The People's Inquiry: One Year On

Evidence presented by Anne Drinkell (AD), retired community matron, West London

Tuesday 16 December
Central Hall, Storeys Gate, London SW1H 9NH

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:
Tell us your experiences. Leave us a bit of time at the end for a bit of a discussion.

AD:
I'd be very happy if you to interrupt me on the way through: some of this might be stuff you have already heard before, because I know you've had Ealing in, and I know they've got some formidable statisticians whom you saw last week. If you have heard this before just stop me because I can move on.

RL: Are you semi-retired, are you still doing some work?

AD: I do some bits here and there. I was slightly blown off course today, because the CQC report on Imperial came through today.

RL: Yes. Spectacular isn't it? And guess what? They don't have enough nurses!

AD:
I thought I would just go through a few things that you can all read and I've sure you've analysed, it's a bit of a blur, but there might be a few bits that we as a local campaign would like to highlight.

The CQC said Imperial required improvements to make it safe, responsive and well led. Across the piece, nursing levels were inadequate. Which is something that we had been saying since time immemorial, but always at the board meetings they are denying it and saying 'Oh it's picking up now, our recruitment process is quicker, our vacancies should turn around next month.' That isn't the case.

It's quite important that stats show the high reliance on bank and agency nurses, because that really does impact on patient care in terms of being able to offer continuity, particularly when it's in the emergency sectors where it really does make a difference if you know the place, if you know who to refer to, if you know the mechanisms, and so on.

Another big issue really is the surgical backlog. Long waiting lists for elective surgery. Again we have heard since time immemorial at every board meeting that the plan is to improve that. But to date it hasn't happened. Ironically, Charing Cross Hospital, the A&E that they want to close, was rated 'good'. St Mary's, the A&E they want to keep, was rated 'inadequate'. Quite tellingly I thought, in the chief executive's press briefing this morning, she didn't refer to the fact that Charing Cross was good. Which felt (a) quite a kick in the teeth for the staff, and (b) was clearly politicking.

Another important thing to note was that the outpatients' departments were noted as 'inadequate' in all three hospitals. I am primarily talking I should say about Hammersmith, Charing Cross and St Mary's. That's significant, because we are supposed to be a fair way through a process whereby people are pulled out of acute beds and into the community, where obviously regular reviews at outpatients by your consultant team are really important. So if those appointments are noted as inadequate all the way through, that clearly has an impact for how well you are going to be managed.

A final point really about the CQC report is that within it they acknowledged ironically again really both that the major trauma centre at St Mary's is doing good work – which is good, and an argument for specialisation which we completely agree with – but also that the hyperacute stroke unit at Charing Cross, again a service they want to move, is doing very well. It has been rated as the best in the country, and there people feel very, very strongly that it is complete madness to move that to St Mary's.

The rationale is that a stroke unit is best placed with a major trauma unit so you can concentrate expertise together. However if the plan goes it will mean ahead that the unit would be only 2 miles away from UCLH, which also has a hyperacute stroke unit, so you will carry on with that doughnutting effect of concentrating the major acute services around the centre of London, and then deserts before the next one. It's also true that UCLH is a stand-alone hyper-post stroke unit. The rationale for the location of one isn't the same as the rationale for the location of the other. To be honest, if you're talking about in terms of a London-wide strategy, it feels that it's a lot more to do with politicking between the different trusts than to do with a genuine clinical need, clinical strategy.

I would imagine that if you met people fromEaling last week they talked to you about the stats around what's happened since Hammersmith A&E and Central Middlesex A&E have closed. I'm not going to go on too much on about that. I suppose what I should just highlight is that both within the Imperial trust and within the North-West London trust the A&E waits, the breaches, particularly the type 1 – the most acute – they've got the longest waits in A&E. This is kind of counter-intuitive in terms of need, but they have really fallen through the floor. I think you've probably seen the stats about that.

It's also worth putting into context that since the Central Middlesex and Hammersmith A&E closed on the 10th September, the idea was that people would either go St Mary's A&E, rated as 'inadequate'; Northwick Park A&E, rated as 'inadequate'; or Chelsea & Westminster A&E, 'requiring improvement'. All of those ratings took place before the closures. So it's got to be the case that things have got worse, because we know that since then the waiting times within A&E have massively mushroomed.

JL:
We have heard a lot about the impact on the hospital services. I know when you came before you talked a lot about the type of services that could be provided.

AD:
I'm getting there, I promise you! This is the last little bit about A&Es. You should also be aware that London Ambulance waiting times are also very significant, in terms of lots of breaches of the 8 minutes target. In Hammersmith & Fulham 64% of ambulances got there within the target time. In Brent, where Central Middlesex was closed and was probably the worst hit in some ways, only 53% of ambulances got there in time. In Ealing it was 51%. So that's the context in terms of A&E.

The plans in terms of *Shaping a Healthier Future* go well beyond that. One of the things which I think has been quite under-played is the loss of acute beds. It's quite hard to quantify because Imperial's plans keep changing, but the business plan talked about around 300 beds going at Charing Cross as well as losing the stroke unit and the intensive care.

Since then they have said 'It's not going to be as bad as that, we're going to have more'. But quite a few of the "more" are going to be what they call 23-hour beds. What's really important to think about that is they are treating them as if they are equivalent. But they are not, in the sense that the kind of people who would be suitable for 23-hour beds are not the same as people who need an acute admission and a few days in hospital. They are not fulfilling the need of people who need an acute admission and a few days in hospital. This is really not comparing like with like.

We've been really heartened by the stuff that has come out from Professor David Oliver recently which I am sure you have all probably seen. As a community nurse, as a community matron, as a district nurse, as somebody who was the first to set up a wellness clinic around Hammersmith, the first nurse practitioner who did district nursing around there, I am completely committed to people being looked after at home when they can be. For a million reasons it's the best when they can. But I also know that in that area, in my patch, often it was not feasible for a whole number of reasons, which I could go through.

When David Oliver talks about 'we need to recognise that hospitals are somehow the right place for older people to be, it's inherently ageist to be talking about how older people should be kept away. It's perfectly consistent to say hospitals can be riskier places for older people, but if you have a broken hip, if you have a stroke, if you have pneumonia, why should you be denied the full facilities of a general hospital on the grounds of age?', that's exactly where we are coming from.

What are they doing in North-West London? There are some good initiatives going on. There have been some real attempts to try and improve community care. Things that I would cite: there's quite a lot of end-of-life initiatives aimed at helping people plan in advance, coordinating their care, it's called Coordinate My Care, and it has made some impact in terms of allowing people to die where they want to die. So you have that discussion in advance, then there is more chance that you will be where you want to be in the final stages of your life in palliative care for people.

Some other positive things that have happened. In the last week or so, maybe in the last 2 weeks, five GP practices within the borough have opened at the weekend.

RL: This is in Hammersmith & Fulham?

AD:
Yes. They are trying genuinely to be an alternative to their A&E in those situations. There's also a thing called the community independence service, which can offer a kind of intensive 6-week intervention with a really massive, multi-disciplinary team, trying to get older people – vulnerable people who might be able to be looked after at home if there is adequate support. That is showing some quite good results.

They are to be lauded, but I think you just have to see that against the background of the overwhelming need. Our concerns about that are, yes they are good. But in a way they are high profile. They have to succeed. They are monitored extremely carefully.

Meanwhile, over there we have a is a district nursing service that hasn't had any investment for about 10 years. Actually it's not just that. What you find is for the core services, the best people, the

brightest people, the ones that want change, are being sucked off into these little pet projects, often that don't have long-term funding anyway. So they are delivering good results within the confines of the project, but the main core service, for example district nursing, is going down the pan.

In fact somebody e-mailed me specifically to say it may be useful to ask the head of the CCG how much investment has been put into district nursing in the past 10 years. There's been significant investment in Western Kensington & Chelsea, but in London Hammersmith & Fulham the virtual ward, case management and rapid response community events service have been investments in the past 5 years: these have generated more referrals to the district nurses with no additional funds. That's just not the case for district nurses. All those core services have really lost out while the pet projects have gone on.

For example, 5 years ago there were five district nursing sisters managing teams in the area of Hammersmith North, and now there isn't a single one. There is one, but that person is off on long-term sick, so there is such a change in the quantity and also the skill mix. That's having a really significant impact on the level of care.

It's also important to think about what primary care looks like around there. I am sure you are familiar with the broad picture of primary care in London, which is not great for a whole bunch of reasons, which NHS London have explained to us. Within Hammersmith & Fulham there are particular issues. There is a fair amount of evidence that actually we're not even as good as the rest of London in quite a lot of areas. We're still not as good as we should be as one of the wealthier boroughs, although there is a big level of inequality there.

In 2013 we had 400 excess deaths. That's deaths that shouldn't have been expected given the wealth of the borough. We were in the lowest ten boroughs in London for excess mortality. Again that doesn't make sense in terms of the relative wealth. When you look at the GP comparisons, (we're doing a whole Commission about this at the moment) it really is quite shocking. There are some areas of quite poor practice – for example, something really basic like flu immunisation. I think if you are talking about offering good out-of-hospital care you ought to have good flu immunisation, it's a completely cheap, quick win that would definitely stop some hospital admissions, and make a lot of people better over the winter. For me, if I was in charge, that would definitely be a really quick easy win of a target. It wouldn't even cost that much. But in the last 3 years, Hammersmith & Fulham has been worse than neighbouring boroughs, worse than the London average, worse than the English average. The flu immunisation rate has actually gone down in the last 3 years, so it was 68.9% 3 years ago, 65.5% 2 years ago and 60.5% last year.

This just tells you that we haven't got the kind of infrastructure we need.

Other significant markers are quite poor rates of cancer diagnosis, quite poor rates of dementia diagnosis and quite poor rates of patient satisfaction in some areas. Even for the factors where we score better, one of the things that's really noticeable is the very big variability in the GP practices. Really, really marked. It's not always the wealthiest southern bit does better than the poorer northern bit, but often there is that kind of a feel to it. It's not just in terms of elderly people. Vaccination rates for cervical cancer are some of the worst in the country within Hammersmith & Fulham.

I am torn because there are actually some fantastic things that go on there. I have tons of respect for most of the health professionals who I know who work there, for most of the doctors, most of the nurses. But it hasn't pulled together in terms of an adequate and safe out-of-hours service. Whilst there were some good initiatives I think part of the problem for us is a lot of them feel they are being

nursed because they are special little projects but we have doubts about their long-term sustainability, and whether the team will be funded long term. That's because we have this history of the name 'rapid response' that has gone through about five different variations. People try tweaking it in various different ways, changing the management, and then a year later it all gets thrown up again.

That's one of the issues around primary care. I also wanted to give a background about funding reductions. Because compared with some London boroughs, we haven't got a very big elderly population but our elderly population tend to live on their own. We've got more vulnerable adults than you would expect. On the whole our elderly population have less unpaid care and support. So people are a bit more isolated. That's quite a significant challenge. At the same time, like everywhere else, social services funding is being dropped and eligibility criteria are being raised.

One positive thing I would like to say – I will end on a positive note – is that in April the local borough are going to drop care charges, so that nobody will have to pay for care. I think that will be really significant in terms of uptakes because I personally know many people who didn't want to get into the means-testing thing and were very reticent about picking up care.

RL:
We heard from the leader of Hammersmith & Fulham Council. They have done it by closing their communications department. So I am not sure how they are going to tell everybody but I expect they will find a way!

Something we did pick up, and I would like you talk a little bit more on. District nurses are rarer than hen's teeth now aren't they? Here we've got a policy that depends on district nurses, or district services in some way or other. I was talking to the Queen Alexander's Nursing Institute the other day and they were saying that there are only three training places in London and they have not been taken up. It seems to me to be insane that we've got a policy of pushing more services towards district nursing, in its generality, and we're just not training any district nurses.

AD:
I think it's about finance. It's been absolutely decimated and I am very friendly with many district nurses and the personal crises and the stress and burn-out people have is absolutely massive. When I raise this at CCGs I am treated as if district nursing sisters, who are therefore trained RGNs with experience, are basically an expensive luxury. They talk all about skill mix. So they are down-grading people a lot, reducing the skilled posts and to some extent trying to substitute with healthcare assistants.

I have got massive respect for healthcare assistants but I think that if you are talking about the kind of caseload that I had, where trying to keep somebody who's quite vulnerable, has multiple conditions, on the edge of being admitted or not, if you are trying to keep them at home and support them you have to have quite finely honed clinical skills. You have to be able to listen to a chest, look at the pattern of antibiotics, work out whether the trajectory is as you expect or not. You can't have it both ways. If you want people to be looked after in the community you have to have those skilled clinicians.

District nursing is absolutely terrible. For example, in Hammersmith & Fulham they are just halving the number of continuing care nurses. They are the people who work out packages of care for our literally most vulnerable people, the people who the NHS are going to pay most of the tab for because their needs are so health related. The skills people need to work out those packages are massive. For example, somebody was telling me recently that for the first time they had somebody

home with a full ventilator. So we are talking organising the package of care for somebody who amongst their other needs, needs people who can look after a ventilator 24/7. At the last CCG I brought this up because the community care nurses had told me that were halving the number of nurses.

RL: What about tissue viability nurses?

AD:
Tissue viability nurses are an absolute problem. The incidence of pressure ulcers, both within the hospital and in the local area, is worse than you would expect and I am not absolutely up to date but until certainly a year ago there was no tissue viability nurse in the community in Hammersmith & Fulham, and we were relying on advice like phoning up people from K&C or Westminster who out of the goodness of their hearts would do things.

That may have changed a little bit, I don't know. The CQC have criticised Imperial for example about their pressure ulcer incidence.

RL:
We are going to have to draw it to a close there. It's so interesting it's a pity we can't talk to you for any longer. Thank you very much for doing this, we really appreciate it.