The People's Inquiry: One Year On

Evidence presented by Dr Gurjinder Sandhu (GS) consultant in acute medicine, Ealing Hospital.

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:
Thank you enormously for coming to see us this morning. Our purpose is to re-visit the outcome and context of a report that we wrote last year, *The People's inquiry into Healthcare in London*, and see what's what pursuant to that.

GS:
I'm Dr Gurjinder Sandhu, I am a consultant at the Ealing Hospital. When I last presented to the People's Inquiry, I was a Consultant in Infectious Diseases. I've had to change my job; I've had to become a Consultant in Acute Medicine, because I have had to move to man the front door of an emergency department that is now dealing with an absolute crisis in North-West London.

Figure 1 is representative of that crisis.

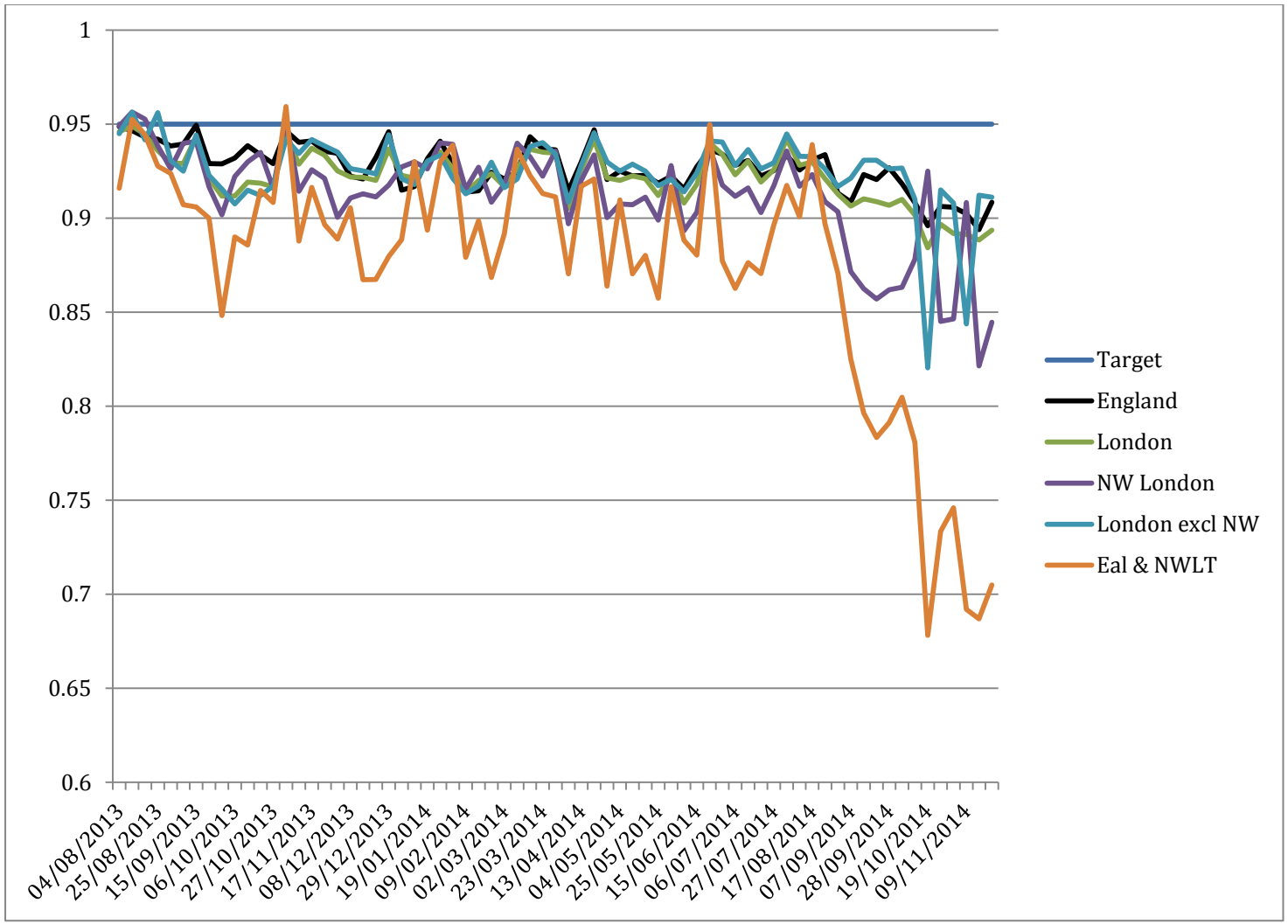


Figure 1 Type 1 A&E admission 4 hour target

This was produced by a colleague, Colin Standfield. The target for Type 1 A&E admissions 4 hour wait is 95% (the blue line in the figure). You can also see the England average (black line) and the London average (green line); the London average falls down to about 90%. But then the Ealing and North-West London Trust line (orange) has dropped down to 65%.

This was dramatic. We worked through this period. If this was an economic graph and you saw something plummet like that off a cliff-top, you would know you were in crisis. This graph has a human face. When you have an emergency department where you have elderly patients coming through, septic patients coming through, patients coming through with airway problems, patients needing resuscitation – let me take you through a journey of what happens when you've got a gridlocked hospital and you're trying to man the front door.

You can arrive in the Resus [resuscitation] department and see every cubicle being used: paediatrics in one corner, in winter, resuscitating children with viral illnesses, resuscitating people with cardiac or pulmonary conditions. You decide you need an intensive care unit bed. There was a type 1 A&E admission that you've seen that is septic. You rush up to ITU and you say, 'I need an ITU bed', but you see that all the recovery spaces, all the theatre recovery spaces, are being used up as ITU beds because we have nine but if we use that extra space we can get up to 12.

'Can you get my lady up to ITU?'
'I'm not sure how we're going to do this, we're waiting for this one to go to Hammersmith Hospital, but Hammersmith Hospital don't have any ITU beds. We're waiting for this one to go to Brompton but Brompton Hospital don't have any ITU beds.'
'Ok, I'm going to start ringing around… Hillingdon, have you got any ITU beds?'
'No.'
'Northwick Park, have you got any ITU beds?'
'Ok, we're going to need to intubate this patient here.'

That's the crisis, that's the septic end, that's the acute end. When an elderly lady with dementia living with her husband – who is quite frail and elderly – puts the electric kettle on to the gas hob and you hear about it, and she's lost in that emergency department somewhere with her family in crisis, that is a type 1 A&E admission. When she comes into hospital I can't safely get her back home. I don't have care in the community or social care that makes me feel safe to discharge elderly patients from hospital.

So we've talked about the front end of the hospital, let's talk about the back end of the hospital because hospitals are constipated, they really are. We can't over-emphasise how difficult it is for acute physicians, for medics, to get patients out of hospital, and how we feel that we are almost basically in a battle with social services, when we used to work in harmony with social services.

You can have – and I've had two admissions like this – patients with severe mental health problems, schizophrenia, psychotic, living in squalor with faeces and flies in the house. It's environmentally not healthy for that person to be living there, so they will be in an acute hospital bed for 7 months whilst we are battling over capacity issues, mental capacity issues, whether it's a mental health admission, there's no mental health beds, well then she sits in an acute hospital bed because there's no right bed because I am not sending her back to that squalor. The same with the elderly, the same with the families who bring someone in: they really have reached the end of their tether, and when they say 'Dr, I can't take her home', it's not that they don't love them – they've got to that point, and that is a type 1 emergency admission. Just as much as my resus department and everything else going on around me.

ST elevation[1] Myocardial Infarctions [MIs – heart attacks]. ST elevation MI presents in A&E in Ealing hospital, goes over to Hammersmith, has the angioplasty – no beds at Hammersmith. No beds at Hammersmith so they send the patient back to Ealing A&E. We could have done it here.

They're removing emergency departments, they're putting strain on the others, there's no bed space anywhere, there is no capacity anywhere, and it gets desperate. Imagine working with an incredibly senior sister who, when she is on duty, you know that you are in safe hands overnight. She comes to you, she is desperate, she looks like she is on the verge of tears, and she says 'Dr Sandhu, where can we put three new beds?'

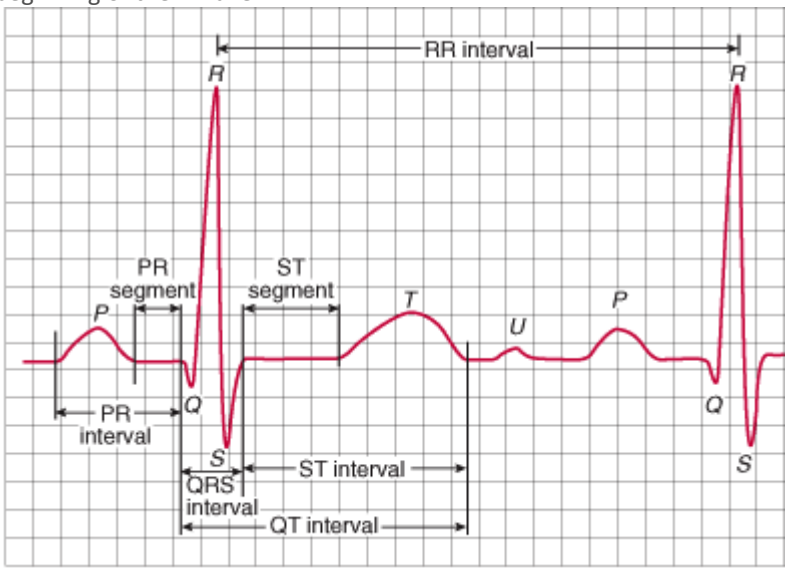
It's not a patient crisis, it's literally 'Where am I going to put people? Can we move all the chairs out of ambulatory care and put three new beds there? Ok, we've used up daycare surgery, the daycare ward, we cancelled the operations for tomorrow already'.

Who watches *Game of Thrones*? There is this phrase in *Game of Thrones* that says 'Winter is coming'. Winter has not come yet. I'm already frightened. Winter is coming. It will take one decent projectile vomit with norovirus to crash the system. It will take influenza to crash the system. As an infectious diseases doctor, I know very well where Ebola patients will be looked after. I know very well where we will assess them. I do not know where all the potential influenzas will be looked after. I do not know where all the potential noroviruses will be looked after. I do not feel that there is the capacity.

Everything comes down to specialist beds. Renal beds. Patients who need dialysis. They are using up ITU beds because there aren't enough dialysis beds for patients. Rehab beds. Ok, imagine the 25-year-old who gets into a road-traffic accident and goes to the major trauma unit. He goes to Paddington, yes they do everything for him. He's got metalwork throughout his body but he is walking, just about. But then he develops an opiate addiction, then his family realise that they can't cope with him, then we realise that it's been multiple motorcycle accidents, then you get to the depth of a boy who is in trouble, we invested in all of that trauma care; what about investing in his rehab? Where's the facilities, where's the beds for that?

There was a week in central London where cyclists were being knocked off and killed every day. We've seen the cyclist who got knocked over on the streets of London and we've tried to get him

[1] "The ST segment is the flat, isoelectric section of the ECG between the end of the S wave (the J point) and the beginning of the T wave"



through rehab, but he spent 8 weeks in an acute hospital bed because there wasn't a rehab bed for him.

The elderly patients who fall: already, you can come back after a weekend with no ice on the streets and find you've got four fractured neck of femurs, sickle crisis, all the things that cold weather brings is bringing. So in *Game of Thrones* terms, winter is coming – and Figure 1 sadly I think is going to go further down, because I don't see where everything is coming from.

Getting back to the elderly, an Ealing statistic is that 58.7% of patients in Ealing are on state benefits only. That means you've got 10% of households living in fuel poverty. When I initially presented to the People's Inquiry I pointed out that in North-West London the emergency departments that were closing were in the most deprived areas. They were in Southall, they were in Harlesden, they were in Acton. The ones staying were in Chelsea, were in Harrow, were in Paddington.

Ten per cent of households in fuel poverty. We have coined the phrase 'hypothermic granny and hypothermic grand-dad' because we say to the junior doctors 'Look out for the elderly coming in with low temperatures, they will be really sick, they will be on coronary care unit with a low pulse rate, but you can get them better – they just need warming up', and they survive. But then they stay in hospital 6 months because we're not sending them back to an environment where they almost froze to death. Once again, getting to the point that there is no social care safety for a lot of these elderly, frail patients.

Migrant health: every year, the mobile chest X-ray unit comes to Ealing and it's now going to come twice a year to screen migrants for tuberculosis. Every year we have found at least one homeless man on the streets of London on the verge of dying from tuberculosis. Tuberculosis is a chronic illness. It's a bit like cancer. We should be picking it up early. Fifty two per cent of tuberculosis in Ealing comes through our emergency department. But last year, four patients with TB came directly through to intensive care unit. That's a chronic illness, you've got people so malnourished that they are actually coming in at death's door to an intensive care unit with consumption.

Getting back to the issue of poverty and migrant health, it is a disaster. It links with substance abuse, it links with domestic violence, it links with so many other issues which mean that the most marginalised in society are out there on their own, because there is no safety net for them, because their hospital has just been closed.

Their capacity has gone. How do you navigate through the healthcare system now? We as educated people will struggle. How does an elderly disabled or person with English that isn't their first language going to navigate through this current healthcare system?

Community services: they told us community services would be in place that will mean that this bed capacity issue wouldn't arise. It's ok, we can close Central Middlesex and Hammersmith A&E's and the associated beds that come with them. 'It will be ok, we can knock off about 1,000 beds in North-West London over the course of this reconfiguration. But we will put community services in place and they will mean that patients will not need to have to come into hospital.'

But District nurse visits are being cancelled because there aren't enough district nurses. Community matrons have been cut. Turnover in the job is huge. Community services don't exist, otherwise I wouldn't be keeping the elderly people in hospital for 6-7 months if I thought it was safe for them to be discharged.

I think it was in your report where social services was described as being 'bleak and getting bleaker'. I just wanted to repeat those words, because you predicted correctly one year down the line.

Staff: how does it feel to work in such an NHS? I haven't got the time. It's the hardest I've worked in my career, which I am not worried about, I am quite excited about. It's the most depressed I've been in my career, which I am not excited about. I don't want to be meeting midwives in the hospital canteen who say:

'Have you got a moment?'
'I've got a moment.'
'I don't know what to do. I've got a family to feed. I don't know what's happening with the emergency department here, I don't know what's happening with the maternity unit here. It's not clear. They said they wouldn't advertise jobs unless they were offered to us first. But we're seeing the adverts out there. We don't want to go. But we don't know.'

Total insecurity.

PT:
Sorry, what does that mean? Why are they advertising jobs? What's going on?

GS:
Imagine that within Ealing Hospital the maternity department is due to close. That was a part of the reconfiguration. That would mean there would be loads of midwives left without jobs. These midwives were told 'don't just apply for jobs and disappear off because the system will fall before anything is in place. Wait until the time and we will make sure that you are offered jobs first, or jobs aren't advertised until you are in a position to apply for them'. But that's not happening.

PT:
So where are the jobs advertised for?

GS:
Hillingdon Hospital, West Middlesex Hospital, all the places that are keeping maternity units.

PT:
And this is because they don't dare shut Ealing yet?

GS:
They don't dare shut Ealing yet. They keep delaying the decision. It was supposed to be announced as a CCG decision before December and now it's in February and it's fear of not knowing your future.

I'm ok, I'm a consultant. But there have been two occasions where I've come in early and stood on the picket line with people just to show my support. The first was with the porters. When I say this is the most depressed in the NHS, when I started in the NHS we were a team. You knew the porters. At Great Yarmouth Social Centre, by the James Paget Hospital, the porters' band would practise every Saturday night. Junior doctors, physios, nurses, OTs, biochemists, all would come to watch them. We were a team. We worked together.

Yet now the porters work for MediRest. They are fighting for the minimum wage and we join them on the picket lines to show our support. These are the guys that are running around like lunatics in that emergency department in that hospital that is full to the brink.

Nurses. We don't even get the opportunity to talk to nurses. They are so run off their feet. You go to admit a patient and you turn around and say 'would you like another form to fill out?'. There was a doctor on Radio 4 who turned around and said 'there's a reason they are called "care bundles", it's because nurses have to fill out pages like that all day long', when they have literally got no time to provide care to those patients that I've just described that have come through the emergency department at the hospital.

Staff are afraid to speak up. Staff are fearful to speak up. We set up a forum in the Ealing Hospital called the Francis Forum. The idea of the Francis Forum followed from the Francis Report. What we felt was that we would have a single logo and we would put it on a badge and it said 'Ealing Hospital Francis Forum, patients come first'. Whatever you do, whatever decision you make, put the patient at the centre of what's going on in your thoughts. Because it's so difficult to practise medicine when money is the centre of your thoughts. It's so difficult to practise medicine when the first thing you are told when you walk into a building is 'no beds'.

The first text I received as I was waiting to come in and see you was 'grim and gridlocked – when can you get here?'. But you've still got to sit there and think, get into that battlefield, hunt out the sickest patients first, deal with them and then try to deal with the discharges. You can't have us going in trying to discharge patients first.

PT: What was it exactly that happened in late August when you fell off the cliff?

GS: The emergency department at Hammersmith Hospital and the emergency department at Central Middlesex Hospital closed in September.

PT: They closed in September. Were they running down before then?

GS: Yes. So Central Middlesex prior to that was not seeing patients overnight.

PT: And what is the plan now for Ealing?

GS: At the moment, Ealing is Chief Executive-less, Ealing is Medical Director-less. Interviews are happening in the new year. There's acting people.

PT: Where have they gone?

GS: There was an initial Chief Executive at Ealing Hospital who left for North Middlesex Hospital. Then we got an interim Chief Executive who was the Northwick Park Chief Executive because we were going to merge with them so we had an interim Chief Executive. Each Chief Executive saw through one part of the process. So the first Chief Executive saw us through the Shaping A Healthier Future Consultation. The second Chief Executive saw us through the merger. Now we are interviewing for a Chief Executive.

LI: Have you merged?

PT: What does merging mean?

GS: We have merged with Northwick Park so in some ways Ealing as a trust that was performing well; merging with a trust that wasn't performing well has brought down Ealing.

Merging in other ways is positive because it then does mean that when you've got that patient that needs the intensive care unit bed, you've got a sister hospital. You've got a sister hospital and you can ring up a friend, and when I was saying I know where Ebola patients would go as an infectious diseases doctor we have already started talking with infectious diseases doctors at Northwick Park, and saying 'Hillingdon have told Heathrow they are not comfortable to see patients coming off airplanes from Sierra Leone with temperatures of 38. We are an infection department, let's merge resources, let's provide the facility of Northwick Park and we will receive, we will triage'.

So there are areas where the maxim that bringing groups together works strongly, yes. But then those beds need to be available. If you have a big winter crisis and all the infectious diseases unit beds are full of influenzas, noroviruses and tuberculosis, where's the Ebola going?

PT: Are those beds sitting empty, the Ebola beds?

GS: There are no beds sitting empty. Every space that's available is being used.

RL:
Can we just look at the bed thing for a moment? You've painted a graphic and very powerful picture for us of what it's like to be in the front line. Can I just invite you to step back for a moment from the front line, as powerful as that is, and say 'ok, we are where we are, what is the solution?' Because I can't see a solution really. Unless we took over a couple of Premier Inns or something and turned them into step-down care. Can you see a solution?

GS: You can't look in the hospitals for the solution. You've got to look in the community. You've got to look at the social care, you've got to look at the bed blockers.

RL: Is the issue, do you think, fundamentally social care or primary care?

GS: It's all intertwined. It really is all intertwined.

RL: We have now got the Better Care Fund to bring into play. It's a billion pounds. It sound like a lot but it isn't. Can you see any sign of better care or anything? Funds? Plans? Action? Cameras, lights? No?

GS: When people talked about how there would be capacity in the community they always talked about this vision, and I never saw this vision. It was there on people's slides but it was never there in any clinician's imagination. They've never materialised.

FW: Where is that money?

GS: It's not so much the money, it's what's needed in the community to change. How do you suddenly provide enough safe environments for elderly patients with dementia to be in, in the community? Because homes aren't necessarily the safest environment.

FW: Are you saying that, the problem with that vision is that delivering care in somebody's home doesn't work if their homes are not suitable? Is that the problem?

GS: It doesn't work if their home is not suitable and it doesn't work if the actual crisis is the home.

JL:

I remember reading two and half thousand pages of the business case for the closures of the A&E units. Fourteen pages were allocated to the alternative services for the community, which concluded that they would still need to go through a planning process and get planning agreements etc. So it was all completely vague then. But there is no sign at all that this is actually taking shape and is moving on it?

GS:
On what? You get told the GPs are merging into small groups and if you've got a musculoskeletal problem you can be seen within the group. It's community stuff, it's not acute. It's not those type 1 admissions where there is the extreme of a septic patient or the extreme of the self-neglected social patient.

JL:
Presumably you're looking at them after they come in as a type 1 and after a period you stay advising and sorting them, then you're looking for somewhere they could be moved which would give sufficient support? There wouldn't be type 1 then, would they? They would be something else.

GS: They wouldn't, but how are they presented? That crisis existed in the community. How is it going to be solved without a hospital admission? What's in place?

RL: Clearly we want to address this and we turn our minds to making some recommendations. Can you help us with recommendations?

GS:
I think if the community has become a virtual ward, a virtual clinic, then staff it the way you would staff a ward. If the community has become the virtual ward then think about risk management the way you would a ward.

If you feel that what you put in place in the community is not working, what is the back-up plan? Admission to hospital. You still need the capacity. Say you've got home IV antibiotics going in the community. I run the service. I'm happy to push patients into the community, but if that line is looking infected, or if the patient starts shivering, I'm not taking responsibility for looking after someone in the community I can't see. Bring them back into hospital, it's not worked.

But don't put me in the more frightening position where you take away the hospital beds and the safety net and then tell me I am looking after patients in the community. You can't take away the acute capacity to provide for the community. The community in its own right needs to be built up as a virtual hospital. Then 5-10 years down the line you might consider what you do with capacity.

SR:
What comes over to me very strongly is that you are in a very, very difficult situation but the thing that keeps you going is your autonomy in making key decisions like not discharging patients into unsatisfactory contexts: homes, wherever it might be. Is that in danger of being eroded? What would happen if those decisions were removed from you in some way? Some centralised, pseudo-medical unit which made the decisions to discharge? How would you react to that?

GS: I'd resign. I wouldn't feel comfortable looking after patients. Why are you calling me a consultant?

RL: Are you put under pressure to discharge?

GS: Yes.

RL: Do managers come along and say 'Dr, we've got to make some space'?

GS:
In the middle of that, the telephone call goes out saying 'All consultants, all registrars need to come to the acute medical unit meeting', managers are all there saying 'there's no beds, we've cancelled all the surgery, we need people out there, we need to get out there, we need to get people home, do it safely obviously, but it's a crisis, we've got to do this'. The teams are out there looking after the sick first. We're not going to change that. That's the ethos of a doctor, you don't look for the most stable patient first you look at the sickest patient first. Then you turn around and you say 'Why are we having this as a crisis meeting when this has been going on since September? Where were the discharge planning meetings at a bigger level?'

But the bottom line is no matter what you do you come across those same groups of patients where social care isn't there and you can't get them home. Doesn't matter how many crisis meetings you have.

PT: So what happens then? You don't discharge them, nobody else can be brought in, you've stopped the cold surgery. What happens then, when you're full up?

GS: We spill over. We spill over into the resus department, we spill over into the ambulatory care department.

PT: And then?

GS:
Then you might go on to divert, we've seen Hillingdon's been on divert, Ealing's been on divert, where you say to ambulances you can't come here you've got to move elsewhere. Northwick Park was recently in a situation where ambulances had to phone ahead to see if there was any space for the patient to be seen.

PT: Has there ever been nowhere to go? What's the furthest people have had to go in a crisis?

GS: Oxford ITU.

PT: Oxford? In an ambulance?

GS: Oxford ITU.

PT:
When was that?

GS: That was probably in my second year as a consultant. But then paediatrics is always going out to Oxford as well for all the emergency stuff.

RL:
It's common isn't it now, if a hospital is filled black. Years ago it was unheard of. I was thinking all the years I was involved I running a hospital we never got anywhere near a black but now it's every weekend, very common. Routine. We're on black.

SR: Are people dying because of this?

GS:
I don't want to have to bring that graph [Figure 1], but if you imagine that I'm saying with sepsis, with acute ITU, I've got a ticking clock, and I'm showing you graphs where people are waiting in the system. Then yes, people will die.

LI: Do you think these are unnecessary admissions?

GS: No. Absolutely not. Categorically not.

RL: We could sit and chat to you much longer, we can't because you have to go and we have our next witness. So thank you so much.