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

EALING TOWN HALL,
NEW BROADWAY, EALING W5 1BY

on

SATURDAY 21 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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MS RENSTEN: We are, unfortunately, one Commissioner short of a triumvirate at the moment. We are very much expecting Mr Mansfield QC to arrive in the next few minutes. Our first witness, who is Mr Pound MP, has a pressing engagement elsewhere, so we have taken the decision that we will press on and catch up with ourselves hopefully a little bit later on. In the normal course of events we would start, as we did on the last occasion, with a very brief introduction but because Mr Pound has to get away, what I am proposing to do with the permission of the two Commissioners who are here is to move straight into the evidence and following Mr Pound MP to do the short introduction that explains the basis of this Commission. Without further ado, ladies and gentlemen, if we could please commence.

MR STEPHEN POUND, Member of Parliament for Ealing North

Examined by MS RENSTEN

Q. MS RENSTEN: Mr Pound, could you please turn to the bundle in front of you. You should have Volume 5 and you should see in front of you your submission. It is the one I think that is open directly in front of you already. Can you please confirm first of all your full name and professional address?
A. (Mr Pound): Yes, my name is Stephen Pound, Member of Parliament for Ealing North, and my professional address is House of Commons, Westminster SW1A 0AA. May I apologise for any inconvenience that I have wished upon the Commission by having to leave early. I do apologise. I am not being precious; I really do have an engagement that is absolutely, utterly unmissable.

Q. Not at all. Can you please confirm the submission there is true and accurate to the best of your knowledge and understanding and that you wish it to stand as your evidence to the Commission?
A. I can confirm that this evidence is true to the best of my recollection, in fact to my knowledge it is correct, and I wish it to stand as evidence to the Commission.

Q. I wanted to ask you first about the consultation phase, please. How well do you consider that your constituents were informed about the proposed changes?
A. My constituents almost unanimously were utterly confused by the whole process. I cannot think of an occasion where there has been less engagement and less sense of ownership. In all honesty, we were actually more engaged with the Heathrow Airport consultancy than we were with this and this is much, much more important. The whole *Shaping a healthier future* exercise was glossily produced in wonderful documentary form and there were a couple of meetings, but the degree of local engagement was profoundly negative, whereas the degree of local opposition was extremely positive and widespread and attracted enormous numbers of people.

Q. I wonder if I could ask you to have a look at Volume 1 which is in front of you as well and just please turn to page 77. This is a submission which has been provided by the London Borough of Ealing. I wonder if you can see paragraph 5, it is headed "The changes set out …"
A. I have it.

Q. What it says there is that public participation was "confined to SaHF 'engagement

events' which were attended by, in total, approximately 360 members of the public." Can you help us with whether or not that accords with your own view of things? Is that accurate or not?
A. That is extremely accurate. In fact, in my submission I specifically refer to the fact that I wish to associate myself with the submission made by the London Borough of Ealing and the Leader, Julian Bell, who is going to give evidence later on today. More people attended the first public meeting in opposition, which was held in Hanwell Methodist Church a few years before that, than did in the whole of the public consultation SaHF exercise.

Q. Still on that consultation exercise, are you able to say if as I think you are saying that the information did not reach all your constituents, were there any particular groups who were least informed?
A. Very much so. One of the specific features of Ealing is the demography. We have a great many people who do not speak English as a first language who in part were excluded from the process. We also have a large number of elderly people and people who were not accessible through the normal mechanisms, ie doctors' surgeries because we have a great many single-handed practitioners and we have a significant number of elderly, single-handed practitioners, particularly in the west of the borough. I was constantly being contacted by people who had heard apocalyptic stories about the closure of the whole system. In some cases their fears were genuine and in some cases they were not but the one, overriding constant feature was a lack of comprehension, a lack of engagement and a lack of penetration into those communities.

Q. Just to be clear, when you refer - and this is at paragraph 9 of your statement - to the "uniformly negative response" from constituents, is that something which over the time has got better or worse or remained a consistent feature?
A. Sadly, it has got worse for a couple of reasons. I did specifically make the point in my submission that there are cases when major reorganisations in the NHS have to happen, do happen and in fact are successful. I am thinking of the closure of the hospital I worked at for ten years, the Middlesex Hospital, which was closed and is now a hole in the ground instead of a glorious mid-Victorian wonderful building, but it was not controversial because it made sense to people. The consolidation of stroke services, initially controversial, when it was explained, when the public were engaged with it and when it was explained that the medical advances in TIAs and various other mechanisms could actually make the process better, people understood. In this particular case people did not understand it and it is a terrible coincidence that this actually coincided with what I would say is a fragmentation of NHS provision where we have a "Notional Health Service" in West London rather than a National Health Service because it is utterly disaggregated at the present time. So those factors came together and at the end of it, the absolute utter hammer blow is this absurd letter that has been circulated this week to say that maternity services will be removed from Ealing Hospital because although they are fine at the moment at some stage in the future they may not be, therefore let's close them down now.

Q. Could I ask you to pause there? I was going to come to that but we may as well deal with that issue now since you have touched upon it. You are referring to a letter from Dr Mohini Parmar, is that correct?
A. I am referring to the email I received dated 19 March from Andrew Pike sent on

behalf of Dr Mohini Parmar.

Q. And the substance of that very briefly is what?
A. Is that Ealing Hospital Maternity Unit is "currently a safe place for women to give birth. However, the standards for maternity units are changing and we know that in future Ealing may struggle to meet these standards." In other words, "My house may be a perfectly adequate home for myself and my family at the present time, but at some time in the future the roof may leak, therefore let's knock it down now." An absurd, ridiculous, tendentious statement that is absolutely inexplicable in any other context other than a wish to centralise maternity services and to remove all maternity provision from the London Borough of Ealing, which is not only deleterious to my constituents but a flipping disaster.

Q. Can we look at that a little bit more broken down?
A. Sorry, I did say "flipping" disaster!

Q. If that service is closed what specifically will be the impact on the service users?
A. For a start, there will be of immense significance the fact that there will be no maternal service within the London Borough of Ealing. They will then have to go to other maternity centres. Like virtually everyone I know, I was born at Queen Charlotte's Hospital. Queen Charlotte's Hospital was the maternity hospital and many people went there. It is no longer at Queen Charlotte's Hospital. It is not there. It is now consolidated within Hammersmith. People would then have to move to West Middlesex, which appears to be the preferred option. If you do not know the borough of Ealing you might think that West Middlesex Hospital is a stroll down the road, it is a gentle, sylvan glade like Windmill Lane, where you can wander through the hayfields. In reality, you have to cross the M4 to get there and there is not a direct bus route from the vast majority of our constituency and there is no tube station anywhere near it. The idea that you can up and stroll down to West Middlesex is ludicrous. It may make sense looking at a flat map, but anyone who had spent three minutes in West London will tell you it simply is not on.

Q. In terms of the consequences to particular groups you have mentioned the large, non-English speaking constituency. Does the potential closure have any particular consequences for that population group?
A. Yes, it does. The maternity service at Ealing Hospital opened in 1988. Up until then we had three maternity hospitals in the borough, the most famous one obviously being Perivale. Between 1988 and the present day, Ealing Hospital's maternity services have actually won for themselves a reputation of being a first-class service, which is not just excellent in terms of maternity services, the antenatal and prenatal months, but also in terms of its accessibility to the local community in terms of nurses, staff, doctors who can actually speak community languages and also the provision and the structure within the system. Cultural sensitivities are incredibly important at this particular time. I am sure I do not need to make that point. Ealing Hospital is a very, very culturally sensitive hospital and the maternity services are a safe, reassuring and comforting place for women to give birth in. It took a long time for them to reach that and at the present time, with some of the best maternity nurses I have ever known in my life and some of the best midwives leaving because of demoralisation, because of what they could see coming over the hills, the closure of the service, that is disappearing and we are already getting the complaints from people who are coming in. I do not wish to go into specific areas but

there are certain aspects of maternity which really do need to be handled extremely carefully. Also, if the look at the FGM issues nowadays which need to be identified at that stage, that is something which is incredibly sensitive. Ealing is good at that and all that expertise, all that institutional memory, all of that sensitivity, all of that is going to get thrown out. I am not saying the West Middlesex cannot do it. I am saying it will take a long time for them to get to do it and people will suffer in the interim.

Q. Thinking about the decision-making process which is taking place, do you have any view about the impact of the delay and then further delay upon staff and users?
A. Absolutely right. I refer in my submission to the statement made by the Royal College of Nursing and they make the very, very powerful point that this is absolutely demoralising to staff. I quote in my submission the statement made by the Member of Parliament for Ealing Central & Acton when she said on the floor of the House, "This is all about money". I think that Angie Bray was absolutely correct on that and certainly a large number of staff say, "We are dedicated and devoted to the National Health Service. It is important to us. These decisions appear to be taken, and our own MP has told us this, on fiscal grounds alone. This is not actually about any therapeutic imperative; this is about money." How demoralising is that? You can see with your own eyes the staff moving away from there. Why have we got a crisis with employment of midwives in Ealing at the moment? I would say to a very large extent because who on earth would take a job at the present time knowing that their job will be disappearing soon?

Q. Finally thinking on this point about the maternity hospitals, in the documentation provided on behalf of Dr Parmar, and there is reference to it in earlier documents, and I will not take you to them unless you wish me to, the thrust seems to be that other services may not yet be quite ready to take on the operational capacity required to deal with Ealing's maternity users. Do you have any comments on that?
A. I have to say that I consider that one of the most breathtaking statements within the email. It seems to me that to say that the London Clinical Senate, which I have to say is a body which is not on the lips of every one of my constituents, you very seldom find people in The Viaduct chatting about the London Clinical Senate, I am sure it is important but it is not something which we discuss at great length. To say that they have endorsed it does not mean a damn thing to most of my constituents. The fact that the services are not ready yet does. The fact that we are losing the maternity services does. And the fact that people would have to travel a long way does. At a recent meeting of the CCG I actually raised the question what would happen to future capitation funding for a borough that has nobody born in it. We already have this ridiculous situation where Northwick Park is actually in Brent and so people born in Brent count as residents of Brent because they are born in Northwick Park even though anybody would say it is actually in Harrow because the majority of the people who give birth there are from Harrow. So in terms of capitation and capital allocation, Brent gets that and Harrow does not. So if all the Ealing people are going to be born in West Middlesex, which is in Hounslow, although I am sure it can be dealt with, these are things that have not been thought through. When I read this statement from Andrew Pike, and I have to say I do not envy him his job as Assistant Director of Communications but he is, for better or for worse, but to actually admit that again is breathtaking, the fact that it is not even ready, for Heaven's sake.

Q. Can we move on now, please? I wanted to ask you about the issue of emergency care at Ealing Hospital. Could I ask you in front of you, you will see another volume, it is

A headed Volume 2, it is the second one.
A. I have it.

Q. Could you turn, please, to page 594. What I am taking you to, and while you are doing that I will explain, is a letter and it is from Dr Parmar, who is the Chair of Ealing CCG, I just wanted to ask you to comment on some of the matters contained in that letter, if you would.

B A. I have it here in front of me. In terms of the anodyne, it is wonderful because it really does sound as if Dr Pangloss is the uncredited author of this. I see the references in there to the community tele-dermatology service and the musculoskeletal services, but we are talking about maternity, we are talking about A&E. The problem with A&E at the present time is there is an existing A&E and acute service facility at Ealing but it is not an A&E.

C Q. Can I ask you to pause there a moment? I want to take you to some specifics. I certainly do not want to circumscribe what you want to say to the Commission. Do you want to finish that point?
A. No, that is fine.

Q. What I wanted to ask you about specifically in this document is what Dr Parmar is
D talking about is a decision to support the change away from Ealing Hospital as a major hospital. What he says at the bottom of that page is that it was such an important ---
A. She.

Q. I beg your pardon, she - was such an important and sensitive change that a referendum of GPs was conducted and as a result of that, it was found that there was overwhelming support. I want to read you the questions that were asked of the GPs and then just ask
E you to comment. What questions were asked were these: "Do you agree or disagree that there are convincing reasons to change the way we deliver healthcare in North West London, including new standards for care in hospital, and concentration of services to achieve them, and delivering some services that are currently delivered in hospital more locally?" Those were the questions put to the GPs. Can I ask you to comment on whether or not you view that as providing a democratic mandate for what the GPs thought?

F A. I think these are pretty much weighted questions. The other thing is to say that this has the approval of the entire GP community is all very well and good but there are different issues here. One of the hardest things when you are talking about objectivity within the NHS is to separate the practitioner and the patient perspective. I entirely understand and respect and I am grateful for the practitioners, obviously there would not be an NHS without doctors, consultants, surgeons and nurses, but the patient view has to be heard as well. It is all very well to say that the doctors know best and the patients do
G not have any say and far be it for me to refer back to Aneurin Bevan's comment about "choking their mouths with gold", but GPs have not done badly at the present time and the position of the GPs within the CCG is so powerful that I find it difficult to disaggregate their involvement within the CCG from their objectivity when it comes to talking about this. These questions, I am sorry, any question which says "delivering some services" would be deemed completely unacceptable by any legitimate polling organisation. You cannot say "delivering some services". That is open-ended and, in
H effect, meaningless.

Mr Michael Mansfield QC arrives and takes the Chair

Q. I also wanted to ask you a little bit about the impact of the closures which have taken place already and again this is referred to in Dr Parmar's letter at page 596. What is suggested there is that the closures took place in a planned and safe manner. Can you help with, to your knowledge, what the impact of the closures of the A&E at Hammersmith Hospital and Central Middlesex has been upon Ealing Hospital and the residents of Ealing?

A. Very much so. You will hear in detail later on precisely how Ealing Hospital is failing to meet its targets and how waiting times are increasing and how the whole clinical aspect is currently failing, but, look, when we spoke to Dr Mark Spencer about this he said he was a GP in Acton, which he is, and he could get to St Mary's Hospital in a very short period of time. It later turned out he was talking about a fairly high-powered motor cycle. I have absolutely no problem with motor cycles, I am a great fan of them, but the idea that a pregnant woman can leap on the back of a Moto Guzzi and roar to St Mary's or that a phlebotomist can jump on the back of a Lambretta LD 175 and somehow get to the outer reaches of the borough is barking - sorry, no, actually you can go to Barking by tube, but it simply does not make sense. What I would like to briefly, if I may ---

Q. Briefly.

A. --- with your permission, there have been a whole number of cases where people have come to me with problems caused by the partial closure of the A&E. If I can just refer to one of my constituents, Mr D, who has a very malign leg ulcer which is being treated at the leg ulcer clinic at Northwick Park and he needed his compression bandage changing at least once a week for the next eight to 12 weeks. His GP was unable to provide the service. He told him to attend a walk-in centre or go back to Northwick Park or failing this to attend an A&E. None of these actually worked. Previously he would have been referred to a district nurse but because there are no district nurses, they will only visit immobile patients, and a practice nurse has to receive specialist training, and according to the staff at Northwick Park treatment must be carried out by a healthcare professional so when his GP told Mr D to learn how to do it himself or - and I quote a marvellous old-fashioned expression - "Teach your wife how to do it", this was not only against the guidelines but it is where the absence of the A&E impacted dreadfully. My staff and I spent an entire morning on the phone to the GPs' surgery, to the walk-in centres, to Ealing CCG, Brent CCG, because, incredibly, there is now a rule that if you live within a mile of the boundary between two CCGs, you come under the one that you would not think you came under, so his GP is in Brent, and he lives in Ealing but because he lives a mile from the Brent boundary Ealing was responsible. We contacted district nurses and Northwick Park Hospital and the Wembley Walk-in Centre. We went on and on and on whereas before either a district nurse would have come round and dealt with the compression bandage or he could have gone to A&E. We have a man who is a shop keeper who is trying to run a business and he is now having to somehow teach himself to change a compression bandage. I think he cavils at the idea that his wife at the snap of a finger is going to rush forward and change his compression bandage. My office is spending half a day making phone calls. The idea that A&E or the district nursing provision was there to represent people in precisely this way is something that most people would think is so, but it simply is not. You cannot go to A&E. It was originally anticipated that there would be 25,000 patients a year at Ealing A&E and it is over

100,000 patients a year, and rising. To even think of closing it is criminal because in the context of rising demand you could not have a steeper graph of demand.

Q. Pause there a moment. I wanted to ask you about, and you touched on it earlier, the reconfiguration of the A&E department. What the Ealing CCG document says is that Ealing will continue to have a local A&E and a 24/7 GP-led urgent care centre. What is your understanding of the provision of emergency services that is going to be at Ealing Hospital after the reconfiguration?

A. At the moment we seem to have a ridiculous situation --- triage was originally invented at the Battle of Sedan when they had a triple stage where there was chance of you living, some chance of you living or no chance of you living, and medical doctors basically threw people in a heap of corpses, having presumably removed their medals and valuables from them. The idea of triage as being some sort of gateway process, some filter mechanism is an excellent idea. Under this new configuration you have a triage on a triage on a triage. I am ready to stand corrected, but I am told that only four blue light admissions are made per day on average to Ealing Hospital. If that is the case, there is something seriously wrong. Why are ambulances not bringing patients in there? The answer is they cannot because they are being turned away. Therefore it is immediately impacting on people. Also, we do have a history because of the demographics, I make no apologies for it, we have the situation in this country, and in this borough particularly, where a lot of people are not registered with GPs. We have a huge transient population. We have a huge population that does not speak English as a first language and we do not have an adequate GP service to cope with it. Polyclinics would have been ideal. They would have been a wonderful answer and would have been very, very helpful, but we do not have polyclinics like that and therefore the A&E still takes up the brunt of it and the present A&E is overloaded, overworked, under-financed, under-resourced and under threat.

Q. What happens if it then becomes an urgent care centre and no longer has the capacity to accept blue light ambulances? What is the impact on your constituents then?

A. I am really reluctant to be alarmist but we are not here talking about some sort of theoretical construct of health provision in some sort of cool analysis; we are actually talking about blood, plain, hurt, life and death. Again, I am not going to be alarmist, but this is something which you cannot take too seriously. If someone in an RTA cannot be taken to the nearest A&E they will probably die.

Q. I want to ask you briefly about the other side of the coin from the acute services provision and that of course is the out of hospital strategy and the primary care services. First of all, on the information that you have, how would you characterise the state of GP services in your constituency at the moment?

A. Very patchy. I mentioned earlier on the very, very large number of elderly, single-handed practitioners in the west of the borough. That certainly does have an impact. I have quite a few of them in mine. We have in Ealing North more of a move towards health centres or conglomerations of GP practices and services, which is a sign for the future, but we still have a great many GPs who will not accept more patients. Over and over again people come to me and say, "There's a surgery down the end of my road and I am told they are not taking anybody else on." That is a huge problem and I am not going to criticise the GPs, I do not know how the structure works, all I do know is that people come to me and they say they cannot get a GP and they cannot go to A&E. That is when

you have a problem.

Q. Do you have any comment on the impact on GP services if they were to have an increased role under the new provisions?
A. Do you know you can load the noble beast of burden up to a certain point and then the back breaks. I appreciate that GPs get a decent wage nowadays, although they probably would not admit that, but this is not actually about money. This is about time. Like most MPs, I do the old "mystery shopper" thing and I go to the A&E at Ealing once a month anonymously and just hang around to get a feeling of it. I also talk to a lot of GPs, not because of my own personal health circumstances (which actually are not bad at the moment) but I do talk to a number of GPs. I spend ten minutes per client in my constituency advice surgery. Most GPs spend seven or eight minutes. They are being overloaded to such an extent that I do not know of a single GP that actually has a lunch break. They are all dining *al desko*. It is an extraordinary situation now where GPs are being massively overloaded and you can tell this because of the lack of community involvement. You used to get GPs in Rotary, they used to be active in local groups. They are so overloaded now that to say that you could shovel this onto the back of that body seems absolutely ludicrous. GPs are not known for their reticence when it comes to making these points vociferously, and I am pretty sure that they would say this, but you cannot simply expect primary care to take up the slack and remove all that need for acute services. It just will not work.

Q. I wanted to ask you to comment again on something Dr Parmar has said. I will not take you through it but effectively in Volume 2, in the same letter, she sets out the Ealing out of hospital strategy and she refers to things which have been successfully implemented. She references GP networks, integrated care for the elderly, the pulmonary rehabilitation service, new diabetes pathways, increases in community dermatology and cardiology services and so on. Are you able to comment on whether or not on the ground you have seen changes as a result of these initiatives?
A. I have to say there comes a point, expressions like "diabetes pathways", it sounds like something by the side of the Thames that you go for a walk along. It just sounds ridiculous but what is not mentioned there, and Dr Parmar is a very, very good clinician and an extremely good doctor and I respect her and I have a lot of time for her, but she has not mentioned the real secret of success in most of those cases which is community pharmacists. The biggest change we have seen in the last five years has been the rise of the role of the community pharmacist. You can get blood pressure checks there, you can get phlebotomy services, you can get travel advice, you can even get some element of prescribing. Nurse prescribing, which came in 15 or 20 years ago, made a difference, but the community pharmacist is now the third leg of the stool, so a really, really key person there. I think Dr Parmar is being a tad tendentious in claiming credit for that because some of these pathways that she refers to are in fact more to do with that. The idea that GP surgeries have taken over those services - in fact, a lot of GP surgeries now have nurse practitioners within them and in most cases that is part of the understandable evolution of primary care anyway and it does not have to be either/or. Most GPs I know want to have a 24-hour 24/7 A&E because they need it. They are more than happy to do things like suturing in their surgeries which they never did before. You do not go to A&E for a few stitches now. But you cannot have a complete handover from one to the other. The GPs are not ready for it and there may well be advances in diabetes pathways but there are an awful lot of other agencies working there.

Q. I am conscious of the time but I think we have ten minutes of your time left.
A. You make me sound dreadfully precious.

MS RENSTEN: Absolutely not at all. Those are the questions I wanted to ask, but if you would not mind waiting there, the Commissioners may have questions for you.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Apologies again for being late but there is a question left over from last week which I am going to carry forward to each of our sessions because I am interested in the response to it. Mr Jonathan Ramsey from the Royal College of Surgeons was on a Reconfiguration Board and he also helped to establish emergency standards, which apparently did not exist before the furore about weekend inability to service the public. But he has a point which I would like to hear what you have to say about and he was saying that as far as acute treatment (in other words A&E) is concerned, it is much more efficient to have the specialists together in one place and if you are going to have to have in future as a basic condition a surgeon or consultant actually on-site plus being co-located with radiology, for example, this is the big debate: can you have that in every A&E? He was saying that was not sensible and therefore you have to centralise. I hope I have made the point clear but that is the one I am interested in.
A. You have made it extremely clear. It is a well-known truism that everybody in this country wants to have open heart surgery in a cottage hospital, and there is a slight contradiction there. Thirty years ago I worked with Dr Howard Baderman, who is the man who invented the Bader wagon, which is a great A&E cardiac arrest resusc kit. He loved gunshot wounds and he wanted to have a central group within the United Kingdom just dealing with gunshot wounds, which not surprisingly was located in the Royal Victoria Hospital in Belfast. He was very, very keen on that, but what it meant was that you could not have anybody who had any expertise with gunshot wounds anywhere else in the country and so after a bit it was thought this is ridiculous, you cannot have that over-concentration. I can understand why specialist consultants want to gather round together. They want to have the most interesting patients and the structure of the NHS in London is very much consultant-based. I am thinking of some of the things the Turnberg Report identified and that was 15 or 20 years ago. Turnberg identified an over-supply of hospitals within Central London because that is where the consultants lived and that is where the patients came to. The patients would flow in from the outer reaches to bring in their fascinating, interesting cases to fascinated and interested consultants. That was the structure of the NHS then and I think that the answer is to have more consultants rather than to have the existing body of consultants concentrated in one particular area. Centres of excellence always make sense. My wife did all her post-graduate work at the Royal Marsden and she worked in oncology and that made sense. The Marsden was and is a centre of excellence, but it should not be the only centre of excellence. What is wrong with having more consultants, a better-funded NHS and having the experts in the places where the patients live? My wife used to say, "Why on earth does somebody come from Truro to South Kensington or to the Bud Flanagan for their oncology treatment, their cancer treatment; why can't we do it there?" That seems to me the problem. I can understand the point being made, but I have to say that is life being looked at from the consultants' or clinicians' perspective. I think the patient actually has a role there.

Q. DR HIRST: I was going to touch on various subjects but you have made me interested in your comments. I have this running bee in my bonnet about medical politics in that when you look at the map, you see these great institutions, and I trained at a great institution, all gathered together, as you say, just beyond the area that we are dealing with there is UCH only half a mile down from St Mary's and St Thomas' and of course Chelsea & Westminster as well. There is a group of four or five very ---
A. I would add the Marsden to that out of spousal loyalty.

Q. My wife also works in the Marsden.
A. We will speak later.

Q. I suppose touching on what you have just said, and also in the knowledge that trains go both ways, why if St Georges went to Tooting and Charing Cross went from Charing Cross to Fulham why can St Mary's not come to Ealing? My worry is that there is a kind of - and I will choose my words carefully - political clan or area perhaps of the privileged who want still to have it in Kensington and Chelsea. Am I being paranoid?
A. My experience in the ten years I worked at the Middlesex, we had a private patients' wing and I could never understand why we had the PPW at the Middlesex or why we had the Mint at St Mary's until I read the history of the NHS and the history of Aneurin Bevan and understood how the NHS had come into being and how that was part of the consideration that was given to consultants. The reality is that the consultants would prefer to live in Central London and be accessible to one of these hospitals than they would to live in Southall. I cannot imagine why. Northolt is delightful place and I wish they would move to Northolt, but there is an aspect of that. The problem is what do we do about it, how can we actually cope with it? I think Turnberg was a very, very good stab at doing that. As you rightly say, moves did take place. The biggest number of complaints I get from constituents at the moment is about their inability to get appointments with hospitals when they have been referred, and I am currently averaging two months for a response from the CCG. I have to say that Sharon Hodgson is a marvellous woman, marvellously polite but she says, "Look, I'm sorry, I'm trying", but you are getting responses in two months. The second volume of complaints is about accessibility. The problem with Chelsea & Westminster, again a marvellous hospital when you can get there, is that it is very difficult to get to and the chances of parking there are negligible. I do not expect people to drive to hospitals. There is one bus that stops outside but to get from Northolt to Chelsea & Westminster means you have to change at least one bus, one tube, two buses. It is very, very difficult. I would rather see hospitals where the patients are. If you look at the fire brigade, fire stations in London are concentrated on property not people so you will find most of them in the City of London or the commercial areas because that was the imperative when the fire brigade was set up; property mattered more than people. It seems to me that the NHS grew gradually. We can go right back to Barts maybe but I would prefer a little bit more modern, maybe from mid-Victorian times, and it was to do with where the consultants wanted to be not where the patients were. Just as much as we have moved tax offices, the DVLA, the Royal Mint and various other people out of London, what on earth is wrong with actually employing a few more consultants and having them where the patients are because not only do you have the advantage of reassurance, because it is the corrosive, acid-like anxiety at the present time where people do not have a hospital near them, but also a good hospital does outreach and indulges in helping people and does health education. That is the sort of thing we need. We need to know about that. Hospitals

should not just be about treating patients when they are ill; it should be about preventative medicine. You cannot have preventative medicine if you have got to go to the other side of London to go to some sort of a clinic. I must admit, I wish I was Secretary of State for Health. I would employ you and your wife immediately and then we would reconfigure the whole damn thing in the interests of the patients; not in the interests of the bean counters!

Q. DR LISTER: To follow through on what you have just been saying about transport links, the notion of centralising services is a bit peculiar when you are in Ealing and it does mean you have got to travel that much further, but I wonder if you could talk about the various options. You talked about maternity and possibly people being expected to go across the M4 to the West Middlesex, but what are the other options in terms of A&E - Hillingdon, Northwick Park - what are the transport links like and bearing in mind for the catchment areas of Ealing Hospital we are looking at quite a deprived section of the population and presumably car ownership is relatively uncommon and so on, could you just talk a bit more about that?

A. One of the things that frustrates me immensely about this is that Ealing Hospital is a brilliant transport hub at the present time. Five buses stop at Ealing Hospital, including two 24-hour buses. Ealing Broadway Tube Station has the Central Line and the District Line. Six buses go from Ealing Broadway straight to the hospital. It is a really, really good transport hub. It is so good one of the reasons they have to charge for car parking there is people were parking there and going into town because it is such a good place to get to. The 92 bus, one of the best bus routes in London, runs all the way from St Raphael's up in Wembley to Ealing Hospital so you can get there from virtually anywhere in my constituency. Ealing Hospital has not been open that long. I remember very well the day it opened. At that time the transport was arranged to go to the hospital. Everything was moved around specifically for that. It took a damn long time to do that. To get from Ealing to Hillingdon is not easy. To get from Ealing, some of my constituency, to Northwick Park is very, very difficult. One bus comes about every 17 minutes. It is very, very difficult to get to. The idea of going across to St Mary's, we cannot all have access to Dr Spencer's motorbike, but if even if you adopt a GP taxi service and sweep by and pick people up, I am still not entirely convinced we could get there in time. The transport links do not work. People in Central London do not understand that Ealing is a big borough, maybe the second or third biggest borough in London, and we do need the transport links. Car ownership is low for two reasons. One is economic factors and the other is that a lot of people live in bedsits, single flats, small properties where you cannot have cars. That is part of it, thanks to the enlightened leadership of Cllr Bell and Ealing Council giving planning permission for properties with no parking spaces. I am sure he will make the point himself. So it is very, very difficult. It also links to anxiety because we have not even mentioned patients' relatives. When somebody is in hospital their relatives need to visit and that is part of the therapeutic process. Having a visitor is important. I can well remember my wife saying that they used to lay out the ashtrays by the bed for the visitors. Those were different times. Nowadays, the visitors come and it is actually part of the healing process and the number of people who say to me, "How on earth can I get to St Mary's or Hammersmith?" Hammersmith is easier but not the easiest. There is also something profoundly wrong I think in our country when Charing Cross Hospital just down the road from where I was born could end up as luxury flats instead of providing health for the nation. What sort of a priority is that? I do not want to make a political point, but I am a politician so I cannot

help it. I am also a human being and I am also someone whose life has been saved by the NHS. I was born the same day as the NHS. My elder two brothers died. They were born before the NHS. Myself (and I hate to say it) and my seven brothers and sisters have all done rather well out of the NHS. It is important and if I get a bit emotional from time to time, do you know, I am not going to apologise.

Q. Just one more thing. Going back to the process of the consultation, and you were talking about your constituents being confused by it and so on, we have had various references to the availability of the literature. Leave aside how adequate the literature might be in actually explaining what they are planning to do, one question I am keen to follow up is the question of availability in suitable languages and access to the detail of the report rather than simply a very abbreviated summary. Could you talk a little bit about that, whether people could actually find it in a language they could understand before the decisions were taken?

A. No, it was not. If you have a look at the two main documents, obviously the *Shaping a healthier future* document which has appeared in various guises, I think there is probably a five-volume version of it somewhere, you could apparently get hold of a copy but it was not easy and there was nowhere I could see a copy in any of the community languages. But the *Healthier North West London* document, which was sent out to people, has no facility whatsoever and a lot of people I know would simply see that, if they saw it at all, in a community centre or GP surgery and take no notice. All it needed was to have one sentence written across the top in Urdu or Hindi or Somali or Polish or Tamil or any of the community languages "This is important". They could then raise it with the nurse or raise it with the receptionist at the clinic. It was a pretty poor job and somebody said to me they are doing it on purpose. I am not a conspiracy theorist but if I were, that might well be a point.

THE CHAIRMAN: I am conscious of the time and I want to thank you very much for your presentation.

The Witness Withdrew

MS RENSTEN: Could we have a very short break for a few minutes?

After a short break

THE CHAIRMAN: May I belatedly welcome you all here today and introduce myself. It is a bit like the pause button on a television and rewind. So rewinding and pretending that we are starting at an earlier time, my name is Michael Mansfield, I am Chair and, as you have already seen, there are two eminent doctors on either side of me, to my right Dr John Lister and to my left Dr Stephen Hirst. Well, he is to my left when he appears in a moment! They have already asked some questions. We have had one hearing last week in Hammersmith. We have another one in Brent and more beyond that. You will all know the objectives. We are independent of the Councils who established this Commission and the idea is that we will examine and review materials that relate to healthcare in the five boroughs and of course one of them you have already heard about. Then we will be issuing an interim report and a full report. In a moment I am going to ask Katy Rensten, whom you have already seen. She is counsel to the Commission inquiry. It is the normal way things operate when we do inquiries; you have a barrister

who will present. She is instructed by Marcia Willis Stewart, who sits to her left, from a well-known firm of solicitors in London called Birnberg's, and again who help Peter Smith, who is over there very efficiently putting papers together, so we are well briefed before we come as to what we can expect. The process itself is as you have seen. A witness will not be led but evidence will be elicited from the witness to highlight the various points and then there is a space for extra questions afterwards.

The terms of reference very quickly before we get on to a brief opening, which would have happened earlier, and that is this, that it seemed to me that it is essential to ask a number of basic questions that we will all be focusing on. One is identifying the constituency itself, I do not mean political or medical but the demographic, secondly, establishing and identifying the medical needs of that constituency; thirdly, asking how they are best met, in other words standing back a bit from what is going on, but, fourthly, asking whether they are being met or will be met by various plans that are in the offing. This is a fairly major task but we are attempting to do it as efficiently and thoroughly as well as within a certain time-frame because otherwise it could go on for ever.

Having said that, may I formally introduce counsel and ask if she will make a short opening for your benefit.

MS RENSTEN: Today's hearing is the second of four, the first having taken place last Saturday at Hammersmith & Fulham. The hearings form part of the Commission of Inquiry jointly commissioned by the London Boroughs of Brent, Ealing, Hounslow and Hammersmith & Fulham. The focus of these hearings and of the Commission as a whole is the long-term as well as the immediate impact of the *Shaping a healthier future* programme currently underway across North West London.

The premise upon which the work of *Shaping a healthier future* was commenced was that there was a pressing need for change based on the increasing healthcare demands of a rising a ageing population and that there was an 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 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 were that whilst five out 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 provisions 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 benefit. In February 2013, the decision-making decision plan setting out the projected costs and the cost-benefits of the proposals 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 proposals

subsequently chosen there ensued a considerable degree of controversy. This generated a number of reviews and reports in which divergent views were expressed both about the decision-making processes 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 A&E departments of Hammersmith and Central Middlesex Hospitals, the opening of the new A&E 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 one of the most current issues being that of the proposed closure of the maternity facilities at Ealing Hospital. A decision on this was to have been taken on 18 March but it is understood that that has now been put back to an as yet unknown date in the future.

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 healthcare and linked social care services to 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 upon those aspects identified by the commissioning boroughs as being of the most immediate and the most critically important to the residents of this 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 at Ealing, the perceived lack of progress in provision of out of hospital services and the financing of the programme. The Commissioners are keen that the voices of as many of those individuals or organisations that wish to be heard in this process can be.

With that in mind and with the permission of the Commissioners, I will now continue with the evidence.

CLLR JULIAN BELL, Leader, and CLLR HITESH TAILOR, Cabinet Member for Adults, Health and Wellbeing, Ealing Council

<u>Examined by MS RENSTEN</u>

Q. MS RENSTEN: Gentlemen, as you are giving evidence together, can I ask you first of all, starting with this gentleman here, to please provide your name and professional address and your current post held?
A. (Cllr Bell): Cllr Julian Bell. I am the Leader of Ealing Council. My address is Ealing

Town Hall, New Broadway, London W5 2BY.
A. (Cllr Tailor): My name is Cllr Hitesh Tailor. I am the Cabinet Member for Health and Adult Services and my address an Ealing Council, Ealing Town Hall, New Broadway, London W5 2BY.

Q. In front of you there should be a volume labelled Volume 1 and at pages 71 to 358 you should find the submission prepared by and on your behalf. Can you confirm that those submissions are true and accurate to the best of your knowledge and understanding and that you wish them to stand as your evidence to the Commission?
A. (Cllr Bell): Yes.

Q. Can I ask you first about the consultation process? If you look at your document, and it is page 77 I would like you to go to please at paragraph 5, you detail there what you perceive as a lack of public participation and you set out a figure of 360 members of the public attending events. Where does that come from?
A. (Cllr Bell): These were figures that *Shaping a healthier future* events led to. I have to say they were very much confined to just one event in Ealing Town Hall. We asked as the Council that there be events in other parts of the borough. Particularly we wanted a consultation event held in Southall where some of the greatest need and highest numbers of users of Ealing Hospital are located, but that never transpired, so, as has been said by Mr Pound earlier, very, very low engagement in the formal consultation processes by SaHF but incredible engagement in terms of opposition from local residents with rallies and marches and people signing petitions.

Q. I am just going to ask you to comment on a sentence in a letter, it is not in fact from Ealing CCG, it is from the Hammersmith & Fulham CCG and what is said there is this: "The public consultation we [globally] undertook for SaHF demonstrated overwhelmingly that what our residents want most is high-quality healthcare for their families, communities and them as individuals." Could I invite you to comment on whether or not that helps in terms of the specific changes that are taking place.
A. (Cllr Bell): I think it is clear that our residents want quality healthcare services and one of the issues that we had with the whole SaHF process and the decision-making process was that the reconfiguration was based on distance to the various options for major hospitals. It was not based on quality of care. Also, I would add there was no reference to the needs particularly or that was not given a higher rating in terms of the decision-making process of the reconfiguration. I think we very much want quality of care to be at the heart of changes to the NHS for our residents, but actually if you look at these proposals, Ealing, which is the third largest borough in London, with an extremely fast-growing population, is the borough that loses out the most. Not only do we lose the only hospital within the borough, Ealing Hospital and its A&E services and maternity services and it is downgraded to a local hospital, but all of the other surrounding most proximate hospitals, many of which are used by our residents, are also being downgraded or having facilities closed at them, so I cannot see how that can be an improvement in quality of our health services for our residents.

Q. You also point to a lack of engagement with the local authority. What attempts did the local authority make to address this?
A. (Cllr Bell): Again it was a process where we were very much on the outside. Both myself as the Leader of the Council and senior officers and the Health Cabinet members

over a period of time leading up to the proposals requested meetings, requested information but we were only really brought in when the decisions were made, effectively, in terms of the proposals as they stood. We had very little engagement or involvement in the decision-making process. That was a great frustration which we tried to put right but were unfortunately unable to.

Q. I would like to look now at some of the issues that underpin the *Shaping a healthier future* programme. First of all, on page 72 of your submission, you set out that you do not consider that out of hospital provision will reduce acute need in the way envisaged. Can you help us with the basis of that view, please?

A. (Cllr Bell): Well, I think we actually have a long way to go in terms of our primary and community care in Ealing. As Mr Pound said earlier, we have a lot of single GPs and I think, as he again said, it is a patchy service and we have some way to go. You could argue that with the resources that the NHS have had in the last ten years before austerity kicked in that we probably could have seen improvements to primary care community services in that time, but we have not. I think as a Council we are very much wanting and have been very positively engaged as a Council in terms of integrating social care with healthcare, to improve community care, but I think our concerns are that with a rising population, a particularly fast-growing elderly population, with the specific health needs of some of the ethnic groups within our borough, that we need to have sufficient acute services to meet those needs and those growing population demands. I might add that I do not think that the figures that have been used by *Shaping a healthier future* in terms of population and need are anything like what the reality is now or in the future.

Q. I wanted to come on to ask you about population figures next. First of all, if they are not correct, can you help us with to what scale they are not correct?

A. (Cllr Bell): The first thing to say is we have got a population at the moment, on ONS figures, of about 350,000 and we have, interestingly, got a significant what is described as "shadow" population. Because of the make-up of our borough and its population with many new immigrant communities, we have on our GP rolls about 405,000 people. So there is maybe 50,000 of a shadow population potentially. That is the current situation. Going forward, by 2031, we will have a population of 405,000. These are significant increases of 9% going forward, but the elderly population of over-65s will increase by 30% in that time. The figures that are produced by SaHF do not include new developments and those potential increases in population that are associated with those new developments. We have massive investment in our borough as a result of the five Crossrail stations that we have. In the Southall Gas Works development alone, which will take place over the next 15 years up to 2030, there will be nearly 4,000 new homes in the Southall Gas Works development. You can then add to that the new developments that are going to be around the HS2 Crossrail interchange at Old Oak Common, which is one of the most significant new developments across the whole of London. Again, I believe it is about - and Hitesh can correct me if I am wrong - 11,000 new homes or potentially more.

A. (Cllr Tailor): Double that.

A. (Cllr Bell): Double that. 20,000 new homes. It is a significant number of new homes. There are many other new developments that are happening in addition to those two really big ones.

Q. Bearing in mind the answer you have just given, what is the scale of the impact on the

projections for future demand of the services?
A. (Cllr Bell): This has always been our concern that we felt that SaHF did not actually acknowledge the true nature of the increased demand on A&E and on maternity services. Across the board in London there is a 5% increase in terms of A&E usage, but I think, given the increases in population that we are experiencing and going to continue to experience, then it will be a significant impact. I just think this is the largest scale reconfiguration in the NHS's history and they are, effectively, using our residents, my residents in Ealing as guinea pigs in this experiment, which is of a scale that has not been entered into before. I just think the risks are huge given the demand on the capacity because once you take the capacity out, it is hellishly difficult to put it back.

Q. Can I just ask you please about something else you have said and it is at page 77 of your submission at the top and you refer to a view that you hold that the reconfiguration is driven by a need to resolve ongoing private finance initiative issues at Central Middlesex. I wonder if you could just expand and explain a little bit more about that, please?
A. (Cllr Bell): Certainly, again as Mr Pound has said, the reconfiguration is being driven by financial issues. There are issues around the PFI at Central Middlesex, but, actually, the other PFI which has impacted on Ealing the most is at West Middlesex. In the reconfiguration options that were put, Ealing was twinned with West Middlesex and it was commonly known before the process had even begun, once it was kind of said that Ealing would be twinned with West Middlesex, that we have no chance in terms of the future of Ealing Hospital as a major hospital because the financial problem that West Middlesex had with its PFI was driving the whole process and that meant it was inconceivable for West Middlesex not to be the major hospital and for Ealing to lose out and just be the local hospital. Again, I would reiterate the point that these decisions were financial and based on distances. Again, travel times were not independently verified and they were not made looking at need and they were also not looking at options to make those financial savings in other ways other than reconfiguration. We were given no option as to whether or not you could make those financial savings in another way besides reconfiguration. It was signed, sealed and delivered and done before we even started.

Q. You have already set out your view that the impact on Ealing has been greater than on other areas. I just want to ask you to comment on something. You will see in front of you Volume 2. It is probably underneath that bundle. Would you mind turning to page 674? This is a submission by Healthwatch Ealing and I just want to ask your view about something they have said. At paragraph 3 they are talking about A&E closures and what they say is this: "Only a small number of Ealing residents are directly affected by this change." I wonder if I could invite you to comment on that.
A. (Cllr Bell): You will have an opportunity to talk to Ealing Healthwatch later, but, actually, if you look at our submission, 56% is the numbers of our residents that are going to be impacted by the changes in A&E services, so I am struggling mightily to understand how 56% can be "a small number of Ealing residents" directly affected. I am bemused.

Q. I wanted to ask a little bit now about some of the accident and emergency issues. According to *Shaping a healthier future*, there will still be an A&E facility at Ealing Hospital. Can I ask you to help the Commission with your understanding of what that service will be?

A. (Cllr Bell): I have heard it from the lips of various NHS managers and they have said this to me on numerous occasions that, notwithstanding what the Secretary of State for Health said when he said that Ealing and Charing Cross A&Es were saved and will be of a different size and shape, what I have been told very clearly is that they will be no different to the original SaHF proposals which were that they are effectively minor injury urgent care centres that are GP-led, not consultant-led. They will not take blue light ambulances. They will not have intensive care units attached to them and, effectively, as far as our residents are concerned and any normal person's understanding of what an A&E is, they certainly will not be A&Es. I have to say I have serious concerns about stand-alone urgent care centres and the delays that will occur when, having triaged people and decided that they need A&E treatment, that the London Ambulance Service, which is not really delivering what is required for our residents, that you have got that extra journey to another A&E after they have come into a stand-alone urgent care centre. I am convinced that they will not be A&Es.

Q. Do I take it from the answer that you have given that you have a view about there not being co-location between urgent care centres and A&Es?

A. (Cllr Bell): They will not be co-located and I am told again that the GPs that lead them will be able to, I do not know whether they are going to Skype or what, but they will talk to consultants at networked A&Es nearby. But, again, you have to worry for your residents' safety if trained emergency personnel are not looking at their needs when they immediately come in to that urgent care centre. So I am very worried about it. There is certainly a lot of scope for confusion about where do you go. Do you go to an A&E? Do you go to a separately located urgent care centre? I think it puts lives at risk with the confusion.

A. (Cllr Tailor): Just to add on to what Cllr Bell has said. I represent East Acton ward and we have had the two A&Es at the Central Middlesex and Hammersmith shut and I know residents in my ward particularly are experiencing that confusion which has arisen. They go to the Central Middlesex because that is where they have always gone and they are actually now told to go somewhere else. I had a case last night brought to me from a resident, her 89-year-old father went for an x-ray and could not get the x-ray and then had to go to St Mary's and face a four or five-hour wait there so it has really had an impact for residents in that part of the borough already.

Q. Can you perhaps help us with specifics? For example, what distance, how long would it take, I am not taking about somebody who is blue-lighted there, a resident in Southall to get to an A&E provision if there is not one in Ealing?

A. (Cllr Bell): I certainly do not believe the journey times that have been put in the SaHF business case. As I have already said, they were not independently verified and I will not even go into Dr Spencer's motorbike, but as an Acton resident I certainly know that it does not take you 15 minutes to get from Acton down to St Mary's. Again as Mr Pound has said earlier, the distances and the difficulty of getting from Ealing Hospital or Southall to Northwick Park is considerable. You are certainly upwards of an hour and a couple of bus journeys and changes if you are making that journey on public transport. So, again, another interesting thing, I do not know whether you are going to come on to it, is the maternity unit closing at Ealing and journey times for mums that are in labour. Again, the evidence that was considered by the CCG at its meeting this week, we do not have what their official journey times are for pregnant mums in terms of the distances to alternative maternity units. I actually highlighted at that meeting what are called BBAs -

births before admission - I have now found a new piece of NHS jargon, of which I have personal experience which you may have seen in the *Evening Standard* a couple of nights ago in that my daughter had a BBA last summer. Even Dr Mark Spencer admitted that his sister had had a BBA in a hospital car park. I have real concerns if you increase those journey times for women in labour by closing down a maternity unit because that increases the risk. Again, the journey times are significant, but we do not know what they are.

Q. Just before we turn to maternity services in more detail, can I just ask you still thinking about the A&Es if you have any comment on the choices of the A&Es which are being kept open and expanded with the background feature being the CQC analysis of the qualities of the various different A&Es across the region?

A. (Cllr Bell): This is the reality now of the point that I made right at the beginning that our ability to choose and want quality healthcare services is now being compromised by these decisions, so, effectively, the CQC says that the A&E service at the closing Central Middlesex A&E is better than the A&E service that we are all being redirected to at Northwick Park and that that is not adequate. Clearly, there are issues around maternity services as well where Ealing Hospital has been performing well, but, again, the CQC has said Northwick Park is inadequate and there are issues about lack of midwives at Hillingdon Hospital. So it is clear from the CQC that the quality is being taken away and we are being directed to hospitals which are of a lesser quality. That is again something that we have not had addressed in the broader decision-making about where the choices were made about the reconfiguration. Quality was not the foremost decision-making criterion by those making the decision whereas for residents and clinicians it is. The final point I would make is that there is a clinical case that smaller A&Es perform better than larger A&Es. That is very much reflected in that CQC assessment of Central Mid and of the smaller A&E doing better than the bigger Northwick Park. I do not accept the clinical argument for bigger is better. The evidence is to the contrary.

Q. Could we have a look in a little bit more detail at the maternity unit. First of all, who is served by the maternity unit at Ealing?

A. (Cllr Bell): We are a large borough and our mothers go to different maternity units. I live in the east of the borough in Acton and my children were born at Queen Charlotte's, and in the east part of the borough I think it is fair to say that some mums do go to Ealing, but not all. Some would go to Queen Charlotte's. However, there is a significant number of our mothers who would go from central Ealing, from Hanwell, Greenford, Southall, their maternity unit of choice is Ealing. Of course, we have just invested £2 million in upgrading and improving the maternity unit at Ealing Hospital and putting a new birth centre in, which has been part of the reason why the performance in recent years has improved. So, again, there are questions to be raised about the use of financial resources in that we have just made this investment of £2 million and then we are striking it off.

Q. How easy will it be for the population that uses the maternity unit at Ealing to go elsewhere?

A. (Cllr Bell): I think it will be incredibly difficult. You are talking considerably longer distances, not only for the actual delivery but for relatives and family to subsequently then go and visit. The plan is to move some of the births to Northwick Park, some to Hillingdon, some to West Middlesex and also some to Queen Charlotte's that were previously going to Ealing, but for those who are living in the centre of the borough and

to the west of the borough these are considerable extra distances that they are going to go to. Again, we do not actually know exactly what the assessments are from the CCG as they are making their decision. Again, I will refer to my BBA experience. The ambulance did not turn up in time so my son-in-law delivered the baby, which I have to say massive respect to him. It was probably more stressful for my wife and I worrying about what had happened, but the ambulance did not turn up. It was an emergency. It took 18 minutes for the ambulance and the child was already born five minutes before the ambulance arrived, delivered by my son-in-law. Those incidents of BBAs will increase inevitably if you are having longer journey times to hospital. I do not want to overdo it because it is not a large percentage in terms of BBAs, it is about 1% I believe, but nevertheless the risks are huge when you do not have that medical support.

Q. Just thinking a little bit about the delays in the decision-making over the maternity unit, first of all, two parts to this, can you throw any light on the reasons for those delays and, secondly, what do you say the impact is on staff and users?

A. (Cllr Bell): The Commission has received the open letter that the midwives at Ealing Hospital wrote about a month or so ago, where they talked about their frustrations and about their lack of morale given how loyal they have been and how determined they have been to keep a good and safe service going right through this time of change, but I think they have been tested beyond breaking point almost and it is affecting them, it is affecting patients and, as Mr Pound said, some midwives who have got literally cumulatively hundreds of years of NHS experience between them, we are losing that, and that has to have an impact on the quality of service, in my view. Again, we always said that with all of these reconfigurations we should have alternative services in place before you make the decision to actually reconfigure, but the decisions were made before any alternatives were in place and we have seen the chaos that happened after the closure of the A&Es at Central Middlesex and Hammersmith in terms of the worst waiting times in the country for type 1 A&E admissions. All of that has meant that the alternative services are not in place before implementation, but actually making the decisions so early on becomes self-fulfilling. It is a self-fulfilling prophecy and therefore it potentially becomes an unsafe service and you have to close it down because it is unsafe because you have already made the decision and the axe is already over the service, be it maternity or an A&E service, and so that is the problem we are faced with.

Q. Can we look now, because you have brought us on to it, at the primary care services aspect? First of all, in your view, can the primary care services in the area cope at the moment with the demand they are under?

A. (Cllr Bell): No, I do not believe they can. I think the examples that SaHF give in their business case are quite small-scale examples that do not address the scale of the challenge that is before us. I think the fact of those worst in the country figures for A&E waiting times at Northwick Park, and at Ealing in the last part of last year and the early part of this year, showed that the whole system is not coping. The primary care system is not coping and the emergency services are not coping either. This is what we always warned would happen. It is not as if they were not warned. We have said all along that this would happen and, lo and behold, it has. That makes me quite angry because this was quite foreseeable.

Q. Can I ask you just to address briefly the issue of in-borough variation of quality of services please, assuming that you are saying there is in borough variation, that is?

A. (Cllr Bell): In terms of primary care, yes, as I have already said and Mr Pound said, there is a variation. I think there is, as has been said, a large number of close-to-retirement, single GP practices, some of which are very good, but they do not always have the capacity to meet the needs of their patients, and I am sure when Dr Sahota speaks he will probably give you a much closer view of that. But certainly, we know that there are improvements required. Also, the issue that we as councillors get brought up with us is the difficulty of lack of access to GP appointments and the length of time that it takes to get an appointment with a GP. I not too recently tried to get an appointment with my GP and it was over two weeks.

A. (Cllr Tailor): Cllr Bell's own surgery is actually in my ward and he is talking about three-week waits, which is what residents report. There are only three practitioners in my ward which is now the largest in the borough. There is his particular one plus a sole practitioner in Western Avenue plus one on the Uxbridge Road. Given the scale of developments happening, that demand for GP provision is absolutely increasing and every local meeting that I go to that is what residents are asking for in terms of the infrastructure being put in place given the scale of developments coming forward. I go to your earlier point about the loss of the two A&Es at Central Middlesex and Hammersmith - that adds to the impact.

Q. Just thinking in terms of the initiatives that SaHF has put in place, and you heard me earlier read some of those out to Mr Pound, the increasing cardiovascular services and so on and so forth, are you seeing any positive impacts from those initiatives yet and, if so, what?

A. (Cllr Bell): I think it is still too early to say that we are seeing massive or significant improvements. As I have said before, we as the Council are very committed to integrating services with social care and health and we are working very hard. I chair the Health and Wellbeing Board as well as being the Leader of the Council and I know that we are working extremely hard to work together to improve care pathways and do these things, but we are still at an early stage. We have not put those new integrated services together. We have just started recruiting at the beginning of this year to the posts that integrate care at primary level and we are at the stage of training those new people in those new co-ordinating positions. So we are still too early, I think, to see any impacts and hence the kind of meltdown that we saw in terms of A&E waiting times and increases in hospital admissions.

Q. Just thinking now about those new services, the out of hospital services, how heavily do you say the success of the out of hospital strategy relies on local authority rather than National Health Service provision? I am going to ask a supplementary question so I will ask it now which is: do you have the budget for it?

A. (Cllr Bell): I will answer the last one first. Obviously, we welcome the monies that we are getting from the Better Care Fund which is allowing us to work with the CCG as the Council, and in Ealing it is about £25-26 million from the Better Care Fund. However, we have £38 million of cuts to our adult social care, so the Better Care Fund is probably a bandage rather than a sticking plaster, but the resources that we have as the Council are significantly reducing and it is what is known as the "Barnet Graph of Doom" where basically by 2018/19 if, as I have said, this 30% increase in the elderly population part of the graph goes up, that is one part of the Graph of Doom, and the financial resources that are coming to councils is the downward path of the Graph of Doom, by 2018-19 when those two parts of the graph cross we as a council, and this is the same for

councils all over the country, will only be able provide those statutory care services and I think we might just be able to collect the bins and the rubbish, but any other of our services we will not be able to provide because unless there is a change in national policy in terms of actually ring-fencing social care budgets in the same way that healthcare budgets are being protected (because at the moment they are not being) frankly, I do not how we are going to manage as a council to meet those statutory social care responsibilities that we have with a reducing budget. And it is not just me, the National Audit Office says that in 2018/19 50% of councils will not be financially solvent if things stay as they are. Sorry, I have forgotten the first part of your question now!

Q. It was whether or not or how heavily the out of hospital strategy depended upon local authority services and provision?

A. (Cllr Bell): Yes, I think it does and one of the interesting things from Lord Darzai's London Health Commission was the way that that Commission's findings were very, very much focusing on and looking towards local authorities and local government as being a primary player in finding health solutions, so we have got public health coming in to local authorities, we have got district nurses coming in to local authority control as of October of this year, and they are critical to it, but we do not have the resources.

A. (Cllr Tailor): I think just to quickly add, and Cllr Bell is quite right about the health visitors coming in because there is an under-funding at that level first of all. The second thing just to bear in mind is that as from April, to go back to Cllr Bell's earlier point, we have got the Care Act coming in as well which is placing new eligibility thresholds for people wanting to access social care, and there is a serious under-estimate of the amount of resources that we are going to require to meet new needs. That is coming from a national level in terms of the criteria that are being applied and local government will inevitably have to pick up the costs of that as well.

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: Thank you very much both of you for the presentation. I have a barrage of questions and I do not think there is going to be enough time but I want to see if we can get through a number of them which I think are important. I will take them one-by-one and put them in encapsulated form. The first one is this. You mentioned the need over the last I think you said ten years that there was a patchy service being provided in primary care and so on. It is a lock-on to that question. Leaving aside all these plans, what would you have seen as the best way forward? In other words, were there shortcomings and how could they have been addressed other than in a finance-driven policy, which seems to be the thrust of what you are saying this present policy is? So that is one question. It is a rather big question and you may not be able to put it in summary form but, if not, you can always write about it later. I have a specific question: has land already been sold off at Ealing Hospital? We heard last week from a urologist there that land had already been fenced off and he did not know what it was for. Thirdly, I have quite a few questions on maternity and the first is when the investment of £2 million was made. Then I have a follow-on question in relation to what Healthwatch are saying. There are four questions there. I am sorry, they are rather far-reaching but I wonder if you could address some of them, if not all.

A. (Cllr Bell): In terms of primary care improvements and the issue of the patchiness of provision, I think we need to move more towards networks of GPs or co-located GPs and certainly we have got that in Acton and in Greenford and in some other parts of the borough, but I think again, as Mr Pound said earlier, the concept of polyclinics or co-located GPs who can then work together to give a better quality service is, in my view, what would have been ideal if we could have moved that forward quicker and earlier over the last ten years. In terms of land sold off at Ealing Hospital, we of course are the planning authority so my officers keep in close contact with all landowners. I am not aware of any land having been sold off. However, there are proposals which have been given planning permission and are progressing in terms of the West London Mental Health Trust and St Bernard's, which is adjacent to Ealing Hospital, so there are developments happening in that part of the site that we as a Council are fully aware of, but all I know is that SaHF says that Ealing Hospital will be bulldozed and levelled and that we have got new proposals for a local hospital which will be further to the east of where the current footprint of the hospital is, closer to where the River Brent is.

Q. And the specific question - and this is maternity - when was the £2 million investment made?

A. (Cllr Bell): I believe that that has been made in the period from 2011 through to the present. It was put in place 2011 to 2013/14, I believe. The Prime Minister himself when asked a question at PMQs by the Ealing Southall Member of Parliament Virendra Sharma, when he asked him at PMQs I think it was back in June 2011, if I recall, what was the future for both the A&E and the maternity unit at Ealing the Prime Minister said that there were no plans for closure of the maternity unit and there was ongoing investment in it. So it was referred to by the Prime Minister himself and I am sure we could find you the relevant section of *Hansard*. In fact, I think Mr Sharma wrote a recent article on the *Ealing Gazette* website which references all of this. So yes, I think that is partly why the midwives themselves are so dispirited by what has happened because they saw that investment coming in and saw the improvements to the facilities and the quality of services improved as a result of that investment and now it is all going to be taken away.

Q. One further question, and it relates to Healthwatch which you have already been directed to, I do not know where it is in the bundle, but I will just read you the paragraph what I want to know is what on earth does this mean. "Ealing Maternity Transition" - this is what they say: "Members of Healthwatch Ealing have been much more involved in the development of these plans and have been successful in having 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." Do you have an understanding of this?

A. (Cllr Bell): There are two things I would say about Healthwatch's involvement in the earlier phase of the SaHF proposal developments. They are clearly saying that they had very little engagement in those and I think that is right. I do not want to cast aspersions on Healthwatch, but I do question, and again when I referred to their comments about only a "small number" of Ealing residents being affected by the A&E changes, I think it is common knowledge that residents do not think that the local Healthwatch have represented their views very well. (Applause)

Q. That may be so.

A. (Cllr Bell): I think things have improved and I think that they have improved in terms of their engagement with these maternity transition proposals but, again, if you want to clarify exactly what you were trying to tease out on that part I would be happy to try and respond.

Q. It is the remodelling. What are they talking about? Do you know?

A. (Cllr Bell): Well, certainly they have changed the numbers in the transition of mothers going to the alternative hospitals' maternity units, so I do not know. There has been a reduction in the numbers that were projected to go to Northwick Park. Whether that was because of Healthwatch's intervention I do not know. Basically what they are doing is they are reconfiguring the boundaries of where mothers will be referred or encouraged to go to particular maternity units and so it means they are having to reallocate all of those Ealing Hospital mothers to all the different hospitals. There have been some changes in the numbers and I know there is a reduction in the numbers that were going to go to Northwick Park. I do not know the reason why. It may be because of concerns about the quality of service at Northwick Park. It may be because the capacity is now not thought to be there at Northwick Park. Another reason for the delay at the moment is that there are estate works that need to be done at Queen Charlotte's and they have not been completed, so, again, there is a capacity problem at Queen Charlotte's and there is the issue of not having sufficient midwives at Hillingdon as well.

Q. DR LISTER: I wanted to take you back to the Independent Reconfiguration Panel report and, as I recall it, from the discussions at the time, they more or less agreed to the closure of the two A&Es at Central Middlesex and Hammersmith, but they expressed much more conditional support for the proposals in relation to Ealing and Charing Cross and were actually specifying that certain additional planning needed to take place and they even raised possibly the question of a further consultation. It is pretty obvious from what has happened that a number of things that the Reconfiguration Panel were told would be put in place before these things happened have not been put in place. Is Ealing contemplating another referral back to the Reconfiguration Panel to re-visit these proposals and see whether or not we cannot actually get them to revise their estimate in more realistic terms?

A. (Cllr Bell): I would certainly concur with what you have said and certainly as a Council we were looking to probably follow in the footsteps of Enfield Council, which was basically promised all kinds of alternative services when Chase Farm A&E was closed but when in fact reality has progressed they have not had those alternative services provided and Enfield went down the JR route in order to question the legality of the decision and the fact that they had not been given what they were promised. We are certainly keeping that option open and I am certainly open to the idea of perhaps going back to the IRP because that was the one encouraging part of their report, that there should be more engagement, which I have to say I have not seen or experienced, and I do not think the residents would feel they have as well in terms of proposals for alternatives at Ealing and Charing Cross. So, yes, certainly we would need to explore that.

Q. DR HIRST: I have only got a small point. I just want to pick your brains generically as a politician how you would see things. Presumably as a politician you are in receipt of petitions and I notice that in the decision-making business case executive summary they say there was a total number of responses, I think this is to the Mori investigations and polls, et cetera, of 17,000, but they only count the petitions as 18. Presumably that means

18 petitions containing many thousands of responses. Would that be a normal way of a politician assessing a petition?
A. (Cllr Bell): As a politician, the ultimate petition is when I am up for re-election and the good people of Greenford Broadway, which is the ward I represent, or the good people of Ealing speak, and the interesting thing, of course, is at the last local council elections last May, health services and the hospital reconfiguration issue was probably the number one issue, and it is fair to say that as the ruling Labour administration which talked positively about how we were trying to protect local health services, we increased our majority significantly. Our neighbours obviously in Hounslow, Brent and most spectacularly in Hammersmith & Fulham did the same, so I do believe that there is a democratic mandate for the positions that we as councils are taking. And yes, there were all kind of fudges going on in terms of how they counted the petitions. We had literally tens of thousands of postcards that people sent in and signed. They allowed individuals to write their own personal comments on those postcards but they also had a standard template at the top as well. They were all discounted almost as just kind of round robin-type postcards that did not really reflect what people thought but, actually, again in my experience as a politician knocking on lots of doors and talking to people, irrespective of their political views, they are united in their opposition to these proposals and that is very, very marked.

THE CHAIRMAN: May I thank you both very much indeed for your presentation. We will pass to the next witness please.

The Witnesses Withdrew

DR ONKAR SAHOTA, Chair, GLA Health Committee, Assembly Member for Ealing and Hillingdon and Ealing GP

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your full name, professional address and current posts held.
A. (Dr Sahota): My name is Dr Onkar Sahota and I am a local GP and also a member of the London Assembly representing Ealing and Hillingdon and I chair the Health Committee for the London Assembly. My address is 20 Church Road, London W7 1DR.

Q. Could you please turn to Volume 5 which you should find in front of you? I think it might be the one to your right there. If you turn to page 1745, you should find your submission. Can you confirm that that is true to the best of your knowledge and understanding and that you wish it to stand as your evidence for the Commission?
A. I do confirm it is correct.

Q. Can I just ask you first of all, you say you are a GP and you head three practices?
A. Yes.

Q. Can you help us with what areas they cover? Are they similar or different demographics or what exactly?
A. Two practices are in Hanwell and one is in Southall.

Q. What is the constituency of the population? Do they differ from one another or are they very similar?
A. The population in Hanwell is probably about 30-40% of Irish ethnic origin and the BME community is about another 30%. In Southall we have a larger BME community mostly from the Punjab. Probably about 90% of patients there are from the Punjabi community.

Q. Do you feel that your experience in those three practices gives you a wide knowledge of patient needs across the borough and the region?
A. I do and particularly as I have been working here since 1989.

Q. Do you also have a second hat in your role at the GLA?
A. Yes.

Q. Again, do you feel that that gives you a broader overview as well?
A. Being a member of the London Assembly of course I represent a huge area, serving a population of 600,000, but also as I chair the Health Committee of the London Assembly I often do look at issues right across London.

Q. First of all, dealing with the consultation process, you make mention, it is at paragraph 11 of your document, to the consultation being limited. Do you therefore say that your patients were or were not properly consulted?
A. I think when the consultation process was originally started - and let's not forget that Ealing Hospital geographically sits in Southall with a population there of about 80% BME communities for whom their first language is not English for a large proportion, they cannot read English - would it have been sensible when the SaHF document originally came out it was only found in one or two libraries? It was not available in the first languages of the community. It was a very complex document. So there was a lack of consultation with the patients given the time limits and given that they could not get access to the documents in the languages they could be comfortable with. In addition to that, the response document was very, very complex. You would lose the will to live by going through it. It was so complex and also all the questions led to one conclusion. The other thing of course which one must remember is communities were being played off one against the other. You could save Ealing Hospital or you could save West Middlesex or you could save Chelsea & Westminster or St Mary's, so the community was divided up and one trust was being placed against another trust so people were very torn apart, particularly the doctors in Ealing were very torn apart.

Q. Could you just pause there and explain a little bit more about what you have described as the setting of one trust against another?
A. I think for example the choice was given that if Ealing Hospital was to be a major hospital then West Middlesex could not be a major hospital. If Charing Cross was going to be a major hospital then Chelsea and Westminster could not be a major hospital. So people living in Charing Cross would obviously vote for Charing Cross, people living in Chelsea & Westminster would vote for the Chelsea & Westminster and people living around the West Middlesex would vote for their hospital. So the community was divided up and because the consultation was not undertaken collectively right across the areas, no clear opinion would emerge with the way the community was being divided up. I also think that different trusts responded differently to the consultation process. They were

trying to fight for their own survival and different trusts encouraged people to respond in different ways and that was also apparent in the consultation process.

Q. You refer in your document to a survey of GPs. Could I ask you, please, to pick up Volume 2 which is in front of you? I am going to take you to the letter from Dr Parmar, the Chair of the CCG, if I could ask you to look please at page 594. At the bottom of that page, and we have referenced this before, Dr Parmar refers to feeling that the issues - and this was in relation to the A&E services, acute hospital care - "were so important and sensitive to the needs of Ealing people we took the unusual step of issuing a referendum on the changes." When she refers to the referendum and when you talk about a survey, is that the same thing you are talking about?
A. I think so, yes.

Q. Can I ask you to comment please, just take a moment to read that paragraph, on Dr Parmar's analysis of that exercise?
A. (After a pause for reading) Yes, I have the survey in front of me. The exact figures, right. She is right that of the people who responded, and of course the response rate was 41.6%, 58.4% did not respond, of those who responded, 68% felt that there was a case for change. Then option C where Ealing Hospital was to be retained, 54.2% of the GPs who responded said they wanted Ealing Hospital to be saved. I have the document here.

Q. I wonder if you would be good enough to provide that for the Commission as I do not know that is a document that we have. That would be very helpful. So on the basis of what you have just said, can you help us to clarify whether or not you consider the analysis as set out by Dr Parmar is correct or incorrect?
A. I think her analyses as far as they go are correct, but she has been selective, right, in not giving you the whole figures. It would have been more helpful if she had said to you this is how those options were responded to by the local GPs, and let's not forget the GPs around Ealing Hospital in Southall are the ones who responded the most. They were most concerned about what was happening and that is what I was talking about the community being divided. If people were living towards Acton they were more concerned about Charing Cross and Hammersmith. If you were living around Southall, which is the most deprived area of the borough, then you vote to save Ealing Hospital. Of those GPs who responded, the largest proportion of GPs wanted Ealing Hospital to be saved, as is apparent here - 54.2% of GPs who responded wanted Ealing Hospital to remain the major hospital.

Q. Can I ask you as well to expand a little on your view, you described the configuration as "ambitious and untested" and you say that the system needs "resilience and capacity" before shutting any acute services. Can you help the Commission with your view of the impact if that resilience is not there?
A. When I said is in North West London we have got nine A&E departments and what SAHF proposes is to close four of them. They want to close Ealing Hospital A&E, the one at Hammersmith, Central Middlesex and then Charing Cross. In addition to that, they are proposing to close inpatient beds at Charing Cross and Ealing Hospital, which is about 900 patients so 900 beds. So far we have had the closure of the A&E departments at Central Middlesex and Hammersmith and, of course, they will say that Central Middlesex was unsafe because they could not recruit the doctors to man it there and the nurses were not available, that is why they closed it down because it was unsafe for them

not to do so, but, as a consequence of closing down, the pressure it put on Northwick Park was that Northwick Park broke the four-hour wait every week for the last year. It was the worst-performing hospital in the country. When you ask them why did this happen, as I did indeed ask them at the Health Committee hearing, we were told that the number of sick patients has increased, but if you look at the data of the type 1 cases arriving at Northwick Park, that is the people who are very unwell, that has not increased at all. What has increased of course is the number of people attending Northwick Park Hospital, and they cannot cope with the pressure. So by closing A&E departments in a community without replacing it with alternative services you put pressure on the A&E, and the A&E departments are the barometer of the Health Service in any given area. That is where the pressure point is initially. When GPs cannot cope, when patients cannot get appointments with GP practices, when they do not get the advice they expect from the 111 service, they will attend to an A&E department which is trusted, safe and they know they will get some care, and that is what is happening.

Q. Dr Parmar also sets out a list of initiatives of community care which are either in place or in train, and that is at pages 593 and 594 of that document. Are you not in any way reassured by what is said there, that resources are being committed and progress is being made and, if you are not, why not?

A. Yes, well look, you can draw up a plan for anything on a piece of paper. The real test is how does it play out in reality and in what happens. Increasingly, I know that GPs are working in networks and that means that they want to get together and provide services, but what is holding them back is the infrastructure, the premises. The other thing that is holding them back is staff. It is getting more difficult in this country to get a GP appointment, but even more difficult to recruit GPs. We are dealing with the London Borough of Ealing which has a large proportion of single-handed and two-partner practices. We have 82 practices in the borough serving the population and I think about 40% of them are single-handed or two-handed. In London, we have a recruitment and retention crisis, so the real issue is that you can create all the networks you want to, but the buildings are not there to give the care to patients and there are not enough staff to deliver that care. I do not perceive any benefit to the patients at all. Patients are still struggling to get GP appointments. Patients are still struggling to get the care they want. Let's also not forget that the complexity of patients in general practice is now increasing. We only have a seven and a half minute appointment. About ten or 15 years ago the gold standard was a ten-minute appointment with the GP. Even ten minutes does not give you very much consultation time at all, two or three minutes to say "Hello, how are you, what's happening?" and then looking at the records, if you examine them, if you diagnose them and then issue a prescription or further treatment. You are dealing now with much more complex patients who have diabetes, who have been discharged into the community, people with rheumatoid arthritis, hypertension. So complex patients are coming from the community and they are not being given time to be seen. I think the provisions are there on paper, but I do not think they are effective at all and they will have no impact on patients. If you ask the patients "Have you noticed anything?" they will say, "It has got more difficult to get the care we want."

Q. You make some specific observations about Southall in term of deprivation and morbidity rates?

A. Yes.

Q. How straightforward do you say it will be for members of that community to obtain treatment, both acute and planned, if Ealing Hospital is reconfigured in the way that is proposed?

A. Ealing Hospital, as I say, is geographically in Southall and it is the towns of Hanwell and of Southall, which are predominantly on it. You were talking about maternity services and 50% of the patients who go to Ealing Hospital for maternity services come from Southall and Hanwell. Lady Margaret ward, Dormers Wells ward and Southall Broadway are some of the most deprived wards in the country. These patients have great difficulty using public transport. They have great difficulty in making their way round and Ealing Hospital is so accessible and it understands their problems. They have the expertise of dealing with the communities which they serve and they suspect if this hospital is closed they will not have access to these services and public transport will be very difficult for them.

Q. In terms of the population, what do you say the effect would be of the proposed reduction of bed spaces on what appears to be - and correct me if I am wrong - an increasing population?

A. I think that the premise that these calculations are based upon may be inaccurate. We were all surprised at how rapidly the population of London is increasing. By 2025 the population of London will be nine million. By 2035 the population of London will be ten million. London is a city growing very rapidly. We are being stretched in terms of our education system, public transport and hospitals. I think the premise that they have the capacity to deal with it is based on a false premise. That is one thing one needs to test out on what the population is based. Secondly, I think that patients are getting much more ill, they have more specific needs, and what we need to do is a huge investment in primary care in community services if you ever want to think about closing your hospitals down. On the current model it does not operate at all and you would not be delivering care to the patients.

Q. Thinking about the specific concerns you raised about the A&E, as a GP who presumably refers patients or liaises with A&E, what is your understanding of what the reconfigured service will provide?

A. Well, of course, one of the things they talk about is when you ask the Secretary of State, he keeps saying that the A&E will not close down at Ealing Hospital, but very little about type 1 and type 2 A&Es, so I am not really sure when an A&E is no longer an A&E. Certainly what they propose at Ealing is that they will not be able to accept blue lights, and there certainly will not be any intensive care beds there so no really sick patients can come there. The other thing they propose is that the urgent care centre, which is a GP-led model of care, would still exist on that site. Currently, 28,000 patients every year are transferred from the urgent care centre, which is on the same site as the current A&E department, to the A&E department, so these are sick patients who need specialist care or investigations which the urgent care centre cannot deliver. If you remove that A&E department from the same site, those patients will need to be transferred somewhere else. That will add to travel times, that will delay the treatment and the confusion exists in people's minds when do you go to a type 1 A&E, when do you go to a type 2 A&E, when do you go to an urgent care centre. When you are sick or your child is crying and you want help, you do not have time to sort out in your mind which of the care pathways you should be following. You want to go to the nearest place which you are sure is going to give you the best care and the care you need in a safe

environment. I think people will be at risk from that.

Q. Again, speaking as a GP who will need to know about the service, what information have you been given about how transfers between the urgent care centre and an A&E will be organised where it is required?
A. I do not have any specific information about that at all. I have not been given any information as a GP at all. They also say they will discuss this with the ambulance people about ambulance times. I do not know what the impact of all this is going to be but there is going to be a huge impact on the ambulance staff because there will be sick patients needing to be transferred to Northwick Park and that will have to be done by the ambulance crews. We already have a shortage of ambulance paramedics in London. We are 400 short of paramedics across London. I also have no idea on the travel times for these patients and the waiting times for transfers. We are already hearing about babies being delivered at home because the ambulance cannot get there in time.

Q. Thinking about the transport then, first of all, the ambulances, do you say that there will be an impact on ambulances which are available being called by other members of the public because of the need for ambulances doing transfers? Have I understood correctly that that is what you are saying?
A. The other impact of course is when you increase the travel times patients will call the ambulance as a choice. We have already seen that the pressure on the ambulance crews has increased. We are getting more calls to ambulances than previously. The question is why is this happening? Is it that people generally are getting more sick and they cannot travel or is it that travel times have increased to the nearest urgent care centre or nearest A&E department that they choose to call the ambulance? I am sure when you close Ealing Hospital the pressure on the ambulance staff will increase. They will be called more to convey patients and also it will have an impact on the ambulances conveying patients from the urgent care centres to the nearest A&E department.

Q. With your GLA hat on, you say that there has been no consultation with Transport for London. Are you able to help with whether or not there has been any discussion about that at GLA level, for example when Dr Rainsberry attended in January?
A. The evidence at the London Assembly which we heard was when we were talking about transfers of patients from homes to hospitals. Apart from ambulances there are other emergency transfers of patients which need transport. Clearly what came over to me was that these travel times given in the SaHF document were travel times by the ambulance crew, but no-one had talked to Transport for London about what the public travel times were. They had their own tools and methods of assessing them and they had not been consulted before. Even now three days ago I was a CCG meeting, which is held in public, looking at travel times for patients to travel from maternity departments because they want to close the maternity department at Ealing Hospital and they have a travel group set up which still has not reported, is still looking at the evidence and they still have not made an assessment through Transport for London of what the travel times are, so I do not know where they get these figures from.

Q. Could you clarify for a moment, you said that they are still awaiting the report?
A. I was saying they were looking at the travel times for maternity services to Northwick Park, they are still working on the travel times and the impact, so certainly I do not know who they are consulting, but I get the impression that Transport for London have not been

consulted and certainly were not consulted before the SaHF document came out where they were quoting travel times.

Q. Just briefly while we are on that subject, can you encapsulate what your views are for the plans for Ealing maternity unit?

A. The plans for Ealing maternity unit is they want to close this down. The argument is that they are not delivering enough babies because the service has become unsafe and they want to give 24-hour cover by consultants. Just looking at it in a broad sense, all the SaHF argument is that we want to provide 24-hour cover to our patients, 168 hours a week, 24 hours a day, seven days a week. They also recognise that the recruitment of doctors and nurses is difficult and that is why they want to put them on fewer sites, but what they forget is the ratio of doctors to patients will not increase unless you can recruit more doctors. The ratio of nurses to patients will not increase unless you recruit more nurses. What is driving them is a recognition on their part that they cannot recruit enough doctors and nurses. That is why they want to consolidate on fewer sites so they can provide the cover they want to. The argument they put forward is we cannot get 24-hour cover with consultants at Ealing Hospital so it has become unsafe and only 40% of patients choose to go to Ealing Hospital. Of course, the people who live around Ealing Hospital would choose to go to Ealing Hospital. That is almost 50% of their workload. People who live around Acton choose to go Queen Charlotte's. People who live towards the other part of the borough may choose to go to Hillingdon, but most people want to go to Ealing Hospital. If you give them the choice that Ealing Hospital is no longer there any more, where will you go then, that is when they make their second choice. As a doctor when I say to my patients, "Where do you want to go?" they often say to me, "I want to go Ealing" but then they say, "Can I ask, Dr Sahota, will it still be open in six months' time when I am ready to deliver?" It is almost becoming a self-fulfilling prophecy that when you threaten to take away an option then the choice of the patients becomes restricted. I was astonished that they sell the closing of the A&E and the maternity department as increasing patient choice. It is not; it is a reduction in patient choice. They have been told you can no longer choose Ealing Hospital. That is why they would choose to go Northwick Park or to Queen Charlotte's or to Hillingdon or the West Middlesex. If you leave Ealing Hospital going, which did very well in the CQC report and it delivers very good care in maternity, they would choose there, but if they want to close it down then of course patients will go somewhere else. They are really reducing choice rather than increasing it in what they are doing.

Q. Finally, you attach some graphs to your document. These are, as I understand it, dealing with the problems with ambulance times and so on and so forth. I wonder if could you just explain very briefly for the Commissioners what those graphs demonstrate, please?

A. The purpose of those graphs was to show that Northwick Park has failed in all its four-hour waiting times, but that has not been because of the number of seriously ill patients that has been going there. The number of seriously ill patients has remained the same throughout, if you compare this year with last year. The reason it has broken its targets is because of the increased workload from non-urgent cases who would have gone to Central Middlesex or Hammersmith and are now ending up at Northwick Park. Their premise of we are bringing up targets because we are getting more sick patients does not hold up. That is what the graphs are meant to show.

MS RENSTEN: Thank you. Those are the questions I wish to ask. If you wait there, the Commissioners may have questions for you.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much. I would like to start with a question which relates to the bigger hat you wear dealing with Greater London Authority Health. Is it possible to say looking across London that the driving force behind the plans, as we have heard from one witness today and one last week, is financial and is linked to the PFI initiative? That is the first question. The second question is perhaps a rather fundamental question and perhaps rather obvious in terms of Ealing Hospital which is situated in perhaps the poorest part of the borough, and I think you gave a figure of 50% of the maternity admissions there come from that part of the borough. Has there been an analysis of attendees at the hospital generally? In other words, never mind maternity, what about the rest of the hospital? Where do they come from? Two points.

A. First of all, I think that what is driving this must be they want to save money. They want to save £20 billion in the NHS. The PFI has contributed to some burdens on the system, but we certainly do not think that spending £3 billion for a top-down re-organisation which no-one wanted and no-one needed has helped the NHS at all. £3 billion has been wasted on reorganising the NHS. I think what the reorganisation has done is two things. One is of course that we have got GPs now, and I speak as a GP, sitting across the various CCGs looking at contractual arrangements, they have been taken out of consulting rooms, they are sitting now in CCGs and do you know these poor doctors are so busy with their day job looking after patient care, they are given documents by the civil servants "Thou shalt sign this and if you don't make these decisions they will be taken over and these people may be called McKinsey's or PriceWaterhouse", so the GPs have gone for the worst of two options, either privatise directly or we will do some of the dirty work. But I think in my own personal opinion the GPs should have said to the Secretary of State, "You look after this baby. Don't hide behind our skirts." £3 billion has been wasted. The other thing that has happened is that when you start putting services out to the private sector under contractual commissioning you start defining services. When you put a contract out you say, "This is the service we will provide and the ones outside we do not provide." I am now hearing increasingly from our patients that they are told, "We do not provide those services." I will tell you an interesting thing. Last week I saw a patient who had a telescopic examination of the knee called a arthroscopy. She should have had her physiotherapy in the hospital because that is the contract. You have a knee arthroscopy in the hospital; you have physiotherapy in the hospital. That is the contract payment they get. A month later on the patient did not get an appointment from the physiotherapy department at the hospital. She came to see me and said, "Dr Sahota, I want to go back to work. I have had no physiotherapy." I rang up the physiotherapy department and said they had not received a referral from the consultant and I said, "Can you help me?" My problem was this; I could not refer her to the hospital because they only take referrals from the consultant. I could not refer her to the community physiotherapy service because that care already been paid for to the hospital. This is a fragmentation of care. £3 billion - more fragmentation. Stephen Dorrell, the Chairman of the Health Committee, once asked the question: "How much money do we spend on transactional costs of the NHS?" That means monitoring contracts, setting contracts up. The answer is about 10-11% of the NHS budget is spent on negotiating contracts, monitoring contracts, seeing whether the contracts are being put

out. Local GPs in Ealing had to set up a federation because the local CCG is required to tender out contracts. They recognise that GP services should be GP-centred but they got them to form a company, they waste their time. So I would say put the clinicians back to the clinical work, let us lift the morale of the nurses and doctors. We are 6,000 doctors short in this country. In London we are 8,000 nurses short. We are 400 paramedics short. You can do all the planning you want to do, but if you have not got doctors and nurses to deliver the care you will not deliver anything at all. The morale of the NHS is at rock bottom and that is what needs changing. That is where the money has been wasted. Secondly, the majority, I would have thought, 60-70% of patients who come to Ealing Hospital are from the poorest part of the borough - Southall, Hanwell - and that is where they go. It is convenient. The hospital delivers a grand service to them and they know what these patients need. Ealing Borough is the borough with the second highest level of tuberculosis in London and London South is the capital of tuberculosis in Western Europe. We have high deprivation areas looked after by Ealing Hospital.

THE CHAIRMAN: Thank you.

Q. DR LISTER: I would like to come back to the question of the referendum of GPs that was held. The first question is do you think if another referendum was held now that GPs would be more clear on exactly how they responded to some of these proposals and maybe with more categorical questions? That is one question. Secondly, if you were given a blank cheque now to reorganise, what would you do as a priority to get GP services up to standard across the area?

A. I think that looking at how this SaHF has played out, the implication is if the GPs were given an option now they would be much more knowledgeable, they would know what is happening and they would come back with a much stronger voice that they would want Ealing Hospital to be saved, even more than the 54.2% that responded last time. That is my firm belief. People are very, very concerned about what is happening in Ealing. Secondly, of course, what we need to do is make a reasonable investment in the infrastructure of primary care. I have seen no new GP centres going up. The idea of GPs being put up into one big building five, six or seven together is a good idea, but I have seen nothing happen about that. I have been a GP for the past 25 years in this part of the borough. No investment has taken place. Certainly nothing happened since SaHF came out. What we have had is a reduction in the budgets spent on general practice. 90% of consultations in this country take place in general practice yet only 8% of the NHS budget goes on general practice. I certainly think we need to put huge investment into our premises and we certainly need to increase the number of doctors and nurses so that they can give the time and care to patients and lift morale up. The reason morale is low is because they cannot cope. The workload is so much and by closing hospitals down, closing down services, you will be adding to that pressure, so I think we need huge investment. I think the other thing, and I agree with this entirely, is we do need to link up social services, GP service, community care and hospitals into one organisation so they work collaboratively rather than as barriers. At the moment the hospitals can discharge patients into the community but they have no idea what sort of care they are going to be getting, whether they are going to be picked up and when patients are in the community, they do not know who is going to be looking after them. There has been a huge cut in social services. That is what is driving this. Patients cannot be looked after in the community. They go to A&E departments, they get admitted, they cannot be discharged back into the community so I think we need to ring-fence the social service budget and

healthcare budget and integrate them and cut out the costs. Let us accept that the NHS is responsible for the care of those patients without going to market forces and let's deliver co-ordinated healthcare, publicly funded, without going to the private sector and let us make sure that we do not negotiate contracts between providers but make sure we give the care the patients need in one consolidated organisation.

Q. DR HIRST: In fact, Dr Lister may have explored and you may have answered what I wanted to ask, but I will just add my two pennyworth if I may. In fact, I was one of Mr Pound's lunchless GPs and I am feeling rather guilty having retired, from what you have told me, but I want to explore why it is that GPs' views are being misrepresented and perhaps how it will be possible to get a true view of what they think. You must also be aware of the pressures that GPs face in coming to organisational meetings, feeling perhaps as battered as I felt in large CCG meetings having had delivered to my desktop the night before several mega-bytes of papers to read, with results to look at that night, a full surgery to do the next morning and visits and then get to the 1 o'clock meeting, using one of my staff hopefully having read the stuff and telling me about the meeting as we get there. Did you also have a feeling that the CCGs are led by a small group of very dedicated, very energetic GPs who are using most of their time in non-clinical matters? I am not saying they do not still see patients because I think some of them do the odd urgent surgery, et cetera, and some of them are very committed, but that the rest of my colleagues - and maybe I was one of them - tend to leave it to the committed. My fear is if we are successful in getting this to go round again, how do we know that the 90-95% of GPs who are struggling just to get through the morning without killing anyone, and perhaps do a little bit of good while they are at it, how do you know they are not going to be steamrollered again? My final thought is perhaps it might reflect why there have been relatively few responses from GPs, that there is a worry about speaking out. I wonder if you had been aware of that. I speak as somebody who perhaps was not frightened of speaking out, being older in the profession and, with no disrespect to yourself, but having done quite a few more years than you have done, who used to get passed little messages to ask difficult, awkward questions "because Stephen wouldn't mind asking them". Have you been subject to those types of pressure and are you aware of colleagues under those same pressures?

A. Look, I am very grateful for your insight. It is something which I recognise. Nationally only 5% of GPs are involved in CCGs. Those are the same GPs who were previously on the PCG groups and were previously on the PCT groups. 95% of GPs are not engaged in the process at all. As you say, they are working very hard to deliver the contracts, which are very complex, and looking after their patients. Apart from seeing patients let's see what the GP work is. This is not just about seeing their patients. After they have seen their patients, they have got to deal with lab results. They have got to deal with the correspondence. They have then got to get some of the targets and then they have got QOF things. Then they have got to do their annual appraisals. Then they have got a CQC visit. These guys are working very hard. Do you know, on a personal basis the happiest day of my life was when I graduated when I was going to be able to look after the patients I wanted to. The next happiest day of my life will be when I have saved enough pension fund to retire because I feel so tired of the system. That is the morale and not just how I feel, how a vast number of GPs feel. We know that last year something like 5,000 GPs went to the GMC for a certificate of good standing so that they could apply for jobs possibly in New Zealand, in Australia and in Canada. These are people who are wanting to leave the NHS. Something is happening here. We are taking medical

students who are dedicated to work hard at A levels and work very hard at medical school. The system does something to them and they say why did they go to medical school. I agree entirely. GPs currently, you are absolutely right, the documents come on your desk 48 hours beforehand - complex meeting documents for a CCG meeting where you are told you must make a decision, it is a crisis, if we do not sign this we will have missed the boat. I know that our CCG applied to join the co-commissioning even before they had consulted the members because they were under a deadline. Then when they realised that they would not be able to push it through, that is when they withdrew the application, so when Dr Parmar relies upon saying that the GPs responded, let us not forget that these are the very GPs who are working very hard, they are frightened they might not get an improvement grant or they might get a nasty complaint to the GMC or they might get a letter of appraisal. These guys are highly regulated and highly victimised sometimes and they fear for the very worst and they are just surviving. That is what the land is like outside. For any Secretary of State to say that the clinicians are behind this is lying not only to himself but lying to the nation. There are no doctors behind this. The CCG have been given a choice: if you do not agree there will be no other alternatives. The Secretary of State is hiding behind GPs. I just hope that someone has the guts to stand up and say we will do your dirty work any more. (Applause)

Q. THE CHAIRMAN: Thank you very much indeed, Doctor.
A. Shall I leave this?

THE CHAIRMAN: If we can have a copy of the document (Same handed).

The Witness Withdrew

MS RENSTEN: Members of the Commission, I am conscious we have overrun our time somewhat and I am just wondering what the view is about whether or not to press on with the next witness now and truncate the luncheon adjournment or not.

THE CHAIRMAN: My inclination, but I will be contradicted left and right, especially as there is a witness presumably waiting somewhere, is to press on. We had to do this last week and we will truncate lunch.

MS RENSTEN: The next witness then is Clara Lowy.

MS CLARA LOWY MD MSc FRCP, retired Diabetic and Endocrine Physician and Ealing resident

Examined by MS RENSTEN

Q. MS RENSTEN: It is page 1079. Could you please give the Commission your full name and address, if you are prepared to do so.
A. (Ms Lowy): My name is Clara Lowy and I am a retired consultant physician from St Thomas' Hospital. My current address is 44A Rosemont Road, Acton W3 9LY.

Q. In front of you, you have your submission. Is that true to the best of your knowledge and understanding and do you wish it to stand as your evidence to the Commission?
A. Yes.

Q. I wanted to ask you first a little bit about your experience. You are a retired physician. Can you just expand on what your expertise and experience was/is, please?
A. I eventually had a Chair in Endocrinology and Diabetes at St Thomas' Hospital as part of King's College. I had a special interest in diabetes and pregnancy and set up the combined pregnancy diabetic clinic. I also did the first UK survey on the outcome of babies of diabetic mothers for the whole of the UK. Perhaps most important of all, in my view, is combined with a patient, I invented with her home glucose monitoring which completely transformed the management of diabetic pregnancy. Diabetic women with type 1 diabetes would be admitted at about 32 weeks and they would spend the rest of their time in hospital. As a result of introducing this, they were able to stay at home until the time of delivery.

Q. Thank you. I want to just ask you a question which is related not to your expertise but to what you have said in your covering note which is you comment that you have difficulty accessing your GP practice. Just following on from the last witness, could you just tell the Commission in what way, what the difficulties are?
A. If you have a problem that might not be an emergency it is difficult to get an appointment. On a recent occasion I said, "This is not an emergency but I do need an appointment." "Well, we have only got two appointments in this month so we cannot make one at all." So there are great difficulties. I may say that I was part of the Hillcrest Surgery, which is Mark Spencer, and their performance, in my view, was poor clinically particularly, not the nurses but the clinical performance was poor, and I have just changed to Mill Hill Practice.

Q. Can you perhaps expand and tell us then in your view both on a personal and from your experience as a physician how would that practice, the Hillcrest Practice cope if it had to manage with providing an extended range of services?
A. I do not think they would cope at all and I will give you just an example of that. Two years ago I broke an arm and a leg skiing and I could not go home because I have stairs. I sorted out my own care privately, £2,000 a week, but I needed to have some information clinically sent to the home where I was and they could not even manage that for three days. The whole delay for three days was because they were so incompetent in being able to transfer clinical information so that the home could accept me.

Q. In the body of your submission - this is still on the GP service issue - you raise several issues about how GP and hospital services should work together and first you put it in the context of surgical follow-up care. Can you help us with what your concerns are about the monitoring angle and the communication aspect please?
A. I think there is relatively poor communication between hospitals and the community. In the community there is not really much care - physiotherapists, dieticians - when I asked my GP at the Hillcrest Surgery, "Do you have a dietician that looks after the diabetics?" "Well, we could call one." Well, that is not good enough. You have to have an integrated care system. We set up a diabetic clinic at St Thomas' where we had dieticians, the consultants themselves registrars, teaching, nurse practitioners, podiatrists, eye screening all in one centre and what is interesting is in that community where we all met once a week and discussed our problems different patients related to different individuals but we all understood that that worked, and that sort of coherence just does not exist. It could exist in the community but it is expensive and nobody has really

thought this through properly.

Q. So how, in your view, with the planned reduction in acute hospital beds, will services be impacted on by the reduction in hospital beds and the increase in community-based care if it does actually take place?
A. There has to be communication between the hospital specialist and the community but the problem is that the community care just does not exist. Not only that, it is no good having a specialist nurse in one practice who does not talk to any other specialist nurse. She needs to be organised in such a way that she is within the community where they can discuss each other's problems. Health centres, as Darzai suggested, and a billion sum of money spent on these organisations would solve some of these problems, but it would not be any cheaper. It would be just as expensive but it might be better.

Q. One of the issues you also raise is late diagnosis of cancer and you talk about late diagnosis being one of the issues. If that is something that needs improving, how should that be done?
A. About 20% of cancer diagnoses occur at A&E. Why is that? I think the answer is that if a GP has ten minutes in order to see a patient they are never going to get there because there is not enough time, so I think the way to improve it is partly education of the GPs and partly having more time for that kind of activity. When I was running an endocrine clinic in St Thomas' I always overran. My clinic went on until 6.00. Patients accepted that although they had to wait longer. GPs cannot really do that because they have got other activities.

Q. What impact do you say the proposed reorganisations will have on specifically the diagnosis of cancer?
A. I think it will almost certainly make it worse.

Q. And given that you have just said that a lot of cancer is diagnosed at A&Es, if there are fewer A&Es, again the same question: what would the impact be?
A. The impact will be, I do not know whether the urgent care centres would be able to take up the slack on that but I would doubt that. We have to put that back to the GPs but we have got to give them time.

Q. You raise as well the issue of the ability of members of the public to judge the quality of GPs. Does this become more of a problem, does this become more important if more work is devolved to GP services?
A. Again, there has to be a bit more feedback between the patients and general practitioners and I think there is a problem here in that if you are sick and you want to see your doctor, the last thing you want to do is to criticise him or her, so there is a difficulty of being able to express your views and then not being discriminated against. I think it is a difficult problem and I do not quite now how you solve it.

Q. I am just thinking about you say that some of the issues that would previously have come under the scrutiny of consultants are now moving towards GPs and you are talking particularly in terms of follow-up appointments?
A. Yes.

Q. Is that a concern for you?

A. It is a concern because, for instance, if you have a chronic psychiatric condition like depression and you have been seeing the hospital specialists in that field and that is now going to be transferred to the general practitioner who may not have any particular skills in looking after psychiatric services, that is not going to work very well. I think it is particularly a problem actually for paediatrics. I wrote to the Royal College of Paediatrics and Child Health to ask them about their views about how they saw the development of paediatric services because it is inadequate. The training for GPs in paediatrics is poor and it is recognised as poor and they did actually set up a training service and then deemed it to be too expensive. The College suggested that they did bigger hubs with more specialists but they also wanted them to have consultants in the community and, above all, specialist trained paediatric nurses. They have not happened. The College at the end of this very helpful letter said, "But of course we do not have any money and we do not have any power and we can only make recommendations that people can ignore."

Q. So is the thrust of what you are saying that for GPs to do more they require more?
A. Exactly.

Q. Can I ask you turning now to your particular specialism, you set out in your submission some of the issues around diabetic mothers and concerns in respect of babies and neonatal care. Can you expand upon that and help us with where those women need to be, who needs to oversee their care, the setting and the risks, please?
A. I think there is the preventative thing so there is the question of education before women get pregnant. There is the question of the type 1 diabetics who are insulin-dependent who will probably still be attending hospitals and they need to be in a combined diabetic antenatal clinic, but there is a particular problem with gestational diabetes. This is hugely on the increase and particularly in Ealing and also in Newham. Up to 30% of these women develop diabetes in pregnancy. Who is going to diagnose this? Not only that but a woman who develops gestational pregnancy starts off her pregnancy fit and well and thinks she is doing something really helpful. Then she is told "We think we ought to do a test" and it is positive so suddenly a doctor or a nurse has thrown a disease upon them and most patients are angry and say, "But I don't have any symptoms" and then they are frightened because they have got a baby and they want the best for the baby. That needs careful handling. What we are doing here is we are doing it possibly in the new configuration either at Ealing or possibly in the general practice or in the health centre and it is going to be totally fragmented. On top of that even if you get that bit right, postnatally these patients need to followed up because about a fifth will have type 2 diabetes and type 2 diabetes in the fertile age are more likely to go blind, more likely to need renal dialysis, more likely to have heart attacks, so they are a very vulnerable cohort and in the configuration we have got at the moment I think they will get lost.

Q. At the moment in terms of the Ealing maternity service, what do you say about the service that you know provides for that group of women?
A. I am talking from my own experience so I have not had any direct dealing with the Ealing maternity service, but I understand they do have a combined diabetic clinic. I think it should be coherent and I think it should stay in one place and it should perhaps be linked up with the local GPs, who should have much more understanding of the severity of what seems to be an asymptomatic disease.

Q. Following on from that, are you able to help with a general view about whether or not you consider the maternity unit in Ealing should be shut or should remain open?
A. I think the maternity unit in Ealing should definitely continue and I think be expanded. We have got an expanding population and not only that but we have also got an expanding population of diabetes, so this is an area that needs to be conserved.

Q. Finally, can you help with any other issues specific to your areas of expertise that you think may assist the Commission?
A. I think I have said enough.

MS RENSTEN: I am very grateful. Please wait there, there may be some more questions.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much. Two questions. One is you make an interesting point in your written submission about the need to precede reorganisation and reconfiguration, whatever you want to call it, with some kind of in-depth pilot. I would like you to expand on what kind of in-depth pilot you would conceive in that question. One other question. You talk about integrated hospital and community and you describe the various expertise which would be gathered in such a system. I just wondered if you were able to make a comment on the original notion of polyclinics which has been mentioned today and again was mentioned last week as well. So those are the two questions.
A. My great grandfather was a chap called Charles Booth who was a philanthropist and if you go to St Paul's you will find one of the thing he said was if you ever want to move forward, the first thing you have to do is have facts, and if you want facts you have at least got to do a pilot. He did a pilot looking at the life and labour of London in 1900 and as a result the old age pension came about. Therefore you need to have an in-depth assessment of just where you want to go rather than rolling out something over the whole of the UK. I think that is the point I want to make.

Q. I am going to stop you just a moment. That is an assessment. Of course, they will say they have done an assessment. A pilot usually is some sort of practical implementation so you can watch how it goes on the ground. Did you mean that?
A. Yes, I think I do. Of course how you set up that. There was a pilot set up in Hammersmith looking at over 70s and I think it was diabetes and hypertension and a number of GPs joined together to sort out a coherent plan and it was actually working very well, it was reported in the *BMJ* but it sort of got lost, so, yes, it has to be on the ground. I do not think it has to be a paper exercise. That is useless.

Q. Second question polyclinics?
A. I think a polyclinic is good idea because (a) it allow GPs to interact with each other and also for nurses. Nurses are crucial and they are cheap compared with doctors. They need to interact with each other too. They have to learn from each other as well as from the whole community, so I think polyclinics is the way. I do not think that an individual single-handed practice can really in modern society function sufficiently well. When I retired I was fully NHS. Lots of diabetic patients said to me, "I would like to see you

privately" and I said, "No, because I am working as an individual, I do not have the specialist nurses, I do not have any of the ancillary services, who are just as important as I am, and possibly more."

Q. DR LISTER: You referred in a general heading about how you judge the skill of the GP, you made some interesting points about psychiatric conditions, which obviously are part of the caseload of GPs and you make the point there has been a 17% reduction in hospital psychiatric nurses for only a 1% increase in community psychiatric nurses, which I think is a very valid point. Do you have any awareness or knowledge about the relative treatment of mental health conditions in primary care and possibly a need for further training and development?

A. The answer is I have no personal knowledge. These are publicly available figures to everybody, but I think we have this mantra of saying that everything can happen in the community and would be so much better for patients and then we do not actually put the staff there. One of the things that is so patently obvious is that all the failing trusts are short of staff and have too many agency staff. I do not know whether any of you work with agency staff, but it is a nightmare. I can elaborate but I will not.

Q. DR HIRST: Just two perhaps unrelated questions, if I may. The first thing is I ought to start with a preamble. I actually come from a polyclinic background. I worked in a large group practice and 20-25 years ago we peaked at about eight or nine equivalent hospital outpatients running. I think my antenatal clinic was the biggest one in Hounslow I was told with the number of people going through. So you can see I am adapted that way. Also, I have to be honest, I am not prejudiced against the out of hospital services being provided. I think with the right facilities they could bring very fulfilling medicine to practice and actually bring doctors who want to work in general practice to use their training and be fulfilled. Also I would say that Hounslow, which is the CCG where I was working, is at the forefront of bringing in these services, and one of the services they are proposing is three levels of diabetic care, including insulin initiation, which I was just dabbling with before I retired. That is an example, but the one worry I have is that of course is important, I believe, and I think you would agree because of the sheer numbers of diabetics. They patently cannot be managed all in hospital outpatients. However, my main concern is to do with training of diabetic specialists. My fear is if it all comes our way, although it is great to do and very, very interesting, you need time, as you are aware, who is going to train the people that we go to for advice because they are not seeing anybody? What are your feelings about that?

A. I think training is crucial. How you set it up is probably expensive and that is why it has often been neglected. How you train people, probably the hospital hub should provide that service of training in all manner of things. And it just does not happen. I went through the era of when specialist nurses first came into being and as consultants we recognised that nurses were actually crucial. The one thing is doctors are supposed to get rid of your disease; nurses are perceived as helping you to cope with your disease, so they have a very different role from the doctor in many ways and therefore they need training. Just who that training should be, I am not so sure because I think the nursing fraternity and the medical fraternity and the physiotherapy fraternity are all very separate and I am not sure that they have really got their act together to try and come into one unit and that has not been thought about.

Q. Obviously that is specific to Ealing Hospital because it serves a population, I cannot

remember the exact statistics, but we have the highest ratios of diabetic patients in this catchment area.

A. It is huge and what is more it is going up. These are young people now. Type 2 diabetes is now affecting a young population and therefore they are going to go blind, they are going to have renal problems and they are going to have vascular problems at a much earlier age than was the case previously, and nobody has really thought about how to deal with this. There are also major things on diet, eating, all sorts of preventative programmes that ought to be in place and are not, but the polyclinic could be a source where this could take place.

Q. I hesitate to make you work even harder, but just shifting it a bit and as others will have heard this morning, this is a hobby horse of mine, again touching on medical politics. You have been a Professor at one of the great English institutions, St Thomas' Hospital, and I cannot get out of my mind this map, and I target St Thomas' as well because it is one of that circle of hospitals in the centre. What do you think is stopping St Mary's or some of those hospitals coming this way where we have this wonderful catchment area of people to treat, especially in diabetes? My theory is it is to do with medical politics and I wonder if you have any thoughts about it.

A. Yes, I do. It is all to do with private practice. I was a junior doctor at Hammersmith Hospital with the most fantastic set-up. I then became a consultant at St Thomas' and they were all busy going off and doing their bloody private practice. There was a time when St Thomas' might have moved to Canterbury but the staff did not want that because their private practice would have gone down the tube. So I think private practice is still a major problem in holding the bit in the middle, so to speak, together. For instance, if you went to the Hammersmith open ward rounds, they were fantastic but at St Thomas' the senior staff did not turn up, or a few did, but it did not have the same atmosphere, it did not have the way of discussing things. The level of the academia fell. That is my personal view, mind you. My consultants at St Thomas' might not agree.

THE CHAIRMAN: Thank you for your clarity. I think we are going to have a lunch break now.

The Witness Withdrew

After the luncheon adjournment

THE CHAIRMAN: I am going to slowly ease us into the afternoon at 1.35 and try to keep us to the timetable, at least when the trains are on time. We may or may not have an afternoon break. It depends on how we get on. As you can tell, the points and issues are intense and interesting so we may just plough through but if there is desperation breaking out we will have a break. May I please ask counsel to call the first witness this afternoon.

MS RENSTEN: The next witness is Ms Sadie Eyles-Slade

MS SADIE EYLES-SLADE, Midwife at Ealing Hospital

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commissioners your full name, your

professional address and the current post you hold?
A. (Ms Eyles-Slade): My name is Sadie Eyles-Slade. I work at Ealing Hospital on Uxbridge Road UB1 and I am a midwife working across the triage and birth centre team.

Q. If you look at the documents in front of you, you should see your submission. Could you confirm that it is true to the best of your knowledge and understanding and that you wish it to stand as your evidence to this Commission?
A. Yes, I can.

Q. I wanted to start by asking you how long you have been a midwife at Ealing Hospital for?
A. A year and a half. Coming up to two years actually.

Q. I understand from your submission that you started just as the new birth centre was opening, is that correct?
A. Yes.

Q. Can you explain to the Commissioners, please, what the centre offers?
A. It offers low-risk women and high-risk women who have been through supervision and made plans with the medical teams. It offers active birth, mobilisation and water birth. Just more choice really than existed already. It just increases the chances and rates of normal birth.

Q. By whom is the service on a day-to-day level led?
A. We have a manager on the birth centre, Louisa Salman Diez(?) and it is led by the midwifery that lead the whole unit.

Q. In the background are there consultants present as well or not?
A. Not in the birth centre, no, but we talk with the medical team if we need them and we are alongside the labour ward so we transfer to them when we need to.

Q. That is on the same site, is it?
A. Yes.

Q. Can you help us with what standard you say the facilities at Ealing maternity unit are?
A. I think they are very good. We have done very well on our score card, I know that. I can speak for the birthing centre where I work, but we have exceeded the initial targets that were set for us in terms of the number of women we take and the number of normal births in the unit. I should also say I work in a new triage area as well so it is two quite distinct areas. The triage has had great success in making plans for women with complex needs.

Q. You briefly told us what the choices you provide are. Are you aware of whether those choices are all available at other hospitals? I do not mean are some available at some hospitals, but are you aware if there is another hospital or hospitals in the area at which all of those facilities are available?
A. I do not know because not every hospital has a dedicated triage area so I cannot speak for the triage.

Q. In terms of the choices of birthing form such as water birth and so on and so forth?
A. Yes, I think most of the other hospitals do. I think the difference obviously is just how piecemeal the care is. I think what we offer is we offer for Southall women who did not have access to this kind of birth before, this kind of choice before continuity of care and that is very important because we have a high caseload of vulnerable women who really need continuity of care. They are getting continuity within the same team but with choice as well.

Q. Can you expand on that a little more? Tell us about the population groups that you serve.
A. We have a high rate of black and ethnic minority women. We have a lot of women who do not speak English as a first language and many who do not speak English at all, a lot of immigrants. There is quite a high rate of issues like domestic violence and poverty and very low housing standards among a lot of the women who we serve and although possibly not all women in the borough of Ealing get their maternity care at Ealing, just about all the women in Southall do. It is a highly populated area and those are the most vulnerable of the women that we serve. So basically what we offer them is we offer them antenatal care, choice of place of birth and postnatal care all within the same organisation so there is continuity, which is really important in terms of understanding their social needs and plans and records being made and kept for them.

Q. In the time that you have been there, what do you say the impact has been on the lives of the women and babies coming through your and your colleagues' hands?
A. I think because of what we have done in the birth centre there is a higher rate of normal birth amongst this group of women which is really lovely to see. I think it is as simple as that, but I think that impacts on family bonding, on breastfeeding rates and really importantly on patient satisfaction.

Q. Are those things you say apply specific to the services that Ealing provides or are there other services elsewhere that provide similar things?
A. Other places provide similar things. I think what is specific about what we are offering for Southall women is the continuity. The birth centre has changed their choices and they are able to now access those choices within the existing continuity of care and that is really, really important for these women.

Q. If that service goes, if the unit shuts, what will the effect be on that group of women?
A. I think the care will just be more piecemeal because, as I understand it, Imperial would be taking over the community care, but I am not sure that a lot of the Southall women would choose to go to Imperial. They might be more likely to go to Hillingdon.

Q. Pause there, when you say Imperial, which part of Imperial are you referring to specifically?
A. Either but I imagine Queen Charlotte's is the closer one. I think a lot of the Southall women, anecdotally from talking to them and from seeing the other choices they are making, would go west rather than east so they would probably go to Hillingdon, possibly to Northwick Park and then they would be getting their community care through Imperial, as I understand, so basically they would be experiencing more piecemeal care which I think for this particularly vulnerable group of women could be really bad in terms of continuity, in terms of record-keeping, in terms of following plans because it is always

very difficult when you shift care from one organisation to another and actually we are always trying to encourage continuity. It is really key.

Q. Thinking about accessibility, if the service shuts do you have any comment about how easy or difficult it will be for that particular constituency of women to reach the other facilities?
A. I think it would be really difficult and I am not sure if the other hospitals have taken on board how much work we do in the triage area with, for instance, women in early labour in Southall, who live really quite close to the hospital but do not always cope very well in early labour for a number of reasons, often because they just do not have the housing to feel comfortable at home in that period, and it puts a really big burden on the antenatal wards when you are looking at a lot of admissions in early labour. You need to be able to reassure women that they can reach hospital within a good time and they are going to be safe at home. That needs to be realistic. Of course, if you have got any doubts about that or about their ability to cope or their anxieties or how fast they are going to progress, then you need to admit them if they turn up rather than sending them home, and then you need the antenatal capacity to deal with that. Having talked to Imperial about this, but I am sure it is the same in the other hospitals, I am not sure if they have taken on board how much work we do in triage with our early labourers. It is quite a burden of our work.

Q. Can I just check I have got this correct, that if they have to travel further there may need to be more earlier admissions because of the uncertainties of travelling?
A. Yes, of course.

Q. Is that what you are saying?
A. Yes, I am saying there would need to be more early admissions, for several reasons. Some of them are simply because it would not be safe for women to be sent home if you did know how fast they were going to progress, but some of them would be simply for reassurance and anxiety. A lot of our women do not cope very well and I think there are a number of complex reasons - housing, the fact that they are often new in country and do not understand the system - and just for those reasons I think for social reasons there would be more admissions.

Q. Again, have I got this correct, is it your evidence that the work that your triage service does keeps women out of hospital?
A. I think yes, and I think it is partly the work that the triage service does and it is partly our location, the fact that we can reassure women that we are very close to them.

Q. What about knock-on effects if the maternity unit is shut? Is there any impact - there may not be, I do not know - on women who have other children, other responsibilities? Is that something that you have given consideration to?
A. Yes, definitely. I think it is very difficult for women with large families without a lot of extended family support in this country to come to hospital and leave their families, so in the birth centre quite often, even though we are very local, we have families who turn up with all their children and we have to try and facilitate the whole family in the birth centre. They will be waiting for somebody to come up from Southall to pick the kids up which will often happen just before birth, so, yes, definitely, the distances would impact on childcare.

Q. Just in terms of the financial implications, are there financial implications for patients?
A. Yes, there are, because often if we have women in triage who we feel are fit to go home they tell us that they cannot afford the taxis to and from the hospital and I think we have quite a high rate of ambulance use in early labour. It is not necessarily appropriate but I think again it is a social need and it is something that we try to explain to our women and we try and explain appropriate use of ambulances. I do not know if that has been budgeted by the other hospitals because that will definitely increase if they have got further to go.

Q. I want to ask you about some documents that are not contained in that bundle but were made public by CCGs fairly recently. What is contained in there is an indication that a maternity booking service has been launched in January 2015 which is supposed to make access easier for women. First of all, can you tell us whether you are aware of this and, secondly, if you are, if you can help us with how it is working?
A. No, I do not know much about it. The booking is at the community end so it is the antenatal, so, no, I am not sure, sorry.

Q. We are also told that as at February 2014 a letter was written which indicated that views were unanimous that Ealing maternity services should transition to the planned timetable. I take it that that means that the plan was for it to shut down, I think, fairly soon if not already? Does that accord with your understanding of the views of consultants in your department?
A. I think it is fairly unanimous in the maternity unit. I think there is a lot of stress amongst the staff and really low morale because at the moment even our annual leave has been put on hold so nobody is able to book a summer holiday at the moment or say if they can go to a wedding in a few months' time or move house. A lot of us are in rented accommodation and do not know where to move or when to move. So the staff are just kind of on hold with their personal lives really and have been for quite a number of months. It is becoming quite a big issue when you think that that is an awful lot of people. So whilst unanimously ideally nobody would want the hospital to close or the maternity unit to close or to lose the service, I think the secondary and really strong frustration is just that the timescale on it keeps slipping and keeps moving and nobody knows what they are doing and staff are feeling really undervalued and frustrated.

Q. What about impact on patient services?
A. Well, I do not know, I think for the patients definitely I suspect that the booking numbers are falling just because patients are confused about whether we will be there and how long we will about be there rather than because they do not want to be there any more. We get women and their families coming to triage all the time saying, "Oh my God, you're closing, why are you closing, what's happening?" and we just kind of say, "We don't know and we are still here and keep coming." So, I hope and I feel that staff morale is not directly impacting on patient care, but I definitely feel patients are confused about whether they should be booking with us, whether they should be coming to us and if they are booked with us because it is where they want to be, I think they have quite a lot of anxiety about whether we are going to be there when they come to have their baby in a few months' time.

Q. There is a volume in front of you marked Volume 5, if you would not mind turning to

A the very last document in that bundle, please. What that is is a letter dated 18 March and it is a letter to this Commission from the North West Collaboration of Clinical Commissioning Groups and it sets out --- I beg your pardon, it is the very last document, it is 1756 and it is a letter sent on behalf of Dr Mohini Parmar. It is headed up "Dear Colleague" and then you go down two paragraphs and what it says is this: "Ealing Hospital Maternity Unit is currently a safe place for women to give birth. However those standards for maternity units are changing and we know that in future Ealing may B struggle to meet those standards." I wonder if you could comment on what you think about that?
A. It is not something I have seen. I do not know what that is based on. I would have to know more about where that is coming from. Certainly I feel that it is safe and I know that we are achieving good outcomes in our score card so I do not have anything else to say on that, I am sorry, without knowing the background to that comment.

C Q. Can you just perhaps help us with this, the next sentence, and I understand you do not know the basis for this: "This could lead to an unplanned closure would which could increase clinical risk." In your view, working in the service at the moment is that something that you think is likely to happen or unlikely to happen.
A. No, it is not something that I am seeing evidence for at the moment.

D Q. So you are unable to comment?
A. I am, yes, sorry.

Q. No, that is perfectly reasonable. I just wanted to ask you finally this, and again you may not know the answer to this because it relates to the other services. Do you have any information or understanding about the state of readiness of the units which are to receive the service users from Ealing?
E A. We are told that they are not ready. We had a meeting yesterday with our Head of Midwifery when we were told that Imperial had estate issues still and that Hillingdon are still nine staff short of being ready. Obviously in the NHS it takes quite a long time - not necessarily obviously - but it takes quite a long time for posts to be filled because there is a lot of paperwork to go through and a lot of checks to be made and it can take months, so I do not know how far off that means.

F Q. Do I take it from that you were not given an indication of when the closure would happen?
A. We were told possibly a closure in June but we been told a lot of dates over a period of months so nobody knows. We were told June and, if not June, October so nobody really knows what that means.

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

<u>Examined by THE COMMISSION</u>

Q. THE CHAIRMAN: Good afternoon. Thank you for your information. These are specific questions that really I want to ask is. In terms of the other units you have just been asked about, you have said Imperial has estate problems and Hillingdon are nine H staff short. Almost by implication do either of those observations apply to your unit?

A. In terms of staff shortage or estate problems?

Q. Yes.
A. No, not at the moment, not for the caseload that we have.

Q. And not foreseeable?
A. Well, possibly I think if this deferral of dates continues and we stay open for some time we could lose staff because of the uncertainty, yes.

Q. Because of the uncertainty?
A. Yes.

Q. If there were not the uncertainty you would not have a staff problem?
A. I do not think so, no.

Q. I just want to continue with the specifics. We were told by an earlier witness that actually a rather large sum of money has just been invested in 2011-2013 in the birth centre and something in the region of £2 million has been spent. So far as investment is concerned, he then went on to talk about the quality of care. As far as you can see in terms of this unit, you have talked of score cards and so on, does it appear to be failing in any regard?
A. No.

Q. The score card you use what is the score card you are talking about?
A. It is the reporting score card to the Commissioning Group.

Q. What kind of criteria are involved in that?
A. Off the top of my head I cannot tell you.

Q. Do not worry if you cannot but I would not mind seeing a score card at some point. Do you have one with you?
A. On my phone, I believe. I may have one.

Q. You know what the inquiry is so I would quite like to see what it is they are looking at.
A. I think they should be publicly available.

Q. DR LISTER: Very interesting. When you say Hillingdon are nine staff short of what they require.
A. So I have been told.

Q. Even assuming it is eight or whatever, would you think there is a chance that some of the staff currently working at Ealing would be among those they would be aiming to recruit?
A. My understanding was they have already accounted for our numbers because we have already been allocated to the other West London trusts, so they know exactly how many of us are going there and actually in some instances exactly which roles we are taking as well. I do not think we are part of that. I think they still need extra staff.

Q. So from your point of view if the closure goes ahead, then we will have to do this and at that point you will move to whichever hospital?
A. Yes, exactly, I have already been allocated a role at Imperial if the closure goes ahead. Sorry, was that the question?

Q. That is fine. I mean it is fine for an answer; obviously not a very good situation to be in. I was going to ask you for some idea of scope of how many births and how many staff you have and whether you feel that the new capacity that is being opened up will be replicating that elsewhere?
A. I think we have around 3,000-3,500 births a year at Ealing. We are taking 20% of those in the birth centre and we only have three rooms there, so we have kind of exceeded the target set for us there. I think the birth service, the choices will be replicated, as I have said. It is just repeating what I have said. I think it is a really important point that the care will potentially be piecemeal and a kind of continuity of care in terms of antenatal education, antenatal care particularly for vulnerable women directly impacts on women's birth choices and how comfortable they feel when they go to their place of birth and how well received and how well understood their care plans are, and that has a direct implication on their postnatal care, on postnatal outcomes, on things like postnatal depression and bonding and breastfeeding and larger family outcomes really. For a robust family those things do not always matter so much but for vulnerable women they matter a lot. It is just repeating those concerns.

Q. DR HIRST: Thank you. Just two short questions really. Referring back to this email that was sent round by Dr Parmar, she comments that the changes would involve having more senior consultant cover in maternity units. As a working busy midwife do you have any concerns in respect of the consultant cover you have at Ealing at the moment?
A. No. I know that we do not have the 24-hour cover that other hospitals have but we do have on-call cover so we have 24-hour cover but not in the hospital necessarily.

Q. In the hospital are they senior registrar status?
A. Yes, absolutely. There is always a senior registrar.

Q. For example, if you need to do an emergency Caesar the skills are there to do one instantly?
A. Yes.

Q. The anaesthetists are there?
A. Yes.

Q. And you can resuscitate a baby?
A. Yes, everybody can. Everybody is trained to.

Q. Of course you can, but there is a special care unit for babies?
A. There is. So there is a special care unit, there is an anaesthetist team on call. They are part of the crash team so there is always a crash team on call

Q. They are there 24 hours a day?
A. Absolutely 24 hours, yes. I do not think you could run a labour ward without that.

Q. So even though you have not got a consultant you have a member of the Royal College of Obstetricians and Gynaecologists?
A. Absolutely.

Q. And they are available to do a Caesar if you need to do one?
A. Yes and they do go on every day any time as necessary.

Q. So there is skilled cover available?
A. There is.

Q. Without this magic phrase "consultant cover"?
A. Yes, absolutely and the consultants come in when they are needed if they are needed.

Q. If needed and that has not been a source of anxiety to you?
A. No, not at all.

Q. The other thing is just pushing the idea of home births, I know there is controversy around whether there should be home births or not, but accepting that they have a place, the community you serve would you feel it is one that would accept an increased number of home births or would be able to, having regard to Dr Parmar's email?
A. Sorry, I have not read all of this email so I am not sure about everything that has been said in it.

Q. It is in the penultimate paragraph halfway down it says "expanding the number of community midwives and investing in the home birth team". Having regard to the facilities and the resources that the community that you serve have?
A. As a birth centre midwife, I have worked with home birth before I came to the birth centre, so I am an advocate of home birth, but I would have really strong questions about whether these women have appropriate housing, whether this is a choice they would want to make because a lot of these women find it difficult to stay at home in early labour because they are often in very crowded housing situations where they may have a room in a house where there are other families and this is something that women tell us over and over again and whether home birth is something that they would want. I would be very happy to work with any women around home birth, I would not see it as a safety concern, but I think socially it may not be what our women want.

Q. There may not be privacy?
A. Exactly, yes.

THE CHAIRMAN: May I thank you very much for your attendance today.

<u>The Witness Withdrew</u>

MS CARMEL CAHILL, Healthwatch Ealing

<u>Examined by MS RENSTEN</u>

Q. MS RENSTEN: Could you please give the Commission your full name, your professional address and the post that you hold.

A. (Ms Cahill): My name is Carmel Cahill. I am Chair of Healthwatch Ealing and the address of Healthwatch is Lido Centre, Mattock Lane, West Ealing.

Q. In the bundle in front of you, if you turn to page 673, please, I think it is towards the back of that bundle; is that your submission?
A. It is our submission.

Q. Can you confirm that it is true to the best of your knowledge and understanding and you wish it to stand as your evidence to the Commission?
A. Yes.

Q. I wanted to ask you first of all if you could please explain a bit about the role of Healthwatch Ealing? Who is it made up of in terms of board and staff and so on?
A. Healthwatch is a voluntary organisation as they are across the whole country. They are all independent social enterprises and/or charities. Each Healthwatch is slightly different. In Ealing we have a board of trustees to run the organisation as a voluntary organisation and I want to be really clear about that. We then have a staff team who co-ordinates volunteers who undertake the work of Healthwatch.

Q. So three tiers, if you like: board, staff, volunteers; is that right?
A. That is pretty much.

Q. To whom does Ealing Healthwatch report?
A. We are funded through money from the DoH which is passported to the local authority. We have a contract with the local authority and we also have a reporting line to Healthwatch England and through them to the CQC.

Q. Just looking at your submission, is part of your remit to cascade information about the *Shaping a healthier future* programme?
A. Yes.

Q. Is it any part of Healthwatch's function to offer any challenge to what *Shaping a healthier future* is proposing, perhaps as a critical friend?
A. Yes.

Q. And is that something that you consider the organisation does?
A. Yes.

Q. I want to ask you about your role in publicising the consultation. In your document you set out events and public meetings that you were involved with?
A. Yes.

Q. Can you help us with your view about how successful those events were in engaging and informing the public?
A. I am going to say that we are going back quite a long way now and it was an organisation that undertook it that does not exist now.

Q. Can you just pause there and help us with what that organisation was?
A. Ealinglink was the predecessor of Healthwatch and Healthwatch came in to being a

bit after the end of the consultation on *Shaping a healthier future*, so it was Ealinglink that undertook the first stage of this. Because we have had continuity in Ealing we have access to the archives but some of this is going to rely on my memory as well and because we do a lot of public-facing work, it can tend to run in to one another. The public meetings were very successful. We had attendances well over 100 people and we always do with our public meetings, so people had the opportunity to hear what people were saying. The early what I would call pre-consultation meetings which happened at Lord's Cricket Ground and a couple of other places around, we publicised, and I would have to get checked on this, but there were quite large numbers in proportion to the people who went from Ealing, both those who right from the very beginning wanted to challenge *Shaping a healthier future* and those who went to find out more.

Q. Could I ask you, please, to have a look at Volume 1 and you should find it in one of the bundles in front of you. Could you have a look please at page 77? This is the submission from the London Borough of Ealing. If you go down to paragraph 5 what you can see there is a view that there has been insufficient public and patient engagement and what they refer to as SaHF engagement events, attended by in total 360 people.
A. Yes.

Q. Can you comment about that level of public engagement and how that sits with the picture you have just outlined of your more positive role?
A. Right, in general I agree with this and we had said to SaHF, the Healthwatch Chairs across North West London had formed (the Link chairs as they were then) a patient reference group and we had challenged them all the time around more the timing. This is the outcome and the reason for that outcome is that they were moving too quickly. Engaging patients and the public is a long time thing. You cannot do it quickly. Leading up to the actual consultation those public meetings were publicised at quite short notice and that is why in our submission I have said that the voluntary sector and Healthwatch knew this was happening so they supported getting information because we all thought that our residents needed to know more. So the actual documentation around the consultation was available at a whole number of community venues separate from what the Council is talking about here. They were at Southall Community Alliance, Acton Community Forum, the Lido Centre in West Ealing, where we are based, and Grand Union Village in Northolt. Those are community hubs. Healthwatch, working with those community hubs, tried to get more of the consultation out into the community. If you would like me talk a little bit more, there were difficulties because the documentation itself was quite impenetrable to your average Joe in the street. But having had a look at any of the other reconfiguration consultations, in fact, North West London was slightly less impenetrable than most of the others that I have looked at. To help people, Healthwatch actually ran some days at the Lido Centre where people could actually come in and complete the forms with assistance, and so did the other community venues. I do not have figures on how many actually attended those, they were not huge, but that facility was available to the community and we in fact set up half a dozen computers so that if people wanted to they could complete them on-line. The on-line document was not easy also because it took quite a long time to complete and if you did not save it every ten minutes you would lose your whole document, so there were definitely issues around consultation. It certainly was not perfect by any manner of means.

Q. Given the explanation you have given about how those figures sit with your figures,

how confident are you that the consultation was widely enough disseminated amongst the relevant populations?
A. I do not think it was perfect by any manner of means. I think that they tried reasonably hard to get it out.

Q. Pause there, when you say "they", who do you mean?
A. That is *Shaping a healthier future*. We as the patient advisory group had to push for some of the things that were done that they were not planning. I still think they could have done better.

Q. As you may know, we heard some evidence last week from one of your board members?
A. Yes.

Q. And he expressed a degree of surprise about the submission that he had not seen the contents and perhaps they were not what he was expecting?
A. Yes.

Q. Can I ask you therefore who was involved in agreeing the contents of that submission and to whom should it have gone or to whom did it go before it was sent out?
A. It was prepared between two board meetings. The team put it together and I reviewed it and I took Chair's action and signed it. I felt that it was primarily an operational document giving the facts of what we had done as an organisation. It was not giving opinions that would need to be referred to the board before it was sent off, although I did think it had then been sent to the board afterwards, and I have apologised to John for the fact that he had not received it before and it had been tabled at this next board meeting.

Q. Can I just be clear on this so that I understand. In fact then this is a document which was not ratified by the board before it was sent out?
A. No.

Q. One of the things that Mr McNeill spoke about, and I will not take you to his document unless you want me to, is he had a particular interest in patient transport.
A. Yes.

Q. And he was surprised to see in your document mention of your involvement with the Transport Advisory Group?
A. Yes.

Q. Can you help with what specific work your group has done with the Transport Advisory Group?
A. Yes, we have two Healthwatch members who actually sit on the North West London Transport Advisory Group.

Q. And what have they reported to you in terms of their findings about what is going on and whether or not it is satisfactory?
A. The Transport Advisory Group tends to be project-led rather than generally-led. I think that from what John was saying that he was talking around hospital-to-hospital patient transport on a general basis. I would have to check with our two members who sit

on it, but I do not believe that work around that is actually being done by the Transport Advisory Group so far as I am aware. The work that they have been doing in recent times has been very much related to they did work around A&E and I am not certain of the full details of that, I would have to check with them, but in the last six months or so it has been very much around the issues and around the moving of the maternity because that is quite a complex transport issue.

Q. Are you able to say whether Ealing Healthwatch has a view about whether or not enough has been done to explore the interface between Transport for London and what they are doing and the reconfiguration?
A. Transport for London sits on the Transport Advisory Group as well. We have also worked with people, including some of our MPs, who have been in touch with Transport for London advocating to possibly move slightly some of the transportation. That has not happened and probably is unlikely to happen because of the numbers involved and the cost to move anything, particularly on bus routing. The numbers involved in some of these infrastructure changes are just too small to generate from that Transport from London so, yes, there has been a Transport for London interface all the way along as far as I can see. I am just getting reports back from my team. It not an area I have been working on directly myself.

Q. Are you therefore not able to comment on whether you think enough has been done or not?
A. Enough has been done in what respect?

Q. In terms of Ealing Healthwatch's input into working towards sorting out the transport difficulties?
A. I think that our input has been exceptional. We have two people who have been working tirelessly over the last six months who have been going out with a team of people and testing the bus routes and working with Transport for London to get spider maps and challenging North West London that they have enough data to be able to do this properly. So I think that we have worked tirelessly around transport.

Q. Do you think that tireless work has produced the results that you would want it to produce?
A. Not completely.

Q. One of the other matters which was the subject of some consternation was paragraph 3 of your document where it says "Although only a small number of Ealing residents are directly affected by the change …"
A. That was the A&E.

Q. The A&E, yes. Could you please assist the Commission by explaining a little more about what that statement means and how you have arrived at it?
A. Central Middlesex Hospital's A&E had only been open during the day for the last three years prior to closing so it was not giving a full A&E service at any rate. It had about 30 people a day going through, if my memory serves me correctly. It is not particularly accessible from all but the very north part of Ealing so the numbers coming into it from Ealing are not great.

Q. Sorry, can I ask you to just pause there so we are not talking at cross purposes. Are you saying that that paragraph relates solely to the closure of Central Middlesex Hospital?
A. No, I was going on to mention Hammersmith.

Q. Please do.
A. Hammersmith Hospital probably slightly more people. It is some time since I have looked at the figures, so I cannot quote them, because people from East Acton would tend probably to use that, but as a proportion of a population of Ealing, those two would not be the largest A&E places where people from Ealing would go.

Q. What do you say then, because I perhaps had misunderstood this, will be the impact if Ealing Hospital's accident and emergency is closed? Will that impact on a small or large population group?
A. The answer is I do not really know at this stage, as with most people here, because they say that there will be some form of A&E still remaining, the system is saying, and until that is defined, it is really difficult to make an assumption. Ealing Hospital already has very few blue light ambulances going through because trauma, stroke and major cardiac already go to other major centres, so those things do not go to Ealing currently. As we see the big services more centralised, so there may be less. I just do not know, is the answer.

Q. So this paragraph relates to the closures that have already taken place?
A. Yes.

Q. Not the planned closures?
A. No.

Q. And if I say to you that the London Borough of Ealing submission suggests, and it is at page 72 in Volume 1, if you want to look, 53%, there are some figures for impact on Ealing residents and it says 53% in terms of A&E, is that a figure you recognise or something that you think is perhaps inaccurate?
A. This is at the bottom of page 2?

Q. No, this is Volume 1.
A. It is page 72.

Q. You can see there are three sets of figures given and it is talking about impact there. Are those figures you recognise? I am just wondering if you can help ---
A. They are not ones that I know. I would have to look at them and I am not competent in making a judgment on them.

Q. Can we just turn and have a little think about the maternity unit now. We know that Dr Parmar, who is the Chair of Ealing CCG, says that further work is needed on operational readiness?
A. Yes.

Q. Can you help us with what is your understanding of where things have got to? What stage are we at?
A. I have actually visited each of the hospitals with the internal assurance to have a

patients' view.

Q. Can I ask you to pause there. Before you go on to answer, could you explain a little bit about what is entailed in being part of the internal assurance group and what that means?
A. There have been various levels of assurance that have been undertaken as part of the transition of Ealing Hospital. The North West London internal assurance had two levels. One level was that the hospitals had to go to their local CCG and report on their assurance about their readiness and be questioned on that. Then a second phase of that was that a joint group visited each of the hospitals, and that included clinicians, the senior nurse for the area and some patient representation, and I was one of the patients that went to all of them.

Q. What was your role in that process?
A. My initial role was to watch, I thought it was to watch and listen, and that if any of the people from Ealing asked me what were these hospitals like, did they offer the services, I would actually be able to answer the question. As it happened, I was able to and felt capable of actually challenging and asking several questions as part of these reviews. An area that particularly concerned us was the interface with some of the other services where the borough would not naturally interface, such as the Ealing local authority's children's safeguarding board and the mental health services in areas where the hospital is based, where there is a different organisation running mental health services.

Q. Can I ask you just please to explain, because I am absolutely confused by it, paragraph 3 where you talk about the work that you had done leading to a remodelling of numbers of women who would go where?
A. Yes.

Q. What was it that had been got wrong that you say you were able to get changed, if I can put it that way?
A. The very first modelling that was done around where women would go, I think that the easiest way of saying it was done on what was most convenient for the hospitals and they just split the women across the round.

Q. By that do you mean the hospitals that would remain?
A. Yes, and just split them evenly. We said that people are not going to move that way. People are going to make choices and lots of people will make choices on very different reasons and that they had to look further into that in doing the modelling. One of the things that we challenged was the number that would go to Imperial, not that Imperial was any better but Queen Charlotte's has an international reputation and just through reputation more people would probably go there. No-one knows until it actually happens, but a greater number of women would probably put Imperial down as their first choice. I think that as far as choice of women and where they go, the key to it is going to be the discussion that is had at general practice level with the women and the information that they are given around the options. This has been one of the things that I have certainly been fighting for right from day one of this so that a really good document was produced so that every woman was able to make an informed choice around the hospitals where they might give birth. So saying, it is quite well-known that quite often, particularly in some areas of the borough, at the moment women will go in say, "I'm pregnant, doctor",

and the doctor will say, "We'll send you here", and that is going to take some movement.

Q. Were you able to hear the evidence of the midwife?
A. Yes, I was.

Q. Given what she was saying about the specific requirements of the population in the hinterland around Ealing, what can you help us with about how that loss is going to be made up? If you cannot, please say that you cannot.
A. I can, but can I just say a couple of things beforehand?

Q. Please?
A. At the moment somewhere between 60-65% of women who give birth in Ealing do not give birth at Ealing Hospital. The system of how those women are dealt with all across the borough has worked quite successfully. Part of this is not just, as I am seeing it, about the women who are currently giving birth at Ealing, but giving a more consistent experience to all of the women who give birth across Ealing, those who currently already give birth at other hospitals. With the women who give birth at Ealing, yes, there are a fair number that come from Southall but, as a Greenford girl, 30% of them come from Greenford as well, so it is not just Southall who give birth at Ealing, but, again, they tend to be ethnic minority and there is a very high Polish population at the moment, so there are quite a lot of Polish around. If we look at the journey of a woman, a woman goes to a GP and makes a selection of which hospital she is going to go for. She would normally go to the hospital for a visit and the first scan. The rest of her antenatal most likely would be somewhere closer to where she lives, probably at a children's centre. This is a normal birth pattern, not the more complex. Then they would have two scans in the hospital and they would give birth. Your average woman only goes to hospital three times. That would not change when Ealing is not operating in giving birth. In fact, the Ealing site is likely to be used for antenatal by Hillingdon, Northwick Park and probably Imperial as well.

Q. Antenatal but not birth and not postnatal, is that right?
A. Not birth and my memory is not as good, I cannot remember postnatal, but I think there will be some postnatal there as well.

Q. Can I just ask you a very simple question then: is it your view that Ealing maternity unit should be closed or not?
A. Is it my view?

Q. In your role as Chair of Healthwatch, do you think it should be closed or not?
A. Well, the decision has been made.

Q. I wonder if I could press you a little bit more. If you feel unable to provide a view please do say so, but I am just wondering, if you are able to, if you could do so?
A. I think we have reached a stage that the answer is my heart would say no but my head would say yes.

Q. If it is to be closed, what is your view about the impact of continuing delays on staff and users?
A. I think it is extremely unfortunate.

Q. What should be done, assuming for a moment it is going to close, and that is right, that is where we are going, what should be done in terms of the delay to ameliorate that situation as much as possible?
A. I think the first thing is that on the workforce it is really important that there is continuing dialogue and that there is some certainty with the workforce. If that is not done then I think then because, as the midwife said, the staffing levels are predicated on the Ealing midwives being allocated across the patch, if that does not happen, then the staffing levels may not be at the levels that they should be, so I would say that workforce is probably the most important issue.

Q. Just finally on another little subject, the out of hospital services. One of the things you say that raises concern about is the hubs are not being developed?
A. Yes.

Q. Can you expand on that and explain to us what the hubs are and what would be missing if they are not available for several years?
A. This feeds into the --- if you go back to the beginning of *Shaping a healthier future*, our understanding was that major reconfigurations of the hospitals would not happen until good out of hospital services were in place and working properly. That is the main reason why I raise that concern in the document. If anyone has seen the time it takes to get funding in place and to build things, it is a concern. I have read the IMBC. Do not ask me, I cannot remember what IMBC means, I do not know if someone else can help me, which is the document which is going to central government to fund *Shaping a healthier future* which has the hospitals and the out of hospital services. There are two hubs that are proposed. One is a major rebuild of an existing health centre. The second one is a brand new centre up in Greenford which is part of a major development in the area. Those take time and my concern is that it will not dovetail as well as it should.

Q. And if it does not dovetail as well as it should, can you help us with what the impact would be?
A. I do not know what the impact would be but I do not think it would be good.

MS RENSTEN: I am grateful. If you would like to wait there, there may be some questions from the Commissioners.

Examined by THE COMMISSION

Q. THE CHAIRMAN: Good afternoon and thank you for your presentation. I have got a series of questions I want to clarify in my mind. As Healthwatch, am I right in thinking that part of your role is assessing the impact of any change upon the population?
A. I do not think we have the expertise to do that. I think that what we would do is we would get as much information as we could and question the impacts that have been done in any of the documentation that has been developed.

Q. I want to take this a bit further. Do you see yourselves in a position to assess the impact of proposed change upon the local population?
A. I do not know is the interesting answer. I actually cannot answer that question.

Q. There are reasons for these questions ---
A. Obviously there is.

Q. I am going to just follow it through.
A. Yes, certainly.

Q. So you can see where I am going. You would be concerned for a population if the impact of a proposed change was going to be detrimental, would you not?
A. Yes.

Q. And you would want to flag that up, would you not?
A. Yes.

Q. What percentage in relation to the maternity unit at Ealing comes from Southall where it is situated?
A. The figure is somewhere around 35-40%, if my memory serves me correctly.

Q. We heard a figure today, and I do not know whether you were here?
A. No.

Q. Dr Sahota this morning gave us a figure, he is the Chair of the GLA ---
A. I know Dr Sahota.

Q. The figure he gave was over 50%. Did you know that?
A. Well, I did not think it was quite as high as that and I would have to go back and look at the last figures that I have to actually be able to, because we have UB6, UB5, and in fact there are people who give birth there who are not even in the borough.

Q. You gave figures of 30% in relation to another area. If it is 50%, the closure of the maternity unit is going to have a severe impact, is it not?
A. It is going to have an impact, yes.

Q. A severe impact on at least half the population that already use it?
A. It would have an impact. Because the options that have been made and two of the hospitals are not that much further away from Southall than Ealing Hospital is.

Q. I just want to pursue it a little further. Do you accept the evidence we have heard today that the hospital is in fact serving one of the poorest areas in the country?
A. I would accept that, yes.

Q. And bearing that in mind the people who live in one of the poorest areas of the country are less likely to have the facilities to travel, do you agree?
A. I think that is probably true, but not all of the women from Southall are currently going to Ealing Hospital.

Q. I did not say they all were. I came up with a figure - not my figure, somebody else's - of 50%. The reason I am concerned about this is because we have also heard that it has a very high incidence - the area, not necessarily the maternity unit at all - of TB. Were you aware of that?

A. Ealing has a high prevalence of TB, yes.

Q. And do you agree that the closure of facilities ---
A. It and Brent.

Q. Right. Do you agree that the closure of facilities does not exactly increase choice, does it?
A. I am sorry, I am not --- that is really general.

Q. I am going to take a specific case of a person who is not very well off, who certainly cannot afford taxi fares, who may have to have recourse to an ambulance which again may be unnecessary use but necessary in her case. If you close a unit, whether it is A&E or maternity, that is serving a hinterland of that kind, do you not agree that it is going to cause enormous disruption and anguish and have an adverse impact on that population?
A. It will have some impact. It is really difficult, but I do not think it is to the extent that you are portraying it at the moment.

Q. To what extent do you think it does not have an effect then?
A. Firstly, maternity is a pretty normal thing at any rate, as a women who has had babies; it is not an illness. The majority of women go through and have their babies without too much difficulty and where they go to have them is not a major issue. I think that there is a percentage of women who need a lot more assistance, particularly those who have co-morbidities and already have illnesses where they would have to spend more time in hospital and if they have to attend hospitals a little further away, that could cause difficulties for them, definitely.

Q. One final matter and that relates to out of hospital developments. To what extent are services being closed down before alternatives have been established?
A. There have not been any that I am aware of at the moment, but I have raised it as a concern.

Q. Are there any planned?
A. Not that I am aware of at this particular moment in time.

Q. DR LISTER: I notice you say in your second paragraph towards the end "As active lay partners our members have taken part in a range of strategic meetings over the last three years. They have devoted their time to analysing and challenging business cases…" What areas have you chosen to challenge the business cases that you have seen and I notice also you refer to an investment making business case (IMBC). We have been told for this Commission that that is not available to us because it is not complete. What version have you seen and when was it?
A. I think the last version I saw was draft version 4 or 5. I would have to go and look and see what the number was. There is a group of lay partners who have been asked to review it from a lay person's perspective to see what they felt was said in the IMBC resonated with them or not.

Q. All the numbers have changed from the first business case?
A. It certainly has.

Q. So you are not sure whether you seen the final one or not?
A. I do not think there is a final final one yet.

Q. But they are closing things already so it would seem to be that they ought to have a final business case before they proceed, would you say that is right?
A. The business case is around investment to build new estate.

Q. Yes, but it is also about closing things to send people to those new facilities, is it not?
A. If you are talking about closing the maternity, the initial request to look at transitioning of maternity actually came from the hospital itself.

Q. I was not particularly looking at that. I was thinking we have already seen two of the four A&Es that were able to be closed as part of this same business transformation, as it were, have already closed and they served huge numbers of people directly in Ealing. Certainly the people who are no longer going there are going to be sharing facilities with people from Ealing which would mean quite a large number of Ealing people would be affected. But I am also saying that the business case is about the entire process. It not simply about where to invest, is it, it is about what services would remain where?
A. It states the services that are going to be around, yes.

Q. So if they are going to close something it will be in there and if they are going to spend money it will be in there?
A. Certainly expenditure. It is such a big document ---

Q. Yes. Would you expect a strategy such as that to be in place before they started doing it? Is it the sort of thing you just start and hope that it is going to work out in the end?
A. It would be preferable.

Q. So what areas have you challenged in the business case?
A. The main area that we challenged was around the out of hospital developments which we did not feel were given enough prominence in the actual development of the business case when we saw it.

Q. That is quite a substantial element of the business case?
A. It is quite a substantial element.

Q. The decision that you are going to close hospitals and you are not going to replace them with clearly defined alternative services?
A. They were in there but we felt that the IMBC had a far too acute bias and the out of hospital needed to have stronger bias within the document.

Q. In your final paragraph you say: "Healthwatch Ealing is committed to ensuring the plans around the Out of Hospital developments are fully implemented prior to the closure of any services currently delivered in acute settings."
A. Yes.

Q. Would that include maternity or not?
A. The answer on that is that the decision on closing maternity was made; it was a matter of when. The hospital had come and asked to look at a transition programme so because

of that I would say that we would support it.

Q. So your view that you act to challenge the proposals stops when they have decided and you just help them implement it?
A. No, no, I did not say that. What I said was that we had looked at it. The CCG had been asked to look at transition because of the falling numbers, which the numbers had fallen ahead of this because in fact the numbers I think are down around 22 births currently for this year at Ealing Hospital and we have been working alongside saying if we are going to do this, we have got to do to properly.

Q. Okay, this is my final point, but this process has been going since 2011, the whole process?
A. The whole process.

Q. So by last year we were three years into it, so would it surprise you that people are not necessarily confident to book to have their births in a place if they are not sure if it is going to be open or not?
A. No.

Q. DR HIRST: I am afraid I want to push a little bit along those lines. I sense a volunteer who is working very, very hard, as they see it, on behalf of the people of Ealing.
A. Yes.

Q. I must say as an Ealing resident I was not as aware as I should be before this project of the work of Ealing Healthwatch. Again, the "watch" bit in the Healthwatch makes me assume that yes, you would indeed be a critical friend, so I am quite interested, having read what you have written and knowing that there is so much going on to challenge about this project, I am trying to form a view of the role of Healthwatch and what the pressures are on you. For example, I suppose if, say, early on a couple of years ago you and your colleagues on the board, for example, had formed a view that this was just terrible, that the most deprived areas were losing out and the most privileged areas in North West Thames were gaining. That is the gut reaction that one has about this. If you had formed that view against it, what would have been you and your board members' position in respect to the authorities in Healthwatch?
A. It is difficult to ---

Q. Would you all have resigned en masse, for example?
A. I would not have thought so. We would have said if we had felt that and we certainly would have put information out. We are a very small organisation so there is only so much as an organisation that we can do. We try and our key thing is to look at what information is available, get as much as we can so that people can make up their own mind and either join in a challenge or if they have a particular point of view for the group that would take that forward because as such small organisations with such a broad remit, there is only so much that we can do.

Q. So you are more of an information service rather than an advisory service?
A. Information? Why do you make the differentiation between the two because I am not sure I think that---

Q. For example, it might have been if you had formed a view, say, a couple of years ago or even more recently, say you formed a view as a result of this Commission's work, that something very bad was going to happen for the residents of Ealing. I am only saying that because it might come from a gut reaction that poor people are losing out.
A. We have ---

Q. Who would you confront, for example, about that?
A. There are various levers that we have.

Q. Yes, thank you.
A. One is escalating it to Healthwatch England to say, "Look, this is happening and it is not good; what support can you give us?" The second one is that we do have a right to contact the CQC if we think that things are not right in any of the services and we always give information prior to any CQC visit. We have those sorts of levers. As Chair I also sit on the Health and Wellbeing Board and whether it be about this or about other things I have certainly said on the Health and Wellbeing Board quite vociferously about some things that I have not agreed with, so we do have mechanisms to be able to raise a voice.

Q. Do you think you are listened to by the people with power, politicians, for example?
A. Variable.

Q. Variable?
A. Variable.

DR HIRST: Thank you very much.

THE CHAIRMAN: Thank you very much indeed for attending.

The Witness Withdrew

MS EVE ACORN, Ealing Save Our NHS Action Group, Committee Member

Examined by MS RENSTEN

Q. MS RENSTEN: Could I ask you please to give your name, address and current role to the Commission?
A. (Ms Acorn): I am Eve Acorn. I am a member of the public and I am a patient and I attend the Ealing Save our NHS Action Group.

Q. Could you look at your submission and you will find it at Volume 3, page 1083? Can you confirm, please, that that is your submission?
A. Yes.

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

Q. I want to ask you first of all please about community care services. In your

submission you deal with funding cuts to various clubs and centres. How do you say cutting these facilities will affect delivery of the SaHF proposals?
A. The community centres, unfortunately, the Council are going to have to reduce the subsidy and possibly completely do away with the subsidy to community centres. At present I play table tennis and do short tennis. This helps with my health and I feel that all keep fit activities and also things that stretch particularly elderly people's minds will be very good for keeping people healthy, which is what the *Shaping a healthier future* says, trying to keep people out of hospital and keep them healthy, so I feel that that is part of care in the community.

Q. You quote a figure of £96 million required in Ealing Council. Can you just help us with where that figure comes from, please?
A. It was in the newspaper. Julian Bell, the Leader of the Council, has quoted it.

Q. You say that the *Shaping a healthier future* is premised on increases in community care reducing the need for acute services. Why, in your view, as you have said, is that simplistic?
A. I think it is simplistic because care in the community is almost certainly primary care whereas A&E, when I talk about A&E I mean the proper A&E type 1 rather than the urgent care, the proper A&E, things that happen, accidents, appendicitis, COPD, et cetera, all of that is the sort of thing that only an A&E can deal with. GPs in the urgent care centres and GPs out in the community are not going to be able to help deal with such urgent emergencies.

Q. Just moving on, you talk about seven day GP facilities. Can you tell the Commission what you know about the implementation of those, please?
A. Are you talking about my experiences?

Q. Just in general, yes, on two fronts, one, your personal experience and, two, what you know in your wider role.
A. One thing, I did actually attend a CCG meeting the other day, and I actually spoke to Dr Mark Spencer and told him of one of my experiences that in Hanwell, I rang on a Saturday at 11 o'clock the 111 and I was told that there was no out-of-hours doctor in that area, so I explained this to Dr Mark Spencer and he said he did not know or he did not know where the out-of-hours doctors were, but that there was a service in his area, so obviously it would appear that it is not just not in Hanwell, it would appear that perhaps these out-of-hours are not in other places around the borough.

Q. To your knowledge, are they evenly spread or are they more in some areas than in others?
A. No, I do not have any knowledge other than what I have related about Dr Mark Spencer and of course my experience which is in the documentation that I submitted about the 111.

Q. Just before we come to that, what, if any, comment do you have for the Commission in relation to the closure of Hammersmith and Central Middlesex Hospitals' A&Es?
A. I know that Northwick Park and Ealing have both not managed the four-hour target, they were having to wait over four hours. Do you want me to say about my experience years ago?

Q. If you wish, please do.
A. Some years ago --- no, it was not, it was recently, was it not, December I think it was, I had a problem with my breathing and severe pain in my chest and I went to the GP and the GP said that she thought I might have a pulmonary embolism. She felt that I would be quicker going by car rather than getting the ambulance so she asked whether I could go by car and my husband could take me. Prior to that she said, "Wait, I will write a letter to say that this is urgent because it is a serious life-threatening condition", and she also rang through to the hospital and spoke to the registrar on call and told me that they were waiting for me. When I arrived I gave the letter in and explained that I felt that the doctor was waiting for me, that was what I was told and I was told, "No, you have to wait your turn and see the doctor. He is not particularly waiting for you." So I waited two hours before I actually saw a triage nurse. My husband went up and said, "What's going on? We were told that she should be seen straight away and that she needs an injection?" and I still had to wait another three hours before I was actually sent round to the back. As soon as I was in a cubicle at the back, the doctor saw me immediately, gave me an injection, sorted me out and there was a rush to deal with me and get blood tests, et cetera. So I do not feel the doctors behind the scenes realised what was going on. But it did appear, and I did see quite a few ambulances when I did arrive and every seat was full in the A&E, that it was a really rushed time. If that is the case, if they cannot deal with it then, and that was before the Hammersmith and Central Middlesex closed their A&E proper, if Ealing cannot cope then, at certain times, then how are the other hospitals going to cope with all those extra A&E people in the future if the Ealing and Charing Cross A&E type 1s close?

Q. Can I ask you about something else you have said? You have mentioned Clayponds Hospital. Could you help us very briefly with the service it provides and what you say will be the effect if it get subsumed into the new Ealing Hospital.
A. Clayponds is in South Ealing and it is a rehabilitation hospital. A while back one of the wards closed and they had to actually re-open it because they could not cope and they needed more beds. It is obviously a very necessary facility. The plan under *Shaping a healthier future*, as I understand it, is to close Clayponds and possibly knock it down and then put all the patients into the new so-called local Ealing Hospital. We were also told at one of the meetings, I am not sure whether it was a board meeting or a CCG meeting, that there are going to be 82 beds in total in the new Ealing local hospital, 30 for the normal Ealing patients and then 52 for the remainder patients, which would be divided between Clayponds --- 52 in total is not 70 but those 52 would be divided between the Clayponds rehabilitation patients and West Middlesex step-up step-down patients coming from West Middlesex because there will not be any operations in Ealing in the future and the operations will be done in West Middlesex Hospital, and as soon as the patients are well enough after the operations, presumably the idea is to transfer them over to Ealing, so those 52 would be split. I have asked at a board meeting how many beds were allocated for Clayponds and how many for the step-up step-down and they cannot tell me. I have asked three times and I have not been given an answer.

Q. Can we move on now and can you help us a little bit with your experience of the 111 service. First of all, could you elaborate a little bit on your experience when you failed to have a full postcode?
A. That one? I had had some strange spots on me and I was actually going to help on a

stall to distribute leaflets about saving the hospitals and one of the ladies who was going to help as well was a retired GP and I explained to her about these spots which my husband was convinced were fleas and my son, who has a cat, was quite upset about this said. "My cat doesn't have fleas." However, I explained about these spots and this doctor suggested that she felt sure that because of the position of the spots on one side and along the line of the nerve endings around here that it was probably shingles or almost certainly shingles and that, since I had had the spots for four or five days, it was imperative that I got antiviral medication as soon as possible because after five days that medication is very unlikely to work and so the shingles would be very much more severe. So I rang up 111 out in the street in West Ealing and I was asked a couple of questions and then I was asked, "What's the postcode?" So I said "Well, W13", and I was told, "You have to give the full postcode." I said, "Well, I don't know it but ask me the next question in the meantime and I will see if I can find out from a passerby." I was told, "No, we can't ask you the next question because the computer won't let us", so you have got to go through this system, you have got to answer that before they can ask you the next question and "I can't give you any further advice where to go or whatever until you tell me your postcode." In other words, anybody who does not know their postcode, and probably some people with dementia who are actually in their own homes would not know their full postcode, I have come across people who do not know their full postcode, they will not be able to get the help. Since ambulances can find where people are when they have road traffic accidents, I cannot see that this is impossible. There should be a system where you can give part of the postcode and say, "I am on the main high street, I am near Sainsbury's" and that should be good enough.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much for your presentation. I have one question arising out of the last witness's evidence. I think you have been here and heard the last witness talk about Healthwatch's role. She indicated under A&Es that she made it clear that she did not think the closure, for example, of Charing Cross was one that would have much effect on people in Ealing. However, two A&Es, as you are aware, have been closed without alternative measures being put into place. What do you see is the effect of Ealing's A&E being closed as well as the two that have already taken place?
A. I would like to talk about Charing Cross as well as Ealing, if that is possible.

Q. Yes, certainly.
A. If you could repeat that question later because I tend to forget things.

Q. It is my fault, I will put one question at a time.
A. Can I say my bit about Charing Cross?

Q. Could you include West Middlesex as well?
A. About one and a half years ago, because I have got breast cancer and I had radiotherapy, I had problems with my chest and I was admitted via the A&E to Charing Cross Hospital and I was put on the oncology ward and I saw the oncology team. If Charing Cross A&E, and it was a proper type 1 A&E who admitted me, obviously, if

there were not a proper A&E there, I would not get on to the oncology ward (in fact, they are going to close loads of beds anyway) and I would not see my oncology team, so that is fragmentation and I just wanted to bring that point out. Can you repeat the other question?

Q. The second half of it was really if you put on top of that the proposed closure of Ealing A&E as well how you see the effects on the community.
A. Well, as I was saying, when I had to be admitted and I had to wait five hours, if A&E in Ealing was closed, there would be all those people who would normally go to A&E proper, they would have to then go to other hospitals and, as I understand it, the other hospitals' A&Es are already full, so there would be a big problem with other hospitals trying to cope with all the extra number of type 1 A&E patients.

Q. DR LISTER: Just briefly, you talked about operations having to take place, after Ealing loses the acute services, in the West Middlesex, and I think you are the first person who has talked in those terms about West Middlesex. Most of the other people have talked about the link being to the hospital Ealing has merged with, which is Northwick Park, as the alternative. From where you are, what are the logistics of getting to West Middlesex? What would you see as the implications of using West Middlesex rather than Ealing Hospital?
A. As far as I am concerned, it would be very difficult for me to get from Greenford to West Middlesex. Is that what you meant, the travel of it?

Q. Yes.
A. Yes, it would be very difficult. I certainly have no idea how to get there by London Transport. I am sure my husband knows exactly how to get there by car but he would not know how to get there by London Transport either and since he is often in the car up in Northwood where we happen to be building a house, he does most of the work himself and he takes the one car we have, if I am on my own and there was an emergency or anything else I would not be able to get to West Middlesex. I would not have a clue and I am sure lots of people would not have a clue how to get there. In fact, with that 111, if you remember, I was told to go to West Middlesex Hospital in the first place because there was not an out-of-hours doctor in Hanwell and I said, "Well, I do not know how to get there. I know it is at least two buses from here, what is wrong with Ealing Hospital down the road." The 111 people taking the call did not know obviously, possibly they were up in Leeds or somewhere, I do not know where the centre is, but they certainly did not know the geography of Ealing, the West Mid or anywhere else.

THE CHAIRMAN: Thank you very much indeed.

The Witness Withdrew

DR K, Formerly Ealing Hospital

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your name, professional address and current post held?
A. (Dr K): My name is [name given]. My professional address, I currently work at

(work address given). My address is (home address given).

Q. What post do you currently hold at that hospital?
A. I am currently a GPVTS year 1.

Q. If you look, please, at Volume 4 which you should find somewhere in front of you, if you would turn to page 1383, please. 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, it is true.

Q. Can I ask you first of all just to help the Commission with a little bit about your practice and your specialisations, please.
A. I am doing a Masters in Public Health at the London School of Hygiene and Tropical Medicine. Previously I was working in medicine and surgery as an SHO, so ST1/2 level hence I worked at St Mary's in Paddington, Charing Cross, Ealing, all over the area, and Northwick Park as well, both in surgery and medicine and now just because I do want a career gap I am doing GP training.

Q. Do you have direct experience of working in A&E at any of those hospitals?
A. Yes.

Q. Which ones, please?
A. Ealing, Northwick Park and as in once the patients come into A&E they refer on to the surgeons or the physicians and I have been both a physician and a surgeon so I have seen patients come in that way.

Q. Just in terms of first of all with Ealing, can you give us a flavour of what A&E at Ealing is like, please?
A. It is incredibly busy. You have got lots of patients coming through the door. You have got lots of people who have mental health problems. One shift I remember a patient with mental health problems jumped in the river, so you have got lots of really sick people. We have also got a very fluid immigrant population. People come from all over the world, mainly Somalia in Ealing, so you have got a lot of mixture as well and you have got lots of interesting pathology so they come with very sick problems.

Q. What can you tell us about the A&E composition at some of the other places, for example Northwick Park?
A. Compared to Ealing it is quite far away and it is also still very busy. You still have a large number of people who go and see this. The area that these A&Es cover is quite large and as we have got an ageing population people are getting sicker and they are coming with more problems and their illnesses are not just one tablet, go home, they are going to come with problems that will need acute medical beds, maybe an ITU bed and they will need more work than say someone who is 23 with a cough.

Q. Obviously you said that you have studied health economics. On that basis, can you help us with why it is you say that merging A&Es may not actually provide better outcomes?
A. I have brought my book, it is in my bag. It is from the London School of Hygiene and

it was updated maybe a year ago and we have got years of evidence, not one year, not two years, maybe 20 years of evidence from the States and worldwide which shows that the best number that hospitals should run on is about 300 beds. When you merge hospitals this is a bad idea because then you get inefficiency and it is inequitable so you have both problems running side-by-side. It is not something I have made up at 31. This is evidence of numbers of years that go ahead of me.

Q. In terms of Ealing specifically, and in terms of the A&E, what do you say would be the impact of, it has been variously characterised as closing it or changing it? What do you say would be the impact of that?

A. As I have detailed earlier, we have got a highly immigrant population, we have got lots of people that come from abroad and come back and move around. We have got a huge mental health centre and also because of previous policies we have got a large number of people with mental health problems that live outside of Ealing Hospital. Closing or changing the A&E will be detrimental. I am lucky, if I get sick, I am a doctor or I can go to one of my friends, I can see someone privately and I will get an appointment within maybe ten or 15 minutes. When you have got someone who is very vulnerable with no money and very little education, Ealing Hospital A&E is their lifeline and I think by closing it, by changing it, by making them go on a long journey to another part of London will probably kill them, effectively.

Q. In terms of the unit which is going to be replacing the current A&E, variously described as an urgent care centre or still as an A&E, what is your understanding of what services it will provide?

A. I am not entirely sure because, as I am sure most of the people in this room know, everything changes every week, especially with a General Election coming. We get a new story, new theory, new idea. I am really at a loss and I genuinely think what we should do and I hope what this Commission finds is the necessity to keep our A&Es open, especially at Ealing.

Q. If there is an urgent care centre at Ealing and it is not co-located with an accident and emergency department, which can take for example blue light ambulances, what do you say the impact will be on the local population?

A. I think it will be incredibly detrimental because a lot of people do not realise when a hospital does not have some services. I have personal knowledge where we do not offer in the same hospital maternity services and you have pregnant women who turn up only to be turned away to give birth in the car park. When you remove A&E from a place and make it urgent care, if someone came in off the street not in a blue light ambulance but with a cardiac arrest, you have got a very short window to deal with it, and I think again it is going to be awful because the most vulnerable people are the ones that are going to suffer. They are not aware of what they can have in what places.

Q. If Northwick Park has an extended and expanded A&E, does that not fill the gap that you are talking about?

A. Completely not. You are saying if I had mental health problems, I am a paranoid schizophrenic, I now have to take three buses to this place with no money, I then by the time I rock up have maybe a window of five minutes to be seen by someone to recognise that I have an acutely unwell problem. Again, if you are merging places, you are going to have a large volume of patients with the same number of doctors that are then going to be

A listed to go to see a physician, to see a surgeon, but when I worked in places, I now work in a hospital where our other local A&E has shut down, there have been no provisions made in medicine or surgery to have more doctors seeing the people coming from A&E yet the workload has doubled. What that means sadly is if someone is acutely unwell and they have not been seen to with urgency or the nurse has not picked up that they are urgent or A&E have not said this patient is acutely unwell, people die.

B Q. Can you help us with your view about the out of hospital services and the suggestion or premise that by increasing these the need for acute services can be reduced?
A. I think it is really difficult if you have got an acutely unwell problem to then be treated in secondary care. No-one says, "Don't worry, in two months I am going to have a heart attack. Can I come in and get a statin or can I get a tablet?" People get unwell and it is unexplained. If we knew exactly what we are going to get before we get it that would be great. I would love to know when I am going to die; I can then plan C accordingly. A lot of times when someone is acutely unwell, it is a surprise, it is a shock. Death comes and no-one knows it. Okay, if we help the morbidity of the people around us, yes, we probably could help mortality. There was a study a few years ago saying everyone should be on the magic four pill, give everyone a statin, an aspirin, a beta-blocker and we will reduce heart attacks. Yes, we could, maybe ten or 20 but we would not have the reductions in 100 people or 1,000 people. People would still be acutely D unwell and they would still need access to an ITU, an emergency physician and acute medicine. You cannot just give everyone one tablet or one shake of a hand and hope everyone is okay. That is not how life works.

Q. Finally from me, do you have any comments or views about the closure or continuation of the maternity unit at Ealing Hospital?
A. To be honest I have never been involved in maternity services at Ealing so I would E not be best placed to comment on that.

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

<u>Examined by THE COMMISSION</u>

F Q. THE CHAIRMAN: Good afternoon. Thank you. I want to enlist your help on health economics. First of all, health economics I presume, but correct me if I am wrong, embraces more than just the cost of medical provision but actually should be looking at the social cost as well; is that right?
A. It should be, yes.

Q. I want to move to the next question. We had evidence last week and I put this G question to an earlier witness, although I think you were not here at the time, that a member of the Royal College of Surgeons Mr Jonathan Ramsey - you may or may not know him - indicated that he has intimate familiarity with standards at A&E and he indicated that at one point there were no standards but that he was part of a body that set standards within the recent few years after the scare of weekends not being covered. Are you aware of the minimum standards that were set by his board or not?
A. Not by his board but I know that the one main standard is every patient should be seen H within four hours at A&E or have a decision made.

Q. That is one criterion. There are two others that he mentioned and this is where the health economics is going to come in, I think, besides the time. He was suggesting that really it made sense, that is the word he used, it would be sensible to co-locate expertise so that you would have an on-site consultant, which was part of the problem highlighted in the media, an on-site consultant co-located with, for example, radiology facilities. In order to do that what he is saying about sense is you therefore bring those areas of expertise together in one centre. The point I was trying to put to him was whether in fact it should not be contemplated that all A&Es have that facility. I think there is a tension here and I just wanted to know the answer, if you have one. Does it make sense economically to have the same facilities and high standards at each A&E rather than centralising?

A. Completely. I am completely against centralising and I think from all the A&Es I have worked at you do have radiology on-site. As doctors we are not diagnosticians as they are in the States (where I have also worked) where someone comes in, you do a full body MRI and CT. We are socialist healthcare so when someone comes in as a clinician the whole point of a doctor is to examine them. When you centralise you take away things so you are saying this person may need this, however, we do not have those facilities so we are going to have to send them to another place and then you deskill people so if someone came in off the street who was unwell as a doctor because you do not see that you would be, "I don't know what this could be. Go home. I am sure it is okay." As of now all A&Es do have if they are not on-site radiologists you can call the consultant in from home and everyone at their home has access to their screens and they can actually see scans and report on them and you can call them up and say "There has been an urgent scan, can you tell us what the report shows or what the scan shows?"

Q. So on the basis of health economics, health defined as I did at the beginning, it is not going to cost more to have the same facilities I have just described at all A&Es?

A. Because it already exists in the infrastructure. Every hospital has a radiology department and every hospital has a radiologist consultant and registrar and they are all on-call anyway. They may not be on-site at 2.00 in the morning but they are only a telephone call away and they get paid to answer their phone and look at the scan. So if you are saying instead of them being at home you want them to be on site, we are already paying them to work from wherever they are in the world, they still work and they are being paid, so if you said actually we want them to come in on-site, we think that is going to reduce waiting times, that is going to reduce the time it takes for a report to come through, we are already paying for that service and that should be fine. If only health economically, yes, it makes sense for them to be on-site.

THE CHAIRMAN: Thank you.

Q. DR LISTER: Continuing on this theme about centralisation of services, I am presuming when you say that you are against centralisation you are not including stroke and trauma where they already have done that and obviously that has worked? You are talking about the broader sweep?

A. Yes, I am talking about people coming in and saying this is not an A&E, go 20 metres down the line or 12 miles away, like that.

Q. Let's take West London for example, if you were going to be talking about

centralisation then the health economics side of it means that you would be talking about not just centralising the flow of patients but you would have to centralise the availability of beds and resources and you would be talking about an enormous hospital?
A. Yes. And when you talk about that, as I have already discussed, from published literature which they are using to teach public health/health economics, hospitals greater than 300 beds are not efficient and they have said when you merge hospitals and you have lots of managers, what the studies have shown is it becomes more inefficient because now everyone thinks someone else is doing something and someone else is doing something else. That is again not a Dr K thought; it is evidence.

Q. You did refer right at the beginning to a book with some statistics.
A. It in my bag actually. It is health economics.

DR LISTER: Could you make that available to us? That would be really helpful. (Same handed) Thank you very much. I am not going to read you that and ask you another question!

THE CHAIRMAN: You will get it back at the end.

Q. DR HIRST: I am afraid mine is just a very short question along the same theme. Again Jonathan Ramsey and others have spoken about this need to centralise not only because of the investigations but also because you have to have a back-up of individual specialties. This is again because we no longer train general surgeons any more and basically they are abdominal surgeons, are they not, and a so-called general surgeon will only go so far and also, for example, we now have the duty urologists. When I qualified we did not have the duty urologists. It was handled by the surgeon on-call. Firstly, do you think, yes, we do have a need for each hospital to have those sub-specialties on call or in the hospital, and, secondly, from your personal experience working at Ealing in A&E, have you ever felt short of those huge specialties, felt vulnerable because you could not call on one of those particular sub-specialties?
A. With the first question I was working at Barnet Hospital where they have merged with Chase Farm and Chase Farm has lost their A&E so if anyone comes acutely unwell to Chase Farm they get immediately sent to Barnet. Unfortunately, I had a patient, I was doing general surgery night shift, who came in with a torsion of his testicles and he needed an urgent operation. His fertility has dropped by 50%. If there was an A&E in Chase Farm he would have had that operation straight away.

Q. If I remember correctly, it is alert theatre when a GP rings in suspecting one, is it not, it is that quick?
A. Yes. Okay, he is still alive, he did not have cancer, but I would not be happy if that was me. He was so nice about it. He was, "What can I do? It happens." So, yes, I do think all doctors should have a core set of skills they should know. What I mean by that is it is not good enough if you are a surgeon to say you cannot read an ECG or you do not know how to do an ABG. Every doctor should have maybe 30 things that regardless if they are the consultant or they are an F1, so they have just qualified or they have got 50 years of experience they should know, because I think then what is the difference between someone having a cardiac arrest in front of a lay person and a doctor.

Q. So when you were working at Ealing, you felt, where nowadays an acute torsion

would be done by an urologist, but of course you would expect any surgeon to do that. At Ealing did you feel exposed that you did not have that back-up?
A. No, because even now, say in other hospitals, the only general surgeons, the one urology thing they should be able to do is a torsion. It is one of those skills that they have to have and if they do not feel confident they have to call the consultant in. At Ealing when I worked there both in general surgery and in general medicine, I never felt exposed. I knew that I had got senior support that will come in and will cope. Because at the end of the day, especially as a doctor, it is not about my feelings or my heroics; it is about patient safety.

DR HIRST: Thank you.

THE CHAIRMAN: Thank you very much indeed for your help. (Applause)

The Witness Withdrew

MR COLIN STANFIELD, Ealing resident

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your full name, address and your current role?
A. (Mr Standfield): My name is Colin Standfield. I live at 20 Balfour Avenue, Hanwell W7. My current role as an unemployed person is a fairly full-time activist on behalf of the hospitals in North West London.

Q. Could I ask you, please, to have a look at Volume 3 and it is at page 1093? That should be your submission.
A. That is very much like it, yes.

Q. Can you confirm that it is true to the best of your knowledge and understanding and that you wish it to stand as your evidence to the Commission?
A. It is true but it is now three months out of date and I have brought a couple of the slides updated to the figures which were published on Friday of last week, if that would be helpful

Q. Could you first of all explain in brief terms what it is you have been monitoring over the past two years?
A. I have been monitoring certainly over the past year's worth of data the attendances at A&Es and type 3 emergency facilities, the waiting times for type 1 and for all other attendances and I am starting to do the same for admissions from those departments.

Q. As I understand your submission, it consists of a slide form presentation that was made to the People's Inquiry, is that correct?
A. That's correct.

Q. Can we just go through some of the key features of it, please? First of all, what is it that you say about the closure of Hammersmith Hospital and Central Middlesex Hospital's A&E being necessary or not on the grounds of clinical safety?

A. The story we were told was that it was on the grounds of clinical safety. The *Shaping a healthier future* had spent months and £4 million on the McKinsey organisation coming up with the proposals in a pre-consultation business case which ran to 1,162 pages and a decision-making business case that ran to over 2,000 pages and the Independent Reconfiguration and "Don't Rock the Boat" Panel came along in a couple of weeks and said, "We think that these two hospitals may be unsafe", and it struck me as slightly unusual that after all the years that the same people were working on behalf of the community in developing the hospital that they should come up with a plan that said over five years we might wish to close four A&Es, that these people came along and said we had better do it now. I think that is what they wanted to do and I think they took their cue from the Scottish Play and said: "If it were done when 'tis done, then 'twere well it were done quickly: if the assassination..."'

Q. After the Shakespeare could I ask you to pause a little bit and move forward because I am not sure people are getting your voice. I would not want people to miss more Shakespeare.
A. That is all the Shakespeare I have got today!

Q. Moving on from that, what is it that you say about the clinical safety of those organisations? Are you able to comment on that?
A. I am not clinically competent to answer that. What I do know is that we should have been assured that the hospitals were safe. I think what happened was that the *Shaping a healthier future* team took advantage of the fact that the IRB had put this in more as a footnote than anything else and decided to close it. When I asked Dr Spencer, the Medical Director for *Shaping a healthier future* why that should be given that there had been numerous assertions and reassurances that nothing would happen in terms of closing A&Es until all of the work in the community was in place - and I cite a number of those in my document - he said to me, "We were advised to close the A&E department at CMH and the emergency unit at Hammersmith earlier than we had originally planned." So that meant that it was done in a hasty, unplanned fashion and he said it was too early to see the extent of reductions caused by improved community and primary care which are still in their early stages, so everything we were told about replacing A&Es with this wealth of community and out of hospital care did not happen when it came to the closures of those two hospitals. I think they were done in haste because it suited their programme and they had this Independent Reconfiguration Panel footnote to say that is something you should do.

Q. Did he indicate where the advice came from?
A. He did not, he said "We were advised..."

Q. Were you able to elucidate anything further?
A. No, my correspondence with Dr Spencer is sporadic and mostly one-sided, I am afraid.

Q. You also talk about funding investment in out of hospital services and you discussed a figure of £190 million. Can you help the Commission with where that comes from and what it is that you say those funds will be available for?
A. The figure moved from £120 million in the pre-consultation business case. Dr Spencer told the *Evening Gazette* it was £138 million over three years and we have a figure of £120 million in a summary of the business case. Then suddenly in the decision-

making business case it had grown to £190 million, so I made some enquiries of the team and of Dr Spencer of where this £190 million came from because it kept being represented in different forms - it was accumulative, it was recurrent and so on - and after a series of emails I got to the very helpful and very clear statement: "The out of hospital services' investment will have accumulated to a recurrent £190 million by 1917-18. This means that each year new money will be invested. The total invested will increase and by 2017-18 we will be spending £190 million more on out of hospital services each year compared with now." I hope you followed that because I cannot understand that, but that is what they were planning to spend. That is an awful lot of people if most of that is going on staff. Looking at the HSCIC data ---

Q. Pause there, could you state the name rather than the acronym.
A. Sorry, I will have to go back a page. It will be the Health and Social Care Information Centre.

Q. Thank you very much.
A. The average salary in the NHS is £30,846. If you add on something like 22% for on costs, an average person will cost you £37,000. £190 million would buy you 5,048 of those, which would mean, if for example, they all went in North West London into doctors' surgeries, there would be 11 extra staff in every single surgery. I have not seen that. If some of them were in the community, you would have three or four extra staff in the GPs' surgeries and a load of people in the community somewhere in a building running something, but I have seen none of that because I think that figure was a pure fiction. They wanted to have a figure in there to reassure people that they were doing something in the community when they were closing hospitals and they obviously could not put in a figure with ten digits because £1 billion is what they were expected to save from the budget. They could not put in a figure below £100 million because how on earth could you replace four A&Es with a figure of £80 million, so I think they invented £120 million from nowhere and it crept up to £138 million, it crept up to £190 million and nobody has explained where that would come from. If you look at the business cases for the individual CCGs, you will see figures of around, it is always £18-£21 million for this, but no-one has specified what this will go on other than "mostly on staff". I do not think that is a basis for closing four hospitals because they had no idea what these new services will be. I am not aware of anything that has happened in my part of Ealing. I am aware of some pilots and trials of services, there is an operation called Stars running in Brent which works in the community, but I have no idea where they would spend £190 million. I do not think they could get the money away but that is the figure they have given us.

Q. Moving on, thinking about accident and emergency attendances in North West London, are you able to help from your documentation and your updates whether those are rising, decreasing or remaining static?
A. I would say they bobbled along. There is nothing in the original NHS Act that said that patients had to line up in an orderly fashion and book their attendances so that there was a smooth curve of attendances, so, naturally, they will go up and down, but the general trend is around the average. There was a slight rise just before Christmas of last year and there was a slight rise in June and August but, generally speaking, the charts simply show that the attendances bobble along, up and down, and it is the same as in the document. I would not say there were any great changes. Certainly for Ealing and Northwick Park it is more or less a flat line, so attendances are not a problem.

Q. What do you draw from that in terms of the attendances? What relevance do they have?
A. I draw from that the fact that where you have more or less stable or cyclic and seasonal attendances, you should not have a massive drop-off in performance after September of last year when two A&Es were closed. The drop-off happened nationally and across London as a whole but it happened an awful lot worse in North West London and massively worse in Ealing and Northwick Park. Of course Northwick Park bore the brunt of the closure of Central Middlesex.

Q. Are you able to help us with up-to-date figures about whether that is still the case or not?
A. It is still the case that Ealing and North West London languish a long way below the London average and they languish much further below the average for London when you take North West London out and they are well below the England average for type 1 waits to 15 March 2015.

Q. I want to ask you now ---
A. Sorry ---

Q. Do go on.
A. And that is with the inclusion from 12 December of the new A&E unit at Northwick Park which is no bigger than the old unit at Northwick Park. It has exactly the same number of beds.

Q. Can you help us with how many beds that is?
A. I think it is 20 beds but I would need to check.

Q. Are you able to say definitively that that is the same number of beds?
A. It is the same number of beds. It has been reported in the *Brent* and *Kilburn Gazette*, I think. I am fairly certain it is the same number of beds but they are saying they work in a different way. This is always the case that you say there are not as many of these and people say "Ah, but it will be working better because something else will apply." I do not know what it is that is supposed to apply, but I do know that in the week after the new unit opened it recorded its worst ever A&E performance. That may be teething troubles but I do not believe in the Health Service you should ever, ever use the excuse of teething problems.

Q. I want to ask you about ambulance waiting times, please. You seem to suggest that there is a failure in ambulance waiting times at the moment. Is that part of a London-wide phenomenon or is something else going on? Is it particular to this area?
A. There is certainly a London-wide shortage of paramedics and they are being currently recruited mostly in Australia and New Zealand. There is a problem which is difficult to pin down because I do not have access to the data, but it is known that ambulances are waiting on ramps more than they used to. An ambulance waiting on a ramp means that three patients are waiting. There is one in A&E waiting, there is one on the ramp waiting and there is one waiting for the ambulance that is on the ramp to get to there. They are in short supply and the Ambulance Service in London (LAS) are acutely ware of the problems of recruitment and availability of paramedics. Having A&E backing up is not

helping that. It is a perfect storm that ambulances are taking people in and of course at Northwick Park with their new A&E since November, the month before the new A&E started, they have been doing a postcode allocation of patients coming in, so if you are in NW6 or NW10, the ambulances will not take you to Northwick Park, they are told to take you to St Mary's. Ambulances are required to ring in advance into Northwick Park before they bring anybody in. There are doctors in South Brent who are being told not to refer patients to Northwick Park. They are tipping out patients who desperately need beds to Mount Vernon Hospital and Willesden Community Hospital because they do not have the bed capacity in Northwick Park and having cut beds, as a result of *Shaping a healthier future*, they are now desperately putting them back. They have put 48 in.

Q. Pause there. They put 48 beds in where, please?
A. Somewhere in Northwick Park to take people. I was simply given a list of beds, 10 in December, 10 more in January and it will be 48 some time soon and some new portable units will deliver another 50 beds, I think it is some time later this year.

Q. Can I just check that I have understood your evidence correctly which is that beds which have been taken out as part of the SaHF programme have now been reinstated. Is that correct?
A. They are now desperately reinstating beds at Northwick Park.

Q. One of the other things you talk about, it may be this is linked, you talk about cancellations in elective surgery and you seem to draw a causal link between that and the closures of accident and emergency units. Can you explain your reasoning around this?
A. Yes, if the accident and emergency units close and put pressure on the remaining services, which is my thesis and I think I have the evidence for it (graphically I do), that means that people are increasingly filling up A&Es and within the four-hour waiting time, particularly for type 1s, the more serious cases, they are struggling to do anything with them in the four hours because of the numbers going in rather than the quality of what is there to receive them. So the four-hour limit is for discharge or treatment or for admission and what they always do is admit when they come close to the four hours. It is known on data running up to August last year that 51% of admissions from type 1 A&Es occurred in the last hour and of those 44% were in the last ten minutes, so that is what happens. In A&E when you get crowded, you try to admit. If you have not got beds to admit people to, you end up with a pressure on beds and so what happens then is that in the evening of the day before a planned operation, a group of people will sit down and decide to cancel them. Hospitals are not supposed to cancel elective operations, certainly not on the day, which is why the meeting is held the evening before so it is on the day before so it is operation cancelled in advance technically, not that the patient would recognise that, so after the closure of the A&Es, I was hearing stories anecdotally of operations being cancelled at Ealing and so I asked Dr Spencer in an email why this should be because an email had gone around saying there is great pressure on beds and services so please will everyone get people discharged as quickly as possible. He said to me that this was having no effect on planned operations. I asked under Freedom of Information for planned operation cancellations for that week, which was I think the 19th and the following week, 26 September, and there was a total of 29 planned operations cancelled for lack of beds. In the first quarter of this financial year, Ealing cancelled 22 operations for all causes for the whole quarter, so in two weeks they had cancelled as many as they had cancelled for all quarters in the first quarter. Because I thought I

needed to get this for the whole of North West London I put a Freedom of Information request in on 11 November to all of the trust to ask for their planned operation cancellations for the period covering September and October up to early November, the date of writing. As usual with FoI requests at North West London, nothing happened for 20 days and what came back was a mish-mash of disparate data. What I can say in the interim, having had a letter from the Deputy Chief Executive of Northwick Park, that 29 figure for two weeks in September came down in his letter to 13 for the whole month and in my FoI request in November it came down to six for the whole month. I have not been given an answer as to why the planned operation cancellations should have been, I would say, massaged downwards because that is an indication of the A&E pressure. I cannot tell you what the planned operation cancellations are across London because the data are so badly presented. I cannot trust them.

Q. Can I ask you just very briefly now what, in your view, are the risks, if any, if the current proposals for SaHF globally continue to be rolled out?
A. Having seen half of it I would say it will be twice as bad as it is now. If Northwick Park can plunge to a level of 51% of type 1 A&Es seen within four hours on one day, 16 February, then that means that the whole system is under pressure. It may not be only as a result of the two closures, but I do not know what else can be responsible for that significant effect, given that certainly in North West London and certainly in Ealing and Northwick Park the number of attendances is not the problem. There is no increase in acuity, which is the latest spin that they are putting on it, that people are sicker now. The only ones who are sicker are the ones who have had to wait longer for an ambulance and they are looking desperately for some reason to explain why people are staying longer in A&E and are being admitted and they are saying a rise in acuity. There is no data for that at all but that is what they are saying.

Q. Just thinking on the other side of the coin if the proposals are rolled out, what, if any, positives are there from that?
A. None that I can see. I have heard you discussing this idea of centralising. Centralising specialist care in larger units works for a very small number of conditions. It works obviously for burns. It works for major trauma. I tend to disagree over stroke because the development of hyper-acute stroke units went along with an increase and more widespread availability of thrombolysis or clot-busting drugs, and I would say rather than flog all the way to a hyper-acute stroke unit, you are much better off getting a paramedic to administer thrombolysis, which can be done under NICE and under NHS guidance. Okay, I will take the position that everyone else seems to take that having hyper-acute centralised stroke units has helped but I think it is a marginal thing. Obviously for trauma and burns it helps, but for everything else, and it is about 96% of cases, it is not worth passing even a mediocre A&E to get to a specialist unit with all the bells and whistles. Most A&Es are perfectly good. I do not actually want, I have to say, a world-class A&E at Ealing Hospital. I want a competent, London-class, Hanwell-class A&E at Ealing Hospital and I think all hospitals should do that. If all hospitals did that you would not need to pass them and you certainly would not want to pass them for conditions that are not better treated at these super hospitals. Conditions like anaphylactic shock, cardiac arrest, asthma, choking, drowning, hanging, all sorts of conditions are much better treated at a wide availability of good district general hospitals and you do not need this centralisation. Centralisation means people are travelling longer and we know from evidence submitted by Professor Nicholls from Leeds that that leads to worse

outcomes.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much. Two questions, firstly, in relation to your point about wanting a competent, essentially local A&E hospital, is that to be geared numerically to population or some other criteria? That is the first question.
A. Generally speaking they are and at the moment the boroughs in North West London are on the England average for population per hospital. If they take four out we will be up to something like a quarter of a million per hospital from something like 180,000 now, and it seems to be somewhere around the 200,000 level, but you can argue the case in a number of different ways. You could say you could manage a half a million population and then you would need to know what else you need to build in, but it seems to be that about 200,000 per hospital is reasonable.

Q. A supplementary to that: is the figure in fact dependent to some extent on the demography, in other words, the nature of the population being served, you could have a much smaller population needing an A&E than a bigger one.
A. I doubt that the differences would be substantial. You would be predicating a huge population of people over the age of 70 or 80 or a huge population of very sick people. We do have pockets. I did hear somebody talking about TB.

Q. There is a pocket here possibly.
A. There are parts of Ealing which would rank in the top 22 countries in the world for TB incidence, so, yes, TB is a massive problem in parts of Ealing.

Q. The second question is something quite different. Having spent, as you put it in part of the summary of your submission, two years or more monitoring the reform proposals, I want to stand back for a minute and ask you this question - and if you cannot answer it please say so - and that is, on reflection, do you think in fact something needed to be done or not, if you follow the question?
A. I do follow the question. I think that something needed to be done if the data were correct about the problems that they had. I do not trust all the data that they produce. If there is a problem with lack of consultant cover then you do what Nye Bevan said and stuff their mouths with gold to make sure that you have consultant cover. If an Agenda for Change or some other bureaucratic structure prevents you from paying bonuses to A&E surgeons or radiographers or whatever it might be that you are short of, that is a management issue. The whole problem in North West London that was summarised in great length in the two volumes of the business case, is a management issue, and it should not have devolved to, well, the easy way out of this is to take all of the consultants and divide them into a smaller number of hospitals; job done. That is not how you do it. We know that those things are wrong. We know that does not work when you start trying to plan for recruitment of people. It happened with nurses. They said we will not need so many nurses and they stopped recruiting nurses and now they have a nurse shortage. You do not do it that way. You say what do we need to have in this hospital? If we need to have a rota which has seven A&E consultants, or nine or 11 or whatever it might be, to

cover the hours of daylight and the weekends. That is what you do. What you do not do is say we seem to be running short of consultants over the last few months, let's close a hospital and shove everyone over there because the problems you then get are much, much worse than having a consultant on the end of a telephone. So I think something needed to be done if the problems were as they hinted, but think never give data on what the problems are.

THE CHAIRMAN: Thank you very much.

Q. DR LISTER: Colin, you have been following this for a long time I know and of course it began before the CCGs were formed, it began under the so-called NHS North West London and the grouping of PCTs?
A. Indeed.

Q. And it is now they call themselves the North West London Collaboration of CCGs and with some involvement of Dr Mark Spencer which is now part of NHS England, London area teams so there is kind of a bridge over.
A. He is part of the furniture.

Q. Yes, that is one way of looking at it. They have produced these enormous volumes of apparently now completely superseded business cases, but I seem to remember at one point you identified why it was that nobody on the boards of these various bodies and collaborations had actually read the whole of the business case. Can you remember what that example was? It was an example that you gave.
A. Yes, it was at the meeting of the Joint Committee of the Primary Care Trusts in February 2013 when they were debating the decision-making business case and I asked them to put their hand up if they had read all of it and nobody did and subsequently I was told, "Ah well, you were just conducting a straw poll and no-one was interested in playing." I think they did not put their hands up either because they had not read it or because they probably thought I had a follow-up question which would have put them on the spot. I had read it, tedious though it is and chaotic though it is in its pagination, but I wanted to see what was in it and what I found in it was a number of inconsistencies and a number of lies. The egregious lie which occurs six times in the decision-making business case is "National evidence demonstrates that home birth is safe and recommended". I looked everywhere for any document that suggested that home birth was safe and recommended. Home birth is safe where it is safe. Home birth is safe for a woman who has had children before, who has no pre-existing conditions and who has, according to the Royal College of Obstetrics and Gynaecology, rapid access to obstetrics if needed. To say that home birth is safe and recommended and there is evidence for it is a lie, and I challenged them and they did not come up with any evidence, except a number of people saying it is awfully good to have home birth as an option, which it is. That was the sort of thing that was going into the decision-making business case. Lots of assertions about what was going on, but no facts, no data, no research cited and it happened in the foreword to the consultation document where they said "We believe that more care in the community produces better outcomes". Not a shred of evidence was cited. I think if you look through my submission, I have not actually attributed all the graphs to the unified data set that comes from the NHS, but everything I say comes with an acknowledgement of the source. They do not tend to do that. They tend to rely on airy statements about, "We believe it is better to have care in the community than in hospital". Where? What

are the outcomes? Where have they tried this? It is never there. Yes, I did read the business case. I found it flawed and I found an egregious lie and they refused to accept that they had actually overstated the case. I do think home birth should be an option. My child was born in the middle of nowhere so I know it can work, and it should not be a medical condition, but they do need to have access to obstetrics and having one in the next borough is not good enough. To have the possibility that no child will be born in Ealing ever again other than children born at home or in toilets of pubs to desperate teenagers is not a situation which I would call a "healthier future".

Q. Can you remember out of those thousands of pages roughly how many you would think were actually discussing proposals for community-based services to replace the hospitals?
A. If I were to be glib, I would say three or four. Not very many. I do not think there is anything in there that suggests what the nature of out of hospital services would be five years after they wrote that plan because I do not think they knew, I do not think they had any idea of either that or how much money they were going to spend on it. I think they picked a number that seemed reasonable and they said there would be a number of programmes, but I have no idea. I really do not know and I do not think they know what kind of out of hospital care provision they are going to put in place to replace the services of four A&Es, which are all the four central ones in their area.

Q. Why do you think it is that people who obviously have some record of involvement in their own local health services and so on, Dr Mark Spencer, a local GP and so on, why do you think people would be pressing ahead with a policy on such a flawed foundation?
A. I call it the "Georgie-Porgie Syndrome" so they can sit in the corner and say "What a good boy am I. I have saved £1 billion for Mr Hunt."

Q. Will they save £1 billion?
A. I do not think so. Of course they will not. It is just specious mathematics that they like to indulge in. There is no way that they will save £1 billion out of the health economy unless they want to do it in a way that reduces the services to people and increases the risk to patients even more than they have done already. They cannot take £1 billion out of the health economy in North West London and not suffer appalling consequences.

Q. DR HIRST: I am afraid you might feel my question is frivolous and perhaps you have already answered it, but it is surely to extend the Georgie-Porgie Syndrome, I am trying to understand why we have got this juggernaut moving and it is impossible to stop. Like Dr Lister I know many of these people to be hard-working, sincere, good people. Maybe I am not taking the Commission down a byway because maybe it is important for us to understand their thinking. I think you are the person closest to them. Is it a matter that it is like group cognitive dissonance?
A. Yes.

Q. Oh it is?
A. It is. The people that put together *Shaping a healthier future* are the people who have been running health services in North West London for ten years. They then said, "This is appalling. Look at those two hospitals, they are unsafe. Look at those two hospitals, they are unnecessary. But we have the answer." To me that is rather like the German

submarine rescuing you from the ship that you have just been torpedoed in. They come along and say, "We have been running this all these years. It is a mess but we know how to get you out of it." I do not think that they come at it from the right angle. I think they are probably burdened by their past. I think they are not aware of the problems that they have created and what they are looking at is a problem that they think somebody else has created and they can do something better for it, and I do not think they can, not by taking the easy option which is to chop out some hospitals and save some money. You do not save a lot of money by chopping out A&E. You only save money by chopping out other things as well. A&E represents 2.65% of the London NHS budget so it is a very small amount of the total amount of money spent on the NHS in London, so taking out A&Es does not help you very much, especially when it is only four-ninths of it, but it does help if you can then take out paediatrics and general surgery and all the other ancillary services and then particularly if you can knock down a hospital and sell it for flats to investors from Dubai and put up a shed with some diagnostics in it and call it an emergency centre, which is the latest I have heard for the Ealing site. It is not going to be an A&E. Dr Spencer said in an interview a couple of months ago that it would be an emergency centre but not an A&E, no blue lights. But I do not know what it is going to be. Nobody knows what is going to be on the Ealing site. I challenge anyone to tell me what will be on the Ealing site in four years' time.

Q. Can I push this a little bit further then? I suppose my real question is who are the decision-makers here because every time you confront them with an untruth or an inconsistency or something that is not congruent you get, and we have heard earlier, "I am advised that ..." "I am told that ..." Who are the decision makers in the hierarchy? Does it go all the way up to Mr Hunt that is directing things? Who is saying this has got to happen?

A. Well, the decision-making authority appears still to be an entity known as *Shaping a healthier future* because I keep being told that this has to be done because *Shaping a healthier future* says so. I do not know what *Shaping a healthier future* is. I know some of it is people. Dr Anne Rainsberry, Dr Mark Spencer and somewhere along the line this nexus of Clinical Commissioning groups who all signed up to the original pre-consultation business case.

Q. So it has the feeling of a cult then? So who is the cult leader?

A. Well, most of us would probably say Mark Spencer was at least John the Baptist.

Q. I do not think so.

A. It is just cult. *Shaping a healthier future* is, in my book, two documents that came out, put together largely by McKinsey's at a cost of nearly £4 million that we know about and in fact in the year 2011-12 they were being paid exactly £7,000 a day for whatever it is that they did for *Shaping a healthier future*. So they put the document together along with the nodding dogs of the CCGs and the medical directors of the hospitals, one of whom I am told did not know what he was signing when he signed up to the letter which said, "I as Medical Director of this hospital agree with *Shaping a healthier future*." We know that the Ealing CCG was told at a meeting which Mark Spencer presented that at the end of the meeting the Chair will be required to sign a letter of agreement to *Shaping a healthier future* and that is in the minutes, so the CCGs were told, "You sign up to this," and the medical directors were told, "You sign up to this", so they could then say we have clinical agreement for *Shaping a healthier future* because a load of people had signed

precisely the same letter with once exception. I forget which one of the CCGs it was that said "provided suitable provision is in place" right at the end. Otherwise the paragraphs are exactly the same so they all signed a round-robin letter. I do not mind that if it was presented that way, but it was not; it was as if they were all individually saying how wonderful it was. So this thing called *Shaping a healthier future* is what is driving the process and it is an assembly of various bodies, some now defunct like NHS North West London, some more or less alive, I am not quite sure, CCGs, Dr Mark Spencer is a continuing thread as is Dr Rainsberry and various people pop in and out from the clinical profession and utter things and various administrators pop in and out. Mr David McVittie, who calls himself a "recovering accountant", who now runs North West London NHS Hospitals Trust, is off at the end of this month so he pops in and out. Do not ask me who is running it. It is called *Shaping a healthier future* and that calls the tune.

DR HIRST: Thank you.

Q. THE CHAIRMAN: One last question: do you have a figure attributable to the current running total of costs for consultancy in relation to this exercise?
A. I would have to do another FoI. I do not know. I forebear to ask because I know it will frighten me.

Q. Would you ask, please?
A. I shall do that.

THE CHAIRMAN: Thank you.

MR JOHN McNEILL: I can provide the Freedom of Information figures, Sir.

THE CHAIRMAN: If you can speak to Marcia just here. Thank you very much.

The Witness Withdrew

DR GURJINDER SINGH SANDHU, Consultant at Ealing Hospital

Examined by MS RENSTEN

Q. MS RENSTEN: Could you give the Commission your name, professional address and current post held, please?
A. My name is Dr Gurjinder Singh Sandhu and I am a Consultant in Infectious Diseases and Acute Medicine at Ealing Hospital, Uxbridge Road.

Q. You should have open in front of you your submission. Can you confirm please that it is true to the best of your knowledge and understanding and that you want it to stand as your evidence to the Commission?
A. Yes, I confirm that.

Q. I want to ask you first of all about the statement you made that the SaHF reforms are economically driven. Can you say in a nutshell why this is your view, please?
A. On one of the pages I have produced a *Shaping a healthier future* graph and I

superimposed it on to levels of deprivation. It is page 768 and I put a star over the emergency department if it would close and levels of deprivation appears as hotspots. The emergency departments in Southall, Harlesden and Acton are set to close whilst the emergency departments in Chelsea, Paddington and Harrow are set to stay open. As Dr K has also said earlier on, there is evidence from the US that emergency departments were closed primarily in Medicaid areas, black minority ethic areas and areas where you needed a safety net for a core of patients. All of these changes seem to be occurring after the 2008 financial crisis where top-down reconfigurations in health have been far greater than anything I have experienced in my career, so it is economically driven.

Q. Can you help us with whether or not other consultants at your hospital and perhaps beyond share those views or differ from those views?
A. All of the consultants from the Medical Staffing Committee wrote a letter to Jeremy Hunt at the time of the Independent Reconfiguration Panel. It was a universal opinion amongst the paediatricians, obstetricians, radiologists, consultant surgeons, consultant physicians that these changes were not good for our population, yet, as Colin has inferred, our Medical Director still managed to sign one of those letters which totally betrayed our viewpoint.

Q. Pause there a moment. Can you confirm first of all that the letter you are referring to is the letter dated February 2013?
A. Yes, it is.

Q. Can you confirm whether or not to the best of your knowledge the consultant body at Ealing continues to hold the views expressed in that letter or whether that has changed?
A. The consultant body at Ealing continues to hold this viewpoint and I could quite easily do what *Shaping a healthier future* does and get them to sign another letter to say they share this viewpoint.

Q. You just mentioned the letter relied upon by the Secretary of Stated signed by the Medical Director of Ealing. Can you tell the Commission a little bit more about how that came about and how it came to be signed, please?
A. I think Colin has already mentioned this a bit as well. We were feeling a momentum building up as the Independent Reconfiguration Panel was getting there. You have obviously heard a lot from residents of Ealing and Ealing Council. The Ealing consultants had a big rally where the elderly and the disabled walked all the way from Southall Broadway down to Ealing Common. That was a long distance for them to walk. The momentum was there that there was outrage against these changes and what I heard is, and I have read in subsequent articles in the news, that the Prime Minister and the Secretary of State were anxious about these changes and *Shaping a Healthier Future* ran around, got the same letter for the Ealing CCG and got people to sign it and the same letter for the medical directors and got them to sign it and suddenly came out with this statement "This is clinically led and clinically supported".

Q. Why is it that you say those medical directors signed it if it was not something perhaps that they subscribed to, or was it?
A. Because we then called our Medical Director up to the Medical Staffing Committee and said, "Why did you sign a letter which totally contradicts everything we stand for in this Committee, in this hospital, with our community, with our local GPs?" and he said he

did not read the content of the letter he signed.

Q. Are you able to help in terms of any of the other Medical Directors or is that the extent of the knowledge you have?
A. I think we were only able to push our own as to why he betrayed us.

Q. In terms of the reconfiguration of emergency services, can I ask you what it is that you understand by an urgent care centre and what you understand the proposed urgent care centre at Ealing will actually do?
A. An urgent care centre will not see patients brought in by ambulance. An urgent care centre will not have a chest pain unit associated with it or a coronary care unit associated with it. It will not have the back-up of consultants in orthopaedics, consultant physicians, consultant surgeons, consultant pediatricians. It will be run by GPs. We did actually right at the beginning of this process see a list of exclusion criteria for Care UK urgent care centres and it seemed like you really just come to an urgent care centre if you had sprained a muscle and even then you could not be in too much pain because you could not really handle too much in the way of painkillers that an urgent case centre could give out.

Q. What happens to cases that an urgent care centre cannot deal with, please?
A. Currently, with a co-located accident and emergency department, the urgent care centre is able to refer those patients on to the accident and emergency department and the specialists within the hospital can see that patient and admit that patient. In the future where you have got urgent care centres which are stand-alone without an emergency department then it is my understanding that that patient will have to make their own way to an appropriate facility that can manage them.

Q. Have you been given any information or do you have any knowledge of what, if any, transport can be provided or will be provided in those circumstances?
A. I have no knowledge of that.

Q. Are you aware of whether or not ambulances will be called to UCCs to transfer patients or not?
A. I am not aware that they will. The idea is that you would make your own way to an urgent care centre and presumably you would make your own way from there if it is not the right place.

Q. Thinking about the closures which have already happened in Hammersmith and Central Middlesex, do you have any comment on the impact, if any, that those closures have had, particularly on Ealing, the hospital that you are at?
A. There is a human face to Colin's graphs. You see Colin's graphs where everything is hovering round 90% and then plummets down to the 50s. When you work as an acute medical physician you can walk into an emergency department and see every resuscitation bay being fully used, the paediatricians in one corner, over winter dealing with viral pneumonitis, you are dealing with septic patients. You then identify as a consultant someone who needs ITU. You run up to ITU. You are thankful you see the matron there and you say, "Matron, I need an ITU bed," and she says, "Step this way and let me show you the recovery theatre spaces and every single space is being used for ventilating patients." So you are running intensive units at over 100% occupancy. You then start phoning the other intensive care units around the area, Hillingdon, Northwick

Park, West Middlesex, and none of them has intensive care unit beds. That is just the acute end of things. Then every assessment bay in majors is full of patients. You may well have the elderly patient who has fallen down and spent most of the night on the floor who is hypothermic and we possibly have not got around to getting her something to eat or drink yet because everyone is so busy in resusc dealing with acute emergences. The spin-on effects that we witness in the emergency department is pretty much a grim and gridlocked scenario, yes.

Q. What do you say will happen if there are further closures?
A. Absolutely catastrophic. It will have a huge impact on the morbidity and mortality of this population. We are talking about people who are waiting longer for the ambulance to arrive and then they are waiting longer in the ambulance to get to their destination. Then they are waiting longer for the ambulance to offload them. Then they are waiting longer in the A&E to be seen. Then there would not possibly be the appropriate intensive care unit bed for them at that location. If you look at something like sepsis or you look at something like renal failure or you look at the unconscious patient or respiratory distress, all of that amounts to minutes and hours which would be life-saving where cells are dying kidney cells are dying; patients are dying.

Q. You talk about black breaches for ambulance waits. I think you have touched on it, but could you just explain to the Commission, please, exactly what they are and what it is that the graphs and figures that you have provided actually mean?
A. Before I do that I did hear some comments earlier on about how many ambulances actually come to Ealing Hospital, and that was not true and I have emailed Peter the exact ambulance statistics for how many come through to Ealing Hospital. A black breach is where an ambulance is taking more than one hour to offload a patient so they can actually be seen by the accident and emergency staff. If we look at the graph black breaches last year we had possibly 142 in Northwick Park and about 32 in Ealing. This year there have been 633 black breaches in Northwick Park and that is not complete data because the complete data will be ready by April so that is 633 patients waiting more than an hour to be offloaded from the ambulance. All hospitals in North West London saw a rise in black breaches after the closure of these emergency departments.

Q. Do you know that to be something that is continuing or has it changed in any way?
A. I think it has got a little bit better as a lot of the so-called winter crisis problems are starting to get better, but I do have photos on my mobile phone which I take as I go home where there are nine ambulances lined up outside Ealing Hospital accident and emergency department.

Q. Is that some very recent ones?
A. Yes, I can send that photo from about two weeks ago. I can send it over to Peter.

Q. What do you say the impact will be if that does not improve?
A. To be honest, if I put it into context with a visual story. A man who has got cancer has chemotherapy at home and a district nurse would come round and take the chemotherapy off, but when she arrived she noticed the man was not very well and felt he needed to go into hospital. He was actually unconscious and he was on the verge of fitting. The family phoned the ambulance 111 and eventually realised it was going to be better to bring him in themselves. So you have actually got a son carrying his 80-year old

cancer-stricken father into an emergency department because it is easier than waiting for an ambulance. That image is developing world.

Q. Is that an isolated incident or something that you have more knowledge of?
A. That is an isolated incident. I can only talk about the on-calls that I have done, but the stories that people will tell me about waiting for ambulances or waiting to get to emergency departments are already horrific. If you start removing further emergency departments from this infrastructure it will just get worse.

Q. Just thinking a bit about the out of hospital services, can you help with your understanding of the quality and availability of those services now?
A. I do not categorically believe that any out of hospital services that I have seen people write about are going to stop acute hospital admissions. We have heard about musculoskeletal services. That is not going to stop a granny slipping on the ice and breaking her hip and needing an operation. We have heard about diabetes networks. That is not going to stop a teenager coming in with diabetic ketoacidosis or people coming in in comas or diabetic patients coming in with renal failure needing dialysis or diabetic patients coming in with ischemic legs needing surgery for them. We have heard about dermatology out of hospital services. My understanding is that is a photograph that a dermatologist might look at on Skype or something but that in not acute emergency care. It is outpatient care. You are not going to prevent acute hospital admissions with these kind of out of hospital services. You then talk about intermediate care services whereby you have got people to help the elderly get back into their homes. What *Shaping a healthier future* wanted was a system which was admission avoidance but, actually, what clinicians want is supported discharge. We acknowledge that when an elderly person comes in and they are confused or they have a urinary tract infection they may actually be quite aggressive towards their spouse. We cannot just say, "We are going to send you home with some antibiotics and there will be a physiotherapist who will make sure you can get to the bathroom." You actually need to admit that patient and make an assessment of what is going on. Making assessments of elderly patients as an acute physician is not an easy task. You should not be doing it in the emergency department and sending someone home quickly. You need to have time to see is this early dementia, is this delirium, does the patient need a scan, what is going on. We are living in a world with resistant bacteria and resistant organisms. We heard Dr K say, "One tablet, off you go home." We do not work like that any more because Amocycillin does not work any more. To be honest, you may well need to be in hospital for a week with intravenous Meropenem. The bugs have changed the goalposts, as an infectious diseases doctor I would say.

Q. Particularly thinking about your elderly patient group in that case, where does the input from social services fit in?
A. (Gesturing)

Q. I wonder if you could encapsulate that verbally!
A. It is just frightening. I am sorry, it really is just frightening, the lack of social care for people in the community. I work with 50% fewer social workers than when I started as a consultant at Ealing Hospital. I feel that we are battling with social services because we heard earlier on from Julian Bell and the Council about cuts to social care and sometimes it would be very clear that someone needs to go to a residential home or go to a nursing

home. If granddad keeps putting the electric kettle on the gas hob then that family cannot wait for the big kaboom before they all come in. When we have identified we need more care space for this person, it almost feels like social services have got a remit from higher above not to send them to a residential home, it is going to cost too much, you have got to get them home, you have got them back out, whatever it takes, get them back out. I am sorry but the doctors, the nurses, the occupational therapists and the physiotherapists are not going to do that. They are going to keep that patient in hospital until they know it is safe for them to go somewhere in the community that is safe. Then you have got this situation which is called bed blocking. We do not like the term but it does have an equal impact on the emergency care crisis.

Q. So to fulfil the objectives that *Shaping a healthier future* has of having an infrastructure in community and primary care that allows a reduction in the bed blocking, if you like, allows those things to flow through the system, what is needed?
A. Then you actually look at a much greater societal issue. The first thing that is needed it that you put the patient at the centre of what you are doing and not the buck at the centre of what you are doing, which is what appears to be happening. You are talking about an ageing population which every document starts with but you almost feel people want the second line to be "Well, hurry up and die then". In reality, we need to invest more for our elderly. They were here at the birth of this NHS and they are here at a time when we are dismantling it and they need it the most. We would have to accept with rising rates of dementia that we probably do need more in the way of nursing homes and residential homes for people to actually be safely discharged to but that investment is never coming.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Recognising acutely that I think I fall into that category, I just want to see, given your experience, what category of investment is required here, do you think? What kind of figures are we talking about? What kind of person power is going to be required?
A. I am not a politician, I am not an economist; I am a doctor. What I would say is that you would really need quite significant levels of investment in community and even then I do not believe that you can take away acute hospital beds because you can take an influenza outbreak like the one that we had in 2009-10 with pandemic flu which just crippled our population and we had filled our intensive care unit beds. We need an acute buffer in the hospitals and we need safety nets in the community. Although it sounds like the doctor who says you need to fund everything more, that is actually the national debate we need to have. Do we need to just shove up taxes and really invest more in social care and healthcare? I believe that is probably what we do need to do.

Q. DR LISTER: You said to the People's Inquiry recently that if we are going to run as if the community is a virtual ward it needs to be staffed as a virtual ward, and you were talking quite positively about how you would like to be able to discharge patients with support back home. I would like you to expand a little bit more on that. What type of teams do you think would be needed in the community to make this a real possibility?

A. Let's say what do you have on a real ward? You would have a ward where you have got a nursing to patient ratio of, say, six to one. You have then got a junior doctor that is able to be called by bleep 24/7 to come in and deal with the issues and then you have a senior doctor who is on call, whether they are on site or at home. Are you going to invest in the community to that degree? The workload of district nurses is huge. The time they get to spend with patients is minimal. GPs are not on call 24/7 to be able to come out and deal with the acute issues. I help run a home IV antibiotic service and we always say we need a back-up plan so we can have that patient out in the community on the virtual ward under my care getting IV Meropenem or whatever it is, but if their line becomes dusky or if they start having shivers, then they need to come back to the emergency department and be readmitted into hospital so you need to staff the virtual ward in exactly the same ways or with the same principles in mind, the same safety principles in mind that you staff hospitals. This is just one tangent, I do not know if I can make this point just on safety again. As a junior doctor going through my training, risk management was a concept that was drummed into me and post the Francis Report the duty of candour and transparency is something that is very, very clear to me. When you see graphs where emergency care plummets off the scales kind of thing and then you have CCGs and *Shaping a healthier future* submitting to your Commission four lines of what they feel has happened post the closure of Hammersmith and Central Middlesex Hospital A&Es, then you do not have clinicians who are practising risk management. You do not have people who have stopped and paused and asked themselves what have been the consequences of our actions: are we going to be transparent with the population and say these have been the consequences of our actions? Are we going to categorise those risks and are we going to stop closures any further until we know exactly how we can do so safely? That is not happening.

Q. DR HIRST: Just one question but just one comment first. As a young doctor I found the answer when I used to say, "He's leaving the gas on, we have got to do something" was, "We'll put in an electric hob." That was their temporary measure, God bless them.
A. That was the temporary measure. It still is, to be honest.

Q. More seriously, I understand that perhaps at Charing Cross and perhaps at Ealing there will be this thing we have not got a grasp of yet called a local hospital. I have not yet been able to pin down in my mind what that means. It has been suggested that the word "hospital" is being used to allay the public's fears. What may be at its best for these local hospitals, it was suggested by a specialist there might be something very good, there could be 30, 40 or 50 beds remaining which will be used to tide over the elderly admissions during acute problems. At first sight I thought, "Oh good, that will make it easier to get them in," and then I thought that is a two-tier system. For example, I have a relative who has now passed away but who had a heart value replaced to get a better quality of life. I attended a lecture some years ago at which it was suggested that you would replace a heart valve in somebody who is terminal with a six-month prognosis with cancer to have a better quality of life. In other words, you are now treating a patient or a person who would never have been treated before who will need very briefly intensive care facilities. It seems to me that if you are going to have these beds reserved for the elderly with their acute pneumonias and you think you only need two or three days and you can get them out, what if their pneumonia goes off? There is no intensive care unit to admit them to. Does that mean you are not going to admit them to an intensive care unit or are you going to be able to transfer them? I am sorry to lead you, but do you have any

thoughts about that?
A. I have absolutely the same viewpoint and I would use the word "discriminatory". I believe at the moment if an elderly patient comes in they will have access to a diabetes physician, they will have access to a cardiologist, they will have access to an intensive care unit, they will have access to a full rehabilitation team through a major hospital where all specialties are present. Quite often the elderly are coming in with poly pharmacy, they are on huge numbers of tablets, and we can come along and we can work collectively and we can rationalise it. You then turn that into a local hospital where they do not have access to all of those clinicians but basically the young people have access to all of those clinicians and you have discriminated against them. We had step-down beds or community rehab beds over the winter crisis where we could admit someone into one of these beds and they may well get there but three days down the line they deteriorated and they were readmitted back into the acute hospital and, luckily, the acute hospital was still there for them to be readmitted into, but when that acute hospital is not there, then I do fear that the elderly will be discriminated against and put into smaller hospitals where they do not have access to everything that they are entitled to. The other thing that then happens which is a bit frightening, to be honest, but is happening in the medical profession is the "do not attempt resuscitation" orders, where you have then got people making decisions I believe on the basis of resources available to the country and its health that this life is worth saving and that one is not.

DR HIRST: Thank you.

Q. DR LISTER: Just to follow that through a little bit, are you saying, because of course one of the big areas that has disappeared in the NHS since 1993 I think is the geriatric bed, and geriatricians are generally very hard to find now across the NHS, are you saying what we are getting is like an equivalent of that emerging if these small hospitals are built only taking elderly patients with those conditions; you are getting a geriatric bed but without geriatricians and without the actual resources to treat them properly?
A. We have fantastic geriatricians but geriatricians work with the rest of us as consultant physician colleagues. They work with cardiologists, endocrinologists, infectious diseases doctors. I do not want my geriatricians working in a separate hospital to me. As an infectious diseases doctor I am now seeing an ageing HIV population and I want a geriatrician that I can refer my HIV dementia patient to. We need to not fragment people on the basis of what economically works for us as a healthcare system and still keep things in one place. Another example, centralisation we have talked a lot about, but when my elderly man who has renal failure and his hip dislocates and he has got a weak heart that the Brompton says he needs an angio for before he can have his hip done, trying to find one hospital in North West London that could do all three of those was difficult because Hammersmith could deal with renal and cardiology but did not have orthopaedics to deal with the hip. St Mary's could deal with the trauma and the hip but could not deal with the cardiology and the renal. We ended up admitting him on to our own ITU, dealing with the renal, getting our cardiologist to deal with the cardiology and then popping his hip. They are telling us we have to send people to these central hospitals but the central hospitals have not got everything under one roof. You have this farcical situation where you had gynae oncology at one point (I do not know what the system is like now) at Charing Cross Hospital whilst gynaecology was at Queen Charlotte's. It just does not make sense. They are talking about a maxim of centralisation when it does not even exist at the moment.

THE CHAIRMAN: Thank you very much. That was very clear. (Applause)

The Witness Withdrew

MRS JUDY BREENS and MR ARTHUR BREENS, Ealing residents

Examined by MS RENSTEN

Q. MS RENSTEN: Could I ask you, starting perhaps with Mrs Breens, to give your full names and address, please?.
A. (Mrs Breens): I am Judy Breens, 12 Waldemar Avenue, Ealing W13.
A. (Mr Breens): Arthur Breens, 12 Waldemar Avenue, Ealing W13.

Q. If you turn to Volume 3, I think it is open in front of you, page 1207, there should be submissions that were prepared I think by both of you. Can you confirm they are true to the best of your knowledge and understanding and that you wish them to stand as your evidence to the Commission?
A. (Mrs Breens): Yes.

Q. And I presume that goes for both of you?
A. (Mr Breens): Yes.

Q. If we start with Mrs Breen, you relate a number of anecdotes about past NHS care in the area that you and your family have experienced. In broad terms. was that satisfactory or not?
A. (Mrs Breens): It was excellent, yes, very satisfactory.

Q. Can we look at your views now about the care and treatment and what it might look like under SaHF. First of all, what did you think of the pre-consultation and consultation process?
A. (Mrs Breens): It is quite a long time ago now so I am struggling to remember, but I think we both felt it was pretty poor. I think I have written stuff here so let me see. Are you talking about actually the meetings and all of that side things?

Q. If I can assist, what you have said in your statement is that first of all it seemed I think the phrase you used is "plausible"?
A. (Mrs Breens): Yes.

Q. And then you went on to develop that and there was perhaps a difference of view. I wondered if you could help us with what made you become more sceptical?
A. (Mrs Breens): I think I just felt in the end it was a cost-cutting exercise, but why did I come to that conclusion? It looked as if it was the areas of deprivation. They were not going to remove the ones from Chelsea & Westminster, were they, but they were happy to remove it from Ealing, which is next to Southall, and similarly Hammersmith, so that seemed to be a bit suspicious. Also the fact that Ealing and Charing Cross Hospital are fully paid for. They are not PFI hospitals so it is easy, is it not, to sell the whole land and make money which they could not do for some of the others.

Q. Did you find it easy or difficult to access information about the process? If you cannot remember say so because it is some time ago.
A. (Mrs Breens): I think the document was very long and complicated. Yes, I could understand it when you waded through it all.

Q. Thinking specifically, I want to ask you about the changes intended for Ealing Hospital. We know that there is a shrinkage of acute beds proposed and a change in A&E. What impact do you think that is going to have on you and your family and other local people?
A. (Mrs Breens): Well, I think it would be devastating to lose the A&E and Ealing services. Ourselves we have a car and we are reasonably fit at the moment, but what if you do not have a vehicle and what if you are not very fit and you are very elderly? The idea of going to Northwick Park or getting three buses to West Middlesex, it cannot be an improvement for Ealing residents.

Q. Thinking about that, is something that would be a source of anxiety to you?
A. (Mrs Breens): Yes, I think so, definitely, especially as you get older.

Q. One of the other aspects you mention is your treatment at the Western Eye Hospital. What are your views about the plans to move those services to St Mary's?
A. (Mrs Breens): I just felt it was very sad. I had a cataract operation recently and I have been frequently for various things. It just seems such an excellent hospital and easy to get to. Why move it to St Mary's which looks very overcrowded? It is just hard to fathom why you would do this if it was not just that you want to make a lot of money by selling that site. What other reason could there be?

Q. Again thinking about your own position, would you be anxious about eye care if that hospital disappeared?
A. (Mrs Breens): It is difficult to say that because I do not know what would be provided at St Mary's or what it would look like. It is hard to see they would have room, but I do not think I can really honestly say because I do not know what they would put there.

Q. Can you help us just with your general view about what the proposals will mean and your concerns, if you have any?
A. (Mrs Breens): The eye hospital?

Q. No, the SaHF proposals. I beg your pardon. It was not a clear question.
A. (Mrs Breens): I think it would be. I just looked through a whole lot of things here. For example, you have got to get to other hospitals and that will be difficult. How will the A&Es cope when you close one? How will the others cope? I have not ever been to A&E and found doctors twiddling their thumbs exactly. Everybody is busy. You cannot imagine how other hospitals' A&Es would cope if you closed one. The whole idea of community settings when we do not see any plans. Where are there any plans? Nobody even knew during that *Shaping a healthier future* discussion we went to, nobody really could explain what these community settings would be. Nobody seemed to know so it is hard to have any faith in them. The idea of urgent care instead of the A&E, I do not know how people are going to know when they should go to urgent care and when they should go to A&E. If they go to urgent case and they need A&E, how are they going to get to the other place in time? It just all seems very difficult. Then there is the question of

beds. Ealing has got 327 beds and Charing Cross has got 498. That is 825 beds together. If you close these two and there is maybe 100 in each, that is a loss of 600 beds. It does not inspire confidence does it? How will they manage without these beds? The other thing is the Ealing birth rates are rising. Ealing Council are planning to build 12,000 new homes on the Uxbridge Road corridor. That will be apparently 12,000 new homes with 25,000 new persons. Similarly, the Gas Works site in Southall is going to have 4,300 new homes and 9,000 new residents. And you close Ealing Hospital! Do you think that is sensible? It does not seem sensible to me.

Q. I wonder if I could ask Mr Breens, could you briefly explain, you have set out your experience of other public consultations and what that leads you to think in terms of common themes here.
A. (Mr Breens): I think this was like many of them very poor, but it was different in that it was enormously complex. You got two large documents, one that you filled in and one was the reference document.

Q. This is the consultation phase you are referring to?
A. (Mr Breens): That is right. I taught for about 20 years of my working life and I know roughly what average is and this was well above the heads of the average. This was very complicated. In fact, I cheated because I was really busy at the time and someone wrote out a crib sheet and I cheated and I used the crib sheet.

Q. So is it your evidence that the questionnaire that was sent out was too difficult?
A. (Mr Breens): Far, far too difficult. These were thick documents and I am sorry I have not bought them. I have got some clever friends and so some were lucky enough to have a hard copy of one document or the other and the other one on screen and they were timed out. They had spent an hour and a half and suddenly the screen went dead so they could not do it on-line. They needed both hard copy documents. I think *Shaping a healthier future* took lots of small cards because clearly most people could not fill these in and took little cards. I did offer to help them with designing the consultation document but there is a certain arrogance of these people that "we know best". It is not confined to them. We get it in this borough. There are experts here who know best and the consultation is really a tick-box exercise, but this was flawed in many ways. The thing that I thought was really bad was that it was flawed in the fact that it was very poorly distributed and there were no checks on the distribution or the authenticity. If you sign a petition you sign your name and you put your address. You could fill this in with no authentication and if you put a postcode which comes with your address they could have plotted this. After the consultation was nearly completed I was asked by *Shaping a healthier future* whether they had missed some hard-to-access communities.

Q. Pause there a moment. Can you help us with why it was they were asking you and what was your interaction?
A. (Mr Breens): I think I had left a video at one of these meetings. They had a camera and you were able to go into a little room and say what you thought of the process and maybe they contacted me because of that. If they had had a postcode in there they could have plotted all the responses and they could have seen from a map roads that never replied.

Q. On what is it that you base your views that the consultation did not reach all areas? If

the SaHF documentation could not tell you that, how do you know that that is the case?
A. (Mr Breens): How do I know that it did not reach all areas? Because I have been an activist and people do not know it exists. They do not know that these hospitals are going to disappear. I know it is difficult but surely there are better ways. They spent a lot of money on this consultation. It might have been better to have done every tenth house or something like that. My feeling is it was just like scattering seeds and farmers actually have very precise computer-controlled drilling systems now and they were throwing these consultation documents around like that. There were no checks and balances as far as I can tell and no-one put my mind at ease. Random and arbitrary.

Q. One of the things that you mention is a meeting at which you sat next to a GP. It was at Wembley, I think.
A. (Mr Breens): Yes.

Q. I wonder if you could just explain to the Commission what happened and what was said to you?
A. (Mr Breens): He was sat next to me. He had come in between surgeries on his bicycle so he had appeared in Lycra. We were all old duffers and he was young, fit and vigorous and you could see he was having to get off for his next surgery and he said to me, "This is appalling. They are closing the hospitals in the poorest areas." I think up until that moment I had gone along with a lot of this because, remember, I am of a generation where GPs were honoured members of our community. When I was a child they were the only people who had a car in our community and so you tended to think they knew what they were talking about. This GP was incandescent. I think I have used that word. Then off he shot, but I thought about that and my local knowledge and he was spot on; they were all in poor areas. Then you start to think what are they up to? As I went on, I started to see this as an estate management exercise really. We have been through a couple of these with the police. You can spot what they are doing. You can see the sites that you know are valuable as someone who lives in the community and watches these facts, and it did not seem to be on medical grounds, I do not know as much as some of the people who have preceded me but it looked like estates to me.

Q. I wanted to come on to that because you talk about Clayponds. Can you help us with how that hospital figures in these plans, as far as you are aware?
A. (Mr Breens): Clayponds was not in the consultation document. Lots of our neighbours go to Clayponds. It was purpose-built. It is a lovely place. You can drive in there on the way to work. You do not have to pay to park. There is plenty of parking. It has got a nice atmosphere. You can go in any time to see, as I did, my next door neighbour who was rehabilitating from a stroke. You do not have to make a special journey. You are on the way back from work, pop in there, go and see him, "Hello John". The staff are nice, my daughter worked there, a lovely place to work from her point of view, a lovely place to be a patient, purpose-built, all on one floor. That was not in the consultation. Why was it not in the consultation? That is a little jewel in the crown in West Ealing.

Q. What is it that you say is happening to that? What is going to happen to that?
A. (Mr Breens): I think it is going to be closed. The patients are transitory but the teams will all be moved to Ealing Hospital. I think that is what I understand but that came out later. That was not in the consultation, as far as I remember.

Q. Do you have an understanding or knowledge of what is planned for the site?
A. (Mr Breens): I am sure it will be housing. The targets that all the west London boroughs have signed up to are enormous. It is interesting that the planners in Ealing never talked, I do not think, to the *Shaping a healthier future* planners and the *Shaping a healthier future* planners never talked to the planners in Ealing. We have got this very heavy housing vote and I know there is an enormous crisis, but it is a very heavy load and is it not strange that the corridor in which this load is going to be imposed upon existing residents happens to be the corridor between Charing Cross and Ealing Hospital and those two sites as well? Clayponds will have 50 units built on it.

Q. Just thinking about transport, you have touched on the road issues, but can you assist the Commission about the transport issues? I think perhaps you have dealt with it but a little more, what is the significance of Ealing Hospital being on the Uxbridge Road?
A. (Mr Breens): The Uxbridge Road is the main east/west route. It has been the main east/west route since the stage coach. That is what attracted Ken Livingston to it to try and impose the West London tram. People know it. They know Ealing Hospital is there. Some of the bus routes actually go right to the front door. I think maybe McKinsey, the consultants who prepared this, do not realise how difficult the tube is in West London for those with physical disabilities. We do not even have lifts on most of our stations and the bus is the only easy method, in other words. In my work with another organisation we tried to get Transport for London to change the bus route from Ealing to West Middlesex Hospital. There is not a direct route. But that is like trying to re-enliven some frozen mammoth. They are very slow and they will not do anything unless the economics work out and that might never happen. So going from Ealing to West Middlesex which is a near option, that is going to be three buses or two buses and a walk and it really only needs extending one bus route round a corner almost to make that just two buses. That is the difficulty. Northwick Park is impossible. You look on the Transport for London website and you are up and down tube stations, changing tubes, buses, goodness knows what. It is difficult if you are car driver because when you get there, there is a small car park and it costs £12.50 a day or something ridiculous like that.

Q. You talk about McKinsey's. Can you just elaborate for us, who are they, who appointed them and what do you say has been going on, if you know?
A. (Mr Breens): I do not know. All I can say is I would not have written a consultation like that for the general public and if they had any hand in it then they are a flawed consultation organisation. It is not suitable for the general public at all. How you would have written it I do not know, but I would have thought anyone with any sense would have realised that was wrong. When I have criticised this before Dr Anne Rainsberry said we went to the Consultation Institute. Well, I went to the Consultation Institute with a colleague when we were doing a consultation because I am part of West Ealing Centre Neighbourhood Forum under the Localism Act. We went to the Consultation Institute but they would not tell us what they had said to Anne Rainsberry. I think they got worried because there was a lot of criticism and they had to check the legal position to see whether they could fend off if there was a legal challenge. That is my own opinion but that could be rubbish.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much. I have just got one question for both of you. I am doing it from the point of view of assessing the citizens' position or at least your citizens' position. Do I have this right that really what you are advocating through all your submissions here is a co-ordinated, publicly funded National Health Service? Is that really your basic position and all your comments fall into that bracket?
A. (Mr Breens): Yes!

Q. DR LISTER: I am interested in the point you made about the no postcode so that you cannot chart where the responses came from, because I am aware of the paradox of a series of changes that basically affect three boroughs but which are consulted on over nine boroughs and there appears to be no differentiation from where the support, insofar as they found any support, has been forthcoming. I do not know if you would like to say a little bit more about what approach you think might have been appropriate to test out views in the areas where they are most affected?
A. (Mrs Breens): It is just that when you answered that consultation you did not have to put your name, address or postcode, absolutely nothing at the end. People could have made it up. They could have sent in 25. It was completely open to fraud. It is possible because you did not put even your name let alone an address and postcode.

Q. You are not saying it is Dr Spencer doing it all with biros, are you?
A. (Mrs Breens): Who knows!
A. (Mr Breens): I think the consultation may have wished to have put hospitals and supporters against hospital and supporters. As I say, it was very, very complicated. You could not see where you were going. You understand what I am trying to say. In a coherent and relatively simple document you can see where you are being led as you go through because you can remember what has gone on before. You can see what is coming. There was none of that. It was a very dense and complicated document. It had never been trialled as far as I could see. If you were doing an exam paper, and I have written exam papers, I would have had those trialled first to see how you got on and then move on to the real thing. It was a very amateur document - but it was not amateur because they were paid an enormous amount of money. It was a poor document and to miss the postcode misses a trick. Forget the authenticity; if you have got a postcode you have a lot of information in your hands. You will know which roads never replied and you will think, "Why on earth is that?" If you have got a whole area that never replied it could have been your distribution, it could be that they were all Somali speakers and they did not understand any of it, but at least you have got some information. These are supposed to be clever people. It cost £4 million. I do not know, I cannot remember but they missed so many tricks it was unbelievable.
A. (Mrs Breens): Can I just say one more thing and that is you were asked in the consultation to say what hospital you wanted kept or something, so you were shamelessly supporting and NIMBY-ism could apply. Also, we were told that there were cards that got sent in supporting one hospital instead of the whole document. I do not know, it just seemed a very suspicious thing. I have also got here a figure, I am just looking at the thing that I wrote, they would claim that there were 17,000 responses and then I have got that Colin Standfield - maybe he has gone - was later told that there were only 4,500 responses. Nobody knew who had written them. As I said, who knows?

Q. I would not necessarily assume that they did not get the result they wanted from the exercise, but just coming back to the options you were offered and the fact it was a flawed consultation, was there, for example, a do minimum or do nothing option? Was there an option to say "I want none of these"?
A. (Mrs Breens): I do not think there was ever a stay the same. I cannot really remember. You must have got copies of this thing, have you?

Q. I know. I am just asking for the purposes of the Commission.
A. (Mrs Breens): I cannot remember. It was quite a long time ago but I do not think there was an option to keep it the same and I think you had to choose a hospital so you were shamelessly playing one area against another.

Q. So it was which one do you want to close rather than do you agree to close any?
A. (Mrs Breens): Yes, I do not think you were allowed to say keep the same as now. Do you remember?
A. (Mr Breens): No. I think there were no options. I think the options were various but there was not the option to keep everything as it was and we were told right at the beginning that London was over-bedded.
A. (Mrs Breens): Yes, we were.
A. (Mr Breens): That was the premise on which they were cutting beds, London is overbedded and then about eight weeks later, some clever person - because there are lots of clever people around here, we are surrounded by clever people - someone found out there were .001% more beds in London per head of the population than there were in Strathclyde or Hull or Liverpool. So that is another fiction. We have just lost any trust in this lot really. Not on the basis of scientific analysis but just generally it did not seem right and we still do not think it is right and we know that enormous amounts of money are still being paid to these consultants who probably did a bad job in the first place.
A. (Mrs Breens): The other thing was that they did have a favoured option in this thing. They had their own favoured option and – surprise, surprise – that was how it came out at the end. So when you saw nobody putting their addresses or signatures or postcodes you did feel rather suspicious.

DR HIRST: I have no questions but thank you.

THE CHAIRMAN: Thank you very much for your time.

The Witnesses Withdrew

THE CHAIRMAN: I think we are approaching the last witness today?

MR RICHARD HERING, Ealing resident

Examined by MS RENSTEN

Q. MS RENSTEN: (Document handed round) This document has just been handed up but I do not think there are enough copies. Could you give the Commission your full name and address?
A. Richard Hering, 58 St Margaret's Road, Hanwell, London W7.

Q. I just heard you say you have a cough. Do take your time and do not get out of breath giving answers if you feel you need to pause. In front of you, you will see your submission.
A. I have it, yes.

Q. Can you confirm that it is true to the best of your knowledge and understanding and that you wish it to stand as your evidence to the Commission?
A. I do. I did say that the experience with the ambulance delay was in the middle of the night. I have given you a copy of the complaint I sent to the ambulance people which you have not seen and actually it was around about five to seven on a Friday evening.

Q. Subject to that correction, you are content?
A. The other thing is I have been an in-patient four times and I have said in the last three years. One of them was actually in 2007, but it is not really material, I do not think.

Q. You have also just handed up another document and again that has been copied now.
A. That is the one.

Q. You can confirm, can you, that you wish that also to stand as your evidence?
A. Yes, please.

Q. What I wanted to ask you about, first of all, you say you have been a hospital patient and is that as an in-patient and an outpatient?
A. Both. I now have eight ailments. I have collected two more and as an outpatient I have been seeing a consultant once every six months for the various ailments which I have. And the most serious one is I have liver sclerosis and that might have caused me to die last March.

Q. Can I just ask you to pause there a moment? Am I correct in thinking you have also had a number of emergency admissions to A&E?
A. Yes. In 2007, I took myself because we did not have an urgent care centre and I had cellulitis and my head was swollen like a football so all the consultants came to inspect it. The remaining three were emergencies. I was virtually passing out at home in September 2012 and that was through loss of blood and my haemoglobin count was very low indeed. That is when I discovered that I had sclerosis of the liver, cortal hypertension and bleeding varices. The second occasion was in October 2012 when I had a very severe infected gallbladder and that was when the ambulance took two and a quarter hours to get to me even though I could see the hospital from the bottom of my garden. The third occasion was in March/April 2014. Again, I had lost a lot of blood which I had not realised and I was nearly fainting and so I rang up and got them to collect me and they were treating me and I was planning to go home and then in the hospital the big bleed happened and I lost two and a quarter litres of blood and they had to put some bands on my oesophagus to stop all that.

Q. Could I ask you just to confirm which A&E you were taken to?
A. In all cases Ealing.

Q. And can you help us with what you think would have happened if there had not been

an A&E at Ealing?
A. Talking to the ambulance men on the ramp outside Ealing Hospital I think there is a strong tendency for them to want to take you to Northwick. Northwick is six and a half miles using Google maps whereas Ealing Hospital is 15 minutes' walk along a towpath.

Q. So what do you think would have happened to you if you had had to go, say, to Northwick Park? If you are not sure, say you are not sure.
A. Obviously the whole process would have taken much longer and with the event in October 2012 when I was screaming and they took two and a quarter hours to get me to Ealing Hospital, God knows how long they would have taken to get me to Northwick. In the end I became breathless and perhaps it would have got a lot worse. I do not know.

Q. If the accident and emergency at Ealing becomes an urgent care centre, are you clear about what it will and will not be able to do?
A. Yes, I was reading the other day if you break your ankle or you drop a stone on your toe or you fall over and it is not a life-threatening situation, as I understand it, and then it is listed in the other section of this document I was reading at the local GP, life-threatening situations which you would need an A&E for and I definitely have a life-threatening thing that I have to live with for the rest of my life.

Q. Bluntly, would an urgent care centre be of any use to you, do you think?
A. Not so far as my problems are concerned, not at all, no.

Q. One of the other things you discuss in your document is super hospitals which is what you have called them. What do you say are the problems with that model?
A. It is quite hard to answer that question because I am not a medic.

Q. I just mean from your own perspective.
A. I just read the *Guardian* and the *Telegraph* and the BBC website to get a lot of my information and talk it through with friends. Well, I am all in favour of super hospitals because we need medical science to advance, but not at the expense of sacrificing the other hospitals, particularly if it means that they are going to close down. What I want to see is a spread of that wonderful knowledge that we have in this country being spread around our remaining hospitals. I do not believe in the specialisation that we seem to worship these days, unlike when I left school and Mr Mansfield left school when lawyers did a wider range of legal advice over a wider range of issues, they do not seem to do it either the lawyers or the medics, and I do not agree with that. If we could do it, then, okay, I understand why the law has moved and medical science is moving us in that direction, but you have got to draw a line somewhere, otherwise you are going to have an awful lot of people in those pockets which are not served by those super hospitals because they are too difficult to get to, they are going to suffer. If it is going to happen, picking up on the Breens' point that we are dealing with hospitals in an area where you have got very high deprivation, we have some of the highest deprivation figures in the whole country. I have worked with old people in deprived areas both in Hackney and in Southall and I think it is a disgraceful way to treat people. You should spread the service more widely rather than just focus in one or two places with super hospitals.

Q. So where an earlier witness indicated that what was needed was not a world-class A&E in one place but good, competent A&Es across the borough, is that a view you

would subscribe to?
A. Yes, most strongly and across the country.

Q. In terms of the Clinical Commissioning Groups, you make the comment in your submission that they have refused to engage with the public except what you describe as at a barely minimal level. Given that the Clinical Commissioning Groups say they consulted and engaged extensively, can you help us with what you base your view on?
A. I have not had extensive correspondence with the CCG. I have only written to them once or twice, but I have looked at some of their minutes, if you can find them on their website, and they say that they have their meetings which are open to the public. I have never seen in the local *Gazette* an advertisement saying "We are having our open monthly or whatever meeting on such-and-such a date." So who knows about it? When you are dealing with areas such as Southall or such as Acton, they are not going to know anything about that, are they? I have written to them and I said, "I think you should write to all the…" - I do not know if it was the CCG I wrote to but I know I have written to McVittie and I have written also to the Council saying that the residents' associations should be notified of meetings. I think that the CCGs and the McVittties of this world should hold more public meetings more frequently, if at all, and tell the residents of Ealing what they are going to do to us, what they are planning for us and to engage with us and to get feedback from us. I do not think they are working for the residents of Ealing or for West London as a whole. I think they are working more for themselves and they are driven by politicians or senior members of the Civil Service.

Q. I wanted to ask you about a comment you have made about what we could describe as "disaster scenarios". You raise the question of what would happen in those scenarios. Can you expand a little bit on that?
A. I have started some correspondence with Ealing Council over disaster planning if there is a flood in my area because we are in a flood area by the canal. I am not at all impressed that they know what they are doing. They do not seem to have enough information. They had a disaster exercise concerning a collapsed bridge in Southall in the last fortnight, I believe. It has not had any reporting at all except on one website, so far as I can make out. There is no report of it in the *Ealing Gazette*. And disaster planning? Well, they used to do them in the City when I worked in the City and they would have Bank Station which would be closed down because a bomb had gone off and they used to engage a lot of people as well as the services. People would learn what they had to do. A collapsed bridge in Southall? I wonder how many people learnt anything from that.

Q. What do you say the impact of the reduction, if there is to be a reduction, of A&E services would have on disaster preparedness?
A. If there is a plane or something like that, some horrible thing happens, and we have got far fewer A&E departments, they will not be able to cope.

Q. Just moving on finally, you make a suggestion that Ealing Hospital is being undermined by staff being moved to Northwick Park ahead of the closure. Can you help us with what you base that on and what you say is the effect?
A. It is very much opinion but when I talk to the hospital staff, they tell me that people have been moved to Northwick Hospital so the pressure on the remaining staff at Ealing is increasing. And the reputation of Ealing Hospital, if you read local opinion and talk to local people, as I do because I am on the committee of a residents' association, it is very

variable, unfortunately. I have had generally very good experiences at Ealing Hospital, but if there is a drive to try and close down Ealing Hospital and one of the councillors in the previous administration in the ward that I live in was convinced that Ealing will turn into a block of flats and will not have any hospital at all, what is happening by the senior management of the North West London Hospital Group is if they are taking out all the staff from Ealing Hospital people will end up by saying the rump that we have at Ealing Hospital is not really serving us so, yes, go ahead and close it down.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Just one question. Given your contacts with your community, you have just been talking a bit about it, but if people are presented with the proper options that are open rather than a *fait accompli*, how much support do you feel there is for the NHS as such?
A. I do not know how to gauge the answer to that question. Are you saying how much does the population support having the NHS as opposed to a private system?

Q. Yes, I gathered from your last answer that the problem often facing you and others, take your residents' association, is that they feel, in other words, that the decisions have been taken and you are having to face a different future. How much do you feel there is a real resistance to some of these plans in order to place, let's take Ealing Hospital as an example, that at the centre of the community?
A. On balance, I would say that there is a resistance to it. May I just talk about the West Middlesex Hospital very briefly? I am quite familiar with the West Middlesex Hospital and that is where I would go if they close Ealing Hospital down. There is no transport there, as you know, and that is going to be impossible. My mother died at the A&E there in June 2011 and the A&E at the West Mid was chaos then and I understand that it is chaos now. Ealing Hospital I have never encountered chaos on those four occasions and neither did I meet with chaos in A&E years ago when my children used to go to A&E on the rare occasions they got into trouble, so that is another reason why I want to see A&E Ealing hang on in because I do not think we have got enough capacity because we all know that Northwick is not providing the capacity. Thank you.

THE CHAIRMAN: Thank you very much for your attendance.

The Witness Withdrew

THE CHAIRMAN: That brings us to the end of today's hearing. Next Saturday we are going to Hounslow so obviously those who can come are very welcome. May I just thank the staff here and the stenographer who has sat for a very long period this afternoon. We are very grateful indeed for her doing that. And also to counsel's solicitor and everybody else who has shown enormous patience in order to get through the material. We are almost spot on time. Thank you very much.

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