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

BRENT CIVIC CENTRE, ENGINEERS WAY, WEMBLEY, LONDON HA9 0FJ

on

SATURDAY 9 MAY 2015

Before:

Mr Peter Wilcock 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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I N D E X

THE CHAIRMAN: Good morning, everyone. Welcome to the final hearing of the independent Healthcare Commission for North West London. Thank you all for giving up your time this Saturday to come and witness proceedings and give evidence. It is appreciated by all of us. My name is Peter Wilcock and I am a barrister. I am here to chair the proceedings. We had expected of course Michael Mansfield to chair proceedings today. Unfortunately, he has had a very recent close bereavement and so has been unable to make it but I am going to try and step into his shoes and chair these proceedings. My colleagues sat with me those of you that have been to previous proceedings will recognise. To my left is Dr Stephen Hirst and to my right is Dr John Lister. Between us we are collectively given the title of the Commissioners to the Inquiry. We are assisted in this task by, sitting at the disk in front of me with the blue box, Katy Rensten, who is Counsel to the Inquiry. I will explain her role and the procedure in a few minutes. Sat beside her we have Marcia Willis Stewart who is from the well-known firm of Birnberg's who is here to give some assistance. I was looking to introduce you to Peter Smith but he appears to have left the room. Here is there. He is looking for attention. Peter Smith has given us a lot of administrative support because plainly we are not just hearing oral evidence but we have had an awful lot of written submissions, and those of you who have given those written submissions but have not been called thank you very much for doing that.

The purpose of the proceedings is really to review the implementation of the *Shaping a healthier future* programme and, in particular, we have been looking at the impact of the reduction to acute provision on the North West London population, the extent of progress with investment in capacity and the capability of community and outpatient hospital services to meet local needs and the extent to which demand for acute services has changed as a result of those investments. It is a detailed analysis that has been conducted. We have been helped so far by those witnesses who have given evidence in the previous three hearings and this morning we are going to hear some very important evidence from the NHS representatives, if I can use that rather loose terminology. So, as I say, I thank you all for attending.

We are operating a quasi judicial process which means that the way we are doing it is the witnesses will be called to give evidence. Katy will ask questions to try and focus their evidence on the issues. We are running against time. We have got 11 witnesses to deal with and we want to try and leave here some time before teatime. So Katy will run those witnesses through their evidence and my colleagues will ask questions thereafter. Because of the odd nature of my role in the sense I am pretending to be someone else, I will ask questions only if I need clarification of any points which have been raised. So that is the procedure we are adopting.

I think it would be useful, Katy, if we could start by you explaining to people who perhaps have not managed to attend previous hearings what has happened to date and where you see today going.

MS RENSTEN: If I can begin with an opening summary to set out where we are. Today's hearing is the final one of four, the first three of which took place during March at the town halls of Hammersmith & Fulham, Ealing and Hounslow. The hearings form part of a Commission of Inquiry that has been 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 which is currently underway in North West London.

The background to this is that in 2009 work began on a programme, the purpose of which was intended to shape a strategy to provide sustainable, high-quality health services throughout the region. The premise upon which this work was commenced was that there was a pressing need for change based on the increasing healthcare demands of a rising and ageing population and that there was unacceptable variation in levels of service both 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 was that whilst five out of the nine hospitals in the region were to continue to provide the full range of services, including accident and emergency, the remaining four were to adopt reduced or changed roles. The changes to acute hospital services were to be offset by the development of enhanced out of hospital provision and other associated services. The three options presented for consultation were all variations of this plan with the stated benefits envisaged being those of increased quality of care, improved access to care and cost benefits.

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

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

Following a formal referral by the Adult Services arm of the London Borough of Ealing in March 2013, a review was undertaken by the Independent Reconfiguration Panel at the behest of the Secretary of State. Although identifying some areas of uncertainty and making some recommendations, the Reconfiguration Panel broadly endorsed the proposals for change.

Implementation of the proposals then began and has since mid-2014 been in the process of being rolled out across the region.

By December 2014, when this Commission was established, a number of key events, including the closure of the A&E departments at Hammersmith and Central Middlesex Hospitals, the opening of the new A&E 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.

The purpose of this Commission is to engage in a transparent, open-minded exchange with all interested parties to examine the decisions made thus far and to look afresh at whether those decisions and the plans arising from them are indeed those that are best able to provide the optimum available healthcare and linked social services care to the residents of this region, or if, upon fresh examination, there are other alternatives which may 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 in mid-stream, the emphasis of the hearing has been and will be on those aspects identified by the commissioning boroughs as being of the most immediate and most critical.

It will surprise no-one that chief amongst these are the changes to accident and emergency and acute services, the prospective closure of the maternity unit at Ealing Hospital, the perceived lack of progress in the provision of out of hospital services and the financing of the programme.

The Commissioners are keen that the voices of as many of the individuals or organisations that wish to be heard in the process can be.

With that in mind, and with the permission of the Commissioners, may I now call the first witness and the first witness is Dr Mark Spencer.

DR MARK SPENCER, Medical Director, *SaHF* Programme Deputy Regional Medical Director, NHS England (London) GP at Hillcrest Surgery (Ealing)

Examined by MS RENSTEN

Q. DR RENSTEN: Could you please give the Commissioners your name, your professional address and your current posts held, please?
A. (Dr Spencer): Certainly. I am Dr Stephen Mark Spencer, normally Mark Spencer. I have three main roles. I am the Medical Director for *Shaping a healthier future*, the lead Clinical Director for that programme. I am a part-time GP based at Hillcrest Surgery in Acton W3. My main role is as Deputy Medical Director for NHS England (London). My professional address therefore is Southside, 105 Victoria Street, London.

Q. In front of you, you should see a number of bundles. Could I ask you, please, to look at bundle 2 first of all. If you turn to page 603, you should see in front of you a letter dated 23 February which you sent to this Commission. Can I ask you to confirm that that is true to the best of your knowledge and understanding and you wish that to stand as your evidence to this Commission?
A. It is.

Q. Then in bundle 5 there is a supplementary letter. If you have a look, please, at page 1755, you should see there a further letter sent by you dated 18 March this year.
A. Yes.

A Q. Again is that your evidence you wish to stand before the Commission?
A. It is.

Q. Can I begin, Dr Spencer, by asking you briefly about your views on the consultation process. We know that the options that were put to public consultation were all based on the reduction from nine to five hospitals retaining their major hospital status. Would it have made for a fuller or more open debate if other options had been included?
B A. So we planned to have five major hospitals, they are not retaining, they are being built and developed to become larger and better. Four other hospitals we intended to become smaller so that we could localise more care, but centralise care where it was necessary to do so. In the consultation we asked for both information around that principle, which was strongly endorsed by the consultation, as well as the particular options and consultation and there was further opportunity in the consultation for people to propose other models.

C Q. Can I just be clear though that the models that were put forward were the three options A, B and C?
A. And, as I say, before that there was the principles and whether people agreed with the principles that got to those and there was strong endorsement of that and there was an opportunity for people to give alternatives.

D Q. Is it your case that in fact there was an ability to have a wider view put than the options that were put forward?
A. Indeed yes.

Q. Given that the time three options were put forward as preferred options in that way, these were the fleshed out options rather than the ones that invited perhaps comment on a more general basis from members of the public or other organisations, do you think that
E pre-ruling out of those other options damaged public confidence in the process?
A. As I say, we did not rule out any other options.

Q. Can I ask you to have a look at your letter. It is page 608, Volume 2. What you say there on this subject you talked about the work involved and you say: "Despite our best efforts to communicate with stakeholders the benefits which we know this programme will deliver, there remain misconceptions about this programme." Is that an
F acknowledgement that, for whatever reason, the communication has not always worked as you would have wanted it to?
A. That is true.

Q. And you are aware, are you not, that issues about the consultation process is one of the themes that has frequently been raised by a number of the campaigning groups involved in this matter?
G A. Indeed. It was the reason why the Council referred us for judicial review which was turned down and the consultation was found to be exemplary.

MS RENSTEN: Can I ask you please to have a look at another matter in Volume 5. It is at page 1734. What this is ---

Interruption as observers cannot hear proceedings

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THE CHAIRMAN: Thank you for bringing that to our attention. We will try and make sure it does not happen.

Q. MS RENSTEN: Let's try and see if that works better. Can I say one of the difficulties with these hearings is the way council chambers are made is just simply not helpful for public gatherings because of course the very nature of it that we are facing away from you, so I apologise for that and, please, if there are any further difficulties with hearing do speak up immediately. Can I ask you, please, to look at Volume 5 and it is page 1734. This is a submission by the Joint Health Overview and Scrutiny Committee. What they say is, and there is a section marked "Consultation Period": "… the process of consultation needs to be grounded in a genuine commitment to engage with the public, with staff and with partners from the outset." Is that a sentiment with which you agree?
A. Of course.

Q. And over the page at 1735 there is a section headed "Public Engagement" and what they say there is whilst acknowledging that efforts were made to consult, JHOSC concludes that the numbers reached directly seemed very low, and they point to failures in availability of documents in key locations and community languages and they also raise concerns over patient engagement and consultation taking place over the Olympic and holiday period. Are those issues that you recognise?
A. No.

Q. Not at all?
A. Well, first, the JHOSC were invited to comment on the duration and timing of the consultation and then JHOSC approved that. We asked them if the length of time was adequate and the JHOSC endorsed the consultation time and period, which is a matter of record. Secondly, there was a two-week period when there was a difficulty in accessing translated materials. After that period, that was rectified and public information was available in all local GP surgeries, in libraries, in town halls, in multiple languages and on our website and publicised as that. We had a worker working full-time reaching hard-to-reach groups like the small Somali groups working throughout Southall and other areas. We worked extensively with groups that helped with translation so they could reach into areas where there was difficulty understanding English, attending gurdwaras and temples. A very extensive consultation.

Q. If JHOSC's concerns were correct, that would be a serious concern, would it not?
A. I think these are important areas to consider.

Q. You have gone into this a little bit further in your latter response and the latter letter that you provided was a response to the Brent Patient Participation Group. Can you just have a quick look, please, at page 1755? In this what you are doing is you are talking about the consultation pretty much as you have just set out. What I wanted to ask you about is given the extensive steps that you have just described and that you set out in that letter that were taken as part of the public consultation exercise, why is it do you think there is such a strong and widespread perception that that is not the case?
A. I think the timing of our consultation was very difficult. The timing of this whole programme has been difficult because it coincided with wider changes in the NHS that were being imposed by Government which were unpopular amongst a wide range of people. There has been a lot of campaigning to save the NHS and to stop privatisation

within the NHS and people have become confused about the various processes in here. I would argue very strongly that what we are doing in North West London is exactly doing those two things and I would sign up to many of the petitions that have been around to save the NHS because we are exactly having a programme that does that.

Q. Does it trouble you given that you are obviously very passionate that these are the right decisions, these are the right changes to be made, that some three years down the line after the consultation process, this is still an issue?
A. It is going to continue to be an issue for a long time. This is a complex change and we need to continue working very hard to communicate as well as we can.

Q. Do you think now if the changes were delivering the benefits envisaged some of that concern about the consultation and lack of communication might have faded away by now?
A. A small amount of it may have done. I think because of the timing with the Election and the various campaigns that have been going on, that has continued to elevate concerns beyond where necessary.

Q. Can we move on and can I ask you about the business case. First of all, am I correct that there should be a business case for each individual hospital and for each CCG?
A. Yes.

Q. And that is there is also an overarching Implementation Business Case for the *Shaping a healthier future* programme itself overall?
A. Indeed.

Q. Can we go back to JHSOC, please, and can you look at pages 1707 and 1708? This is a section marked "Financial Viability and Business Cases" and what is set out there and going over the page is a series of requests from the JHOSC for the outline business case to be shared with the Committee. We can see they raised it in February and March this last year, August and finally March 2015. Are you able to assist the Commission with where the ImBC is at the moment?
A. It is in draft formation being informally discussed with the Department of Health and the Trust Development Agency.

Q. Are you able to help with why it is still in draft form?
A. Because part of the recommendations from the Secretary of State was that further discussions should happen with the local population around Hammersmith and Ealing to help define what a local hospital would be on those sites. That discussion and engagement has continued and helped define that and that has inevitably put in further time delays in that. There have been other delays around the merger with Ealing and Northwick Park Hospital as part of a separate process. That has delayed their ability to pay attention to this. A series of factors like that.

Q. Do you know when it is going to be completed?
A. I am the clinical lead. I am not a finance lead.

Q. Have you been given access to the draft document?
A. I have seen an early draft of it, yes.

Q. Are you able to help the Commission with why it has not been possible to share that document with this Commission?
A. It is in early draft formation, as I said.

Q. Are you able to help with who has made the decision that that documentation cannot be shared?
A. It is an implementation plan designed by the HCCGs but it is being shared with the Trust Development Agency and the Department of Health and they have given advice at this stage in its early development that it should not be shared.

Q. Can you indicate by whom you have been given that advice?
A. I could not be accurate with that, no.

Q. Is that something you could find out for us?
A. I can ask. I do not know whether I can find the answer.

Q. I wonder if we could turn back to your original letter in Volume 2 at page 607. You refer at the third paragraph down, it starts: "Significant progress has been made in this area …" and you are talking about out of hospital services. First of all, you describe the outline business case for the hubs as "in development". Again, in terms of that outline business case is that something that you have got access to?
A. I have not seen those, no.

Q. Do you know who has got it?
A. They are being developed by each individual Commissioning Group.

Q. But in that case the one for your area, is that something you have seen?
A. I am not working in a particular area.

Q. As the co-ordinator of the HCCGs, does it not strike you as strange that you have not seen the outline business case for the hubs - for all of them?
A. No, each borough is working locally to develop local hubs. They are included in the Implementation Business Case but when I am reading that I am interested in the clinical evidence around the changes that are being imposed, not the financial management of individual hubs.

Q. Do you know when those outline business cases will be ready?
A. No.

Q. If we turn next to the outline business case for investment in acute hospitals across North West London, again, is that something you have seen?
A. As I have just said, I have seen the overall Implementation Business Case in its early draft.

Q. Could you say that again?
A. I have seen the overall Implementation Business Case in its early draft.

Q. But you have not seen the specific business cases for the acute developments across

North London?
A. They are all included within the overall Implementation Business Case.

Q. So when you refer to "the consolidated ImBC being developed to provide a single consolidated view of these investment requirements", is that the overarching one you are talking about? It is the same one?
A. Yes.

Q. At the end of the paragraph you set out that once the ImBC is agreed further work can be taken forward. That is right, is it?
A. Yes.

Q. Can you clarify, are you saying that the developments that you set out for the hubs, the acute services, the developments you outline in those three paragraphs can go ahead with the plans still in development or do they need to wait until the ImBC is completed?
A. They will be going ahead of the full ImBC. The ImBC includes all the investment in all the hospitals. The local development in hubs in the community can happen before that. Indeed, it must do.

Q. Can you help the Commission understand the thinking behind the implementation of these changes on the basis of plans that have not yet been completed that are still in draft form?
A. Because that is the nature of planning within the NHS and Department of Health. The consultation was made on a pre-consultation business case where we had the outline financial analysis. Following that there is now a wider, more detailed business case that needs to be developed for each site.

Q. Is there a risk that proceeding on that basis might give rise to errors?
A. There is an opportunity to continually improve our plans.

Q. Is there a risk that it might give rise to errors though if the business plan is not fully formed?
A. If we did not have proper procedures to check that things were developing well then there would be problems, but we have a governance structure that enables us to improve our plans.

Q. Can I take it that you are confident there is not a risk?
A. For example, in the planned changes around maternity we have been investing in maternity services at West Middlesex ahead of our plans.

MS RENSTEN: Still on the ImBC, can I ask you to have a look at Volume 5 again and it is page 1806. This is the budget for external consultancy from February to December 2014. Could I ask you to have a look, please, on page 1806 there is an item, it says ImBC Assurance.

THE CHAIRMAN: Katy, can I just interrupt. If anyone does have a mobile it would be very useful just to turn it off or else you will be as embarrassed as that lady was when she just left the room.

Q. MS RENSTEN: Sorry, Dr Spencer, it is about halfway down the page. In fact, it is three items up and what it says is "Hospital BC Assurance Support and ImBC" and there is a figure of £1,235,000 to a consortium led by McKinsey's. Then slightly further down it refers to an item which is for August 2014 over the page "ImBC production not in original spec". Given that the ImBC is not yet completed, can we assume that there are going to be further payments required on top of those already made?
A. I would imagine it is highly likely. I am not the person to answer financial questions.

Q. Who is the person to ask the financial questions?
A. The Finance Director.

Q. It is unfortunate perhaps that we do not have the Finance Director here, is it not?
A. You could have invited her.

Q. Would you be able to ask the Finance Director if she would be prepared to put in a document addressing these issues?
A. I am sure you could do as well.

Q. I am going to continue asking about these items anyway. Can you help the Commission to gain an understanding in terms of the ImBC of why that spend of £1.25 million represents value for money?
A. As I have explained to you, I am the medical lead. I am not the Finance Director.

Q. Let me take it in short form then because I suspect your answers to all of these questions are going to be "I can't answer this because I am the Medical Director..."
A. That is what you invited me here to answer.

Q. "I am only able to deal with the clinical matters." Do you think that the £13 million which these consultancy fees amount to represents good value for money for the public?
A. If we are improving the quality of care and improving the outcomes for our population across North West London I would imagine this would be an extremely good investment.

Q. One of the issues, moving on, that has generated considerable controversy has been the closure of course of Hammersmith Hospital and Central Middlesex Hospital's A&E units. What you say in your letter at 605 is that you set out the closures were in response to increasing clinical risks, but it was quite a departure, was it not, from the original plan?
A. Indeed it was. It was a recommendation of the Independent Reconfiguration Panel.

Q. That original plan had envisaged that there would not be any closures of that nature until the out of hospital services were much more further advanced. That is right, is it not?
A. It is.

Q. We know, do we not, that after the closures in September 2014 there was a dip, a falling off in performance at North West London Hospitals in terms of accident and emergency waiting times?
A. There was a reduction in performance prior to the closure which continued afterwards, in line with many other A&E departments across the country.

Q. Am I correct that what you say in your understanding is this was to do with winter peaks and other variations and was not connected in any way to the closures?
A. I cannot exclude there being a small part of the latest closure. Change inevitably or often causes a small deterioration in factors. We have had meetings afterwards to look and see what we could learn and there are inevitably things we learn when we make changes.

Q. Can I ask you about that because there was an analysis put in place, there was an NHS inquiry put in place afterwards to see what had gone wrong. Do you know where that process has reached?
A. Again, I have not seen even a draft formation of that. My understanding is that there were delays in putting in place some extra beds in Northwick Park beyond where we had expected them to be. Those were put in place very shortly after the changes and that helped address the matters.

Q. Just in terms of the report I was asking about, do you know where that has got to?
A. It is within NHS England. It is not something I am involved in.

Q. So again no idea of when it is going to be completed or when that might be made public?
A. Again you would have to ask the NHS England London office for that.

Q. Turning back to the dip in performance, what you say is that despite that North West London was the highest performing sector in London and above the national average, is that right?
A. Indeed.

Q. I want you to comment on some other people's views of that and see if you can help the Commission understand how people have arrived at these different views. If we look at Volume 5 again and it is page 1860, this is from the Brent Patient Participation Group and what they say in the last paragraph, and I will read it out, it is about the four-hour waiting times, they are talking about your view of the causes for the failures in A&E. They say: "The focus on the aggregated figures for all A&E patients included urgent care centres and this disregards the widely publicised crisis at Northwick Park." Can I ask you whether the figures that you draw your evidence from do include UCCs as well?
A. Yes, that is the national target to include those figures. There is not an independent target to meet type 1.

Q. Can I also then ask you to comment on what is said in that document about the specific situation at Northwick Park Hospital? Is it correct that Northwick Park Hospital, despite the aggregate figures, was amongst the lowest performer for many weeks?
A. If you are looking at specifically type 1 figures, yes it was, and it is something that we take seriously and have continued to take seriously and is improving.

Q. Both the authors of that submission and a number of other witnesses have clearly discerned that they think there is a causal link between the performance at Northwick Park Hospital and the closure of the other two A&Es. Why is it you say they have got it wrong?

A. Because, as I said, there has been an external review to look at that.

Q. This is the review we do not have yet, is it?
A. Indeed, but if you look at the figures across North West London there was a deterioration in figures at Chelsea & Westminster for example which had previously been performing amongst the very best in the country which deteriorated at the same time by a similar scale. It is impossible to imagine that patients from around Brent were travelling down to Chelsea & Westminster to cause the deterioration there. We saw a similar deterioration across the rest of the country.

Q. Is it your thinking that it was largely about seasonal impacts?
A. It was very largely about seasonal impact, yes.

Q. If that is right, one would expect moving into spring and summer that effect would dissipate, would it not?
A. So you will find that NHS England's figures and North West London's figures improved in the last quarter as opposed to the quarter before. That is the only part of the NHS that has done that. Around the rest of the country has continued to deteriorate. You will find that North West London improved faster than the rest of London.

MS RENSTEN: Can we have a look slightly further on in that Volume at page 1851. This is a newspaper article, I grant you, but this is a recent document from April and it says: "All of West London's hospital trusts miss A&E waiting time targets in the last month".

Interruption regarding sound problems

Q. MS RENSTEN: What I am going to do after this witness is stop for a minute and reconfigure this slightly. Can I ask you ---
A. After consultation I hope?

Q. I do not have to! Can I ask you to comment please on that Met figure of only 89.2% so it is right, is it not, that they are still falling quite short of the targets?
A. I do not deny at all we have got more work to do.

Q. And you still say that is completely unrelated to those A&E closures?
A. I have said there may be a small interrelation. It is not a major factor.

Q. Can we move on and look at the out of hospital situation. What you say in your original document is that each CCG has made significant progress. Can we look at Brent? As I understand it, the out of hospital strategy is rolled out in five waves, that's correct, is it not? Can you assist with where that process has reached so far?
A. You would need talk to Brent CCG to be specific about Brent.

Q. Are you able to help with any issues which relate to specific CCGs?
A. In generalisation only.

Q. So if I ask you to comment on what has happened with the Wave 2 musculoskeletal services and the gynecological services tendering process in Brent, are you able to help

with that?
A. No.

Q. Do you know anything about it at all?
A. Only the headlines.

Q. Has anybody brought it to your attention or discussed it with you?
A. Some of the lay members here have raised it with me.

Q. Has anybody in Brent CCG raised it with you?
A. No.

Q. Can we go this far: there is still, is there not, a long way to go in terms of rolling out the out of hospital services?
A. Indeed.

Q. You also raise the issue of Ealing Maternity and in your original submission - and it is at 607 if you want to go to it - you set out that the timetable had been accelerated due to concerns about sustainability. At the time of your document a decision was expected on 18 March and that has also been delayed, has it not? Are you able to help with why that has been delayed?
A. As I mentioned earlier, one of the problems we had in A&E changes was we thought a ward had already opened and we had been told it had and yet it was delayed until after the A&E changes. When we were planning to make maternity changes we found that some of the increased maternity services at the Queen Charlotte were not yet available and ready so the CCG advised not to make a decision until it could be guaranteed that the premises would be open.

Q. Do you know when a decision will be available?
A. The CCG are planning to meet in a couple of weeks' time, I think, on the 20th to make a decision about this.

Q. So how does that delay and some of the delays that I know you cannot speak about in detail with the Brent tendering, how does that sit with your view that progress is going well?
A. I am very pleased with the way that has gone. Some of the changes happened earlier than we were expecting. Some were going slower than expected. This is a very complex process across eight boroughs, eight CCGs, and we are expecting it to take five or six years. I would be very surprised if there were not hiccoughs along the way.

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. Then with your permission, Commissioners, we will take a break afterwards and shift things around a little bit.

<u>Examined by THE COMMISSION</u>

THE CHAIRMAN: Dr Spencer, Dr Hirst is going to ask questions first, then Dr Lister and then I may have one after at the end.

Q. DR HIRST: Dr Spencer, unfortunately I have got several bees in my bonnet and I can see familiar faces and I apologise to them if I press you on certain things. One of them is about the geography of the area and what is happening. I have rather too small a map so I will have to do it out of memory, but when I look at the map of the reconfiguration that is going to occur across the whole of the area that you are Deputy Director of, I see St Mary's Hospital to the east, just by Chelsea & Westminster Hospital, and on the other side of St Mary's is University College Hospital. The Chelsea & Westminster is a very grand building. UCH is a huge massive building. UCH has its own acute stroke unit. St Mary's has its own acute stroke unit. I also understand from my own patients just before I retired how many services were being transferred from Charing Cross to St Mary's. I also know other than one ward in St Mary's that the most depressed and the most diverse and the most deprived areas are to the west - Ealing, Southall and some in Brent - and yet most of the services are being concentrated in what some would say are the most privileged areas. If you look at the map you would think the concentration should be in the middle somewhere. Why do you think that has happened?

A. If you look at stroke services, the ones you raised first, stroke services and where they were sited was part of a pan-London process that happened prior to *Shaping a healthier future*. It recommended that there would be in North West London two major acute stroke units. One would be at Imperial and the other would be at North West London Hospitals at Northwick Park. In the original designation, they said initially it should go to Charing Cross but when the opportunity arose it should move to St Mary's to be adjacent to the vascular services and the major trauma unit. That is what we were able to do with this thing so it is moving from Charing Cross to St Mary's, but there is also a stroke service and vascular service at Northwick Park to provide care in the outer parts of North West London. The concentration of population of course is different than just the geography. It is more concentrated and higher density in Central London and I agree with you entirely because of the historical nature of centres of excellence, there are more major teaching hospitals with clinical co-dependencies that enable you to run these major services in Central London. So major trauma, if you look at them there is the Royal London, St George's and Charing Cross all in the centre of London and not on the outside and the next major trauma centre along the road is in Oxford in John Radcliffe, but nonetheless we know, despite those great distances, they have had a major impact on reducing morbidity and mortality.

Q. But they were at Charing Cross and working very well. You have chosen the stroke unit as an example. You as an Ealing GP will know of course that that was great at Charing Cross.

A. I was trained at Charing Cross.

Q. And it is great at Charing Cross. All the expertise is there, the team is there.

A. And it will be the same ---

Q. I am not sure I agree with you about population either but UCH, I am right in saying has an acute stroke unit as well?

A. Yes.

Q. We were given the argument, "We are moving it from Charing Cross to St Mary's because there is a trauma centre and a neurosurgical unit is going to be there (although it was at Charing Cross and working very well there; in fact I am told it had been a leading

world centre) but that is going to be moved."
A. It will be.

Q. Whatever teams are going to be broken up and moved.
A. They will move in blocks. They will not be broken up.

Q. You hope.
A. That is what they tell me.

Q. That is what they tell you but you know it does not happen in that way. Next door - and it is next door because I do not walk very well - to where University College is and University College does not have a trauma centre, so you can have one without a trauma centre. Two acute stroke units are almost adjacent. I suppose what I am getting at is why St Mary's?
A. This was the designation of the *London Health Programmes* prior to *Shaping a healthier future*, not part of this programme.

Q. Could that not be changed?
A. It could be but we recognise the benefits of the co-dependencies with major trauma and with vascular surgery.

Q. That co-dependency is not happening next door.
A. It is not happening at Charing Cross at the moment. We can make it better.

Q. But it was happening at Charing Cross. There was a trauma unit.
A. There was not a trauma unit at Charing Cross.

Q. Neurosurgery was done there.
A. But not trauma.

Q. But neurosurgery was and if UCH can run one without a trauma unit ---
A. Are you denying there is a benefit to having major trauma and neurosurgery next to each other?

Q. Apparently UCH does.
A. Are you denying there is a benefit?

Q. Apparently UCH does.
A. And it can be done and ---

Q. Why can it not be at Charing Cross?
A. Because of the benefits of moving it. Can I just assure you the Royal College of Surgeons and the stroke unit both agree with me.

Q. Maybe they could be wrong. You never know. Pushing that a bit further, if, for example, something did come up that convinced yourself or others that things were not going in the right direction in a particular area, what is the mechanism for change in this project?
A. From a clinical point of view we have a clinical board which includes the medical

directors of all the trusts, some of the nursing directors, pharmacists and the chairs from each of the CCGs who meet together on a regular basis. We review the data around any changes that are happening and we make recommendations to the Implementation Board.

Q. A recurring theme in these events has been that there almost seems to be a juggernaut which seems to have started and it is impossible to stop, no matter what the argument. Taking it a bit further, how would the residents, for example in the west of the area, feel about having to travel in centrally when they are the most deprived and St Mary's and UCH are perhaps the most well-endowed and sophisticated ---
A. Which is why we are developing five major hospitals distributed across the area to provide good care close to where anybody lives. At the moment and in the past ---

Q. Not for Ealing surely?
A. Indeed they could go to Northwick Park, West Middlesex and Hillingdon and they are all available. At the moment those hospitals are much smaller and less able to give good care.

Q. And you would call those close hospitals?
A. I would say they are closer than the major teaching hospitals are at the moment.

Q. I am not sure others would agree transport-wise.
A. It is quite clear where the major teaching hospitals are at the moment.

Q. Can I put this a bit further then. St George's moved to Tooting and St Mark's moved to Northwick Park, a great distinguished bowel hospital. Major institutions do move. Why could St Mary's not move to Ealing for example?
A. Because then it would be too close to both West Middlesex and Northwick Park.

DR HIRST: Oh dear, but it is too close to UCH already, is it not?

Interruption

THE CHAIRMAN: Can we please ---

THE WITNESS: If you look at the geography of North West London and were to put five hospitals on there you would distribute them much the same as they are at the moment.

DR HIRST: I beg to differ.

THE CHAIRMAN: Can I just ask people in the public gallery, it is not easy for us to follow if you interrupt and I know it is sometimes difficult but can you try just to keep quiet. Thank you.

Q. DR HIRST: Forgive me for going on but what do you understand a local hospital will have within it?
A. A local hospital will have an urgent care centre to provide urgent care. It will have outpatients, diagnostics, some facilities, depending on the area, to provide renal dialysis, chemotherapy, day case surgery.

Q. But no inpatients?
A. It can have some inpatient beds normally for rehabilitation or for low acuity admissions.

Q. So do you think it is right to call that a hospital? Do you not think it gives a wrong impression? It is an outpatient centre, is it not?
A. As I say, it will do surgery and other things. It is a hospital. There are many of these around the country.

Q. Who would be admitted to such a hospital?
A. Somebody having day case surgery. Somebody who is rehabilitating from a stroke or from other trauma who needs local rehabilitation. Somebody who has instability in their social circumstances and needs some support and care before they go home.

Q. So they are going to be rehabilitation units then?
A. Yes.

Q. Do you not think the public has got the impression that when you put local hospital in that it is the type of hospital that you go in if you have a pneumonia?
A. I do not think so, no.

Q. We have had a different view expressed to us during this period and again if I could ask you about another phase that is coming up and was used by some witnesses that I think are appearing later today, which is this concept of "hollowing out" services. I just want to see what you think about it and whether you think it exists. If you reduce services from a major, successful institution or, even more than that, you say that it is at risk, then by definition it is not used and then you can say it is not used so we do not need it. Does that process exist?
A. So I think it is quite possible when people know that a unit is going to close that it will exacerbate that closure. Part of the success at Central Middlesex A&E, it partly failed because of the extreme success of its urgent care centre which took 85% of the work away, which is unprecedented around the rest of the country, people have not attained that, but It meant that the activity which was remaining at the Central Middlesex site was too low to allow its success to continue.

Q. But thinking of the role of the Central Middlesex, which I understand is a big building to be used ---
A. Indeed.

Q. --- Why was gastroenterology moved there? It was a major world centre, was it not?
A. Because, as you said, it wanted to be next to St Mark's the major unit that was at Northwick Park.

Q. It wanted to do that?
A. It did.

Q. I am interested to hear that is the view, but surely that argument was later used that Central Middlesex has reduced activity therefore there is no purpose to Central

Middlesex?
A. Central Middlesex absolutely has a purpose. It is going to be developed as a major elective centre.

DR HIRST: Thank you very much anyway.

Q, DR LISTER: Just a couple of questions, Dr Spencer. First off, the Independent Reconfiguration Panel obviously gave a limited, conditional endorsement of what was going forward. That was at quite an early stage, was it not, because the plans they were discussing and the assurance they were given were based on a much earlier version of the business case and the business case, as I understand it, from evidence we have heard, is actually looking at a scheme increasing in scale from £190 million originally right up to, I think the latest estimate is between £700 million and £1 billion and the whole scheme seems to have changed. Do you think it is appropriate now that the endorsement that you had from the Reconfiguration Panel still could be seen to apply to what is currently taking place?
A. Yes, I disagree it was done at a very stage. Certainly the business cases have developed since and the business case that they considered did not include either Charing Cross or Ealing because those were still being designed. Those are things that include the figures. Because of the time delays brought in by the IRP and by the judicial review, it has meant that the land values have changed and hence the increase in costs, but the overall plan of what is being designed is exactly the same.

Q. But the business cases still have not been put forward, have they?
A. As I say, they are in draft formation at the moment.

Q. As a doctor and a clinician you work on the basis of evidence presumably and wanting to know what the outcome is going to be before you start an intervention? Should it be appropriate to have the business cases finalised before hospital closures and changes are taking place?
A. You would have to change the planning cycle of the NHS, which is not something I can do.

Q. If the business case is not in place, is it appropriate to start major components of that business case in advance of knowing what the full business case is going to be?
A. The things we are doing at this stage are implementing out of hospital which we need to do prior to the business case.

Q. On the out of hospital thing, presumably you are following the developing evidence on the question of out of hospital services replacing and supplementing hospital care?
A. Indeed.

Q. And you saw the Barclays research for the Nuffield Institute which surveyed a range of community-based interventions and came to the conclusion that the impatience in the system to show changes on what might be an unrealistically short timescale was a bit of a problem. Given that we still have not got the community services in place, do you think it is still appropriate to press ahead with reductions in hospital services?
A. We have currently said we are not changing hospitals until we have effective community services and that is still our intention.

Q. But you are pressing ahead with the closure of Ealing Maternity most likely when the CCG meets. This has been postponed rather than altered, has it not?
A. And the alternatives for that have been put in place already.

Q. You are convinced that the population of Ealing with all its social problems and mobility issues and so on will be satisfactorily served by hospitals in West Middlesex, Hillingdon and Northwick Park?
A. The maternity services yes, the majority of their care will continue and increase in the community closer to them.

Q. So more home births in Ealing?
A. A small amount more home births. There is room for more there but we recognise the growth of that is likely to be very slow. However the antenatal and postnatal care which often at the moment means travelling to hospital will happen in community centres and child centres closer to people.

Q. You say in your evidence that the closure of Ealing was brought forward because of the concerns over the quality of services and issues there. There are two possible responses to that. One is to address those problems by increasing the investment there and developing the service to maintain a provision and the other is obviously to close it down. Given the uncertainty that has been generated over this period of time, do you not think possibly investment in that service, which has already been there and is well established and a very substantial service, would have been a better way forward?
A. So the key thing that needs investment in is staff. The key reason why there is a failure to progress in quality of services at Ealing compared to elsewhere is their inability to attract new staff. The standards across London, which are an improvement on current, is that we should have a consultant obstetrician on the labour ward day and night, 24 hours a day, seven days a week so 168-hour consultant cover. At the moment Ealing is doing that for 60 hours a week. If you go two and a half miles down the road to West Middlesex, it is at 140 hours and in six months' time they will be at 160 hours. That means that women there are getting a substantially better quality of care than is able to be delivered at Ealing. Ealing had vacancies, they have advertised for them and are unable to fill those posts. It is inevitable that if you are a local GP you will start referring people where there is a demonstrable higher quality of care. You could call that hollowing out or you could call that building a better service and enabling people to choose that.

Q. You could call it making it very unattractive to apply for a job in a place that is known to be on the brink of closure. Finally one other question which is about this whole question of the Commission on Hospital Care for Frail Older people which was run by Serco and the *Health Service Journal*. This was last year in 2014. They said: "There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true." Do you have any evidence that these assumptions are true?
A. I am very glad you raise that because it is quite clear we are making changes for clinical increment, not for financial changes. There is no good evidence that community services are cheaper and this programme is not designed to be cheaper. We are going to

A continue to invest in healthcare because what we do know improves healthcare is 24-hour, earlier consultant assessment and the more senior the person assessing the person earlier gives a better outcome. It is improved by having good nursing available more often and improved most by having good, higher quality general practice. Those are things we are intending to invest in and enable.

B Q. One inevitable final follow-on question then, if you are investing all this money, given that the best offer that we had during the Election for the future funding of the NHS was a continued freeze on real terms funding over the period of time, where is this extra money going to come from?
A. It is by redesigning the way we work, enabling GPs to work in networks of care which can provide weekend access in other services, and it is by working more integrated with community and hospitals working together which is more efficient. It reduces the number of readmissions which are expensive in monetary terms but immensely more expensive in
C terms of personal cost.

DR LISTER: There is obviously a long debate to be had. Thank you very much.

Q. THE CHAIRMAN: Can I ask you one question. Could I ask you to look at page 608 of your bundle? It is a document we have already looked at. The last but one paragraph
D if I can just read it to everyone. You say quite properly that "local clinicians have worked tirelessly to agree a deliver changes that we know will result in better care for our patients." You go on to say: "But change in the NHS often raises concerns and this programme [by which you are talking about the *Shaping a healthier future*] has understandably met with significant opposition from a range of stakeholders who are concerned about the future." My question is this: which of the concerns about the programme that have been raised do you think are the most understandable?
E A. The most understandable? People are concerned, I think probably access is the thing that most concerns people and most worries people. There is a myth that having a hospital close to you improves outcomes. There is no evidence whatsoever that having a hospital close to you is better for you. That is a myth that is propagated regularly. I think that is the most understandable. The one that is most evidently incorrect is that somehow this is running down the NHS to make it privatised. Clearly by improving the NHS locally we make that less likely but that is not what the campaigns are saying.

F Q. You have given two examples of the most understandable concerns and you have dismissed them both pretty robustly. Are there any concerns that have been raised that do concern you?
A. I continue to be concerned about all the things that are raised, listen to them and try to understand if there is a basis for them rather than anxiety.

G Q. With that are you saying there is no basis for any of the concerns?
A. We continue to monitor them very closely.

Q. That is not an answer to my question. I will ask it one more time: are you saying that there is no basis for any of the concerns?
A. I have not found a basis so far, no.

H THE CHAIRMAN: Thank you very much. We appreciate you coming to give evidence.

A Thank you.

The Witness Withdrew

After a short break to reconfigure layout of room

DR MOHINI PARMAR, Chair, Ealing CCG, GP Partner, Barnabas Medical Centre

B

THE CHAIRMAN: Can everyone take your seats, please. Dr Parmar, thank you very much. I see you have been listening to the last witness so you know the procedure and the order in which we will ask you questions.

Examined by MS RENSTEN

C

Q. MS RENSTEN: Dr Parmar, can I ask you to give your full name, professional address and current posts held to the Commission please?
A. (Dr Parmar): My name is Dr Mohini Parmar. Postal address is Perceval House, Uxbridge Road, Ealing, London. I am a part-time senior partner at Barnabas Medical Centre in Ealing and I am also Chair of the Ealing Clinical Commissioning Group.

D

Q. Could I ask you please to turn to Volume 2 and to page 591 to 598? Can you confirm that is your submission and you wish it to stand as your evidence to the Commission?
A. It is indeed.

Q. Can I ask first of all about what you say about the specific needs of the Ealing population. It is growing rapidly, that is correct, is it not?
A. At the moment the ONS figures have said that is inevitable but not that we know how much the growth is going to be. At the moment the ONS figures have not shown from the figures that we have got that there is growth, but we do know that there are some developments going on in the Ealing borough.

E

Q. In front of you, you will also see Volume 1. Can I just ask you to have a look at page 74 in Volume 1? This is the submission that was provided by the London Borough of Ealing and I just want to take you to what they say about population forecasts and ask about your views on that. It says that Ealing's population, as per the latest statistics, is estimated at 342,500. The borough's population is forecast to grow to over 400,000 by 2031. "These figures are significantly higher than those referenced in the *SaHF* business case." Can I invite you to comment on that, please?
A. I am aware of this discrepancy on the ONS numbers and I am also aware of the numbers around 400,000 because we also know from the GP registered lists we operate to a working number of around 390,000.

F

G

Q. If the figures are an under-estimate, does that not have a significant impact on the projections of what services will be required?
A. The services that we are planning and budgeting for within our out of hospital services relate to the GP registered list so closer to the numbers that have been submitted by the London Borough of Ealing.

H

Q. So you are saying that the *SaHF* proposals are based on GP figures not the ONS

figures?
A. What I am saying is Ealing CCG when it plans for its out of hospital services, when it plans for the services it is going to commission from hospitals is working on the GP registered list.

Q. If that is not correct, if it is an under-estimate, does that cause a problem?
A. The GP registered list is perhaps one of the most accurate numbers we have. We know that we have a certain element in London of an unregistered population and we cater for that, but the GP registered list, we have always had this discrepancy. This is not new.

Q. What about hard-to-reach populations which are not on the GP list, how does that figure in the population estimate?
A. It absolutely figures. We are well aware of the wards and the particular GP lists and the particular parts of Ealing where we know we have hard-to-reach groups and the services and special care that we need to take to commission services from there and to ease the access for those residents.

Q. So are you confident that the population projections are accurate?
A. I would say that the planning assumptions that we are putting in place for out of hospital services to ensure that access to all Ealing residents is uniform is based on the GP registered list and on the patient flows, the demographics, taking into account deprivation.

Q. Just thinking about some of the groups, am I right that the most high index of deprivation in the area is concentrated around the Southall, Northolt, Greenford and East Acton areas.
A. Yes, there is Walpole, Southall, Greenford and East Acton, yes.

Q. So those are the groups you particularly want to reach in terms of provision of high quality, accessible services, is that right?
A. My responsibility as Ealing CCG Chair is to commission services for the entire population of Ealing and take special account of those groups for whom it is not as easy to access NHS services.

Q. Are those not the very populations whose natural hospital is currently Ealing?
A. Again I will come back to say that my responsibility is to commission services and to commission the services that are delivered to the high quality standards to which I would expect every Ealing resident to have access. It is on the basis of quality that I would determine where the services are to be commissioned. The second point, it is then the responsibility for us to make it easy for people to access those services as close to home as it is possible to do so and in the right place when it is right for that to be done.

Q. I understand. I was just asking whether at the moment you agreed with me that the natural hospital for those populations to gravitate towards is the current Ealing Hospital?
A. Ealing Hospital has been in Ealing since 1970. It is well established. It has served the Ealing population and continues to serve the Ealing population extremely well, but what I come back to again is it is about us commissioning for high-quality clinical standards and the ability for us as a NHS to be able to provide that equally for all residents.

Q. If the function of Ealing Hospital changes though, will it have a significant effect on those populations?
A. Where we commission services, plan them and mobilise them, we will do it on the principles, and we have talked about these three principles, which is to localise whenever it is possible to do so as close to a person's home, to centralise when it is right to do so, and, more than anything else, to work with our social care colleagues and the voluntary sector to integrate it across the system. This is absolutely in response and planning for the changing needs of our population.

Q. So am I right that you would only endorse changes to hospital services if you felt confident that the alternative out of hospital services were able to ensure that the quality of healthcare would not be diminished?
A. Absolutely. There is absolutely no doubt in my mind that the quality of service that we deliver in acute, out of hospital care and primary care needs to be delivered to equal quality standards. We cannot accept anything less than that.

Q. And is it equal quality or are those changes only to be endorsed if they will deliver a better service?
A. When we commission services we will set up quality standards which will allow the individual to have an integrated pathway across the system, considering, as far as the patient is concerned, the quality of care that is offered to them from their GP, from community services, from an integrated care service and acute service to serve their needs.

Q. So is it just exchanging like-for-like? That is what I am asking. Is it just exchanging like-for-like or are you driven by the idea that the services you are seeking to provide must be better?
A. Not better but they should be more appropriate for the person's clinical need, so when it is absolutely appropriate for the individual to have their care in an out of hospital setting, because we know now with the changing demographics that people with long-term conditions and people with cancer are living for longer which is all a good thing with integrated services to be able to offer that composite of services closer to a person's home when it is appropriate to do so and right to do so and clinically right and gives us better outcomes then absolutely yes, yes because that is what I would want for me and my family as well.

Q. Is that not just a different way of saying "better"?
A. Yes. Good!

Q. Can I ask you, please, to look at Volume 5 which is one of the volumes in front of you. It is the first document in there. If I could ask you, please, to look at page 1544. What this is is a submission by a gentleman called Dr Tomas Rosenbaum, who is a Consultant Neurologist at Ealing Hospital and I just want to invite you to comment on what he says. On the bottom paragraph at 1544 he says: "Ealing Hospital is located in an strategically perfect place. It is radially easily accessible from Southall and Ealing, it has excellent public transport access mainly radial along the Hillingdon Road and crucially only 150 metres … away from the about to be developed Hanwell Crossrail Station." Do you agree?
A. The Ealing Hospital site, yes, it has got very good access to public transport. Yes, it is

very well located.

Q. And then what he goes on to say at the top of that page, by contrast in relation to Northwick Park Hospital and West Middlesex, he says there are very poor transport links. Again, is that correct?
A. I would not say that West Middlesex and Northwick Park do not have good transport links. Northwick Park has an underground station next to it and it has good transport links just as Ealing does.

Q. Is it as easy to get from Southall to Northwick Park Hospital as it is to get from Southall to Ealing Hospital?
A. From Southall it is probably easier to get to Hillingdon or West Middlesex Hospital or take the train to St Mary's than it is to get to Northwick Park. You are crossing two roads, yes.

Q. Let me rephrase it. Is it easier to get to Ealing than it is to get to any of the other hospitals which are going to stay as major hospitals?
A. Ealing Hospital is located in Southall so for obvious reasons it is within the geography of Southall.

Q. So at a very basic level will the transformations that you are talking about mean the people who do need hospital services, and I appreciate that part of the driver is take things out of hospital, which are currently provided at Ealing, they are going to have to travel further, are they not?
A. The services that are provided on the Ealing Hospital site, the services that all of us get as NHS most of them are provided in an outpatient diagnostic setting and I would expect all those services to continue to be delivered on the Ealing Hospital site. Now we have got a merger with Northwick Park and Ealing it is actually easier to be able to support the delivery of all those outpatient services, whether it is renal dialysis, whether it is outpatients, whether it is diagnostics, whether it is day case surgery, on the Ealing Hospital site. What is also true further on to add is that for patients who do require interventions, for which we know specialist expertise and technical expertise with the new technological advances, asking them to travel to a place where they get the best clinical care to improve the outcomes for their clinical case is the right clinical thing to do.

Q. But the question I was asking - I appreciate you are answering a slightly different subject - is whether they will have to travel further if they have got to go to hospital? We understand the clinical superbness of that hospital but will they not still have to travel further and have longer and more expensive journeys?
A. The balance of being able to provide a service for the right clinical outcomes and having to travel slightly further, all the evidence is that to get the better outcomes mitigates some of the inconvenience of having to travel further, but again coming back, it comes back to the point that 80-90% of the activity will be delivered locally because that is the right thing for the patient.

Q. When you say it will be delivered locally, do you mean on the Ealing Hospital site still?
A. On a combination as currently happens in the Ealing Hospital site and in the other

community hubs in Ealing but within Ealing borough.

Q. I just want to tease this out a little bit more just in terms of the transport links. Could I ask you please to have a look at Volume, page 1745. This is a submission from a gentleman called Dr Sahota, who I am sure you know because he is a fellow Ealing GP and he is also a member of the Greater London Assembly.
A. Yes, I do.

Q. What he says at his paragraph 4 is that *SaHF* has failed to take into account the impact on the local population. West London has pockets that are the most socially deprived in the country and Southall is particularly deprived. Then what he goes on to talk about at paragraph 7 is this: "I am also very concerned at the increased travel times for patients as a result of the A&E closures. If a patient lives in Southall or Hanwell and needs to get to Northwick Park, it will take about an hour and 40 minutes on buses." Are you confident that that is not something that is going to cause difficulties?
A. In the *SaHF* proposals, we said we would have five major hospitals. They are St Mary's, Northwick Park, West Middlesex, Hillingdon and Chelsea & Westminster. Patients from Southall could travel to any of these hospitals and that is what it will be and the evidence that we have had in terms of travel times, in terms of blue light ambulances is there in the *SaHF* business case which says there is a very marginal --- for blue light ambulances there is no difference. What we do know is that for carers there is a slight increase but that is where we are with the travel times.

Q. So two experienced practitioners, one based in Ealing Hospital, a consultant, and another a GP with a wide ranging practice in the area, are they both wrong to be worried?
A. I think the concerns are valid and right and I think it is our responsibility to address the concerns. We also know that on the Ealing Hospital site in the *SaHF* proposals, whether it is urgent care centres, and we do not know what the A&E changes are going to be because we are waiting and waiting for Bruce Keogh's report to come through at this point, so some of these things are still to be determined.

Q. So are they wrong to be worried?
A. I do not think it is right and wrong. It is quite right for people to be concerned, to address those concerns and it is our responsibility to address them and communicate our responses and deal with them.

Q. Thinking about the plans for Ealing Hospital, we have talked about this it bit, can you assist the Commission with what services will definitely remain at that site once it becomes a local hospital? Do you know?
A. The plans that are in the outline business case which have been jointly developed by Ealing CCG, we had three or four public consultations and roadshows where we talked about it along with Northwick Park and London North West, as you know, it is now a merged organisation. The services that will stay on site will be a 24/7 urgent care centre which would then be enhanced to the new London and North West London specification and it would have full outpatient facilities, full diagnostic facilities, renal dialysis, Moorfields on site. It would also have day case and inpatient beds on site.

Q. Do you know how many inpatient beds?
A. That is still to be worked through at this point. The numbers that have been around in

A the public domain are somewhere between 70 and 100.

Q. Do you know when that will be decided?
A. The clinical model of care has been worked through to a degree with the consultants. As Dr Spencer mentioned earlier, the outline business case is currently being discussed with the Department of Health and NHS England at this point.

B Q. In terms of whether you know when that is going to decided, is that a "No" you don't know?
A. Indeed.

Q. Can I ask you about the plans for the closure of the A&E department at Ealing Hospital. You have just said it is going to have an urgent care centre. What you describe that as in your document that you produce, and it is at page 596, is a local A&E and GP-
C led urgent care centre.
A. Would you remind me?

Q. Volume 2, 596, this is your submission to the Commission. What I wanted ask you about is what is a local A&E?
A. So what is clear is that we know that there are no planned changes to A&E at this
D point and we are all waiting for Sir Bruce Keogh's report to come through, which is being discussed at a national level, and when the report comes through clearly we will look at those and comply with all the requirements of that report for how we deliver services for people in North West London.

Q. Does that mean you do not actually know what a local A&E will be composed of at the moment?
E A. That is correct, yes.

Q. Do you know for example - you may simply not know - will it be able to take blue light emergencies?
A. I don't know. We have to wait for Bruce Keogh to give us his full report.

Q. Do we know when Bruce Keogh's report is going to be available? I know that is not
F in your domain?
A. Apologies, I do not.

Q. Assuming that a local A&E is in some way different from the current A&E because otherwise there would be no point in this exercise at all, what would happen to service users and patients who require full A&E? Where will they go?
A. We know to improve outcomes for patients if we have what we call a full A&E it is
G co-located with surgery, it is co-located with other units so that patients have the full senior clinical input and more than that the technological support in terms of radiology, in terms of intervention and radiology to give them the best outcomes. So we know that the big A&Es in *SaHF* we have got a proposal for five major hospitals but, as I said, what is going to happen to a local A&E we will wait and see when Bruce Keogh's report comes through.

H Q. So we do not know what a local A&E is going to be composed off?

A. Yes, as I said, we are waiting for some of the clinical guidance and the evidence to come through and, as in anything in medicine, things change and we will respond to it.

Q. We do know there is not going to be a full traditional A&E at Ealing Hospital any more?
A. There are no plans for any A&E changes we have said for the next three years.

Q. When this service comes on stream will it be GP-led or consultant-led?
A. Once again once we get the clinical model of care we will work through what is the right clinical expertise. GPs will always be working in urgent care centres. They work as a combination. What we have also done in Ealing at the moment is GPs are providing extended hours over the weekend. The range of services that we are trying to provide in an out of hospital setting continue to increase. A lot of people do go to urgent care centres. We know there is a need for primary care but the right place for a lot of those patients to be seen is by a GP.

Q. I do not know from your previous answers if you are going to be able to answer this but what you also say on that same page, and it is in the second section, is that urgent care centres will be the first point of access and then you go on to say: "The Urgent Care Centres at Hammersmith Hospital and Central Middlesex Hospital now offer an 'enhanced specification' to widen the range of conditions treatable. This ensures that Ealing patients accessing care at these sites are able to access services at urgent care services which would require accident and emergency access in other parts of London and England." What services does an enhanced urgent care centre provide? What are the A&E services that it will provide that a normal urgent care centre would not?
A. Some of this stuff is around pediatrics in terms of having additional paediatric support on site and it is also to do with the access to radiology investigations. So when Ealing's urgent care centre was commissioned about three or four years ago our specifications were already of a higher standard but we are reviewing them at this point and over the next year our urgent care specification will be completely in line with those of Central Middlesex and Hammersmith but, as I said before, they were already commissioned to a higher standard.

Q. What Dr Sahota says, and I will take you to it if you need me to, at Volume 5, 1745, is 28,000 patients a year transfer from Ealing Hospital UCC as it currently stands to Ealing Hospital A&E. Those departments are both on the same site. What he expresses is concern about the risks if the two are no longer co-located. Does he have a point?
A. There are examples of urgent care centres up and down the country which are not co-located with A&E. Hemel Hempstead is one of them. There are examples. For those areas where urgent care centres are not co-located, there are proper clear pathways in place. Those are networked with major A&Es. There are clear pathways with local ambulance services to ensure that patient safety and quality is not compromised.

Q. Can I ask you just to have a look at Volume 4, page 1421, and what I am going to take you to is a very short submission by somebody we are going to hear from later. This is a short submission from a member of the public and what she sets out in this is an incident that she says occurred with a neighbour of hers and what she describes is this, and I will read it very briefly: "One of my neighbours was taken ill. His brother, knowing that the Ambulance Service was very busy, took him to CMH in a cab. In the Urgent Care Centre

his condition worsened and he collapsed. The staff at the UCC had neither the right equipment nor the specialist knowledge to revive him, so they called an ambulance. By the time he was revived, he had not been breathing for 15 minutes and suffered brain damage. He died in hospital two weeks later." What I want to do is invite you to comment on whether you think there is a risk in non-co-located A&Es and UCCs in the light of that anecdotal evidence?

A. Obviously I cannot comment on this because I do not have any details on it, but I think what I will come back to saying again is that there are examples up and down the country where we have urgent care centres which are not co-located with A&Es. It is our responsibility when we commission those urgent care centres that they are properly networked with a major A&E, that we have very, very clear clinical pathways in place which are agreed with the hospitals, with the London Ambulance Service and that these pathways and they processes are clearly owned and vigorously tested by the clinical and operational teams.

Q. You say in your statement about vision. Services need to be easy to use and well understood by users, do they not?

A. Absolutely.

Q. Is there not a risk that people, particularly from non-English speaking communities, simply are not going to understand the difference?

A. I completely recognise that risk. I think it is our responsibility to spend time in different methods of communication because all of us learn and absorb information differently to ensure that people understand what is the best way to access services.

Q. Do you think you have been successful in doing that?

A. We have been successful in some parts. I would completely acknowledge that we could do more.

Q. You talk about the time for closures and I think you have said nothing will happen for three years. Can you be more precise about the time-frame?

A. What I can say is there are no planned changes for the next three years. I cannot comment beyond that.

Q. What effect do you think that uncertainty has on public confidence?

A. Any uncertainty creates an element of anxiety and I recognise that, but I can say categorically, and I have said this publicly, there are no changes for the next three years.

Q. Thinking about the out of hospital services, they are still at a fairly early stage of development, are they not?

A. Our out of hospital strategy is clear. We have shared this with our Health Development Board and with our scrutiny. It is in its early stages of implementation but it is a clear plan across the health economy.

Q. It is a pretty Herculean task, is it not?

A. It is what is the right thing to have done, irrespective of anything else.

Q. I do not know whether you can answer this or not but given what we hear about the tightness of funds and the need to spend public money wisely, what is your take on

spending £13 million on consultancy fees in ten months?
A. I am not going to comment on that. I think you need to talk to the Finance Director please.

Q. You are clear that your CCG wanted to keep Ealing Hospital as a major hospital but ultimately you chose to support the changes. That is right, is it not?
A. My letter to the JCPCT was very clear in what our preferred option was and we are absolutely going to go forward with it.

Q. Does that ultimately suggest that there was a lot of discussion and perhaps dissent about this issue?
A. I think it is fair to say and I have been to many, many public meetings and I have met many people before that people clearly have anxieties and concerns.

Q. I meant within the CCG because ultimately you said you took a decision to support and I wondered what the thinking process to get to that was?
A. We are GPs. We live in Ealing. Most of us live and work around the area. We are going to have concerns but eventually we have to make decision on the clinical evidence that it provides and what is the right thing to do.

Q. Can I just ask you hypothetically, if the *SaHF* programmes was reviewed and a decision was taken to keep Ealing as a major hospital, would your position then be that is clinically unsafe and should not be done?
A. What is true is that the *SaHF* programme looked at how we were going to deliver services across a health economy around a population of two million and how the services were going to configured. The plans put forward allow the best opportunity for that to happen. Ealing residents use every hospital in North West London. We are absolutely unique. We use every hospital in North West Hospital. Sixty per cent of Ealing women choose to deliver outside. What I spend in Imperial is equivalent to the same amount of money I spend in Ealing Hospital.

Q. If *SaHF* turned round and said you could keep Ealing Hospital as a major hospital would you say to them no, that is not a good idea?
A. The option of keeping Ealing Hospital as a major hospital, if there was part of the way we could deliver it, we are talking in a hypothetical situation. It is hypothetical. If you have a blank piece of paper, who knows.

Q. So hypothetically as an Ealing GP would it have been your first preference to have Ealing as a site for a major hospital?
A. If you have a complete blank piece of paper and yes you had a hospital in North West Hospital that catered to all the residents of North West London and was able to provide care and provide an even easier access to Ealing residents, of course.

Q. Can I ask you about the maternity service? We heard on one of the previous occasions from one of the midwives and what she told the Commission was about the modern birthing facility that had been open there for only a few years. She talked about the changes and improvements she had seen in local women particularly from BME communities accessing services and becoming more open to new ways of thinking about birthing plans and taking a more empowered role. She was very positive about that. We

also heard from Dr Lowy, who is a retired endocrinologist, and she spoke about the needs of women who had gestational diabetes. What both were talking about was the particular expertise that had built up linking the populations that are using Ealing Maternity and the staff that were working in Ealing Maternity. Both of them were very worried about that particular expertise becoming dispersed and therefore lost. Can I invite you to comment on those views, please?

A. Absolutely. Ealing Maternity has provided a service to women. The changes that we are proposing will retain the ability and enhance the ability for the community model of care for women who have got diabetes, for low and medium- risk pregnancies in Ealing within the Ealing borough and some of them on the hospital site itself. I do not see that clinical expertise being dispersed. What I see is that clinical expertise being integrated and linked across both the primary, the midwifery and the acute sector so the woman get continuity of care.

Q. So you do not share those concerns?

A. I would say that the community model of care and the model of care that we have designed will enhance the clinical care that she will receive.

Q. In terms of the actual decision-making process about the closure, in February when you prepared your submission what you said was that the change had been accelerated as a result of concerns about future sustainability given the falling number of bookings. I just wanted to ask you this: is it not something of a self-fulfilling prophecy if you say somewhere is going to shut, people will not book into it, particularly with something which is so time-sensitive as pregnancy?

A. I can understand that hypothesis, but what is also evidenced is that Ealing Maternity historically has been a very small maternity unit, one of the smallest in London. The number of births across North West London has been declining and in Ealing it has declined further than in any other unit across North West London. It then became clear that we could see that rate of decline and it was our responsibility then to plan for when that closure would happen and in that planning to ensure that we have both the physical capacity and the workforce in the right place at the right time and that it was tested before we had make to a decision on the date of closure.

Q. Do you know when the decision is going to be made?

A. Ealing CCG has a governing body in a couple of weeks' time and we will be looking at the evidence at that time.

Q. Is that going to be a meeting at which a decision will be made or is it a discussion meeting?

A. I can say at this point that it is a meeting we will be having in public and that is all I can say right now.

Q. Just finally, the last thing I want to ask on this and indeed any subject is you have provided a further document and it was an email which was sent by Andrew Pike on your behalf about the delay in closure and what you say is that: "Ealing Hospital is currently a safe place to give birth but we know that in future Ealing may struggle to meet those standards." First of all, can you explain what you mean by that and, second, can you tell us what the evidence for the prediction of future risk is based on?

A. Yes, of course. We know, and this has been seconded clearly by the Royal College of

Obstetricians, that to deliver the best quality outcomes for women we need to have increased clinical and consultant input which would require 168 hours of consultant cover and a one to 30 midwife ratio. We also know that the other hospitals in North West London have been investing in their workforce and provide much more consultant hours in the labour ward. Ealing only provides 60 hours of consultant cover. This will inevitably lead to an unequal service for Ealing women. It is my responsibility as Ealing CCG Chair to ensure all women in Ealing get the same quality of care. For example, West Middlesex already provides 140 hours and after the changes it will go right up to nearer 160. Northwick Park already does 98 hours. Queen Charlotte's already does 98 hours. It is about having the same access to quality care for all Ealing residents.

Q. It is currently safe on 60 hours, is that right?
A. The services being provided on the Ealing Hospital site are clinically safe.

MS RENSTEN: Thank you. I have no further questions. I should apologise, I have slightly overrun my time.

THE CHAIRMAN: I think we will be okay from the indications I have had from Dr Hirst and Dr Lister. Dr Hirst?

Examined by THE COMMISSION

Q. DR HIRST: I have not got much because Ms Rensten has explored most of my concerns. I can only ask this: I have been given the impression that many Ealing residents feel that they are the cannon fodder of this process. As much as there is the need to improve the out of hospital services, and many of those services that have been suggested are already established in other areas in Hounslow, for example, and so on, and these are very, very good, I am not sure how relevant they are to *SaHF*,; they are just to do with good practice. I speak as an Ealing resident as well and, nevertheless, secondary care is the major focus, the major concern. I just need to ask you, as I suppose I tried to ask Dr Spencer, this paradox that those who are most deprived and the poorest are having to travel the furthest – and I know you have made light of it but we have heard evidence that this is not the case and the travel issue is great - and are having to go the furthest and use the most money for their secondary care and that those who are most privileged do not. It is the opposite way round. In other words, you mentioned the train service from St Mary's to Ealing but the service goes in both directions. I will not go on too much about it but putting that case and seeing that as an Ealing resident and you as the Chair of the CCG which represents Ealing, perhaps it is your role to look for that blank page and maybe fight for Ealing to have a major hospital?
A. Okay, so that is an interesting question. I would say my role as Ealing CCG is to commission the best services for Ealing residents. It is quite an interesting paradox and what you have suggested is that if somebody is from a deprived community the best care should be through the secondary care sector. I would submit to you that actually the more difficult it is for people to access services, the more deprived they are, it is our responsibility to provide the care closer to the patient's home and make it easier for them to access primary care, make it easier from them to access care for long-term conditions and provide an integrated health and social care model. You and I know for a lot of these people ---

Q. I was asking about secondary care. As I say, I accept all of that and we all accept that but people approach me in the road and they are concerned about their secondary care and where it is located. We accept and take as read all you have said, and as a practising GP that is what I worked for all my life, but where secondary care is necessary is it not your role as Chairman of Ealing CCG to perhaps fight, I do not know what verb to use, or what word to use, so that Ealing residents who are the most deprived have the same privileges as those who are not so deprived?

A. Absolutely. So I would agree with you entirely.

Q. I am talking about secondary care.

A. If we take just secondary care I would expect the same access and the same quality of secondary care for everybody.

Q. But that is not the case, is it?

A. So therefore I would say a large proportion of Ealing residents go to Imperial, some proportion go to Chelsea & Westminster when we do elective care. We choose as GPs to refer for where we get the best clinical outcomes. For a lot of my paediatric surgery I refer to Chelsea & Westminster.

Q. Why could Chelsea & Westminster not come to Ealing then?

A. If you can get them all to move ---

Q. Why could you not fight for that because hospitals do move, do they not?

A. Yes, hospitals do move but the question is also services can move so now that we have got the Northwick Park and Ealing merged trust and Northwick Park is a regional centre for max fax. You have got St Mark's there. For Ealing residents we have a real opportunity to be able to provide access to these services on site because Northwick is also a regional centre for vascular surgery. So actually that allows that to happen.

Q. Thank you. Forgive me, just one more point. I just want to understand how much you feel you have taken the residents and your clinical colleagues with you. You quote on page 594 the questions that you asked, three statements: "Do you agree or disagree that there are convincing reasons …?" The three bullet points you raise are about new standards of care in hospital, delivering some services locally, et cetera. Forgive me but that is a motherhood and apple pie statement, is it not? We would all agree to that. How much have you carried Ealing GPs with you then?

A. So when we went through the decision-making, it was absolutely clear that for Ealing, the fact is there if you are going to make a change of that dimension people are going to be concerned and quite rightfully so.

Q. How do you carry the Ealing GPs with you?

A. I am trying to explain. We did exactly that. We had three are four meetings with Ealing GPs where we had an open discussion, we had people coming to talk to us. We went through discussions. Ealing CCG was the only CCG that actually went through a full reporting process because it was absolutely clear that we needed to work with our colleagues and you have got the results of that work. Since then at every council members' meeting we have discussed the proposals in small groups and as a larger meeting so people are fully aware of what is happening.

Q. They are aware but do you think they agree with it?
A. Like in any other profession there will be some people who will agree and some who will not.

Q. I still not know whether you have the majority with you or not?
A. You have the vote from them.

Q. Forgive me but that is what I call a motherhood and apple pie statement.
A. We are where we are. As I said, some people will agree; some will not. It is my responsibility to continue to give the clinical evidence in the case and demonstrate what we are doing to deliver out of hospital services and to commission acute hospital services in line with clinical evidence.

DR HIRST: Thank you.

Q. DR LISTER: Dr Parmar, just a couple of points. You say the A&E is not going to chose for three years and you said it several times. How can you be sure of that because if you announce the A&E is going to close and we now have a timescale that is starting to tick down towards the three years or whatever it might be, if you are a consultant or a A&E professional are you going to apply for a job at a unit you know is going to close a couple of years down the line? Are we not going to create the same kind of scenario we have seen with the maternity services where it is difficult to recruit staff because the service is seen as blighted. You cannot really guarantee, can you, that it will be three years?
A. Yes, we have said there will be no changes and we are now in a very privileged position in that Northwick Park and Ealing are now a merged organisation so therefore we do have now a very large, major hospital supporting and working with us to deliver emergency care on the Ealing Hospital site. And absolutely I would expect to deliver that.

Q. Five years ago in South East London there was a pledge to keep Queen Mary's Hospital open in Sidcup and within three months actually in that particular case staffing problems were invoked as a reason for closing it down earlier. How can you guarantee that during the course of these three years that is not going to happen at Ealing?
A. We can only continue to provide services provided it is clinically safe to do so. If there are clinical safety issues it would be my responsibility, like it would be any other clinician's responsibility, to make the right decision for patient safety and patient quality. On that there can never be a *carte blanche* guarantee but we have no plans to change A&E services. Clinical safety and quality of patient care is paramount.

Q. The other thing is you repeatedly said or admitted that you did not actually know exactly what mix of services will be involved in this local A&E service. Obviously, there is a wide range of parameters because use of the term "A&E" suggests a full scale service with all the back-up whereas an urgent care centre is clearly a walk-in clinic with some professional staff available, and there is quite a big difference, but a "local A&E" is an ambiguous quality. If you do not know what that is now, how can you accept local people in Ealing to understand what that is or to accept the idea that it is necessarily going to be as good as you are hinting it might be? The whole issue around the emergency care pathway, local A&Es, the emergency pathway and primary and secondary care is a

national issue and for London it a unique issue. London is unique. Bruce Keogh is looking at this. He is going to give us a report. We will have some clinical evidence and we will be guided and work with that to deliver what is the right service. I think it is fair to say that when the *SaHF* proposals happen that is the information we will have. We will now have some additional information and we will make a decision on that.

Q. The figure has been given of 28,000 transfers from the urgent care centre to A&E within Ealing Hospital and that is clearly a way of working that is developing and people have become aware that if you go to the A&E and it is something more serious, it is not a problem because you can be transferred quickly into the hospital. 28,000 patients needing a transfer to a hospital which is several miles away is quite a logistical effort for the London Ambulance Service. Are you really thinking this through? Are you really ready for the scale of the problem that could be unleashed even if these plans are implemented in the way you say?
A. I am completely aware of the scale of the problem and I am also going to go on to say that the changes will be made in line with clinical evidence with full information, with consultation on the plans as and when they happen. I can say no more at this time but I am absolutely aware of the scale of the change.

Q. Just finally, you say with consultation, consultation with whom?
A. When we worked through the process for our local hospital we have been very open and transparent. We have had our meetings in Ealing Town Hall. We have invited members of the public. We are very fortunate in Ealing in having a very, very strong and engaged voluntary sector. We work very closely with the London Borough of Ealing and we work very closely with the patients and public. Our governing bodies are attended by members of the public. We will have an open and transparent process like that.

Q. So there will be a new public consultation on the new hospital?
A. I did not say we would have a new public consultation. We always engage and we design services together. In all of the community services we have designed we have worked with members of the public that have been on our various steering groups and various committees.

Q. So it is a conversation rather than a consultation?
A. What we need to do is to design services that make it easy for people to use the services and to pick up where the difficulties are going to arise.

DR LISTER: Thank you.

Q. THE CHAIRMAN: Dr Parmar, I just want to ask you a very short series of questions and it is really returning to the topic that Dr Hirst was asking about, the change in position, if I can use that word, that Ealing CCG took towards Ealing Hospital. Can I ask you to look at page 595 of the bundle where your statement is set out?
A. Is it Volume 2?

Q. It is the paragraph where you say at the top of the page: "As a CCG, we expressed our preference to retain Ealing Hospital as a Major Hospital within any future configuration of health services in North West London." The first question is what timescale are you talking about at that stage, so when was that your view?

A. So this letter was 2012.

Q. So are you saying that you expressed your view in a letter in 2012?
A. So this was the letter to the JCPCT, if I remember correctly.

Q. Explain to me what the JCPCT is?
A. The Joint Committee of Primary Care Trusts where the decision for the *SaHF* proposals was recommended.

Q. What was the basis in that letter for your preference that Ealing Hospital be retained as a major hospital?
A. Ealing borough is a large borough. We have got a GP registered population of 390,000 patients and if we had a blank sheet of paper it would be very nice to have a very big hospital located somewhere that was very central. Possibly with a blank sheet of paper, yes.

Q. Let me just press you there. I cannot believe you wrote a letter saying it would be very nice to keep the hospital. What did you actually say were your reasons for preferring to keep the hospital?
A. The question about access to clinical care and the question about delivering clinical outcomes was never an issue. It was only the question about the location of the estate of the bricks and mortar of that. Yes, it would have been much easier to have said Ealing Hospital can provide all the services but Ealing is a small district general hospital.

Q. That is what I wanted to come on to. You are making representations as part of Ealing CCG.
A. Ealing's residents use all the hospitals in North West London and I keep coming back to that. 34% of Ealing residents use Ealing Hospital; 70% use other hospitals. It is my responsibility to commission for all the residents of Ealing.

Q. I understand that. I am just trying to give you an opportunity of explaining what you did in between your initial view and the end. So the Joint Committee of Primary Care Trusts their response to you was what? When you said you would prefer to keep Ealing Hospital in your letter in 2012, what did they say?
A. You have seen the decision-making business case which was led by clinicians across the whole of North West London. It then had an economic or financial case, a commercial case which was reviewed three times and, looking at all those parameters, a set of options was discussed and recommended.

Q. Did you repeat your initial preference or did you decide at that stage, looking at things in the round and taking into consideration residents outside Ealing, this was the best thing? What I am trying to get at is how often did you express this preference and how quickly did you change your mind and look at the bigger picture?
A. I was involved with the planning and we were very clear right from the beginning what our preference was. It was also becoming clear, and again I am going to come back to 70% of Ealing residents - 65-75% - use other hospitals.

Q. I understand that.
A. It is a fact. It is my responsibility to commission and ensure the care we get for all

A Ealing residents, so that has to be my responsibility.

Q. And to be fair to you, I am sure you would say that if you thought that there was a clinical disadvantage in the overall proposals you would say so?
A. Absolutely and we have made decisions on neurology cancer at Ealing three years ago.

B Q. Putting it all in the round, do you accept that you did not fight for your initial preference because you looked at it in the round and decided that you felt that looking at everyone's interests, including those outside Ealing, this was the best way forward?
A. No, I come back to it and say my responsibility is to commission for all Ealing residents and 60-65% of Ealing patients use hospitals other than Ealing Hospital.

C THE CHAIRMAN: Thank you very much for attending and answering our questions. It is appreciated.

The Witness Withdrew

PROFESSOR URSULA GALLAGHER, Director of Nursing, Brent CCG, Director of Quality *SaHF* programme

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Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your name, professional address and current posts held?
A. (Professor Gallagher): My name is Ursula Gallagher. I am the Director of Quality and Patient Safety for Brent, Harrow and Hillingdon CCGs. My business address
E currently is The Heights, Lowlands Road, Harrow.

Q. In front of you, you will see some documents. In Volume 2 can you please turn to page 561. This is slightly unusual as this is not your document; it is a document prepared by Dr Kong, but your role is to speak to it. It should be a letter dated 23 February from Dr Ethie Kong. Is that the evidence you wish to stand as your evidence before this Commission?
F A. Yes, it is.

Q. And there is a further document and it is at Volume 5 and it is at pages 1855 to 1856 and this is a further letter from Dr Kong dated 30 March of this year. Again the same question: is that the evidence that you wish to stand before this Commission?
A. Yes.

G Q. Can I just check first of all about your roles. Am I correct that you have one role with Brent CCG and another with *Shaping a healthier future*?
A. No, let me explain. For Brent CCG, Harrow CCG and Hillingdon CCG I am their Director of Quality and Patient Safety and I am the nurse member of their governing body. In those roles I am member of the clinical board for the *Shaping a healthier future* programme.

H Q. So the descriptor that I have heard "Director of Quality for *SaHF*", is that a

misnomer?
A. It is represented as a misnomer, yes. There is not a Director of Quality employed by the *SaHF* programme. *SaHF* is a programme of all eight CCGs working together and therefore one of the things that we do when working is people in substantive jobs within the CCG and trust teams contribute to the work of the *Shaping a healthier future* programme, so I am not employed by *Shaping a healthier future*.

Q. Can I just be clear because this may just be me, but to whom do you report then?
A. So I report to the accountable officer of Brent, Harrow and Hillingdon CCGs and I report to the clinical Chairs of the three CCGs. I am not within the *Shaping a healthier future* reporting structure.

Q. Who is the accountable officer?
A. Mr Rob Larkman.

Q. I do not know whether you are able to help, and obviously if it is a reason unconnected to these issues please feel free not to answer, but can you help with why Dr Kong is not here to speak to her own evidence?
A. No, I cannot. I think that because I have had a wide involvement in the programme it was felt that I was the best person to represent the views of the three CCGs that I work for in relation to *Shaping a healthier future*.

Q. It is just that it strikes one as slightly strange because of course we have had Dr Spencer and we have had Dr Parmar who were speaking very specifically to Ealing and I wonder do you think it would have been helpful for Dr Kong to have been available?
A. I cannot comment on that. I have been asked to be available and I am very pleased to be here.

Q. Can we start briefly then with the closures of A&E at Central Middlesex and Hammersmith Hospital? As I understand it, the position of Brent CCG is that the problems which then ensued with missed waiting time targets were not related to the closures, is that correct?
A. No. The missed waiting times, as we have argued, North West London Hospitals was already missing the waiting times target for a number of reasons. The decision to close Central Middlesex A&E department was part of a strategy to address those issues, but the coincidental issues that Dr Spencer already talked about, about the sudden national surge in demand that happened within the A&E department, was not directly related to the A&E closures.

Q. Are you saying that the closure of two A&Es simultaneously did not create any extra pressure at other hospitals?
A. There were the planned for changes --- There are two bits of the jigsaw puzzle. There is what we planned would happen and for which we have planned very carefully, and I have no doubt you will ask me some more questions about that, and then there is the completely unpredictable issues that happened, particularly the very early arrival of the winter surge.

Q. Can I ask you this, obviously they are both close together, are you saying that the closure of either site singly would not have created pressure elsewhere either?

A. That is one of the reasons why we decided to close them together in the planning process.

Q. Because?
A. Because a serial closure if we closed them separately there was a risk that the initial flow given how close Central Middlesex and Hammersmith were, there was a significant overlap in the population flow between those two departments, and given that those were both departments under considerable pressure already, not so much in terms of numbers but particularly in their ability to safely staff those units, there was a very explicit decision taken to plan to close them together so that we did not actually end up with a number of weeks with increased pressure on one or the other that we knew it would not be able to cope with. Those were the recommendations of the Clinical Directors in both of the trusts.

Q. Can we just follow that through? Can we have a look at page 563 of Dr Kong's submissions. It is the last paragraph and what she says, I think this is what you are saying: "Following discussions, it was agreed that the A&E departments should plan to close at the same time (as this would cause less confusion for the public and patients and prevent displacement of activity to the other site if one closed ahead of time)..." Is that what you were talking about?
A. That is essentially what I was saying.

Q. If you shut one and people have to move to the other, that creates pressure on the other, does it not?
A. Yes.

Q. So if you shut two, does that not create pressure on what is left?
A. So it is about we did not shut until we were sure that the other sites could cope with the planned move of patients. What we did not believe would happen, and what the clinical directors told us would happen was that there were plans that we could put in place to enable one to cope with the short-term displacement if we closed them serially.

Q. Do you think that the plans for the closures simultaneously worked?
A. So there are a number of elements to that. In terms of the primary purpose of *Shaping a healthier future*, which is about providing improved care and safer care for patients, then the answer to that question is "Yes". It is entirely acceptable that given what also happened with emergency care demand both in London and across the country that it could seem as if we had not planned properly. We planned properly for what we expected to occur and even for a degree of unexpected occurrence. We got something that was completely unpredictable.

Q. It was completely unpredictable that closing two A&Es at the same time might create pressure on that which remained? Is that what you are saying?
A. No, no. What I am saying is the impact of the planned closures based on the evidence of numbers and what was going to move, we had planned for. I believe that that happened as planned. In addition to that, there was an unplanned, unpredictable increase in emergency activity which, as Dr Spencer said, we saw right across the country and even though we had built in some 20% contingency to our plans it was not sufficient to cope with that completely unexpected excess of A&E demand.

Q. Am I right that you attribute the problems of missed targets to winter peaks? Is that right?
A. Part of the issue and one of the reasons why we were closing in September was to try and make the changes before the winter, so it was an early surge.

Q. So the problems that ensued at Northwick Park with four-hour targets being missed on a very regular basis do you say that they were due to seasonal variations?
A. Yes.

Q. So if that is right, why do you think it is that they are still missing their targets by some considerable way?
A. Northwick Park were not achieving the target before so part of all of this is Northwick Park has a trajectory in place to improve. The impact of the winter was that it fell below being able to achieve that target and it is now seeking to get back on track to deliver that target. The changes to the A&E services and the concentration of services and particularly the concentration of staff in the Northwick Park A&E department is all part of helping that to happen.

Q. Can we unpick that slightly. Northwick Park was not delivering the service it should have done before the closure of the two A&Es. The two A&Es closed and it continued not to deliver the service and it is still not delivering the service? How is that good patient care?
A. It is good patient care because lots of the things that were driving, --- because clearly the waiting times are only one aspect of what we look at when we look at quality. So for example, and Ms Benson would be much better placed to answer the detail of some of these questions if you wish to put them to her later, but some of the big issues were about the number of consultants able to be employed in the A&E department, the number of temporary staff that were in place across both of those sites that we were able to consolidate together so actually the quality of patient care has been improved although the waiting time targets have continued not to be able to be met.

Q. Is that a concern for you?
A. Yes.

Q. What is being done to address it?
A. We have had a further joint investigation of what is going on. The Trust have had a great deal of additional support and there is a remedial action plan in place with the Trust which is monitored on a weekly basis to access some of those improvements. Some of the other factors included the London Ambulance Service and we have worked with the London Ambulance Service in terms of how 999 patients particularly flow around the system with the use of something called “intelligent monitoring”.

Q. Have we had that report made available?
A. The remedial action plan report?

Q. Yes.
A. If you have not I am very happy for you to have it.

Q. I wanted to move on now and ask you a little bit about population because of course it is right, is it not, that *SaHF* is quite an ambitious programme and it is based on future predictions of a number of things including population. If the population data is wrong that is going to have a knock-on effect, is it not, on the calculation of service need?
A. Potentially, yes.

Q. So if there is a substantial development like that at Old Oak Common, with the best will in the world, which nobody knew was going to be signed off as something to happen in 2012, that is going to have a substantial effect on the population figures, is it not?
A. Potentially, yes.

Q. The figures I have seen for Old Oak Common vary but the most consistent and conservative ones seem to say 24,000 new homes and 55,000 new jobs. Is that going to have a major impact on the population of this area?
A. If it happens as predicted then clearly yes.

Q. Is that going to have a major effect and impact on the *SaHF* plans?
A. It will need to.

Q. Is it safe to assume because of course we know that part of the rationale behind *SaHF* is that there is an ageing population and greater co-morbidities and so on, is it safe to assume that any population that moves in, whether or not it echoes that profile, just by force of numbers, it is still going to have an effect, is it not, so even if it is a young, fit, healthy, rich working population they are still going to need services?
A. Absolutely.

Q. And those have not been factored in yet, have they?
A. One of the challenges of the *Shaping a healthier future* programme is (a) as you have said, it is extremely ambitious but it is also quite a long-term programme and therefore it needs to be constantly refreshed as new information both about clinical evidence and population comes on stream which could include population growth linked to developments or not.

Q. So would it make good sense to pause and review at the moment, particularly looking at the Brent situation, although Old Oak Common crosses borders, and think how is this going to affect it, do we need to re-look at our figures, do we need to re-look at the reconfiguration?
A. No. That is why the *Shaping a healthier future* data is continually refreshed. It is why the draft ImBC business case process will include the latest most up-to-date information that we have. Of course we are under an obligation to be dealing at any point in time when we make a decision not with 2012 data but with 2015 data.

Q. You referred to the ImBC. Do you know whether it includes this new data or not?
A. I certainly know that refreshed data was supplied to the ImBC both on activity and on population.

Q. By whom?
A. By the people working within the programme.

Q. Could you be a bit more specific?
A. No.

Q. Do you know and have you seen the ImBC and are you able to say from that whether you know if it has taken account of this new data or not?
A. I have seen the early draft that Dr Spencer saw and certainly for the three CCGs that I work for I recognise the data as the kind of data we are currently using which, as Dr Parmar said, is not the same as the ONS survey data, so in terms of registered population and our own plan for population growth which in Brent does include as best we can at the moment some of the major planned developments.

Q. So is the answer that in fact - I am not being critical at all - you have not seen the ImBC in its updated form so you do not know how these things have been factored into it?
A. Yes.

Q. Turning to a slightly different subject, Dr Kong sets out at 567, she describes Brent CCG as being the "co-ordinating commissioner" for London North West Healthcare Trust and says that as such it undertakes all contract clinical and governance meetings. Can you explain a little bit more about that role, please?
A. So given that many patients in North West London and outside, but in North West London, receive services from a number of trusts across the area, we have a system which we call lead or host commissioning whereby one CCG leads on working with the other eight in the relationships with all of the trusts. For Brent CCG that relationship was with North West London Hospitals Trust as is now the North West London Healthcare Trust so the contracting team is based within Brent CCG and I as the lead Director for Quality and Patient Safety am involved in all of the discussions with respect to clinical and governance meetings, for example the Clinical Quality Committee.

Q. Does that indicate that Brent CCG holds within it a high level of expertise and experience in terms of contracting and commissioning issues?
A. Yes, both within the CCG itself and with the shared service arrangements that we have in place across North West London.

Q. What are the shared service arrangements, just very briefly?
A. We have a number of specialist people so some people work specifically for individual CCGs and some people share their expertise across a number of CCGs. I share my expertise, such as it is, across three.

Q. So when we turn to looking at out of hospital strategies, the CCG presumably would apply its expertise to the commissioning and procurement services?
A. Yes, and it would seek additional expertise if it felt that it did not have everything it needed in-house.

Q. Can I ask you please about the musculoskeletal and gynaecological service procurement, please? At page 571, in February, what Dr Kong said was this: "These services were being developed and evaluation of the pilot schemes had shown good evidence of improved clinical outcomes." Then if we move on to Volume 5 and that is the second document, this is the letter dated 30 March, that process seems to have ground

to a halt. Can you help the Commission with what has gone wrong?

THE CHAIRMAN: Could you when are referring to the paragraphs and pages indicate where they are.

Q. MS RENSTEN: I beg your pardon. It is slightly difficult because of course none of the paragraphs is numbered. In fact, in terms of the paragraph at 571 I think there are some bullet points and the fourth bullet point down says: "We are developing more Consultant Led Community Services to include gynaecology and musculoskeletal services …" and there is an indication there about the progress and then later on in Volume 5 at 1855 in substance it is the totality of the letter because what the letter says is this: "The CCG governing body has decided to discontinue the current procurement exercises for gynaecology and MS care. We understand that this may come as a surprise to many stakeholders ..." et cetera, et cetera, and then it talks about lessons learned and it goes on to say: "We will be arranging a meeting shortly for stakeholders involved in these procurement exercises and we will update further." What I wanted to ask you was in global terms can you help us with what has happened?
A. Yes, I can.

Q. Thank you.
A. I will do my very best. Brent CCG, again predating *Shaping a healthier future*, although obviously built into the *Shaping a healthier future* plan, developed a series of what it called waves of procurement around planned care. So those are mostly surgical but not all surgical, to separate from the emergency care pathway. We are in Wave 2 which, as it says here, included musculoskeletal and gynaecology, and I think it is worth separating out in this conversation the two bits of the jigsaw puzzle. The first point is to say that first and foremost it is about establishing a clinical case for change and redesigning a clinical pathway and model. The second is then deciding what is the right vehicle for delivering that change. It all comes under the banner of procurement but there are, as you know, a number of rules that help CCGs to decide which of the procurement routes they need to go out. What we have decided at the moment is that the original belief that the best way to do this was to go for a big procurement, put it in the *European Journal* and do a big procurement from the things that we have learned ---

Q. Could I ask you to pause there. When you say the *European Journal*, enlighten me?
A. If you go for a big open procurement there is a very set out legal process. You have to advertise it in the *European Journal* and anybody from anywhere in the country or even anywhere in Europe can bid to provide those services. So, as you know, the Health and Social Care Act lays down rules about how those decisions need to be made. What has happened is learning the lessons from cardiology and ophthalmology and we have said a number of times today that we seek to be evidence- based and learn lessons through the programme has caused us to say that although the work that we have done with patients and clinicians and others has made huge progress on the pathway and the clinical model of care, we are no longer convinced that a big procurement exercise is the best way of delivering that improved pathway and outcomes and experience for the patients of Brent and that we will be looking at other ways of doing that that deliver the pathway we want to deliver but not necessarily obtaining it in the way that we had thought.

Q. What has changed your mind?

A. The experience of cardiology and ophthalmology.

Q. I am going to come back to that in a minute. Can I ask you and see if this chimes, West Sussex had a similar exercise and when Dr Kong refers in her letter to lessons learned she talks about outcomes and reviews of similar procurements relating to MSK. Is she referring to those exercises in other areas in the country?
A. So that was part of the information that we looked at of our own experience from our Wave 1 and emerging national evidence across the country about how successful these things were being.

Q. So is it the case that perhaps these things appeared to have been less successful than you originally envisaged they would be?
A. Again it is about unpicking it. They all have different criteria of success but certainly they were more difficult and therefore the benefit ratio and particularly the time taken to get the benefit for patients seemed to be longer and more difficult and hence we are saying is that the right thing to do.

Q. So, just thinking about that a little bit more, my understanding is that there was an integrated impact assessment conducted by a consultancy firm called Mott MacDonald to look into the impact of changes. That was due on 6 February. Do you know if that report is yet available?
A. I think so. I will happily find out for you.

Q. I would be grateful. If it is available is, it something that you could make public?
A. If we can then we will make it public.

Q. Dr Kong talks about stakeholders being updated. When must stakeholders be updated?
A. So it is my understanding that there is a piece of work --- so there are a number of ways in which stakeholders are currently being updated. The disadvantage of being in a procurement process is that there are some very complicated issues about commercial in confidence that can make it difficult for us to always be as open as we would like to be at different stages of the process so we have committed that within the next two to three weeks we will be in a position to share with stakeholders where we are going from here.

Q. Can you help with what the aborted procurement process cost?
A. No, I can't.

Q. Can you give us any kind of ball-park figure?
A. That I can't.

Q. Will you have to start from scratch?
A. The honest answer is I do not know, but I do not believe so because particularly the work on the clinical pathway and clinical model has been done. We do not have any reason to believe that there is any problem with the pathways so we will just have to think about how we will go about implementing those pathways.

Q. Having said that you do not think a full-blown procurement exercise is the way now, what is the way forward?

A. I think we would like to be talking with our local providers about whether there is a different way that we and they could collaborate together to deliver the pathway rather than a big procurement.

Q. Is that another way of saying can you keep the service where it is and just beef it up a bit?
A. No.

Q. Is that another way of saying that you want to work with the existing providers rather than buying in from elsewhere?
A. We would like to explore if the existing providers can deliver the model of care.

Q. Can I be clear, are the existing providers the London North West Healthcare Trust?
A. No. Again for Brent there are a number of existing providers which would include Imperial and the Royal Free as well as London North West.

Q. But it is one of the ---
A. It is one of them but it is not the only one.

Q. So you will be talking to all three?
A. Yes.

Q. And how public will that consultation and that process be made, subject of course to commercial discipline, I understand that.
A. Clearly, ultimately the decision will be taken at our public board meeting.

Q. Will the cost of the aborted procurement exercise be made available as a public document?
A. I honesty do not know.

Q. Do you think they should be?
A. Probably.

Q. Let's just say for a minute these two services are up and running, the gynaecological services and the musculoskeletal services: how do you say they might reduce the need for hospital admissions? It is what they were designed to do, designed to reduce acute need? How will that happen?
A. One of the things that we know about a range of long-term conditions is that if we can help patients to come forward for services earlier, so we can reduce the number of women who arrive in acute abdominal pain having a gynaecological emergency, if there is an easier route, better supported GPs to help them identify and diagnose issues earlier in women and clear pathways by which they can come to community-based or other appropriate services pre a crisis. The same with musculoskeletal, it divides into a number of bits, there is acute musculoskeletal of perhaps somebody who has an acute back injury following digging the garden. There are then people who live with a number of rheumatological and arthritic conditions again getting the highest possible quality of care with appropriate management both of the disease and of things like the pain and therapy support to support mobility and quality of life. So it is about how best do we do all of those things to prevent older people with poorly managed osteoarthritis who are more

likely to fall because they are in pain and not able to walk well and therefore might end up with a fractured neck of femur.

Q. Do you have a percentage figure for the percentage of hospital admissions you think this is going to reduce by?
A. That figure does exist. I do not know it off the top of my head but again I will be very happy to get it for you.

Q. And the same for gynaecological services?
A. Yes.

Q. Thank you. Can I ask you to assist by providing an update for some of the other out of hospital services. First of all, at page 637 there is a reference to the Peer Referral Advisory Service. I may have got the page reference wrong but I think you are familiar with what I am talking about. Are you aware of that?
A. Yes.

Q. Can you tell us how that has worked, please?
A. So one of the things that Brent CCG, along with everybody involved in the *Shaping a healthier future* programme in terms of the out of hospital strategy, is about improving general practice and one of the ways in which we improve general practice is to provide support and provide expertise to GPs in the delivery of their work. One of the issues therefore is about both the quality of the referral information and perhaps the work up that has been done of a patient prior to that referral. The referral facilitation or advisory service is local GPs helping other GPs to be able to access some of their advice. The second thing is in particular through a change programme such as *Shaping a healthier future* it is really hard, when I am in surgery it can be really hard to keep quite up-to-date with exactly what has changed and exactly what some of these referral pathways are, particularly in terms of knowing how to refer patients to new services. Again these sorts of referral services help to be able to help direct patients and check GPs and patients to be able to be directed to the most appropriate service if the GP has been unaware that that service is available.

Q. There is a suggestion from other witnesses that that service has been discontinued. Is that wrong?
A. I think the principle of the service is recognised and valued. I think the precise way of delivering it at the moment is under review.

Q. Does that mean that the service that was originally started has been in its existing form stopped?
A. I don't know is the answer as to whether it has actually been stopped. I can find that out.

Q. Can you help us with how it came to light or how you came to decide that that was not the appropriate or best way of running it?
A. No, I think what there was --- my understanding is that there has been a pilot and the discussion is about the evaluation of that pilot about whether it continues or not. We need to learn the lessons from the pilot.

Q. Do we know who is evaluating it and when?
A. No, but I can find out for you.

Q. Do we know what the pilot cost?
A. No, but I can probably find that out.

Q. Can you look at page 568? I just wanted to ask about a couple of specific points. There is a reference, and it is the second bullet point from the bottom, to Brent STARRS. There is a reference to an expansion of a social worker. Does that mean what it says - just one additional social worker, "Extended our Brent STARRS to include a social worker to enable better links with the Local Authority"?
A. I honestly ---

Q. I understand you are in difficulties as it is not your letter.
A. Although I did read it clearly this is drilling into a level of detail that I was not expecting to be asked about. We did say if people wanted particular detail there was an opportunity to advise us before we came. Certainly I know that the whole conversation around STARRS, which is linked to our Better Care Fund process with the local authority, is investing whether it is a social worker in this particular team but there are many more social workers in STARRS.

Q. From your own knowledge do you know whether the expansion is a social worker or a plethora of social workers? Are you able to help with that or not? If you are not, you are not.
A. I could not be confident that I could give you the detail. If you wish to ask me fuller detail I will find it out for you.

Q. Moving on, there is a reference at 569 to Sickle Cell, the second bullet point talks about improved care through an integration and support programme in March 2015. It refers to a pilot. Can you help us with whether it has started, what the size of the pilot is and when and how it will be evaluated?
A. I think it has started but again I will supply you with that information.

Q. Brent Integrated Diabetes Service, same page, in the first bullet point it is described as being too soon to provide a robust analysis as to whether it is delivering. Any idea when we will know when it is delivering as hoped?
A. No, but I can find out for you.

Q. Cardiology, page 571, we know that the cardiology programme had some difficulties. Are you able to tell us whether or not it has hit its launch date, 2 March? Has it yet been launched?
A. Yes, it has been launched.

Q. Where has it been launched?
A. The service is being provided from two sites in the borough, one of which is at Willesden.

Q. And the other?
A. I cannot remember.

Q. Can you tell us what the timeframe will be for the analysis of whether this service is delivering?
A. This is a contracted service so the evaluation is built into the length of the contract.

Q. Can you tell us what that is?
A. I think it is five years.

Q. So we will not know for five years, is that right, whether or not ---
A. No, there will be ongoing evaluations through the programme.

Q. Do we know when the first information from the first evaluative work will come out?
A. At the end of the first year. It would be risky to evaluate these things too early.

MS RENSTEN: Can I ask you please to look at Volume 3, page 947 ---

THE CHAIRMAN: Katy, I am just looking at the time. We are well over this witness's time.

Q. MS RENSTEN: I just want to ask a particular issue about this, if we look at that page. This is a London North West Healthcare Trust complaint against Brent CCG for the way the cardiology procurement was conducted. Were you aware of that complaint?
A. Yes, but I was not involved in any of the detail and may not be able to answer questions.

Q. I am not going to ask you about that. What I want to know is has this impacted on the working relationship between the CCG and the Trust?
A. I do not believe so.

Q. You are confident that that is the case?
A. Yes, I am.

Q. Finally, my last question is there is a reference in Dr Kong's document, I do not need to take you to it because I am sure you are familiar with it, about Brent CCG commissioning a report from Dr Angela Coulter (non-medical doctor).
A. Yes.

Q. Can you tell us how that came about, what it was for and what the results of it were?
A. As with all CCGs, Brent CCG is committed to involving patients and the public in all the work that we do as well as having a number of statutory duties that we need to deliver by law. We were getting lots of feedback from lots of stakeholders that our current arrangements were not working well and that we were not doing patient/public engagement well enough and we decided that the best thing to do was to commission an independent external review. Dr Angela Coulter, as many of you will know, established the Picker Institute and is a recognised international leader in this field. Dr Coulter produced her review which was accepted in its totality by the governing body and those recommendations have included a number of changes to how the CCG should be doing its patient and public involvement in the future.

Q. Incredibly briefly if you can; what did it say? What changes did you need to make?
A. It said that we should separate out the operational delivery and strategy for patient and public involvement from its governance. The board sub-committee we had effectively was assuring itself for what it itself was responsible for doing, so the governance terms there was part of the problem and those two should be separated out, that we should strengthen our relationships with a number of partners, in particular Brent Council, around the use of insight and intelligence and shared understanding of our resident population and that we should strengthen our outreach work to work particularly with some of our hard-to-reach communities. It recommended the removal of the strategy document from the constitution, as a strategy document should be able to be more iterative than you are able to do if it is in the constitution, and that the local patient participation group should also be removed from their constitutional role as a separate conversation about how they might continue to work locally.

MS RENSTEN: Thank you. I apologise for taking rather longer than I had intended. If you would like to wait there, there may be some questions.

THE CHAIRMAN: Do not apologise. It was very useful.

Examined by THE COMMISSION

Q. DR HIRST: I appreciate your difficulty because you are talking to somebody else's document and also once again most of my concerns have been put by Ms Rensten. Just on page 563 there is a comment by Dr Kong that local clinicians strongly supported the programme and "The Programme therefore proceeded with implementing these changes as local commissioners(*sic*) strongly supported the *SaHF* programme and SoS decision." As you can tell, I want to know what approval people have had from working doctors and other clinicians. What evidence does Dr Kong have, do you think, that this was no more than the clinicians on the CCG and associated bodies involved? What does she mean by local commissioners?
A. Local commissioners or local clinicians?

Q. For anybody reading that that gives the impression that all the GPs in Brent were all for this, let's crack on, and all the nurses were all for the changes, but who are the local clinicians?
A. They are all of those people. In terms of the particular duties of the Clinical Commissioning Group, the Clinical Commissioning Group is a membership organisation and all the practices within Brent are members of Brent Clinical Commissioning Group. Therefore there have been a large number of processes for consulting and involving those clinicians and on a number of occasions there have been votes and decisions taken within that membership body. So in terms of the GP community there has been lots of work. Do not forget that our GPs and myself, when I am in practice we have the first-hand experience of what services are working well and what services are not working well and what are the challenges that we and our patients are experiencing.

Q. Forgive me for asking, but I have been at the front-line as one of those member GPs and I have my suspicions about how decisions are taken and whether there is a true understanding and approval if only because of the fact that half an hour before a meeting I might get megabytes of information to read. That is not your concern. I will condense it

down. One of the concerns you touched on just a moment ago, it is difficult for you but there is a submission this afternoon, and witnesses who are coming this afternoon, and in one of those submissions actually on page 803, it refers to abolishing the EDEn Committee and even the Patient Participation Groups. That is the Quality, Diversity and Engagement Network. Having seen the quality of the work done by these groups are you not worried about the proposal to abolish them or even reduce their contribution?

A. As I said, the advice of the independent review was that the EDEn Committee should be changed and that particularly its governance function should be placed elsewhere within the governance structures of the CCG. The CCG's commitment is that there will be a new committee established which will focus on the operational delivery of the patient and public involvement strategy. The local patient participation groups I cannot abolish. They are independently established participation groups that sat originally within the constitution. It was an anomalous group and we need to be working with all our patient groups and with all our residents' associations. The advice was that removing it from the constitution is not the same as abolishing it. Can I just add one other thing. I think we know that in Brent we have been extremely fortunate to have an extremely dedicated and knowledgeable group of patients and members of the public that have chosen to work with us and that was acknowledged by both us and the Coulter report. The issue is the degree of ambition to do more and to do it better.

Q. So we can have your assurance that in fact it is impossible to close the locality of PPGs?

A. They are not our body to close. They have been removed from the constitution so they no longer feature as part of the constitutional structure but they are independent groups.

Q. God forbid the thought that you were trying to suppress some awkward customers.

A. If I was then it has been a dismal failure, do you not think, as I sit in front of them at the moment.

Q. DR LISTER: Just one just one thing I want to focus on. There is a reference again in Dr Kong's statement page 567 of the letter: North West London had the best performance across London [this is for A&E performance] in quarter three of 2015. This relates to the whole burden of A&E obviously and which obviously in the North West London an exceptionally high proportion is the urgent care centre caseload, is that right?

A. Yes.

Q. You yourself made the statement about a national surge in A&E towards the end of last year. That is not reflected in the figures. The figures of A&E total attendance at type 1 continues to be pretty much an average of 275,000 since 2010 looking back on the figures. What has changed is the delays at type 1. You are a Director of Quality and I would have thought your main focus would be on the people who are most seriously ill and those needing most serious attention which is the type 1 cases. Again the figures shown North West London from being one of the best in London almost consistently right through to 2011 suddenly in the second half of 2014-15 became the worst in England by a long way and the worst in England by quite a long way for delays in type 1 A&E. How do you square that with saying you are happy with the quality and the safety of the services being provided?

A. The first thing to say is I referred earlier to the remedial action plan and the remedial

action plan and the work led by myself and members of my team focuses entirely on improvement in type 1 performance. Absolutely from a clinical perspective it is type 1 performance that is most important. What we have done of course is look at a range of things that matter to patients. You are absolutely right that delay in accessing a bed is a problem and we are working with the Trust on that, but in terms of the other things that were consequential to the closure of the A&E department, a move from four A&E consultants to 14 A&E consultants, a significant increase in the number of permanent staff and nurses available and the ability to monitor those patients more closely and to make sure even if they are waiting for a bed longer they are starting their definitive treatment earlier if they need IV antibiotics and that they are receiving a range of care with respect to privacy, dignity, hygiene and nutrition. I am confident and myself or a member of my team visit the A&E department on a weekly basis and talk to patients. I do know that the quality of care in the round, even acknowledging issues about those patients waiting for beds longer than we would like, has improved since we closed the A&E department at Central Middlesex.

Q. There is a short follow-on from that. The other spin-off from that is there were pictures in the local press about the ambulances queuing outside with patients who were not yet receiving this consultant-led care. Is this also a concern and it relates to bed numbers, does it not, it relates to the capacity to actually admit patients? Have you been following that one through as well?
A. Yes, there are two issues about following that through, so in terms of the total bed numbers the CCGs have commissioned a large number of additional step-down nursing home beds or purchased rehabilitation beds so that the actual numbers of beds in the system as a whole in Brent and Harrow is greater than it was this time last year. We have an extremely good relationship with the local council in terms of delayed transfers to care and there are daily meetings to discuss that to unblock any of the ways in which we can act together to move patients through the system preferably home, but if not home to an alternative sector facility so that a patient waiting in A&E can access that acute bed.

Q. Were those part of the original plan?
A. Yes.

DR LISTER: Thank you.

Q. THE CHAIRMAN: I want to ask you some very, very quick questions based on something you have covered. Could I ask you to look at page 637 please which are submissions we are going to be hearing later on this afternoon from the Brent Patient Participation Group. You looked at the bottom paragraph with Katy and I just want to give you an opportunity of dealing with the assertions that are put in that paragraph. Do you see paragraph 7.7, it says that Brent CCG have introduced a 'peer-to-peer' hospital advisory service. I think you agreed with that and you explained to Katy what that actually involves, correct?
A. Yes.

Q. It goes on to say they "repeatedly emphasise a wish to eliminate unnecessary hospital referrals in accordance with *SaHF* policies". Do you accept that is repeatedly emphasised in the peer to peer hospital referral advisory service?
A. Yes. The *SaHF* is about local where possible, centralised where necessary, integrate

all the time, so supporting practices and local services that we put in place by not sending people to hospital services if they do not need to go there, yes. The language is not my letter, I am hesitating because I might not have written it in quite that way, but I think the principle is in line with the *Shaping a healthier future* principles but also what we know is best practice anyway.

Q. The next sentence says: "They" [Brent CCG] have promoted a US commercial 'Referral Facilitation Service' to monitor referrals by individual GPs. This steer for GPs appears to contribute to patients resorting to A&E departments on a self help basis." Do you accept that statement?
A. No. As I said earlier, I have not read the evaluation report. That is not an opinion that I recognise.

Q. Then finally the authors say they have heard from various members of the CCG staff that the RFS in its original form is it be abandoned. I think you indicated to Katy that is right?
A. I indicated to Katy that I knew a review was underway. Whether a decision has been taken to abandon it I am not certain but I did say that I would supply the Commission with a definitive answer to that question.

THE CHAIRMAN: I just wanted to make sure I understood. Thank you very much for attending.

The Witness Withdrew

MS TINA BENSON, Director of Operations, London North West Healthcare NHS Trust.

Examined by MS RENSTEN

Q. MS RENSTEN: The same routine as you have seen before. Can I ask you to give your name, professional address, current posts held and to confirm that the evidence that you have provided, in your case it is at Volume 5, page 1817, is correct and you wish it to stand?
A. (Ms Benson): Is this the letter written by Simon Crawford?

Q. That is correct, yes.
A. So shall I explain why it is me?

Q. You can do that if you wish to do so but can you please confirm those details first?
A. I am Tina Benson and I am the Director of Operations at London North West Healthcare. I am based at the Trust headquarters, Northwick Park, Watford Road, Harrow. The evidence supplied to the Commission is a letter written by the interim Chief Executive when our permanent Chief Executive, David McVittie was off having his hip surgery, which is why he wrote the letter. We have since had a new Chief Executive, Dame Jacqueline Docherty, who started with us five weeks ago so it was decided since I was involved with the changes to the A&E at Central Middlesex and more latterly with the proposed transition of the maternity services at Ealing Hospital that I was probably the most appropriate person to come and answer the Commission's questions.

Q. Thank you very much for clarifying that. I wanted to start not unnaturally with the closures of the A&Es at Hammersmith and Central Middlesex. Your document, unsurprisingly, deals only with Central Middlesex Hospital. Did you share the view that Hammersmith Hospital should be shut at the same time?

A. We set up a process across the North West London sector as part of this. That was for all operational directors across the sector because it was important to us that we took those decisions as a system. We considered closing them separately. We felt that would be confusing for patients and considering that we were doing this particularly as a Trust for patient safety and trying to reduce the risk of having a Central Middlesex emergency closure over the winter we decided together that, yes, it was the most appropriate thing to close them at the same time.

Q. Did you have concerns at all about the capacity of Northwick Park and other facilities to soak up the work of two other A&E at the same time?

A. We had some very detailed work in terms of planning for this change. I will not detail it all but just quickly there were the original numbers in the *SaHF* business case. We then remodelled the most recent numbers for both sites. We also did patient questionnaires to check whether our assumptions around flows were likely to be correct in terms of asking people at Central Middlesex and Hammersmith "If this unit was not here would where would you most likely go?" If I just talk about Northwick Park, we knew there was a very limited flow from Hammersmith to Northwick Park - one patient a day in fact - so in terms of Northwick Park (for which I am responsible) we did not have any concerns at all about the Hammersmith closing. In terms of Central Middlesex to Northwick Park, as was said before by Professor Ursula Gallagher, our challenges are bed capacity not actually A&E capacity so the attendances are not a specific concern to us. Admissions are a concern so that was the piece of work we did in a great deal of detail to look at how many admissions would be coming to Northwick Park. We felt we had enough capacity to manage that. Going back to the point that we were not meeting our A&E targets, what we were aiming to do was to not make things worse and to try and keep things stable in the system and for us as a Trust it was a balance of risk. So there was the risk of knowing we had a capacity challenge at Northwick Park versus the potential of the inability to staff Central Middlesex medically over the winter period and having to do an emergency closure. So we had some ongoing concerns but we felt that we had planned well enough to maintain safety, which was always the key.

Q. Do you share the view that the subsequent downturn in performance at Northwick Park Hospital was unrelated to the closures?

A. Our model has come to absolute fruition. I have a detailed model which shows flows of patients. In brief, 12 patients were to be admitted from the Central Middlesex previous catchment area. That is exactly what we have been admitting. The additional surge over and above that has been largely Harrow patients which is unrelated to the Central Middlesex closure.

Q. Can I ask you please to turn to Volume 3, page 1173, and if I explain, this is a graph submitted by a gentleman called Colin Standfield, and I see from your smile that you are entirely familiar with him.

A. I provide Colin with most of his data.

Q. That is very helpful because I can omit to ask whether you think he has accurate data

because clearly you will have supplied him with accurate data. What I wanted to just ask you about is how this graph fits with what you have been saying. I do not pretend to be a statistician or have any kind of expertise in this but looking at the figures there he has disaggregated the various different figures that you can arrive at. Ealing and North West London Trust seems to be from 14 September last year to 12 December this year on a catastrophic downturn. How do you explain why it is so much worse than all of the others?

A. If you disaggregated this one level further you would see that Ealing is not on a catastrophic downturn. They had the same surge as previously described in terms of the whole winter and have completely recovered, in fact last week they delivered 95% type 1 activity so I would dispute that Ealing is a challenge. In terms of Northwick Park, if we look back at a complete year (so the winter that we have just had to the winter that we had before) actually our type 1 performance this year was a lot more stable and resilient than it was the previous year when Central Middlesex was open.

Q. I understand what you are saying but I do not understand it, and it may simply be that I do not understand how that equates with what looks on a visual basis like an extremely sharp downturn.

A. If you disaggregated this what you would see is Ealing did this (indicating) and Northwick Park has always been this (indicating). In the period shown before September it had been propping up the Northwick Park type 1 performance

Q. Your contention is that the two situations were entirely unrelated - the downturn, the missing of target times - to the closures?

A. What I am saying is Northwick Park has been missing the target for a long time and in fact this year we were more resilient in terms of type 1 than the previous year when Central Middlesex was open.

Q. What are the up-to-date figures at the moment for targets at Northwick Park?

A. Last week at Northwick Park for all type performance, which is the one that includes the urgent care centre, was 88%. For type 1 it was 69%.

Q. Over what period is that?

A. That is a week.

Q. Are you able to provide a slightly longer digest in terms of ---

A. I can provide that to you, not off the top of my head, but I can provide it.

Q. Can you tell us whether the figures in the weeks approaching that are similar?

A. At the moment the figures are improving so since December we have steadily, and I mean steadily literally 0.1% week on week improving at Northwick Park and, as I said, Ealing has completely recovered its previous position.

Q. So the type 1 admissions at Northwick Park if they are at 69% so it means that between December and now they have been lower than that?

A. Type 1 attendances, not admissions? So, yes, previously they were down to around 66% as being about the lowest point.

Q. What does that suggest in terms of reliance on the problems having been related to

seasonal variations if they are still continuing?
A. We saw an early surge in activity from August. We have not seen any reduction in demand as yet.

Q. If and when Ealing Hospital (because of course Charing Cross is a slightly different matter) A&E closes will that put more pressure on the service at Northwick Park?
A. I have not got any plans as being the responsible Director to close Ealing A&E and in fact I am working with my Ealing team at the moment to expand the footprint in A&E at Ealing.

Q. So are you saying that the A&E department at Ealing is not going to close?
A. I am saying at the moment there are not any plans to close Ealing A&E. Certainly the Trust clinical strategy would not want to see that happen until we were convinced as a Trust Board there was sufficient capacity to allow that to happen if that remained the plan.

Q. THE CHAIRMAN: Can I just interrupt. You said something about "expanding the footprint". Can you repeat what you said and then explain what on earth it means?
A. The physical space at Ealing A&E. We are looking to make it a bit bigger because it is an incredibly small department so it only has 12 trolleys and if you compare that to Northwick which has 43.

THE CHAIRMAN: It was just the particular expression "expand the footprint".

Q. MS RENSTEN: Leading on from that, you are expanding Ealing A&E at the moment?
A. We are just expanding the space to allow them to cope with the activity that is currently coming through the door.

Q. I know you do not know when it will close and you are saying there are no current plans to close it, but if it closes is it not simply a matter of logic that there will be an increased volume of patients and therefore an increased pressure on Northwick Park?
A. So if we were to look at closing Ealing, exactly the same as I described in terms of the work we did around Central Middlesex and Hammersmith, if you look at the likely flows of patients which we have not yet done in the detail I described, but if you go back to the original *SaHF* case actually a very small proportion of patients who currently go to Ealing A&E would flow to Northwick Park and part of that is the geographical nature of North West London.

Q. I was just going to come on to that. How accessible is Northwick Park for residents of Ealing?
A. So I think it is reasonably accessible. Both have reasonably good tube links. I think bus links are not as good as they could be. In terms of emergency care, clearly there are other ways to get to hospital other than public transport. In terms of LAS the flows tend to be not across the A40 during peak times but actually it is not inaccessible. As a Trust we are looking at, as we potentially change flows later, whether we would provide some patient transport between our sites.

Q. So that is something you are keeping in mind but has not been modelled yet?

A. We have not made any major changes between sites currently through Ealing and Northwick so it is not required at this time but it is something we would look as we model any further changes.

Q. Is there a risk if longer journeys are involved that patients will be more ill by the time that they reach A&E and are able to be treated?

A. Whilst I am a clinician by background I am not a doctor so I think I would find it quite difficult to answer that. I guess in my experience of the closure of Central Middlesex that has not been what we have seen in that change.

Q. Given the geographical relationship between Northwick Park, West Middlesex and Ealing, and having heard what Dr Parmar had to say, could there be some merit in having Ealing becoming a major hospital?

A. If I look at it from just a Trust perspective rather than necessarily any population perspective for a minute, if you would just forgive me, we review consistently all our services across sites and I think the thing that is really important to us as an organisation is to make sure we have the right skills to provide the care we want to give to people. What the challenge was for Central Middlesex was making sure there were sufficient skills nationally to do that. So I would suggest it would be hard for us as an organisation to run several large acute trusts or even for the sector in terms of getting enough skilled people to deliver the quality of care that we want to.

Q. But if the funding was there and, if I can put it this way, the political will was there, would it be an ideal spot because of its geographical placement to locate a major hospital?

A. In terms of funding we have never had any challenges around funding. We had the funding in the budget for enough consultants to run Central Middlesex A&E. We have enough funding in our budgets to run A&E at Ealing and Northwick. We do not have enough consultants currently on our books because they are just not there so I would not say that this is a funding issue. This is a skills issue. In terms of would Ealing be an ideal place for a major acute, I do not think it is necessarily about location; it is about the services and skills we can provide in each hospital and the co-location of other services and I think we need to look at that as a whole and not isolate one particular hospital or another.

Q. I just want to ask you very briefly about bed space. You are increasing bed space at Northwick Park. Is not the whole premise of the *SaHF* about reducing acute bed space?

A. I cannot comment because I just do not know the detail across the whole thing but it has always been the plan to increase Northwick Park by about 100 beds.

Q. Is that enough?

A. It is enough currently as I sit here today. There are a few things we need to do as a wider health system to make sure that remains to be enough, and I think Ursula described some of those so I will not repeat it, but it is about patients who are currently in an acute bed who could have different care outside of the Trust and that is a significant proportion. It is about 40 to 50 patients on any one day.

Q. At the moment does it not suggest there is still a rising rather than a falling need for bed space?

A. At the moment since our surge in August it has been fairly flat, it has not risen again

A but, as I said before, it has not fallen yet in terms it is spring and summer.

Q. I want to ask you very briefly about some of the funding issues. Can you explain - and for reference it is Volume 2 and I am looking at pages 614 and 615 and this is Brent PPG and they talk about marginal cap rates - can you explain, please, your view of how does a marginal cap rate work and how does it control A&E workload?

B A. That is quite complicated. I was trying to make it simple. So there was a change to the way that hospitals are paid nationally. The thought behind it was to try and look at how you could from the same money encourage services outside of hospitals. So as a system we looked at how many patients in 2008-09 attended A&E and we said that is our baseline to start from. So any activity which comes to an A&E over and above that baseline only attracts 30% of the normal payment for that patient. However, the 70% is then invested in services outside of hospital in order to try and reduce the attendances.

C Q. Have I go this right, if you took a patient as a person who was over the expected numbers to go to that A&E, the baseline, you could slice them in half and 30% of the funding that came with them would go to the A&E and 70% would stay with the CCG? Is that right?

A. To invest in services outside the hospital, yes.

D Q. What seems to be said, I am just going to invite you to comment, can you have a look please at Volume 2 and it is page 615, paragraph 1.9, what is being suggested it talks about the Northwick Park Hospital marginal cap and it is referring to the tension that that may cause between what the CCG might want for funding and what the hospital trust might and there is reference to what is described as a tug of war behind the scenes. Can I ask you to comment on whether that is something you recognise?

E A. We have a whole wide health system for which we all have to ensure we provide the best care we can for all of our patients, so it is really important that through contracting rounds there is a healthy tension between the Trust and the CCG. Clearly, the Trust wants the most money it can get in order to continue to provide all the services at the gold standard and the CCG have other things to commission than just the hospital services, so I think that is a healthy tension. However, I will say that we have had good negotiations with our lead commissioner, which is Brent CCG, and they did last year up the baseline from the 2008-09 level and in addition they did not remove the activity from Central

F Middlesex. They left that in our baseline so they have increased our baseline. This year the national rules changed and actually that reduction is less.

Q. So there is, whether healthy or not, an inherent tension between what you want to do with the funds and what the CCG might want to do?

A. That is not what we want to do with the 70%. It is about us trying to increase the bottom number.

G Q. I understand that.

A. In terms of the 70s%, there has always been very good agreement about what is re-invested in the hospital trust in terms of the STARRS service.

Q. But it is about how much of the 100% comes to ---

H A. No, it is not, sorry. It is about how many patients we only get the 30% for. We always argue about that. And then it is about which services would be best invested in, so

there is always a debate about that because clearly there is a very acute view, which is the view we have, and there is a community view that the commissioners might not.

Q. Further down this page there is a quote from a meeting which is said to have taken place, it is paragraph 1.11, 17 December 2014. It is a QuIP - a Quality Innovation Productivity and Protection - meeting and if I can just read out the quote because not everybody has got it: "The Clinical Directors stressed the need to use financial penalties and decommissioning to achieve better services from LNWHT and expressed great concern that despite assurances over the years from the Trust, there was still a deterioration of performance in services and that additional funding under Winter Pressures may not improve performance. A broader debate was called for to bring to the attention of the Trust the frustrations and anger that the GPs had at the service provided to their patients over the last 20 years. The GPs had no confidence in the LNWHT managerial side, nor in the manner its clinical teams run their departments, nor in the A&E service." Can I invite you to comment on those criticisms please? What do you say about them?
A. I cannot comment on this particular quote because I was not there. I can comment more generally. I think we have very good meetings between our clinicians and the GPs at the Clinical Quality Group. There is challenge raised to our doctors, our managers and the services we provide and rightly so. It is important that the CCGs are assured that we are providing the services at the quality for which they are commissioned. I think equally we challenge back in terms of the CCG doing the things that they say they are going to do in terms of referral management. I would not necessary plan to comment any further but I think actually relationships are very good between our clinicians and the CCG.

Q. Volume 3, page 947, this is a matter I took Ms Benson to. It is a formal complaint by your Trust about Brent CCG's procurement. This is a document that has been cc'ed to you. It is not one that you have signed. Page 951 at paragraph 4.14: "The Trust submits that NHS Brent [which is the CCG] is not acting with a view to improving the quality of the cardiology services". Further down: "There is no evidence to suggest that clinical quality outcomes would be improved by the approaches taken by the CCG". Does that not rather suggest to you that there is in fact quite a degree of difficulty in the working relationship between you and the CCG?
A. I do not think it means generally there is difficulty in the working relationship over this specific issue. They had made a decision which we did not think was correct and we challenged it in the appropriate way.

Q. Do you think that could have an impact on delivery of service?
A. For cardiology?

Q. Yes.
A. So we did not agree with the way that it was commissioned and we have made that clear. I think as Professor Gallagher has said, they will be keeping a close eye on the quality and we would trust them to do that.

Q. If you tender for a service and the CCG awards the tender elsewhere, presumably that involves a loss of income to the Trust, does it not?
A. Potentially, yes.

Q. And that is going to have a knock-on effect on the viability of the site or the particular service that lost the tender?
A. So it would potentially have an impact on the viability. Currently in terms of cardiology we have continued to maintain the service that we provided before and we have not seen any detriment as yet to income.

Q. Explain that to me. The service that been tendered out on cardiology, so a different provider is now providing it and you are also providing it?
A. We have continued to carry on providing a service at Central Middlesex because there is still patient choice.

Q. So there are now two services being provided instead of one. Is that a service that is supported by the CCG or not?
A. The CCG have not commissioned that particular service so it is a continuation of a current service which has not been commissioned to it is difficult to say supported or unsupported. All I can say is commissioned.

Q. Are these two services which overlap? Are they providing the same service to the same population or different services to different populations?
A. I do not have enough clinical detail to answer that question, I am afraid.

Q. If services move away for example from Northwick Park because they are commissioned elsewhere, what implications does that have for the hospital?
A. It clearly depends on the type of service but we would always look at potentially why that service is moving away. I think on most occasions we have had very healthy conversations with the CCGs where there have been quality issues and we have improved those if a service is commissioned from another organisation and decommissioned from us. Clearly we have to look at disinvesting in that service or continuing that service at risk, depending on the service.

Q. Just very briefly, if there are services for which no-one wishes to tender, does the Trust get left holding the less attractive, less lucrative services?
A. It is really hypothetical. I have never known that situation.

Q. You have never known a situation where nobody wishes to take up a bid?
A. I have not personally, no.

Q. I suppose I can ask you and you can say you are not prepared to answer but hypothetically would you be left holding the baby?
A. I cannot see that that would be a scenario.

MS RENSTEN: I think probably those are all the questions that I can respectably ask in this time-frame so I would be grateful if you would wait for the Commissioners.

<u>Examined by THE COMMISSION</u>

Q. DR HIRST: I have done my best in this process to step back and get an overall feel for what is happening. As I have said, I have great respect for the out of hospital services that have been developed. I think they are to do with good medicine and good practice.

They also make the family doctors' role so much more interesting actually. However, it does not take away my worries on behalf of my fellow citizens and my ex-patients in respect of secondary care. One of our initial witnesses from Imperial (unfortunately, they are not represented here and I might ask you to take a view) said he thought in the three years since 2012 there had been a major change in the way medicine was practised. For example, he said that we were admitting much more elderly patients and doing things to them that we would not have considered doing three or four years ago and that in turn they needed acute hospital beds and moreover they may need the most intensive type of care and yet do extremely well. I can quote an example of a relative in her 90s who had a valve changed. These are things that 10 years ago we would not have considered. We are changing valves in people who are terminally ill with 36 months' life expectancy because it can improve their quality of life. I see doing out of hospital services, as I have said, as a laudable and wonderful thing, if it can be done, but going this other way to do with technology where the *SaHF* project is trying to close down beds and close down secondary services, I suppose a bit of me is thinking it is a bit like Beeching in the 1960s, probably before you were born I know, who closed down the railways and suddenly we discover we need railways such to the point that only as recently as six months ago 40 miles of railway have been re-opened. You are obviously familiar from the quality aspect. Do you not have those concerns as well that we are giving away all these assets and all this land which we can never get back?

A. No, I do not share the concerns and the reason I do not is I can really see how the jigsaw fits together. I go into A&E on a daily basis because, as we have said, our performance is not where we want it to be, I am there on a daily basis so I can see first-hand the type of patients coming in and I can almost in my head see where they would be in the future. There are at least 40 to 50 every day who I can see could have better care and never have touched A&E at all. There are other patients you have clearly described who are acutely unwell and quite often are more frail and do need to be in an acute bed but actually in terms of do they need to be in an acute bed for a long period of time? No. If I talk to my doctors they say that most people need that acute phase for about four days. Then there is a whole big step-down facility so as Professor Gallagher said they earlier, they have invested hugely in step-down capacity. Across our Trust with Brent, Harrow and Ealing we have 200 community beds. Then from there you step down into social care and back into those community services. So whilst I hear your concern, I really can see that jigsaw work, but it is going to take a lot of energy and effort to get us there.

DR HIRST: I wish I had your confidence. Thank you.

Q. DR LISTER: I was just going to ask you going back to the A&E performance and this was type 1 and I think you said 69% was the most recent figure of people achieving the target of being seen and dealt with within four hours? That is late April or May?

A. Yes, that is May.

Q. So not winter pressures?

A. We have not seen any decline in attendances since that surge in August, so we went up and then we have just stayed broadly flat from there.

Q. Where is the problem? Why is it that none of these promised alternatives seem to have actually delivered the release of pressure on the A&E service?

A. That is a rather complicated question.

Q. The reason I am asking it is because obviously the plan is supposedly we will not need so many of these services.
A. There are different strands in terms of our trusts so if I look across our Trust actually the attendances at Ealing Hospital have declined so that is where it should be. If I look at type 1 attendances over the last five years at Northwick Park they have declined and actually the ones that are going up are the urgent care centre type 3. We have seen this surge. The challenge for us is bed capacity. Once we get that bed capacity right on the Northwick site, and we have 63 beds opening before this winter, my expectation is that we will resolve much of that issue. The other piece of work that we are doing is to get those patients who are described who are post that four-day stay, into community facilities. If we get that flow right, I think the services externally will take the pressure off. It is just being masked by the fact that we do not currently have the right level of bed capacity.

Q. But these community facilities will need investment and resources?
A. Absolutely and we are currently looking with our CCG partners at how we might do that in a more efficient way because the other thing we also need is flexibility so that we can always meet the needs of patients no matter what their need is rather than having a very fixed set of beds for one particular need.

Q. I am going to come on to the other side of resources which is obviously the Trust in quite a substantial financial hole at the present time, a £50 million plus deficit on the last count I saw.
A. It is.

Q. I know you have said there are no immediate plans to close the A&E in Ealing but the plan in *SaHF* is for Ealing to become a local hospital, which would basically have outpatients, an urgent care centre and possibly some day surgery and so forth on site. On an economic level, how does that actually work for the Trust because you are not going to be generating anything like the income that would have been coming from there before and you are still going to have a requirement to staff and deliver services there?
A. Economically, obviously the business case is at a very high level at the moment. They are not down to that sort of level in terms of the broader picture, but actually it is achievable because you also reduce your costs in those hospitals that are reducing to local hospitals, but it is a careful balance that has to be met and clearly for our organisation especially careful because that is three sites plus we have also got 29 community sites, so, yes, it is a challenge and we keep a very close eye on that in terms of what services will be been provided there in the future.

Q. Just finally then, how are you going to save 50 million quid?
A. That is a question I wish I could answer. If it was easy we would have done it already.

DR LISTER: Thank you very much.

THE CHAIRMAN: I do not have any further questions for you. Thank you very much for attending. What I suggest is we break now until quarter to. I know it is a shortened

lunch break but I am anxious that I keep us on track this afternoon. Thank you all very much.

The Witness Withdrew

After the luncheon adjournment

THE CHAIRMAN: Can I just say a few words before we start this afternoon. We have got seven witnesses that we want to hear from this afternoon. With the best will in the world, I suspect the time constraints that imposes means that people will not get to say everything that they probably want to say. You have, however, all given us very detailed and helpful written submissions. Please do not go away feeling shortchanged. If you have not had a chance to say everything you want to say because of course we have read and will take into account in any final report what is in those documents. With that in mind, I am going to try and keep to the published timetable as much we can which involves hopefully having a break at 20 past three. If we overrun the first two witnesses I might re-visit that because even on the current timetable we are not due to finish until half past five. With those words, Katy, if I could ask you to start.

CLLR MUHAMMED BUTT, Leader, and CLLR KRUPESH HIRANI, Cabinet Member for Adults, Health and Wellbeing, Brent Council

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your full names, professional addresses and current post held?
A. (Cllr Butt): I am Cllr Muhammed Butt, Leader of Brent Council and my professional address is Brent Civic Centre.
A. (Cllr Hirani): I am Cllr Krupesh Hirani. I am the Cabinet Member for Adults, Health and Wellbeing at Brent Council. My professional address is Brent Civic Centre.

Q. In front of you, you should have Volume 1 and if you look at pages 45 to 60 can you confirm that that is the evidence that you wish to stand as your evidence to the Commission please.
A. (Cllr Hirani): That's correct.
A. (Cllr Butt): Yes.

Q. I want to ask you first of all briefly about population. Leaving aside any other issues about the inaccuracy of estimates and figures, can you help us with the impact that you say the development of the Old Oak Common will have on Brent's population?
A. (Cllr Butt): At the moment the figures for the population of Brent are about 320,000 and with the Old Oak development coming in it is going to be about 24,000 homes coming in there and that is going to have a massive impact on the potential to skew things around health and transport and the infrastructure that is in Brent and surrounding areas.

Q. Can you help, do you have any awareness of whether or not those figures have been factored into the *SaHF* proposals?
A. (Cllr Butt): From what I have seen, absolutely not. They have not been factored in. There is so much regeneration that is going on in Brent as well that would need to be

factored in as well. It is amazing the numbers of people that will be coming in the next ten to 15 years.

Q. What impact do you say that will have on the ability of health services to meet that need?
A. (Cllr Butt): If you take a look at what is happening already in Brent, health needs are not fully being met, so if the population figures continue in the current trend of increasing we are going to be having at least 5,000 people coming in the next few years in the Wembley area are alone and we are predicting another 25,000 people in the next 15 to 20 years. I do not even think those figures have been factored in so the impact is going to be absolutely horrendous and it is going to put more pressures on the services that we are facing in Brent.

Q. One of the most difficult issues of course is the closure of A&Es and we know about CMH and Hammersmith Hospital closing together and we know the views because we have heard them this morning of the CCGs and the Trusts that the closures did not have any impact on performance. Can you help us, what are your views on that?
A. (Cllr Hirani): Just to add an answer to the question in relation to population changes as well, if we take it beyond A&E looking at things like GP capacity and the health and social care infrastructure as a whole, we need to make sure that capacity is available in all sectors of healthcare, not just A&E, but it needs to be factored into the amount of GPs that we have across the borough as well. That includes recruitment policies for GPs. Are there enough GPs? From what we have seen, the GPs around the borough are getting close to retirement age as well so there are massive infrastructure problems in trying to recruit the GPs that we need to meet our population demands.

Q. In terms of the closures and the pressure on Northwick Park, do you have any view about how that is performing at the moment?
A. (Cllr Hirani): The figures show that Northwick Park is consistently amongst the worst performing A&Es across the country and we were under the impression that that might be mitigated by the expansion of spare capacity at Northwick Park but the trend seems to have continued across the same level. A&E waiting times are still consistently poorly performing at Northwick Park Hospital.

Q. And what is your view about accessibility of Northwick Park for residents particularly in the south of the borough?
A. (Cllr Hirani): For residents south of the borough Northwick Park A&E in particular is furthest away from them obviously. Central Middlesex Hospital, which had an A&E hospital and was operational during the daytime, would be closer for patients who are living south of the borough and for those further south of the borough towards Kilburn, St Mary's would be the most appropriate hospital for those patients.

Q. Do you have a view about the wisdom of having closed the CMH and Hammersmith Hospital A&Es?
A. (Cllr Butt): It has been touched on slightly before. If you take a look at the social make-up of the Stonebridge, Harlesden and Kensal Green areas, those are some of the most deprived areas we have in Brent and some of the poorest paid individuals live in those areas as well. They have some of the most acute health needs as well. Making these people travel that much further over to Northwick Park when the transport

infrastructure is not in place, they have to take a minimum of two buses to get over there from Stonebridge and the 18 bus and then trying to change over at Sudbury or even Wembley is an absolute nightmare. Even having discussions trying to persuade people to use the tubes and train. But if they are some of the poorest paid individuals that we have in society, forcing them to use more expensive modes of transport is having a negative impact on their health and their social outcomes as well.

A. (Cllr Hirani): Just to go back to your question as well, you talked about our view of the closure of the two A&Es at Central Middlesex and Hammersmith & Fulham. To us we think they should not have been closed. There are two caveats I would add to that: the out of hospital strategy and GP opening times. The out of hospital strategy is supposed to be where the bulk of A&E admissions are mitigated. If these are not ready it does not make sense to close Central Middlesex and H&F A&E when they were closed because quite clearly from what we have seen the out of hospital services are not ready to pick up that slack.

Q. I wanted to ask you a little bit about urgent care centres. Are you able to help, do you have a clear idea of what an urgent care centre is to provide?

A. (Cllr Hirani): Yes, I do have somewhat of a clear idea of what urgent care centres are to provide. I am sure that the general public do not and going by some case studies of what residents have told us I am not sure that GPs are sure either.

Q. So when Dr Parmar says that the UCC at Hammersmith Hospital and Central Middlesex Hospital now offer enhanced specification, is that something that is understood by your residents?

A. (Cllr Butt): Just going back on the first question and the second question together, many of my residents in Brent come from outside of England. 64% of the population is made up of BME individuals. Most of them do have problems trying to understand how to access GP services anyway. Trying to explain to them you have got the urgent care centres, I can assure you even I struggle to understand what an urgent care centre provides. I have people phoning me up trying to find out whether or not Central Middlesex does x-rays or whether they can go in there for a quick check-up. The communication has not worked. People just do not understand what these urgent care centres are and it has not been done in a manner or method that is understood by the people of Brent because most of them have English as a second language and their access to health services in their countries is not exactly the same as what we experience in this country and they do not understand the changes that have been implemented. We need to make sure that that message has got through to them and what they can do at an urgent care centre and what hospital is for and what the role of the GP is because trying to get through to a GP sometimes can be difficult for people.

Q. Given that we know that CMH now has a 24-hour urgent care centre, and you have touched on this in your submission, why is it that you say there is under usage of it?

A. (Cllr Hirani): There are two problems. One is referral and the second is about information. I can give a particular example because it involved my mother who fell over on the driveway and damaged her hand. She went to the GP and rather than being referred to the urgent care centre for an x-ray she was referred to A&E at Northwick Park. What this tells me is that there is a problem in making sure that people are referred to the right place by professionals. If professionals are struggling to understand where to send people what hope do the general public have?

Q. If there is confusion about this issue, one of the later witnesses suggests that they should be renamed "minor accident treatment centres" or something similar; do you have a view about whether that is sensible?

A. (Cllr Hirani): I cannot comment on that particular phrase but I think it is in our interests between the Council, residents and our partners at the NHS to see if there are ways we can improve that messaging. We have the avenues, we have the Brent magazine, we have children's centres, libraries, schools where we can help deliver that message, but we need to come to that common view and we are happy to help with that.

Q. Do you have a view about whether co-location of urgent care centres and A&E is appropriate or not?

A. (Cllr Hirani): Co-location has the potential to deliver the best outcome because what it means is that a person can go to a single place and can be triaged and depending what their need is they can be directly sent to the urgent care centre part of the business or to the A&E side.

A. (Cllr Butt): Can I just add, it does go back to the consultation process around *Shaping a healthier future*. A lot of input was made into the process about some of the concerns that are being raised now and those concerns were raised at that time as part of the process. As far as I can see, none of those concerns has been taken into consideration in taking things forward. It causes me even more concern that we are sitting here two or three years after the whole process and we are talking about the exact same concerns that still have not been addressed. We have still got a system at the moment that is not delivering. The A&E waiting times are absolutely horrendous. I know that Krupesh has had his own personal issues as well and I have been there personally myself trying to wait for an appointment to get my hand seen to. People are sometimes just sitting there trying to understand what is happening. The flow of information to those people who are waiting there is lacking. They have not got the information while they are at the A&E departments or the urgent care centres and they have not been given the information prior to it either. The whole thing needs to be looked at in order for it to be redefined in a way that people understand what these centres are for because if people like myself are struggling to understand what services are provided and what they are there for, it bothers me that my residents are going to suffer.

Q. I just want to move on and ask very briefly about bed space. Accompanying the changes to A&E are plans for a reduction of acute beds across the region but with Northwick Park, as we are heard, expanding. What is your view about whether that is sufficient?

A. (Cllr Hirani): On the bed spaces at Northwick Park, I think the hospital trusts themselves at a recent scrutiny meeting said there is insufficient bed space. From a non-clinical position, I cannot comment on that aspect but they have already commented and if that is what the experts there are saying that there is not enough bed capacity at Northwick Park Hospital then I will have to trust their judgment on that and I would strongly suggest that there would need to be more bed space if that is what the experts on the ground are telling us.

A. (Cllr Butt): On the bed spaces, look, we have been promised bed spaces in Northwick Park and do you know what, I have not seen any of those bed spaces materialise. There are figures of 50 bed spaces that we are supposed to be having in Northwick Park and 80 was mentioned in the Scrutiny Committee. I have seen different reports. I do not even

know which figures these people are referring to. Are they referring to the original proposals on the transfer of the services to Northwick Park where 50 or 60 spaces were supposed to be there? Are we now talking about the shortage of beds they promised as part of the consultation process or are we talking about beds that Mr David Cameron is supposed to have promised us? There is no clear figure of what we have been promised of what is supposed to be in there. The only people it is going to impact is the people of Brent, Ealing, Harrow, Hounslow and everywhere else because they do not know where to go for some of the services they need.

Q. I just wanted to ask you a little bit about the out of hospital plans. Can I just take this very briefly and ask this. Would it be fair to summarise the local authority's view in this way: the intention is good but the execution is not because you support the extension of out of hospital services? Is that a fair summary?

A. (Cllr Hirani): Where possible people do not need to go to A&E unless they really have to. You and I do not want to go to hospital. We only want to go if there is something wrong. So that is the premise that we should all work to and, as mentioned earlier by one of the evidence givers, A&E should be a last resort. On the out of hospital strategy, a draft form was produced in 2012. As far as I am aware, an actual out of hospital strategy never came back for decision and there is no out of hospital strategy. So the basis on which the changes have been operating, I cannot see it. I cannot see what is supposed to replace A&E closures and that is what frightens me the most.

A. (Cllr Butt): You are correct that we are generally broadly in support of the changes that were put forward, but the caveat was that everything else needs to be in place before you start making these changes. I am sorry, the changes that were required are not in place, especially round making sure that the GPs have the support and capacity to take on some of those services. That is not in place. The transport infrastructure that we were speaking about and that was supposed to have been taken on board, I am sorry but nothing has come out of it. The increased number of buses going to Northwick Park has not materialised. The changes have not happened. If I did something like that in the Council I would be held to account. Everything that we do has to have an equalities impact assessment on the outcomes and the needs of those individuals that I am providing a service for. How can we move forward in trying to deliver a service for the 320,000 people of Brent without having positive outcomes and having a proper plan of execution as well? I am sorry, it is not there and it is failing and it is hurting my residents.

Q. You touched just then on something I was going to come on to which is GP services. Can GP services in Brent cope with existing demand?

A. (Cllr Hirani): We are hearing from residents about how difficult it is to get a GP appointment. I understand that that is a national problem as well but it is local and it is what residents are telling us as well. GPs do not have the capacity to meet the current population need in Brent.

Q. In terms of the GP hubs, how will that help? Will that help at all?

A. (Cllr Hirani): It would help because it would mean that there are extended GP opening hours, but again the problem does come back to what Councillor Butt says about information and about people not knowing about it. People do not know where to go and when they are in a situation of need rather than try and find out where to go, the hospital is the easiest option. It is there. The buildings are there and it means that people are going there because they cannot get the appointments locally when and where they need

to.

Q. I wanted to ask a little bit about the interface between the local authority and the health services because obviously you are coming at it from a local authority perspective and many of the services that are involved in this transition will presumably involve local authority input and local authority secondary care services and social care services. What input have you been asked to give? How has the liaison been between the Health Service and the borough?

A. (Cllr Hirani): I think the governance arrangements is one of a number of worrying aspects about the possible strategy. It feels to us like a lot of these changes have happened at a North West London regional level. Our local government structure has meant that the ability for us to have a leadership input into this has been very limited. It has been done by joint overview scrutiny committees rather than through leadership and rather than being co-produced so that we can come to something that we can work with the NHS on. Locally we have in place health and wellbeing boards. We are looking at a Better Care Fund which has been something that has come through on a national basis that we are working through locally, but the governance arrangements, as Councillor Butt said, if we made a decision that impacted on residents that was not working, we would be held accountable for it. The same does not exist and what worries me is how constitutionally has this come about and how in the first place the Clinical Commissioning Groups were put together on this regional basis and what is the legitimacy for rolling this programme out across the whole of North West London.

A. (Cllr Butt): Can I add something on that? The process that Krupesh touched on is the regional issues but when you lump together Brent, Ealing, Harrow, Hounslow and all those boroughs you have to take into account each borough is different and quite unique, and trying to provide services across a wide area without understanding the demographics and the impact and the outcomes on those individuals that you are trying to provide those services for I do not think enough work has been done at that council level. It is too wide a level to have a broad brush approach for these kinds of services that we are trying to provide in Brent and the other areas.

Q. I just wanted to ask you one final question because it is palpably clear that you are very passionate about this and this is something which matters to you. What do you feel you need to say, what would you say if you had a single message to give to *SaHF*? What would you ask them to do? What should happen for Brent?

A. (Cllr Butt): The simple message is that the people of Brent and other surrounding areas need a Health Service that actually delivers for them. There is no way that you can have a Health Service operating out of one major hospital trying to deliver for four or five different boroughs. It is not going to work. The GPs need help and support to make sure that they can actually deliver some of the services that are supposed to be farmed out that are not there. The infrastructure in order to help those residents get to those services is not there either. The communication has been so lacking. Like I said, I am getting lost for words because I do feel quite passionate about it. If I had failed in my role in delivering services I can assure you when it comes to 2018 the residents will speak and I will not be sitting here.

A. (Cllr Hirani): The only message I would add in addition to that is to pause and reflect. I think it would be dangerous to continue down the *Shaping a healthier future* route without sorting out the out of hospital services and the extended GP opening hours. We need to be at a place when A&E capacity is telling us that it is okay to continue. We are

not at that place. It is going the wrong way at the moment. A&E waiting times are going up, not down. We are massively over the four-hour waiting time for our residents at Northwick Park especially.

MS RENSTEN: Thank you. I would be grateful if you would wait there. There may be some questions from the Commissioners.

Examined by THE COMMISSION

Q. DR HIRST: I fear I might be asking rather a waffly question but I will try not to. I am trying to get an understanding of how things work and how things are changed if you need to make changes. You are our representative politicians here. I do not have any national politicians to ask so I must ask you. My understanding is if, say, you have a project, and you do have large projects, you have housing estates and so on to build, et cetera, involving many millions of pounds, if you were to see for example that in the middle of a housing project that for some reason it goes over an earthquake region or something major is happening or it is not going to fulfil its aims, what are the processes by which you change that project. Do you wait until the next Election and you are out? How would that be done? Would you listen to your residents? Do you have an inquiry? Do you get in consultants? How does that work?

A. (Cllr Butt): As part of a new project we have points along the process where we take stock, we reflect, we review and analyse the process that we are following. If there are obstacles and barriers in the way we tackle those straight away. As part of that, in local government we have to engage and consult with all our residents, stakeholders and partners involved. That is the way you do things. You heard Krubesh touch on the aspect of what engagement there has been. There has been some very limited engagement with us. We have had one or two presentations at one of our Scrutiny Committee meetings about *Shaping a healthier future*. As I said, concerns were raised and a process has been followed, but no-one has actually listened to the concerns that we have been raising. We even had a submission to the Independent Reconfiguration Panel. That was in 2013. We have been trying to air those concerns and highlight those issues and once again I was just saying to Krubesh earlier, going through it again, everything that we have put forward nothing has been addressed. It is exactly the same. Not even a slight deviation. We would have been happy to see something there but, like I said, two years ago, July 2013, submissions were put in and we are here in May 2015, two years down the road, and really nothing has changed from that submission.

Q. As local politicians, who do you see is your direct contact then in the NHS? Say there is one particular point you want to change, for example, I do not know, could they hold on to a service for X amount of time, who do you approach to do that?

A. (Cllr Hirani): I am the Cabinet Member for Adults, Health and Wellbeing at Brent Council also supported by the Directors of Public Health and Adult Social Care. The problem is that the decision-making structures for what we have in place are not co-terminus so our boundaries are the same as Brent Clinical Commissioning Group, however, most of the changes made over the whole of the *Shaping a healthier future* programme project is a regional project. There is no equivalent or no individual that matches from a local government perspective in terms of governance arrangements to the structure that has led to this decision-making in the NHS.

Q. So it is a bit like a vehicle that has been set off for which there are no brakes?
A. (Cllr Hirani): Am I allowed to refer to previous evidence givers' answers.

Q. THE CHAIRMAN: You can but can I just ask you to be succinct in doing so.
A. (Cllr Hirani): Dr Mark Spencer, when he gave his evidence and you probed him about what is happening in local areas, said that it is for local areas to decide, but *Shaping a healthier future* and the programme in changing the hospital services was as a result of the regional services that he led. So what that tells me is regionally he will make the changes and what happens locally is up to you boroughs to sort it out yourselves.

Q. DR LISTER: This is fairly focused anyway and I hope brief. It is following on what you said about not receiving any out of hours strategy. Presumably any out of hours strategy would necessarily involve a liaison with social services and would necessarily involve a liaison with the Council and whatever services you were required to provide as part of that. That is quite shocking in its own way. You referred briefly to the Better Care Fund. Again, the Better Care Fund is a pot of money that has been put aside. Some of it has been top sliced from the NHS budgets and some of it from presumably the ever decreasing amount of money that you are given for local government but if the out of hours strategy is not there how can the Better Care Fund strategy be drawn up that is going to actually integrate that and go further and build a broader support for vulnerable people in your area.
A. (Cllr Hirani): What I would say is that the Better Care Fund has come out separately and much later in the process, which is why I mentioned about pausing and making sure that things are ready out of hospital before we make the changes to these hospitals and to see if it works, frankly, because if it does not work people still need a service somewhere and A&E is still an option but let's see if we get to the point where people do not need it before we look at configuring A&E services at hospital. With the Better Care Fund we are working to help with the discharge process so we can get reablement and making sure that people do not have to go back to hospital once they have been and make sure that at home is support is there when they are discharged. We are looking at Whole Systems Integration for all patients over 75 and so there are things in place that are just starting but we are not at that point where those things are entrenched in our services so that we can start changing services at the bigger, wider North West London region.

Q. So (a) does that potentially give you a little bit of leverage to say, "Come on, where is this out of hospital strategy?" and maybe go back and press them harder for this because obviously that is something you need as a borough if you are going to take your responsibilities for that side of things seriously, or if they are going to be able to count on you doing what they expect you to do rather than just assuming somehow you are going to work it out. Secondly, I have forgotten what the other part of the question as so that will do!
A. (Cllr Butt): As I say, this is part of an open and transparent decision-making process and the reason why I did not mention about the out of hours hospital strategy not being finalised or appearing not to come anywhere back for decision, if we take it back to our Council decision-making processes, when we make draft strategies and we bring it out for consultation we expect the results to come back. We expect there to be a paper trail and we expect there to be a decision and to be held to account for that decision as well. So that is what we are asking for, openness and transparency, and to see what they are working on and what strategy they are working on. Where is the final document that has

A been approved by the Clinical Commissioning Groups in the relevant areas?

Q. This is the final part and the second part of the question on what you can see so far in terms of what is available through the Better Care Fund and what is actually in the pot in terms of the availability of resources to the borough. Do you think there is enough money there to make this work or do you think this is something that is just a wing and a prayer and they are just hoping somehow they are going to get away with it?

B A. (Cllr Hirani): At the moment I would say there is not enough money to make the whole thing work because health and social care needs to be looked at in the health and social care economy. If you look at how our funding has been affected as a local council, we are the primary deliverer of social care and it is not just social care we have to look at, we have to look at other things like housing which impact health as well, so as a health and social care economy I would argue the Council is chronically underfunded and that is likely to be the case at least for the next five years as well. So funding I would say does

C not match up to the ambitions in this case and what I would say about whether it is a wing and a prayer, it is precisely that, and that is why I am saying we need to have that out of hospital strategy and the extended GP hours in place and then we can see from that whether it is working and whether we need to make those changes at hospital. We are doing things the other way round in this process and that concerns me.

D THE CHAIRMAN: Councillors, thank you both very much indeed for your help.

The Witnesses Withdrew

MR PETER LATHAM, Chair, Willesden PPG and MR ROBIN SHARP CB, Chair, Kilburn PPG, Brent Patient Participation Groups

E Examined by MS RENSTEN

Q. MS RENSTEN: Gentlemen, we will try and take the formalities fairly quickly. If you could please give your names, addresses and confirm that the evidence which is at Volume 2, pages 611 to 670, and Volume 5, 1857 to 1862 is your evidence that you wish to stand for the Commission, I would be very grateful.

A. (Mr Sharp): I am Robin Sharp, 30 Windermere Avenue, NW6, retired civil servant,

F Chair of Kilburn Locality Patient Participation Group, Interim Chair of Brent Patient Voice. You are correct about the evidence.

A, (Mr Latham): I am Peter Latham, Chairman of Willesden Patient Participation Group. I am a retired circuit judge. My address is 55 Kendal Road, London NW10. So far as the evidence is concerned I should point out we submitted with our original evidence appendices but appendices 2 and 3 which are our correspondence with Imperial and with North West London Hospital Trust about the accident and emergency figures

G have been missed out of the bundle. It is a rather tedious correspondence and you may not want to read it but if you want it I can resend it. But, importantly, in our update and response dated 1 May we have referred to an appendix 6 and I have not been able to send you that appendix 6. That is my fault because of computer incompatibility. That is a chart that I think is quite important for the topics you have been asking about produced by Mr Colin Standfield who gave evidence at Ealing. Professor Gallagher and Dr Spencer this morning were giving as one of their explanations for the inability of Northwick Park

H Hospital to cope with the type 1 accident and emergency four-hour response times a surge

in demand. Mr Standfield has produced a very helpful chart that goes back several years, and this is appendix 6, and that reveals, if the figures are accurate, that there has not been a surge. It has been remarkably consistent.

Q. Can I ask you to pause there and simply confirm that you will liaise with Mr Smith and make sure that the missing appendix is provided in due course?
A. (Mr Latham): Since your ---

Q. THE CHAIRMAN: Can I just say I think we do actually have most of the documentation you have spoken about.
A. (Mr Latham): It is not in the bundles here but I would like at some stage convenient to you to update on two of the topics that Dr Spencer and Professor Gallagher talked about this morning.

Q. If you do that by liaison afterwards and we will not eat into the time you have got to give oral evidence.
A. (Mr Latham): I can do it very succinctly.

Q. MS RENSTEN: Can I start by taking you back to somewhere you probably will not want to go. I just want to ask you very briefly about the consultation process. You heard Dr Spencer this morning talking about the extensive efforts that have been made and the steps he had taken in respect of that. Can you help with your view of whether the process was appropriate and, if you do not think it was appropriate, what you say was lacking?
A. (Mr Sharp): We say in our evidence that we believe the process was flawed and we think that is the case because in spite of a large number of documents printed, the main consultation document ran to 80 pages and as a retired civil servant I know that ordinary members of the public would find it difficult to digest a document of this length, added to which the extreme complexity in here because it covers eight boroughs and very few ordinary residents, or even Health Service nerds which some of us have become since this document appeared, would find it very difficult to understand the situation in other boroughs, so it is a very challenging document. The simple, short document was so short that it was not meaningful. The response to the questionnaires which was reported in a meeting held by *Shaping a healthier future* chose, for example, that of the questionnaires completed and the questions answered on the main option, the response was as follows, the heading was just over three-fifths support option A, but when you look at the numbers that is 3,770 in support and 1,780 opposing so that is only 5,000 responses out of a population of two million. Since there was no stratified sampling, this is not a reliable way of gauging true opinion.

Q. I think that has probably answered all the questions I was going to ask about the consultation, neatly broken down and then summarised back into one. Can I ask that we now turn to the question of A&E provision. In your original submission at Volume 2 on page 614, you talk about the marginal rate cap. What I wanted to do is ask if you can help us with this to explain why you say this has had an effect on A&E efficiency.
A. (Mr Latham): The marginal rate cap was based on a definition of appropriate accident and emergency department admissions based on the 2009 level. As Tina Benson explained this morning, there is a disincentive built into the remuneration because for patients over that level they only have been getting 30% of the money and that is proposed to be changed this year to 50%. As Tina Benson explained, the balance of that

money (previously 70% to be in the future 50%) goes to the Clinical Commissioning Group and there was a publication by the NHS last winter about the effects of this and the increase of the remuneration to 50%, explaining that there has been considerable tension between hospital trusts and clinical commissioning groups about what happened to the 70% and transparency about how those funds have been used that were intended to provide at least part of the community services in the hopes that that would reduce arrivals on the doorstep at accident and emergency. It is clear that although Tina Benson and the trust for Northwick Park say we do not allow that remuneration to affect the level of care for our accident and emergency patients, it does appear that when they were doing the projections for the closure after Hammersmith and Central Middlesex Hospitals that, consciously or unconsciously, the level of remuneration affects the targets that they produced. As we have pointed out, it is likely to produce a reduction in morale at the hospital for all the staff concerned if there is no money and they continue to lose money. And they already have, as has already been pointed out to you this morning, a deficit of something like £50 million a year and it is clear that NHS England have had to recognise that this is a problem for many trusts because despite their wish to put in place this disincentive they have had to increase the money, and I think that is a large part of the reason. I can expand on that if you wish.

Q. Just thinking about the closure of the two accident and emergency departments at Hammersmith and Central Middlesex, we have heard a number of witnesses now say that the closures were not related to the increase in pressure at Northwick Park. You I think take a different view. What is the basis for your assertion that the NHS witnesses are wrong about that?

A. (Mr Latham): I was not involved in this local NHS business until the autumn of 2013. My colleague Robin Sharp can talk better about the history and the consultation, but so far as the rationale that is put forward by Dr Spencer and Professor Gallagher in relation to the two elements, the inability of Northwick Park Hospital to cope with the four-hour waiting time, type 1 level, there are two factors. One is that they insist on continuing to repeat the aggregated figures which underplay the extent of the problem at Northwick Park Hospital for the type 1 figures and we have never been able to get from them the completely disaggregated figures for Northwick Park, but it is pretty clear that they would be worse for at least seven weeks between October 2014 and now. As the figures from Cllr Keith Perrin have shown, they have been the worst in England and for many other weeks they have been bumping down at the bottom fourth or fifth or second from the bottom. But there is an important factor that I started by saying I wanted to introduce. Dr Spencer and Professor Gallagher have talked about two components in their difficulty in coping at Northwick Park with the accident and emergency arrivals, number one being the planned excess and, secondly, the unexpected excess due to surge. That surge, on Colin Standfield's chart is simply inaccurate. The figures have been remarkably consistent and that reveals that what is likely to have gone wrong is that their projections and modelling for Northwick Park and other surviving full accident and emergency departments after the closure of Central Middlesex Hospital and Hammersmith Hospital have been inaccurate. I hope that answers your question. I think Mr Sharp has something to add.

A. (Mr Sharp): I do not think we have said anywhere that the NHS side claims are wrong. What we have said is that it has not been substantiated that there is no connection. We heard about a report being prepared internally in NHS England to look into the deep reasons for this. Dr Spencer mentioned this morning that this has not yet

passed into the public domain. Some of us did receive a document from one of our contacts which appeared to be such a report. It contained one figure in it which was a very bland claim so it did not enlighten us. That said, we have not been back to argue about where this came from and whether it was authentic, but nothing has been put into the public domain which shows there is no connection. What is really evident is Northwick Park were not ready to deal with the situation, however caused. There was no surge in attendances. The range of attendances for all cases was between 5,500 and 6,500 throughout the period since last October just after the September closures. It may be that the seriousness of the cases has changed. The fact that Northwick Park, with the assistance of the CCG, has put in, as we understand it, 50 extra beds to deal with people coming out of A&E (that was last November) and is planning to put another 60 beds in place by the end of this year, surely that is absolutely clear evidence that it was not ready and that the planning was wrong and that some wrong assumptions were fed into the modelling, probably over optimistic assumptions. Everybody may have been acting in very good faith but clearly they got it wrong.

Q. Can I ask you now a little bit about the out of hospital service for Brent. We know about Wave 1 cardiology. Do you have a view about how effective or accessible the proposed or just started service is likely to be?

A. (Mr Latham): There are two services that have been put in place now. One is cardiology which is now being run by the Royal Free and has been taken away from Northwick Park and North West London Hospitals Trust because they did not succeed in their bid. The second is ophthalmology which is being provided at two centres, at Wembley Centre for Health and Care and Willesden Centre for Health and Care, by the commercial providers who run the Clementine Churchill Hospital. There are two centres so there is accessibility from those two different parts of the borough. Personally I am less concerned about the travelling implications. My concern is clinical excellence. For myself if I were thought to have cancer I would want to go to, say, the Marsden, or if I was thought to have some heart condition, I would be very happy to go to the Brompton. I know many people are concerned, particularly for poorer people, about the travelling problems, but my own personal focus is on clinical excellence rather than travel difficulties.

A. (Mr Sharp): The ophthalmology service has been running since last September and there is some information in the possession of the CCG about how it is working. I have not seen any figures myself. I think reports to my Patient Participation Group suggest those people have been reasonably happy and the GPs have been happy with the reports they have been getting. However, low take-up of this service has been cited as one of the key reasons for not proceeding with the Wave 2 procurement, which we have enlarged upon in our evidence and our supplementary evidence. There must always have been an issue as to how many people exercising patient choice or how many doctors exercising GP clinical freedom would send people to this new and untried service as opposed to services that already seem to be reasonably available and not too far away: the Western Eye Hospital and Moorfields and Moorfields outstations and so on. Cardiology is really a very short time since it began. I have heard unofficially that it is not going very smoothly but I cannot tell you more than that.

Q. You have actually brought me on to what I wanted to ask about next which is the Wave 2 services. Just very briefly because we have heard some evidence, what is your take on what has gone wrong with the procurement for MSK and gynaecology?

A. (Mr Latham): That was the topic that I did want to update you about so I am glad you have asked that question. Professor Gallagher gave a short summary in answer to your question this morning about the governing body's decision to discontinue the procurement of the Wave 2 musculoskeletal and gynaecology procurement halfway through the bidding process. But Robin and I went to a stakeholder engagement meeting on 9 April when the senior responsible officer for those two projects gave us some amplification of the reasons which cast quite a different light on it from the emphasis that Professor Gallagher put on it this morning. I can give you those reasons, succinctly I hope. You asked about the Mott MacDonald impact assessment this morning. I have read that. It is available I think on the CCG website. One reason that we have been told by Howard Lewis, the Senior Responsible Officer, for discontinuing that procurement was that the Mott MacDonald impact assessment was that of the £9 million budget for those groups of outpatient consultations, about £4 million was still going to have to go to the secondary hospitals in any event because the draft specifications for both gynaecology and for MSK had a whole list of excepted conditions which were going to have to go to the secondary hospital in any event. Cancer is one example. Some rheumatology conditions have very toxic drugs which were not appropriate for being managed in the community clinics. You do not want to hear the whole list. I can give you more detail. I am sure you understand the point. So that was one financial reason. A second important financial reason was that on examining the Bedfordshire MSK project that has been put in place contracted to Circle Healthcare, as I best understand it, a full scale, multi-disciplinary integrated combined assessment and treatment centre as proposed in the 2006 Department of Health document, they ran into serious difficulties for a very simple and important reason. The local secondary hospital in Bedfordshire was invited to become a sub-contractor to the new MSK service and in November 2014 they announced that they were not willing to become sub-contractors and they were going to go into competition with the new private commercial MSK service and, as Howard Lewis told us, that has been a disaster because local GPs are continuing to refer to the secondary hospital that they have experience of and are not sending anything like the patient numbers that the CCG wanted to their service and so, in effect, in Bedfordshire the CCG is paying twice over. They are paying set-up costs for the new MSK service and they are paying for the referrals to continue to go to the secondary hospital. So it is perhaps not surprising that the Brent governing body GPs on learning that have decided we would be wise to discontinue this procurement until we have had another think about that aspect of it. That has important issues of principle because Brent CCG in their original draft specification for MSK wanted to insist that GPs send all their referrals through the successful provider's triage service which I thought was a disguised way of trying to achieve a monopoly. That may be unlawful under the EU but it was also interfering with patient choice and it was interfering with GP clinical freedom in relation to referrals, so I had to pursue an appeal to NHS England. NHS England upheld me on patient choice and so patient choice has had to be reinstated into that draft specification but they continue to want to have all referrals going through the triage and NHS England told me they approved that as a way of improving the quality of referrals. They have now discontinued it we suspect that there were other financial reasons because we have not been told about those. I think that is probably sufficient.

Q. I am mindful of time so please do go ahead but what I am going to do is turn you over to the Commission because I think that is probably all the questions I wish to ask. Mr Sharp, do add if you wish to and then, Commissioners, please do.

A. (Mr Sharp): Just a quick extra word. On the whole we think it is right that the CCG have now abandoned this procurement, but it is after huge expenditure of time, money and involvement of outside experts and the patient volunteers. Had the advice that we were giving 18 months been taken we might now be where Professor Gallagher suggested we should be this morning: talking to existing providers and finding out the strengths and weaknesses of the services now provided and then seeing what is the best way forward. Everything can be improved. It does not necessarily all have to be thrown up in the air at huge expense with the risk of the hollowing out - the word that was mentioned this morning - of the existing clinics. We have in Brent Patient Voice suggested a round table involving all those with an interest in this topic before anything formal gets underway in terms of taking this project forward. We are waiting to hear the response of the CCG to our suggestion.

Examined by THE COMMISSION

Q. DR HIRST: Firstly, can I congratulate you on your contribution, if that does not sound condescending. Reading it I thought it was like a stiletto heel politely administered into the body of the *SaHF* project, although I am not sure you have quite killed the beast yet. There is also a sledgehammer from some other contributions coming but there are many, many things that, I have to be honest, almost upset me and also I suppose crystallised a lot of what I was aware of as a practising GP, but I will only pick out one or two. You spent a few sentences discussing the concentration of services and in fact on pages 6 to 18 you actually say they talk about how it has been shown, and we all accept that stroke and heart attack, et cetera, should go to specialised units and the evidence is there but it does not follow that other common conditions needing urgent admission to hospital will benefit from some form of concentration. I suppose it touched a nerve with me because I have a worry about outreach clinics and I come from a practice which 20 years ago used to run, at the last count, perhaps eight, nine or ten outreach clinics including gynaecology in the practice. Although it was wonderful for our patients I know there was a cost to it, so I suppose what I am asking is perhaps you can expand on what happens when you move clinics or fragment clinics. I am worried about teaching for example, and who is going to teach the new doctors coming up. I am worried about the fact that the consultant may be in the outreach clinic, which as a GP was great for my patients, they thought we were wonderful, but takes that consultant away from being asked by a junior about an acute problem that comes up or a gynaecologist being told there is a problem on the labour ward. In your reading and so on do you think patients - I call them patients - or citizens are aware of those difficulties even though having an outreach clinic looks so attractive to them?

A. (Mr Latham): I think there is a big development that patients and residents barely begin to be aware of at all and that is that NHS England and the Department of Health are encouraging GP practices to form networks and acquire legal NHS provider status so that they can bid to do specialist primary services such as diabetes clinics. I can see that may be a very good idea but, unfortunately, it is bedevilled by conflict of interest issues and the NHS in December had to publish a paper beefing up the safeguards in relation to conflicts of interest. That is vividly illustrated in Brent CCG, who I hasten to say I am not casting any aspersions on the good nature and integrity of the doctors on the Brent Clinical Commissioning Group, but Harnass Care Co-operative has acquired provider status. They are a provider for some of the existing projects, but the Chair of Brent CCG, Dr Kong, is a member of Harness, the Deputy Chair, Dr Sarah Basham, is a member of

Harness, the Clinical Director, Dr M C Patel, is member of Harness and one other member of the governing body at least is a member of Harness. So there are serious conflict of interest problems and in our update and response we have pointed out that when they made a decision on 25 March, I think it was to discontinue the current Wave 2 projections partly as a result of representations that I had to make about conflict of interest, all those doctors had to leave the room and the minutes of the report in relation to the discontinuance reveals that one of the factors that they had to take into account in discontinuing Wave 2 was that they are having difficulty getting a quorum on the Executive Committee because so many members of the governing body are tainted by conflict. I do not think the general public are aware that GPs are being very strongly encouraged to form these networks and acquiring provider status and I dare say you will remember that Aneurin Bevan said in relation to specialists the way he got what he wanted was by "stuffing their mouths with gold". Whether the same thing is happening with GPs --- (Applause)

Q. After reading your evidence I was prompted to dig out the RCGP article on managing conflicts of interest in clinical commissioning groups so you have helped my post-graduate education at least. One final thing, it is interesting on page 627 at paragraph 2.16 you say that the King's Fund report that the NHS in recent years has been very burdened with such administrative re-organisations that inevitably they are distracted from managing healthcare and disrupt the consistency of long-term local healthcare planning and its implementation. I suppose what my worry here is and that paragraph set me thinking and the preceding paragraph set me thinking, is the *SaHF* project, with all its intricacies and conditional points and different organisations to relate to and even to be yet created, is it a doable project or are we looking at one of the nation's computer projects that we have had in recent years or is it a TSR-2 for example? At what point, people will not remember TSR-2, but from your experience, to call you laymen does not quite measure to your knowledge, is it a doable project? As interested outsiders who want the NHS to work (and you have got no side to you) is it a doable project?

A. (Mr Latham): I have never been a member of any political party. I like to think I am quite disinterested on this. In relation to both the *Shaping a healthier future* project and in relation to these planned out of hospital projects that Brent want to do, I am quite open-minded about the merits. I can see the concept could be made to work and in relation to *Shaping a healthier future* it seems to me that that is not really such a difficult thing to manage. I am sure Robin Sharp has managed two or three projects like that at once when he was a senior civil servant. It seems to me that the difficulty is because of so many people pulling in different directions with different interests. For example, in relation to the discontinuance of the MSK project, one of the factors that they took into account was the West Sussex situation where the successful provider was BUPA and BUPA pulled out because they were concerned about destabilisation of the secondary hospital, which goes back to the point you were making about training facilities for doctors. Why BUPA should pull out because of that concern, I do not know, but clearly one strand of interest is the specialists and another strand of interests is the GPs. There are political issues on the right wing and left wing between privatisation and adherence to a free at the point of delivery state model. Then there are the interests of all the various NHS bureaucrats who may or may not privately support the idea of going for privatisation. It seems to me that the whole thing is made difficult because there are so many competing interests at stake rather than the inherent difficulty of the concept of the project. I do not know whether Robin Sharp agrees?

A. (Mr Sharp): I have my own take on this. You focused on those paragraphs in the submission. It may well be that it is doable but at what cost and at what benefit? That is the issue, not just keep on doing something that was probably first envisaged in 2009, put into the public domain to some extent in 2012 and is now rather opaquely proceeding as far as we are concerned. It seems to be basically going back to a strategy that Lord Darzai was prominent in in terms of concentration. I think from our experience and study of what is going on in the last two or three years, we would all be in favour of improved out of hospital services, but they have a long way to go. We can be critical and say it said in the strategy that it would all be completed by March 2015. That was probably never realistic. All these things take time. They are incremental. But the big problem about even what was outlined there is that GPs are required to get more involved with hospitals, to pool services in the way that Peter has described in these networks which are still very opaque and the patients do not understand them. We are told that a third of the GPs in London are due to retire in about five years and the intake is not sufficient to replace them and there are many who say that GPs often need more time than they are given at the moment by the rules to have proper holistic consultations. There does not seem to be any thinking in *Shaping a healthier future* or anything we have seen from the CCG since then that really addresses this problem of GP capacity to take forward out of hospital initiatives. There is certainly a shortage of district nurses to deal with this integrated care which we welcome in principle and there is certainly a shortage of social workers because of the cuts local authority have had to face. There is a whole series of very difficult issues which have not yet been faced up, but I think we would like to see much more of a focus on that, and any questions of cutting beds in acute hospitals has to be addressed in the light of the overall situation and not just the mechanical fulfilment of what was mentioned in 2012.

Q. DR LISTER: Fascinating and it is very tempting to spend another period of time with anecdotes of different CCG conflicts of interest and bizarre decisions, but just a short question. You mentioned - and it has come up again from this morning - the question of the costs of the abandoned procurement project. Has your group considered a Freedom of Information request to try to draw that out and if so, what response did you get.

A. (Mr Latham): At the meeting on 9 April of the stakeholder engagement group, one of our colleagues, Dr Michael Turner (non-medical), put forward three requests because this was the final meeting after the discontinuance had been announced. One of those was to call for the figures both for the staff and volunteer time and also for the consultancy fees that have been paid. Howard Lewis told us that he was astonished at the money that had been spent on this project but he did not give us details and the reply that has come back in relation to the minutes of that meeting is that Dr Turner's request will be considered and we will be told in due course.

Q. It might be worth considering a Freedom of Information request which at least gives you some timescale you can complain about if it is not met. You are obviously on the case. I just thought there might be something you have not immediately thought of.

A. (Mr Sharp): We have submitted quite a lot.

A. (Mr Latham): Could I answer one of the questions that Mr Wilcock asked this morning of Professor Gallagher that was about the cost and reasons for cancelling the Referral Facilitation Service. In our response update that is the last document in your bundle, Volume 5, page 1857, on page 2, halfway down the page, we give the answer to that. Another Brent *Shaping a healthier future* initiative was a referral facilitation service

intended to improve the efficiency and cost effectiveness of GP referrals to secondary hospital. This was put place for one year through the Harness GP Co-operative NHS provider entity and the US Minneapolis Minnesota Corporation United Healthcare. So far as we can discover this has been abandoned after one year. Professor Gallagher explained that it was a pilot since it did not deliver value at a cost of about £375,000. I cannot remember the precise source from which I got that. I think it was from the CCG Executive Committee meeting minutes but it is certainly something I have recovered from one of the CCG documents. I hope that answers your question.

THE CHAIRMAN: Your skills have not left you. I was about to ask that question. Thank you very much.

The Witnesses Withdrew

MS VARSHA DHODIA and MR ROB SALE, Committee Members, Harrow Patient Participation Network

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your names and current posts held and confirm that you wish the evidence which is at Volume 5, pages 1609 to 1704, to stand as your evidence to the Commission?
A. (Ms Dhodia): My name is Varsha Dhodia of 59 Kenton Park Avenue, Harrow, Middlesex . I am currently a member of Harrow Patient Participation Network. This is a group of people, every GP surgery should have a patient participation group. The chairs of the GP surgeries in Harrow have come together to support each other, to learn from each other and that is why they have formed this network. I can also say that I have been involved in *Shaping a healthier future* for the last three years in different capacities so I have fairly detailed knowledge of how this programme was set up and has been executed.
A. (Mr Sale): My name is Robert Sale. I live in Chandos Road in Harrow. I am the Vice Chair of my local Patient Participation Group at St Peter's Medical Centre. I am also a Committee member of the Harrow Patient Participation Network.

Q. Can we just look at some of the borough-specific issues first? You set out that the CCG in your area is in deficit to the tune of £10 million and that is on page 1613 for the Commissioners' benefit and it is the second paragraph headed up "Setting the scene: the financial position in Harrow". The CCG says it can prepare a balanced budget for the coming year but to balance it, it will need help from the other CCGs. Can you explain a little bit more about that and what you think the likely reality is?
A. (Mr Sale): Certainly I can. I think this is one of the things that underlies a lot of what we say. Just in context we did this because we realised and our members realised that the resource pressures on our surgeries are one of the biggest things that they face in trying against considerable odds to continue providing a service in our surgeries, and we decided from our PPG and took that up to the group that the resource issue would be the thing that we could best try and flag up from the patient perspective to assist them in providing services. The situation in Harrow, and I am sure it is the same elsewhere, but we will talk specifically about that, we are not saying Harrow is worse than anywhere, except there is this fear that telling the truth is going to cause more of a problem. The situation in Harrow is that in February of this year it looked as though the commissioners were

about to come in because Harrow could not set and was struggling to set a legal budget. The main issue was there is an £18 million debt brought over from the old PCT. They have an operating annual budget deficit of £10 million. The core thing of our evidence was that this formula that is used to allocate monies both to primary care and to the CCGs and to the public health function is radically unfair to Harrow, as it is elsewhere but in the Harrow case because the way the formula works does not recognise the kind of place that Harrow is now. So a budget we believe has sort of been cobbled together for the next six months, but that underlying problem will not go away, and we also know that because of the precariousness of the situation in Harrow the request of the collaboration of the eight CCGs to have fully devolved commissioning was turned down because of the precarious nature of the funding situation in Harrow. We have very severe concerns about the whole co-commissioning and GP networks and conflicts of interest that came up in the previous evidence, but the situation there is very dire. We are not blaming the CCG people. I believe they want to do the best for the patients. The system is irretrievably broken and if we go on pretending that it can be fixed we are doing everybody a huge disservice.

Q. Can I just be clear about this, what you are saying, if I have got this right is that the deficit is such that if they are not, to use the common phrase, bailed out by the other CCGs they are in serious trouble, is that right?
A. (Mr Sale): That's correct as I understand it, yes.

Q. If we look at Harrow CCG's submission. I will not take you to it but for reference it is Volume 2, page 553, what is suggested there is it says that the CCG are embarking on an exciting programme as part of the out of hospital strategy. Are you saying they cannot afford it?
A. (Ms Dhodia): What Rob has just explained is historically we have a structural deficit. In 2014-15 some monies to tune of about £25 million came into the borough, CCG, from the collaboration. NHS England talks about distance from a target. This is the way the funding formula works. Harrow is second from the bottom so we were nearly 9% lower than our target. With some extra money that Jeremy Hunt declared in December, they were given another 4% so for the financial year 2015-16 they have some extra money but no way to plug the gap. Harrow's population has also changed in the time the formula has been in existence, so what has been happening is that the need in Harrow is far greater. We have the largest proportion of older people, people over 85, and this population requires a larger amount of health care so structurally both the population need and the funding actually exacerbates our situation. For the out of hospital strategy we have to deliver but we cannot deliver in a big leap. We have to take small steps. So at the moment in the out of hospital strategy we talk about whole systems change; we are looking at a virtual ward because in some way if we can keep people at their home or place of residence and provide care in their own homes for those populations who can safely have that care we are looking at that because we really need to find savings. The QuIP programme, which is in a way finding more productivity, that is an NHS word for it, is really large and very difficult to deliver.

Q. So are you saying that the financial position impacts negatively on the ability of Harrow to deliver the *SaHF* programme?
A. (Ms Dhodia): *SaHF* is about making a change so when you are making a change you are going to keep the old system running, you need to make the changes until the new system is in place so, yes, we have not had you all our sections of out of the hospital

strategy in place. So if you look at Harrow as a borough there is talk about walk-in centres so in one half of the borough in the north and the south we have walk-in centres. East Harrow has no walk-in centre and for the last two years the CCG has been trying to get a service up and running to have a hub in East Harrow. We have not been very successful.

Q. I was going to ask you about that. Can you explain why it is you say in your submission you think it is unlikely that they will receive viable bids for the hubs in east and centre of the borough?

A. (Mr Sale): I can say something about that, I think. Again, I have seen the presentation from Dr Kelshiker in his evidence and I have got that here and I really was struggling to recognise the borough I live in and have our practice in when I read it. I think this is illustrative of what I am saying about the pretence that everything is rosy in the garden. We had a meeting with our local Medical Committee and one of the key issues that we brought up when we had meetings with our CCG is concerns about the fact that there is no out of hospital hub in the east of the borough or in the centre of the borough where the more deprived parts of the borough exist. We find out that there is no chance of the hub being built in the foreseeable future and that is very much to do with the funding that is available and the way that the funding from Government keeps changing from minute to minute. The Chair of the local Medical Committee said there was no chance of that happening in the foreseeable future. I believe that they have had one bid come in from local surgeries and it is not viable. There are all sorts of other issues to do with land values and all the rest of it that are putting the kibosh on this, but I think what needs to happen is that people need to speak out as to what is actually going on and until that happens, as far as we are concerned, there was a consultation that was held way back last year and it happened at the very drop of a hat and at that time people went away from that meeting thinking they were going to have an out of hospital hub service like there is at Alexandra Clinic, the pain clinic or somewhere like that, and of course that is absolutely not going to be the case in the foreseeable future, and yet nobody will tell the public and be honest about it. I think that is the biggest criticism I have. Not that they are not trying to do their best in impossible circumstances but it ain't going to happen. Be open, up front and honest about it and tell people.

Q. Can I just ask you when you refer to a consultation is that the "Take Part" consultation that you refer to?

A. (Mr Sale): No, it is not. It is a specific consultation that was held in the Belmont area in Wealdstone in May last year, I cannot remember, which they put it together so fast they did not get it put in the local press so not that many people turned up but nevertheless there was some discussion about it and they said that they had done the business case and they had put whatever you call it, this business case one and business case two and they had got this contractor in and PA Consulting and Jimmy whatever and all the rest of it but it was going to happen. And then silence. And it was not until we went to meet with the local Medical Committee Chair earlier on this year and he said, "Sorry, I don't think you are fully appraised of the facts." Another issue is 8.00 to 8.00 opening. A lot of our patients think because of Mr Cameron our surgeries are going to be open 24 hours a day seven days a week and they ask, "When is it going to happen?" and the local Medical Committee Chair says, "No, I think you are wrong there. You'll be lucky if you are going to get a few extra phone calls out of it."

Q. Can I ask you very briefly then, you refer to something called the Take Part consultation and I think it is in relation to the relationship between the local authority and the CCG. Can you flesh that out a little bit and tell us what that was about.

A. (Mr Sale): Just on that and then I will let it go and then Varsha. The Take Part consultation was on top of the perilous financial situation that we have got in the CCG. Equally, the local authority was forced (for ideological reasons obviously) to make what is currently £82 million worth of cuts in local government services. There are very serious concerns about that consultation as well, which hopefully may be resolved elsewhere, but the fact of the matter is that there was very little communication between the CCG and the Council in looking at how they could manage both of these financial crises. The reason we did what we did here with this evidence was not because we thought we were going to take them to court. We thought okay, you have been saying it is unfair, you have been saying it is outrageous for the last ten years, come up to the mark, get together, we are only patients from our group, get your finance departments, get your lawyers to look at it and do it properly and they would not do it and that is why we thought all right we will put it to Leigh Day and see what comes of it. That is where this arose. We were trying to say if you want to fight for your community, like the people were saying about Ealing, and you are honest about it, this is the way you do it. You do not just write to the paper and start a petition when there is an election.

A. (Ms Dhodia): The Take Part consultation was part of the local authority but we know that the health and social care economy is intertwined. If there is a reduction in adult social care, the eligibility criteria is pretty raised and, as I say, we have a large older population in our borough, some of the people who may have social care needs but will end up in a place of care because their care needs are not met. Things like falls, not having enough nutrition, et cetera. In some way one marker I would say is that our commissioning service from London North West Hospitals is always overspent because they commission a service but they are taking more of it and in a way to reduce admissions to hospital, which is one part of the Better Care Fund, admissions to nursing homes and residential homes, so a lot of these services need to be brought into people's homes but you need to have a place where you could manoeuvre it and you could channel some of the funding, and at the moment we are really constrained in both the health and social care.

Q. So was the Take Part consultation addressing those issues of communication between the local authority and the Health Service?

A. (Mr Sale): No, I think you can see from the evidence that we provide, there are two things that come to mind. First of all, there was the final commissioning intentions report that was produced by the CCG was sent over to the Council the day before the Overview and Scrutiny Committee was due to meet. It was a huge document and so the head of policy at Harrow Council put a very strongly worded letter back to the CCG saying "Hardly consultation". The CCG response to the Take Part consultation was submitted on 4 November last year, I believe, and I think the consultation was due to finish on the 7th. Previously they had identified about 13 areas where they felt they had not been given sufficient information, so despite all this talk about local collaboration and joined-up thinking and not working in silos and all that blah-blah, it was quite obvious they had not been talking to each other. At the meeting that I was at where they were discussing the impact of the cuts the CCG suggested to the Council they were trying to blame the CCG for the shortfalls in funding. What we were trying to do was to get them to work together for the people of the borough. Clearly in our estimation that was not

happening.
A. (Ms Dhodia): One thing I would add is that if you look at a very constrained health and social care economy, it is the voluntary sector that actually supports people because people do need support and indeed we have had a massive cut in voluntary sector funding. So, in some ways the CCG are saying people who are isolated, people who need support with some of benefits, they would go to the voluntary, but the voluntary sector funding is cut, so you can see in a very constrained economy what the left hand is suggesting the right cannot deliver.

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

DR LISTER: I think the evidence was very clear, thank you.

THE CHAIRMAN: The fact we have asked no questions does not mean to say that your evidence was not very clear. Thank you.

The Witnesses Withdrew

After a short break

MR IAN NIVEN, Co-ordinator, and MS ANN O'NEILL, Healthwatch Brent

Examined by MS RENSTEN

Q. MS RENSTEN: Could I ask you please to go through the same rigmarole we have put everybody else through and give the Commission your names, professional addresses and current posts held and confirmation that the evidence that you have put in, in this case pages 677 to 734, is true and that you wish it to stand as your evidence for this Commission.
A. (Ms O'Neill): I am Ann O'Neill. I am one of the founding Directors of Healthwatch Brent. My business address is c/o Brent Mencap, 379-381 High Road, Willesden NW10 2JR. And yes, the evidence that we have got here is the evidence that we wish you to take into account. My colleague will introduce himself.
A. (Mr Niven): My name is Ian Niven. I am the Co-ordinator of Healthwatch Brent. I have the same business address as Ann just gave.

Q. Could I ask you both first to explain, please, by whom your organisation is funded and to whom do you report?
A. (Ms O'Neill): Healthwatch Brent is actually funded by Brent Council. A consortium of local voluntary sector organisations in Brent bid for the Healthwatch contract in October 2012. We heard that we had been successful in February 2013. It is a consortium of organisations including Brent Mencap, CAB Brent, Age UK Brent, Brent CBS and Elders Voice Brent, all organisations that work with some of the most vulnerable people in Brent and we felt that we would be able to enable their voices to be heard.

Q. To whom do you report?
A. (Ms O'Neill): We report to Brent Council to what was then the Policy and Resources,

A I am not quite sure, I think it might be the Partnership section now after the reorganisation.

Q. We have had witnesses from Healthwatch organisations from Ealing and Central West London and they both describe their relationship to *Shaping a healthier future* as that of a "critical friend". Is that a fair description of your organisation or would you put it differently?

B A. (Ms O'Neill): Our relationship with *Shaping a healthier future*, I think a lot of the work was done prior to us being set up and we were in the throes of setting up in early 2013 so we were aware of what was going on. We tried to translate what we understood was happening in the Bulletins and in the information that we sent out to people in Brent and asked them to get involved and give their views. We attended some of the meetings and felt that what was being presented at one level seemed to be sensible, but obviously we are not health professionals, we are not health analysts, we are a group of voluntary

C sector directors, and our key aim was to try and make sure that people in Brent who were perhaps not *au fait* with it understood that there were major changes going on and that if they did not agree with them we would help them have their voices heard.

Q. I just want to ask you a little bit about the consultation process. In front of you, you will also see Volume 5. Could I just ask you to turn to page 1747. I want to see if I can

D invite you to comment on something. This is a document by a GP, Dr Sahota, who also sits on the GLA. If you look at paragraph 11, at the bottom of it he talks about the consultation and what he says is this: "Further the response questionnaire was 15 pages long with 50 questions designed to frustrate and exhaust the respondent. The questions were framed in a way to lead to the conclusion that the proposed A&E closure was based on sound science. The response document was not designed to get genuine feedback from the local population. Further, one NHS trust was set to compete with another." In

E terms of the design of the consultation document, do you share Dr Sahota's view or do you have a different take on it?

A. (Ms O'Neill): I think generally one of the positions that Healthwatch Brent has taken in all the meetings that we have attended is that most of the documents produced by the NHS and at times the Council are written in very highfalutin language, they use a lot of acronyms and I do not think anybody would say people feel that there is a real genuine wish to consult. They go through the motions of saying, "We are consulting, we are

F engaging", but it is often done at very short notice. Sometimes they will give you two weeks and want you to comment on or get feedback on something that actually would take a good two months to really explain to people, let them go away and think about it and then come back with an informed response. I think his points are well made.

Q. You talk as well in your document about being overwhelmed by the large volume of documentation. Given that you are people who are tasked and employed to deal with

G that, what, in reality, do you think are the chances of lay members of the public being able to digest the necessary information to make sense of this?

A. (Ms O'Neill): You have got lay members here who have digested it really really well, I think, but I think they are extra special. I think the average person in the street, they just want to be able to go to their GP or they want to be able to turn up at the hospital or they want to come here to the Council and they just want to have a decent service. They trust the professionals to actually deliver that for them. I think there are things that you can

H consult meaningfully on with residents if it is done in small chunks and in accessible

language, but I do not think most members of the public would understand it. When you think that we are not health professionals and not council employees and all of the people that were involved or are involved in Healthwatch Brent struggle. We struggle to make sense of the complexity of the meetings that exist and the governance and how the federation, for example, there are three boroughs in one federation and there is another federation that has got eight boroughs in, and you have got these weird and wonderful committee structures and it is really, really difficult to get your head round.

Q. Are you saying in reality for you and for people who are participants in this, there is a difficulty in being able to first of all read and digest the documents properly and secondly to actually engage fully in the meetings that you attend?
A. (Ms O'Neill): I go to the CCG's Quality --- I even get confused with the name of the meeting. It is the Quality Research Risk and something else meeting. I get sent a bundle of papers. It is about that thick (indicating) that contains different reports. It contains the performance reports from the different hospital trusts. It contains how the CCG is doing. It can take me two hours to work my way through and generally I am able to comment, but it took me probably about eight months of going to that meeting to actually feel I could say much more than "You need to make this easier understand, there need to be easier summaries". That is one meeting. If you were to attend all the meetings that we were invited to attend, it would have been a full-time job for somebody to have actually gone to those meetings, understood them and commented. That is not allowing any time to actually find out what other people think. Certainly colleagues over there would often give us their views on particular papers or particular issues but it is impossible, I think.

Q. Do you think that there may be a risk or there may have been a risk that on occasions people have signed off on matters that they did not fully grasp?
A. (Ms O'Neill): What people were you thinking of?

Q. Participants at committees asked to endorse a decision by a committee or to lend their name to it, is there a possibility that because of the plethora of documents, the confusion, the difficulty of digesting that you have just described that there may have been occasions where people have signed off on documents and said "Yes okay" to stuff without really properly understanding what was being asked of them?
A. (Ms O'Neill): I think that is probably likely. Again, when I think of the Risk Committee that I attend, it is a two-hour meeting and you are going through anything up to about 18 quite important documents and they generally do only take two hours and I think they are just whizzing through really, really quickly. I imagine there are other meetings where people are attending and possibly not interrogating what is in front of them because they trust the officers that are presenting the evidence to have done an investigation.

Q. So in terms of your organisation's ability - and I use this term loosely - to scrutinise what is going on, how does that impact on your ability to fulfil that role?
A. (Ms O'Neill): We were not set up to scrutinise. Healthwatch is not a Health Partnerships Overview and Scrutiny Committee. Its role is much wider than that and my colleague can explain it in a bit more detail. It is about being a champion for the consumer but it is not just about health, it is also about care and it is also about having links with Healthwatch England, it is also liaising with the CQC, it is about enabling people to know where they can complain and that their voice is heard. Scrutinising these

sorts of things is only one part of the work that Healthwatches do.

Q. But as far as that part is concerned?
A. (Mr Niven): I am operational. I am more strategic in this. I just very recently asked and I am waiting for guidance from Healthwatch England in terms of local Healthwatches' role and scrutiny and to what degree, and it is one of many areas that needs a bit more clarified. There could be a choice within a local Healthwatch to do nothing but scrutinise something as complex as this and absolutely nothing else with the resources available or fulfil its wider function of actually getting patients' voices heard and as wide a range as possible representing whatever those issues may be. It would certainly be impossible in a particular complex case like this. And yet there is some expectation around local Healthwatch scrutinising. So I think that needs to be clarified and we need to be quite realistic to what degree, where are the limits of that given the resources available to local Healthwatch.

Q. So are you saying there is perhaps a slight confusion of your role as to whether or not you are there to scrutinise what is going on or whether you are there to provide a conduit of information from the CCGs and *SaHF* to the public?
A. (Mr Niven): I am just clarifying that. I think some of that has been clarified over the last few years, but I felt the need to go back to Healthwatch England to ask and clarify that a bit further. I think some language is used in different documents and the words "scrutiny role" we will find in various Healthwatch guidance. I am saying clarity of just exactly what is meant by that. The other thing I was saying, which I think refers to the question, in terms of capacity, for something as complex as this, it is not something that a local Healthwatch would have been able to do unless that is all it devoted its attention to. It is so complex and time consuming so we could not scrutinise the whole *Shaping a healthier future* and fulfil other expectations and roles and functions.

Q. Can I just ask you a couple of specific matters? On pages 710/711 you talk about staff turnover at the CCG and I wanted to ask you about that. First of all, what seemed to be the problem?
A. (Mr Niven): Getting answers. So the people who write our Bulletin would often be seeking answers to questions that patients had raised or issues that had been raised with us. So it was actually trying to get straightforward answers to things. That was made difficult by people changing roles within the CCG and other organisations and the number of interim roles. And we did enquire --- was this the one that turned into a Freedom of Information? Yes, it did. We just wanted top know who was who, who to speak to, who would give us an answer on what and the CCG turned that into a Freedom of Information request, which seemed uncalled for.

Q. Pause there. When you say "they turned it into", did you make a simple enquiry?
A. (Mr Niven): Yes.

Q. And did you ask for a Freedom of Information request?
A. (Mr Niven): No.

Q. Do you know why they turned it into an FoI?
A. (Mr Niven): No.

Q. What was the response?
A. (Mr Niven): There was a list of paper which I have not included here although we do have, it was a list of names and roles. The list here on page 711 was an explanation of acronyms that were used in that list of roles. The list of roles itself did not precisely answer our question either. It just added a bit to the confusion. It did not precisely say this committee, this line of enquiry, this workstream will be answered or dealt with here.

Q. What I wondered about because what you say in your document and it is at 4G on 710 is this: "AHS Commissioner James Lorigan has left his post. A member has reported that 80% of the Commissioners have been "laid off". Healthwatch Brent is trying to find out who the new or remaining Commissioners in Brent CCG are and their area of responsibility." Are you able to comment in any way on why or what seemed to be happening for 80% of the Commission to suddenly be laid off?
A. (Ms O'Neill): I think after the changes in early 2013 some people stayed on, some people I think who had been made redundant seemed to come back. It seemed to be a common factor and also it is a bit of a theme with the Council after some of the changes that took place that I think the amount that CCGs can pay in management costs was restricted and I think they thought they would use interims or agency people for a period of time to continue to be able to run the Commissioning Group and work out what it was they actually wanted to do. You go to meetings and there would be somebody who was the lead commissioner for children's services and then at the next meeting they would be gone and there would be somebody else. So I do not think that kind of instability was at all helpful. We would say that in meetings. It is really hard if someone is saying this and then --- if I quote an example of Brent Mencap. We had been delivering some work for the CCG. We then had said, "It is coming to an end, what is going to happen to it?" There was an interim person commissioning the learning disability services. She said, "That's fine, that's great, we will come back to you once I have got it agreed." I did not get a response so I went back about six weeks later only to be told nobody knew anything about that and that person had gone and we had to start the process again. I think that is fairly common, which is really frustrating but also the knowledge and experience people had, you think if there is that turnover and churn how can you really deliver on quite major changes. That is certainly a concern for us at Mencap and I think it is a major concern when you have got such big capital or big changes, where is the continuity. Is somebody actually seeing this through from beginning to end? One of our questions was very much about who owns those projects, whoever it is, who is actually going to take it forward. So I think part of the reason for questioning that was to try and get a feel for what is their strategy in terms of keeping key people.

Q. Were you able to get a satisfactory answer from that?
A. (Ms O'Neill): No. We may have got a snapshot at that time of who was in post but I think there has continued to be movement within the CCG.

Q. I just want to ask you very briefly about your work in Northwick Park Hospital because you have conducted two patient surveys. One was in December last year and one was in February. Would it be a fair summary to say that what those surveys revealed was that once people were treated they were relatively happy with the care but that the areas of concern were waiting times, lack of efficiency in referrals, lack of information about services and difficulties about accessing hospitals? Is that a reasonable summary of the findings?

A. (Mr Niven): Yes.

Q. I know because you refer to this, you asked some specific questions, you sent in some specific questions to the operations manager. You will have to forgive me because I should have asked her and I forgot, you asked Tina Benson to respond to your enquiries. Have you had a response?
A. (Mr Niven): They were very sluggish. Disappointingly so. We do have a meeting with them on Friday of next week with the management team of the emergency department to discuss that report and get feedback from them. That was as a consequence of me asking them if they needed me to remind them of their statutory duty to respond.

Q. When you have been to that meeting are you able to please feed back into the Commission the results of that, please?
A. (Mr Niven): Absolutely.

MS RENSTEN: Thank you. I am very grateful. I have no further questions but if you wait there may be some questions from the Commissioners.

THE CHAIRMAN: Katy, can I just clarify the questions you were asking about Tina Benson are the ones on page 717?

MS RENSTEN: Yes.

THE CHAIRMAN: When you were talking about the response or lack of response from Tina Benson, is it 717?

MS RENSTEN: It is 716 and 717. I beg your pardon, I should have given the reference.

THE CHAIRMAN: Thank you very much. Dr Hirst?

<u>Examined by THE COMMISSION</u>

Q. DR HIRST: Again we have these recurring themes. You are at least active observers of one part of the *SaHF*. Having regard to words such as "confusion" and "80% of Commissioners being laid off", from the small part of this huge project do you think the systems are in place to push a project like this through? Again, is it doable what there is?
A. (Mr Niven): It is enormous. I simply echo other voices you have heard this afternoon. The principles and ideas behind this have some good sound elements to them but it is clearly struggling. We have been unable to do this forensic analysis that PPG clearly have done. It is a massive project and it needs to bring people with it. We are at least not been kept up-to-date and informed and kept in the loop as to whether it is actually progressing, so we are blind and so in part answering your question is we do not know and that is worrying. We certainly cannot be certain that the facilities and the mechanisms are there to make it succeed. I can look on a smaller scale at the Whole Systems Integrated Care and the way that is going about and again that contains stuff that everybody wants: a far more holistic approach to patient treatment. That is a meeting I was at. That is in itself a massive undertaking and is deeply flawed from the outset. I am not quite sure how they expect to proceed with that. That is only one tiny project in comparison to *SaHF*.

A. (Ms O'Neill): I think also one of the things that has not been taken into account is obviously all this development which has been taking place at a time when the Council has had to cut quite senior staff who normally probably would have had more time to scrutinise what was going on and also to be actively involved in developing project plans. So I do think there is also that side of it that where the CCG might have asked for involvement the people that are having to get involved are probably doing three jobs now instead of just one. I do think that there that the Health Partnerships Overview and Scrutiny Committee that existed going back was doing a relatively good job of looking at what was going on. I think that is probably not functioning quite as well. I do not think it is functioning at all in the same way, so I think that again is something that maybe the Council needs to think about. Lastly, there have been times when Healthwatch Brent has been quite critical of Council involvement at the Health and Wellbeing Board. I think there have been times certainly early on when there were not as many councillors present and there was not a substitute system present, so the CCG, to give them their due, would be turning up to explain things and there might only be two councillors in the room. I think the overall effect of cuts has probably lessened the ability of the Council and also officers to really look at things and interrogate them whereas perhaps three or four years ago they would have had more capacity to do so. Having worked in Brent for quite a long time, I have seen a decline in that. Those people are often referred to as bureaucrats and all they do is sit in offices and push bits of paper around. Actually what they do or what they did was a very important function of actually trying to look at bigger things impacting on Brent and I think that kind of cutting of those sorts of posts has probably also not helped. I think that has been a shame as well.

Q. DR LISTER: Back on to this question about staffing or the role of the commissioners and who is doing it and so on. There was a recent survey in *Pulse* magazine that said on average only 11% of GPs were involved with their local CCG. I am just wondering among those who are not there on a regular basis, would that include GP members of the executive or are they regular attenders? In which case, if a lot of the day-to-day decisions are actually being taken by GPs who is doing the donkey work behind the scenes? I presume this is the Commissioning Support Unit. Do you see any sign of them?
A. (Ms O'Neill): I cannot comment on the GP attendance at the CCG Board meeting because I do not go to that.

Q. They are public meetings, are they not?
A. (Ms O'Neill): Yes. So you probably could pick up the data on whether they are attending or not. In terms of their attendance at this Quality Risk --- I am sorry, I never can remember the name of it, the clinical leads are often present there. I think only on one occasion one had to participate through a telephone conference call to the meeting. The rest of the GPs I have no idea. There are 70-odd practices in Brent. I do not know. We are told that they are all behind it and they are very committed to making sure that the services delivered in Brent meet the needs of the people of Brent, but I wonder how much they are all struggling like we are with understanding the impact that they can have on planning.

Q. To what extent do you see evidence that some of this documentary material coming from the CCG is actually drafted on their behalf by consultants or by the Commissioning Support Unit outside the CCG and so on? Do you get logos on there and extra names and "researched by" on these documents or are they simply all branded CCG and that is it?

A. (Ms O'Neill): They are all branded CCG. The Commissioning Support Unit, again when we were first involved they were still I think part of NHS London so they were watching over the eight boroughs. Then I think the CCG made a decision, because they were paying to have that support, they wanted a more local CSU so I understand now the CSU are working just for Harrow, Brent and Hillingdon because Ealing is no longer part of that federation. They seem really, really knowledgeable and they will come and say, "Look, this provider is having a problem with this thing. This is the action plan we have agreed", or they will look at their quality account and say, "We have told them this is not good enough." I get the impression that they are very, very knowledgeable and they are holding weekly action meetings with Northwick Park for referral to treatment and the problems that they had. I do not know if the CCG think they have got enough capacity or not, but I think they are probably restricted by the amount of money that they can spend on management costs. I think there is something somewhere that they can only spend X amount on those sorts of management costs. Where it has sometimes got confusing is obviously Brent has one approach, Harrow will have another approach, and, as colleagues said, different problems, and Hillingdon will have another approach. This insistence of almost having a federation approach to things certainly from the perspective of, say, for example, the Safeguarding Adults Board in Brent, pressure ulcers was a key priority and there were certain discussions that were happening about the trusts not necessarily reporting that. There was going to be a federation-wide approach to when they should be reported and when they should not be reported and I think that, for example, the Brent Safeguarding Adults Board said, "We want this reported," but over the federation this is what we have agreed. I think there are tensions even on other aspects of things which I think must make it difficult for them. Trying to have a three-borough approach probably makes sense at one level but it must be frustrating at times because the needs of the three boroughs are very different.

THE CHAIRMAN: I have no questions. Thank you again very much for your work and submissions.

The Witnesses Withdrew

MR KEITH PERRIN and MS GAYNOR LLOYD, Brent residents

Examined by MS RENSTEN

Q. MS RENSTEN: If you could kindly give the Commissioner your full names, addresses and I know you have a long list of current posts held so if you could go through that very briefly please and then confirm your evidence which is at Volume 3, page 801 to 1075, that it is true and you wish it to stand as your evidence to the Commission.
A. (Ms Lloyd): My name is Elizabeth Gaynor Lloyd. My home address is 16 Pebworth Road, Harrow HA1 3UD. I have not got a list of current posts but I am at the moment a member of the EDEn Committee, the Equality, Diversity and Engagement Committee of Brent CCG. And he is my husband.

Q. You may now speak!
A. (Mr Perrin): I was going start with "This is my wife"! I am Keith Perren and I am a Councillor in Brent. I am not here in that capacity. I am here as a concerned resident who has been involved in healthcare with my wife. I am Chair of Wembley Locality

PPG. I am Chair of the Sudbury Surgery PPG, I am on their board as well as the CIC as patient rep. I am a member of the Northwick Park Arthritis Clinic PPG. Other bits and pieces that would be of use to you, I applied to be the lay member on the CCG about two years ago. I remember one of the questions was, "What would you tell the public about the closure of Central Middlesex?" and I said I would tell the truth, which you can question me on later if you wish. I have had experience in the borough in the third sector running a day care centre for the elderly, helping with a charity for learning disabilities for a couple of years and after leaving Barclays Bank in 1998 I worked in an IT training charity providing IT training to long-term unemployed within the borough. So I think I have got a feel for them.

Q. Can I just confirm, Ms Lord, that you were also a non-executive director of the Northwick Park Hospital in the 1990s?
A. (Ms Lloyd): Yes, I was.

Q. And a shadow director of a local GP surgery until 2003?
A. (Ms Lloyd): Correct and I was also a Community Director of Healthwatch Brent for a while.

Q. Am I also right that you also have patient connections, if you like, in terms of the rheumatoid services?
A. (Ms Lloyd): Yes, my husband is a rheumatoid arthritis sufferer. I just did not run through everything that he did. I am on the same Arthritis Patient Panel and PPGs.
A. (Mr Perrin): I missed one off which you might want to pick up. I applied and was successful to become the representative for people with long-term conditions in the borough. I applied to the CCG on the EDEn Committee and was accepted.

Q. So is it fair to say that you both come to these issues with quite a number of different perspectives?
A. (Ms Lloyd): Yes.

Q. I wonder if I might just ask if you could give the Commission your perspective on the demise of the EDEn Committee following the report by Angela Coulter?
A. (Ms Lloyd): We thought that it was quite a lot of money to pay because they spent £50,000 on Dr Coulter and her associate, essentially, and it is probably a little unfair, to abolish us. They EDEn Committee were classed as malfunctioning. I think what really happened was that it was very unfortunate that when we came into it we suddenly discovered there was this proposal to tender out musculoskeletal services. Keith has mentioned that he is the long-term conditions rep. In fact it was exactly two years ago because we were away and I was reading the EDEn papers (as you do when you are having a nice holiday!) and right at the back it said in July they were going to have an consultation on the recommissioning of the musculoskeletal service, so we leapt out of our respective chairs (in so far as he can with his disability) and we immediately wrote back and said, "Why didn't we know anything about this recommissioning?" That then meant that immediately we were going to the next EDEn Committee with our colleagues and talking about this recommissioning that was taking place. In fact, we found out that they had already decommissioned the services from Northwick Park from North West London Hospitals without any consultation, certainly with the long-term conditions patient rep (who actually suffers from one of the conditions that they were going to be

tendering). In a lot of ways that made it quite unfortunate because we got into quite a lot of challenge when we went to the CCG committees. I have to speak very highly about the EDEn Committee because I think Brent CCG did a very good job in trying to set up this Equality Diversity and Engagement Committee. They had the elected chairs of the five locality patient participation groups and they had eight, so the elderly, I cannot remember them all, elderly and long-term conditions and Ann's one, I think, children. There are lots. I cannot remember all the categories and all those people were interviewed and they used a proper procurement process to appoint them. Everybody was a volunteer, but, on the face of it, it was set up in a very good way to bring representatives on board essentially for them to bring their commissioning strategies and to use them as a sounding board and other things. I think it probably fell apart because we ended up being horribly involved in discussing the first, as we were starting to discover, procurement procedure and challenging it, and there was a lot of, "But you haven't engaged properly". Peter of course with his legal background, we started analysing that they had not complied with section 14Z2 and that in a lot of ways has actually had some quite good effects but it did mean that suddenly there was an at atmosphere of challenge because this committee was set up and the only people who could vote on it were patients and there were a lot of us so that meant it had a real voice and it was a formal part of the CCG. It had the downside that some of the community representatives I think started to think that there were a load of old crazies on this committee who just never shut up about the defects in procedure, so in a way it was good and in another way I can see why people marked it as dysfunctional. All I would say is that everything, as I think Robin has said before, that we said to them two years ago about what they were doing wrong with the MSK procurement I believe has been shown to have been slightly why they abandoned it. That may be a bit unfair but I am sure it has got a lot to do with it.

Q. I will come back to that in a moment, if we may. I just wanted to ask you, you just touched on this very briefly, in terms of the out of hospital strategies you raised what you suggest was a failure of the CCG to comply with its statutory duty. Do I understand it correctly that the duty is one of public consultation or patient consultation?
A. (Ms Lloyd): I always defer to my colleague over there on exactly what the duties are under section 14Z2 because we did actually go to the Ombudsman or one patient went to the Ombudsman about what they were doing. In fact, they had to re-set the way they were doing the consultations.

Q. You express - this is at page 807 of your document and it is at the bottom in the last paragraph - concern that there is a poor working relationship between the London North West Healthcare Trust and Brent CCG and you express concerns about how that might affect the commissioning process. Can you expand on that please for us?
A. (Ms Lloyd): We attend a lot of board meetings. It is a very sad life really. I attend a lot of CCG meetings as a result of this EDEn Committee and sometimes when they were talking on the Board about the hospital you would think that they were the enemy. I have come to the conclusion that a lot of it has got to do with the money side because the CCGs are busy trying to push down the cost of everybody. I learnt these expressions like the hospital is "over-performing." We never really knew what that meant, but I think what it means is that they are doing more than somebody estimated they were going to do and so the CCG were having to pay them more. So it was not good really because you sit in a meeting and think this is funny because most patients, although everybody has a quarrel and we all know people who have had a bad experience of the hospital or

whatever, but for most people we say this is our local hospital and it seems a bit odd to hear it being spoken about as the enemy. I think I quoted a couple of things because again I am a sad person and I read a lot of board minutes and you read one of the quotes that I put in earlier that had actually come from executive committee minutes.

Q. Can you pause there? I think you will find that as well in the Brent PPG, just for your reference it is also at page 811 of this document.

A. (Ms Lloyd): There was another one certainly. I do not know whether I sent both of them but there was another one that "until we improve we do not want to do any more business with them", which worried me, but, having said that, it was interesting because I went to the London North West Healthcare's last trust board meeting and it was quite interesting that the Chief Operating Officer said that they had seen a sort of sea change with the CCG in the latest negotiating round. It looks as though maybe, and that is terrible because it sounds as though we think it is because of the battles we had over musculoskeletal, but certainly I got the impression that they thought they were having a better negotiating round, but it worried me that in their open conversations at board meetings and in the evidence of papers that we looked at there seemed to be an attitude of not a very good relationship.

Q. Can I ask you please to turn on to something you deal with at page 810 and it is at paragraph 213. Reference is made to you pursuing Freedom of Information requests in relation to the costs of the Wave 1 bids. Can you update us with where you got to on that, please?

A. (Ms Lloyd): Mostly the cost on this relates to what I viewed as a subsidy that was paid to the successful bidder. The cardiology bid was a bit strange and I go on about it a lot in detail but the last two bidders, as I understand it, were the London North West Healthcare Trust and the Royal Free Hospital and the Royal Free won the bid and there were patients who were complaining about that, principally the community heart failure cohort, but I seem to have got on to the back of it because, as you will see from the evidence, I got quite involved in looking at the costs of LIFT buildings which are the responsibility of Brent CCG and they are quite expensive. So a throw-away remark in one of the meetings - and I am sorry this is a bit involved - indicated that they were having some trouble in negotiating the lease to BMI who were one of these other Wave 1 providers. The lease was a problem because of costs. Because of my involvement with my own GPs who are in a LIFT building, when I was the shadow director, I realised ---

Q. Could you pause there because LIFT is an acronym. Can you help us with the acronym?

A. (Ms Lloyd): I am not quite sure. It is like PFI. I think it is "Local Something Funding" but effectively it is the same, it is just a different way of, but I think there was local authority involvement in it.

Q. Thank you for the clarification. Do go on.

A. (Ms Lloyd): The problem with being in a PFI building of course is that the rents tend to be extremely high and you have also got what can be an unlimited exposure to service charges and costs so, for instance, if you do alterations or anything you have to get, let's call it the PFI provider to come and do it so if you want to put up a notice board, you have got to pay 150 quid or whatever, so if you enter into any kind of lease obligation on that you are a bit worried because you may have unlimited costs. I thought, "That's

interesting, I'll just ask a few FoI questions and make sure that in fact there is no hidden subsidy." First I got really worried because the private sector provide the BMI so I thought, "I don't want the CCG subsidising their rent, but I asked about both and I also said, "And by the way, have you got to do any alterations?" And of course the answer came back ---, well, the answer about subsidy on rent is extremely difficult to follow. I cannot really get to the bottom of it, but on alterations what I regard as a subsidy was made because they had to modify these two LIFT premises in order to make them fit to be used, certainly in the case of community cardiology rooms, so I suddenly discovered in a set of minutes that in a QuIP committee somebody had said we are going to have to fund this, it was something short of half a million, to do these alterations. So that was in the QuIP Committee and then the payment of that money was resolved by Chair's action. I immediately thought (a) this is not very transparent but (b) far more putting my commercial hat on, in the commercial sector if you do a tender and you win on it then you do not suddenly lob another half a million to the successful provider, in my opinion. So I raised that with Monitor, who already had a complaint, somebody referred to it earlier. I have just heard from Monitor that they are definitely not going to bother taking it up because it is too small and they have not really got the resources to be dealing with all this.

Q. We have some pressure of time I know so can I ask that we cut to the MSK service. Clearly there is a wealth of information in your paper about it so can I ask you in this way: what has gone wrong with the procurement exercise? Can you help us with that?
A. (Ms Lloyd): I think it took two years for a kick off. What they originally said they wanted to do was that they were going to procure all these waves of services by something called "competitive dialogue" which, as I have said in the paper, I do not think is necessarily a good idea, but on MSK they have had changes of personnel, they have had dedicated teams coming along. They have involved stakeholder engagement groups. We have all put our half penn'orth in. We expected that the bidders when they all came in, the whole idea was that they were devising a service. Then we suddenly got notified they had got a new person who was advising them who turned out to be a person who was a quite a big proponent of the lead provider model. So everything started to change slightly. They said they were going to have it as the lead provider model. That means, as far as I can ascertain, you have got one overall person who takes charge of the contract and then sub-contracts everything out. Peter mentioned the difficulty that had happened with other tendering processes. Bedford has been a disaster and also the Coastal one has. To me the bigger difficulty is how does that affect if you have got ordinary provider trusts coming in as the ones who are going to be to doing the bidding. They are not set up to be themselves overall commissioners of services. They are there to provide them, not to actually say, "Oh dear, we have got to do this contract at a particular cost and then we have got to find other people to do it underneath us." Suddenly we seem to be lumping this lead provider model on to what was meant to be, if you agree with competitive dialogue and say let's not design the service ourselves and let's get somebody else to come in and do it, then I could not quite understand why we had suddenly got the CCG saying it was the lead provider model. I suspect it is because they thought they could do a costs envelope where they could say, "Here you are; you have got to do it all for this amount of money." As to what went wrong we think because certainly a previous Chief Operating Officer, Joe Ohlson, did say that they would pause once they had got the initial impact assessment in and see what they think, and I think with the weight of evidence with other difficult things around the country, they thought they were not going to make

savings. I think they had looked at the Wave 1 inputs where they had found that the ophthalmology certainly was not getting the take-up. The cardiology has got major problems because a few weeks ago they still had not managed to get the Virgin telecommunications thing into one of the facilities so they cannot actually operate out of one of them. I think that they have had big difficulties and I am sure it is taking a huge amount of time and resource for the CCG. In fact, there was one thing that the new Senior Responsible Officer said when he arrived, "There are very few employees in the CCG and we can't give the resource that we are having to give to this." They have spent two years and an enormous amount of time on it.

A. (Mr Perrin): I was just going to make one overarching comment and that is about a year ago Joe Ohlson actually said quite openly that the PPG Chair and EDEn were too challenging; it was like being in court. I put that on top of the challenges through the MSK SEG, the same people again, and the EDEn Committee. Is that why they have got rid of EDEn? Is that why MSK has failed? Has it failed?

A. (Ms Lloyd): The other thing that also strikes me, and somebody was saying do you think *Shaping a healthier future* can work, I think the biggest problem is from the evidence that we seen about doing these out of hospital services, they take an enormous amount of manpower. They have got to have legal advisers, accountancy advisers, they have to bring in the Commissioning Support Unit just to do the procurement. We have been very closely involved looking at four waves, the first two of which have not been very successful, two they have abandoned. Hopefully they are going to get some good stuff out of the work that is being done, but can you imagine if you then spread that across all eight CCGs, trying to do these out of hospital strategies. GPs are not trained to do all this sort of stuff and that then combined with the other issue which we raise which is massive conflicts of interest. Again we are not impugning any GPs but we know that particular locality networks are bidding for these things as well, which is very difficult because they are the commissioners and they are the providers. I think that is another thing that went wrong because there was a very strong challenge from the PPG Chairs saying you must reveal your conflicts of interest. We got them to do their declarations of interest. As soon as they did, the main clinical lead, who was actually excellent, suddenly at the end had to make a declaration of interest to us in the stakeholder engagement group. He sort of muttered and said, "If my group wins this job I personally won't take any profit from the contract." You sit there and you think, "This is ridiculous." We quite wanted him there because in fact his interventions in the stakeholders' group were really good and really practical and we thought if only if he had been talking we probably would not be here, but I think conflict of interest is very difficult for them, very difficult.

Q. I was going to ask about that anyway but you have covered it very nicely. I just wanted to ask one final question. You talk on page 861 about the involvement of Mott MacDonald. I just wondered, briefly, what is your take on their involvement and do you think they are value for money?

A. (Ms Lloyd): I know that they were initially paid £71,000 to do the impact assessment. I do know that. I think they probably pull a template out of a drawer because every time you see one of these things they always say: "How far have you got to travel? Do you feel that people discussed it properly?" They seem to have a template of questions that do not really ever answer: Are you feeling better? Are you feeling as though you are being treated? I have to say they slightly improved when they drilled down into the final bit of the impact assessment where they gave us (more than just me) an hour long discussion on the telephone going into what do you think are going to be the impacts of this? Can you

see any advantages? Can you see any disadvantages. And they certainly fed them into the final impact assessment on MSK and gynaecology, which I think again because the impact assessment when it was done was another thing that definitely contributed to, as far as we know, to the CCG abandoning it. What do I think? I was a commercial property solicitor and I remember Mott MacDonald as a lot of engineers and I think what happened when they did PFI projects they thought it was a jolly good thing to have a consulting arm who would do public engagement. When they do their travel analysis, blimey, it is the same old thing, you have the ratings and they are totally meaningless because, as I say, some people from Harlesden, they do not drill into the detail, nobody bothers to say we have got a demographic map here which shows where people suffer from these particular conditions, let's actually look whether they are going to be better off travelling to Willesden Centre for Health and Care, where there is hardly any carparking, or whether they go to Northwick Park Hospital at the north end of the borough or Central Middlesex at the other end of the borough. It is not really robust stuff at all and I just think it is a box-ticking exercise. The consultation was awful. They shoe horned a consultation on gynaecology in with a consultation on MSK together in the same brochure. They had road shows. They would stand there and I stood behind one lady who was doing it and the girl just said, "Well, here you are, just read the booklet and it's all about which hospital you go to." Then they forgot to collect a lot of the questionnaires that were specifically left at the Arthritis Centre.

A. (Mr Perrin): Just quickly, the one at Northwick Park Arthritis Clinic, I actually turned up in the morning and Mott MacDonald did not for a few days. They were doing something else.

A. (Ms Lloyd): They did turn up in the end but probably only because Keith had phoned up and said, "Where are you?"

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

Examined by THE COMMISSION

Q. DR HIRST: I described an earlier submission as a stiletto. I think yours is a hatchet. As I say, I am not sure if the beast is gone yet. Firstly, I am also embarrassed to ask this question as a GP but if I was practising in the area where you live under the auspices of Northwick Park, say, and I want to ask you as an expert patient and arthritis sufferer, say you called me because you had a fever and you are on your Methotrexate or anti-TNF drugs and I organised an urgent white cell count and your white cell count is so low you have individually named the white cells, and I know you have got to go in because you have probably got septicemia and the musculoskeletal service has been commissioned away, who do I ring?

A. (Mr Perrin): That is a good one. Something very, very similar actually happened. If my service had been at Willesden or somewhere else like that, I am not sure I would actually be here. I had an operation on my hand and it started to swell. I went to see a nurse at the hospital and she said, "No, that's fine, it should be like that." The next day I had my appointment with my consultant and he said, "I have operated on you; it should be like that." The next day in Wembley I was on the floor almost. I went to Wembley MATS, if anybody remembers that, which is a minor accident and trauma service, which is closed now or changed. A young doctor there said, "Oh, my dear, take these antibiotics straight away and go and see your GP." I did. The next day was my appointment at the

Arthritis Clinic. I walked in, staggering almost I suppose, and my specialist nurse said, "Oh my God, Keith, lie down on there." Within about 12 hours I was on a drip and I think I probably would not have made the day out without that. Does that sort of answer your question?

Q. If this commissioning had gone through, where was it going to go, to the Royal Free, or who else was going to manage it?

A. (Ms Lloyd): We do not know who all the three providers were but we do know that one of them was a consortium of London North West, Imperial and Harness group of GPs.

Q. I suppose actually thinking about it, you would ring the acute medical registrar at the ---

A. (Mr Perrin): I have a helpline for the arthritis team.

Q. But that would not exist any more if it was decommissioned. Would that exist if it was decommissioned?

A. (Ms Lloyd): It would depend on how they redevise the service. From what we could tell of the way they were redevising the service --- no, because a lot of it is more directed back to the GP, interestingly. There is a lot of stuff about, "Let's educate the GPs, let's make sure that you are back with the GPs."

Q. I used to do a lot of monitoring of disease-modifying agents. Three years ago we just did it and it is scary but I can tell you I would never have treated a septicemia. If you have got to go in, you have got to go in, and, presumably, I know when the service was run out of Charing Cross, which is the area I know, I could ring up the rheumatology registrar or I could ring the medical registrar on-call knowing that an opinion, while they were in a different unit would have been taken from the rheumatologist because, as you know, it is a very skilled business knowing what dose to change, when to stop a disease-modifying agent, when to restart it.

A. (Ms Lloyd): I regret to tell you that the DMARDs service is now out with the GPs and in fact part of one of the consultation things when Mott MacDonald listed a whole list of things for the GPs, they were very good, they put down everything and one of them was we do not think this DMARD monitoring is safe and we know from our own acute provider that they are worried about the way the monitoring is done because I think in Brent they are still using yellow cards which we banged on about saying no, you must do them properly, so it is all linked in with secondary care.

Q. I have to say I am not against it, I think GPs can monitor it as long as they have got the back-up. What I am concerned about is what are the routes of back-up for a GP who is stuck with a problem?

A. (Ms Lloyd): It is fine if you are talking about an educated patient. I do not mean that in a patronising way, but supposing somebody turns up without a yellow card, supposing they forget it, that is the worrying thing, because what we have always tried to do is to speak for - and it sounds terribly patronising - those who do not know all the issues and do not know the problems.

Q. Again I want to see your view as experts in the NHS and, as you can hear, I keep talking about bees in my bonnet and here I go again about levers. I just want to know

what are the levers of change? Where are they and in fact are there any levers of change or is it totally chaotic?
A. (Ms Lloyd): You mean to change the way ---

Q. When you want to change something.
A. (Ms Lloyd): You mean in a project?

Q. To who do you go as an educated patient, as a representative of other patient groups, how does one make a real change, do you think? Do you go through your councillors? Do you go to NHS England?
A. (Ms Lloyd): We have tended to bang on at the CCG a lot as you can gather because they abolished us, so we carry on banging on as individuals now.

Q. Do they have power because it seems to me that they have to appeal through rigid mechanisms?
A. (Ms Lloyd): I think they have a reasonable amount of power, you know. NHS England are just --- I will not say what I was going to say. We have appealed to NHS England. We did when we did not like the way that Brent CCG were going to change their constitution basically as part of this getting rid of the EDEn Committee but I would not say they were exactly --- We were ushered off to their offices. We had a very nice time talking to them in their offices and they were going to do lots of things but they did not.

Q. I do not think you have given me any comfort really.
A. (Ms Lloyd): We just bang on basically and join up with a lot of other patient groups.

Q. Where do you think the locus of power, to use the jargon, is in *SaHF*?
A. (Ms Lloyd): I have no idea. The big, big flaw I think or one of them, of *SaHF*, or whatever we call it, is that it is founded on a basis of first of all shoving out these out of hospital strategies which by our experience is such a difficult process for any of them to do because, apart from all the time it takes, they have got to comply with competition rules so as soon as they decide they are going to do one of these out of hospitals services, they have got to do a supply to health tender, they have got to encourage everybody in. So there is all that. Then the other side of that of course is that they are saying what we are going to do is we are going to do it through networks of doctors. Apart from the conflict of interest issue on that, my own experience through being on this shadow CIC taking over a doctors' practice is that doctors do not have a clue about corporate governance. They run their business, yes of course, it is a small business, but the running of a network so for instance, the networks are getting in Prime Minister's Challenge funding and so they have set up this corporate body, so they have this money in but my experience is I do not even know that they know how to run a board or that there is corporate governance on a board. You sit and they say, "We have got this contract from the government, we have got to fulfil it." Whether GPs, who are used to running their own businesses, understand that that means --- so I think how on earth are you ever going to implement these out of hospital strategies when you are dealing with competition law, feisty patients whom you have also got to consult. How do you do a real consultation? It is extremely difficult. Ann O'Neill is from Brent Mencap and I always remember her saying to me, "I have not got ten learning disabled people to pull out of a drawer for a consultation." I feel sorry for them in a way but if you factor that into *Shaping a*

healthier future I do not see how anybody could ever put those out of hospital strategies in place. And I think the networks, I was at a presentation at a Brent Patient Forum the other day where somebody said, "You can forget the idea of seeing your individual GP", and you can see why because the message is coming it is networks, we have not got enough capacity; we will have to do it through networks, but what worries me, and Whole Systems Integrated Care is the same, is you will not be seeing your GP. You are going to be a complex patient managed through this multi-disciplinary team but then of course they say of course the social worker is not going to turn up because they have not got any. But never mind at least we have tried. Suddenly - and I am probably rambling far too much - I am just trying to say you cannot implement the out of hospital strategies. You are never going to do it. It is going to cost a flipping fortune if you want to comply with everything. You will spend a very great deal of money on lawyers. We have persuaded the CCG to publish all their contracts over £25,000 and the money is eye-watering, most of which is going to Mckinsey, I have to say. There is no accountability as to what it is being spent on. I think the consultants come from a different budget from everything else they are doing, so they can bring these consultants in but they spent £107,000 on a mocked-up public/private partnership. They advised on Wave 1 and I have to tell you that the Wave 1 tendering process that they advised on had to be abandoned because they had done it all wrong.

Q. Thank you.

A. (Ms Lloyd): Can I just say one thing? It is just because somebody has mentioned the PPRG for *Shaping a healthier future*. When I was the Community Director for Healthwatch I went along to some of those and the original assessment of those was that every CCG's lay member and every CCG's Healthwatch should send a representative. At the first meetings I went there to they were all there and, as Ann O'Neill said, we were running to catch up. There were clearly some people who were well-embedded in the process and knew exactly what they were talking about and it was very intimidating. That was an enormous process and they also had terms of reference and arguments about whether it should be confidential. We said, "Hang on, if we are meant to be representing the patients how can we make it confidential?" But those minutes, I know quite a lot about that but I had confidentiality imposed on me and that to me seemed absolute mad. I was never absolutely able to establish that we had a Brent resident who was a representative on the Travel Advisory Group. I still do not know whether there is. I keep asking. There may well be. We have put people forward. If you have a Patient Participation Group you should be able to be saying what they are. The minutes should be available. There are loads and loads of them but it is all confidential so how do you get the feedback from the patient representatives.

THE CHAIRMAN: Thank you very much.

Q. DR LISTER: Well maybe it is just a patient involvement group as in "one" patient somewhere that has been involved that does not bother to tell anybody! I think you are painting a vivid picture as others have of a bit of a shambles here. Would you agree with the idea that maybe the GPs are out of their depth in trying to actually make this work? What would you as campaigners think would be a way out of this because we appear to be locked into this scenario now where people are passing responsibilities from one side to the other, you have got management consultants come in with whiz-kid ideas that nobody quite understands and cannot quite implement. We need to make some

recommendations in our report. What would be a more rational way of doing it?
A. (Ms Lloyd): It is like that joke about I would not have started from here. Not all GPs engage. Some are engaged for purposes that may possibly be more to do with their pocket as well. It is the same old thing. I wish somebody was actually planning it. If I believed that somebody was planning it, I would be a lot happier. I do not see any evidence. When Mark Spencer was talking this morning and saying, "I am not the financial person", it seemed to me to be absolutely crazy because if you are in charge of the clinical side you have got to know that you are going to have the money to deliver the plan. If you believe in the grand plan you have to have the money. The idea that nobody has actually worked out how much the money is seems a bit odd. So perhaps what I would start at is trying to find out what the real budget is. What are we being allowed for this transformation process and somebody do what I used to have to do when I was at work and do a business plan and say this is what it is going to cost me, this is how it is going to fit and I would make the --- the eight CCGs are allegedly working together but there is absolutely no evidence that when, for instance, Brent decommissions MSK that they have talked to Harrow. Are they doing the same thing? Someone said they were waiting to hear from Harrow whether they wanted to do the same commissioning and when we went to ask Harrow (because at Harrow you are allowed to ask questions) they said, "We don't know anything about this thing that Brent are alleged to be waiting for." You need somebody with a proper view about improving health to sit down and plan it properly and have a budget but do not, for God's sake, leave it to all these different CCGs to go out and do their own different processes. Are they talking to each other? They say they are. I do not know whether they are because of course they are all trying to make their own QuIP savings so, as Rob and Varsha said, if Harrow are £11 million in deficit already and Brent have got £34 million, all it is about is money and savings. They call it Quality, Innovation and all the other stuff but it is money.

Q. THE CHAIRMAN: Can I interrupt you there.
A. (Ms Lloyd): I am sorry.

DR LISTER: I think you have answered the question. It is not that easy.

THE CHAIRMAN: It has been very helpful. I am just mindful of the poor stenographer who has been typing now for over seven hours. We have two more people who need to speak and I am going to have to draw that to a close, but it was very, very useful, thank you very much.

The Witnesses Withdrew

MS RUTH BRADSHAW, Brent resident

Examined by MS RENSTEN

Q. MS RENSTEN: I wonder if you could please give the Commission your name and your address.
A. (Ms Bradshaw): Ruth Bradshaw, 6 Cooper Road, NW10 1BG.

Q. You will see in front of you Volume 4, and at page 1421 ---
A. Yes, that is the letter I wrote.

Q. And is that the evidence that you wish to stand for the Commission?
A. It is the evidence. I want to make one very minor correction or addition to it and that is that I am not certain, somebody just said that the MATS at Wembley Centre for Social Care does not exist. If it does, it does not seem to have changed its name to "urgent care centre" if you look on websites. On the other hand, if you look up the words "urgent care" on NHS Choices, it lists all the walk-in centres under urgent care and the only distinction is that they have a pair of footprints beside them instead of the words "A&E". The one at CMH is not the only one. There is another 24-hour one at Hammersmith Hospital that has been mentioned and one at St Charles' Hospital that is open from 8 am and 9 pm seven days a week, so what happens if you want urgent care at 9.30 pm? The problem is not just confined to the place that I wrote about. The description is very misleading for all of those and if the A&E at Ealing closes, as was mentioned as a possibility this morning, then it will arise there and anywhere else that they decide to do the same thing.

Q. In your submission you set out an account of events in December that led to the sad death of a neighbour?
A. Yes.

Q. I wondered, because although those of us who have got the document know, could you very briefly set out what happened?
A. Okay. I think he was 59. He lived in a house with his brother. I do not know precisely what the symptoms were but they were enough for them to feel he needed to be in hospital. It was at a time when ambulance services were pretty stretched and the brother put him into a cab and took him to Central Middlesex Hospital and took him into the urgent care centre. I am not certain whether the initial symptoms were an asthma attack, I only have this from other neighbours because I naturally do not wish to question the surviving brother, who has not blamed himself for doing the wrong thing and I do not want him to. So he has said very little to me about it and I have heard it indirectly from I think three other people. But anyway, at some point while he was in the urgent care centre he stopped breathing and what I have heard was asthma attack but it may not have been and the staff there were not quite sure what to do. They could get at the right equipment. I think they actually phoned Northwick Park but they ended up phoning for an ambulance and the upshot of it was that he was not breathing for 15 minutes before he was revived and that he was then admitted to a hospital (I am not sure whether it was Northwick Park), and he died there two weeks later having been, I think, extensively brain damaged by not breathing for 15 minutes. It was a great shock to all the neighbours because he had seemed a reasonably fit man who was actually the youngest of a set of brothers. Basically talking to several neighbours, as I said, it was obvious that nobody really understood the difference between the urgent care centre that is now at Central Middlesex and what it had been like when the A&E was in the next door room and you could get past through in a couple of minutes. Basically they did not understand the difference between "urgent" and "emergency". These are ordinary people. They were not second language speakers that I spoke with. The man who died was from an English family who had lived in Willesden all his life. I think he left school at 15 and they did unskilled or semi-skilled jobs, mainly involved with driving heavy vehicles. The others I spoke with were either English or Irish, again not non-English speakers. "Urgent" and "emergency" sound incredibly similar and although there had been all this publicity that

all the nerds here like myself have read and we all knew what had happened, we also, because we are the sort of people who read every word we pass, had seen the notices on the bus stops and things like this, most people blank these things off. They do not even read the *Brent Magazine* which goes to every home. It goes straight into the recycling bin in many places if it does not go to landfill. That is an attempt to tell everybody but when you look at the number of people who go to Brent Connect meetings, local neighbourhood watch meetings, meetings like this, CCG consultations, it is a tiny, tiny fraction of the population and news that is as local as this does not get well reported on the televisions that most people watch and very few people now read the local paper, which also has reduced its news coverage, although to do it justice it did cover the A&E changes in quite a lot of detail but very few people read it. The point is not that you need to put out more means of publicity for people to blank off. The point is that the words used have to be unambiguous to the most basic speaker of English. They have to be words that a ten-year-old could understand because even a ten-year-old can take somebody to hospital or call an ambulance in an emergency.

Q. THE CHAIRMAN: We understand the point entirely. I think one of the things you would ask the Commissioners to do when they do their report is to highlight the example you have given as a clear example of how these terms need to be strictly made different so that ordinary people can understand that there is obviously a difference between urgent care and accident and emergency?
A. It must not be called urgent care. I suggested going back to "minor accident treatment centre" or "minor ailment treatment centre" or as in Edgware walk-in centre. Any of those I think people understand that if they go in there, there is not going to be a consultant or someone who knows how to revive them when their heart and breathing has stopped.

THE CHAIRMAN: Thank you very much.

MS RENSTEN: Can I indicate that you have very neatly taken me through every single question I was going to ask you so I therefore do not need to ask them. Thank you for helping me out. I do not know if the Commissioners have any more questions but I am most grateful.

Examined by THE COMMISSION

Q. DR LISTER: One point, it does flag up an important thing about ambiguity. We had this morning a discussion about what was going to be a local A&E and a debate in which nobody could define what was going to be in it. It does not appear to have been agreed yet but a local A&E could be as confusing as an urgent care centre. I do think clear language that is unambiguous that people can understand what services they are going to get inside is very important, so thank you for flagging that up.
A. When I heard that mention of local A&E I did actually make a note of but it was not with my other notes. I was appalled. It is either an A&E or it is not an A&E. If it cannot revive you when you are apparently dead it is not an A&E. (Applause)

THE CHAIRMAN: Thank you very much.

The Witness Withdrew

MS RENSTEN: On that last note, can we please have our last witness Dede Wilson please.

MS DEDE WILSON, Save Our Hospitals Campaign

Examined by MS RENSTEN

Q. MS RENSTEN: Can you please give the Commission your full name, address and details of your interest and confirmation that the evidence that you have provided - and you have provided two sections, there is one in one of the earlier bundles but I am going to take you to the section in Volume 5, pages 1547 onwards - is true, please, and you wish it to stand as your evidence? It is Volume 5, 1547 to 1592. Could I ask you to confirm your name and details, please?

A. (Ms Wilson): My name is Dede Wilson. I live in Fulham, near Charing Cross Hospital. I am one of the early founders of Save Our Hospitals in our area. I was involved in it very much from the very, very beginning when the consultation was first brought out. My interest in it has been that I have been a patient there for over 40 years myself. Both of my children were born in Charing Cross, one of them born in the original Charing Cross, so I have seen changes in the hospital that have occurred both from the original and the move to Fulham. I am involved in education and have been involved in education and training for most my life. I am mentioning this because this is a very very important factor in terms of my interest as well because Charing Cross is a teaching hospital. It is a very very key, very important teaching hospital, registered as one of the top ten in the world, so for me that is a very key issue and I also know people who are working there. So I feel very very strongly about it from that perspective as well and from the building itself in the sense that it is a building that is very user-friendly, both for patients and for doctors, for people working there and for students and medical students, and all of the facilities and everything that are there. So it is quite comprehensive as to why I am involved.

Q. Can I just ask you to pause there and explain that you were in fact going to give evidence originally at the hearing in Hammersmith & Fulham Town Hall?

A. Yes, I was going to give evidence in March.

Q. But it is fair to say that you find yourself rather than at the beginning at the end of the process taking the graveyard slot, I am afraid.

A. Yes, I am taking the graveyard slot because in fact what happened was that unfortunately my mother had an accident. She spent a month in hospital in Canada where she lives and I had to go there to become a carer and I was her carer for almost seven weeks there after she came out of hospital. I have experienced first-hand in many many ways changes that have already occurred there that have not occurred here yet because of the trade agreements between the US and Canada.

Q. What I wanted to ask you about first of all was a little bit about the consultation process because you have dealt with that in some detail. Can you give the Commission your overall succinct views about whether it was fair and appropriate and did what it was supposed to do?

A. Right. That is a wonderful question. In a word "No", it was not fair. It did not meet

many of Andrew Lansley's criteria to start with. There were things to do with, for example, the timing and when it was introduced. When it was introduced it came out. In July we heard about it in Fulham but in fact they knew about it in Chelsea in June because it was introduced at Chelsea & Westminster Hospital in their Trust news in their broadsheet in the hospital itself. So they had pre-advance information about what was going on. The consultation itself was only online. It was not possible for people to do it until they were able to get hard copy. Hard copy was not available unless you went online to get hard copy or you went to a meeting where it was presented and you could get hard copy. This did not actually happen for people until September, unless you lived in Chelsea where they were delivered to people's doors. In Chelsea as well in September when we came back, we set up Save Our Hospitals in July when the consultation was first introduced. The consultation was brought out just before the school holidays, just before the Olympics, just before a time when people were not going to be around or be able to be consulted at all. So it meant that people did not know about it until they came back from the school holidays. Nothing was advertised. There was no leafleting in Hammersmith & Fulham whatsoever. The only way that people knew about it was through newspaper reports and advertising in the *Fulham Chronicle*. Otherwise it was not available unless you went online to Hammersmith & Fulham Council to find out that there was something there and that there were going to be meetings. The first public meeting was not held until September, not until the September of that time.

Q. But how does that sit, we heard evidence from various health professionals including Dr Spencer saying that there was extensive consultation, that they had done everything they could, that they had put out numerous documents in numerous community languages. Did they not do everything they could be reasonably expected to have done?
A. Not at all because in fact, as I said, in Chelsea those things were available; in Fulham they were not. In Hammersmith & Fulham there was a complete blackout in most of the hospitals and things and I think it was the same thing in Ealing and all of the hospitals where they were not the favoured hospitals, if you like, not option A. If you wanted to find out, the only way you could find out was as I have just said. That was the only way you could actually find those things out. I do not have a huge amount of faith in Dr Spencer because the very first time I spoke to him and told him what my interest was and that my children were born at Charing Cross Hospital he told me that was not possible and I said, "What do you mean that isn't possible?" He told me that was not possible because they did not have a maternity department. I said, "My first daughter was born at Charing Cross on the Strand," and he said, "Well, I was working there, I was doing my training at that time", and I said, "Oh well then you must have known Dr Hugh Jolly" who was Head of Gynaecology and Obstetrics at the time and a well-known authority on paediatrics. "Oh yes, I did know Dr Jolly during my training." So I am afraid I do not have a huge amount of confidence in Dr Spencer.

THE CHAIRMAN: Can I make a suggestion. Rather than asking open rhetoric questions you might want to ask leading questions.

Q. MS RENSTEN: I did want to ask you about the closure of the A&E at Hammersmith Hospital. Do you have a particular view about that? Were you able to provide information on that or is that outside your remit and would you prefer to focus more on Charing Cross?
A. I would prefer to focus more on Charing Cross but I have been up to Hammersmith

and I have been outside as part of the campaign at Hammersmith. I went into the A&E department and I also did know that in both of these places things like the consultation documents were not available and also many people who were working within the hospitals did not really know what was going on or what was happening to their hospitals.

Q. If we move on to Charing Cross, looking at the site in Charing Cross, do you know what the plans are for the site in terms of sell off, if anything?
A. Specifically, because I have been away since a lot of the more recent things have come out, I only know that the Imperial College plans at the moment are really to demolish the main site and, as far as I know, it is to demolish the main site and to rebuild and this has been part of their plan for what they call a health and social care hospital which will be much, much smaller. It is outpatients only. And basically is to provide urgent care and walk-in. It is going to be quite limited but I cannot say because I have been away.

Q. We know that the new urgent care centre at Charing Cross is designated as an accident and emergency unit?
A. Yes.

Q. Do you know what that is going to consist of?
A. I do not know exactly but the only thing I can say is that I have had experience since things have happened in the accident and emergency on two separate occasions. Once when I was severely concussed and taken into hospital and because I was severely concussed I had no idea where I was. I was taken not in an ambulance and ended up having to go through the triage. If it had not been after three hours for the person who was with me who went and said what was happening here, I would not have been treated. My neck should have been put in a brace and things like that and that did not actually happen. Eventually I was seen and was taken into the hospital, into emergency. The second time was when I went in through my GP with septicemia and I was taken in and did not have to go through the triage and went in but had to wait for a very, very long time before I was admitted to hospital and put on a drip. I was on a drip for three days actually before something was actually done because new people kept coming in and if you do not get treated on the night of treatment the next day other people have taken your place.

Q. Will the closure of the A&E as it stands at that hospital cause risks to patients in that area?
A. I think it will cause severe risk, yes.

Q. What do you say is the appropriate service that should be at that hospital?
A. I think we need a blue light A&E and that is what we need more than anything.

Q. I just want to turn briefly to out of hospital services. In terms of Hammersmith & Fulham's out of hospital services, do you have a view about whether they are advanced enough in terms of where they have got to have reduced acute beds or not?
A. No, I do not think so. Not at all.

Q. Do you have a view, are you able to help us with whether or not you think that even if those out of hospital services are put in place that will have the stated effect of reducing

the need for acute beds?
A. No, I do not think so because I do not think that the services or the standard of the services is appropriate enough to be able to meet the needs of people out of hospital yet, to keep them out of hospital.

MS RENSTEN: I have actually reached the end of the questions that I needed to put to you. I am just being asked if after the Commission have finished we could have short five minute recess before we close matters out.

THE CHAIRMAN: That would make some sense because there are matters I think we need to discuss. Do you have any questions.

Examined by THE COMMISSION

Q. DR HIRST: It is funny that you mentioned Dr Hugh Jolly because I worked for him. He is a paedriatrican and God bless him; he occasionally gave me a hard time.
A. He was wonderful.

Q. I still quote him actually. Also I delivered babies in West London Hospital which is actually part of Charing Cross.
A. My second daughter was born at the West London.

Q. I hope I did not deliver her! You have touched on two sensitive issues for me in your evidence. It is page 1552 and also 1553. Going backwards you mentioned Dr Spicer when asked why GPs had not been balloted as they had been in Kingston he replied that it was not necessary as the PCTs knew what the doctors involved thought?
A. Yes.

Q. Gosh, that is very impressive! Here I want to go gently because I had colleagues at the Lillie Road Surgery many years ago and remember it as a really quite excellent practice.
A. It was.

Q. An excellent practice, so I would not want to in any way criticise ---
A. No, and I do not want to criticise them.

Q. Why was it they were reluctant to allow you to leave leaflets about the process? You might say that Save Our Hospital is a particular view, but you say you also wanted to leave consultation leaflets as well?
A. Yes.

Q. Why do you think they declined to let you leave consultation leaflets because they, should have had some in the surgery anyway I would have thought.
A. Yes, they should have and why they did not, I do not know, and I could not actually get any answers about that. This was very early on in the early days of having set up Save Our Hospitals and it was after the first public meeting that we had in Hammersmith Town Hall. I went in to ask specifically if we could put up some Save Our Hospitals posters and have some information there so to that patients could see what was happening and had access, because one of the things that we had found, for example, when we were

doing our campaigning outside the hospital was that there were many people who were signing petitions for example who did not have access to computers and they had no way of finding anything out at all, so they were reliant on having hard copy. There was nothing in the hospitals and you could not get hard copy in the borough anywhere. I was quite surprised, at the time I did not know that they were, I have forgotten what you call ---

Q. Nurse practitioner or practice manager.
A. Yes, she was the one who said, "No, we can't do anything, we can't take sides so we can't actually put any information out because that would be taking sides with the hospital campaign." I found that completely baffling to the point where I did not really know what to say to her. Also at that time the consultation documents were not available. The only places you could see the documents were at public meetings.

Q. So they were not available? Now I remember, I do not think they were available in GP surgeries.
A. No.

Q. I asked the question because I have been puzzled why there was such a limited response from GPs in respect of submissions?
A. I went round to a lot of the GP surgeries and I talked to people. For the most part they were very - and I am very open and quite easy to talk to, were reluctant to talk - very reluctant to talk.

Q. Have any of your colleagues, for example, been approached in a confidential way by GPs and doctors?
A. No. My feeling - and it is just a sense here - is that the GPs themselves felt quite intimidated. That was my feeling about it, that they did not want to put their heads above the parapet and very, very few did, and certainly within the hospital, and I know people working within the hospital and having spoken people within the hospital nobody would speak out because they were too worried about speaking out or saying anything.

DR HIRST: Yes, that is a point I was interested to draw out. Thank you very much.

THE CHAIRMAN: I have no questions. The one I was going to ask has been stolen from me. Thank you very, very much for attending. It has been useful as with everyone else that we hear you speak to us in person, as it were. What I think I would like to do is I think I need to discuss with the Commissioners what will happen next and so I am going to have a five-minute break and then we will come back and we really want to update people as to the likely timetable of publication, bearing in mind some uncertainties. If you would not mind, we will come back at 20 past. We should still be in time to leave before 5.30.

THE WITNESS: Can I possibly mention just one more thing?

Q. THE CHAIRMAN: Of course you can.
A. That is that one of my major concerns in this was the open electioneering that was allowed - and it was open electioneering in all of the favoured hospitals - and this was most evident in Chelsea & Westminster. In Chelsea & Westminster, when I went in, it

was not just the Trust newspapers that were there, there were actually instructions as to how to vote for Chelsea & Westminster. No only were there instructions of how to vote, and I went through the whole hospital into every single department, on every counter in every reception department there were these purply blue cards where people could tick a box and they could submit this. At a meeting, Colin has got a thing there on it, when I challenged Dr Tim Spicer about this at one of the public meetings I said, "Are these going to be discounted?" he assured me that they were going to be discounted, but as there was a blackout everywhere else this for me was nothing short of third world. He did say, "They are a foundation trust so they are allowed to do this kind of thing." That was the other thing he said. Thank you very much.

A SPEAKER: Can I add something to that very briefly? Every one of those cards was counted of one vote. A petition we collected with 2,500 signatures in Harlesden and that was one vote. Hundreds of thousands were collected in Ealing and in Hammersmith but one petition counted the same as each Chelsea & Westminster card. That is consultation for you!

THE CHAIRMAN: Many would agree. Thank you very much.

After a short break

THE CHAIRMAN: Two matters before we adjourn. Firstly in relation to the evidence we heard from Ms Bradshaw, Ursula Gallagher has asked us to say that had she been asked about this when she was giving evidence she would have said that North West London Trust continues to provide doctors to deliver resuscitation in the UCC at Central Middlesex and there is a critical care unit on the site which is able to deal with patients who become critically ill on site. It is not for us to decide between two pieces of evidence, but it is only fair to everyone that we put both sides of the case, as it were. Anyway, that is the first matter and I put that on record.

The second matter relates to telling you what happens next. The eagle-eyed amongst you, and I fear from what I have heard there are many in the room, will have noticed that there is an indication that the report will be out I think within around a month or so. We are not able to say that that commitment will be honoured because of Mr Mansfield's difficulties at the minute. We hope that the most likely time of publication of the report will be around the time of Parliamentary recess, which is some time in July. So that gives you a broad ball-park, but you will appreciate that we are in a little difficulty being precise given the uncertainty of Mr Mansfield's situation.

So with that, can I call things to a close and just thank absolutely everyone for attending. It has been illuminating for me certainly having been parachuted in at the last minute. It has been educational for my two colleagues on either side who have told me that they have learned a lot they did not know and they will go away with Mr Mansfield to consider what has been said and write a report. Thank you all very much. It is now half past five. We are bang on time. Have a good evening.

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