in out of hospital services?
A. I have had contacts with friends who have had contacts with maybe family members who feel that they are not getting now a good enough service when it comes to A&E responses.

Q. For example, can I push this a little bit further, do you know anybody who has come into contact with a care planning co-ordinator?
A. No.

Q. Have you had contact in respect of your obviously chronic medical condition with any prevention or planning?
A. No, I have a good relationship with --- well, I have had to change my GP because I have just had to move into sheltered housing, unfortunately, and I have had to change my GP as a result of that. I have always found GPs who I have seen and been with before, and my new one who I have met once now, are very supportive and want to do everything they can for me, so if there was a crisis I am sure they would do their best to help me. It is just at the moment I do have several conditions which require me to make lots of hospital visits.

Q. But you have not yourself heard of anybody making use of one of the new projects in which those who are chronically ill are assessed in order to prevent admission?
A. No, I have not.

DR HIRST: Thank you.

THE CHAIRMAN: Thank you very much for your presentation and for coming.

The Witness Withdrew

Witness: MR TOMAS ROSENBAUM FRCS, Consultant Urologist, Ealing Hospital

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your full name and professional address and your current post, please?
A. (Mr Rosenbaum): My name is Tom Rosenbaum and I am a consultant urologist at Ealing Hospital.

Q. If you turn please to Volume 5 of the documents in front of you, your submission should be the very first document there. It is pages 1543 to 1546. Can you confirm that is your submission?
A. Yes, I can confirm.

Q. It is true to the best of your knowledge and understanding?
A. Correct.

Q. And that you wish it to stand as your evidence to the Commission?
A. Yes.

MS RENSTEN: I have just been reminded to check can people at the back hear this witness?

SPEAKER: I can see the microphones are switched on but I am not convinced the speakers are working?

THE WITNESS: Can you hear me now?

Q. MS RENSTEN: We will do our best, okay. Can I begin by asking you to confirm how long you have worked at Ealing Hospital?
A. 19 years. I was appointed in January, I started working in January 1989.

Q. January 1989?
A. Sorry, 1996.

Q. Is it fair to assume then that you have an in-depth knowledge of the local population?
A. Well, I think so. I think I have got some knowledge of the local population. I have worked in intimate contact with them all that time, yes.

Q. And in your submission you set out the development of your service and the surprisingly high uptake of that service. Could you recap for the Commission and others present, please, what you say about who is using those facilities and why? Can I give you a reminder with the voice straightaway.
A. I have worked very hard at Ealing Hospital over all this time and I have always seen myself my main duty being to provide the best possible service to the local community.

Over the years, my work increased constantly and eventually I was driven to count how many patients I actually saw and why my service was so big. Essentially, I was getting 50 new referrals every week, which is a large number in all terms. Nobody believed it so I collected the referral letters from GPs and presented them to the Chief Executive and they tried to back up the service accordingly. There was always reluctance to do that because it was costly and the usual excuses, but it was a large service. I also had a very open service to the local GPs. We had a lot of communications by phone and then eventually by email and my secretary was always very busy. In fact, the impression was that nobody knew where the patients came from. I was not the only one of the clinicians at Ealing who had that experience. At meetings in the hospital we were told that that could not be possible because the population that we serve was very small, it was 200,000 or around there. Eventually, most of my colleagues that worked at Ealing agreed that the numbers did not tally with the population that we seemed to have, so that is where I started looking at different reasons why this would be the case.

Q. Can you pause there? Can you help us with when you undertook your research, just roughly?
A. About three years ago, three or four years ago.

Q. Please do go on.
A. We all agreed that the reason is that the population that we serve is probably much, much larger than what is generally assumed and looking at the type of patients that we look after, I looked after, most of them came from Southall. The work I did is very simple, I just went to some travel agents in Southall and asked what was the communication between Southall and the Punjab. Punjabi is the largest minority group of patients that we look after at Ealing. I was astounded when I found out how many flights there are between Heathrow Southall and the Punjab and they are all full.

Q. Pause there a moment. Am I correct that what you are saying is, one, there is a much larger resident population using your service in Southall than is measured?
A. Correct.

Q. And, two, there is also a large peripatetic population, again unmeasured, that comes and goes? Have I got that right?
A. Correct and what happens in the clinics it is very common that patients come and say "I am just about to take a two month holiday." "Where are you going?" "I am going to visit my family." That is extremely common.

Q. As far as you are aware, and I do not know if you can help with this or not, do you know whether those sections of population have been included in any of the figures on which this exercise is based?
A. No, I do not know that. It is impossible. I would not have the tools to do that.

Q. Are you able to say, you have estimated, or guesstimated I should say, 400,000 to 500,000 in terms of the population. Is that including the peripatetic population or excluding it?
A. Including those I would imagine, but talking to my colleagues in the specialty very few nationally have got such a large number of new referrals every week. It is very rare. So they keep asking where do these people come from. Well ---

Q. So your clinics deal with a far larger population than on paper you would imagine them to?
A. Correct, what we expected.

Q. You say in your submission that it is "madness" to downgrade Ealing Hospital. Can you help us with why it is madness to do that?
A. Well, my experience has always been that the main population that we look after is in Southall and Southall is a large urban area of population which requires healthcare services. They are poor, they are in a poor health state. We know there is a much higher than average level of cardio-vascular disease and of certain infectious diseases and of metabolic syndrome. Also it is a very buzzing area that is very active commercially and productively and on the educational front it is quite buzzing, and I am sure they contribute largely to the local economy and Ealing is their local hospital.

Q. If we take it stage-by-stage, if the emergency service at Ealing is downgraded to an urgent care centre, what is the impact on that sector of the population?
A. Again, I cannot say, I am not a healthcare economist but I can imagine, we know already there will be great difficulties because other sectors of the hospital have been downgraded and the communications to and from the hospital are not very good transversely. They are good radially but not very good transversely. And the other hospitals available are transversely away - West Middlesex and Northwick Park - and it takes a long time to go to those hospitals. I know that because I have meetings there, I drive there when I can. The buses are hopeless. I am sure that it is going to have a big impact. In fact, a number of my patients have been transferred because half of my service has been decommissioned. 500 of my cancer patients have been decommissioned and there have been huge difficulties.

Q. Pause there for a moment. I am going to come back to that in a second. In terms of in-patient beds, if those are reduced at Ealing, again, same question, what is the impact?
A. It is very difficult to say. We know that in my specialty we ran for a while a "see and transfer" service from the casualty department. That has been reversed now because the other hospitals could not cope. So we are at the moment seeing the patients again at Ealing Hospital. So the provision available at the moment is not sufficient. That may change in the future but at the moment that is the situation. The long-term impact - I have not got any scientific data on that. I know that a lot of patients would find it much more difficult to access the other hospitals from Southall than they did and they would do so in future if Ealing is no there.

Q. Is this something that patients have been saying to you directly?
A. Yes, many times. Not only that, I have been accused of seeing patients outside the rules because they could not access the other hospitals and that has led to disciplinary action on me because I saw patients that I should not have seen because the service is decommissioned theoretically.

Q. Thinking about it from a clinical rather than a personal for individual convenience perspective, what do you say the clinical effects of patients having to go for treatment to those other places will be?
A. I personally think that long term we are going to see a decrease in standards of

healthcare in Southall but that we are not going to see that immediately because it takes a number of years to see the final healthcare outcome in conditions like cancer services, for instance.

Q. You mentioned that half your service was being or had been decommissioned?
A. Correct.

Q. Can you help us with whether that is part of the *Shaping a healthier* future programme or outside of it, if you know?
A. I do not. I do not. What I do know is that there was great pressure to do so and as part of a number of reviews there were studies done, I do not know how correct they were, on the provision of cancer services, and the decision by the Commissioners was to decommission all urology cancer services at Ealing, and that was half of my patient load. I have got another colleague, but in my patient load that meant that 500 patients who were being seen or followed up for cancer were told that they would have to go to another hospital.

Q. Do you know which hospital that was?
A. They were sent a list of hospitals and were told that they could go to any of them but not to Ealing.

Q. Do you have a view about the impact that that has had on those individuals?
A. Yes, of course. I have got a very strong view about it to the extent that I felt that my duties as a doctor were more important than that and a number of patients that could not go to the hospitals they were told came to see me, and I did see them and as a result of that I was sanctioned.

Q. Do you also have a view about the proposed use of out of hospital and primary care services to reduce acute beds and acute facilities?
A. Yes, I do. I think that medicine and society is changing all the time and fast and technology changes, and I think that the provision of healthcare services will change and I think that is very important that it should continue changing. How much of those services go to the community or which ones, I am not sure, but I think that we should be aware of costs and as long as quality is maintained I am very supportive of transferring services elsewhere.

Q. Are you able to give us a view or comment on the extent to which you think use of primary care and out of hospital services will allow acute services to be reduced?
A. No, it is only empirical really. No, I am not sure. It will be 10% or 20% less perhaps, I am not sure.

Q. Finally, I just want to ask you this, the *Shaping a healthier future* programme is predicated on the reduction from nine major hospitals to five major hospitals. Just from your experience as a clinician, do you have any comment about whether you think that is an appropriate or safe way to proceed?
A. Well, I think that from my experience, from what I have said, it is obviously not a good move, but I do think that health services will change. I think that they should be changed according to the needs of the population rather than on a theoretical appraisal which does not follow the needs, as I have just said. The local population at the moment

is exploding, is growing, and I personally think that, geographically, Ealing Hospital is the one that is placed in the most accessible position for that population. It is amazing. It is on a main radial artery. We are going to have a major new public transport service which is about to be built in Hanwell through Crossrail.

Q. This is Crossrail you are referring to?
A. Crossrail. We are walking distance from Hanwell Station and Crossrail. This is a major public service. I cannot believe in the middle of those changes and progress we are actually planning to close or downgrade such an important public service.

MS RENSTEN: Thank you. I have no more questions, but if you wait there, there may be questions from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Just in the light of your last answer, is there any indication that they might want to close Ealing Hospital in order to buy the land or use the land in relation to projected building work for private enterprise?
A. There are a lot of rumours about that. I have no hard evidence but I have been told many times and that may have already happened.

Q. But you have not heard anything more than rumours at the moment?
A. The other thing that I see is that there are areas within the land of Ealing Hospital that are fenced away now as we speak and building work is taking place.

Q. When did that start happening?
A. About three or four months ago. That is independent from the re-development of the mental health trust which is behind the hospital, but on the west side of the hospital a number of areas which were residences and near what we call the Gatehouse are now completely fenced off and serious building is taking place there.

Q. What sort of building?
A. I cannot tell you. There are big fences around that.

Q. The second question relates to your predicament if you do not mind me asking you about this. What were the other hospitals that could not cope? Which other hospitals? Where were they such that there was an influx to you as a result?
A. The closest communication we have now is with Northwick because (a) we are now merged officially and (b) the urology department is technically a joint department, so our patients from casualty, if they are transferred, are transferred to Northwick Park but when they cannot cope they stay at Ealing, so Northwick Park is the closest unit at the moment.

Q. Can you give us some indication of the extent to which they cannot cope and you have to take over?
A. To the extent that the see and transfer policy that was implemented for a while over weekends has ceased to be implemented because they could not cope.

Q. I need to get a numerical figure, some idea of what we are dealing with here, what you are dealing with.

A. I am not sure. We are talking about maybe half a dozen patients every weekend.

Q. That is quite important. The third question: you were sanctioned for it seems to me performing a public duty. What is the sanction and who imposed it?

A. Well, that is a very poignant question. It was imposed by hospital management for not following to the letter the cancer guidelines. They brought to the inquiry at the time about six or eight clinical examples of patients who were largely mixed pathologies who had cancer and also had, for instance, stones or incontinence or bleeding and who were generally quite infirm and had difficult mobility and obviously I said yes, I will see them, they need to be seen, and they were all brought up as examples of me breaching the guidelines. The final example was a patient who was referred directly to me because I had operated on him in the past and he was seen in a multi-disciplinary meeting and had a further finding that required surgery that could possibly have been cancer, and I was asked by the oncologist that saw him if I would see him again, because he knew me and he wanted me to see him again for the same condition, and I said of course if the patient wants to and needs it, of course I will see him. And on the basis of that, I was sanctioned quite severely and an attempt was made to suspend me and fire me. I was fortunate in having a good legal team and I took them to the High Court and the High Court judge decided that that was unlawful and that I should be reinstated. The hospital had to accept that, but in fact up to today in practical terms they have not yet allowed me to continue my clinical work at Ealing.

THE CHAIRMAN: I will reserve judgment for a moment. Any other questions?

Q. DR LISTER: I declare an interest because I was actually in a car with Tomas Rosenbaum trying to get from Ealing Hospital to Northwick Park for a meeting a reasonable time ago and it did take an incredible amount of time, about four times what you thought it was going to take. Two things. You refer to dogma underlying the plan to reconfigure the hospitals along these lines. I would like you to say a little bit more about that and then I have got another question for you.

A. I am not an expert in health economics, I am a urologist, but I try to understand a bit about the impact of medicine in the society I live in. I do believe that there is an ideology behind the change that they are trying to impose and the ideology is partly that big hospitals are better than small hospitals and that they may provide long-term a better healthcare outcome, and that is what I consider a dogma. However, there are other ideologies at the moment, perhaps more modern ideologies, that say in fact that has been shown not to be the case and that district general hospital are probably more beneficial to the population long-term. That is all I want to say. I think this is complex. I think there is dogma. There is ideology behind this and different interested groups will use whatever dogma they prefer to their advantage. My feeling is that the service that was provided and is still being provided to some extent from Ealing Hospital is so vast to this big population and needy and vulnerable population, which has such an important impact in our society, that I just cannot believe how somebody can come to the conclusion that this is the place that needs to be downgraded and possibly closed.

Q. I believe the research indicates that the economies of scale stop at 600 beds and between 200 and 600 you get economies of scale and not beyond that. The other question I wanted to ask you is about these 500 patients that you can no longer treat and are now having to be passed on somewhere else and you referred to guidelines. Did the guidelines

take any account of the fact that there may not be capacity in other hospitals in North West London to treat these patients? Do you know where they went to?
A. No, I do not. The guidelines obviously did not take that into account. The guidelines have been shown to be not sufficiently clear and they in fact did not explain or were not useful for the management of these patients that I did see and that has been shocking. That is why the High Court judge said it was unlawful.

Q. So were they drawn up by the trust or by the commissioners?
A. They were drawn up by various people and they continued changing over time and various groups of networks developed them in each area. We have a cancer network in the area that continued inputting and are continuing inputting now into those guidelines.

Q. Could we get a copy of the guidelines to have a look at?
A. I certainly can pass you some copies, yes.

Q. DR HIRST: I think I have got three questions but I will limit it. The first thing I would like to test is the idea that Ealing is an example of a hospital which could not have A&E services because it could not provide the necessary acute specialist skills that are necessary nowadays. I suppose this is because there are no surgeons like you who would have had a general training. They do not exist any more and we have the fast track specialties and therefore you have to have a degree of specialties available. If that were true, and I am prepared to have that challenged, how would Ealing provide that? How would Ealing manage to provide that range to cover a modern A&E?
A. The only thing I can say is that over the last month Ealing has appointed two new general surgeons. It was a clinical need. It was advertised. Two very well qualified general surgeons applied and got the jobs.

Q. Who can use an endoscope?
A. They are fully qualified surgeons that do laparoscopic surgery, general surgeons.

Q. So they would cover the acute trauma or acute soft tissue injuries and so on?
A. Not only that but I also want to say that if there is the will to develop a service then it can be done.

Q. It can be done?
A. Yes. The one thing that does take longer to build up is the team but individuals to do certain specific jobs can be appointed. The team takes longer to build but if there is the desire to keep the services at Ealing then it can be done. At the moment a lot has been downgraded already. It may have to be reappointed and redeveloped. Fine, it is not a big problem.

Q. I think we may hear this from other witnesses, but I have heard this idea that when SaHF was being proposed it was based on the idea that modern day case techniques were coming in that would allow people to be discharged on the same day and therefore the number of overnight stays, unless there was a boo-boo that happened, would not be needed. But on the contrary, as I saw in fact before I retired, we are beginning now to treat patients of a great age who are much more frail and therefore with the best will in the world need beds to manage. Do you think that is a reasonable thought? Has that met your experience in recent years?

A. Yes, both statements are correct. In my practice over the last almost 20 years the number of day case surgeries and the number of patients that are treated by keyhole and endoscopy and laparoscopy has increased dramatically. About half of the patients in my operating list are day cases and quite sophisticated, complex procedures. Many of them are very aged as well and they often can go home if not the same day, very soon afterwards. If that can be maintained when patients get even older and frailer, I am not sure, but what I am sure is that the closer the hospital is to their residence, the easier it will be to discharge a patient back home and to back them up if they have any problems again, but then one has to find a balance because you cannot have a hospital on the doorstep of every individual.

Q. A final thought, I do not know how to phrase this, and you can decline to answer this especially if you are a "bad boy" at the moment. When I look at the map I have this feeling of bias, if you like, towards St Mary's and so on. How much do you think medical politics has influenced the fact that seemingly a black hole will develop around Ealing?

A. I think we are free to talk about it because in fact at my age I am not that at risk any longer. I think hugely. But having said that, personally I have quite fluid communications with most of my colleagues. Everybody wants to develop their own service and we know there are big pressures on St Mary's to develop their hospital. Sure, huge, huge. But I also believe that long-term we will realise that the attempts to close district hospitals like Ealing close to such a big and growing population will be a mistake. What happens at St Mary's it is difficult to judge. There are huge politics in medicine. There are enormous politics. There have always been huge politics in medicine. Again, on that front, my feeling is that as doctors go in general, doctors are not participating in politics sufficiently. I think that we must wake up and participate a lot more. We must realise that our job is important in society, in the community and our views and our experience matter. Therefore one of my, if you like, little statements these days is that we can no longer afford not to be involved in politics and, at the end of the day, this is one of our duties in society.

Q. THE CHAIRMAN: I have a follow-up question. I am interested to know on the ground at the moment to what extent you are able to encourage your colleagues to follow your thoughts?

A. Well, I have tried, I am active in the BMA, in the British Medical Association. I am in fact the Honorary Secretary of the local division and I keep sending emails to my colleagues saying that. Most of my colleagues agree with the statement that I just made and I have got a second little statement which is "If we are not at the table, we will be on the menu" and it causes exactly the same reaction, but from that to action is a long way to go.

THE CHAIRMAN: Thank you very much. (Applause)

The Witness Withdrew

MS RENSTEN: I think the next witnesses are Merril Hammer and Jim Grealy

Witnesses: MS MERRIL HAMMER, Chair, and MR JIM GREALY, Assistant Secretary, Save Our Hospitals.

Examined by MS RENSTEN

Q. MS RENSTEN: Starting on the left, could you please give the Commission your full names and addresses.

A. (Ms Hammer): I am Merril Hammer. I am Chair of Save Our Hospitals. My address is the same address as is used for Save Our Hospitals, 7 Kimbell Gardens, London SW6 6QG.

A. (Mr Grealy): My name is Jim Grealy, same address, 7 Kimbell Gardens, SW6 6QG and I am the Assistant Secretary of Save Our Hospitals, Charing Cross and Hammersmith.

Q. Could I ask you, please, to look first of all at Volume 3 and if you could turn, please, to page 1178, that is a document from Charing Cross Hammersmith Save Our Hospitals. First of all can you confirm that that is your submission?

A. (Ms Hammer): I can confirm that but I apologise for some of the typos I found yesterday.

Q. Do not worry about that. Subject to the typos, can you confirm that it is true and accurate to the best of your knowledge and understanding?

A. (Ms Hammer): I can.

Q. And you wish that to stand as your evidence to the Commission?

A. (Ms Hammer): I do.

Q. Can we also turn very briefly, there is another bundle in front of you, Volume 4, and if you turn, please, to page 1439, there is another short document there. I think that Ms Hammer only, can you confirm again, is that your submission?

A. (Ms Hammer): It is a personal submission, yes.

Q. And also true to the best of your knowledge and understanding and you wish it to stand as evidence to the Commission?

A. (Ms Hammer): I do indeed. I could almost add to it.

Q. I am sure you will have time to in due course. Could I ask you first in your non-personal capacity, your Save Our Hospitals capacity for some views about the consultation phase of events. First of all, can you help very briefly with your involvement in the consultation phase and your experience of it?

A. (Ms Hammer): My involvement was more limited because I had to be back in Australia looking after my mother who had had a fall, but what I do know is that - and this partly includes me - a very large number of the local population only found out about the proposals coincidentally, that many of the public meetings were meetings where it was very hard to get local views heard and where it gave very clearly the impression that it was pretty much pre-decided. I have to say that the written consultation document actually had closed options which meant that there was no space to raise a whole lot of issues that people had about the proposals.

Q. In your attendance at and your knowledge of public meetings were you able to form a view as to whether or not there were representatives of all sections of the population or did you feel that some may have been excluded or were not represented?
A. (Ms Hammer): I think that is very hard to actually assess if you were not at a wide range of meetings. Probably minority ethic groups were under-represented even when the consultations were in parts of the borough where minority black people would be the largest percentage of the population. Certainly the meeting that I attended at Phoenix School was significantly under-represented by a range of ethnic minority groups. I think almost more to the point was the way that those meetings were structured that it was extremely difficult to raise the sorts of questions that local people actually wanted to ask.

Q. Pause there for a moment. Mr Grealy, I see you want to come in.
A. (Mr Grealy): One or two points I would like to add to what my colleague has said and that is some of the meetings were very badly advertised where were one not part of a circuit of people who are interested in public health one would not know the meetings were taking place. I do recall one meeting at the Hammersmith School, chaired by the then Director of Finance for Imperial, Mr Bill Shields, when he was asked about the limited circulation of knowledge about the public meeting, he quite simply shrugged and said it had nothing to do with Imperial. I do recall going into that meeting where there were a number of customer services people, if I can put it like that, with a pile of documents much higher than these who wanted any anybody who came into the meeting to sign up to membership of Imperial there and then. That was a meeting where going into the meeting the staff at the door did not know the nature of the meeting into which they were admitting people, so in terms of willingness to consult it was quite the opposite. It really was customer sales rather than consultation.

Q. Just pause for a moment because your colleague was telling us about what she felt were the difficulties in local views being heard. Can you just amplify a little bit how those meetings took place and what it was that you say caused difficulty in those views being given airspace, if I could put it that way?
A. (Ms Hammer): The one meeting I was able to attend there was a platform of speakers. There was very little time for speakers to speak from the floor and, interestingly, a number of those speakers from the floor were actually medical people who seemed to have had prior conviction, if I can put it that way. In other words, there was not the space for an adequate debate about the issues. I do not think that sort of public meeting anyway is the way to actually get at the views of people about their health services.

Q. What should have been done, in your view?
A. (Ms Hammer): First of all, people should have known much more about it. Secondly, there should have been a different sort of discussion forum, I think, to actually enable people to express their views. I have to say that the CQC's meeting, although rather limited prior to the inspection of Imperial, was a better mode of actually hearing what people had to say because it spoke to people one-to-one and allowed the space for people to raise their issues.

Q. Just in terms of the basic premise of the consultation that was put to the public, can you help with your view about whether the premise of reduction from nine to five major hospitals was a wide enough ambit or not?

A. (Ms Hammer): I am not quite sure what you are getting at.

Q. There was a pre-consultation stage at which a number of options were whittled down to three options which were placed before the public. Those options were all premised on the reduction of acute services in four out of the nine hospitals and what I am seeking to ask you is your views from your campaigning point of view as to whether or not that was an appropriate way to proceed or not?

A. (Ms Hammer): I think it is quite clear that we would think it was not, not least because of the support we have on the street week after week and by this stage year after year. It was a pre-decided issue. They even in the consultation papers had a preferred option. It was quite clear they were driving the consultation to get the answers that they wanted, in other words, to support the preferred option. And, as I understand it, a lot of the submissions that were for example petitions and so on, which represented thousands of people's views, were counted as a single submission.

Q. I want to move on from that aspect and I want to ask you about something you have touched on in your submission, borough-wide provision. Just in terms of Hammersmith and Fulham, can you help us with whether there is an even spread over the borough or is there a discrepancy between provision in different areas, sorry, rather a long question, and, if so, what is behind that?

A. (Ms Hammer): I am not sure I can say what is behind it but I think one of the things Save Our Hospitals did was to actually send round, which I think we have submitted to you, our response to the Independent Review Panel.

Q. Are you referring to the Independent Reconfiguration Panel?

A. (Ms Hammer): Reconfiguration Panel, yes. What we decided to do, we were quite pleased with it but we thought we ought to let GPs see that and we actually hand-delivered to every practice, to every GP in every practice as well as every practice manager a copy of our response to the Independent Review Panel with a covering letter. The two of us actually did that entire delivery. The part of the borough we happen to live is in is in the south of the borough and it is quite clear that there is a greater density of GP surgeries and GPs in the richer south part of the borough than there is in the north part of the borough, where a lot of the GP surgeries are rather rundown. Some of them are single doctor surgeries and they are spread further apart, so there are quite clearly differences in the two parts of the borough and they do relate to wealth.

A. (Mr Grealy): Could I add to that? One of the factors which we have not looked at is the relative affluence between the quite rich south for the most part of the borough and the very poor north of the borough. We know that life expectancy is shorter and chronic conditions are worse in the north of the borough yet public health facilities really are very sparse. In the part of the borough we happen to live in there is an immense choice of doctors' surgeries. In the north of the borough, they are few and far between and public transport links in the north of the borough between our surgeries is not very good. Furthermore, many of the people in the north of the borough are old people who need public transport, therefore they have no choice.

Q. Bearing that in mind, and focusing perhaps particularly on that aspect of the population, what effect has the closure of the A&E at Hammersmith Hospital and the Central Middlesex Hospital had?

A. (Ms Hammer): Again, I do not have concrete evidence of that.

Q. From your knowledge and understanding as far as you can tell?
A. (Ms Hammer): However, we have had discussions with Healthwatch, and perhaps, given some of the earlier comments about Ealing Healthwatch, I have to say that our experience in Hammersmith & Fulham has been somewhat different, that they have been champions of local patients to a very large extent. But Healthwatch themselves have said that attendance at Hammersmith Urgent Care Centre has fallen dramatically. Indeed, it was suggested that should I need some urgent care that would be a really good place to actually go to rather than waiting for a long time at Charing Cross or at Chelsea & Westminster. So I think one of the things that has actually happened is that people do not know what to do and Healthwatch again have reported that their evidence is that it is not that people are going somewhere else but that in many cases people are just not going when they probably do need medical help.

Q. I do not know if you are able to help with this but do you have an understanding of where they have getting that information from? What is the evidence base for that?
A. (Ms Hammer): I think they did some research on it. I think you have to ask them and I gather you are meeting with them later on.

Q. Moving on from that, if Charing Cross Hospital goes down the same route and Ealing goes down the same route and the A&Es are either shut or changed in their format, if we can put it like that, again, from your understanding of the situation, what do you say the impact will be on, first of all, let's just take the south richer population and then the north poorer population?
A. (Ms Hammer): I have recently had reason to go to the urgent care centre at Chelsea & Westminster Hospital and the waiting times there were not good and I was told it was a good time of day to be there. What I think will happen is that other hospitals will be under huge, huge pressure. Did that answer it properly, sorry?
A. (Mr Grealy): Could I add just one factor to that because we do campaign in a variety of parts of the borough and what we do know is talking to people, for example people who are frail, people who are quite old, mothers with one, two or three children, who find it very hard to travel far because of their condition or because of who they are in charge of, they say, "If we had to get up to St Mary's or to Chelsea & Westminster, we just could not manage it", and they add significantly that were they to go and seek help and then have to travel home afterwards, often people of low income, they simply could not afford taxi fares. What we draw from that is that people would only go to travel a great distance if they were certain they really were in a very bad condition. People tell us they are not trained medical staff so they do not know how to self analyse. What happens thereafter I would like the local CCG to explain to us.

Q. Can I just ask you a little bit about the waiting times? You attach to your submission, I think it is at page 1197 it starts, some graphs and perhaps, without going into huge detail about it, if you could just take us through what those graphs mean.
A. (Ms Hammer): Someone else has done the graphs.

Q. They have done them very beautifully. I am just wondering what in broad terms that actually tells us about what is going on now?
A. (Ms Hammer): I think what is key in terms of the graphs is that at a certain point - not everyone can see it but there is a vertical orange line - that is the point at which the two

A&Es closed and what you see is the meeting of the A&E waiting times being failed, falling below the 95% requirement.

Q. This is the four-hour time you are talking about?
A. (Ms Hammer): Quite dramatically, yes. But I think there is other interesting information in these graphs because much has been made in the press about the fact that this has been an England-wide phenomenon. The actual graphs show that this is not the case. To the extent that there was a national problem, that is certainly reflected in this area, but if you disaggregate the information you actually find that North West London Healthcare NHS Trust has failed dramatically, that Imperial Healthcare Trust has failed pretty badly and, if you take those figures out, that London was doing better than England as a whole, so there has been a significant local effect in terms of the closures of those two A&Es on hospitals actually meeting the required four-hour waiting time requirements.

Q. Are you able to help with whether or not that is something which is changing now that we are coming out of the winter period into spring or whether that is a continuing situation?
A. (Ms Hammer): The information that I have is that it is a continuing situation but with possibly some amelioration.

Q. I just want to move on and ask you a little bit about the standards at St Mary's and the Chelsea & Westminster Hospital because we have the CQC assessments of those. Do you have any comment that you wish to make about those and about the use of the services there?
A. (Ms Hammer): I think one of the things that we would not want to do is to put one hospital against another hospital, but at the same time we do have to say that it is quite astonishing that the hospital that has become the prime location for most of our care in the future is to be St Mary's, which has failed quite dramatically in much of the CQC inspection, whose A&E (not just for the cleanliness issues but on an range of other issues) was deemed to be "Inadequate" and yet it is to be the preferred A&E rather than Charing Cross. At the moment Chelsea & Westminster has been doing reasonably well in terms of meeting demand but what happens of course when you lose the other A&Es? Who knows?

Q. Can I ask you please now to turn on to thinking about the out of hospital services. There is a bundle in front of you marked Volume 2 and I would like you to turn, please, to page 586 and that should be a letter from the Hammersmith & Fulham Clinical Commissioning Group. If you look at the penultimate page of that letter, there is reference made to initiatives taking place for out of hospital services. I wonder if you could just take a moment to scan that and tell me whether or not you recognise or are aware of any of those initiatives having come into play?
A. (Ms Hammer): Can you tell me which section?

Q. Volume 2 and it starts on page 585 and then if you go through over the page to 589 and it starts "Providing integrated services", it is slightly before then, in fact it is 586 and it starts at paragraph 2, "Investment in out of hospital services..." I am certainly not asking you to read all of it but simply to flick and see if you recognise any of those initiatives as being things that you are aware of taking place at the moment.

A. (Ms Hammer): I actually do not think that we need to read it because we have been following the CCG actions, indeed we were at a meeting last week where I did raise questions about out of hospital services. Yes, we are aware of the initiatives, but we are also aware that there is no evidence that those initiatives will reduce the need for hospital beds. Indeed, and this is not in my evidence because it only happened last week, at the CCG, in the small number of minutes they allow for people to raise questions, I raised questions about out of hospital services. I asked it particularly in relation to whether they could provide prevalence evidence that they would reduce significantly the numbers of people needing hospital beds so that they could justify the closure of the beds in hospitals. Dr Spicer answered me by saying "*Shaping a healthier future* is not about reducing beds". I really can comment no further on that point, but when pushed on prevalence studies he mentioned one study in Manchester that was not actually about prevalence but was about setting up out of hospital services and he mentioned one study about prevalence in a very similar area of course to ours - Torbay(!) - showing that it would reduce hospital admissions. One of our problems is we actually think these initiatives are good. We are not opposed to these initiatives but we want the evidence that they can justify closing down our major acute hospital services safely by actually increasing the out of hospital care. I do not think they have ever provided that evidence. We have been asking for two years.

A. (Mr Grealy): Can I add to that? One of the significant difficulties that we face is quite simple; when we ask the CCG detailed questions, and we really do have our research done when we go to meetings, we are told that things are happening which actually do sound very good, but when we ask questions about the numbers involved they are both very reluctant to answer and when informally people answer afterwards the number of people involved in each of the initiatives really is tiny and the initiatives which they talk about we would love to see expand, but in terms of the needs of people in this borough it really does not approach the problem and to put it as a success indicator for what is being done is as misleading as you could possibly do.

MS RENSTEN: I have no further questions, but if you wait the Commissioners may have questions for you.

Examined by THE COMMISSION

Q. THE CHAIRMAN: I have got a specific one to kick off and it is in your paragraph 5 at 1181. It is really the assertion that there is a need for co-location, that is trauma and stroke, and also I have a bigger question about the merit of specialist units as against all A&E s having the same standardised range of provision as an alternative model, so if you could comment on that please.

A. (Ms Hammer): I think as a campaign group we fully accept that there is clinical evidence that for a certain number of very specific conditions it is important to have that concentrated medical help. Therefore a HASU or a trauma centre need to be located somewhere where there is good access across a number of hospitals and a number of areas. But as you will know from our submission, we have actually met with Imperial Health Trust and we have asked Imperial Health Trust on both occasions that we met them what the clinical evidence is for co-locating a HASU and a trauma centre, and they have not been able to provide that evidence. It might be true but we would love to hear the evidence. That for us is one of the big issues - that we ask questions, we do not think they are stupid questions, but we cannot get answers. We cannot get answers on the

clinical/scientific evidence that backs up their assertion that you need a trauma centre and a HASU together and when you point out that just down the road from St Mary's there is a HASU that does not have a trauma centre with it, the answer is sort of like that.

Q. DR HIRST: Just a note to that. I am unsure what is going to happen to the regional neurosurgical centre at Charing Cross because that is why there is a HASU there because, I presume, there is a cross-fertilisation between, for example, intervention or radiology, et cetera. I do not know whether you know any more about that?

A. (Ms Hammer): I think all we have learnt is there are going to be 24 overnight beds instead of 360 and what they are going to be used for and how they relate to other services is as clear as mud, I am afraid, at the moment.

A. (Mr Grealy): We have met twice over five hours with the Imperial management and we do attend CCG meetings as well as Healthwatch meetings and we have asked questions about this. I think what is most troubling for people we meet on the street and our campaigners is something straightforward. We are told that the provision is right, but when we ask what it is that is going to be at Charing Cross when they open a new hospital at rather large expense, they actually are blunt ad they say, "We don't know." So they know the general plan will work but they really have not planned out the specifics. Under pressure, they will tell us that. There is a second string to it and that is each time we ask we are told that they are bound by *Shaping a healthier future*, which really was a product of an earlier body which no longer exists and there is no one body responsible who can take decisions. We have been told, for example by Dr Tracy Batten, the CEO of Imperial, when we pointed out that we thought a re-think was needed on some parts of the plan or the whole plan, to go and ask the CCG because their Secretary was leaving soon, but the CCG said, no, it is not their responsibility, so as patients our local residents - and I have been a patient at local hospitals - it is impossible to work out who is in charge or who is in charge of what or if things go wrong who will take the buck.

Q. It seems to be a matter of faith. Just a final comment, how do you manage to get in to see Imperial when the London Borough of Hammersmith & Fulham cannot?

A. (Ms Hammer): A challenge in one of their board meetings when they kept failing to answer questions and I leapt up and invited them to meet with us and much to my astonishment they agreed.

DR HIRST: Well done.

Q. DR LISTER: I am just thinking about these initiatives that keep being mentioned and obviously Torbay is the example that is used everywhere. Torbay, for those who do not know, is actually falling apart now because the different components that came together are going in their different directions and it is no longer running along the same lines. Even there it presumes a certain continuity of effort. To what extent do you get the impression that these initiatives are taking place? You mentioned the small numbers, and I think that is definitely the case, and they are normally over a restricted time. Do you get the impression they are also given additional resources and preferential spending compared to what might be available?

A. (Ms Hammer): Certainly temporarily they get extra resources but they are pilots. They talk about them as pilots and there is never any talk about implementation should the pilots be successful and how that will be funded. One of our questions has also been about who will fund out of hospital care because at the moment hospital care is paid for

through our taxes. Are we going to have this as means-tested care? How long will it continue? A lot of the pilots are for periods of ten days or six weeks, depending which particular scheme they are looking at. So basically the answer is no, we do not actually have any sort of clear idea of anything in terms of how it is going to be instituted.

Q. Has anybody come up with any suggestions as to how it might either be the same price or cheaper than the current balance of care?

A. (Mr Grealy): There is one very important factor to look at here because we have asked the question of Imperial and the CCG about paying. Currently everybody in the country is treated free as part of the NHS and the most recent pilots shown at Healthwatch lasted for six weeks. It sounded very good but at the end of six weeks you pay. We were told frankly that was the case. People who need at the end of six weeks further treatment either have to admit themselves to hospital or persuade their GP to send them back in or to pay. When we have asked the questions about payment, time after time, people become very evasive. This is particularly worrying because this very week the Chair of the local CCG told his members, that is Dr Spicer, that what is happening in this part of North West London is a "pioneer for England as a whole". What works here is going to be rolled out everywhere, but we are in the dark as to what would work and what would not work.

Q. Another word for pioneer is "guinea pig" of course. Do you get any impression and is the information there to suggest whether or not these services might, as they claim, save money, because overall you have got the context of a billion pounds of saving that they are looking for out of this re-organisation?

A. (Ms Hammer): I personally cannot see that the pilot schemes that we have actually been to briefings about can possibly save money, particularly if they going to be on the sort of scale that will be required if you are going to actually close down hospital wards and remove beds.

A. (Mr Grealy): Again let me add one little fact to that. At the January CCG meeting, a number of initiatives were looked at and we were told the budget will stretch to 2016 and thereafter they do not know what will happen. So for what does look like a small set of quite good initiatives, funding thereafter is not at all clear. But there is one other factor which we have not touched on, it is in our paper, and that is the relationship between *Shaping a healthier future* and mental health and when we broached this with Imperial management they were quite frank that the local mental health trust would not co-operate. At the January CCG, the Vice Chair of the CCG, Dr Susan McGoldrick, said, with some passion in fact, that the West London Mental Health Trust is the worst trust with which they have ever dealt. Given that we had already been told that 20-25% of those who present at A&E had mental health conditions, this for us is very worrying indeed.

THE CHAIRMAN: Thank you very much indeed. I have had a request for a short break. We are halfway through the witnesses. It is a longer afternoon than the morning so ten minutes.

<u>After a short break</u>

THE CHAIRMAN: I would ask counsel for the inquiry to commence, please.

Witness: MS ANNE DRINKELL, Brent resident and Secretary, Save Our Hospitals

Examined by MS RENSTEN

Q. MS RENSTEN: Could I ask you please to give your full name and address?
A. (Ms Drinkell) My name is Anne Drinkell and it is 5 Chandos Road.

Q. Could you turn please to bundle 4 and it is page 1239. Could you confirm they are true to the best of your knowledge and understanding and that you wish them to stand as your evidence before the Commission?
A. Yes.

Q. There are three apparent documents that you have submitted. The one in the centre, it starts at page 1243 and is a paper on primary and community care not being a panacea, can you confirm, because it does not say, whether you are the author of that document?
A. I wrote it, yes.

Q. Secondly, I would like to begin by looking at the other two documents, the first the one starting on 1239, that is an interview with an emergency nurse practitioner ,and the document at the end is an anonymised email from an Imperial College Trust employee?
A. Where is that email?

Q. The email is at the end of your long document.
A. Yes.

Q. Can you please explain how and why those two documents have come into your possession?
A. I am the Secretary of Save Our Hospitals so we put out an email asking for any evidence that people felt they would be nervous to give directly because they were working and worried. An emergency nurse practitioner contacted me and said that she would give evidence but she wanted to give it anonymously, so I arranged to interview her. That was the first thing and then the email was something that came through on our email communications.

Q. Did either of those people give you any specific reasons why they felt the need for anonymity?
A. Both of them said it was more than their jobs were worth paraphrasing them ---

SPEAKER: It is difficult to hear.

Q. MS RENSTEN: Could you repeat that last answer?
A. Both of them were very clear it was more than their job was worth.

Q. Because these are documents that you have brought in but are not written, are you able to comment on the content at all?
A. The email I have not had any more interaction than that so that really has to stand by itself. I took some bits of the email out that might have made people able to identify that person. The interview is somebody who I have had long discussions with and they have authorised me to speak about the interview, so I feel comfortable about doing that.

Q. Bearing that in mind and bearing in mind the contents of that, can you assist the Commission on your take on the confusion between urgent care centres and accident and emergency departments?

A. I should say I have worked as a nurse practitioner and I have worked in a walk-in centre and I have been a nurse practitioner in a homeless clinic, so I have some personal experience as well. I think that there is a huge amount of confusion around the difference. I think the evidence is that urgent care centres work best when they are co-located with A&Es. That makes perfect sense because you can triage and if you need more back-up then you have got it in the A&E departments. I think the fact that the *Shaping a healthier future* plans say there will be A&E departments when they are effectively talking about something that is more like an urgent care centre is quite irresponsible long-term. At the moment there is still no standard for what an urgent care centre does, and I think that makes it quite confusing, and I think there are also internal issues, so for example within the document you will see that the nurse practitioner reports that in some areas GP consortiums are urging nurses to turn away, redirect patients who come to urgent care centres back to the GP practices because they do not want to pay twice for treatment.

Q. Can you pause there for a moment? Could you explain a little more carefully what a redirection policy means? If you look, and it is 1240, it is the third paragraph down and the nurse practitioner says that in K&C some of the practices now have a redirection policy and goes on to explain, but I wonder if you could encapsulate that?

A. What it is the GPs, I presume, are thinking there is a duplication of resources and they do not want to pay twice for it. What you have to do if you work in this clinic if a patient comes from one of those practices - and this is absolutely second-hand, but this is as I understand it - you have to contact the practice and check that there are no appointments possible that that person will be able to seen by in an appropriate time. If there are, you are not supposed to treat the person; you are supposed to send them back to the GP practice where they will deal with them. What the emergency nurse practitioner I interviewed talked about was just how time-consuming that is because you are really busy, you have got a room full of needy people and you are messing about trying to get in touch with the GP practice and to phone and fill in all the statistics. She said it is very time-consuming and annoying, distressing and confusing for the patient.

Q. Can I be clear about this, is what you are saying that if a member of the public arrives at an urgent care centre one question they will asked is where are you from and who is your GP?

A. What I am saying is that new forms of confusion are happening in little pockets locally, so this is just a small pocket, an area where this particular problem is happening. At the last Scrutiny Committee, one Conservative Councillor in Hammersmith & Fulham raised a little idiosyncrasy that complicated things. He was talking about patients not registered with GPs being asked to pay at Parsons Green Walk-in Centre if they had treatment. I do not know if that is true or not. He talked about that at the Scrutiny Committee last Monday. It is just examples of how it is extremely idiosyncratic what goes on.

Q. So in terms of urgent care centres, is it the case then that there is not a consistency of approach? Is that what your evidence is?

A. Absolutely. Even within urgent care centres it depends who you are treated by. You

might have a nurse in terms of skills, so some emergency nurse practitioners will have extended prescribing and will be able to prescribe pretty well anything a doctor could; some would not. Some doctors are less confident with trauma and injury, they prefer medical conditions, and the fact that staffing is such a big problem between and within CLCH means that a lot of the staffing at the moment or quite a high proportion has been agency. Again you have got less standardisation about what skills those people bring in.

Q. Just still on the question of urgent care centres, one other thing the nurse practitioner says, this is at 1242, "I don't always get the impression services are working together for the patient's best interest. There are turf wars between 111 and the UCC doctors about who should see particular patients …" Are you able to explain what is going on here?
A. I think she was referring to when the urgent care centres are either at or near the end of a shift, I think urgent care centres for example, they may want to push the referral over to the 111 service and the 111 service do not want to give it to them. I think that is one issue. And just more generally there are lots of turf wars about whether it is reasonable to ask people to come in to be seen or whether they will do home visits. The guidelines are not clear and there is a lot of scope for people who are under pressure to try to pass the buck.

Q. Is there a financial implication involved in who is seen where?
A. There is because obviously there is a cost to being seen. There is the cost of the consultation. I do not know if that is the reason or not. No, I could not speak to that.

Q. You cannot take that any further. Can I just ask you very briefly then to have a look at the email, and it is at 1253, and this is the email that we have just referred to, and I realise you said you do not have any background detail but are you able to help, without providing identification, with what level or type of employee this is from?
A. That person is an experienced staff nurse who has been in the Trust for a number of years.

Q. Her comment is that the information that is being fed to the local community is far from reality; are you able to make any comment on that assertion or not?
A. I absolutely know that is the case. I know that from my own clinical practice and I know that from my position in the campaign, and, actually, I think it is one of the really big problems of the whole health economy here that because there is such a pressure on corporate reputations and getting business and looking good, bad news in terms of poor performance or vacancies or whatever is swept under the carpet. That is why it is so hard to get a serious debate about what could be improved and what needs to happen.

Q. Is it your evidence to the Commission that you have direct knowledge of wrong or faulty information being promulgated?
A. I am not talking about falsehoods but, for example, I am talking about quite selective information. If you look, for example, at vacancy rates amongst community nursing which is massively, massively high, I think the community trust would acknowledge that is a problem. James Reilly, the Chief Executive, said last week there was an overall 17.6% vacancy rate and they have that as a red risk, but actually, if you dig beyond that, the figures for clinical staff are higher and for community nursing they are significantly higher so that, for example, in Hammersmith & Fulham amongst trained district nurses there is a 60% vacancy rate. There is only one district nursing place for the whole of

Hammersmith & Fulham this year. There are 15 community nursing vacancies. And that broad brush stroke does not get down to that kind of level of detail, which is what you need if you are really going to assess whether a service is capable of delivering or not.

Q. Can we turn now to your central submission? What your premise appears to be is that the primary care and the out of hospital initiative will not do what *Shaping a healthier future* says they will do. Is that your premise?
A. It is. I am very for primary and community care. It is what I have spent my professional life doing and pioneering and I know of lots of out of hospital strategies locally that are really useful and good and probably will deliver something and should be supported. I think the issue is that they have not been tried and tested. They need to be properly resourced and unless they are delivered on a much bigger scale for a much longer time on a much wider premise, then, although they will be very good and very useful in themselves, they are not going to stop the tide of unplanned admissions and deliver what SaHF wants to deliver.

Q. Just breaking it down, the current state of out of hospital services in the borough is what?
A. I think there are some very interesting pilot projects going on. I think there are small examples of some positive developments. I think the CIS project, which is a virtual ward type of thing, is potentially very useful.

Q. Can you just tell us what that acronym is CIS?
A. Community Independence Service.

Q. Thank you.
A. But it only lasts for six weeks and it only involves a limited number of patients. And also what I should say is one of the reasons it will probably deliver good things is because it is well resourced and it has got highly motivated staff. The problem is they are not coming from anywhere else except the ordinary pool of community nursing staff so what they do is (a) often take the most lively people from the bread and butter district nursing service and (b) what they then do, if they work well, is they then generate referrals back to the district nursing service, which has been depleted, so although you can get these small pockets of very good performance, it is against the backdrop you have privileged that little service at the expense of the bread and butter stuff.

Q. So is this robbing Peter to pay Paul?
A. Yes, killing Paul.

Q. To what extent do you consider that the relevant Clinical Commissioning Groups have understood this?
A. I think there is a really big problem. I think there is that problem about not being able to hear the message and I think both across Imperial and the CCG and CLCH, it is such a tough corporate world, and they are so busy trying to get a big enough share of the market to survive and become a foundation trust and meet all those targets, that there are lots of reasons why they would not want to necessarily pay great attention to bad news. I think that is one factor. Then I also think there is an increasing disconnect really between the leadership and the clinicians on the ground who, to be honest, mostly now your workload is so high, if you look at, for example CLCH's vacancy rate which I have talked about,

they have got really high sickness rates and a lot of their sickness is stress. They have got a really high turnover of staff. I know from all the colleagues I used to work with their workload in terms of number of visits a day is at least double what it used to be, if not more, with more expectations as well. What that means is real exhaustion and difficulty engaging. You get a medal if you finish the day job and then trying also to engage with all of this stuff is really difficult. On a broader level, the King's Fund has just put some evidence out about how within the CCGs there is an increasing disengagement between the GPs who are on the face, doing the consultations all the time and the senior leadership, and I think that is a phenomenon we will see here as well.

Q. Have you had any conversations with GPs which would underpin the evidence we have just heard?
A. Yesterday.

Q. Are you able to give a flavour without giving identifying details?
A. I was speaking to a GP who I have worked with for a number of years who rang me up to wish me luck for today, said he wished he could be here but that he was too worried about the consequences and he did not think there was much point because he did not think things would be able to be changed. He is somebody who I have masses of respect for as a clinical pioneer.

Q. Is that an isolated conversation or something you have heard more than once?
A. Yes. Sorry, I should say we have a number of GPs, hospital doctors and consultants, we have a weekly email newsletter that reaches about 500 people and I would say there are about 40 GPs and doctors and consultants on there.

Q. And are they aware of the existence of the Commission?
A. They are, yes. We have tried hard. There is a real culture of nervousness about getting involved. Partly I think it feels like we are not some little place in the country where we are taking on a little health board. The hospital trusts here are very, very big. They are very good as well. I would not want to knock Imperial's results because in many ways they have got the best mortality rates, et cetera, in the country and we want to preserve that. But it means it is a huge enterprise. They are an NHS trust but they have also got the College. They have really big global ambitions in terms of that and they have a lot of research that links up with lots of drug companies, and they own lots of property in the area. The point I am trying to make it is not an insignificant thing to challenge them.

Q. Just turning to some of the other issues you raise, you mention the frail and elderly as a particular group. Can you assist with what you say they require most in terms of services and whether or not the current proposals under SaHF can deliver that?
A. I think one of the most telling statistics for me is the number of pressure sores that are being recorded by CLCH on a monthly basis because I think that is quite a good indicator of level of care. CLCH are completely open about that ---

Q. Just remind us, CLCH is?
A. Sorry, it is the Central London Community Health Trust. It is the NHS Community Health Trust for the area. They are quite open that that is a problem and to me it is quite an indicator of the difficulty of, in the main, very caring staff having enough time to do

what they need to do to look after the patients competently. I think another indicator, really basic things that if you cannot get them right do not tell me you can put more people out in the community, is the flu immunisation rates. We have got really, really bad flu immunisation rates for staff within CLCH of around 25%, which is the lowest tenth in the country, which is pretty poor, but concentrating on frail elderly people, flu immunisations is a really good way of protecting somebody and we have got very, very poor rates for that as well. We have put the stats for that in the paper. I kind of think they are such basic things that honestly do make a difference to whether somebody feels well and is able to manage at home or has to go to hospital. I could give you loads of other things, but I think let's get those real, ordinary basic things right first and then let's talk about doing something a bit more complicated.

Q. Can you just help us by talking us very briefly through your argument that out of hospital services will not reduce the need for acute bed space? I know that is a rather wide question but ---

A. First of all, I just think the arguments should be decoupled. I think it is wrong to make expanding out of hospital services depend on closing acute beds. You should be developing the out of hospital and primary care and if because it is succeeding there is less need for hospital beds, that is absolutely fine. I have no personal ties to bricks and mortar, but I think that has to be decoupled. I think if you look at the stats around how we are doing at the moment, and I could go through them but I think you probably do not want me to, if you look at the public health outcomes which we have listed in terms of not just flu immunisations but all of our immunisations, they are pretty poor. We are not great on a whole number of mortality rates for various illnesses. I think that it is obvious that we have got a long way to go and I think there are things we need to do to improve that before we can look at taking anything more on. I also think there is a problem that GP practices are getting overloaded and in a funny way we are saying that things are so specialist in the acute service that all the hospital doctors have to be more and more specialist and yet it is quite illogical because actually we are expecting the poor GPs to manage more and more and more. The final part around that is I think that all the SaHF proposals may get blown out of the water because there are things beyond the control of the local health economy that may affect hospital admissions and health so wider determinants of health. For example, we have got a really big problem with air pollution in this borough which causes a lot of mortality and causes a lot of hospital admissions. We have got a huge problem with child poverty in the north of the borough and we have got a huge problem with some kinds of homelessness. Up in Brent, which is only three miles away, the levels of rough sleeper homelessness are massive. I am just giving examples of things that can completely disrupt any other plans because all of them lead to bigger demand for acute services.

Q. Finally, can I just ask you this, just in terms of the implementation of the rest of the SaHF programme, what, in your view, should happen now?

A. It is not a speech, but I just thought I had better remember the main points. I think first of all there needs to be an honest debate, so people have to be prepared to listen honestly to the problems to come to some kind of useful discussion about it. That partly means not being afraid of the public and actually genuinely engaging with the public because, to be honest, we are sort of made out to be the enemies of this process but we have all got a genuine interest in getting better primary, community and acute healthcare and we are all supporters of the NHS, so we could actually have a proper debate about it.

I think that there has been too much of a focus within the trusts on stuff that is not their main job, their clinical job. I think that is backed up by CQC reports. So being fixated around foundation trust status or getting a bigger market share has become at least as and sometimes more important than basic clinical priorities. If you go to any of the board meetings, the board papers are piled up and at least 50% of them are on just bureaucracy that is irrelevant. That is not just a waste of time; it is a waste of resources, and it is silly to put the very, very brilliant clinicians we have, why cannot we put them in the operating theatres and in the consulting rooms instead of getting them messing about trying to get 20 more members for the foundation trust bid. Finally, I think that there does need to be adequate resources to fund all of this. Actually, that does not seem to me as challenging if you think about how much we are wasting at the moment on competitive tenders and commissioning and blah blah blah. I think it is entirely possible to have a retreat back into actually practising healthcare and medicine and ordinary decent nursing and that would make a difference. That does not mean going back to old-fashioned stuff. I think there are some fantastic out of hospital projects here, but I will just give you one example, the Co-ordinate My Care, which is not just about co-ordinating, it is about planning end-of-life care before you are too ill to make decisions so that people know what you want to happen and where you want to be. To me this is a fantastic initiative and if as a byproduct it means that people do not end up in hospital, that is fine, but it is a really good use of technology and communication and it should be supported. There are really lots of innovative things we could do, but if we could shape it so they are being done for the best clinical reasons rather than the kind of corporate rationale that is often tied around it, I think we would be making a better job of things.

MS RENSTEN: Thank you. If you would like to wait there, there may be questions from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: I want to ask one question, but preface it with something that you may not have heard this morning which is this is intended and will be an independent Commission. Secondly, we intend to focus on the terms of reference which I drafted early on and we are all agreed on, which is identifying the constituency that needs to be served; identifying the needs of that constituency and how they are best met. That can only be done if there is a transparent and honest debate: your point. My concern is that a whole sector of the constituency is, in fact, excluding themselves because of fear. They are on your database. I am talking about the 40 people. They need to speak. They absolutely need to speak if we are going to progress at all, for the benefit of the community. I do not want to put them in the position - none of us does - which we heard about one example this afternoon. That kind of harassment has to stop. However, bearing that in mind - and it is a long introduction - I am wanting on behalf of the Commission your possible help with regard to those 40, or even more, because we have procedures, we can anonymise, but it can go further than that. If they are worried that what they have to say may identify which hospital they are in, we can deal with that as well. If they want to deal with their observations or points in a general way they can be dealt with. I am issuing this generally if there is anything else here today who can help. Are you able, do you think, to go back to these 40 and see whether any of them will come out of the woodwork, because at the moment that whole area we are realising it is other people who are having to come forward and speak on their behalf? We do not want a

A situation at the end of all this process saying you have not got the information or you have not got the practitioners on the ground and all that kind of thing. That is the point.
A. Some of the clinicians have been in this room today and will show support by being here, but I can really understand some of their concerns. One thing I think would make a difference is if you could do some closed sessions because that might reassure people. I will certainly circulate anything you give and try really hard, I would make it a priority to get people because I know that nothing counts as much as that, but you will know people
B like Charlotte Munro and a whole lot of other health workers that have had a really tough team when they have whistle-blown. This is not even really whistle-blowing. Every single thing I have told you is public information. I have got it from raw papers and people are quite nervous even about that. I will try really hard and our organisation will. I would suggest that closed sessions might help a bit.

C THE CHAIRMAN: I am sorry to have this debate in public, but I think that is what we want to be, in public and transparent, so having closed sessions provides a real difficulty because of course you are not transparent and then how do you publish what you have heard in closed session? It is a difficult situation and I think some of us would be reluctant to go down that route. What I am really saying is you can anonymise observations as long as we are in a position to know who the people are. We will give undertakings that their confidentiality will not be breached in any way at all, but there has
D to be an effort to, as it were, provide public information to give us insights from genuine practitioners. That is all I need to say on that and perhaps too much. Anybody?

DR LISTER: I think it was very clear in the presentation. Thank you very much.

THE CHAIRMAN: Thank you very much. (Applause)

E The Witness Withdrew

MS RENSTEN: The next witness on the list is John Ryan but I am not sure whether he is actually here yet. He was not the last time we looked. If he is not, the witness after him is Jonathan Ramsey and, if Jonathan Ramsey is present, could he please step forward

Witness: MR JONATHAN RAMSEY, Director of Professional Affairs, Royal College of
F Surgeons

Examined by MS RENSTEN

Q. MS RENSTEN: Could you give the Commission please your full name, professional address and current post held.
A. (Mr Ramsey): My name is Jonathan Ramsey. My address is number 5 Southlea Road
G in Datchet. I am a consultant urologist. I work within Imperial presently at the Hammersmith Hospital. I also work at the West Middlesex and the Chelsea & Westminster.

Q. If you turn please, there should be a bundle in front of you marked Volume 1 and page 7, if you would. That should be an email from you.
A. Correct.
H

Q. Can you please confirm that the contents are true to the best of your knowledge and understanding and that you wish it to stand as your evidence to the Commission?
A. Correct and I do.

Q. What I would like to ask you about first is your role in *Shaping a healthier future*, can you explain to the Commission what your involvement and remit was please?
A. Indeed. I represented the Royal College of Surgeons of England to give advice principally about emergency surgical provision within the sector.

Q. When were you last involved in the board in that role?
A. Approximately six months ago.

Q. And at that point were you broadly supportive of the aims of *Shaping a healthier future*?
A. So the aim, I must preface that remark by saying that I need to stick to surgery and I am well aware, particularly having listened with great interest to the last witness, that in fact surgery, particularly emergency surgery, is a very small part of total healthcare provision. It sometimes gets an unequal share of the action because it is exciting in the true sense of the word, it is expensive, and the people who talk about it often talk quite loudly and forcefully. But, nonetheless, it is a small component of the whole. So my role was relatively small and narrow, but did concern a very important part, nonetheless, of health care provision in terms of quality.

Q. So limited to the area that you were directly involved with, were you, as far as that area was concerned supportive of the reconfiguration and the aims that were being promulgated in this programme?
A. Absolutely.

Q. At that time, was it your view that the reduction, and you may say this is outside your remit to comment upon, that the proposed reduction from nine major hospitals with all services to five major hospitals was a proper approach or not?
A. I would, for the purpose of providing the quality of emergency surgery, principally because of the standards that surround such provision. Those standards were then being developed by Healthcare for London and I worked with them as one of the team that looked at appropriate standards for emergency surgery.

Q. Did you at the time think that there could have been other equally legitimate solutions to that proposed?
A. If we talk about what those standards are, the solutions become clearer. The most important thing is for an acutely ill surgical patient, or indeed other patients, to have the benefit of consultant opinion within a reasonable time of their admission, which was set to be 12 hours, and surrounding that admission there needs to be the sort of services that we would all want and expect in terms of radiology, in terms of interventional radiology and of course this requires a lot of personnel and equipment to be co-located. The only solution to providing this bit of emergency medical care must be from more centralisation. After all, we are not talking about Suffolk or East Anglia here. We are talking about a relatively small geographical area. When we make these pieces of advice, and this was not just the Royal College of Surgeons but Healthcare for London, those stipulations, those standards were surprising congruent between those two bodies. One

has to be aware of the unintended consequences of making such statements. Certainly, however, such a reduction to five centres in terms of acute surgery only would be the right thing to do.

Q. And that remains your view?
A. That remains my view.

Q. You say in your document that the Reconfiguration Board considered sites but assumed that the trust responsible for the reconfigured site would manage the diverted cases on their remaining facilities. I wonder if we can break that down a bit and you can help us with this. What sites did the board consider and what, if any, conclusions did it reach?
A. It considered the Imperial sites as being one. I am talking for emergency surgery. In terms of emergency surgery, it was considered that as Imperial was responsible for those three sites, they would make suitable arrangements to deal with the emergency surgical workload. It was assumed most probably in the majority of cases on one of those sites because it was assumed particularly that Hammersmith, which was not an emergency surgical site at the time, would certainly not continue as such. So the board's deliberations assumed that policy for Imperial, not dissimilar from what had happened with the North West London Hospitals, and they regarded Northwick Park and Hillingdon as being outside a networking capability because the distances were too far to allow an easy co-operation. Within the centre, Imperial was one unit, North West London Hospitals was another unit and the Chelsea & Westminster estates were separate and at that stage were considered as being apart.

Q. So that was what the board considered. Are you able to help with why the board was confident in that assumption? Why was it that the board thought that those assumptions could be relied upon?
A. I cannot really answer why they thought they could be relied upon, but it was not an unreasonable assumption, being in the room at the time, to imagine that one of the sites within Imperial, particularly that one designated as a major trauma centre would also be entirely competent to deal with emergency surgery.

Q. Were there any assurances given by any Trust members who were present that that would be the case?
A. I cannot answer you that because I was not at every meeting.

Q. Were you aware of any assurances given?
A. No.

Q. Was it explored - and you may not be able to answer this - with those members of the Trust that were present that those assurances might not be correct and that it might not be the case in fact?
A. There was a part of the clinical board, a group within it, who considered emergency services as a general issue, not just surgery. I was not party to that group, but I think it is my impression and my view that they took that matter seriously. Where their advices came from, I am not sure.

Q. Are you aware of whether or not any specific assurances were given by Imperial in

respect of the removal of acute services from Charing Cross Hospital?
A. I am not.

Q. Are you aware if there was any evidence provided by Imperial to underpin the assumption that St Mary's would be able to accommodate all of the cases which were coming in their direction?
A. I am not aware of such evidence.

Q. You set out in your short paper a number of changes which have occurred since your involvement which have impacted upon your thinking. Could you expand please on what you say has changed first of all with regard to emergency surgical volumes? Do we know why the increase and do we know what the size is?
A. We know neither of those things. We can adduce that this has happened by an increased demand for level 2 and level 3 care, that is what is also known as high dependency HDU and intensive care. That is level 2 and level 3. So we can adduce that. We can adduce it from attendances in A&E, although it is quite difficult to separate acute surgical attendances which relate to abdominal surgery from the others. It is quite difficult in terms of coding. I believe that at the present time the board is trying to look at current evidence, contemporaneous evidence for the number of acute abdominal surgical cases that are entering the hospitals in the sector. But you have to do that by HES codes and that, as I say, is not easy. At the present time the College of Surgeons is doing a laparotomy audit which may throw some light on the question that you have just asked for there is a suspicion that this type of work, this type of surgical emergency is increasing nationally.

Q. That is not something --- I think you used the word "suspicion" carefully; it is no more than that at the moment?
A. It is no more than that.

Q. Complexity and co-morbidity, again, that is another area you identified. Again, is it increasing and, if so, do we know why and by how much?
A. We know that it is increasing. We think we know why. Of course that is the trouble with all doctors as they get more senior, we are more and more sure we know why, but we think we know why and that is because as the population ages and our techniques improve, therefore you tend to operate on more patients.

Q. Are you able to assist to any degree about the scope and size?
A. Well, you can adduce this within specialties, so, for example, if you look at my own specialty the number of people, the number of patients, mostly elderly, who can undergo a very major intervention to have their bladder removed is increasing significantly. By how much? Over the last three years, by approximately 10%.

Q. You also talk about capacity in the region being saturated. Can you help us with whether this was foreseeable and, if it was, why it was not foreseen?
A. It is the Donald Rumsfeld foreseeing the unforeseeable.

Q. Yes.
A. I think that the board attempted to come to the right judgments about acute surgical care, particularly in terms of those patients who might need the level 2 and the level 3

care because within the board there was a separate group who looked at intensive care and looked very, very closely to see what would happen if you moved intensive care facilities around the region and took some of them out and what would be required to be re-provided or to be increased on the remaining sites. This was a very careful piece of work. It was orchestrated by intensivists and these were not people who had any other interest than to get intensive care right, so these were intensivists from the existing trusts. The expenditure in order to re-locate and re-create these facilities was quite considerable. They built in a little bit of extra capacity for this new network. I think that that was a right-minded piece of work. I do not think contemporaneously (I went to some of their meetings) that they were under-estimating because all of those front-line clinicians know that if you under-provide HDU care for acute surgery then you end up in a far worse place, it is more expensive, the outcomes are worse; it is a disaster. So that piece of work was right-minded. I think it was based upon correct fact and probably a correct prediction. Once again we are talking about this work having been completed about 18 months ago.

Q. And I suppose question is but then?
A. Since then I think if you wanted to update that particular evidence a good place to go would be the intensivists who made those predictions. That would give a fairly accurate view of the probable increase in acute surgical activity over the last three years.

Q. So the conclusion that you then draw is that at the moment capacity requires all of the Imperial sites to continue?
A. In order to maintain the elective surgery and the emergency activity, it is difficult to imagine that the facilities that are currently used will not need to continue to be utilised to their full.

Q. If the reconfiguration continues and the proposed changes take place, what is the likely effect on the areas you have talked about?
A. So it is clear that the currently utilised facilities would need to be provided at the same level or indeed at a greater level on the new reconfigured sites.

Q. So finally, what should happen now?
A. So what is happening, what I can tell you, although I am representing the College of Surgeons I must add that I have not been harassed by Imperial, and I do not think I will be, but currently I can bring some news from at least one of the Imperial sites which is that I am pleased to report that there are currently adverts ---

Q. Could I ask you to keep you voice up because I am straining to hear something I perceive as good news.
A. A bit of good news. There are currently adverts which I have seen for the appointment of three new general abdominal surgeons the Imperial. This increases the numbers to a level at which I believe that the very important standards that we started with should be possible. I should add of course that when I visited many of the trusts in London for Healthcare for London (as it was then called) none of those trusts was meeting those standards, so there is a London-wide problem which primarily requires to be addressed by the appointment - I know all senior doctors say this - of more of our tribe, but that is nonetheless a true statement, and I am pleased to report that currently there are those three advertisements extant.

MS RENSTEN: Thank you. I have no further questions, but if you wait there, there will be questions from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much. The question I have to ask, and it may be too compendious for you to answer in the time we have available, but I feel compelled to ask it nevertheless so that we can start with, as it were, the analysis. It ties in with what you have just said about none of the trusts that you examined in the North West London area achieved the proposed - and that is how you have written it down in here - emergency standards. I want to take this in stages. Before the proposed standards, obviously there was another standard because otherwise you would not be talking about proposed standards, I do not think. If there is a difference, what is the difference? Secondly, to what extent did the trusts fail to meet the proposed standards? In other words, was it all the same, because you mentioned particularly at the beginning of your evidence on-site consultants and radiology. Are those the standards that you are talking about or is there much more that I am missing here. Do you see the thrust of the question?

A. I see, precisely or I think I do, but put me right if I do not. The first thing to say is that I did not say that it was most of the trusts in North West London; this was most of the trusts in London.

Q. Yes, you did.

A. It was London-wide. Secondly, it is right for me to say that prior to the congruent attempts of the College of Surgeons of England and Healthcare for London (as it then was) prior to their attempts to derive standards, there were no standards, so this is the first proposition, the first and only proposition of standards. This arose because of the report by our friends in journalism on the dangers of entering a hospital in London over the weekend with an acute surgical condition. I am sure you will remember that this was five or six years ago and Healthcare for London and the College of Surgeons picked up on this and responded and hence those proposals were the first proposals.

Q. I have a supplementary, needless to say, and that is instead of reducing sites, was it considered by the Board there was a possibility of raising all the hospitals to the same standards?

A. A very good supplementary question. I think all doctors, all surgeons and particularly those groups of us who are in Suffolk and East Anglia would clearly take that view - the view that you just increase the staff whatever. But, of course, when you are only dealing with a catchment population of perhaps 200,000 or maybe 180,000, as is typically the case in North West London, if you are going to meet the emergency standards and have sufficient numbers of consultant staff, both radiologists and surgeons and sub-specialty surgeons, which was interestingly alluded to by the previous witness, then you do not have anything for them to do that is not emergency in their elective lives. This is partially a problem because of sub-specialisation. This supplemental question is fundamental. When I started at the West Middlesex Hospital, there were five potential surgeons and I was appointed as a urologist and a general surgeon. One of the other general surgeons happened to do most of the breast work but his colleagues did this as well. The vascular surgeon did most of the vascular surgery but also the general surgery, so with a catchment

of a couple of hundred thousand around the West Middlesex five surgeons produced a unified on-call rota, and because they were sharing what are now sub-specialty interests, there was enough work to go around to maintain the skills. As soon as you say we have breast surgeons and they just do breast surgery, we have colo-rectal surgeons and they just do colo-rectal, the urologists have gone off in a separate tribe many years ago, the vascular surgeons have just split from the general surgeons, then in order to have sufficient tribes and sufficient numbers of people (because we cannot just have one in a tribe, it is immediately three) you suddenly have 15 consultants on one site for a population of 180,000. If that is the only hospital and that is the catchment and the next one is 70 miles away, so be it, but in terms of a dense population of 1.8 million in North West Thames, to raise the standard to the proposed criteria for each of that unit, and I speak for surgery and emergency surgery, is not a sensible proposition, irrespective of money. There may be unintended consequences of stopping the other equally important medical activities, and I prefaced my remarks by crediting what I thought was a wonderful statement from the previous witness, so I am well aware that I am only talking about a fragment of the totality.

THE CHAIRMAN: I understand.

Q. DR LISTER: Just to take it a different way round, if we can. Presumably you are saying to have a full range of those different sub-specialties in a team to deliver services you need a certain expanded catchment population, but am I also right in thinking that if you had that expanded population and these teams working effectively then you would also need a certain number of beds to go with that in order to ensure that they could actually place their patients for recovery having operated on them?
A. Absolutely.

Q. So is there a bit of a trade-off between reconfiguring to reduce the number of hospitals and the number of bed and at the same time bringing catchments together so you get more surgeons?
A. Sure. Underlying that is a very important question - and as you can see, I am very interested in healthcare - which is if you do it better, and by that I mean do it better for surgery and indeed my colleagues in orthopaedic surgery have an initiative at the moment, the paraphrase of which is "get it right first time", so if you do get it right first time and you have the resources to get it right first time your question is do you actually save money and therefore beds? The answer is probably you do. Whether you do to the extent which it is necessary to say that you do to make your sums work, I do not know. I am not an accountant or a politician.

Q. That was not quite what I was getting at. I was not actually talking about money; I was talking about the fact that if you reconfigure hospitals to take one out, in this case take four hospitals out of the frame in North West London, and we are now looking at the plans as drawn up which involve 1,000 fewer beds in North West London, so if you take those beds out, but you have then got these bigger teams of surgeons able to deliver services, will they have the beds to put the patients in? I do know that a number of years ago now there was a joint report, I think it was the Royal College of Surgeons, the BMA and some others, who got together and proposed a much bigger catchment site, a million and a half/two million or something but they never drew the conclusion as to how big the hospitals needed to be in order to treat the catchment that they had.

A. So it would not be unreasonable to say that you must re-provide the same number of beds that you are currently using. All of us would suspect that there would be two consequences of centralisation. This is a suspicion. The first is that we as surgeons would become more adventurous and we would operate on more people. The second is that probably within that we would also do it better - right first time, with more senior people, getting to the patient sooner, having made the diagnosis by cross-sectional imaging and not allowing them to languish for 24 hours or over a whole weekend, so we would do it better, but at the same time we would probably do more of it. I suspect in terms of beds and resources it would end up as neutral. However, I am getting a little bit off piste here so I must be careful.

Q. Whose piste are we talking about?
A. Mine.

Q. DR HIRST: Could I keep you off piste then?
A. Only because you are a friend.

Q. I happen to know that you have got a wide experience beyond the narrow confines you have talked about today. Would you mind if I asked you a question based on your previous experience because I would like to explore a little bit how out of hospital services will maybe reduce admissions because that is what we are meant to believe is part of the SaHF, and, to that end, can I call on your experience because I happen to know that you were a pioneer of running outreach clinics which you did back in a place I know very well 25 years ago. I remember you telling me at that time you wanted to do it because you wanted to make the decisions as a consultant first. Although we did not audit it, we did discover that, yes, you could probably reduce outpatient attendances by, firstly, educating us and secondly because you were making decisions. Assuming a consultant is available to make decisions, do you really think that outreach clinics actually prevent admissions? They might prevent outpatient attendance but did they actually prevent admissions? I can give you an example if you want.
A. It is a very interesting point. I think the answer to that question is probably yes because of course you avoid the patients getting into a system which might - I am being frank here - which might actually do them harm. It might worry them that there is something the matter with them when there is not. They may be attended to over-zealously or they may not be attended to zealously enough. Once they get out of a consultant-based and indeed primary-based environment, it may not be quite as safe, contrary to what may be often said. So I believe that using specialists who currently are in secondary care and tertiary care and being able to co-operate, the co-operation between the secondary, the tertiary and the primary care physicians in the setting of a poly-clinic does have a great deal to offer, both in terms of quality and in terms of equity of access and probably - probably - in terms of saving a bit of money.

Q. Can I push you a little bit further then? Unfortunately, I only have a tiny little map but knowing that you are in contact with the great and the good in the profession I am trying to understand when I look at this map, which shows St Mary's at one edge of this great huge area of two million people really on the periphery, I am told half a mile away from UCH which probably duplicates a lot of what St Mary's does except for the major trauma centre, including, we have heard, down to having an HASU unit. Would it not make more sense, having regard to the fact that but for the one ward in Paddington the

most deprived, the most unequipped people are to the west of North West Thames, would it not make more sense to have your major, major centre somewhere in the middle, or at least a little bit of a way over, if not in Ealing, where geographically it might make sense, at least in Charing Cross where it already is or has been? If so, why has it gone to St Mary's?

A. The last bit I cannot really answer. I really do not know. The first bit about what might have been perceived to be the most useful central location, it is my view that the perception of the board probably was (I was not influencing this at all because I did have to be very careful not to be partial because I was there as representing another body; I was not there as a consultant from Imperial) that they probably thought that that central location for all services and emergencies would be West Middlesex. That was my impression. Now, why not Charing Cross? Crikey. It is supposed to have been falling down due to concrete rot for the last 30 years. Paediatrics and maternity, the obstetric services are not there at all at Chelsea & Westminster and proposed to be another central unit. So you could say that the Charing Cross site was terminally disadvantaged before any further discussion went on.

Q. Can I just take it a bit further? I have been told by a correspondent that Hammersmith Hospital was seriously considered. It had the medical expertise certainly, it had good buildings and it had land owned by the NHS and, if not, contiguous land which could be acquired, as opposed to St Mary's which has difficult transport links, old buildings, et cetera. In your experience in medical politics, do you know what happened to that Hammersmith proposal?

A. I do know that the original Hammersmith proposal was actually many years ago when I did have something to do with the disposition of services. This is long before *Shaping a healthier future*, this is 15 years ago, and indeed there was a very comprehensive plan drawn up by the Old Hammersmith Hospitals Trust (as was) to redevelop the Hammersmith Hospital site, including a station, including a separate slip road from the A40, extensive car parking, all kinds of things, shops, gyms, swimming pools. This was in the heady days before the crash, I think. So there was certainly that plan. What happened to it, I do not know. Part of it, the first part of it I think was to develop a renal unit on the Hammersmith site, a dialysis unit, which of course has been very successful. But I do not know, Stephen.

THE CHAIRMAN: I have to keep an eye on the clock, I am afraid, and there are probably at least two other witnesses. Thank you very much for your attendance.

THE WITNESS: It was a pleasure.

The Witness Withdrew

Witnesses: MR SEBASTIAN BALFOUR and MS GRAINNE PALMER, Hammersmith residents

Examined by MS RENSTEN

Q. MS RENSTEN: Could I ask you both to give your names and addresses, please?
A. (Mr Balfour): Sebastian Balfour, 59 Wallingford Avenue, W10 6PZ?
A. (Ms Palmer): Grainne Palmer, 59 Wallingford Avenue W10 6PZ.

Q. If you could please look at page 1393 and confirm that is the submission you put in? And is it true to the best of your knowledge and understanding and do you wish it to stand as your evidence to this Commission?
A. (Mr Balfour): I do.

Q. I want to ask you first about your use of Hammersmith Hospital. In the past when did you last use A&E services there?
A. (Mr Balfour): This was in 1996 when I have admitted for an operation to the heart, a heart operation.

Q. And what was your experience then of travel times getting there and by what mode?
A. (Mr Balfour): It was a very, very good experience. It was very accessible.

Q. What mode of transport was it?
A. (Mr Balfour): I could use the bus, I could walk from my residence and a car.

Q. And in terms of waiting times at that stage?
A. (Mr Balfour): At that stage there were reasonable waiting times, yes.

Q. Can you put a figure on "reasonable waiting time", just roughly?
A. (Mr Balfour): It is very difficult to remember, it is a long time ago, but I would say it was certainly within two hours.

Q. Quality and standard of care received?
A. (Mr Balfour): Very high indeed.

Q. Moving on to post the closure in September 2014, you described attending at the urgent care centre at Hammersmith Hospital. Can you help the Commission by explaining what happened?
A. (Mr Balfour): Well, we understood that there was no A&E service. We attended the urgent care centre because I was undergoing considerable pain and I was seen there by a GP who, like my own GP, failed to diagnose what the problem was.

Q. Pause there a moment. Are you aware - you may not know - if there were any consultants available or was it simply GPs at that stage?
A. (Mr Balfour): There was just that GP available.

Q. Continue please.
A. (Mr Balfour): And it was only a week later when I was under continued considerable pain that I went to Chelsea & Westminster A&E where they diagnosed my condition.

Q. Pause there a moment. So you went to the UCC and they failed to diagnose. Where were you sent, if anywhere, from the UCC?
A. (Mr Balfour): Nowhere.

Q. You say a failure of diagnosis; was it simply a non-diagnosis?
A. (Mr Balfour): Shall I actually give the details?

Q. Only if you are comfortable.
A. (Mr Balfour): I am quite happy to. It was diagnosed as IBS when in fact it turned out to be diverticulitis.

Q. Then explain to us please how you came to go to A&E and how you knew on that occasion to go to A&E?
A. (Mr Balfour): Well, the pain was unbearable and so not having had a diagnosis that explained the condition, in my opinion, I went to A&E in Chelsea & Westminster.

Q. Why was it that you went to Chelsea & Westminster?
A. (Mr Balfour): Because that was the closest, as far as I could tell, A&E that was open.

Q. How were you able to get there? What form of transport?
A. (Mr Balfour): By car driven by my wife.

Q. And how long were you waiting once you got to Chelsea & Westminster?
A. (Mr Balfour): It is difficult to remember the exact time but it was several hours.

Q. I do not know if your ---
A. (Ms Palmer): Yes, it was definitely several hours we had to wait.

Q. And what were you told, if anything, about the impact of the delay from having been seen at the UCC to having been seen at A&E?
A. (Mr Balfour): Well, I think it is clear that this diagnosis should have taken place a long time before and that a referral to a consultant should have taken place at least a year earlier.

Q. If you were in a similar situation now, and were unsure about the gravity of your condition, where with you would you go?
A. (Mr Balfour): I would go to Chelsea & Westminster.

Q. Would you consider using an urgent care centre?
A. (Mr Balfour): It would depend very much on my own judgment. In a sense, we have to take ownership of our condition and find out as much as possible about it, and this is what I attempted to do. In any case, on the basis of having gone for over a year with periodic pains of considerable intensity, I had actually insisted with my GP that I should be referred, but the referral will take a while obviously to go through the administrative procedures, but it was a week later that the condition was so bad that I decided to go into A&E and it was there at A&E they immediately decided to hospitalise me and went through the tests where they determined that this was a case of diverticulitis that needed urgent attention.

Q. I do not know if you can assist. Were you able to or did you provide any feedback or have further discussions with the urgent care centre about the failure to diagnose?
A. (Mr Balfour): Not the urgent care centre. Certainly with my GP, yes.

Q. And what was the GP's response, if any?
A. (Mr Balfour): The GP was very glad that this matter had been cleared up. I certainly did not go with any grievance to him. It is not his job to diagnose something as

complicated a diverticulitis.

Q. In a nutshell, what do you want to say to the Commission about the closure of the Hammersmith Hospital accident and emergency unit?
A. (Mr Balfour): I hope my case might reinforce the argument for retaining and restoring local A&E units. I welcome the extension of urgent care units and the extension of GP hours, but I do not think those are sufficient to diagnose cases like my own, as I have tried to make clear. I think there are two problems with the present situation. One is the question of capacity. That has already been discussed here. The other is the question of access. I find it very hard to believe that the five remaining A&E units will be able to deal with the number of patients, even though these are filtered out by urgent care centres and GPs. The numbers are going to increase at an extraordinary rate. Access is another problem as well. For a broken bone I have been to St Mary's Paddington and getting there has been extremely difficult. This is with a broken limb. Extremely difficult. I can imagine now with the closure of local A&E units that access will be extremely difficult. The volume of traffic will grow exponentially and the problem of parking, it is not possible to park there and it was very, very difficult, as it stood before the closure of the local A&E units.

Q. Do you regard St Mary's as a hospital therefore that can or cannot provide you with emergency services?
A. (Mr Balfour): Well, I cannot be so categorical as that. I am just saying that it will be extraordinarily difficult for St Mary's Paddington to cope with the volume of traffic that will result from the closure of local A&E units.

Q. You also detail in your email an incident involving your neighbour. Obviously of course you are repeating what has been said to you, but I wonder if you can give us some details of that if you think they are pertinent for the Commission.
A. (Ms Palmer): I am not obliged to give the neighbour's name, am I? It was about three weeks ago. A neighbour had what he thought was a suspected blood clot near his groin and he went to St Mary's and he waited for between four and six hours. The conditions there were so bad he was really worried for his health because he was parked right next to a woman lying on a trolley coughing and vomiting and screaming and without any protection from her coughing. He felt he might pick up something and he was so upset he actually went home and did not see any medical adviser for another two days.

Q. Are you aware of where he went afterwards? Did he go back to St Mary's, do you know?
A. (Ms Palmer): I do not know.

Q. Is there anything else you can help us with or is that the scope of what you know about that incident?
A. (Ms Palmer): That is all I know. He is okay, he is being attended to now and I think it is all under control, but that kind of delay when people go somewhere and they actually walk out because they feel their health is in more danger by staying than going is ridiculous and between four and six hours, actually I think it was six hours he said. So no good.

Q. Finally what I would like to ask you about is this: from your perspective, what do you say should happen in terms of the acute care, the A&E in the area?
A. (Ms Palmer): I do feel that it is very important for us where we live, which is in North Kensington just north of Latimer Road Station, to be able to have an A&E department in Hammersmith Hospital. I think some of the points I heard earlier about the space there to acquire land, parking is okay there, we are both able to walk, there is a bus service, it is very accessible for people living in our area.

MS RENSTEN: Wait there please, there may be some questions from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much to both of you. I have a question which you may feel you are not equipped to answer so please say so, but I feel since you have come straight after the last witness and you were here hearing what he had to say, how do you say we as a board, if we can be regarded as that, but anyway as an inquiry, should be marrying the standards which have now been set, apparently for the first time, which involve on-site consultants and radiology possibly to the extent of intervention which means the only way they can provide it is to reduce sites, how do we marry that with your needs? If you follow the question, do you have some observations about this?
A. (Mr Balfour): I sympathise with the arguments he was putting forward about the need to concentrate skills and specialisms, but it is not as if there is no alternative. We should be able to provide those skills and those specialisms in all A&E units, including the ones that were closed. I do not think closing those has made the situation any better. Of course, this involves greater resources to be put into the NHS. I think this is an argument. Why does the NHS have to suffer these cuts? This is central to all our lives and our families here. There should be more resources put into the NHS and the A&E should be reinstated. We should have local A&Es because in the scenario that the previous witness was putting forward, the stress on the capacity and access to the remaining A&Es, it does not seem to me to have been studied very thoroughly. Anybody who has gone to St Mary's Paddington will be aware of the difficulty of getting to it. Where there is urgency, where somebody is dying, where there are broken limbs, then it would be much better to have closer local A&E units rather than one which is going to be overcrowded and where the traffic is going to be enormous. I hope that answers your point. I am really saying there should be increased resources.

Q. Which was my supplementary question to him and his answer was it is not sensible. Does it appear to be that it is not sensible for clinical reasons or not sensible for economic reasons?
A. (Mr Balfour): I think it was for economic reasons. That is what I had understood the prevailing policy of cutting services, of reducing expenditure. This is the framework in which that sort of argument is put forward. I do not accept that argument or that framework.

THE CHAIRMAN: Thank you very much indeed.

(Applause)

MS RENSTEN: I think I am being told that the other witness is not expected to come having been told a 3 o'clock slot so I think that probably concludes the evidence for today.

THE CHAIRMAN: That will conclude today's hearing. May I thank everybody for coming and attending so attentively and particularly thank counsel to the inquiry for the particularly efficient and clear way in which matters have been presented.

The next session is going to be at Ealing Town Hall next Saturday, the same times, 9.30 in the morning through to 5.30, but obviously with a different set of witnesses. Thank you. (Applause)

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