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

HOUNSLOW CIVIC CENTRE, LAMPTON ROAD, HOUNSLOW TW3 4DN

on

SATURDAY 28 MARCH 2015

Before:

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

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

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I N D E X

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THE CHAIRMAN: Good morning and may I welcome you all today to the hearing. It is in fact the third one in a series and there is another one to come in May after the Election, as it happens, in Brent. The object of the hearings, as you may be aware, is an independent examination of healthcare policy within the North West London area. When I was asked to be Chairman, I considered that really we should examine it from certain terms of reference. Most importantly, we are looking at identifying the constituency (I do not mean political but medical constituency) that we dealing with in each area, because obviously they may be different, and identifying the needs of those constituencies and how their needs are best met and are they being met at the moment. Those are rather obvious questions. I am being assisted, as you can see, to my left by Stephen Hirst and to my right by Dr John Lister, both well-known figures in this area. We are also assisted greatly by counsel to the inquiry, Katy Rensten. Essentially, this is a mechanism that is used commonly in judicial inquiries, and classifying this as quasi judicial. She is going to in a moment open the whole proceedings so that people who have not been keeping up have a rough idea of where we are going and why we are doing it. She is instructed by Marcia Willis Stewart who sits to her left and who is part of the firm of Birnberg's. Peter Smith, who sits to my left, has provided us with excellent administrative backup because there is a lot of paperwork involved in this. We are not just having oral witnesses. Plainly a lot of people who have not been able to come have submitted written evidence.

As far as procedure is concerned, Katy will call the witnesses and take them through their main points. We have a time structure so that it does not run over. We may have supplemental questions. We will then move to the next witness. There will be a break this morning and a break this afternoon and we are aiming to finish at around 4 o'clock this afternoon. That is the structure of the day. May I ask Katy Rensten to open the matters today.

MS RENSTEN: Today's hearing is the third of four, the first two having taken place in the past two Saturdays at the town halls of Hammersmith & Fulham and Ealing. 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 will be 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 hospital 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 possible options for change. These were then whittled down to three potential options which became the subject of public consultation in July 2012. The broad thrust of the proposals presented for consultation were that whilst five out of the nine hospitals in the region

A were to continue to provide the full range of services, including accident and emergency facilities, the remaining four were to adopt reduced or more specialist roles. The changes to acute hospital services were to be offset by the development of enhanced out of hospital provisions and other associated services.

The three options presented for consultation were all variations of this plan with the stated benefits envisaged being those of increased quality of care, improved access to care and
B cost benefits.

In February 2013, the decision-making business plan setting out the projected costs and the cost benefits of the proposals was published and the Joint Committee of Primary Care Trusts, which was the then decision-making body, approved the programme. Over the course of the consultation, and following the adoption of the proposals subsequently chosen, there ensued a considerable degree of controversy. This generated a number of
C reviews and reports in which divergent views were expressed both about the decision-making processes and the substance of the programme itself. Following a formal referral by the Adult Services arm of the London Borough of Ealing in March 2013, a review was undertaken by the Independent Reconfiguration Panel at the behest of the Secretary of State. Although identifying some areas of uncertainty and making some recommendations, the Independent Reconfiguration Panel broadly endorsed the proposals
D 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 department in Hammersmith and Central Middlesex Hospitals, the opening of the new accident and emergency facilities at Northwick Park Hospital and the merger of the North West
E London and Ealing Hospital Trusts had taken place.

Further significant changes are taking place on a continuing basis with, perhaps one of the most current issues being that of the proposed closure of the maternity facilities at Ealing Hospital, a decision the date of which remains currently unknown.

The purpose of this Commission is to engage in a transparent, open-minded exchange
F with all interested parties, to examine the decisions made thus far and to look afresh at whether those decisions and the plans arising from them are indeed those that are best able to provide the optimum available healthcare and linked social care services for the residents of this region or, if upon fresh examination, there are other alternatives that might be as good or better and which merit exploration.

Given the implementation of *Shaping a healthier future* is well underway and many of the
G planned changes are already in mid-stream, the emphasis of these hearings will be on those aspects identified by the commissioning boroughs as being the most immediate and the most critically important to the residents of the region. It will surprise no-one that the chief amongst these are the changes to A&E and acute services, the closure of the maternity unit at Ealing, the perceived lack of progress in the provision of out of hospital services and the financing of the programme.

H The Commissioners are keen that the voices of as many the individuals or organisations

A that wish to be heard in this process and, accordingly, with that in mind and with the permission of the Commissioner, may I call the first witness, please.

CLLR MELVYN COLLINS, Chair, Joint Health Overview and Scrutiny Committee (JHOSC), Hounslow Council

Examined by MS RENSTEN

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Q. MS RENSTEN: Could I ask you, please, to give the Commissioners your name and your professional address, please?
A. (Cllr Collins): My full name is Cllr Melvin Barry Collins. My professional address is Civic Centre, Lampton Road, Hounslow, Middlesex TW3 4DN.

C Q. What post do you hold, please?
A. I am the Chair of the Joint Overview and Scrutiny Panel for North West London *Shaping a healthier future* known as JHOSC.

Q. You have a document in Braille in front of you and that should be your submission which is at Volume 5, page 107 to 1740. Can I ask you to confirm to the Commission that the statement is true to the best of your knowledge and understanding and that you wish it to stand as your evidence to the Commission?
D A. It is.

Q. I wanted to ask you first about the role of JHOSC. You say that it was set up to scrutinise SaHF, to make recommendations and to require information from those statutorily obliged to provide it. Are those, broadly speaking, still its objectives?
A. That's correct.

E

Q. So when you say in your submission that the approach that it takes has changed over time, is that more about the way in which you have approached your remit rather than a change in the remit itself?
A. It is actually both. We have changed our approach because that has been driven by the information, or may I respectfully say the lack of information that we have received on demand. I believe the role of the scrutiny panel is to actually ask the statutory bodies
F to present their evidence to us so that we can examine it because we are there to represent the patients' views and interests.

Q. You say that JHOSC has taken a more proactive stance. Can you help us with why you say this was necessary?
A. I think in the beginnings when JHOSC was set up, and that was set up by NHS North West London, we took a pragmatic view because we needed to feel our way to find out
G what our remit was and from whom we could actually search for the evidence. However, as time elapsed, it became very obvious that we were being fed what they thought we ought to be fed and so therefore as the membership of the JHOSC changed, and the leadership of the JHOSC changed, we then decided to change our emphasis on to a much more rigorous scrutiny role in order to unearth the evidence that we need to actually ascertain the necessary need for change and how that would affect the very people whom we were there to represent.

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Q. As I understand it, the Committee's starting point was that it accepted that there was a case for change and that the SaHF proposals were appropriate. Is that still the case?
A. We did not actually accept --- sorry, Madam, yes, we accepted that there was a case for change. However, within that parameter we felt that there were an awful lot of angles within that case for change which had not been met, which is why the JHOSC was set up and which is why throughout the course of time to today we actually have become much more challenging because of the lack of information, which I hope we will be able to address within the next 20 minutes. A direct answer to your question is yes, I think everybody felt initially that there was a case for change. However, there was a particular viewpoint expressed by the JHOSC that that case for change actually had not been fully explained nor the impact that it would have on the diverse communities of the areas which the JHOSC serves.

Q. Just turning to that, you say in your submission that the case for change would have been better understood if it were part of a clear and agreed strategy of integrated health and social care for North West London. I wondered this: is that not what SaHF was supposed to do?
A. Yes, Madam, exactly. We always believed, and particularly when the JHOSC was set up we always believed that out of hospital services had to be the forerunner and the parameter of any case for change because unless you had a very strong and vibrant out of hospital service, backed up with a properly integrated transport system, both in terms of public transport and of hospital transport, the rest of the challenge could not be met. However, as time has elapsed, and you alluded to it in your opening address Madam, the eight Clinical Commissioning Groups have not provided us with their cases going forward and so therefore it has become much more difficult for us to understand how, in the first instance, it was necessary to close the two A&Es when it was done and certainly the case most definitely has not been made for the services for the acute sector going forward. The out of hospital services is the key, is the whole parameter of making *Shaping a healthier future* work, but that has to be in parallel with a very strong, robust infrastructure of transport, both hospital transport and public transport. I do not wish to repeat myself.

Q. Thank you. One of the things I would like to do is to take you to the list of key concerns on page 1707. It is a list of key concerns that you as a Committee raised in 2012 and you say they have remained the focus of your work since then. I just wanted to ask you a little more about them. One of the recommendations you made was for further development and direct involvement of non-NHS partners around the out of hospital services. By that, were you referring to local authorities or local authorities and other organisations and, if so, which?
A. Yes, local authorities, obviously, with the changing role of public health and their other statutory obligations within the health and social care sector, play a very, very crucial rule role. However, the local authority cannot do that on its own. Here in Hounslow for instance, and I know across the other boroughs whom I am representing here today, the third sector, as it is called, or the people that give services outside of the statutory sector have to play a very, very crucial role, and that includes community pharmacists and also people who provide backup services for mental health, backup services for people with learning disabilities and backup services for people who have very severe physical disabilities or sensory disabilities, so it is a parameter of engagement with all sectors to make the out of hospital services work so that there is connectivity

between all of the agencies to understand the pathway of an individual.

Q. So might I ask you this: is that not something you would have expected to have been an integral part of the process from the word go?
A. My short answer to that is "yes". My longer answer is actually it should have been the pillar.

Q. Given that that is the case, does that raise concerns for you about the process of the reconfiguration if it is being done in isolation from, as you would describe them, the third sector arms?
A. Madam, the very curt answer to that is "yes", because if you are not talking to your supporting bodies or you are not willing to engage with your supporting bodies, then the out of hospital services just cannot work. I am sorry to repeat myself but, again, I go back to the non-emergency ambulance service, the hospital transport services, transport to get people from A to B to get services in order to keep people away from the acute services. So we as a JHOSC, although it is fair to say that in our first year was a learning curve for everybody, the out of hospital services, the connectivity with local authorities and the third sector has always been our main plank. I have been involved virtually since the first meeting of that and I have always said that the rest cannot work unless the out of hospital services are actually in place and seen to be up and running, with an understanding by the people to whom those services are going to be administered.

Q. Can I just ask you a little bit more in detail about some of the out of hospital services. One of them is the seven-day GP services. Do you know what stage the roll-out of seven day a week GP services has yet reached?
A. It varies from borough to borough. Some boroughs are stronger placed than others. In some areas it is working and in other areas it is not. The short answer is that it is patchy and to go to the school report, as we are at the end of a term, "could do better".

Q. The Committee asked for a progress report in relation to workforce recruitment because that was an area you identified as problematic. Can I ask have you been provided with that report?
A. No.

Q. Does that give you cause for concern?
A. Very much so because it is the very pillar which is going to make the service work, from either keeping people out of hospital or picking people up from the hospital service. In very recent days we have now understood that there is to be a social work service which is going to be based at our acute services and at all of the major hospitals that are in situ at the moment. This is a big step forward. However, because we have not got the Clinical Commissioning Groups' strategies going forward, which on Wednesday we will be approaching the third year of the strategy, and here, Madam, may I point out that it was because of the JHOSC's intervention that we actually got the strategy moved from a three-year strategy to a five-year strategy. So I think that was a major achievement of the JHOSC by putting pressure on North West London NHS to actually recognise that they could not deliver in three years, and *I hae ma doots* they are going to deliver in five, but at least it has given us the opportunity to be able to look at the services and examine them in a very full and frank manner.

Q. I just want to ask you about the 111 service as well. Again, have you yet been provided with any measurable data as to how successful or otherwise that service is proving?

A. Data in this field has always been hard to achieve. We have had some data but the data is not clarity. Of course, one of the issues which the JHOSC has raised on more than one occasion, but more particularly recently - and here, Madam, I would have to declare an interest because I have had to use it within the last four months - is that the staff at the coalface are just not NHS-trained. They are there simply as operatives and it can become exceedingly frustrating. We have as a corporate body of JHOSC fed that information back because to us if the out of hospital services are going to work, again, that is another integral pillar of the system which has to be manned with people who have at least some basic knowledge of the NHS and indeed the ambulance service.

Q. Another issue that was raised in your document was that there were supposed to be joined-up IT plans. Are you able to help with where those have got to?

A. Again, I can give an honest and frank answer. In some areas they are now doing very well. However, it has become impossible to get the knowledge as to when System 1 will actually be on-stream for all of GP practices and the hospital services themselves, because unless you have got joined-up thinking and joined-up access to patient knowledge and patient data, then you are faffing about and you are not actually giving a good service to the patient in 2015. So the quick answer to that is they are struggling.

Q. Moving on to the closure of the two A&Es at Central Middlesex and Hammersmith Hospital, your Committee asked for details about the impact of closure; were you afforded any?

A. We were afforded some information which we strongly believed was the information they wanted us to hear. The worrying thing is that there is a leaked Care Quality Commission (CQC) report which actually belies the argument that it was safe to have closed those two A&Es on 10 September 2014 because everything was in place. Particularly the closure of Central Middlesex, we as the JHOSC had pleaded with them to at least hold back until it was clinically proven that all - and I emphasise the word "all" - services for Northwick Park were fully in place, particularly the backup service to the A&E. That is like recovery wards, reception wards and a good service for patients to be transferred into the hospital should they have needed additional care once they have gone through the A&E system. The report, as I understand it, is still in draft form and so therefore has not been published for anybody to examine, particularly the JHOSC. Should the A&E services have been closed? I think long-term there certainly was a case that Hammersmith may have been an ideal A&E service to close, but, again, that was too soon because the infrastructure behind that closure was not in place. The case for Central Middlesex was much more tenuous and most definitely was far too soon and now that is having an impact on Ealing A&E and particularly West Middlesex A&E, whose capacity went up within the first week of the closures.

Q. I just wanted to ask you about something else that the Committee asked for. The Committee asked for clear triggers and milestones so that there could be a proper approach to the implementation of acute reductions. Was that approach adopted?

A. No, it certainly was not adopted because the case for change, as I mentioned some time ago, whilst in theory was a good tool and a good milestone, what certainly has not been taken into account is the growth in population across the eight boroughs, particularly

in Ealing and Hounslow, and probably within the next five to ten years with the Old Oak Common development. These have not been factored in to any of the forward thinking. I talked about not having the CCGs' business cases going forward. We have not got the nine financial business cases going forward either, which should have gone to the Secretary of State on 23 March. They are delayed. We have not even seen them to examine them before they go to the Secretary of State, whoever that may be after 8 May. So milestones and reconfiguration within the nine hospitals that we are talking about is not proven because everything is just so fragmented because we do not have a robust case for the out of hospital service.

Q. Whilst we are on the subject of the business case, are you satisfied with the explanations you have been given for why it has not yet been provided?

A. Certainly not. Unfortunately, there has been a change of personnel quite recently, but I do not accept that that was a case for delay, and then, of course, we are falling within the Election period and on Tuesday we go into purdah anyway, so I would reluctantly accept that that may be a factor. However, as I said before, on Wednesday, we go into the third year of this reconfiguration, and so all of the financial business cases and the CCG cases ought to have been up and ready for examination and certainly the out of hospital services should be in place so that we can then examine what role the acute services are going to play, what specialist services are going to be placed in the general hospitals and why it is necessary to close Charing Cross and Ealing A&Es, because most certainly that case has not been made because we do not have the financial infrastructure to be able to base any logic on.

Q. I just wanted to ask you very briefly a little bit about the urgent care centres. One of the issues which seems to have been developing as a theme is the education of the public as to what they are used for. Are you aware of how SaHF has developed these things and are you satisfied with that aspect of their work?

A. Certainly in the beginnings of the implementation of urgent care centres, which incidentally both myself and JHOSC fully support, it was very fragmented. There were all kind of stories coming out about exactly who was going to, I do not want to use the word "man", but actually the personnel that would actually operate within these services and, much more importantly, the time of day that these urgent care centres would actually operate from. I think we have got an awful long way to go to be able to direct people away from A&E departments for stuff that could either be dealt with at UCCs or indeed community pharmacists. I notice that the Government were talking about the community pharmacists in a very bright light quite recently and I had say "Amen! Hallelujah!" to that because this is something I have been banging on about since 2010. They have a crucial role to play, but there has to be a greater form of education, and here I think that the local authorities and the third sector can help the CCGs to be able to promote the work of the UCCs going forward because they have a really, really important role to play. Having said that, I still think that the case for closure of four A&Es of the nine has not been spelled out to us because we just do not have the financial infrastructure, so, yes, there is still an awful lot of education to do.

Q. Just on the subject of the A&Es, your Committee was told in October 2014 that the performance of the North West London A&Es was improving that and there were no issues from the closure of Central Middlesex and Hammersmith. First, as the closures were only in September, is it your view that it was perhaps too early to know or is that

wrong?

A. You have got that absolutely right, Madam. It is far too early for us to have a clear view of the impact, except that both in Ealing and in West Middlesex the impact of those closures, or some other factor which actually was not spelt out to us, had shown that the attendances at A&E, or more importantly the percentage of people that were not being seen within four hours, which is what we ought to be focusing on, had dramatically changed. When you bear in mind that this has not been, in the run-of-the-mill of things, a particularly severe winter, then we need to be asking ourselves is it because of the closure of those two A&Es, were those two A&Es closed too soon? Without the full CQC report, then it is quite difficult to ascertain whether it was other factors or whether it was genuinely the closure of those two A&Es, but it seems significant that within the first week of those closures there was a shift in emphasis on the remaining A&E departments.

Q. We touched on transport very briefly and I just wondered if you could help with what, if any, actual dialogue there has been that you are aware of between Transport for London and the CCGs and the relevant trusts?

A. This is an area which is of particular interest to myself. There is a Transport Action Group (known as TAG) and they have been in constant dialogue with the CCGs and North West London NHS and more importantly TfL. Unfortunately, TfL at times is not a moveable object. When they plan routes they are the masters and the kings and it is very difficult to get them to change their minds. It is our opinion that if Transport for London were much more receptive to changes in their own infrastructure, then that may well help in terms of the transport infrastructure managing the case for change going forward. It is a very, very important aspect, but we cannot take the public transport aspect on its own. As I said, it has to be linked in to hospital transport, the blue lights, going forward so you have an integrated system. It is worth reminding people that in the year 2013-14 across London as a whole £690 million was lost because of appointments not being kept and a great percentage of that figure was they were not kept because of being let down by the transport infrastructure, either hospital transport or an inability for TfL to change its ways.

Q. Finally, I wanted to read you something from your Committee's report from October 2012 and ask you to comment on it, if you would, and what you say is this: "The absence of core information makes proper evaluation of the proposals difficult. It also makes support for the proposal dependent on confidence that detailed planning will be done AFTER the main decision to proceed is given. We have serious concerns about this being the right way to proceed and what is being proposed might involve an irreversible loss of physical capacity at various important hospital sites. We think it is inappropriate to make support for such serious changes essentially an act of faith and trust in future planning processes." Albeit that the decision to proceed has already been taken, is that still essentially the Committee's view?

A. Madam, yes, it is, and that is enforced by the minutes of our meeting held in October and ratified again in our discussions on 3 March. The JHOSC is particularly concerned about the loss of estate to the private sector. We have two concerns and they are both major. First of all, if the estate is lost to the private sector, it will never, ever come back and we believe that the case for selling off some of the estate on the various sites across the piece has not been properly thought out and whether it is possible to work in conjunction with our social care teams to make greater use of a linking up between health and social care on the same site. In some cases, that may not be possible, but the worry is

that once you have lost that estate it is lost and gone forever and then you are looking around trying to find alternative accommodation which is appropriately situated for people to actually get to and use appropriately. So yes, that still remains our concern. It did then and it has become even stronger now. Coupled with that is the finances that are raised from the sale of those estates and where that finance would actually go. Is it going to the social care sector, is it going to the health sector or is it going like the white smoke of the Pope's chimney? That has never been spelt out to us and that is why the JHOSC has actually changed its stance on being much more robust in understanding what is going to happen with the sale of establishments because we think there has been a massive opportunity lost for reconfiguring some of that estate in terms of working with local authorities, the third sector and indeed the health sector itself in providing services so that they are linked and joined up.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you for your presentation. I have got two questions and I will take them in order. The first one derives from a passage in your report and it goes back to the beginning. In other words, there was an initial acceptance that change was necessary and the way it is expressed is "addressing long-standing quality and patient safety issues". I know we have not got a lot of time, but I wonder if you could just identify briefly what those were? What were the long-standing problems that needed to be addressed that had not been? And then I have got one more short question.

A. The JHOSC picked this up from an early stage and those of us who have been attached to health, either from community health councils or from any other body come to that, have always been worried about the quality of care and patient safety, and we thought that the reconfiguration of services that was encapsulated in the original document, although we had reservations, as I have already explained, in how that was going to be achieved, one of the key components of *Shaping a healthier future* had to be that services had to be in establishments that were fit for purpose, that were modern-day, that were integrated with social care when necessary but that those standards need to be met right across the piece, right across the whole of the eight boroughs, because there was a great differentiation between what was being provided in one place and what was being provided somewhere else.

Q. Can you just give an example of somewhere where you say, just forget *Shaping a healthier future* plan for one moment, since you have an overview of all eight boroughs, a facility was not fit for purpose?

A. Yes. For a start, some of the facilities at Central Middlesex. We always thought that maybe that was one of the A&Es that could close, but then that should become a very specialist hospital supporting local need outside of the acute service. Some of the services at Central Middlesex were not fit for purpose and I think everybody had recognised that. In terms of Hammersmith Hospital, for instance, the A&E department was being serviced by junior staff and so possibly there was a need for change there. Certain services at West Middlesex were not actually fit for purpose but because we now have the potential acquisition by ChelWest of West Middlesex, hopefully that has been recognised and those services will be provided. So it fluctuates between borough and

borough and hospital and hospital.

Q. I understand that and sorry to be particular, but why is reconfiguration necessary to solve the particular ones you have identified? In each case, they could have been rectified long ago without reconfiguration but by investment, either personnel or financial?
A. I would fully accept that and I think that goes back to the argument as to whether the NHS and social care support, whether there was joined-up thinking, and there was not. So, yes, if you like, there were too many managers and not enough staff on the ground actually providing the service and that is where the breakdown occurred. I have a long personally held view that clinical care and some of the ancillary services attached to hospitals should be part of the establishment, they should not have been farmed out, and I think that there would have been much greater emphasis on the use of the finances that were available to provide the services, but with the tiers of management, I think the emphasis went away from the patient towards targets and the management structure and the eye was taken off of the ball for a period of about ten to 15 years, and I think that is what we are reaping today and are having to put that right.

Q. Thank you. One short question, the March meeting where you requested the implementation business case, you were told that it was in draft form. I just want to be specific: who told you?
A. The presenting officer of the day.

Q. Who was that?
A. Mark Spencer and Sarah, who had taken over from Daniel Elkeles.

Q. Were they asked, even though they were not providing it, how on earth they could proceed when the business plan was only in draft form? Were they asked that question?
A. Yes, we did.

Q. What was the answer to that?
A. "We will come back to you at your next meeting or we will get it to you in the interim."

Q. That is, if you like, how long a time-frame. The question is if you asked them how they could proceed with implementation without the business case being in full form and publicised, what was the answer? Have they given an answer to how they can justify that going forward?
A. I do apologise Sir.

Q. It is all right.
A. The answer that they gave was that there were different factors, which we tried to tease out with them but got no answer, but their answer was that the Election is now getting in the way and so therefore business cases will be presented for examination after that time, which of course we did not accept. We said the Election should not get in the way. Your business cases should be ready for examination despite the Election not because of it.

Q. Sorry, to press this. The real question is: did they justify how they could be implementing anything on the ground?

A. No, they did not.

Q. Thank you. There may be some more questions.
A. But yes we did, in answer to your question.

Q. You did and you had no answer?
A. We did and we did not get an answer, any more than we did with the eight Clinical Commissioning Groups' business cases as well. We pressed them and said, "How can we go forward when we have not got the business cases to work with?" Which is why I did say some time ago that one of the proud things of the JHOSC was that we got an extension to five years, and I have my doubts that even at the end of five years the implementation of *Shaping a healthier future,* or any of its constituent parts, will work.

THE CHAIRMAN: I understand.

Q. DR LISTER: I have just got a couple of questions for you about your Committee itself. I am rather curious because it is composed of eight boroughs and it does not include Hillingdon but does include Richmond, which is not in North West London. I just wondered, since you say this was put together at the request of the SaHF and NHS North West London, why they chose to compose it that way?
A. You are asking me to tease my brain here. I think my honest answer, and if I am wrong I apologise to you, was that Hillingdon were approached and did not wish to take part. Richmond were not approached in the first instance and asked if they could take part because of their involvement with the West Middlesex Hospital and we agreed that that would be the case.

Q. I suppose I am more concerned about the omission of Hillingdon rather than the inclusion of Richmond, although Richmond, as you will probably be aware, is also involved in the South West London equivalent process.
A. As I said, Richmond impacts on West Middlesex and so when they approached us we said yes. I am really teasing my brain because I think we did approach Hillingdon and Hillingdon chose not to send representatives despite being asked on two or three occasions and when Richmond came in, because of their significant impact on West Middlesex Hospital, that is why we embraced Richmond. We were sad not to embrace Hillingdon because it would have been an obvious choice, and, as I have said, if I have got it wrong I apologise, but my memory seems to think they were approached and they decided not to participate.

Q. Have you heard reports because certainly it looks from the board papers as if Hillingdon has been noticing the same kind of impact in terms of the closure and the aftermath of the closure of the two A&E units that you have reported in West Middlesex?
A. No, those reports have not reached the JHOSC yet but obviously we have. Certainly at the CCG board on the closure of the maternity services at Ealing Hospital questions were asked, including one by myself, on what impact that would have on patients in West Ealing in particular going to Hillingdon and also coming across to West Middlesex to their reconfigured maternity service at the St Mary's unit. So I actually have not had, or we as a JHOSC have not had, Sir, a direct report from Hillingdon, but I am sure that it is something that would come to us between now and the next meeting. So the answer is no, but, yes, we are aware of the impact that any closure of maternity services at Ealing

may have upon Hillingdon and indeed at West Middlesex.

Q. Thank you. I note also that in this Joint Scrutiny Committee there are three boroughs, if you include Richmond, but two in particular, Kensington & Chelsea and Westminster, where they are not directly impacted by the closures which clearly do have much more impact on other parts of the North West London area. You talked about the movement and the change where you have responded to the situation by changing the attitude of the Committee as a whole. Is there any difference in attitude to some of these questions that you have been raising between the different component boroughs in terms of their feeling about how important it is to challenge some of these questions?
A. Yes, indeed. I have been privileged enough to have been a representative on JHOSC more or less since its inception and so, yes, the emphasis has changed and it is particularly important now that Kensington & Chelsea are part of the JHOSC because of the acquisition of West Middlesex by Chelsea & Westminster Hospital, and so this would have quite an impact on people in the east of our borough in Chiswick, and indeed the reason why Westminster are on the board is obviously because the change in emphasis of service at St Mary's Paddington would impact on the constituents in that particular borough. So therefore it was important to take those two boroughs on board, and I welcome those two boroughs on board because they have had quite a significant impact on the work that we have done and it has given us an insight into two completely diverse boroughs like Brent and Ealing and Harrow and Hounslow. At the end of the day we are talking about services to people and that is what we must not run away from. Going forward, it is probably too late for us to take Hillingdon on board because we are going into our next year, but the offer was there and it was not taken up. I go back to Richmond because I believe it is important because the impact on Richmond of any change of services at West Middlesex would impact particularly on the residents in the north of their borough. We would embrace that and take that on board. I hope that is the answer.

DR LISTER: Thank you, yes.

Q. DR HIRST: The first thing I would like to ask you about, I probably know the answer but I would like to hear it, if I may, are you familiar with the Integrated Care Pilots?
A. I am just becoming familiar with it, yes, because obviously being Vice Chair of my own Health and Adults Care Scrutiny Panel, it is something that we are beginning to look at.

Q. The pilots were quite ambitious, were they not?
A. Yes.

Q. They are likely to form a core of what might be done with out of hospital services. It is just that into my in box came a request as a former GP to review the Integrated Care Pilots and I notice on the outcomes "Analysis suggests that up to 50% of ICP benefits are dependent on the availability of effective out of hospital services." They say they wanted to reduce a £3,620 million annual cost of services for diabetic and older service users by 24%. "Initial evaluations of the programme's success showed negligible improvements in outcomes and service user costs. However, internationally the evidence suggests a minimum of three to five years before there is an impact on activity." Obviously that reinforces what you were saying that you need at least five years to make a difference?
A. Yes.

Q. It also said that the IT system for care planning was slower and more complicated that first anticipated. Do you have any specific feedback in respect of IT?
A. Sir, we did touch on IT very briefly at our 3 March JHOSC meeting and, as I did allude to in previous questions, I did allude to its inadequacies and how scary and worrying it was that if we were going to go into integrated care and we were really serious about care pathways from hospital-based social workers in the acute sector coming out into social care into the local authority and third sector then IT systems had to be upgraded and they had to take account and cognizance of a pathway going right through, and that included whichever hospital that person chose to have their initial treatment. I understand, for instance, and again declaring an interest, I know to my personal cost that Charing Cross's system is not compatible with Hounslow's system. I have challenged Mark Spencer in particular to come back with a much fuller answer in our subsequent meetings this year because that has to be an important part so, yes, we are very concerned about the IT system and it is something that they need to get to grips with.

Q. Have the CCGs reported back to you what might be seen as an initial disappointing effect on hospital admissions of the integrated care?
A. I am sorry to interrupt you but would you be kind enough to use the microphone. I did not hear the first part of your question.

Q. Have the CCGs come back to the JHOSC in respect of what might seem a disappointing initial effect of the pilot programmes?
A. That is a piece of work which we are going pick up in our work programme in the year coming forward. I have to say that our March meeting concentrated very much on transport and the blue light system. In the short presentation that we had at the end of the meeting it did not encapsulate those pilots, so, again, that is something that we will be pressing in our work programme for this ensuing municipal year.

Q. I see a phrase here "whole systems integrated care". Is there an understanding of what that means?
A. With respect, Sir, I hope that I had answered that by saying that in order for this to work there has to be a care pathway from either the hospital going forward or from the GPs going forward so that a person's pathway is planned either at GP level, which to me seems to be a perfectly sensible way forward and the way forward for the future, and it needs a complete change of attitude not only of the GPs themselves but of the practice overall as to what facilities they will encapsulate within their building structure in order for this whole systems integrated care to actually work and operate because that is the way going forward. I think at the end of the day, if I might use the term, it will save money because you will be able to pick it up from the GP surgery or from the side of the patient's bed, depending on which care pathway you are looking at, and so therefore people will be brought into that loop much more quickly and hopefully you would have more understanding of efficiency of budgets that you have got at your disposal. Again, it is all to do with how you integrate that care for the best of the patient. Here may I also throw in a word for the carers because they are the hidden beings of our society and today's carer is tomorrow's user.

Q. One very quick final thing, you mentioned your Chiswick residents; have you had any feedback from them about the possible downgrading of Charing Cross and also the fact

that so many services have moved from Charing Cross to St Mary's, knowing, as I do, how closely allied Chiswick residents were to Charing Cross Hospital?
A. Sir, there have been strong representations from Chiswick residents about the possible movement of services in the future and indeed those that have already moved. People have done test studies from the underground and the overground at Paddington Station to St Mary's and for a person who is either frail or elderly and who may not have access to hospital transport, some of these services are very difficult to access. I have to say that the time to get from either of those two, and indeed the difficulty to get across from Chiswick to St Mary's is not easy, which is why we have placed a great emphasis on transport infrastructure. I believe it is a mistake to downgrade Charing Cross. There is a world-renowned stroke unit in there and there are renal services and, in my personal opinion, it is a hospital that needs revamping not demolishing and the services therein should be preserved because you actually have the specialists there on-site already. Why throw the baby out with the bathwater? I would also emphasise when I was talking about estates earlier that the new footprint for St Mary's is actually smaller than what was envisaged when *Shaping a healthier future* and the option A proposal was actually given to us, so if you actually look at the footprint of what they are now proposing, it is small wonder why the business case is not made and why there is a delay. It is because they have changed their emphasis and so therefore it may become very difficult for them to make a case for the closure of some of the services at Charing Cross - I want to be very careful I do not get drawn into the argument about closing the hospital because I am fully aware that it is not going to close - but it is what you do with the fabric and how you can actually upgrade the fabric that already exists because you have got the specialists there to use.

DR HIRST: Thank you.

THE CHAIRMAN: Can I thank you very much for your presentation. It has been very informative for us. Thank you very much.

The Witness Withdrew

THE CHAIRMAN: I am noticing the time. It was necessary to hear from this witness and it may be we will forego a morning break, but we will see how we go on.

CLLR STEVE CURRAN, Leader, and CLLR LILY BATH, Cabinet Member for Health and Adult Social Care, Hounslow Council.

Examined by MS RENSTEN

Q. MS RENSTEN: Can you both give the Commission your full names, professional addresses and current posts held, please?
A. (Cllr Curran): Good morning. My name is Steve Curran. I am the Councillor for Syon ward and I am the Leader of the London Borough of Hounslow and my address is the Civic Centre.
A. (Cllr Bath): Good morning. I am Lily Bath. I am a Councillor here in the London Borough of Hounslow. I am the Cabinet member for Adult Social Care and Health in Hounslow. My address is London Borough of Hounslow, Civic Centre, Hounslow.

Q. You should find in front of you a bundle labelled Volume 1. Pages 21 to 44 contain your submission. Can you confirm that it is true to the best of your knowledge and understanding and that you wish it to stand as your evidence to the Commission?
A. (Cllr Curran): Yes.

Q. I want to ask to begin with about the aspects of the *Shaping a healthier future* that the London Borough of Hounslow supports. Perhaps not surprising the local authority is in favour of West Middlesex becoming a major hospital, but what you also say is you endorse Charing Cross Hospital becoming a local hospital. Are you content with the level of clarity about exactly what services are going to remain at Charing Cross Hospital?
A. (Cllr Curran): No, I think that has been one of our major concerns. You are quite right when you say that we would have been plain daft not to support our local hospital becoming a major hospital and that is still our position of course, but we are concerned about the type, range and level of services in the other hospitals in our area. And because there has not been clarity, there has been uncertainty, certainly the local authority are concerned.

Q. So when you say that you support that change to a local hospital, do I take it that that is contingent upon more information and your being satisfied about what services are to remain?
A. (Cllr Curran): Yes. I think all through this period of change, and it has been alluded to already here today, it has taken so long to push forward with the case for change and implement that change that things have changed in the interim. We have got a huge population increase in Hounslow. I do not think that has been taken into consideration. We have got increases in waiting times over four hours at West Mid, so generally the picture has changed significantly over the preceding three years which has led to more uncertainty on our behalf. My personal view is that at the strategic level there is little or no engagement with local authorities. We obviously engage with our CCG through the Health and Wellbeing Board and through senior officers, but there has been no engagement with this authority through my office with regard to the merger of Chelsea & Westminster and West Mid and that is something we are picking up, but I think that is the litmus test for how the Health Service deals with local authorities, particularly in London. I am also concerned, and I know other leaders in North West London and across the whole of London are concerned, with the formation of what I would call the "Super CCG" where you get the cluster of CCGs come together and then they are deciding on healthcare and how it is provided for our residents without any formal engagement with the local authorities.

Q. I wanted to ask you a little bit more about Charing Cross because of course the proposals involve a change to the A&E service. I wanted to ask you how those changes sat with the view that you expressed, and this is at page 27 of your submission, that Hounslow does not support the closure of further acute provision across North West London. Can you help us with how the two things marry up, please?
A. (Cllr Bath): In the original proposals we supported the option of supporting our local hospital, West Middlesex University Hospital, to become a major hospital and Charing Cross as a local. We broadly supported those proposals because we understood the demands on the Health Service and the need to have good quality care and to be able to have a sustainable Health Service. However, the recent indications in terms of the

waiting times at A&E at West Middlesex have caused concerns for us and also, as the Leader mentioned earlier, the fact that we still do not have any clarity over what would remain at Charing Cross, so at this present time we would not support the closure of further acute hospitals because if we are seeing this rise in waiting times now, when Charing Cross is still open, that causes concern for us. Our support for the proposals originally was that we felt that this would give a better deal for our residents in Hounslow in terms of supporting West Middlesex University hospital as a major hospital.

Q. Bearing in mind the proposal for Charing Cross for there to be, and whether it is described as an A&E or an urgent care centre, we know it is going to be different from its current shape, do you have any views about whether there needs to be a full A&E co-located at that hospital?

A. (Cllr Curran): I think we would have to see the evidence for that, either for or against. But what we have got to be assured of, and this goes for all of the boroughs involved, is that the business case and the rationale for that is clear is transparent and it stacks up. At the moment, because of all the changes, because of the change in population, the change in the way health services are being delivered, the increased waiting times for GP appointments, et cetera, et cetera, we are moving, we think, towards a perfect storm where we cannot guarantee, even if Charing Cross had a full A&E or an urgent care centre, would that still meet the demand because of, I think, the premature closures of the other two A&Es, which from our information, and it will be for the Commission to decide why, there was a spike over the A&E waiting time of four hours in September of last year. So we need to look at that, but I do not think the case is made either way yet.

Q. Moving on, you also support West Middlesex being acquired by Chelsea & Westminster. Can you help with what you say this will achieve and why, please?

A. (Cllr Curran): To be frank, I am not sure we do support it because we have not been engaged in the process, as I mentioned earlier. Obviously we are informed via our CCG, but this authority has had no formal consultation with anyone in the Health Service about that merger and I think that is a fault.

Q. So is it fair to say that that is not something that you have yet decided upon as a borough?

A. (Cllr Curran): No, we have not because we have not had the conversation with the local health authority.

Q. In principle, the submission that you have put in suggests that you support a shift from acute services to out of hospital services. Can you just clarify, is that support based on an acceptance that the increase in out of hospital services will actually have the effect of reducing the need for acute services?

A. (Cllr Curran): I think the premise is right and the rationale is right, but what we have not seen, and it has been alluded to by Cllr Collins earlier, there is no evidence that the infrastructure in place will support those changes, and that is our main concern.

Q. So should they be decoupled? Should the out of hospital services be looked at on a stand-alone basis?

A. (Cllr Curran): No, I think if we are looking at health services for our residents in Hounslow and across London, it needs to be joined up and it needs the local authorities and the third sector, everyone involved in that dialogue about how services should be

provided, but at the moment I think there is a disconnect between community services and acute, and I could not support any further closures of A&Es until we understand that connection and what it looks like. We have to integrate services. We are not against change either in local government or of the Health Service. We think it is an imperative for both organisations to embrace change. We have got a very difficult financial situation both in local government and in the Health Service which is not going to get any easier. That is the thing we should remember. These proposals were kick-started at a time when the financial position was different. It has got far worse and it is dire.

A. (Cllr Bath): If I can just add, we do broadly support the out of hospital proposals. We believe that it is absolutely crucial in terms of improving healthcare for our residents, but as the Leader has said, what we really want to see and what we would expect to see is some of the results and successes of that. So in terms of the elements of what the proposals are, they are all very sound and in terms of our relationship with the CCG as a Council, we have very strong working relationships. As an example, particularly in terms of health integration we understand that is the way forward in terms of improving health. Recently in fact, a few weeks before Christmas, we opened up a seven-day hospital social work service which basically provides more Council social workers in the hospital which helps with discharge of patients in a timely fashion so that they are not delayed as a result of Adult Social Care. That is a really good piece of partnership working, but however, it is important to stress that that has only taken place literally before Christmas, so although the early signs are that that is showing success, I think the point I want to make is you would want to see the success of a lot of other things in place before you started looking at closing other acute provision.

Q. I wanted to come on to that because of course in your submission you do say that readiness and capacity are an issue but on the other hand you say that progress is being made. Looking at the CCG document that you attach, it is clear, is it not, that some of those initiatives are still pilots? And some, for example the Diabetic Intermediate Care, that is still in its infancy, is it not, so are you as an authority clear about the scale of the services which are currently up and running?

A. (Cllr Bath): We understand what has to be done and we understand the proposals and principles that they are sound, but, as you quite clearly say, I think it is very early stages because a lot of these services have to be embedded. The example that I have given you about the hospital social work service, the early signs are that it is showing a lot of success. However, there are lots of other services that are proposed for 2015-16 and an example that I give in terms of access to GPs, et cetera, a lot of our residents tell us that they have difficulty in accessing GP services, so if residents are having difficulty accessing GP services, the likelihood is that they are more likely to use acute services. I have an example in terms of my own case of not being able to access my GP over the summer of last year and having to use an A&E hospital. So I think, if that is what we are hearing from our residents, then that is a concern that we feel as leaders in our community that we need to raise and we need to ask questions.

Q. You also raise what you describe as a "lack of agreed metrics" against which to judge the success of the out of hospital services. So does it follow then that although, for example, the CCGs may give you specific data about what services they are offering, they do not give you or you are not made privy to a way of measuring whether or not that service is actually effective or not? Have I got that right?

A. (Cllr Curran): No, I do not think you have. We do work very closely with the CCG

and we have, I think, a very positive and good relationship. CCGs are new. Their engagement with local authorities is very new for them. They have never been in the political arena as such and I am sure they find that a strange thing to be in. It is a positive relationship and we do work collaboratively around the analysis of the services we are jointly procuring or providing, and that evidence will come through our joint information departments. I have not seen anything yet, as I chair the Health and Wellbeing Board, nothing has been brought there to raise concerns about the delivery of some of the pilot schemes we are doing or involved with and any proposals going forward. There are exciting things to do and we want to embrace those. It is at the more strategic level around the provision of healthcare, certainly acute care, that we are really concerned about and we may be at odds with the CCG on that.

Q. Are you satisfied though that you are able to measure as services come on-stream how successful each particular service is?
A. (Cllr Curran): I am certain that we will be able to do that with the CCG, yes.

Q. I wanted to ask you about the social care side of things. Can you help us with to what extent out of hospital services in the borough are dependent upon provision which comes from the local authority and whether or not there are resources available to underpin that?
A. (Cllr Bath): I mentioned earlier about our working with the CCG and our partnership and our commitment, and I do stress that we have an absolute commitment and we have a very common agenda in terms of making sure that we provide the best possible healthcare for our residents. In terms of adult social care, obviously we are part of the Better Care Fund framework and process and we have been involved in that for a while from the outset and we have extremely good relationships and working because, obviously, there are lots of projects within the Better Care Fund which will deliver good outcomes for our residents. It is early stages, but there is nothing to indicate that that should be a problem in terms of working and getting good results. We have a very good partnership and working with them and I think the CCG have involved us in terms of making sure that we fully understand what is happening. This will only work if the local authority and the CCG work together. I think even if we did not want to work together we are driven to work together because of the Better Care Fund requirements and the projects in place are dependent on us working together.

Q. I wanted to touch on an issue that you have already mentioned which is the population changes. Am I correct that one of the concerns that you have is about the growth of the population and the impact that that may have had on the factual estimates and the figures that underpin the system?
A. (Cllr Curran): Yes, that's correct. I do not think that when the case was made originally for change it adequately took into account population growth and, as we all know, in London there has been a significant increase right across the board and that will continue. We think there is around a 10,000 to 12,000 under-estimate on the original figures for population growth.

Q. So is it likely then that the emergency care facilities at West Middlesex University Hospital are going to be fully used up by the people who already come from the area with that increased population, and so what does that say about the capacity to take patients from elsewhere if, for example, Ealing and Charing Cross are unable to continue with their services?

A. (Cllr Curran): I think there is a huge risk and, as Cllr Collins said earlier, we had a mild winter, we did not have a flu outbreak of any significance and we were still up against it right across London on providing healthcare, so I think with the population growth, not having the necessary GP availability, certainly in Hounslow, and Cllr Bath has alluded to the fact that people are complaining about waiting times at GPs, we have not seen a significant improvement in the out of hospital services which would then relieve the pressure on West Middlesex Hospital so any further closures of A&Es in this part of London will be a mistake, I think, at this stage.

Q. I wanted to just ask you about transport because you cover this very briefly in your submission. Do you have any views about the increase on travel times if Chelsea & Westminster services are reduced?

A. (Cllr Curran): Yes, travel times are difficult anyway and, again as Cllr Collins has alluded to, if you are elderly or frail that makes it more difficult, but I think travel times play a significant part in people's decision about where they go to receive healthcare and we all know anecdotally how difficult it is to travel round this part of London anyway. Movements of patients across borough boundaries need to be understood as to why people do it. We obviously have a close relationship with Richmond, which has been alluded to, and why they were involved in the process. People do move from parts of our borough and they may go to Richmond or they may go to their walk-in centres, et cetera, so understanding why people move around, why they move and how they use public transport to access healthcare needs a more detailed look at the moment. I do not think it is clear.

Q. Do you have concerns about whether there will be any disproportionate effect on poorer or more deprived areas?

A. (Cllr Curran): I think it is more likely that that will happen. People from those areas are less likely or will be unwilling to travel longer distances to receive healthcare. Travelling is not cheap, so I think people will make decisions around cost and accessibility when using transport and in their decisions around how they receive healthcare. It is very challenging for those particular groups.

Q. Is there any particular group or area that you identify as being particularly vulnerable in that aspect of things?

A. (Cllr Bath): Yes. It going back to our population in the borough. Our population has been growing for quite a while and, in fact, I was reading somewhere we are the fifth highest in London, so it is a population growth that obviously we need to keep an eye on in terms of what kind of services and health services they will require. I think what worries me in terms of the population growth and in terms of the age groups, we have a lot of younger age group in terms of families and babies that will need healthcare but we have also got an older population as well. I think that in terms of transport, as the Leader said, there needs to be more analysis of exactly how do people get to and from and around the borough and accessing health services because, particularly from my experience, so many more residents who are trying to access services, particularly those who have long-term illnesses, are having so many difficulties even with hospital transport. If that is something that you are using on a regular basis, then that worries me because is there then a tendency for people to think, "Well actually, I won't access services because it is just so difficult to do that"? So I think there needs to be a greater understanding of how that is working and I am particularly worried about how this will impact on the very young,

families and the elderly in the borough.

Q. I do not know whether you can help on this or not. It occurred to me that this is a borough which is close to Heathrow Airport and of course we do not know whether there will be an extra runway at Heathrow or Gatwick, and that is very much a matter for others, but I wonder whether you have a view about whether that would have an impact on, for example, your population and also transport links if there was disruption caused, say, by an additional runway and whether that is something that you think needs to be factored in and thought about?

A. (Cllr Curran): Certainly we are thinking about that at the moment. We are looking and we are developing our master plan for the west part of the borough. We are working with Heathrow Airport Ltd on that. I am not sure that health services have even thought about that yet. I think they are way behind the curve on that and, if there is an expansion of Heathrow, then we will need to ensure that there is adequate transport, that is an essential part, but also of healthcare. I do not think the Health Service is ready for that in any shape or form. I have certainly not had any dialogue with anyone about how we will deal with a population explosion if the third runway comes to Heathrow.

Q. Am I correct in saying that if that were to happen it would be completely transformative of the area?

A. (Cllr Curran): Absolutely.

Q. I just wanted to ask you very briefly about the business case. As a local authority, what do you say about the wisdom of proceeding with major changes such as selling off land without having had sight of the business plan?

A. (Cllr Curran): I think it is foolhardy.

Q. Finally, just in relation to the issue of governance, one of the things you say in your submission is that the local authority has been "unsighted" about *Shaping a healthier future*. Could you just expand on that a little bit, please?

A. (Cllr Curran): As I already mentioned earlier, I do not think there is engagement at the right level with local authorities and health services. We obviously mentioned about our good working relationship with the CCG. I think that is really positive but, as I say, I am concerned and some other London leaders are concerned about the formation of "Super CCGs" and as always in the Health Service it goes in circles and then we will have regional CCGs, and I think they are there in all but name and they are making decisions about health services in my borough that I know nothing about and I have no engagement with. I think that is a real concern and should be a concern for everyone.

Q. So over and above the JHOSC scrutiny, what scrutiny mechanisms would you like to see put in place?

A. (Cllr Bath): I think this is an extremely important point for us because in terms of what is happening at the bigger level, we feel that there needs to be a bit more of an holistic approach or an understanding across the whole London area. In terms of what mechanisms that would involve, I think we would probably want to seek advice on that because we do have obviously the JHOSC, but we as Cabinet Members are not part of that and there needs to be another mechanism, something in place that looks at the whole picture across London because what happens in another part of London obviously has a knock-on effect somewhere else. I believe these are the really important overall issues

that need to be looked at holistically before you start making decisions about closing and also to have a look at what the pressures have been to date as a result of some of the decisions being made. We do really support the idea of having a mechanism, but we are not entirely sure what that should be.
A. (Cllr Curran): Just to add to that, I think what I am clear about is that we need to be at the table and we are not. We are playing second fiddle to the decision-makers in health in London, and that is not acceptable.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much for your presentation. I have two questions, one specific and one more general. The first one is do you agree with the previous witness, Cllr Collins, that it would be a mistake to downgrade Charing Cross and what needs to happen is a revamping. I am putting it shortly but those are his words; do you agree with that?
A. (Cllr Curran): I think we need to understand the case for those changes and understand clearly the effects they will have on our residents, and I do not think that case has been made yet.

Q. So is your answer that you do agree?
A. (Cllr Curran): The answer I have given you is the answer I have given you.

Q. It sounds a very political answer, if I may say so.
A. (Cllr Curran): That is what I am.

Q. I know but then you are expressing views on these matters which affect all of us so it would be important to know what your present position is. Your present position seems to be "Well, we do not know". If you want to amplify, please do.
A. (Cllr Curran): I can. Our position is that we do not think there should be any significant changes to acute care in North West London until we fully understand the effects of the two closures that have already taken place, and we need to have a frank and honest and open debate about that. We are not against change and we are obviously not against improving healthcare outcomes for our residents. At the moment we do not see the evidence and we do not see the business case. It is only in draft form. We need to see much more evidence. I do not want to paint myself into a corner. I want to be in a position where we can move in the right direction when we think it is right for our residents.

Q. The second question I have really is a follow-on from what you have just said. If out of hospital services are going to be regarded, again using the previous witness's word or description, as a "pillar" of this whole scheme, then do you believe that what should have happened here if reconfiguration of that kind is going take place, that you need a pilot scheme first? This comes from a witness we heard last week. So, for example, given the needs of a particular area, you cannot start closing acute services unless you know that urgent care centres are really going to fulfil that function, unless you know how an extended GP service is going o in fact satisfy the deficiency and so on. So looking at it

compendiously, would it not have been better therefore to have a pilot scheme that embraced these changes?
A. (Cllr Curran): I fully support that view.

Q. DR LISTER: Just a quick question. There is a reference on page 23 of your submission to a 30% increase from 2011 to 2013-14 in A&E attendances at West Middlesex Hospital. This is very large by almost any comparison and it is certainly much larger than most of London. I am just wondering if there are any particular factors that you may be aware of? I know you are raising the question and there have not been answers from the NHS, but from the borough's side, from the social services' side and so on, are there factors that you are aware of that might have driven that?
A. (Cllr Curran): As a lay person, I can only draw the conclusion from the information given to me that it coincides with the closures of the other two A&Es. I think other people will have to look at that in detail and understand that, but that is the impression I have, that it is too much of a coincidence.
A. (Cllr Bath): If I can just add, I think that is the point that we have been trying to make all along is that we really need to understand why exactly we have had an increase in waiting times in A&E at West Middlesex University Hospital because that seems to coincide with the closure of the other acute settings. As I mentioned earlier, when I went to open the hospital social work service which was a few weeks before Christmas at the West Middlesex, there was, it was described as a "black alert", a term which I had not heard before, and it was very worrying to see. We were trying to open a service but obviously the staff were under an increased amount of pressure running around trying to cope with the extra demand and, from speaking to them at that time, it was clear that they were extremely worried about the situation, and that was way before Christmas, so I think what we are saying is that we want to understand why exactly that is before any further decisions are made.

Q. I would just point out that the period is from 2011-12 up to the final quarter of 2013-14 so that rather predates the closure of the A&Es, which took place at the end of 2014. There must be other factors as well at work in addition to the closures, although obviously it had been talked about for some time, but not to the point that those A&Es were actually closed.
A. (Cllr Curran): Sorry, I thought you were referring to the closures of the A&Es in that time period. You are right, I do not know what those underlying factors are, but there has been, and we all know this, an increase in demand on the Health Service right across London and across the country. Again, it is just another example of why we need to understand why it is there has been that significant change and increase in demand, what are the reasons, so before we make any further changes I think we need to understand that. I agree with the point already made by the Chairman and by a former witness that we should have a pilot study and understand that and see how it works. We have not got that at the moment so I cannot be confident or understand why there were those increases in demand in the period you have described.
A. (Cllr Bath): Also if I could add, this is only anecdotally, I have grown up in this borough and over the years it has always appeared to me that West Middlesex Hospital is quite a busy hospital and in my experience of the times that I have used A&E it has appeared to be very busy, and I am talking for a very, very long time here as a person who has lived here all my life. That is obviously just my experience anecdotally, but it has always appeared to me to be a busy hospital anyway.

Q. DR HIRST: A very short question: I do not have a full understanding of how the Better Care Fund is being used. I understand that it is a positive thing and the Council have spoken very positively about it but where does the money for the Better Care Fund come from because I have read that this is not new money and, if so, where will the money be withdrawn from? What services will be downgraded to provide the resources for the Better Care Fund projects?

A. (Cllr Bath): My understanding is that it is not new money and it is money that comes from acute services. Obviously, we do not know what will happen in terms of the future Better Care Fund, which would be worrying as well, but what we have done is we have taken the opportunity with our partners in the CCG to make sure that we can deliver the best possible outcomes from the Better Care Fund because, obviously, we totally understand the need in terms of integrated working. We have a number of projects that are part of the Better Care Fund and a couple of projects are already off the ground but, yes, it is not new money; it is money that I understand has been taken out of acute services.

Q. I promised to be quick and I am not being quick. My worry is we have heard - and this is the third session - about all the pressures that already there are and the pressures there are going to be on acute services and I just wondered if in your meetings with the CCG and other authorities whether you have come cross an understanding of what services are being reduced to provide this funding?

A. (Cllr Bath): I think that we could probably have a better understanding of that, and I accept that. I think we are trying to make the best possible cases for our residents, but I think you are absolutely right, it is not clear in terms of what is being reduced.

THE CHAIRMAN: Thank you very much to both of you.

The Witnesses Withdrew

THE CHAIRMAN: I am going to suggest we do go on, if that is all right with the stenographer and others, and we will not have a mid-morning break.

DR JULIAN REDHEAD, Chair, London Regional Board, Royal College of Emergency Medicine

Examined by MS RENSTEN

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

A. (Dr Redhead): I am Dr Julian Redhead. I am an A&E consultant and Chair of the London Board of the Royal College of Emergency Medicine.

Q. You have in front of you Volume 5 and your submission. Can you confirm that it is true to the best of your knowledge and understanding and that you wish it to stand as your evidence to this Commission?

A. Yes.

Q. Can I just ask you to clarify whether or not that is your view or whether that is a view

endorsed by other colleagues in the Royal College of Emergency Medicine?
A. It is a view taken from a number of colleagues across the specialty across London but also nationally.

Q. We know that *Shaping a healthier future* is predicated on out of hospital services and community services being able to reduce the need for acute services. Bearing in mind the view that you have set out, and what you say is that patients will continue to need the expertise of the emergency departments in any event, can you help with the extent to which improvement in community services, even if achieved as intended, will actually reduce the need for emergency care?
A. I think you have to look at emergency care as one part of a whole pathway, and that is both the patient coming into the A&E department, but also the flow through the A&E department into the main hospital and then out of the hospital as well. So the A&E is like a barometer of system-wide changes which occur. So any change in the primary care or the community care will have an effect on the A&E development, either through earlier discharge of patients from the hospital but also in terms of patients who will present at the hospital. For me, for us in terms of the situation in community care, if you improve the community care services, you will inevitably have an effect on the A&E department, either in terms of being able to remove patients out of the hospital quicker which helps with the flow of patients into the hospital from A&E, or indeed by reducing the number of patients who need to attend accident and emergency.

Q. There is a Volume 2 and if you could look, please, at page 581. This is a letter from the Clinical Commissioning Group and it is the Hounslow one but really it is just by way of example. What I wanted to ask you is this, it sets out various initiatives such as social work and GPs co-working, GP weekend visits to care homes, community heart failure units and diabetes services. What I wanted to know is this, whether you think those are the right types of services to put in place to best achieve the desired reduction?
A. It is probably slightly difficult to read a whole document to say whether that is a complete list of all the different types of services. The ones that you have read out are certainly ones I would expect to see on that list and certainly there is evidence from different parts of the NHS where those individual pilots have helped produce changes in how emergency care is delivered in their local environment. That is both nationally and internationally as well. So they are the kinds of things you would expect to see on those lists. In the UK I am not aware where population changes have occurred such to allow all of these factors to be placed in one population to see what the effect is, and there is more evidence that comes from the United States around that type of population management.

Q. If those services are the right kind of services, how do we test to see if they are delivering what they are supposed to be delivering?
A. I was listening to the questions before around pilots and things like this and certainly pilots are an established method as to whether a certain system will work. The trouble being is how big and how long you want that pilot to work to produce the statistical evidence that you require to say whether something is proved or not. The difficulty is the changes from each of those parts will be small but together your hope is that they will make a big change, but you need to have a big enough population studied over a long enough period of time to make sure that you are not having unintended consequences. Pilots are tricky things sometimes when you are talking about population management and you need to look at evidence from elsewhere as well.

Q. So how do we establish a firm evidential basis, which I presume you are saying is necessary, before we roll out these services other than on a pilot level?
A. I think you need to look internationally and you need to make some assumptions within your modelling, but your modelling needs to take into account all of those different factors, and an error factor because you will not have the ability necessarily to have established evidence of the changes that will occur.

Q. If that is not done, if there is not a sufficiently robust evidential basis, what is the likely impact of rolling out services without that?
A. If your modelling is incorrect, then there is the possibility that you will overload particular services. It could go in the other direction and you have an over-surplus of services in other areas so you need to understand the movement of patients and the acuity of those patients within the population and take into account national changes in the population as well.

Q. If the out of hospital services do not materialise as fully or as quickly as the programme envisages, what then is the impact on emergency services?
A. I think you would expect to see an increased use of those emergency services and therefore more pressure being put upon the emergency services that are available.

Q. Bearing in mind that some of the out of hospital services will come under the umbrella of local authority provision rather than NHS provision, what if one element, perhaps the NHS element or the local authority element, is not resourced or not sufficiently resourced, what is the impact then?
A. I think it depends largely on which elements you are talking about, so some of these, as I have said, will have an effect on the ability to discharge patients from hospitals and some will have an effect on the movement of patients into an emergency department, so each one will have different effects and needs to be studied independently but we also need to look at how they interact as well.

Q. Do I take it then that if there is a problem at the end that is going to create a problem that pushes all the way back to the beginning?
A. Yes, most likely.

Q. Can I ask you a little bit now about centralisation because that is something you touched on and obviously the number of A&Es is being reduced under these proposals from nine to five hospitals, but can you help, other than the specific trauma, cardiac and stroke services, what do you see are the advantages in centralisation?
A. We have a very good evidence base now around services of trauma, hyper-acute stroke and cardiac that you improve outcomes and save patients' lives by ensuring that the patient gets to the correct hospital with the right backup services in the fastest possible time. The previous system of taking patients to the local or the closest hospital did not have the same benefits to patients as taking them to a hospital which has the set-up and ability to deal with the care that they require.

Q. What about emergencies other than those specific examples?
A. The evidence is less in those because they have not happened. Those big ones which have happened both internationally and locally within London are now occurring at the

national level as well. You could hypothesize for other emergency systems, if an ambulance service can identify a particular sub-set of patients who would benefit from a more advanced approach to centralisation, and I would certainly expect those to be picked out, they could come together. The difficulty we have is in more general services, and the classic example would be general surgery where you need to have surgeons who have experience based on the number of patients that will come through their door for a particular operation. If you are serving a population that does not deliver that number of patients to that number of surgeons, you cannot sustain their workload and their ability to deliver care. Therefore you need to centralise in those aspects to ensure that you have got enough patients coming through to give those surgeons the experience that they require to carry on improving outcomes for patients.

Q. You have highlighted as well, arising from that, that lack of availability of experienced staff is one of the reasons for centralisation. If staff availability was not an issue, would that impact on your view of the necessity for centralisation?
A. It goes again in terms of the population so you could say you have got an extra 100 surgeons coming into West London but each individual one of those surgeons would therefore only operate on a very small number of patients and therefore their experience and their ability to care for patients would be reduced. So it is not as simple as saying you need a large number of surgeons. You need to have the population to provide patients, for want of a different way of expressing it, for them to build their ability to care for them.

Q. If there is an increasing population over and above that which has been estimated, does that in any way impact on that centralisation argument?
A. The size of the population clearly influences the number of procedures and the types of procedures a surgeon would need to undertake, so a larger population most likely would support a larger number of surgeons across the healthcare economy.

Q. Linked to that, you refer to the tariff system.
A. Yes.

Q. I wonder if you could explain to us what that is?
A. The way that the NHS within secondary care is funded is through a tariff system, so in the majority of cases, there are various difficulties with this but in a general sense each patient that comes to your hospital carries a sum of money with them to pay for their care which comes from the CCG. The trouble is that these tariffs were set a number of years ago and were set in a slightly haphazard way so that emergency medicine, where it is changing now to much more senior delivered care, so you are expecting consultants to be at the front door much more, within four hours, the changes in 24-hour practice are all within that emergency department, tariffs have not changed to reflect those services, so, therefore, it is very difficult for a trust to invest money in a department which is losing money for them in terms of the tariff that they receive for it. There is also the fact that across the whole board of acute medicine the Government set a target that said you should not increase your number of admissions over a threshold that was set about four or five years ago and they basically took a 70% tax away from the hospitals, and you were only paid 30% of the tariff when you go over and above those thresholds of admissions. So the whole funding is very, very tricky in order to invest in your systems of emergency medicine.

Q. Does that in itself have an impact on ability to provide and recruit and retain staff?
A. I think it depends on individual trusts, but if you are always having to provide business cases which are going to lose money the more staff you put in, then, yes, it will have that effect.

Q. I wonder if I could ask you, please, to turn to page 1801, and this is a submission by Professor Pollock from whom we are going to hear later. I just want to ask you very briefly about something she says and if you could comment on it. If you look at paragraphs 13 and 14, she touches on the tariff issue that you have just raised and she talks about the 30% figure and at paragraph 14 she says: "The reduction in tariff is supposed to act as an incentive to hospitals to turn people away … The policy is not working as patients unable to access their GP surgeries and out of hospital services are forced to turn to emergency departments", and then she goes on to comment on the other effects. Can you assist us, do you have any comment on that analysis?
A. I think to turn patients away from A&E was not necessarily what the 30% marginal tariff was supposed to do. I think it was supposed to encourage hospitals and communities to work closer together to reduce the number of admissions. The trouble is that that money did not go to the CCGs. The savings that came from the 30% marginal tax were held centrally. So it has not necessarily had the effect that it was supposed to, which was to ask the communities and hospitals to work closer together to try and reduce the number of admissions and to be able to use that money that was being saved at the marginal to come back into the system, but we have not necessarily seen that happening.

Q. Does that system need to be reformed or merely updated?
A. I think the whole way that we pay for emergency medicine needs to be reformed.

Q. I wanted to ask you a little about the issue of urgent care centres and A&Es. One of the major anxieties that seems to be a theme coming through is confusion over what an urgent care centre is and when someone should go to it. As we know, there are proposals for Ealing Hospital and Charing Cross to have on-site only an urgent care centre. First of all, can I ask you how you understand the definition of an urgent care centre?
A. I think it is a very difficult one and it is difficult for the profession and therefore the public as well, I would agree. The Royal College calls for co-location of urgent care centres together with emergency departments to try and avoid some of these issues, but we do know that around the country there are well-established urgent care centres which operate very well for their local communities. London potentially is different because it is an urban environment and certainly when you go to communities outside of urban environments they use their urgent care centres and they appear to be very successful in the way that they are used. So for me urgent care is for those patients who do not require an ambulance, who would not require investigations over and above simple blood tests and x-rays, and it is more to do with the skill of who is going to be staffing the urgent care centres than anything else. That is not necessarily standard across the country. Some GPs, because they are quite a diverse population, will have great skills in how to manage certain situations and some will have had little exposure previously to those and will need more training and better skills in dealing with them. That is where the confusion comes from is what skill level you are going to staff the nurses and doctors working within those urgent care centres to provide care for the population.

Q. For this area, for North West London, what do you say, if any, are the risks of having urgent care centres which are not co-located with A&Es?
A. I think the risk is there is always the potential for a patient to go to the wrong area and the one that we quoted would be a mother with a young child running into an urgent care centre and the urgent care centre not being able to provide that help. The Ambulance Service in London are successful in providing category A services and they do very well in their response rates to those, and that would be the response you would expect to have, together with a large education programme. So long as the urgent care centres have the correct networks and good links back into the hospital, and the Ambulance Service understands how they are going to work in terms of patients who arrive who have increased need over and above those urgent care centres, then those risks can be minimised.

Q. Do I take it that your support for non co-located centres is predicated on there being an effective transfer system to A&E?
A. When it is required, yes. I think that is one of the aspects that would need to be done, together with a population programme of education so that people understand what services are provided in which locations.

Q. So if the transport infrastructure is lacking, does that not give rise to a greater risk?
A. I think if you said that the ambulance service were unable to cope and would not be able to provide the service to the urgent care centres in a timely manner then, yes, that would be a risk.

Q. Are you able to help with what, if any, arrangements there are between urgent care centres and A&Es which do not involve blue light ambulance transport?
A. In terms of, so this is ---

Q. If I give an example: a person turns up to an urgent care centre and is told they need to go to an A&E, and either there is not an ambulance available or it is not a condition that requires an ambulance, what is your understanding of what the transfer links are, how is it done?
A. Usually those would be through public transport links, depending on the condition, and taxi services are other services that they can use, but those would be specific between different networks of urgent care centres and A&E departments, and I do not know all the different arrangements that are in place across London for that.

Q. Again I presume - and you will correct me if I am wrong - it would be important for those arrangements to be in place, for staff to understand what the arrangements were and to be able to communicate that very quickly to patients?
A. Yes.

Q. Can I just ask you to clarify, you have talked about the level of staffing, do you have a view about whether the urgent care centres need to be GP or consultant-led?
A. Again, it depends on the population that you are expecting to come, so if you were to say it was going to be consultant-led in terms of A&E consultants within the urgent care centre, you are talking about a very scare resource already in that we cannot resource the A&E departments that we have let alone resourcing urgent care centres as well. The urgent care centres should be providing care to patients of a level where a general

practitioner or an emergency nurse practitioner can provide that level of care. I think that consultants may have an ability to go in there, as any consultant would, to work in the community and to help within certain parameters between different conditions at certain times in terms of clinics or reviews and things like this, but I would not necessarily say that they would need to be there the whole time to provide that level of care.

Q. Forgive me, when I asked at the beginning of this section about what urgent care centres were actually to cover, I think you said quite simple conditions. I wonder if you could explain to us what they are not supposed to cover?
A. I think they are not supposed to cover patients who are likely to require admission urgently into hospital, so those conditions where it is likely those patients can be cared for within the community, but in order to make those decisions sometimes you need additional investigations which an urgent care centre may not have or the skills of a doctor where they may not have all those skills through their training, so it is a question of picking out those conditions where the patients can be seen by a general practitioner or by emergency nurse practitioners.

Q. Is there not inherent in that a degree of patient self-selection that carries with it some risk?
A. Yes, and that is the reason for the good networks to ensure that you can transfer patients rapidly when they require additional services which you cannot provide in the urgent care centre.

Q. I just wanted to ask you a little bit about your views on the closure of Hammersmith and Central Middlesex Hospital's A&Es in September 2014. You may not have the specific information. I do not know. Can you help us with what the impact has been on other accident and emergency and emergency services in the area?
A. I think this is a difficult one because, if you look at the national picture, the majority of trusts across the whole of England have struggled over that same period to maintain standards, and we have heard of hospitals going on to major incident alert and all these other factors across the whole of the country, let alone across London. So to isolate off the effects of the Central Middlesex and Hammersmith closures within that is very difficult because we have seen this across the whole of the UK. I think we have to rely on what modelling was done and I do not know the details as to whether the modelling has been exceeded or not according to the predictions they made about patient movements.

Q. If I were to say, as other witnesses have said, that the problems which occurred after the closure of those two departments impacted in a way which was over and above that seen outside of the area, what impact would that have on your thinking?
A. If you can prove that the impact has been greater in those hospitals affected by these two closures, then I would accept that that is the case and those departments have been under more pressure than has been seen at a national level.

Q. Can you help us, do you have any views about the wisdom or otherwise of the proposed changes both in Ealing Hospital and Charing Cross Hospital in terms of the reduction of acute beds?
A. Again, the reduction in acute beds will be modelled on the improvements in primary care, preventional medicine and more community care. I have not seen the evidence to know whether those are in place and whether they are having an effect, but you would

certainly want to see those have an effect before you remove the beds from the system.

Q. The follow-on from that, the need to know if things are going to work before you make more cuts effectively, you describe SaHF as "ambitious". If steps are taken which turn out to be erroneous, how easy is it going to be to reverse them?
A. It depends on what they do. If you close a ward, then re-opening a ward, I am not saying it is easy, but it is possible to do it in a shorter timescale. If it is to do with removing entire hospitals or entire infrastructure, then that will take more time, if those things are not available, to be turned back round rapidly into wards if things go wrong.

Q. Finally, I wanted to ask you, can you have a look at page 1805, this is a Freedom of Information request about the consultation budget for this area. If you have a look at that, you will see, and I have totted it up, it comes to something over £13 million. As an emergency clinician, do you have any observations about the size of that budget and the efficacy of it having been spent in that way, and if I say to you that this is a consultancy budget from February 2014, so it is over a fairly shortish period?
A. It is a difficult one for me to answer because obviously I do not know the details of exactly what they were doing and everything else. Consultancies are used because they quickly bring in resources which can help you build up cases and understand the evidence which is there. I do not know what the £13 million went on. It is a huge amount of money to be paying on consultancy. It sounds as a lay member that that is a large figure to pay on consultancy figures, but obviously I do not know exactly what work they were doing and how beneficial that work was to help the project move forward.

Q. I wondered if perhaps you would be able to comment, and you may not be able to, on whether you feel this might have been better spent on direct services? And perhaps there is an obvious answer to that, I do not know.
A. The obvious answer is I would say clearly I want to see investment in the services because those are direct patient care, but you have to allow for the fact that if you are going to make large changes to a system and you need to understand how those changes are going to affect people, and you believe that those change are for the benefit of the population over a longer period of time, then you may consider that a small amount of money to pay.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much for your presentation. I am going to be quick because we are a bit pressed for time. I have a general question I want to ask you. We have been hearing evidence before today obviously from other boroughs, but one of the things that has come across very strongly is the impact of fragmentation which is very much geared to, if you like, the internal market-place, so what is your view about how this affects emergency medicine? I have another question linked to it because you began to define somebody who would not need emergency medicine if they do not need an ambulance. Of course, I want to ask you how do you define what amounts to emergency medicine and who sets the criteria?
A. In answer to your first question about fragmentation, I assume you mean by

A fragmentation the breaking up into CCGs and independent services of trusts and things like that?

Q. Yes, that is right.
A. I suppose that when I was young and growing up the NHS was more unified and you could go to various parts of it and now we are constrained in terms of budgets as to who cares for whom across different systems. My personal view, and I know the view of a
B number of doctors, is that we need to move back to more population management of illness rather than concentrating on institutions or on primary care or secondary care, and we need to look at how you fund healthcare across a population so that you can work across boundaries in a more beneficial way for patients. Does that answer your question about fragmentation?

C Q. Yes.
A. Your second question was about - sorry, I cannot remember now what your second question was.

Q. The second question is a broad one and it may be difficult to answer it. I am conscious of your evidence about pilot schemes, how long you go on and so on, but if you cannot do it that way because it takes too long and you do not know where the cut-off
D point is, I want to go back to the beginning and say how do you define emergency medicine, in other words, what are the criteria? Some of the criteria we have seen are breathing difficulties, heart difficulties and so on and that takes you into emergency. You began by saying somebody who does not need an ambulance does not need to go to emergency, but of, course, that may not be a correlation. So what are the criteria here?
A. I think this is one of the problems that people have had in terms of how you define what emergency medicine is because in a way you have to turn that upside down because
E you do not know who needed the emergency medicine until you know what the outcome of that patient was in terms of the condition that they actually suffered and what needed to happen to them. This has been at the very heart of where the problems lie in terms of urgent care and emergency care and where those definitions lie. I would agree with you, it is not just who goes in an ambulance. Sometimes it is an easy one to go with because it is fairly clear and someone who comes by ambulance in general, but not always, has a higher acuity of care needs than a patient who arrives by foot because by virtue of that
F they have been able to walk there, but obviously that is not true for every single patient because we get a lot of patients who walk in having a heart attack who would certainly need to have emergency care and the talents of emergency medicine. I think for me personally the definition is where you need the skills of an emergency medicine consultant, but I do not think that particularly helps you in terms of defining or deciding how an urgent care or emergency system works.

G Q. DR HIRST: Can I just follow up on that, thinking of my own experience. It has changed now, but I worked at a time when everything went through me as a GP, my on-call at night and so on. I am worried about this definition of what a UCC does and having a stand-alone UCC, especially as I am not sure the public understands that. Previously, and even now, I know that patients walk into my surgery with pulmonary emboli, they walk in with lower abdominal pain and it is a query ectopic. I am thinking of the asthma that goes off while waiting in your waiting room. Those patients may have
H walked in but they go out with an ambulance or, in one case during a strike, I had to take

an ectopic in the back of my car, which is a very dangerous thing to do. My worry is that I do not understand UCCs so how is the public to do that? It might be that my colleagues in general practice have to develop an out-of-hours service that is more focused and understood, but also I am worried about the throwing around of this UCC term and there might be a slow-burning disaster.

A. I understand, and I suppose I would come back to what you are saying in that this already exists that patients turn up to their general practitioner practice with these conditions as well and a system is in place to move them rapidly to hospital, and the same would be true of the urgent care centres.

Q. But we do not know that, do we?

A. I am making this assumption, as you spoke to the Councillor before, in terms of ensuring that there are those good links and those good transport systems between the urgent care centre and the hospital. I think it is to do with getting that localisation of services there so that if you do have to contract the number of A&E departments, the concern is where would people gain access to urgent care that they may require if the general practitioners cannot provide that over a 24-hour period.

Q. Sorry to hog this. There are two things about this localisation in my head. We heard from a speaker last week that there was no clear evidence beyond certain specific examples that centralisation really works but then, as you have said, it takes time to know and it has got to be looked into. Again, I have got these running bees in my bonnet. I look at the map and I see that the inner part of North West Thames is vastly supplied with A&Es. It has St Thomas' to go to, which is not that far, and it certainly has UCH, St Mary's and Chelsea & Westminster. There are small deprived areas, I accept, in those areas, but the great bulk of deprivation and lack of understanding and lack of sophistication is on the western side of North West Thames, and yet it seems as though services are moving in the wrong direction. I just wondered what your feelings were as an emergency medicine consultant, thinking of the bigger picture as you do because you are a leader of that specialty, about that? Common sense seems to me to move St Mary's to Ealing like St George's moved or like Charing Cross moved. What is stopping that happening? It is so obvious.

A. I understand what you are saying and I think if you redrew the map you would want to not necessarily put a hospital in Ealing, it would be a hospital probably closer to other infrastructures, and you may want to build a new hospital, but, obviously, these things take time and you need to look at the population as a whole, but that is certainly something which could be considered in terms of where those hospitals should sit and the services they are best served with. Obviously there are political ramifications of all of those things. If you were to move hospitals out one area into another, I am sure that those local populations would be saying the same things.

Q. You do not think it is to do with medical politics that people do not want the hospital moved?

A. There could certainly be some medical politics as well.

Q. Just one final thing, I am worried about what happens to this talk about so-called small local hospitals with 50 beds to care for the elderly, et cetera. I put this to a medical colleague last week and I would like to hear your views. Does that not mean that if you are going into a so-called local hospital without any of the backup of a major hospital that

you are already being denied full care? For example, if your pneumonia goes off?
A. Yes, obviously I do not know those proposals in huge detail as to how they want to do this, but there is evidence from other countries where they have these step-down or step-up units, which is what I think you are referring to, whereby patients who do not need the full backup of a whole acute hospital can go to an environment where they can receive specialist rehabilitation work and an intermediate stage to going back into the community. There is evidence that that has been very popular with patients because otherwise they are in an acute setting and then straight back at home.

Q. Rehabilitation is not what is being talked about here.
A. I understand, so then we know that the hospitals, if you go round a hospital, say that a percentage, and it is probably quite a high percentage, of those patients do not necessarily need all the backup service of an acute hospital, and therefore moving those into a lower acuity hospital whereby they are not disturbed by all the other things occurring could be to their benefit and they can have kitchens and things where they can do things for themselves but in a safe environment while they are in rehabilitation. I think that is the theory of those particular centres in terms of step-down and the idea that you have good links back into the acute hospitals because exactly, as you say, those patients who deteriorate deserve the care when they are in that step-down environment that they would get in a larger hospital as well, and there are systems that you can build into that to ensure that those occur. The other side is step-up and I know from my practice in emergency medicine that I have a number of patients whom I have to admit into my hospital who do not need an acute bed in terms of a medical bed but they do need care in terms of social care or activities of daily life, which could be better provided in the short-term in that type of environment as well. I think there is a two-edged sword, and I understand exactly what you are saying, but this is where you have to build in the networks, and you cannot see these as isolated units. It is like the urgent care centres, you cannot see them isolated. That is why I think also it goes back to my comments about the funding where the funding has to be seen at a population level. You cannot see it as I am going to a fund a hospital here, an urgent care centre here and community here and 20 GP practices here. We need to do that as a whole and make those decisions together.

Q. DR LISTER: Just very quickly, going back to those services that are proven to benefit from centralisation, you referred to the hyper-acute stroke unit. You will be familiar that Charing Cross is the leading hyper-acute stroke unit in the country at the present time.
A. Yes.

Q. And yet you also realise that that is scheduled to lose those services altogether. Would that fit with your idea of how centralisation should take place?
A. My understanding is that that is going to be moved to co-locate with the major trauma centre at St Mary's, is my understanding, which would make sense because that would bring together the neurosurgical services between those two hospitals and also the imaging-type services as well, so you could see quite a nice synergy between major trauma in terms of some of the backup services they require as well as hyper-acute stroke.

Q. There is that much spare room at the St Mary's site that they can commandeer a large area for that?
A. I am assuming this is post all these things and there are new buildings and other

services in place. I do not believe that they are going to move those until that has occurred, from my understanding.

Q. I suppose the reason I am asking this is because it does seem to me that some of your general points about some of these things are readily interpreted by people who are trying to argue for these schemes as applying here regardless of the fact that actually the circumstances on the ground may turn out to be very different. We have heard earlier evidence that in fact the footprint of the new St Mary's is going to be smaller than the present footprint, in which case it does raise the question of whether adequate space could be provided in St Mary's to deliver those services. Are you concerned that sometimes you make general statements about principles such as urgent care centres and so on and then find that you are being, effectively, misquoted somewhere else for it to mean something you did not really mean it to mean?
A. Absolutely, which is why I would always qualify those things by saying that it depends on the modelling and it depends on ensuring that your movements of patients are following the predicted routes so that you are making those services big enough to care for patients, which is exactly what I have said in the written evidence I have submitted, that the modelling is key and making sure that all the services are of the right size to receive the right acuity of patients, not just patient numbers. It is also the acuity of patients that needs to be provided for as well and if those are not in place then you cannot start altering all the systems until they are.

THE CHAIRMAN: Thank you very much indeed.

The Witness Withdrew

PROFESSOR ALLYSON POLLOCK, Queen Mary College

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your full name, professional address and current post?
A. (Professor Pollock) My name is Professor Allyson Pollock and I work at Queen Mary University of London.

Q. You have in front of you your statement. Can you confirm that it is true to the best of your knowledge and understanding and that you wish it to stand as your evidence to the Commission?
A. I have not read through the draft, but if it is as I sent I am sure it will be fine.

Q. Can you please help by explaining a little bit more about your specific area of expertise?
A. I trained as a public health doctor. I trained in medicine and then I did public health and I suppose for the last 20 years I have been doing quite a lot of work looking at health system changes and reconfigurations, especially those associated with the private finance initiatives, so I suppose that is why I have been asked to give evidence today.

Q. I want to ask you a question, and please do feel free to tell me that it is impossible to answer in this way, you talk about the 2012 Health and Social Care Act; are you able to

encapsulate the main thrust of what it does?
A. Yes, I will do my best. I think the key part of the Health and Social Care Act which we have got to be really concerned about is the abolition of the duty on the Secretary of State to provide listed services throughout England. That is a duty that has been in place since the 1946 legislation, so since 1948. That was actually abolished 2012. That was sections 1 and 3 of the 2006 NHS Act. That duty to provide is a really important duty. What it means in lay terms is, in effect, without that duty there is no anchor to provide a National Health Service throughout England, and I think that is the prism through which many of these changes that we are seeing now have to be looked at. There is NHS funding that is in place but what we are seeing increasingly is the fragmentation of health services, their dismantling, their unbundling and then actually their privatisation. In effect, what this means without that duty is that services increasingly were untethered from that duty to provide because that duty to provide was transmitted from the Secretary of State to geographically based area health authorities. That is what I think we should keep coming back to, what the abolition of that duty actually then means for local residents in local areas. I think the second part of the Act that is important is the entrenching of contracting. The contract is the mechanism now through which Clinical Commissioning Groups are actually contracting for services. Prior to 2012 it was quite possible for primary care trusts to still directly provide the services and to do so through the internal market, through the mechanism of block grants or block allocations known as service level agreements, but what we have now is increasingly commercial contracting, and so we have a different arrangement for the allocation and management of the risks and costs of care. Formerly, the duty to provide meant that the Secretary of State ultimately had the duty and would hold the risks, although since the internal market there has been an attempt to share, to divert those risks to hospital trusts. Now we have a very different arrangement for managing risk which is going to be through the commercial contract, and of course you cannot put a duty to provide into a commercial contract. I think it is really important to understand the way in which the organisational structures and systems are being organised around new arrangements for managing risk. Does that make sense?

Q. What I wanted to ask about then is this: in essence, because you referred to the duty becoming a duty to promote now rather than to provide; is the difference between them that one creates an absolute obligation and the other is a more qualified obligation?
A. There has always been a duty to promote a comprehensive service, but sections 1 and 3 made it very clear there was a duty on the Secretary of State to provide listed service and those listed services in section 3 include hospital accommodation, mental health, community services, maternity services. Now with CCGs the duty to promote is still in place but it is a much weaker duty, it is not a duty to provide, which was an absolute duty, and CCGs have to make sure that they can meet the reasonable requirements of their members.

Q. Turning to denationalisation, which you mention, how does that become possible?
A. Well, it comes back to the fact that you have removed the duty to provide listed services throughout England. That is really very important. So you have NHS funds but they are no longer tied to an obligation on the Secretary of State to provide those services throughout England and through the geographically defined area based authorities because the Secretary of State delegated that duty through area based structures, health authorities and then through primary care trusts. There has been a steady attempt to erode

or defray that duty to provide with the introduction of the internal market in 1990. The internal market tried to bring in competition, contracting through a shadow market, and of course established hospitals and community services as trusts, so there was an attempt, even then from 1990 onwards, to uncouple the planning and needs assessment from the direct service provision. Formerly, from 1948 to 1990, area based health authorities had had an obligation not just to meet the needs of their local population but to directly provide those services. They did that by directly managing the hospitals and community services in their area. Since 1990 the internal market weakened that obligation because it introduced that mechanism of the contract and it established foundation trusts, but there were checks on their freedoms, quite substantial and significant checks on those freedoms, and, of course, area health authorities and primary care trusts because of that duty to provide still had, if you like, a loyalty to ensuring that there were services in their local areas for their residents. That is what has been completely abolished with the 2012 Act. There is no duty to provide. They have a duty to arrange, which is contracting those services, and an overarching framework duty of a duty to promote, and that is the framework duty, and then CCGs only have a duty to arrange, which is a contracting duty using a contract.

Q. So just coming back to this contract issue, are you saying there is a significant difference between how the PCTs worked and how the CCGs now commission?
A. Yes, absolutely, and I think it is one of the lines of enquiry for CCGs how they do work. There are a number of fundamental differences. CCGs are not area based except for emergency care. CCGs are membership based organisations and you become a member of your CCG by virtue of joining a general practice. The second issue is that we have seen a major carve-out of the public health functions, so public health has been carved out and removed from the NHS and moved to local authorities, which means that there is no internal capacity for needs assessment or planning or information. We have also had major changes to information as well. CCGs are increasingly, as we have seen in North West London's case, outsourcing the commissioning functions to McKinsey's and PwC or we have seen these non-statutory bodies of commissioning service units (CSUs) being established which, increasingly, the Government would like to float off but they are non-statutory. We have seen major, radical changes to the CCG composition, who it represents, in terms of accountability, and also the resource allocation mechanisms, which were meant to be changed but they have been using historic resource allocations which are quite problematic, and then finally the fact that they no longer do the planning and needs assessment as we understand commissioning to mean.

Q. So are CCGs then driven by different agendas with different mechanisms than previously existed? Do they have other bosses, if you like, than the patient?
A. They are accountable to the NHS Commissioning Board, which is the correct term, not NHS England, and they receive a larger bulk of expenditure, as you know, but it is pretty opaque how they are operating now and what they are actually doing with the removal of public health functions, but their duty to arrange and to meet reasonable requirements rather than a duty to provide means that the contract is centre stage and increasingly using commercial contracts, procurement and competitive tendering.

Q. I wanted to ask you a little bit about that. I wonder if you could turn up page 1763. This is a submission from a gentleman we are going to hear from later on and he talks about his involvement with CCG tendering panels, and what he says is this, and in this

case it is Hounslow: "That the HCCG was staffed by individuals who had no prior experience of purchasing goods and/or services; in evaluating submitted tenders the panel was never shown any facility operated by the tenderer; there was no systematic review of tenderers' capabilities; one of the potential bidders for Diabetic Intermediate Care was an industrial gases supplier." I wonder if you could help with your view or your understanding about the level of expertise on CCGs with commissioning and procurement?

A. I suppose there are two issues. One is do CCGs have the expertise? And of course they do not if they are drawn increasingly from GPs and others. For commercial tendering, there are two questions. One is whether this is an appropriate way to provide a public service using the very expensive mechanisms of commercial tenders. The second is whether there is experience in tendering. Clearly there is not experience in tendering, just as there was not any experience in doing PFI contracts when hospitals were drawing them up. They were heavily reliant on management consultants and external advisers, so this is what you see. There is not the experience. There is not the knowledge about procurement and competitive tendering, but even if there was the knowledge, then is this an appropriate way to arrange for the provision of a public health service and a national health service? Clearly, we know from international evidence, the US being the best case in point, that this is totally inappropriate, it is very wasteful, because it involves establishing a new market bureaucracy, so we had an internal market which established a new bureaucracy on top of a public administration, which was very cheap 5-6% of the total budget. That doubled when we brought in the internal market and one can hypothesize that we are probably rapidly approaching 20-30% of the budget when we see a move to a market bureaucracy because you need a completely different system to manage the risks and costs of care and that is when you are bringing in a market bureaucracy.

Q. I wanted to ask about the consultancy contracts figure that I took another witness to. It is the same volume, it is page 1805. If we look at some of the items, if we look at the first page, there is an item second down M&C Saatchi Group £301,000 and some odd pounds and the brief seems to be "Closures of Central Middlesex and Hammersmith Hospitals SaHF Communications Lead". We go down a little bit further, there is an item at the bottom June 2014 McKinsey, £1,235,000, "Hospital BC Assurance Support & IMBC" and then below that PwC, which I assume is PricewaterhouseCooper, "Single OBC and Individual Specs for Central Middlesex Hospital". Can you help us with what your view is about these types of spend, please.

A. First of all, these contracts do not actually have any meaning to me when I read through them. The second is they look scandalously high, and I would be very interested to see what services they actually say that they are providing for these contracts. Third, of course, many of the providers of these services have actually been drafting and helping draft Government policies, such as McKinsey and PwC, so they have been very much behind the policy of denationalising and privatising the NHS so they are standing to gain quite a lot. I find it absolutely shocking but it is not atypical. I think if you looked in every CCG in the country, bar a few, you would find exactly the same pattern, so we have got public squalor and private gain happening here on an extraordinary scale. I can give you examples from my own work where I have been working with the College of Emergency Medicine. We do not collect any proper injury data and injury is the most common cause of morbidity and mortality. It would be a very simple thing to do. It would require a few hundred thousand pounds of investment, if the Government were to

invest in things they are going to improve our prevention strategies and the quality of care and lives of patients and their families, and yet we are not seeing these sorts of contracts being awarded.

Q. I think earlier you talked about firms being involved in the governmental development of policies. Are you saying that there is a conflict of interest?
A. Absolutely. No doubt about it.

Q. Just looking over the next page, 1807, there are a couple of items which look much smaller. There is one at the top which says "7-day service Hillingdon Hospital £65,500" and I think there is another one for a similar amount £40,000 underneath for Ealing. Those appear to me - and I wonder if you could have a look and tell me if I have got this right - to be contracts which were involved in the provision of actual services as opposed to provision of communication services or strategic implementation? I wonder if I have got that right or not.
A. Could you just point me?

Q. The top of page 1807, the first two items, June 2014, "7-day service Hillingdon Hospital and 7-day service Ealing Hospital". I wonder if you were able to help with whether those were ---
A. I do not know. I would have to look and see what they say they are doing. I do not know what S&T support is.

Q. Just while we are on that page, there is a third item £4,400,000 to McKinsey & Co "Whole Systems Integration Programme". Obviously you cannot say from that what the totality is, but are you able to give any comment on your view of that size of spend?
A. Again, I think it is shocking. And I know from experience in North West London that they have a bad (or a good) track record of using McKinsey's and I know the people in the Public Health Department were very concerned because McKinsey and Penny Dash in particular, their charges were more than £2,000-£3,000 a day and they said that they were providing good value because the NHS was one of their favourite customers so they were giving them a bargain rate. This was before the 2012 Act. The staff there were so frightened about losing their jobs that they did not speak up, but I saw the internal documentation at that time. So one would have to ask what is the basis of this £4.5 million and is it £2,000 or £3,000 a day for the consultants? That is a exactly the sorts of fees you would see under the private finance initiative as well when you had the tendering process going on.

Q. Bearing in mind that the total of that document adds up to just under £14 million, it is £13,764,000 and some odd pence, do you know where it is coming from?
A. It must be from the NHS, or the NHS funds because there is no NHS now. It will be top-sliced, I imagine, the CCGs are using that as part of the allocation they get from NHS England, but others may be able to confirm.

Q. Moving on from this, you talk about risk from contracted services. What happens if a CCG cannot find a firm or an organisation which is willing to provide a particular service? So if they cannot commission anyone to take a service on, what happens?
A. I have no idea.

Q. Are you aware of any fallback provision?
A. They only have to arrange to meet the reasonable requirements and one way of abdicating the responsibility, a bit like the Secretary of State is not having a duty to provide but also using a contracting mechanism. The Government is very keen on this new idea of a prime provider model where the prime provider will get the capitated budget and then they will do the sub-contracting in turn. We know from the American experience that when you move into market contracting, what we are doing in the UK is we are importing American solutions and at the same time we are going to be importing American problems, because, of course, all contractors want to be able to identify the risks, allocate the risks through the contract and price those risks and they are risk averse. We saw that with the Independent Sector Treatment Centres programme, the £4 billion programme that the Government put out for elective care, that the private sector had very strict algorithms as to which kinds of patients they would take and which patients they would accept. It is very interesting to note that the Government is giving new permissive powers to providers and foundation trusts to actually begin to set up eligibility criteria. This is a matter of speculation now, but the advantage of using a contract is that you give a contract to a large prime provider which in turn sub-contracts out the care and then people will fall through the net. They either will not get it or they will find they are no longer eligible for care. This is speculation now. This is the territory we are moving into.

Q. Is the totality of the evidence you are giving then that, so far as you are aware, if a contractor cannot be found to take on a service, the service may simply no longer exist?
A. Yes, or the contractor may agree to take on that service, but it is not properly defined and specified in the contract and you find that the services fall away. That is really what is happening; we are finding services are falling away. If I give you the example of community services where Virgin, for example, has huge contracts, if you look at the contracts for over £700 million, the risks are not actually set out or specified in any way and neither are the services tied down. Community services are a very nice one to contract out because it is very difficult to define them, there are not very good data, it is very difficult to specify, so the providers are going to be left deciding who and what they will give and we will have very crude outcome measures as to what they will do. So really what you might find is that services will simply fall away and not be provided any more and patients will be going without care, as has been happening for quite a while.

Q. Will it save any money?
A. Of course it does not. Commercial contracting never saves any money. We know that from the US. We have decades and decades of evidence to show that the move to the use of commercial contracts is very expensive. The Institute of Medicine in 2012 has shown that the use of commercial contracting results in over-treatment, under-treatment, the denial of care and enormous transaction costs which they have put at nearly $700 million so that is around 5%-6% of the American gross domestic product spend on healthcare. That is in a year.

Q. Can I just ask you very briefly to deal with the tariff system. I have already taken a previous witness to that. Can you explain to us what it means for people going to A&E, what it means in terms of the services available for them?
A. All market contracts have to have a price mechanism so the tariff is just a pricing mechanism. I do not know that you can translate what it means to the individual. Of much more concern is what CCGs are actually contracting for. We now have stories

coming in from around the country where people are being turned away from the hospitals they used to go to because their CCG no longer has a contract with that provider. An 83-year-old woman got in touch recently to say she had been turned away from the Queen Elizabeth Hospital where she had been attending for 40 years when she presents with empyema (she has chronic bronchietasis, lung disease) and her consultant in that hospital said the only way she could get in was actually by coming in through the emergency department and she could not have a direct referral because the CCG no longer had a contract with Queen Elizabeth Hospital. What you are seeing increasingly is that patient choice - and that is what we were sold the 2012 changes on, that GPs would be in charge and that patients would have a choice of where they went - is no longer the case. It is down to the commissioners and to the providers which patients they will pick and which patients they will choose and who will get in.

Q. Can I ask you this, in this area for example, supposing somebody was a patient who usually went to Charing Cross Hospital, and a new service had been set up at Charing Cross Hospital, if their CCG chose to get that service from somewhere else, are you saying they would no longer be able to go to that hospital; they would have to go elsewhere?
A. They would have to go elsewhere. If there is no contract then they would not be able to go to that hospital.

Q. So could we find ourselves in a situation where the reconfiguration takes place and new hospitals are built and new services are put in place but they would then remain unused because the CCGs have chosen to contract elsewhere? Is that a possible scenario?
A. I do not think we are going to see any new hospitals built through the NHS.

Q. I am talking specifically ---
A. That is not the direction of travel.

Q. I am talking about the reconfiguration, the change in services at, say, somewhere like Charing Cross. Supposing there was a unit in Charing Cross which was set up, do the CCGs have to use that unit or can they say, "We know it's nearer and we know it's new, but we can get it cheaper somewhere else"?
A. Yes.

Q. What I am asking is could you have new facilities which remain under-used?
A. Yes, and that has been happening for quite some time. Good examples are the Independent Sector Treatment Centre or even before that fund holding in the internal market where decisions were being made by the Commissioners, and that actually had a knock-on impact on the viability of local hospitals and services. So of course yes, it would, that is just the way markets work.

Q. I just want to ask you very briefly to talk a little bit about foundation trusts because you have touched on their ability to provide a mixed economy of private and NHS care and I just wondered if you could expand on that very quickly, please?
A. The Government abolished the private patient cap in the Health and Social Care Act which now means that your NHS hospital will now be 51% public and 49% private, so the foundation trust now has the power to raise up to 49% of its income and use up to 49% of the beds and staff for purposes other than NHS patients.

Q. Are they able to do that regardless of the needs of the population or is that something that has to be factored in?
A. There are legal checks in the Health and Social Care Act but the extent to which those legal checks have been complied with is not clear and there is some disagreement over the degree to which they can raise their income. These legal checks are not being monitored. The other thing to say is that the definition of foundation trust income is really now quite problematic because there is not good guidance from the Department of Health, Monitor or NHS England on how to define and measure non-NHS income. The other thing that some foundation trusts are doing is that they can get into joint ventures and so therefore they can appear to remove some of their income from the balance sheet as well to appear to comply with the legal checks. This is an area that needs much more scrutiny, but rather than scrutiny I would advocate that we abolish foundation trusts and we abolish the internal market.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much, Professor. There certainly are some questions. I am conscious of the time but I think we will overrun. You made a remark a few minutes ago, almost a throw-away remark, but I want to pick you up on that and get you to expand a bit. It may be obvious; it may not be. The remark was "There is no NHS now", so I would like you to expand on what you mean by that. Secondly, fragmentation has begun, as you have already outlined, from 1990 onwards, the internal market and so on, and I am interested in accountability in relation to this. Have you done research, and if you have not there is a short answer, on the vested medical interests within the House of Commons and the House of Lords who take decisions about the involvement of the internal market in the NHS? Thirdly, what do the CCGs really represent democratically speaking and their accountability to the commissioning body itself? So there are three inter-related questions in a way.
A. I will deal with the second one before I come back the to first one because I have not done any research on vested interests in the House of Lords and Commons, although others have, Spinwatch and other organisations, so we can easily get that to you, which shows that many of the MPs and the Lords who were commenting, debating and voting on the Health and Social Care Act legislation did have vested interests. Perhaps one of the best known is Alan Milburn of course. They have vested interests and conflicts of interest in that they are often sitting on the boards of some of the private healthcare companies. So there is research but I have not done it. "There is no NHS now" - the fact is that the duty to provide NHS services throughout England was the NHS. There is now only a duty to promote on the Secretary of State, so the Secretary of State has abdicated that duty. There is NHS funding. There is funding for health services which is why it is called the Health and Social Care Act. The 2012 Act is not called the NHS Act. So there is funding for health and social services. That funding is likely to decrease. That duty to provide, which was the check on market contracting, means that now CCGs are unfettered. They can enter into commercial contracting, and indeed they are expected to under section 75, so that money is now increasingly flowing. I suppose you have to use the metaphor of the oak tree and think of the NHS as like an old oak tree and the duty to

provide is the roots and the funding flowed through those roots to all the different parts of the NHS throughout England. Those roots have been completely severed so when you take that duty to provide away the roots have been severed, so, now, where is the money flowing to? It is flowing at random to commercial contractors, regulators and Monitor into an entirely new system. It is very difficult to explain to the public because they see hospitals and foundation trusts but they are not there. If you sever the roots of your oak tree, it does not fall down overnight; it begins to wither away slowly, so the bits wither away, the branches fall off, they drop off and then finally the whole thing is gone. What we are now seeing, in the words of a former CEO of the NHS, is a "managed decline of the NHS". The NHS is withering away and the bit that is now being targeted is the district general hospital or the acute hospital system because that is where the fixed costs are and that is where the staff are. This is the context within which you have got to see these big changes happening in North West London and the Government's desire to cut or halve the number of A&E departments throughout the country. The way in which they do that is through putting in various different mechanisms. You have got the mechanisms of trust mergers. Trust mergers make it easy to close hospitals. You have got the mechanism that the Government can still create and manufacture trust deficits. This is a story that needs to really come out, and Sean and Roger have shown this, that you create apparent failing trusts in order to take them into special administration or to make a case for change, but, as has been shown, these deficits are sorcery, they are not actually real when you look across the whole system which is actually in balance and it has a duty to be in balance, but the beauty of having the internal market and the foundation trusts is like the puppet master you can put these hospitals into deficit, make them fail and that then drives the rationale for service reconfiguration and service change. It is speculative I know, but the bottom line is that we no longer have an NHS, the Government is putting in place the mechanisms which allow the break-up of the NHS and money to flow to commercial providers which then destabilises what remains and then the Government has got to manage the decline and the erosion and ultimately the closure of what remains in the NHS. You will have fewer and fewer district general hospitals, fewer and fewer A&E services and the rhetoric of course is centralisation is good, specialisation is good, but we have already heard the *volte faces* that the Government is doing because a lot of the hospital closures throughout the 1990s were driven by the premise that they were not safe; we could not have emergency care going in there because they were not safe any longer and yet now we have the Government creating new urgent care centres and proposing much smaller hospital units which will not be comprehensive in the way that district general hospitals are. This is the final assault on the district general hospital, which is really important because it is symbolic for people in their area. The residents identified with their NHS through their local district general hospital and community services that were already provided. That is what is actually happening, so when I say that there is no NHS, we have completely new systems that have been put in place to drive the withering away and managing the decline of the NHS in order to pave the way for commercial contracting and increasingly what we will see is a mixed funding system, so patients will find that they are denied care or they cannot get in or the A&Es are too busy so they use alternative sources of funding and alternative providers, those who can afford to pay. You have to remember that the CEO of NHS England is Simon Stevens who spent a considerable amount of time working for United Healthcare.

Q. DR LISTER: I want to take you back, Allyson, to CCGs, commonly depicted in the media as GP-led. I just wanted to explore that a little bit. To what extent is there in the

legislation any obligation for CCGs to actually consult with member GPs in their area before taking a decision?

A. I have not looked at the legislation and I would need to go back and look at that, but we do know that GPs in the area do not feel that they have been consulted and they have no role on the CCGs. That is probably the way I would rather answer that question. But I would put it to you, the evidence that you have seen is that CCGs are not GP-led, they are management consultant-led and management consultant-driven.

Q. And the other thing, you draw out the contrast between the role of the CCGs compared to the previous primary care trusts, for example, but also one of the other things that was abolished was strategic health authorities. I am not a great historic fan of strategic health authorities but one thing that was great that NHS London did in its final few years was to actually raise a levy across London from the commissioners to help to stabilise some of the trusts which had got extremely large debt. My understanding is that CCGs have no obligation whatever to the stability of local former NHS services in their areas. Am I correct on that? How do you see that as part of the whole new system?

A. That's correct. They have a duty to arrange, which is a duty to contract. They are under huge financial pressure or perceived financial pressure, so they will obviously contract out to the lowest bidder more often than not. The other thing that is happening is of course CCGs do not represent the interests of all the residents in their area except for emergency care, only their members. There are two big changes that are taking place. GP practice boundaries have been dissolved so that CCGs in theory could be drawing members from anywhere in the country, so that takes you to an insurance fund or an insurance pool. It is very important to remember that. The GPs and the BMA opposed the dissolution of GP practice boundaries, but the Government pushed that through in January of this year, which means that now CCGs will be drawing and can draw members from anywhere in the country. GP practices in turn are no longer representing their local communities. They are federating, they are integrating across areas so you are going to get federated, corporate structures which no longer are accountability to the people in their local areas. And so too are hospitals and foundation trusts. They are all what the Government calls "integrating" in market terms. You have vertical integration and horizontal integration taking place, but of course as providers merge there is no longer any loyalty to their local community and as CCGs merge and their membership base changes and they become much more like insurance funds or insurance pools, they are not loyal to their local community. If you take Aviva, you car insurer, Aviva does not really care about making sure that everybody in my area where I live in East London has good and adequate coverage and can get access to good house and car insurance. They are interested in whether you can pay the premium or not. I think that is the really big transformation that nobody is talking about. When I said there is no NHS, the NHS is withering away, but there is a new transformation which is moving much more towards a US-type of model, what is called a health maintenance organisation or, ironically, an accountable care organisation, which is premised on insurance pools and is membership based and where you have got integrated, enormous healthcare providers, and the key is there is no accountability to the local community or the local area. That is where all these incremental changes since 1990 have been striving to take us and this is what 2012 and the removal of the duty to provide finally does. That is why we are hearing such a lot about Manchester devolution, for example, where we are going to get local authorities and CCGs coming together to co-commission with no overarching duty to provide, no national framework legislation in place to do that, and that is why we are hearing of the

£1.5 billion Staffordshire contract for cancer services going out to tender and being unbundled. That is why we have got the context for the North West London experiment as well.

DR LISTER: Thank you.

THE CHAIRMAN: I am really grateful to everyone for over-shooting and I am going to thank you personally for coming. May we reconvene at quarter to two? It is a short lunch break, but I think we owe it to the witnesses. Thank you very much indeed for your patience.

The Witness Withdrew

After the luncheon adjournment

THE CHAIRMAN: Could I welcome everybody back to the afternoon session and thank you for your promptness. Can I ask counsel to call the first witness this afternoon.

DR AJAIB KAUR SANDHU, Ealing and Hounslow GP

Examined by MS RENSTEN

Q. MS RENSTEN: Could you please give the Commission your full name and your professional address?
A. (Dr Sandhu): My full name is Ajaib Kaur Sandhu and my professional address is Belmont Medical Centre, 18 Western Road, Southall, UB2 5DU.

Q. Are you a GP?
A. I am a principal general practitioner in the practice.

Q. In front of you, you should see a submission that you put in and it is at Volume 2 starting at page 757.
A. I have got it in front of me.

Q. Can you confirm that it is true to the best of your knowledge and belief and that you wish it to stand as your evidence before the Commission?
A. It is so, yes.

Q. I wanted to ask you, you are a GP and you practise both in Ealing and in Chiswick?
A. I have, yes.

Q. Does that give you an overview of two very different regions?
A. It indeed has.

Q. At the Belmont Centre you say that is seen as a model of good practice, can you help us with the advisory work that you have done flowing from that?
A. I used to work in Chiswick. I happened to do a locum session in Southall because my colleague was desperate and when I saw the care there I was very touched and I said, "I am working in such an affluent community but the need is greater here than in Chiswick"

so I readily transferred and voluntarily gave up my Chiswick practice and I started working in Southall. It was a very uphill struggle at the time but over time we did conquer and we have now achieved best practice status.

Q. I think you said there was some advisory work you did. Could you help us with what that was? Was it advisory work to other GP practices?
A. It was an example which I set in the area because when the QOF came into existence my achievements were higher than the QOF and that is how it delivered me as a best practice, because the QOF was brought in to improve the standard and quality of care but my quality of care was higher than what they targeted.

Q. You set out in your submission that you are a founder of something called SHIP, the Southall Health Improvement Partnership?
A. That's correct.

Q. Can you explain to us why was there a need for such an organisation when health improvement is part of the function of the NHS and the local authority?
A. If the local authority's function was optimally conducted there would have been no need for SHIP. When I worked in Southall after tackling the practice population, which was about 3,500, and I had achieved what I wanted to with the screening and blood tests and whatever, I felt a bit unhappy about what is happening to the rest of the community and how can I conduct it? I was invited to some meetings where I pleaded to the public health directors to do something about it. Our people are dying very young. After 30 years they are gone, leaving young families and children. The answer given to me was not very pleasant. I was told then by a top person, "That is how they suffer, that is how they die and we can do nothing about it." That was unacceptable to me, so I was very frustrated and I appealed to another medical person and said, "Look, you are doing your screening at 35. Our people are dying at 35. Can't we do something earlier?" He said, "No, we can't do anything earlier." I was very, very frustrated and out of frustration I started visiting the local religious organisations one after another during my free time and I conducted these sessions. This is 23 years ago I am talking about and gradually I found satisfaction when people benefited. We diagnosed people who had diabetes which they had never known before and many other things were diagnosed and education was given which we have ever since conducted and we are very happy that we are doing that. The satisfaction is there and the service to humanity is there.

Q. Is it still an organisation for which there is a need?
A. Pardon?

Q. Is the organisation still needed? Is SHIP still needed?
A. It is very much needed because when you look at the population in Southall, having worked in Chiswick, there is such a vast difference in the two communities. The prevalence of certain diseases like for example obesity, diabetes and other related diseases, hypertension and stroke, is so very high and it is so frustrating that you cannot stop doing what you are doing. We are trying to build on that. We started with the health promotion sessions. We then went to the diabetes risk assessment and now we are going into educating them with a dietician because diet plays a very big role, lifestyle intervention plays a very, very big role, which is almost non-existent in Southall.

Q. Is that organisation carrying out preventative work?
A. Very much preventative. I have done screening in my practice. I did not wait for the authority to tell me, "You do this and we will pay you that." I could not care less about that because I wanted my patients to be healthy. I have screened my patients for the last 15 years, which was a big workload but the satisfaction was there that all my patients are screened. We do annual health checks, we do registration health checks and we do regular blood tests. Like my son said to me, and he is a general practitioner at the practice now, "Mum, what you started 20 years ago, now the Government is making it mandatory."

Q. If SHIP did not exist would there be a gap in the service?
A. The gap has always been there and will always be there because the workload is so big. What we are doing is just the tip of the iceberg. We are doing it through religious organisations. From one temple we have gone to all the religious organisations. We go to the church, we go to the mosque, we go to the mandir, we go to the community health centres, wherever we can catch people and give them education. This is ongoing. Because the problem is so big if anybody steps in to do the service I would be only too happy and I am always happy, I say, the workload is so great that it is never ending.

Q. I want to ask you a bit about Ealing Hospital. You say that you conducted something called a practice staff inquiry about the closure of Ealing Hospital. Can you help us with who you asked and what did you ask?
A. Can you repeat the question?

Q. In your submission what you say is this: "I have conducted a practice staff inquiry" - this is about Ealing Hospital - "Now I come to the main query about Ealing Hospital's proposed closure. I have conducted a practice staff inquiry into this question." Can you just explain a little bit more about that, please?
A. We had a practice of nearly 6,500 patients and we have got very good practice staff. When I was to answer this inquiry I thought I should ask everybody what their views are, so I went to the clinical staff and they told me their views. Then I went to the non-clinical staff, that is the admin side, and I got their views. Then I conducted the patients who were sitting in the waiting room and I talked to them and over the period I have asked about this because the topic about Ealing Hospital is not yesterday, it has been there for a while, and I have had conversations with community members as well because SHIP deals with the community leaders. I attend a lot of community forums and there has always been this topic about what shortage there will be or what drastic, devastating effect the Ealing Hospital closure will be. I conducted it with everybody so the view which I have put in here is not my view; it is the view of a lot of people there, and it is true.

Q. I wanted to ask you about access. First of all, can you tell us in your view who uses Ealing Hospital?
A. The whole of the local community from Ealing are using the services. We had a GP meeting in the beginning when all the GPs attended the meeting and discussed the closure of Ealing Hospital and everybody had their hands up and said no, Ealing Hospital should not close, except two GPs who were the lead members in the North West London team. Everybody said Ealing Hospital should not close, but later on they again conducted an electronic voting system which was not fair because when any elections take place, you

do not re-conduct it if you lose it.

Q. Could you help us with when that first meeting was that you went to, just roughly?
A. I think it was in the beginning when they were talking about Ealing Hospital to close. Primary care physicians were there, secondary care physicians were there and there was a voting system, they suddenly asked you to put your hands up if you do not want Ealing Hospital to close and there were only two doctors, which I would not like to name now unless you want them to be named ---

Q. It is a matter for you, if you wish to.
A. Then they re-conducted it electronically. Why, what was the need for the electronic vote? When you lose a General Elections or you win you do not re-conduct them. The first one was the right one. The second one was the wrong one.

Q. Just thinking about the population that uses Ealing Hospital, how difficult would it be for that local population if they were not able to go to that hospital?
A. The local population is very diverse. There are a lot of capability and capacity and linguistic areas and emotional areas, psychological and cultural. Even to go to Ealing Hospital has been an effort for them, but they are used to it. When I see patients in my consultations most of time I conduct my consultations in their preferred language. They are so inter-dependent on the family and now, unfortunately, the families are moving out because their children are very highly qualified people, which is very interesting, they work so hard to give them the very high-quality education. I met a patient two days ago and he said, "My grandson is studying for a PhD in Oxford," and we have had some articles written down as well because the Southall population have got a future generation which have achieved extremely well. They are left on their own and they have not got the means of travelling. They have not got the linguistic advantage of choosing one bus or another bus and they find it easier to get to this particular bus stop and go to Ealing Hospital. That advantage will be lost and they will hithered and thithered without being able to go to a far away hospital where they will have the option of choosing two or three buses. They will not choose the two or three buses and it will be difficult for them to do so due to their set-up.

Q. Why is it do you say that other hospitals, say for example Northwick Park, would not be able to adapt and provide a service which has similar capabilities in terms of linguistic need? Why can other places not do it?
A. Having a hospital nearby has got a big advantage. Why would one choose to go to another hospital when you have got the advantage of a nearby hospital which has served you so well in different dimensions – culturally, timewise, life-saving means - and why would one choose the option of going to a far away hospital when they have not got the capacity? Even to go to Ealing Hospital, they have been trained, you get on at this bus stop and at the other end you will be in the compound of Ealing Hospital. They will lose all that. You are talking about why can Northwick Park Hospital not serve them. We had a forum meeting recently and all the communities were there and what many people pointed out, you talk about Northwick Park Hospital having the capacity, I have seen people waiting in the corridors and they do not even have proper seating arrangements to sit down and wait. I recently had a family member who is pregnant and she is doing a PhD and she said to me, "They haven't got the capacity," and I said, "Why?" and she said, "I am pregnant, I had gone for a blood test and I was supposed to have a fasting

blood test in the morning. My fasting blood test when I am 28 weeks' pregnant came down at 1.30." That is not called efficiency in any other hospital.

Q. One of the other things you say is that Ealing had the highest emergency attendees at A&E nationally a few years ago. Do you know if that is still the case or has that changed?

A. I do not think it has changed because when I attended this particular meeting I was invited by the Department of Health, where a lot of statistics were discussed, and I was very surprised and sad to know that Ealing Hospital has got the highest emergency attendance because of the kind of care set-up they have in the community. Of course, it is justified or understandable because we have the highest prevalence of diabetes, obesity, heart attack and stroke and nationally they are the highest and, if they are the highest, of course emergencies are going to be high. Culturally also, people are not smart like the patients I had in Chiswick where they knew something was going to go wrong and they came to us early. Here people do not come early. They come at the last minute when they have got a problem and then it is a bit late and of course it is an emergency then and they have to attend the emergency unit in the hospital.

Q. You talk about something, you refer to it as "inverse care law". Forgive me, is that a recognised term or is that your own terminology?

A. That is a recognised term.

Q. Can you explain what it means and how it affects the population you are talking about?

A. I was reading a quote in the Bible once after having come across that. The first time I came across the inverse care law was during the QOF visit. When the QOF came into action, all practices were visited and the doctor who came to talk to me said, "Have you heard about the inverse care law?" I said, "Not really", so then I pursued it. Apparently, the inverse care law is even in the Bible where they say people who have got plenty get more and people who are poor are given less according to the Bible, but then this is applied again in the National Health Service where in the very affluent areas, people are given better services and in the non-affluent areas, like Southall, people do not get the services they have in the other areas. The picture is changing now because things have come into the community in primary care and patient participation is taking place and people are coming out to give their voices and hopefully this should change. It is the inverse care law. Southall people have been very much denied and deprived despite their diversity.

Q. Are you saying then that the reconfigurations, the out of hospital services will they benefit the population in Southall?

A. Please repeat your question again.

Q. *Shaping a healthier future* says that it is going to cut acute services and increase primary care services and out of hospital services. My question is will that benefit the population or not?

A. It is not going to benefit them overnight. There is a living example in Sweden. It had the highest mortality rate in the world and it took them 25 years to address that. Today Finland and Sweden have the lowest mortality rate. It will take 25 years for this area to have a lot of health promotion and preventative medicine conducted in the community,

with the primary care services now being magnified, but it will not happen overnight. We need 25 years to change the structures and the system in primary care which has just come into primary care and once we have achieved that, like Finland and Sweden then maybe - I will not say yes - it may be we will do as well. Not immediately.

Q. Is it then safe or unsafe to cut emergency services before those improved out of hospital services are in place?
A. Very much so. Very much so. Needless to say, it is so obvious.

Q. Is it safe or unsafe to cut emergency services?
A. Unsafe. Very unsafe. It is deadly and devastating for the population. It is happening every day and if you cut it, it will get worse. Already the lifespan in Southall, people live ten to 15 years shorter, the mortality rate is high and morbidity is high. If these services are cut it will only multiply that and that will again reflect on the quality of the community services, it will reflect on National Health Service funding and already overloaded GPs working 14 hours a day. People do not like to work in Southall. Why? Because the workload is so much.

Q. Have I got this right that what you are saying is that the deprived constituencies are bearing a greater impact through these reforms than those who live in more affluent areas? It is having more impact on deprived areas than affluent ones, is that correct?
A. It is very much correct because when you are educated like me, I am Asian and I understand everything, I know how to seek advice but the community does not. The next generation are better off and so on and so forth, but migration is taking place, circulation is happening there, so there is not going to be an end to it that the new generation is there. No. There are older people who will always be like that and the cycle has to be repeated.

Q. Can I ask you about the implementation and commissioning of the out of hospital services? First of all, does your GP practice have any involvement with the local CCG?
A. We do not have a direct involvement although we attend the meetings we are supposed to attend regularly. I do participate with them. My son is a GP in the practice and we have got about five other salaried GPs and we attend these meetings regularly, but we do not have a direct involvement because the workload in the practice is so great that I give priority to my patients rather than to attending the meetings and following the procedure.

Q. Are GPs in your area consulted about decisions made by the CCG? If you do not know, say.
A. Can you repeat are GPs in your area ---?

Q. Are they consulted by the CCG about the steps and decisions that the CCG takes?
A. I think nationally though the structure is there, it is not very different from when the PCTs were there; they just have not got the time that people have come to ask them individually and what their contribution is. The meetings are there and I used to be on the PCT group. Of the seven doctors who were there, I was the only woman among the six men and what I noticed was they organised things and they planned things and they called a meeting and they said, "We are doing this, this, this," but that is not consultation. Consultation is when you look in-depth at the problem and see what are the advantages and what are the disadvantages of our decisions. I do not agree with many of them and

many GPs do not agree. Those who are participating talk like the people from the North West London team talk, but we do not talk like that; we talk from the ground level and we talk for the patients that we are serving. So it is not always consulting the way ideally it should be and it is dictating to us. I do have a lot of confrontations when I go to these meetings. Now I am so pleased that the patient participation group is coming up and I am encouraging people, I give talks in public gatherings and I say, "Don't sit down. Go and participate in the patient participation group. Your vote is important. You can either make it or break it."

Q. In your view then, does the CCG in your area have the backing of the body of GPs or not?
A. Not 100%, no. GPs like me do not support them.

Q. Do you think you are the minority or the majority?
A. I think we are 50/50 really. People who are more oriented only with the services and the structure, they may be 50% but listening to the votes for the Ealing Hospital closure, I think the majority are against it.

Q. I wanted to ask you about the maternity unit at Ealing, please. Can you help us with your view about the planned closure of that unit?
A. About the maternity unit we recently had a forum where they invited one of the CCG leads and I said, "Why have you invited him? What is he going to do for you?" When the forum was conducted, I understood that the people were so angry and it came out that Ealing maternity unit had the highest number of births - 5,800 or something - and the question they put was: it is doing so well, it is self-earning and why are you closing it. There is a population that it is serving which is 16 to 59 years and these people are working 22% whereas nationally the working population during that Joint Services Strategic Needs Assessment was 22 for the local population and 11 nationally. When they are earning the money, they are working, they are paying for these services, they need maternity care, they need children care, they need elderly care, why are you shutting it down? There was no answer. He was very embarrassed and then he just went away. Now I understand that there is a decision taken that until the Election takes place the maternity unit will not be touched, which I am grateful for and I hope it continues not to be touched. We had a person in the forum who said, "I have had four children and my four children were delivered in Ealing Hospital." They are a first-class service and I see no reason why it should close. It is self-supporting. It is not a burden on anybody. There is no good reason for this hospital to close.

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

<u>Examined by THE COMMISSION</u>

Q. THE CHAIRMAN: Thank you very much. I just have a question arising out of what you have said. You have indicated how overloaded your GP practice is such that in fact you do not even manage to get to some of the meetings, so would it be right to say that in your case the idea that your practice might be able to take up the slack, as it were, in other words help with out of hospital care, is not something in which you are readily available to participate? Is that right or wrong?

A. Yes, it will be very difficult because we are already overloaded. We are working 14 hours a day, seven days a week. As you know, they usually say, "We don't know how tall our children are. We know how long our children are because we leave them sleeping in bed and when we come back they are sleeping in bed." With that kind of situation, you are working a 14-hour day, what is left for you to do any extra work? You have to have resources if you want services to come into the community. There has to be a balance. At the moment although the GPs are looking after the community and trying to improve their lives, what is their own life? It is not a happy one.

Q. Is that a picture that describes other GP practices you are aware of?
A. I beg your pardon?

Q. Is what you have described applicable to other GP practices that you are aware of in your vicinity?
A. Most of them. I cannot see anybody who is happy about it because the workload is there. I did attend a conference about two years ago and the first agenda item was GP burnout. It is a national issue. It is a problem that a lot of people are facing because the resources are not there and the services are being pumped out from secondary care into primary care. Fine, we are happy, you give us a structure where we can employ more nurses, we can employ more doctors and we can employ more health educators as appropriate for the community, and when they come into primary care we would love to take over the load provided we have got a system to tackle it, otherwise it is inhuman that you should overload it. You are dealing with human lives. You need certain hours of rest and certain hours of upgrading your education to provide better services, but all that is disturbed.

Q. DR LISTER: You have very well described the amount of work and some of the excellent services you have developed in the area and obviously that is a lot of expertise. CCGs, Clinical Commissioning Groups, are supposed to be led by GPs, but it clearly is not you and it is clearly not other GPs in a similar situation. Do you see any evidence that they have taken any note of the situation in Southall affecting patients like yours in drawing up the plans? Is there somebody that they have spoken to who has given them the idea that maybe closing Ealing Hospital is a good idea?
A. I have not come across anybody saying closing Ealing Hospital is a good idea because it will always have an overflow from primary care for people to attend Ealing Hospital. In the next 25 years I cannot see, unless they improve their services and the standard of healthy lifestyles in the community improves, and then it could change, but I do not see it as yet because it has not even started. SHIP are struggling to do it. We are not smiled upon; we are frowned upon, "Why are you doing this?" I am doing this because it is just in me that I will serve my community to the best of my ability. If you cannot do it, I shall try and do it. We collect volunteers, we give them training and we deal with the problem, but I do not see this happening.

Q. I just wonder if you have so some impression? Clearly these ideas do not come from Southall and from Ealing, in fact, so where do you think the ideas have come from about the idea that maybe you could get better services somehow by closing Ealing Hospital and relocating services elsewhere?
A. The North West London panel attended a scrutiny panel meeting and I was there at the time and the panel was composed of members who had no idea whatsoever what was

happening in Southall. They were talking about Finland and I said, "Why are you talking about Finland? How can you compare the two?" I read about the Finland issue as well. 25 years ago they used to have the highest mortality, but they worked towards it and in 25 years they conducted health promotion and lifestyle changes for 25 years nationally and today they have got the lowest death rate, but I told them, "You don't even know what's happening. You are talking about maternity units being closed and deliveries being conducted at home. How can you conduct a delivery at home when the family is living in one rented room? You have got the father there, you have got three or four children there and they have rented only one room, they cannot afford even to rent two rooms, how can you conduct deliveries there?" I told them it is nothing but criminal injustice for you to say that maternity units should close and they should conduct deliveries at home. It applies in the area where people are living in lovely houses where they can have a separate room for all the services to be conducted for home deliveries and likewise for other areas as well. Here we do not have that comfort and convenience, which we should have; it would be a blessing.

Q. Can you offer any explanation as to why the Chair of Ealing CCG has continued to support these proposals regardless obviously of the level of criticism that exists among colleagues in Southall in particular?

A. Well, you know what politics is: politics is supporting people without logic. I am a very ground level GP. I am very realistic and I see not my side as a GP when I see a patient, as I tell my staff, do not look at them from your viewpoint; put yourself in their shoes and see how they feel. If you were in their shoes and you were brought up like that and you were given those conditions, you would be no better than they are. These people in the North West London team are not supporting the community from the ground level; they are supporting the top people there, and that is called politics. That is why I never joined politics. It is not a good game to my taste. Politics have to be there but, again, it is not my way of tackling the problem. I do not join politics, no.

Q. DR HIRST: I am just curious about something. You are still in practice, Dr Sandhu. I chickened out, I am afraid, and I am retired from general practice, but I am still on the Hounslow mailing list.

A. Sorry, can you speak a bit louder please.

Q. I am a retired GP and I am still on the Hounslow mailing list and I am just curious about a letter I got to see if you got it as well. It was an email and it was addressed to the Feltham Locality and it is from Sue Jeffers, who is the NHS Hounslow CCG Managing Director. She thanks the Feltham Locality Directors for meeting her on 9 February regarding the contract and implementation arrangements for the delivery of out of hospital services for patients within Feltham. "I am looking forward to working with you as one of the five new providers for the out of hospital services in Hounslow." This letter refers to a meeting on 9 February. It is an email delivered on 26 March and it says: "Please can you confirm receipt of the above information as a provider of out of hospital services by Friday 27 March and then will be you available to sign arrangements by Monday." Then following it comes another email dated also 26 March from the Local Medical Committee from, and you might know her, Eleanor Scott, who goes through a whole series of reasons, seven bullet points why the GPs who are running this in Feltham should not sign. One of the reasons is that the training cannot possibly take place to enable safe delivery of the individual contracts, specifications have not been agreed, there

is unreasonable time. The reason I am floating it across you now is, firstly, did you see this letter in your NHS emails and, secondly, are you familiar with other instances of GPs being asked to sign documents with only I suppose the equivalent of overnight consideration whilst still trying to run a 14-hour day?
A. It is very obvious that GP input is not there. It is not the first time this kind of situation has arisen. It happens many times and GPs do protest against it. I do not see how that can be conducted from top to bottom; it should be from bottom to top. It is not right. Recently I attended a meeting in Hounslow. Because I live in Hounslow and I serve the community in the London Borough of Ealing, somehow I happened to attend this meeting which was related to diabetes, and there was a nurse who did the presentation. She is a Spanish lady and she speaks English and she said: "I saw 20 patients and out of them only five could speak English." They also mentioned in the agenda that the care in Hounslow was in the bottom 25% in the national audit. So when the standard of care is that low, how can you say that GPs should sign these contracts with short notice when they are coming home? Have they got the brains to read it? Have they got the time to read it? Have they got the time to apply and assess the correct decision on that? It is very unfair. That is why a lot of people do not want to do medicine now. I was talking to some specialists yesterday and I said, "I have got two sons who are doing medicine. One is in secondary care, one is in primary care. Both of them are not happy with what they are doing with the workload they have." I said, "I don't see my grandchildren should be doing any medicine at all because it is not that attractive now when your own quality of life has gone the way it has." It takes me back to the day when I was a medical student. We had a husband and wife who were heads of department and they had a son and I said, "Is he going to be a doctor?" and she said, "No, no, no, my child will never get near medicine because it is such hard work." On top of the hard work, when you have to work 14 hours a day, it makes it harder, and there is no solution to that. It is just bringing the quality down although they are trying their best to keep it high.

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

The Witness Withdrew

DR T, Consultant Virologist

Examined by MS RENSTEN

Q. MS RENSTEN: Can you please give the Commissioners your full name, professional address and your current post?
A. (Dr T): My name is Dr T. I work in (named) Hospital, but I live in the Shepherds Bush area.

Q. Before you, you can see a statement that you made. Is it true to the best of your understanding and belief and do you wish it to stand as your evidence for the Commission?
A. Yes.

Q. First of all, I think you just mentioned where you practise and so it is not in the area. Can you explain a little bit about your specialty and what it is that you do, please?

A. My specialty is in virology/microbiology. I deal with people who have got infections and it could be after surgery or before surgery, after chemotherapy. I deal with infectious diseases.

Q. But you live in the area?
A. I live in Loftus Road.

Q. So are you approaching this from both a professional and a personal perspective?
A. Personal, yes.

Q. Can I ask you first perhaps to tell us a little bit about the personal experience that you have set out in your submission in terms of your having to attend with your wife at Hammersmith Hospital. I know it is very personal but if you would not mind sharing that with the Commission, please.
A. My wife had some abdominal pain and I suspected from the beginning that it would be something like an ectopic. We called the ambulance service to come and take her to Hammersmith Hospital, but when they arrived I think they did not know where to take her, but I insisted on them taking her to Hammersmith. I know that they have a good gynae and obstetric service. We took her there and within half an hour or something, she ended up in the operating room and she was successfully operated on and she is fine, yes.

Q. So from your perspective, what do you say would have happened if the Hammersmith Hospital accident and emergency unit had not been there?
A. I think it is like Chelsea & Westminster for example, for me there is no backup to deal with the different problems, so I prefer a hospital which has a backup in place to deal with other complicated problems. Accident and emergency just puts an IV line in, resuscitates patients and they provide the first service but within hours some of the surgical patients require immediate intervention so it is very important to have a backup.

Q. Taking it now from a professional rather than a personal perspective, what impact do you think in this area the closures of Hammersmith A&E and Central Middlesex A&E have had?
A. It is significant. I like the cleanliness of Chelsea & Westminster. It is nice and we use it for paediatrics. I have a son as well and I use it to take my child. Thinking of other specialities I would be concerned because I worked also in the past ten years in Chelsea & Westminster and St Mary's and I am familiar with the hospitals. I feel like they are not well-equipped to deal with some complicated problems, so I prefer to have Hammersmith as the main hospital for me, the accident and emergency. I also prefer to have accident and emergency in all hospitals. I feel if what we need is to save money, to rationalise the management of patient care and save money, I think the best way would be to create some other innovations to avoid the admission of patients to hospital. That way we can reduce the cost and to take some of the services to the community as well. Those type of things will help the burden on the hospitals.

Q. *Shaping a healthier future* would say that that is what they are doing, putting in place services out of hospital. Do you have a view about whether or not those services, if they work properly, will have an effect on the numbers of people who use the acute services or will that stay the same?
A. I think it will be helpful to have more community-based services, but I think in

practice, from my experience working in Luton Hospital, it seems like they are not engaging the clinicians or the public. It is from the top down and I would say you are forced to do these things and you have to deliver them. At the other extreme, I think the patients will be suffering. Probably bad will follow good things, but I think at the end the patient will suffer. Those will not be picked up. For me we need a transition period, as the earlier witness was saying, a transition period where we will spend more money to create some other services, even accident and emergency what she was saying was right for me. We need a transition period where we need to spend more money and to keep the other central or referral hospitals to create more capacity in those centres would be helpful.

Q. You said you have experience of Chelsea & Westminster and in your very brief statement you say that you do not think that Chelsea & Westminster is the right choice for a major hospital. Can you help us by explaining why it is that you have that view?
A. The space is limited to start with. It is not a big, huge hospital. Number two the specialty it has is limited. It does not have a diverse specialty. If you go to trauma, for example, after a car accident, trauma could be just a bone or it could be involving the head and neck. You may need more than one specialty to carry out complicated surgery. What I feel is a bigger hospital is needed as well to back up to provide a good service.

Q. Have I got this right, are you saying that the physical size of Chelsea & Westminster and the site?
A. Is one of the limits, yes, and the second is the specialities it has as well are limited. Because of the space they do not have a lot of specialities.

Q. But presumably are you saying that the size means that you could not build extra space in to accommodate more specialities, so that is the limit?
A. One of the things probably, yes, probably. At St Mary's, for example, they have got a variety of specialities, from my experience, and the space is there as well. I do not know if we will have to move the services to Chelsea & Westminster, is it needed, I do not know, but why not at least stay in Hammersmith or why do you not keep them in St Mary's?

Q. Coming to that, there is a shift of services towards Chelsea & Westminster and a shift of services toward St Mary's. Do you have a view about what the impact is going to be on the communities that are furthest away from those hospitals? Can you help us with that?
A. I have got a concern on that as well. I think one of the earlier witnesses was saying, I do not know the area around here, I live in the Shepherds Bush area, but geography is one of the constraints. I come from Ethiopia where there is no hospital, but even if there is a hospital in some areas there is a big barrier. It is not just a physical presence of a hospital. Sometimes you have to remove barriers. One of the barriers might be community as well. People going to have treatment at Chelsea, I do not know whether they will be comfortable. It is a different population I think and we have to take all these things into consideration as well at the end of the day.

Q. Are you saying that it would be difficult for communities who are not comfortable perhaps in Chelsea & Westminster to go to that area and are you saying that that would dissuade them?

A. I think there is every possibility, yes. The availability of car parking is another issue as well, transportation; it is not easy to get from here to Chelsea.

Q. So what do you think in terms of the fact that the proposal is to have four less accident and emergencies and for a reduction in bed spaces, what do you say should happen? Is that the right way forward or not?

A. No, I believe the other way. One good example, my background is infectious diseases. I like to have more capacity, more beds, even if they are empty because I do not want to put a patient in straight after we kick out another one, we need minutes and hours to clean those beds, and when you do not have the spare capacity, as we have seen at this time, I think it will cause a disaster, cause a problem. The best thing would be to have spare capacity in beds. I think that is an essential thing.

Q. Do you think that spare capacity is something that can be afforded?

A. I think we cannot afford it the other way as well. Sometimes we could have outbreaks. Essentially, this is our problem in our hospital. Sometimes we could have norovirus or some flu outbreak and when you have it in the ward, to get that ward back to work is really, really very hard. It may take weeks. I think it is very, very difficult. We had last year in our hospital an outbreak in the neonatal unit and we had to close it for a week or two weeks. At the time mothers were forced to go to other hospitals, like another geographical area, another town. If we had the capacity of spare rooms, we could have provided the service but because we did not have a space we had to move these people and I think it causes a lot of problems. The implications and impact are very high.

Q. So are you saying, have I got this right, that spare capacity is not really spare; it is the essential safety valve in the system? Is that right?

A. I mean rooms like physical units or rooms. When people have got infections and come into the hospital they have to be isolated. If you do not isolate them they will transmit the infection to another patient who comes with another complicated problem, so it will be a problem.

Q. Finally, are there any other pieces of information in relation to North West London healthcare delivery that you feel would assist the Commission?

A. I think what I can say is two things. It might be a good idea to review things like that, but the thing is you have to consult with the clinician. When I say clinician, not the superior one like the professors, but if you go to the ones who do the work, that will be very helpful. Number one. Number two, if you fully engage with the community that is very, very helpful. The other thing is to think about a transition period as well. If you move everything next year it does not work and I think the patients will suffer so you have to take it like in a transition period where you will spend more money to continue the service. Like in Ealing, if you were to close it, instead of closing it now, to plan to close it after five years but in the meantime to spend money to increase the capacity for the other hospitals. Those types of things will be helpful.

Q. One matter I forgot to ask you about, I should have asked you at the beginning, as a resident how aware were you of the consultation process going on around the reconfiguration?

A. I have not heard that. I always see people in Hammersmith campaigning to save the hospital but not the other way.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much for your presentation. Just one question from me. In light of your observations about the need for backup, what is your view about the centralisation and co-location of specialisms, which is one of the concepts we come across regularly in this reconfiguration?
A. I believe those will work for cardiac centres. It will be helpful there, I think, but not for the general routine problems. I think it could be very, very helpful. I heard a good documentary on Radio Four, I think one time, about the Indian experience of doing cardiac surgery. What they do is do cases continually and people come one way and they operate and the trainees are excellent as well because they got a lot of opportunity. Those types of things improve the quality of care as well. But I would not make it general like that. It might be good for some things for transplants and cardiac care and other coronary problems I think it would be excellent.

THE CHAIRMAN: It is very kind of you to attend today. Thank you very much.

The Witness Withdrew

MS CHRISTINE VIGARS, Chair, Healthwatch Central West London.

Examined by MS RENSTEN

Q. MS RENSTEN: Could you give the Commission your full name, professional address and current role?
A. (Ms Vigars): I am Christine Vigars. I am a resident of Kensington & Chelsea but the professional address is the Healthwatch offices, 85 Barlby Road W10. I am Chair of Healthwatch Central West London which covers the three boroughs of Westminster, Kensington & Chelsea and Hammersmith & Fulham.

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

Q. I wanted to ask first a little bit about the role of Healthwatch which, as I understand it, has a statutory function?
A. Yes.

Q. By whom is it funded?
A. It is funded by the local authority from money which comes through as part of the Department of Health grant.

Q. And when you say the local authority, in your case do you mean the three local authorities?

A. The three local authorities, yes.

Q. Is part of your function to offer challenge to proposals that are put forward?
A. Yes. We see ourselves as a critical friend.

Q. So when you begin by saying: "Healthwatch supports the principles underlying *Shaping a healthier future*" do I take it from that that the challenges that you offer are to the manner in which the programme is being implemented rather than to the existence of the programme itself?
A. Yes.

Q. Does that circumscribe your remit at all and your independence?
A. I do not think so. Our job, our main concern is around the communication and engagement, or lack of it, that there has been on this programme. We have been involved all the way along. We have been involved as part of the patient and public reference group when we were part of LINk and then more recently as Healthwatch, so we have had sight of all the proposals as they come forward, but we feel that the process of engagement with the public has been very lacking.

Q. I am going to come to that. What I wanted to ask you about first is this; given that *Shaping a healthier future* is not a body or organisation itself, is it, so to whom do you report?
A. In what sense?

Q. In the sense of your findings about matters, in the sense if you have something which is not going correctly or you wish something to be done in a different way, to whom do you take those concerns?
A. We take them to the Overview and Scrutiny Committees in the three boroughs and we can escalate any concerns we have to Healthwatch England and to the Care Quality Commission.

Q. Do you have any direct links and working relationships with the CCGs?
A. We work collaboratively with the CCGs. We have membership on the Quality, Patient Safety and Risk Committees of Hammersmith & Fulham and Kensington & Chelsea.

Q. And who decides what work you undertake?
A. We decide that. We have a specification obviously because we are funded on contract by the Council, but within that we work as a work programme every year.

Q. I wondered if I could just ask about something, it is at page 744 of your submission. One of the things that you say, it is paragraph 8.2 you are just talking about St Mary's and you say "Will SaHF also give assurances" that X, Y and Z is the case. What I wanted to ask you if SaHF is not a body and does not exist how is it that you say that SaHF can give assurances? I was just curious about that.
A. It is being managed by North West London.

Q. From whom should the assurance come, I suppose is the question I am asking?
A. Actually I think on that one the assurance has to come from Imperial because it is

A their estate, it is their hospital.

Q. So in fact SaHF cannot give assurances because SaHF does not exist as an entity?
A. It does not actually have control of the budget and the estate.

Q. You were also talking briefly about the input that you have in various bodies and you mentioned I think that you had the input of patient representation groups, transport groups
B and were on the NHS North West London Outline Business Case working group, is that correct?
A. Yes.

Q. If you want to have a look at it, it is page 739 which is where you set this out. It is at paragraph 1.3 and what you say there you are just listing the bodies you have involvement with. What I wanted to ask you about in terms of the outline business case, if you are on
C that working group can you throw any light on why it has not been provided yet?
A. No is the answer to that.

Q. Any discussion about it? Any hints? Anything that might assist the Commission or a complete blank on that?
A. That is not something I sit on myself and I am afraid I really cannot answer that one.

D Q. As a body involved in a scrutiny function, effectively, would you expect to have seen the business case? Would you expect to have more information than you do have?
A. We would expect to see it in due course but I cannot say exactly when.

Q. Would you wish to be able to see it?
A. Yes, we would wish to be able to see it.

E Q. I want to ask you about the consultation process. You raise some difficulties with that. First of all, in your view, did the consultation reach everyone it should have done?
A. Do you mean the initial consultation?

Q. The initial consultation, yes?
A. You are never going to reach everybody. It was quite widespread in terms of the
F leaflet drop. I think the main issue was that it was limited in the extent of what was being consulted on. It was mainly about which should be the major hospitals. It did not really ask the prior question about is this a sensible way to go forward and it did not go at all into what would happen once that decision had been made.

Q. Do you think it should have been more open in the ambit of what was being asked?
A. I think it would have been helpful if it had been, but I think the main point is going
G forward from that there needs to be an ongoing process, and that is what I think we feel has not really been happening.

Q. Can you expand on that a little bit more and explain what you think is lacking?
A. When the proposals went to the Independent Review Panel they said that there needed to be a shift in emphasis from telling people what was going to happen to an active engagement with the community in order to co-design the services, and that is the shift
H that we would like to see happening because a lot of what has been happening has really

been about telling people who are already very confused. But there has not been an ongoing process of consulting with the community and there have been very confused messages coming out about what is going to happen.

Q. Is that something you as a body have tried to raise?
A. Yes.

Q. What response have you been met with?
A. We have raised it in a number of ways. We as a body have been running an out of hospital group which has met ten times over the last year or so and has been looking at the out of hospital proposals in some detail. We have also held two larger meetings which have been attended by about 40 or 50 people, one addressed by Imperial and one addressed by the CCG. So that was an opportunity for the public to actually ask their questions. But what is needed is a much more joined-up approach because at the moment the consultation is being run partly by the CCG, partly by Imperial, partly by the SaHF team and to an extent there is an interest from the Council as well, so that all those bodies have an interest in consultation and there is not any attempt to bring that all together.

Q. So bearing that in mind, overall are you satisfied that that has been a fair process?
A. No, I am not. I think it has been very slow getting off the ground and I think that there is a lot more work that needs to be happening. In some ways some of that is beginning to happen. There is some progress being made with Imperial around their consultation plans and also with Hammersmith & Fulham CCG, we have had constructive conversations with both of those, but there needs to be much more outreach to the black and minority ethic communities, much more consideration of how you produce materials for people with learning disabilities and in community languages. All of these things really were not integrated as well as they could have been into the consultation around the closure of Hammersmith Hospital A&E.

Q. If the consultation process has not been a fair one, how does that sit with your support for the principle of these reconfigurations?
A. We support the principle and what we are supportive of, we have had a lot of conversations with clinicians who have put the clinical case for this and they are quite clear that we will get better services if we have more specialised centres and better out of hospital services. We know that our emergency admissions over the three boroughs are very high. I have a background of working in older people's services and I have a background with Age UK. I know that hospitals are not the best place for older people and they would be much better served by better community services, so those are the principles that we are supporting.

Q. I wanted to ask you about the out of hospital strategy. At page 740 of your submission what you say is that as a body you are not clear about what has happened to services which have moved out of hospitals over the last two years. I wondered if you could give an example of this?
A. At the moment the movement of out of hospital services under whole systems is in its very early stages. We are not looking at large numbers. But for instance the work that was done around the virtual ward in Hammersmith & Fulham was very good, we are told, but there has not been the time to evaluate that before we move forward, and, at the moment, the Community Independence Service which is coming in across the three

boroughs is just at the point of being rolled out so it is a question, I think, of timing. It seems to us and we always argued from the beginning that the out of hospital services had to be in place before there was a loss of any hospital beds, and that, as a principle, was accepted. However, there has not yet been time to see whether these out of hospital services are really effective before we begin to pull back on the number of beds.

Q. So what needs to be put in place and how long will it take to assess whether those services are actually delivering what they say they are going to deliver?
A. You need an evaluation programme which looks both at the metrics but also at patient experience.

Q. And to your knowledge is there one of those in place?
A. There will be. There are plans to get that in place, but it has not happened yet, so it is a question of timing.

Q. So is there a danger of the timing becoming dislocated and the services being rolled out before the evidence base for them is in place?
A. That is our worry.

Q. I wanted to ask you about GP services as well. Are you able to comment on the readiness of GP practices for the extended role which is envisaged for them?
A. I think it is very varied. We have feedback from our members, not surprisingly, about the difficulty in getting GP appointments, so obviously GPs are under extreme pressure, as the lady was saying earlier. However, some GPs have been very involved in the development of the whole systems work and are very committed to it. The one that I know best, which is West London CCG, there has been a sign-up of about half the practices to take on the extra role of providing out of hospital care for older people which will change their workload. It is also a question of funding. I do not really understand the GP funding but it is a question of how the money is actually shifted so that they are reimbursed properly for the time that they give to these extra or different duties.

Q. So I presume on that basis you are unable to help with whether or not those GPs who have signed up actually have the resources?
A. That is a question I cannot answer.

Q. I wanted to ask you about another service which is supposed to underpin the out of hospital strategy and this is the 111 service? I am not quite sure how much engagement your body has had with that. If you have, can you tell us how it is working as far as you know?
A. We have not had much engagement. What we did do last year was a piece of work in Hammersmith & Fulham where we surveyed about 140 residents and had focus groups which covered another 80 residents. This was asking about their understanding about 111 and urgent care centres and the services on offer. About half the people we surveyed did not know anything about the 111 service and 60% of them did not know what an urgent care centre was.

Q. Bearing in mind that it is quite a small snapshot, what do you draw from that?
A. It is a small snapshot, but it resonates with what we hear from other people. I think that there is an urgent piece of public education or patient education that needs to happen

about what an urgent care centre is and what the 111 service is. On the urgent care centre there was then a leaflet that went round to everybody - not everybody but everybody in the Hammersmith area. That really was not very clear. People found it very unclear because it said things like you take a minor injury to an urgent care centre and nobody knew what a minor injury was and it was not clear whether you also took children or whether it was just for adults. There were gaps in it, there were things that were not mentioned so the Parsons Green Walk-In Centre was not mentioned, So that piece of information was not clear. There is a need for clearer, more focused information.

Q. Bearing in mind that you were aware of that lack, what did your body do to take that back to the people who needed to know that information?
A. We took that one back to the CCG. Unfortunately, that particular leaflet was not shared with the patient reference group in advance. I think that it is difficult for people to move out of NHS speak and to think about what this actually is going to look like and mean to patients.

Q. And what does your body say about co-location of urgent care centres with A&Es? What is your view on that?
A. I think it is largely a clinical question.

Q. Perhaps if we look at it from a slightly different perspective. What do the people with whom you have been consulting, and by this I mean the local population, what do they say to you, what do they understand about the possibility that there may be an urgent care centre which does not have an A&E at the same site?
A. I think the particular worry that has been raised with us has been around children and there seem to be rather mixed messages about that at Hammersmith Urgent Care Centre.

Q. Coming from whom?
A. Coming from the people who are attending our groups, the public. The questions are coming from them. The mixed messages are coming from the responses. Hammersmith Urgent Care Centre deals with children. However, at one of our groups this question was asked to a consultant from St Mary's, he said, "If you have a sick child always take it to A&E." So there are two different messages here.

Q. What do you say the impact of those mixed messages, those two different messages are likely to be?
A. I think it is very worrying. It is worrying for the individuals but it is worrying in terms of safety because people with a sick child do not call an ambulance, they put the child in the car and take it to wherever.

Q. Given these are concerns, I think your document dates from last year in fact, the main body of the document, given that these were concerns that you were raising then, have things changed? Have you had any positive changes noted or are they still the same?
A. I think some things have changed. I think we are developing as from Healthwatch a much better relationship with Imperial, and I think that Imperial are beginning to put in place a programme of consultation in which they will actually get the consultant clinicians out into the community to talk with people.

Q. Are you able to give us a little more detail about that?

A. What we said to Imperial was that they needed to think about pathways, because that is what worries people. If you have experience of someone who has had a stroke or you are the parent of a child or you are contemplating having a knee operation, you need to know actually how that care is going to be delivered and where. We said to Imperial that what you need to do is to actually come out and talk people through what is actually going to happen and where the care is going to be delivered because another issue has been the uncertainty about what was going to happen to elective surgery because originally it was said that that was going to go to Charing Cross and then the Imperial clinical strategy made it quite clear that elective surgery was going to go to Central Middlesex. We have had no answers really to the questions about what is the impact of that on transport and on the pathway because with orthopaedic surgery we are told the most important thing - and it is obvious - is that the operation is successful. The second most important thing is that you get rehabilitative services. So that is what matters to people.

Q. Two questions in one: does it concern you, one, that you have not had the answers about that and, two, does it concern you that it is only now that Imperial are sorting out a consultation of the sort which I must say perhaps one would have thought was rather more obvious? What concerns do you have about that, if any?
A. I think it is late. I think our experience is that very often consultation is something that is left to the last moment. People do not think about it at the beginning and you need to think about it right the way through.

Q. What is the implication of leaving the public behind in terms of information?
A. The rapport because particularly in Hammersmith & Fulham there are many, many people who have a deep loyalty to Charing Cross Hospital, are committed to it and want to see it continuing. Many of these people are our members and it seems to us that this is a passion that could be utilised positively and constructively, but if it is not you risk getting into a much more confrontational situation.

Q. I wanted to ask you about the impact of the A&E closures which have already taken place. You asked for assurances about the ability of St Mary's and Chelsea & Westminster to cope. Have you had those assurances?
A. Yes, they say that they can cope. We raised this at scrutiny. St Mary's have recently employed six extra A&E consultants. However, I suppose that is on the positive side. On the worrying side, the recent CQC inspection at St Mary's, the original inspection report was extremely critical of the A&E service there. The re-visit said that it was now satisfactory, but it is worrying that a major hospital should allow its A&E to get into the state when it was failed by a CQC inspection.

Q. We know that there were difficulties in waiting times and beating the four-hour target. Do you have any information on a very up-to-date basis coming into the spring from the winter that there has been any particular change in meeting those targets or not?
A. Yes. As you know, the waiting times were very bad over the winter period. They are now beginning to come back a bit but they are still not really up to where they should be.

Q. Do you know whether they are still above the national average or below the national average?
A. I could not tell you. I do not have that to hand.

Q. Just moving on to think about the hyper-acute stroke unit that is moving to St Mary's. Does your body have a view about having two hyper-acute stroke units very close to one another (because of course the other one is at UCH) and the impact on the wider population of the region? I wonder if you can help us with that.
A. That is something also that we have raised because it seemed it was something that needed to be looked at not just on a North West London basis but on an across London basis, both in terms of where people were likely to come from and what the patient choice was on that.

Q. What does your body say about that? Broadly speaking is it a decision you support or is it one where you say the HASU should remain where it is?
A. The whole thing is inter-connected. Again, there is a clinical case for having the hyper-acute stroke unit and the trauma unit in the same place. However, we did have assurances that the hyper-acute stroke unit would not move until the St Mary's redevelopment had been done, and one does not know when that is going to happen.

Q. So is there quite a substantial degree of uncertainty about it?
A. A great deal of uncertainty about it.

Q. What impact does that have upon the people in the locality, the uncertainty rather than the actual changes?
A. It is all part of not taking the public with us, because if there is uncertainty about that, and uncertainty about elective surgery and uncertainty about what is actually going to go onto the Charing Cross site, people get frustrated and if they are frustrated they get angry.

Q. I just wanted to ask you a little bit about transport. Not blue light transport but other transport. Are you able to help with what liaison has gone on between the CCGs, the trusts and Transport for London and, if so, what the state of play is?
A. I cannot help you with the state of play. There is the Transport Advisory Group which has been looking at that and has been in conversation with Transport for London.

Q. Do you know if those conversations have actually produced anything?
A. I think not, but, again, I would have to check that one.

Q. Is that something that if it continues to be the case then presumably the Transport Advisory Group needs to tell somebody that is the case? Again, to whom would they report and what should be done with that information?
A. Another avenue I suppose is to the Mayor, if we are talking about transport.

Q. Do you regard transport as critical?
A. Absolutely critical.

Q. So if the transport links are not in place between the various hospitals and the out of hospital provision, if the reforms are done in isolation, if you like, without that element being in place, what is the impact?
A. I think it will have a terrible impact, particularly on Hammersmith, well on all the North West London outer boroughs as well, but in our patch on Hammersmith because that is where the transport links are not good at the moment; otherwise they are quite

good. The other part to put into that is hospital transport, which is very poor. That is an issue that through our Enter and View work, our Dignity Champions work we have raised consistently with Imperial and, actually, the people who need hospital transport can wait for hours for it.

Q. You have raised it consistently with Imperial. Are you able to say whether your raising of it has again produced any positive results?
A. They are looking at the contract. It is out to contract so they are looking at it.

Q. It is at that stage again, still a degree of uncertainty?
A. Yes.

Q. Just bearing in mind all that you have said, at the outset of your submissions what you say is that you recommend no further progress is made until the issues and questions that you had raised have been resolved?
A. Yes.

Q. Does that remain your position today?
A. Yes and no. I think that in some ways there are some things that have gone so far that it is dangerous not to continue with them. So some of these issues have to be resolved and have to be resolved quickly and the out of hospital services have to be in place before we lose the beds. Yes, that is our position with I suppose the slight reservation about if the thing has gone so far that it is not safe to stop it, are you better to go on with it, but that is not a judgment I can make.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you and good afternoon. I am concerned to know from you, it is in a sense the role of Healthwatch and who exactly you are representing. I have got two questions that relate to that. The first is this: to what extent does Healthwatch present the public with a balanced picture of proposals such as the plans that we have been talking about, in other words, provide the public with the pros and cons relating to for example the closure of an A&E? Do you present the various aspects and sides of that argument? Secondly, where the public display opposition to a closure, do you represent that opposition or objection? The reason I ask that is in the documents we have been provided with I do not see any reference to opposition. There are a lot of reservations and a lot of questions but no principled opposition seems to be reflected here. That is the reason for these questions and I wonder if you could answer that.
A. Yes. I can take the second one first. We have a role in representing our members and we have 6,000 members across the three boroughs so they are not going to have a uniform view and among those members are a whole range of different groups as well as individuals. So we will canvas views from our members and we will put those forward. It very often is that there will be diverse views and we will put them both forward.

Q. I understand that, but we do not see here, I do not see here both. We only see one view which is support for the programme with reservations and you have spelt them out

here. Questions have to be answered. Do not close certain services before you put others in place. All sorts of obvious questions. But I do not see any critique. We have heard witnesses who say "We are opposed to these plans" and, if that is right, they must be out there amongst your 6,000. If they are, why are they not reflected in your report?
A. I think that we take a view on what we hear and on the balance of all that is coming in - and remember we have got three boroughs to think about - we then take a view and we reach a position. This statement that you have was discussed in all three boroughs by the local committees, and there are about 16 people on each of those local boards, and it was thrashed around and amended and so forth and so on, so it is not something that I and the Chief Executives sit down and think about and think what should we do. It has been very thoroughly discussed and this is what we came up with.

Q. DR HIRST: Could I develop that a little bit? There has been plenty of discussion on the NHS in England and I see there is a column in which Healthwatch appears along with the Care Quality Commission and Monitor and the Trust Development Authority which is monitoring and regulation. I am just thinking the Care Quality Commission judges practices and other organisations on something they call the key lines of enquiry which are safety, effectiveness, caring and are they well led and relevant. I am just wondering if you were to apply those key lines of enquiry to the whole project whether you would have to say - and I am a CQC adviser so I ought to know this off by heart - is it outstanding, is it good, does it need improvement or is it failing? Where would you put it?
A. We are very familiar with them because we do a lot of interim reviews and are assessing establishments and services on those lines. I am not certain you can apply it to the whole project. You could certainly apply it to bits of it and if we do an interim review, for example of maternity services after they have moved from Ealing, we will do exactly that.

Q. If they have moved it, it is a bit late, is it not?
A. Yes, exactly.

Q. If you find that they are caring, which I have every reason to believe they are, and they are well led, which certainly they are, they are relevant, we have heard that, they are effective and I think they are safe. I am going off down a hobbyhorse of mine. Can I just develop again a bit further, I do not understand where the locus of control is, to use a jargon term, in respect of SaHF. Earlier you were trying to explore that for us, but if you have your monitoring and regulation hat on, to whom do you go to say "Up with this we shall not put"?
A. That is very clear. We go locally to the Overview and Scrutiny Committee and nationally to the Care Quality Commission and to Healthwatch England.

Q. I notice the black line that goes up to the Department of Health.
A. Via Healthwatch England and the CQC.

Q. So if you go to Healthwatch England and you say - I am not saying you think this but say you did think this - "Something terrible is going to happen", will Healthwatch England go to the Department of Health and say, "Something terrible is going to happen"?
A. Yes, they would.

Q. Is there a mechanism?
A. There is a mechanism for that. There is an escalation process and there is the protocol that we have to fill in. We then escalate it. I was on the Healthwatch England Committee for a year so I know how it works at that end. That is all gathered together and the key issues that have been escalated are brought to the Committee and they take a decision what they are going to do with them and then they feed it back to the local Healthwatch. So there is a process.

Q. It perhaps jokingly came out from one witness last week that this thing is almost like a cult. It is operating like a cult where people begin to believe in the project. I used the phrase "cognitive dissonance" where people just ignore evidence. In fact, interestingly, I see you express dissatisfaction in part of your evidence that you would go to meetings where people were not prepared or able to give you answers?
A. Yes.

Q. Except that they seemed to believe in the project. I notice also that you make some very trenchant objections under accessibility, effectiveness, reach, clarity, effectiveness again. Having regard to those concerns, is it possible for you to change minds or will it ever be possible to change minds?
A. I think that Healthwatch is a young organisation and that we are making quite a lot of progress in changing things, but it is a big ask.

Q. I am sorry to keep pushing this but if you push this a little bit further, I appreciate that you are a young organisation, you do not have the political pull, et cetera, but you are an observer and you have an understanding of the system. Who has the power then to make people change their minds in the face of ---
A. The Department of Health, NHS England and the Department of Health.

Q. NHS England? So if we were able to persuade NHS England you think that is something that might happen?
A. Yes.

Q. You have faith in that?
A. You have got to have faith in something.

Q. DR LISTER: You referred several times to 6,000 members. Do you regard that the structure of Healthwatch is based on that membership not on the views of the wider community around it? It is basically for those members to decide?
A. Both. Every Healthwatch is different. We are actually a membership organisation and so we put a lot of work into recruiting and training and supporting our members, some of whom then take on roles within the quality and monitoring process. But we also go out to the wider population, yes, and all our meetings are open, so when I say that we gather 50 to a meeting some of those will be members but it could be anybody. They are public meetings.

Q. But when it comes to shaping up your responses it is the members that you go to and those on the various bodies that you would go to?
A. Yes.

Q. And I am also curious, you do mention that Healthwatches are different, differently composed and work differently. Is there any way in which you co-ordinate together? We had Ealing Healthwatch last week who obviously were putting things from a rather different point of view than you are. Do you have any co-ordination between you, any discussion?
A. We do. There is a regular meeting of the eight North West London Healthwatches, yes. And we are all members of the public and patient reference group for the SaHF so we get the same information and we share it and we talk about it.

Q. It would appear you are rather more on the critical edge of things than Ealing colleagues who appear to be much less happy to criticise what is going on.
A. Every Healthwatch is different.

Q. Just one completely unrelated question, but going back to earlier points. You say that it is worrying that 60% of people did not know what an urgent care centre was or what the difference was between that and an A&E. Do you think it is helpful or unhelpful for those promoting this process, including politicians at parliamentary and local level, to argue that in fact what is going to be replacing Charing Cross Hospital facilities at the moment is an A&E? They do actually argue it is an A&E although clearly what they have got planned is an urgent care centre.
A. Exactly. This is an example of the double speak which is exactly what I think is really worrying because nobody knows what is going to happen at Charing Cross. Is it an emergency centre, an A&E or an urgent care centre?

Q. You have brought another one into play now, an emergency centre.
A. That is what the clinical strategy says it is, it is going to be an emergency centre.

Q. That seems to be outside of all the characteristics that are defined by Bruce Keogh in his analysis. So they are proposing something completely different?
A. No, I think they are proposing the same thing but it is not just a question of terminology; it is what is actually going to be provided at Charing Cross. And local people rely on Charing Cross and are used to going there, so they need to know.

Q. If they listen, for example, to Jeremy Hunt saying that there will be accident and emergency unit there and they turn up and find that it is an urgent care centre, is that not a potentially dangerous error?
A. Yes, absolutely.

Q. So are you raising this with the politicians? It would help life for you and for the local public if people said what was actually going on rather than using misleading terms?
A. But at the moment we are all being told that we are waiting for the Keogh Review and we have been waiting for it forever, so we are not getting very far with this one.

THE CHAIRMAN: Thank you very much for your time.

<u>The Witness Withdrew</u>

MR PHILLIP BROWNLEY ELDRIDGE, Isleworth resident and patient representative on Hounslow and North West London CCG.

Examined by MS RENSTEN

Q. MS RENSTEN: Would you kindly give the Commission your full name and address, please?
A. (Mr Brownley Eldridge): My name is Phillip Brownley Eldridge. I reside in the London Borough of Hounslow.

Q. And you have provided a statement?
A. I have indeed.

Q. Can you confirm that the contents of that statement are true to the best of your knowledge and understanding and that you wish them to stand as your evidence to the Commission?
A. I wish them to stand as my evidence to the Commission.

Q. First of all, as I understand it, you have a dual role as both a patient and a patient representative; is that correct?
A. That's correct.

Q. First of all, in your patient rather than representative role, can you tell us about your experience at West Middlesex University Hospital, please?
A. Yes, I am in the renal clinic there run by Imperial Healthcare and I go every three months, I have a blood test and I visit the renal specialist nurse. On 15 June, I met her last year and she indicated to me that my lipids were so out of control that they had completely blotted out the blood test that I had taken so they could not take any readings from it whatsoever. She then put me in contact with the lipid clinic. A letter was sent to my GP and I was meant to be contacted about one or both of these for a review. Nothing happened and on 20 September I flew to Malaga and checked into the Costa del Sol Hospital because I have joint social security in Spain as well and they confirmed that I had the usual problems that a 20-year diabetic would have.

Q. What do you say that tells you about communication between the services here?
A. Negligable, non-existent.

Q. Is that something, because I am presuming you have had contact with services over some years, which has happened in the past or is it a more recent development?
A. In my opinion, it has got worse since 2010.

Q. What do you say should be done to remedy it?
A. Well, there appears to be constant change going on and the providers of services sometimes fail to deliver what they are being paid for, particularly Hounslow & Richmond Community Healthcare, in the sense that there was no diabetic specialist nurse at West Middlesex University Hospital as there was meant to be and for which they received payment for over 93 days last year.

Q. You say 93 days and that is a very precise figure. Where does that come from?
A. It comes from my observations. As I go through clinics, I spend a fair amount of my time there and I get to know staff and I talk to them and I ask them questions that enable

me to have an informed opinion as to what is going on.

Q. I would like to ask you a little bit more about your experience on the patient representatives groups. First of all, can you explain what your role was on these panels and whether you were involved in any decision-making functions?
A. I first started with the London Borough of Hounslow in 2011 when they tendered for public health provision and some of the officers involved in the London Borough of Hounslow transferred to the Hounslow Clinical Commissioning Group which took over the role of Hounslow Primary Care Trust. One of the staff contacted me and asked me if I would like to be on a tender panel system and I volunteered. I was put on a patient and carer education programme for four months as well to enable me to fully understand how the NHS works.

Q. You say that you were involved in a number of panels and one of them you set out is the urgent care centre panel, is that correct?
A. Yes.

Q. Can you tell us what that looked at and how effective it was?
A. It sought tenders from interested parties to provide an urgent care centre attached to the West Middlesex A&E. Our role was to receive a bundle of documents from each potential what they call the pre-qualifying questionnaire stage and from that would be chosen those who could go through to an invitation to tender, or the ITC stage. It was very much based on an examination of documents and then asking representatives from the various institutions to come to us and explain their policy. From both the London Borough of Hounslow and Hounslow Clinical Commissioning Group there was very little concrete evidence. If I say on one project which was the outs-of-hours GP service, I received at the ITT stage 960 pages of documentation relating to four bids. What happens is that the bid process appears to be that you have to put in the correct statements, like you are all in favour of *Shaping a healthier future*, you will be kind to your staff, you will have multilingual facilities and you will engage in career development, and it appeared to be just this. In hundreds of pages there was never any attempt made to determine as to whether or not what they were saying was actually true.

Q. Pause there a moment, are you saying that that was specific to one particular tendering process or is that something that you say went across the board in a number of the tendering processes?
A. It goes across the board because the Clinical Commissioning Group in particular is not interested in judging whether or not the winner of the bid is suitable on the basis of their prior actions on other contracts.

Q. You say that there was a lack of expertise and experience among the CCGs in dealing with procurement and tendering. Is that something that you discerned from your observations or did you make specific enquiries as to whether people had the relevant skill sets?
A. It came from observations. When I was a younger person I was a management accountant in a company that supplied the automotive industry and when we wanted to supply £5,000 worth of goods we were subject to a three-man team from the Ford Motor Company who would take our enterprise apart. When I was sat on these panels we had people who were sitting on the panels giving us advice, I would refer to the Diabetic

Intermediate Care Panel, which first started in 2013 and finally finished in December 2014. The reason for that was that the management accountants and the NHS employees were unable to comprehend that the TUPE provisions ---

Q. Pause there a moment, for anyone who does not know, can you just tell us what that acronym is?
A. Transfer of Undertakings Provisions. It means that people who are in a business that is transferred to another owner or operator have their benefits and rights carried across to the new employer. We went through a process of pre-questionnaire qualification and that was it and then we were going to discuss who we were going to have at the invitation to tender stage, and we were called into a meeting at 5.30 at night, were told that it was highly hush-hush, secret and we must not mention it. The entire contract had collapsed because the financial expert who was employed by Hounslow Clinical Commissioning Group had forgotten about the TUPE provisions which meant that only the incumbent could win the contract.

Q. Pause there a moment, are you able to recall which financial consultant that was?
A. That was a gentleman called Mr Quentin Symington.

Q. Are you able to say on what basis his expertise was sought?
A. He has one of those histories. I did a case study on him and it came to 13 pages. He is employed at multiple Clinical Commissioning Groups, it would appear, all over South West Surrey and the Home Counties. His advice was sought, it was erroneous and I am rather surprised given his history of working for NHS England.

Q. Are you able to help with whether or not anyone who was on the panels that you were on had enough knowledge about tendering processes to know whether or not the advice they were being given by outside consultants was sound or not?
A. No, the man in overall charge of it was an interim manager which means he is part of the NHS warehousing system and he is moved in and out of locations. The rest of the panel there appeared to be some, I am not being derogatory here, office staff who had low level skills. They were very good probably on Excel and Word but nobody had had any experience in the private sector and what they were trying to do was to imitate the private sector.

Q. In your role did you have any decision-making power or were you there in an observing capacity?
A. Allegedly, according to the standing orders of Hounslow Clinical Commissioning Group, we have to be present to make any decision valid. I found out very shortly that as a patient representative I was only given part of the tender. I was not given anything relating to finance, staffing, IT systems, all of these areas, and, as I pointed out to the Managing Director of Hounslow Clinical Commissioning Group, had I been shown the financials I could pointed out to them that they had a problem with TUPE.

Q. Did you ask why you were not given that documentation?
A. We were considered not able to discuss it. We could not bring the right approach. I would like to make reference to a further matter. I tried to get the performance of the incumbent of the Diabetic Intermediate Care Service and I asked the Managing Director and the Chairman of Hounslow Clinical Commissioning Group for the actual figures of

how they were performing on a monthly basis, because they had to report to the Hounslow Clinical Commissioning Group on a monthly basis with a series of key performance indicators. This I started asking last May 2014 and I finally received them in March 2015 when I served a Freedom of Information Act request on Hounslow & Richmond Community Healthcare. They were adverse responses in many areas and this I thought was essential information that should have been provided so that we could so design the tender to avoid this happening again.

Q. Are you able to help with where that particular tendering process has got to?
A. Yes, a new contract has been awarded and they start, I believe, 1 May.

Q. Do you know or are you able to help with whether or not you feel that is an appropriate appointment or not?
A. We have specific problems in the London Borough of Hounslow. My concerns about the contract are that I feel very much like hostages who are put on the front of a train to stop the guerilla fighters blowing it up and I was a fig leaf, a way of pandering to the need to consult with the patients, given if you have read Francis I and II, patients first and foremost, there should have been a greater patient involvement and role in deciding, but I was actually removed from another tender panel on the instructions of the interim manager.

Q. Can you explain the basis on which you understood your removal to have occurred?
A. I was appointed to the panel to provide out-of-hours GP services for both the London Borough of Ealing and the London Borough of Hounslow. This started in 2013 and in March 2014 I attended a meeting on 31 March at 12.30 to be informed by the interim manager that she was going to Australia for a month's holiday and it was cancelled so I did suggest to her that it would have been nice to have been informed prior to making the journey. I then heard nothing more, absolutely nothing, until I was in the Lambton Centre here at the Civic Centre and the same interim manager walked up to me with a piece of paper and said, "I need you on 21 and 22 August to attend the tender panel on the out-of-hours GP services." This is when I received just over 1,000 pages to read in 15 emails and 129 files. I had concerns about it and at the meeting interim commissioning manager actually expressed that she thought I was unrepresentative, unprofessional and should not have been in the room anyway.

Q. What then transpired that led to your removal?
A. As far as I can see, she did like anybody who had an independence of mind. I am rather a questioning person.

Q. Were you the only patient representative or were there others?
A. No, there was one from Ealing, but according to their own standing orders there has got to be one from Hounslow and one from Ealing because it was a co-commissioning.

Q. Have I got this right then, that if there was no patient representative from one borough, does it follow that a decision that was made in the absence of that patient representative was not a correctly constituted decision?
A. Yes, in my opinion, it is.

Q. Are you able to help with whether or not - and you may not - other panels proceed

either with or in the absence of patient representatives?
A. They may well have done. I have not got a complete list of how many panels they have had and who has attended them. It is interesting that the Ealing Healthwatch representative who was there remonstrated with the interim manager to say that he had brought up this issue five meetings prior.

Q. I just wanted to ask you a little about the use of outside consultants and we have touched on that already. Do you know how those consultants were chosen and who had control over the decision to bring them in?
A. That would have been down to the senior management team at Hounslow Clinical Commissioning Group. One gentleman whose company is called Mouso(?) Ltd I have met him when I was working for the London Borough of Hounslow. In fact, on the out-of-hours GP services he was acting on behalf of both Ealing Clinical Commissioning Group and Hounslow Clinical Commissioning Group, which I thought was a conflict of interest there.

Q. Are you able to say whether there was any consistency as to the outside consultants used? Were they the same for different tendering exercises or not?
A. Mouso Ltd is a household figure at Sovereign Court.

Q. Do I take it from that that they were the favoured, the preferred consultants?
A. Yes, he acted as a mediator on the scoring of each tender panel submission and I thought at the time that it gave him undue influence since he was very much prone to swinging it one way or another. It did occur to me that there were concerns about corrupt practices here.

Q. Can you expand a bit more on that, please?
A. If he has links, we do not know what his other links are. He was acting on behalf of the Hounslow Clinical Commissioning Group and he was also acting on behalf of Ealing Clinical Commissioning Group so who had the priority? Whose interests came first? It is very difficult to represent two arguments. It is like having a solicitor representing both the defendant and the claimant. It does not happen. There is a problem that these people are well established within the NHS hierarchy of individuals. They all know everybody. All the people at Hounslow Clinical Commissioning Group at the top have come from Hounslow Primary Care Trust, so they just transferred across. If you looked at the Primary Care Trust's outcomes, you would doubt the wisdom of appointing the people who drove Hounslow Primary Care Trust into the ground.

Q. Can I ask that we move on a little bit. You raised the issue of fragmentation. Can you expand for the Commission on what you say is happening and what the effect is, please?
A. The effect is that the NHS services no longer come from one source; they can come from multiple sources, and the problem is that all the service providers who tender for these all have teams of individuals who are well versed in NHS policy. They have to be familiar with Francis, patients first and foremost, safeguarding, *Shaping a healthier future*, they have to have all of these things lined up and that means that the tenderer has to have an estates department because when they come into Hounslow they may not get access to the facility like the offices, surgeries and practice areas that the incumbent has so therefore they have people who are versed in dealing with estates. They then have to link their separate IT system to Hounslow's system so there is further discussion there.

A There are complications because we do not have a universal medical records system in this country. You have System 1, you have EMIS, I believe and then in the health centres they use RiO, so every time there is a movement you are having to link different computer systems and it causes problems.

Q. Are you able to help with what it causes in terms of resources and funding?

B A. If you want to tender for an NHS contract you have to take on staff and you have got to pay them whatever the going NHS rate is otherwise they will not move to you, so what has happened is that another layer of cost has been put into the NHS in the sense of the Clinical Commissioning Groups. They have a budget level. They are not meant to spend more than £25 per person in their location per head on their administration. That adds up to quite a lot of money. The problem is of course, and I have looked at the hospital accounts and the hospitals and the hospital trusts and foundation trusts are not shedding

C staff, so in fact the cost of running the same NHS service with no increase in requirements or demand is going to be greater because of the inefficiencies of having five teams of people who go round looking at the estates provision and five teams of people who deal with IT.

Q. Finally, you talk about *Shaping a healthier future* as a Utopian policy. What do you say is wrong with having Utopian vision?

D A. Because if you go back to Thomas More, he came up with a Utopia which was an island surrounded by water where there were no other influences. Utopianism essentially is to project for a better future without any realisation that the concrete reality of the present is going to stop you achieving what you want.

Q. So in the current economic circumstances, realistically, if changes are needed, what do you say should be done?

E A. The major problem is that 70% of the NHS's revenues go to the hospitals, the secondary sector. We need to change the primary care sector because it functioned very well in the time of Dr Finlay in Tannochbrae but it no longer serves in a modern, urban environment. The reason why parents take their children to the A&E and not the GP is because they can park at the A&E, particularly at West Mid. It has a large car park. It is easy to get to. A lot of our surgeries are in residential streets in semi-detached houses. As a person with impaired vision I have an access problem there sometimes because they

F have ramps and steps, et cetera. We should have, I think, five clinical centres within the London Borough of Hounslow that people can go to and they should be manned 24/7. That is key to those functioning. It is very much to on the Spanish system of *ambulatorios* which are open 24/7 and there are doctors there, clinicians, nurses, they can do all sorts of minor surgery. It is much more effective in a modern environment.

Q. Finally, you refer to Morrisonian principles. How do you say those are applicable to

G the problems faced by the National Health Service in North West London today?

A. It has got too large. It is filled with people who are always looking at the entire region. We need people who can focus on the locality and can therefore determine what the locality's needs are. If you look at the joint strategic needs assessments which are produced by all councils, if you read the Hounslow Joint Strategic Needs Assessment, the emphasis is on diabetes. If you go to Hammersmith & Fulham their emphasis is more on liver disease and HIV/AIDS, so they are all very different. No CCG is identical in that

H sense in terms of the problems that it faces.

Q. What do you draw from that?
A. In the old days, in the times of the London County Council, LCC ran 42,000 hospital beds in the Greater London area and I think that is a better mechanism for providing healthcare to everybody in the capital rather than a select few who have the ability to get better treatment than others.

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

Examined by THE COMMISSION

Q. THE CHAIRMAN: Thank you very much. I have one question. It relates to your observations about the Hounslow CCG staffed by people with no experience of procurement or evaluating tenders. The question is this: who exactly were these people and how many of them are there?
A. The panel for the Diabetic Intermediate Care Service had about 11 or 12 individuals on it when it was fully staffed. Not all individuals turned up. There would usually be two or three doctors, GPs, who were part of the Clinical Commissioning Group and then there would be staff within the Clinical Commissioning Group. There would be a patient representative. I never saw anybody from Hounslow Healthwatch ever appear anywhere whatsoever. And that would be it. And myself, the patient representative.

THE CHAIRMAN: Thank you very much. It is very kind of you to come today.

The Witness Withdrew

MS RENSTEN: That takes us on to the last witness for this afternoon who is Dr Louise Irvine.

DR LOUISE IRVINE, Lewisham Campaign

THE CHAIRMAN: While Dr Irvine is walking to the witness stand, I am going to declare a slight interest because obviously I chaired the Lewisham Inquiry. I also want to enquire about the witness's welfare as to when she needs to get away by?

THE WITNESS: Unfortunately, I have to be at Russell Square by five as I have got to be interviewed by somebody.

THE CHAIRMAN: When would you like to leave?

THE WITNESS: Quarter past four.

THE CHAIRMAN: What I was going to suggest to counsel is we have an extensive report from you and obviously it concerns a different area of London, although many of the principles are the same. I will use a frequent phrase, I will take judicial notice of what I already know about Lewisham. I wonder if counsel could really ask you to, as it were, cherry-pick those things from Lewisham that you think apply particularly to what we are doing here in the North West of London.

THE WITNESS: Yes.

Examined by MS RENSTEN

Q. MS RENSTEN: Could I first of all ask you to give your full name, professional address and current post, please?
A. (Dr Irvine): My name is Louise Irvine. I work in the Amersham Vale Practice in the Waldron Health Centre in Lewisham and I am a GP.

Q. In front of you, you will have a document and it is your submission. Can you confirm that it is true to the best of your knowledge and understanding and you wish it to stand as your evidence to the Commission?
A. Yes, I do.

Q. As Mr Mansfield has said, your statement deals very largely with the difficulties encountered at Lewisham. Can you first of all clarify your role very briefly in that situation?
A. I am the Chair of the Save Lewisham Hospital campaign. I helped to found the campaign nearly three years ago when we heard news that the hospital was scheduled to be severely downgraded. I am still the Chair of the campaign.

Q. Extrapolating across from that, how familiar are you with the circumstances currently pertaining in North West London?
A. I am reasonably familiar because we have had quite a lot of contact with people in North West London who have recognised what happened in Lewisham and wanted to learn what they could from that situation. We recently had a member of the Save Charing Cross and Ealing Hospitals campaign in Lewisham giving a talk about some of the issues there and we were able to question her and able to see where there were parallels or overlaps and obviously where there were differences.

Q. Perhaps can we look at some of the areas and you can help with whether or not they are the same or similar or different. First of all, in terms of the consultation process that went on, we have heard from a number of witnesses saying a variety of different things, some saying it was better than others. Are you able to give us any understanding about how the process went in Lewisham and how it has gone in North West London?
A. I think the one in Lewisham was very, very rapid but the same problem even in longer consultation processes is that you are only presented with one set of arguments which is the arguments of those who are proponents of change. The consultation document in Lewisham is very long, complicated and difficult to complete. I understand that it was quite confusing also in North West London. People were given four options, but it was very difficult for people to see "none of the above", as it were. There was no attempt to put another perspective. There was lack of clear data in the consultation in Lewisham. They actually buried really vital things that were not obvious to the population in Lewisham at all. I think that it is easy to manipulate consultation processes, unfortunately. The other thing that happens is even when people contribute and respond there seems to be no mechanism to take on board the responses. Even if they are clarifying matters of fact that are wrong in the consultation document, there is no mechanism for that to ever be corrected, so I think this is an issue about consultations

everywhere.

Q. So, from your experience, if people do not feel their views have been adequately taken into account, if they do not feel that the consultation process has been fair, what impact does that have on the ability to have a proper dialogue about whether change is or is not needed?

A. It has a terrible impact on it. There was one example which was a consultation on the potential closure of the maternity at Lewisham, I know that is not an issue at Charing Cross but it is just an example, they got a group of women who were maternity users together around the table and they really harangued those women. Those women were saying, "We want to keep our maternity", and the people who were advocating the loss of the maternity were saying "Even though it might mean more deaths or even though it might mean it is more dangerous keeping your maternity?" and implying it was very dangerous and they were all foolhardy wanting to keep the maternity open, even though there was no evidence at all that there was any danger with the maternity in Lewisham. Furthermore, they then said it was just because the obstetricians wanted to keep their jobs, it was self interest, so they were feeding very negative lines to these women who were ordinary women, they were not campaigners, to try to mould and bully. The women wrote it all up immediately afterwards and it corralled them into particular positions so they were left feeling rather bruised and battered and not in the least bit as if they had really been consulted properly about their views. There was another public consultation meeting where a woman, who had actually had emergency care at Lewisham and who expressed that she wanted the hospital to keep those facilities, was spoken to so badly by one of the members of the panel that in fact Matthew Kershaw who was the Trust Special Administrator, came down afterwards and personally apologised to her for the way she had been treated, so I think people did feel rather bullied by this process.

Q. If people are not carried along, putting it bluntly, are SaHF missing a trick by actually not doing the consultation properly? Could they perhaps get a better, a more real response if it was ---

A. Of course. One of the amazing things, I am not sure if this is the same, I am just speaking from my Lewisham experience now, is that there was so much engagement in this whole process from clinicians, nurses, doctors, ordinary people throughout the community, if you saw this bubbling up of real engagement and interest, I am amazed they did not see this as an amazing resource to use to help to develop a better plan for local health services instead of trying to dismiss it and either ignore it or write it off. I think there were things pointed out, there was nothing in the consultation about changes to children's services although they represent 20% of the population. When people pointed this out, why did they not take that on board and say, "Okay, we are sorry, we realise we have made a mistake, we are going to go back and do it properly", but they did not. It was a very arrogant way to ignore the views of local people in that way.

Q. Thinking about the proposition for Lewisham which was to close it down, and of course that involved the removal of A&E services as well, translating that into North West London, what can you say about the impact of the loss of local A&E services to the population that has been using those services?

A. We calculated that if Lewisham lost its A&E there would then be one A&E which would be the one in Queen Elizabeth which would actually serve a population of 750,000 people. Luckily we managed to keep our Lewisham A&E which meant that Queen

Elizabeth did not have to deal with this increased influx that would have come from Lewisham and that is just as well. I think I mentioned in my evidence that recently the Care Quality Commission inspected the A&E at Queen Elizabeth Hospital in Woolwich and found it to be unfit for purpose. It could not deal with the numbers going through not just because the A&E was too small but also there were not enough beds. To think how much worse that would have been had Lewisham A&E also closed just does not bear thinking about. The interesting parallel with North West London is that they kept trying to use this double speak and say "We are not closing the A&E, there will still be an A&E there", but they would not define it and when we pushed them it was called an "urgent care centre plus". We tried to say, "Are you going to have emergency nurse practitioners and A&E doctors there and other acute services, because that is what an A&E needs?" and they refused to commit to that. Jeremy Hunt himself called it a "small A&E". So they are constantly trying to redefine what an A&E is to actually make it very difficult to oppose their position. That is exactly what they are doing in North West London. The College of Emergency Medicine does have a definition of what a major A&E should contain and it should have the ability to actually treat and admit seriously ill medical and surgical patients. If it cannot do that, then it is just an urgent care centre.

Q. In terms of the co-location question, again, perhaps just thinking with your GP hat on, what are your concerns, if any, about a model where A&E is not co-located with an urgent care centre?

A. The evidence from the Lewisham emergency department doctors made it clear that one of the reasons that the Lewisham co-located urgent care centre could actually manage the level of seriousness of illness of patients that presented there was because they knew they had the backup of the emergency department with their expertise and indeed with the intensive care unit, et cetera, so when you have got everything co-located you actually have the capacity to deal with a much wider range of acuity of illness and the emergency department doctors and nurses can actually support, for example GPs, et cetera, in the urgent care centre. As a GP referring patients into that situation, I know that the whole point of an emergency department or an A&E is often GPs like myself do not really know if something is serious enough to need admission or not. That is the nature of medicine. There are grey areas. Is this abdominal pain appendicitis or not, is this abdominal pain an ectopic pregnancy or not? Is this child with a very bad cough and high fever pneumonia or not? So you send them there. If you know that there is not going to be the level of expertise there, you are not going to send them to an urgent care centre; you are going to send them to another A&E somewhere else. The idea that just because the urgent care centre could manage a certain number of patients that they could still manage those patients if there was not a co-located A&E is actually wrong because people would only go there with minor problems and GPs would only send people there with the most minor problems.

Q. Is it your evidence that, from your experience, GPs will not want to use those services because they will be fearful of outcomes?

A. Where I work I have also got a walk-in centre which can deal with minor injuries and minor cuts and bruises, et cetera. We are happy to use that service, but the idea that it somehow replaces the vital A&E service is absolutely wrong. We still need that. I still need to know that I can send a child to be seen or an adult to be seen by somebody who is more specialised than I am because they are dealing with those problems day in day out like a surgeon who can assess abdominal pain better than I can as a GP. If I saw a query

appendicitis, a possible appendicitis, I would not be sending them to an urgent care centre with bells on, which is what is being proposed. I would be sending them to St Thomas' or King's.

Q. I wonder whether I am right in thinking there may be some parallels between the Lewisham population and the Ealing population?
A. Yes, Lewisham and Greenwich are two of the most deprived boroughs in the country. I understand that that is the case with several of the boroughs in North West London and also the ethnic minority mix as well.

Q. So one of the areas of discussion around the closure of Ealing Hospital is the ability of other hospitals to take up those populations and to deal with them as well as the existing hospital. Can you enlighten us in any way about what happens when you diffuse that particular skill set? Can it go to other places without difficulty or not?
A. You can but it is not the same. For example, in Lewisham we have a higher proportion of children with sickle cell disease which is a characteristic of certain ethnic minorities. We have nurses and doctors in Lewisham Hospital who know all those children personally by name and they know the families. When children get sick with a sickle cell crisis they are in agonising pain. It is not something where you want to just wait. They know that they can go straight there and they will just be fast-tracked to the quickest care they can get and the pain relief and expertise. You cannot say that could never be replicated anywhere else but it is just if that is something that has built up over years with real local knowledge and real intimacy and connections between a local district hospital, I think that exemplifies what a good district general hospital can achieve, that level of local knowledge and relationship and also with local GPs. That is just one example. The other example is if you were to spread, for example, your elderly patients in Lewisham, I think it is the same in North West London, they are more likely to be living alone and unsupported and be poorer. Therefore co-ordination with social services is absolutely vital to help them to get home and to be supported at home again after admission. If they were admitted to Lewisham Hospital, which is our local district general hospital, there are quite good relationships already with the social services, co-terminus with the borough, with local GPs and it is much easier to co-ordinate. I am not pretending everything is perfect but it is easier. If those patients were dispersed around to four or five other hospitals then the number of different interactions, relationships and teams that one would have to interact with in order to actually make sure that those patients got the care they needed when they got discharged back home is much more complex and it is much more likely they will fall through the net. I think this is a good example of where localism again benefits quality of care for patients.

Q. Just thinking about the other side of the coin apart from the shutting of acute services, and I do not know whether this was so much part of the Lewisham proposition, is the premise is that if you increase and improve community care services, you decrease the need for acute beds and acute services? I do not know whether you are able to comment on that?
A. Yes, because part of the proposals in Lewisham were based on an imagined 30% reduction in acute in-hospital care based on the idea of increased and improved community-based care. We asked for the evidence for that and there was none. I think community care is really important and I would never argue that you do not need to improve it; of course we do need to improve it, but, unfortunately, there is no evidence -

and there has been quite a lot of research - that that actually reduces rates of admissions. It looks as if you need both. You need good community care of course but you are also still going to need your hospital care because no matter how good the care is in the community, people still get sick and in the last six months of life is the time when most people get more sick and need more specialised care. It is conceivable and you can imagine a situation where you could have some more intensive hospital-like care in people's homes, but I would imagine it would need a huge expansion of quite specialised nurses and indeed doctors and other facilities to achieve that. That has never been achieved anywhere. We do not actually know how much that would cost. We do not even know if it would work. It is wrong to base ideas about closing acute services on imaginary, perhaps Utopian ideas which have not yet been demonstrated to work. The best way to do that is to try to see if community care and hospital-type care at home could work and only when that is demonstrated to be true then of course it would be rational to cut back on hospital care. I would give the example of day case surgery. Day case surgery became so obviously successful that it was okay to reduce surgical beds. It was a no-brainer. So why do we not get the alternative services up and working and demonstrated to be effective first before we start closing hospital services? As I say, we still do not know if that would actually be effective.

Q. I just want to ask a little bit about the financial side of things because obviously you set out in your statement that the Trust Special Administrator was appointed to deal with financial difficulties and he came up with a solution of cutting Lewisham. Are you able to comment at all on whether or not you have any understanding of whether the *Shaping a healthier future* reforms are in any way financially driven?

A. First of all, I would like to leave you with a supplement to what I contributed because we actually produced a briefing for the Mayor of London Boris Johnson in which we went into quite a lot of detail and a critique of the financial case as well, which I omitted to put in my main contribution, but I think it is very useful. Basically, it was quite clear even from the introduction to the consultation document that finances were part of it. They talked about the fact that South London Healthcare Trust was not financially viable for it to continue and there would be a £75 million deficit. The bit that was going to involve closing Lewisham was only going to relieve £1 million of that £75 million deficit so it was very difficult to see how they could justify the downgrading of Lewisham on financial grounds, but the whole envelope of why they were approaching the reconfiguration across the whole of South East London was premised on the financial problems of South London Healthcare Trust which was a separate trust from Lewisham Hospital. In North West London what the documents there seem to say is we are living in times of great financial hardship for the NHS and therefore because of that we need to make radical changes to how our services are configured in order to do more with less. They imply that, despite having inadequate money, they are still going to be able to not just sustain but improve services by doing things differently. The context is always one of "We are going to have to do something because of the financial situation". That is what I mean by financially driven. There is no evidence that you can actually not only sustain but improve services on less resources because, in fact, as you know, the NHS has been one of the most cost-effective in the world, so I do not see how they can justify the radical changes they are proposing and pretend that that is going to improve quality. I think they should be honest and say we do not have enough money; we are going to have to cut things.

I think that would be much more honest.

MS RENSTEN: I am conscious of the time, so if you would like to stay there, there may be questions from the Commissioners

Examined by THE COMMISSION

Q. THE CHAIRMAN: This is a question which has arisen today (for me anyway) in relation to Lewisham. It was not something that arose in the inquiry we had there, but I just wanted to ask you, Lewisham successfully challenged both in court and out of court the proposals being made by Jeremy Hunt and others and I just wanted to know, presumably there is a Healthwatch organisation in the South East of London and if there is what role did it play, if any, in the challenge to these proposals?

A. It did not play much of a role at all. If you look at all the contributions on our website, the contributions were from not just clinicians but from churches and from the Council and the Safeguarding Board and from across a range of civil society in Lewisham and yet there was not a contribution from Healthwatch to the consultation process. I think they are very fearful of somehow stepping out of line. They do not see themselves as champions of the people. If they had been doing their job we would not have had to set up the Save Lewisham Hospital campaign after all; we would have had a body that would have responded to the feelings and contributions of people across Lewisham. It was mass involvement, as I say, from football supporters, to small businesses, to schools, to pensioners, to all the faith groups, so it was really across the board. If Healthwatch really was representing the voice of the people then it is really strange how absent they were. I know some of the people in it. They are very nice people. I am not criticising them but I think they are really quite cowed and quite hesitant about speaking out. I do not know why. I do not know what is going to happen to them if they do.

Q. DR LISTER: Just a quick one. The legal challenge to the administrator and Jeremy Hunt was not actually on the merits of the case, was it; it was on the procedure in that the powers applied to South London Healthcare Trust and not to Lewisham. Given that that does not apply to the situation in North West London and therefore that type of judicial review is not an option, if you had been in that situation and there was not a way in which it could be challenged legally, was there any alternative other than the street campaign and the banner waving and the protest that you actually mounted?

A. People talked about a range of possibilities. Obviously there is political activism. People talked about industrial action possibly and even occupation to keep the hospital running, if they dared to try to close it. These were the sorts of things that people talked about kind of in desperation. With that level of mass participation anything is possible because people were so angry. Obviously it was great that we had the law on our side, there was a procedural thing, but what was amazing and what made us angry is that the people ignored all the really strong arguments and the passion and the local knowledge, all of that. I do not think that would have gone away. I cannot see how that could have gone away. It would have found another expression. I cannot say now what that would have been at all but I think it would certainly have been powerful.

Q. Do you find it irritating that the central line of argument in the proposals has not actually been confronted in that way and we have not been able to have an answer to those questions that have been challenged in such a strong way by your campaign?

A. Yes. As I said in my evidence, the thing that struck me most in re-visiting and

re-reading all of this evidence now to come here, I do not want to sound smug but just how very right we were and not just me and a few other people, everyone who contributed from public health, there was a fantastic contribution from Lewisham Public Health, a 32-page document with fantastically deep evidence. There is a real democratic deficit if this level of evidence and contribution and participation can be so routinely and easily ignored by the powers that be. There is something fundamentally wrong to the extent I think now one perhaps should not even participate in these fake consultation processes because they are not real, they are not asking people what they really think and they are not prepared to change anything in the face of real evidence. There is no sense that there is a court. I sometimes used to fantasize that some sort of Martian might come down and be that objective court and would actually sit and weigh up the two sets of arguments and ideas because I felt that was the only way that we would get that true sense of justice. I think this is happening around the country with all these reconfigurations. This fake process is happening. I think politically we should be addressing that as well generally.

Q. DR HIRST: I think you have probably answered my question which is that you use this word "they" and I am trying to get a grasp, as I did with a previous witness, who "they" are. They obviously behaved badly.
A. Yes.

Q. But who is "they"? Is "they" actually the Department of Health? Is "they" the Secretary of State? Is "they" Monitor?
A. "They" were a mixture. So the Department of Health was represented through at that time I think it was NHS London because that was before the Health and Social Care Act changed things, so it was NHS London or the London Strategic Health Authority, that is who it was, but the Trust Special Administrator was appointed by the Secretary of State for Health, Jeremy Hunt, so he was a direct agent of government, Matthew Kershaw. He had a team. He was advised by McKinsey's. Something like £6 million was spent on the whole consultation process of which a large chunk of it, several millions, went to McKinsey's who produced some of this stuff. There were also various clinicians technically that they had somehow roped in to being on the side of promoting the reconfiguration. Many of these were no longer practising clinicians. They were people who had come from a clinical background but had then been not co-opted but they were now employed basically. Fair enough, I think clinicians should be involved in planning and management and there should be a clinical input, but it seemed that they were not particularly objective. In fact, it was some of the clinicians themselves that were the most bullying and aggressive towards ordinary people in the consultation process strangely. So that is who "they" were. Who else was there? Ultimately, it was Jeremy Hunt.

THE CHAIRMAN: That is enough said.

DR HIRST: Thank you very much.

THE CHAIRMAN: Thank you very much indeed. Just in time and good luck.

<u>The Witness Withdrew</u>

THE CHAIRMAN: That brings us to the end of today's hearing. May I thank everybody

A once again for their patience and also their diligence, particularly counsel and instructing solicitor and Peter Smith over there. Thank you very much indeed. See you in May for the last hearing.

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