South East Clinical Senate
Kent, Surrey and Sussex

London Clinical Senate

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Joint Clinical Senate Review of the Case for Change and Clinical Models for Surrey Downs, Sutton and Merton CCGs

FINAL REPORT
September 2018

Foreword

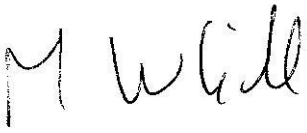
The 12 regional clinical senates were established to provide strategic, independent, clinical advice to commissioners and health systems, to help them make the best decisions about health care for the populations they are responsible for. In line with that remit, the London and the South East Clinical Senates were asked by the Merton, Sutton and Surrey Downs Clinical Commissioning Groups to provide advice on their proposals for acute service sustainability for their populations, to inform the CCGs' future pre-consultation business case.

The CCGs have produced a 'case for change' together with new clinical models and potential solutions ('Improving Healthcare Together 2030-2030'), to address the current and future challenges identified: clinical, estates and financial sustainability. Following formal review of these proposals by the two clinical senate councils, this document sets out our findings.

We recognise the considerable detailed work that has been involved in developing the case for change by a wide range of local stakeholders, but hope this independent clinical review will help in the further refinement of the case and of the future models of care.

Finally we would like to thank the contributing members of our respective clinical senate councils for giving their time and expertise in the production of this report.

Dr Lawrence Goldberg
South East Clinical Senate Chair



Dr Michael Gill
London Clinical Senate Chair

Table of contents

1. Executive summary

At the request of the 'acute sustainability programme' (ASP) led by the three CCGs of Surrey Downs, Sutton and Merton, the South East and the London clinical senates undertook an independent clinical review of the case for change clinical models and potential solutions for hospital based healthcare in their geography. The purpose of the review was to aid the ASP in ensuring that the planned pre-consultation business case was robust, evidence based, sustainable, took account of the local, regional and national context and imperatives, and would maintain or improve patient outcomes as determined by the relevant standards and metrics.

In the time available to undertake this clinical senate review a 'desktop' approach was taken, where available members of each of the two clinical senate councils separately reviewed the document provided by the ASP, called 'Improving Healthcare Together 2020-2030, Issues Paper Technical Annex: Case for Change, Clinical Model and Development of Potential Solutions, v1 draft for discussion. Surrey Downs, Sutton and Merton CCGs, June 2018'. Key lines of enquiry provided the framework for this review. The discussion and notes from both clinical senate councils were combined, and key themes were drawn out and presented in this report back to the ASP.

We appreciate the considerable efforts in bringing the Case for Change (C4C) together and our suggestions have the intention of highlighting areas where further evidence and clarity might be helpful. The following is a summary of the main points. There are additional more detailed points within each section of this report which are not captured in this summary.

Key points

- The complex environment in which the ASP is developing their proposals is recognised as very challenging, with multiple commissioner, provider, political and patient and public stakeholders. Within that context, the collaborative working between stakeholders within the CCGS' geography enshrined in the ASP board, and in the clinical advisory groups, is to be commended.

- There is a need to acknowledge the previous change programmes (e.g. the recent Better Services Better Value initiative that was abandoned in 2013), and lessons learnt and what is different about this case for change.

- Providing a broader, strategic narrative that sets the case for change in context is more likely to engage clinicians, the public and politicians, together with a clear statement of the ambition and vision for future healthcare for the defined population.

- The C4C would benefit from a stronger, clearer statement of the ambition and vision for future healthcare for the defined population, together with a broader, strategic narrative. This will help with the future engagement with clinicians, patients, the public and politicians.

- More detailed analysis of the anticipated demographic changes up to 2030 would be helpful, to understand future healthcare demand and capacity requirements (including hospital beds), as this will be a major factor in determining the feasibility of the proposed centralised model of acute care, and the finances associated with any of the 'as is' or 'to be' options.

- The C4C, clinical models and solutions focussed mainly on the EpStH trust, its services and its viability. This could be better described in the context of a wider system view of the needs of the population. Given the central role of STPs in determining the strategies within their footprints, their perspectives on the proposed clinical models and solutions is important to strategic alignment and cross-boundary issues.

- The drivers for change could be more strongly and broadly described, whilst demonstrating that these drivers are similar across the country, and not isolated to the three CCGs and its main provider. Workforce and quality of care should be considered as separate drivers, even though a key component of quality is workforce related.

- The workforce case focused particularly on A&E consultant numbers (important as those are). It would be strengthened if it took account of other medical (i.e. other specialties, GPs, trainees) and professional groups (especially the specialist nursing workforce and the therapies). The potential of new ways of working and new roles could be emphasised, and demonstration of joint working on this with Health Education England is essential.

- The scale of change proposed is not necessarily brought out in the document, and the case for it would be more forcefully argued with better supporting data. To illustrate the improvement in quality, more data on the quality of care currently delivered across the geography, and its challenges is vital. A broad range of metrics should be considered, referencing the JSNAs of the two relevant Health and Wellbeing Boards, RightCare data, and any other regional or national audit data that is available and relevant.

- Some of the terminology is confusing, particularly the use of the terms 'emergency department' (for A&E) and 'major emergency department' (for a defined grouping of acute services), and of the term 'district' in 'hospital' (vs 'district general hospital'), 'district hospital services' and 'district services'.

- The 'to be' clinical models describe a centralisation of acute inpatient medical services, maternity and paediatrics on to a single site, rather than the current two site provision. We assume further work on travel times will help with decision making. In particular, the increased distance to the nearest A&E and other acute services for patients living furthest from the chosen acute hospital site affects patient flows and ambulance conveyancing. This also has the potential to impact on patient flows to surrounding acute trusts in SW London or Surrey. If this is not to be the case, then the mitigations required need to be more fully articulated.

- Whilst sustainability is considered a key driver, the case is strengthened by describing how the new models will not just deliver better outcomes but better value. Some reference to the proposed models being more cost efficient or affordable could be made.

- Whilst it is stated that the three CCGs have determined that 'major acute services' will be provided within their geography, it will be helpful to expand on the rationale for this *a priori* condition, so that it can be justified if challenged.

- The plans to maintain the SWLEOC on the Epsom site, whichever of the three hospital sites are selected as the acute inpatient hospital, merits further description. Whilst the SWLEOC has been described as a 'stand-alone' unit, there should be clarity about the clinical pathways for such elective patients who devlop urgent or complex needs post-operatively.

- The levels of detail of the four specific clinical models described in the document (urgent and emergency care, paediatrics, maternity and planned care) are very light, constraining any detailed review of these models by the clinical senates. These, and the associated clinical pathways, workforce requirements and benefits, would be helped by some further focus and depth to enable a better understanding of how they will meet the needs of the population.

- There could be more reference to the required improvements in mental health services, for children, young people and adults, and how these will be aligned with the new models of care. Much more integration of physical and mental health care will be required in the future, and it would help to describe how this will happen, or that it is being given sufficient priority. Reference to and demonstration of alignment with local, regional and national mental health strategies and STP transformation programmes by the new proposed clinical models should be included.

2. Introduction

- The three CCGs of Surrey Downs in Surrey, and Sutton and Merton in South West London, consider that current hospital based services (primarily provided across the two acute hospitals of Epsom in Surrey, and St Helier in SW London) for their populations, as currently configured, are not sustainable, and have produced a 'case for change' (C4C) to demonstrate this. Evolving from the C4C, high level clinical models for how urgent and emergency care, paediatrics, maternity and planned care services have been produced by a clinical advisory group of local stakeholders, with proposals to centralise inpatient services on to a single hospital site (currently unspecified), whilst re-designing outpatient, diagnostic and community based services to provide care closer to home and reduce the need for inpatient care.

- The three CCGs, through their Acute Sustainability Programme Board (ASPB), requested an independent clinical 'desktop' review from the London and South East Clinical Senates (who between them cover the geography under review) of their draft C4C and evolving clinical models, contained in the document 'Improving Healthcare Together 2020-2030, Issues Paper Technical Annex: Case for Change, Clinical Model and Development of Potential Solutions, v1 draft for discussion. Surrey Downs, Sutton and Merton CCGs, June 2018.' This document is subsequently referred to as the 'C4C and Clinical Models document'.

- The joint clinical senate review was undertaken to provide an independent clinical critique of the C4C and Clinical Models document to inform the CCGs' further detailed work in preparing a pre-consultation business case (PCBC). The review aims to provide a view on the clarity, evidence base, and relevance of the C4C. It also provides an initial view on whether the proposed clinical models options are realistic, take account of other constraints and opportunities, and are likely to result in better patient care and outcomes.

- Our report and recommendations are presented in two parts: firstly those relating to the case for change, then secondly those regarding the clinical model described, both at a generic level, then for each of the four individual clinical service models described: urgent and emergency care; paediatrics; maternity; and planned care.

3. Methodology

- As the population of the three CCGs spans two clinical senates' geographical footprints - South East Clinical Senate (covering Kent, Surrey and Sussex) and the London Clinical Senate - a joint clinical senate review of the case for change and the clinical models was indicated and requested. The ASP management team had earlier presented an outline of the ongoing work to each clinical senate in May 2018 and received a joint written feedback on those presentations from the senates to inform the subsequent preparation of the CCGs' case. The terms of reference were developed with the ASPB, and the C4C and Clinical Models document was sent to both clinical senates for a detailed, desktop review at their respective clinical senate council meetings in July. For this purpose, a structured questionnaire was used at both meetings (shown in Appendix 3).

- It should be noted that the clinical senate councils are not specialty-specific panels set up to provide in depth analysis of specific pathways and services, but are composed of clinicians with a strategic perspective and experience from a range of professional groups, and do not represent their employing organisations. They were able to provide a high level, broad response to the submitted document, but were not equipped or tasked with critiquing in detail the specific clinical models described in the document.

- Conflicts of interest were declared, and care was taken to ensure that no one from any of the ASP stakeholder organisations or from the Epsom and St Helier hospital trust were involved with the review (for a list of clinical senate council members who contributed to the review, see Appendix 4).

- Each clinical senate council considered the document separately, and the findings of the South East Clinical Senate (SECS) Council, which met first, were not shared with members of the London Clinical Senate Council before or during their meeting.

- Subsequently, the notes from both council meetings were combined, and the two chairs of the two clinical senates prepared a draft report. This was then shared back to the contributing members of the two clinical senate councils for comment, before finalising and submission to the STP Senior Responsible Officers (SROs) and ASPB leads on 24th August 2018.

4. Review of the case for change

4.1. Strategic context and history

- The health, care and political landscape within and surrounding the 3 CCGs' footprint is recognised as complex and challenging, with multiple CCGs, 2 STPs, 2 London boroughs; Merton and Sutton, 1 local council; Epsom, one county council; Surrey, 2 community and 2 mental health trusts, 2 ambulance trusts, numerous acute hospital trusts in close proximity, and many parliamentary constituencies. The statutory commissioning framework for health care and service change has also shifted from regional, Strategic Health Authorities and PCTs pre-2013, to CCGs and NHS England specialist commissioning, and NHS England and NHS Improvement oversight. In this context, we were aware there have been previous reviews of how health care is provided in this geographical area, particularly on potential reconfigurations of the acute provider landscape. Most recently this was the Better Services Better Value (2011-2014) programme[1], and there may have been other reviews that preceded this. It would seem important that explicit reference is made to such previous reviews and plans for change, and reasons why these did not progress would provide a useful, honest and compelling 'lessons learnt' narrative that acknowledges the various challenges that major service change faces in the locality, and will help avoid pitfalls and concerns that could be addressed pre-emptively.

- Providing a broader, strategic narrative that sets the case for change in context is more likely to engage clinicians, the public and politicians, together with a clear statement of the ambition and vision for future healthcare for the defined population.

- The C4C focuses on reconfiguration of the acute hospital trust and the services provided from its three hospitals as the answer to the drivers within the case for change. A narrative on what other options have been considered or tried, with clarification on why reconfiguration has been chosen as the way forward, would pre-empt such predictable challenges.

- Other regions and health systems across England have gone through similar reconfiguration programmes, and reference to such examples, and any lessons learnt, will help to demonstrate that the drivers for change are felt similarly across the country, and that the pressures for change within the Surrey/SW London area under review are not unique.

[1] Better Services Better Value, for South West London. http://www.bsbv.swlondon.nhs.uk/

4.2. Alignment with local, regional and national strategies

- Clearer reference should be made to the various analyses and strategies from local to national, which should be shown to influence and evidence the case for change, to demonstrate alignment. This would include:

    - The JSNAs (joint strategic needs assessments) and JHWS (joint health and wellbeing strategies) of their health and wellbeing boards. Assuming these are still current, there will be much intelligence within these documents about the current and future health needs of the population and how these might be addressed.

    - The current strategy and plans of the two relevant STPs (Surrey Heartlands, and South West London) and their organisational membership (especially the other CCGs and acute trusts) in relation to potential acute service reconfiguration. Whilst there is ample reference to excellent plans and initiatives for more community based, integrated care, and a summary of their 'key principles (section 1.3.1.1) there are no clear indications of support for the centralisation of acute hospital services. If these have been agreed, it would be important to refer to these.

    - The Five Year Forward View, in relation to models for acute hospital care.

    - NHS England's urgent and emergency care review, referencing the need to provide care for those with serious or life threatening emergency needs 'in centres with the very best expertise and facilities, in order to maximise their chances of survival and a good recovery', and the benefits of centralising some specialist services[2,3].

[2] Transforming urgent and emergency care services in England. Urgent and Emergency Care Review. NHS England November 2013. https://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf
[3] Transforming urgent and emergency care services in England: Update on the Urgent and Emergency Care Review. NHS England 2015. https://www.nhs.uk/nhsengland/keogh-review/documents/uecreviewupdate.fv.pdf

4.3. Geography and acute hospital provision in Surrey and SW London

- Within Surrey and SW London there are a number of acute hospitals other than those of the Epsom St Helier NHS Trust, and these gain only passing reference (C4C table 2, section 1.3.2.5). The location of these other acute providers is critical when considering current and future patient pathways, and future potential coordination and collaboration between providers, and a map that includes these hospitals should be included. Figure 1 is one example produced by the clinical senates for internal use, which could be adapted for the PCBC.

Figure 1. Acute provider landscape in SW London and Surrey

- In addition, current patient pathways for the range of specialist services that are provided outside of EpStH should be described, to give a more comprehensive picture. This presumably would include major trauma, vascular surgery hub (arterial centre), acute stroke, specialist cardiology and cardiac surgery, specialist cancer surgery and tertiary paediatrics and paediatric surgery.

4.4. Demographic profiling, population projections and health care demand modelling through to 2030

- C4C Section 1.2, Needs of our Population, describes the current demographics, disease burden and health inequalities within the three CCGs. The descriptions, data presentation and paragraph headings could be strengthened as they seemed too simplistic and could be better summarised. For example; they did not provide a clear picture of where unmet need is greatest, the impact of areas of deprivation on health outcomes and life expectancy, or how the populations across each of the three CCGs are different, and each of their specific issues.

- It was not clear that this section was clearly aligned with strategy, and had public health director involvement in its preparation, which if not is strongly recommended for the PCBC.

- There was lack of analysis of future local population growth (by CCG) and anticipated demand for healthcare in the period covered by this C4C (2020-2030 as per the title), which is crucial when planning future services and healthcare provision, which is the stated purpose of this programme. This is essential for understanding the capacity and workforce required in the coming decade, for all of community based, acute and mental health services.

4.5. The drivers for change

- The drivers for change (outlined in section 1.5 of the C4C and Clinical Models document) are listed as:
  - Delivering clinical quality.
  - Providing healthcare from modern buildings.
  - Achieving financial sustainability.

  The document relates these mainly to the EpStH Trust's viability, rather than to the wider current and future health challenges of the population, and to the clinical imperatives for change. These would include demographic changes up to 2030, especially the marked anticipated increase in the elderly, patients with frailty, and with people with multiple morbidities, and how local health systems will evolve to cope. There may also be different drivers for change in each the three CCGs, and if there are these should be made explicit.

- Workforce challenges and clinical quality although related, may need to be considered as distinct drivers. The section on clinical quality refers primarily to the consultant workforce challenges, particularly those highlighted by the Care Quality Commission (CQC), and would be stronger if it covered other staff and more detailed actual clinical/patient outcome metrics and areas needing improvement. Without demonstrating that improvements in clinical outcomes are necessary, it will be much harder to convince the public that major change really is required.

- The potential patient benefits of improved quality of care and outcomes is likely to carry more weight with the public than the workforce argument (unless there is real and present patient safety issue that requires urgent action), and can be seen to compensate for the reduction in patient choice that could be a consequence of centralising inpatient services on to one site.

4.5.1 Workforce

- **Need for a broader perspective**
  The workforce discussion is focussed almost wholly on the medical workforce, and within that almost exclusively on the A&E consultant gap. Important as this is to sustainable acute hospitals, the pressures on other specialties, and on other professions (especially nursing and the therapies), should be discussed, as these may help strengthen the case for the future reconfiguration of services.

- **Current focus on consultant workforce in A&E**
  - Given the paramount issue being highlighted of A&E consultant numbers, it is essential that the steps to date taken to recruit additional staff are described, and why these have been unsuccessful so that the only realistic alternative is to centralise A&E on to one site. A clear statement is required that the trust will not have, and won't be able to recruit, sufficient medical staff to maintain two A&Es in the future to provide safe and high quality care in the future.

  - The focus on consultant staffing in A&E (as highlighted by the CQC) as a quality of care issue, is not shown to translate across to poorer care (the data presented shows that the A&E is one of the best performers in London). If there are any metrics that currently demonstrate that this relationship, this would provide a powerful case to the public and staff for why addressing this workforce issue is so critical. Data for the performance at each of the two acute hospitals' A&E departments may demonstrate that there is not a site-specific issue obscured by aggregate trust data.

- The benefits of having consultant numbers at levels to meet national standards and recommendations should be much more clearly spelt out. This is a very powerful reason for doing something differently, and this is currently limited to three bullet points on page 31 of section 1.4.3. Elsewhere, simply referring to 'meeting SW London standards' does not in itself make a compelling case to the public.

- **Other specialties**
  The clinical workforce constraints in other key specialties should be referred to (e.g. acute medicine, general medicine, elderly care, acute surgery, ICU, anaesthetics, cardiology, paediatrics, diagnostics). Critical staffing and safe rota issues in the future, as in A&E at present, can be anticipated, and may add to the case for the centralisation of acute inpatient services.

- **Future workforce projections**
  Whilst information is provided on the current workforce gap against recommendations, there are no projections of how the workforce will need to flex to meet adjusting patient need in the coming years. The narrative would be enhanced by the inclusion of workforce projections for the next 10 years (in collaboration with Health Education England).

- **Networking solutions**
  Is there scope to utilise the workforce in neighbouring trusts through shared rotas or in-reach? The workforce solutions are primarily focused on the single provider, Epsom and St Helier. This approach reduces the options to consider alternative more creative workforce models that could involve other providers.

- **New staffing models: skills and competency based vs profession based.**
  The narrative should refer to evolving workforce models that are less traditional, and focus on required skills and competencies rather than rigid professions. Examples include advanced care practitioners (nurses and paramedics) contributing to the junior doctor A&E rotas. The assessment of the constraints on the workforce detailed in the C4C are well recognised, however consideration could be given to more creative, alternative workforce models, (as is being developed by Health Education England).
  The phrase 'top end of their licence' (section 2.3.3.2 Staffing and Diagnostics) is not common parlance, it is unclear what it means, and would be best removed or clarified further.

- **Workforce requirements of the 'district hospital'**
  The modelled local hospital with an urgent care centre and range of outpatient facilities will have specific workforce requirements that are not discussed. It will be helpful to outline the anticipated workforce, including the mix of professionals, and the support required from secondary care specialists. Dependence on the primary care workforce (including extensivist GPs, nurse practitioners) will create its own challenges, and some acknowledgement of the need for a credible, realistic workforce plan will be required. The staffing needs of such a local hospital will depend critically on the hours of opening (e.g. Will they be 24/7, day time only or weekdays only).

- **Ambulance service staffing**
  The impact of centralising A&E to one site on the ambulance service workforce will need to be considered in detail with the ambulance trusts in light of the changes to patient pathways and the impact on journey times.

- **Staff engagement**
  How the wider workforce has been involved in the development of the case for change and clinical models to date could be clearer (which could be an issue further down the line if staff speak out against the proposals due to lack of engagement). This would be over and beyond the membership of the clinical advisory groups that have been developing the clinical models.

- **Need for better recruitment and retention**
  There is no discussion of the additional challenges posed to the recruitment and retention of key staff by the trust. It may be helpful to refer to the opportunities afforded through key worker accommodation as a means to attract staff, and the need to explore other enticements/attractions, importantly including the opportunity to sub-specialise and develop further skills in bigger centres with more activity.

4.5.2 Identifying and addressing the quality gap

- There needs to be a compelling narrative that states and explores the quality gap that needs to be addressed (assuming there is one). Where this is identified, clear standards and metrics that will be used to demonstrate the ambition and future performance should be stated. There was no reference to the Joint Strategic Needs Assessments (JSNAs) which could have been used to create a clear analysis of the quality gaps and challenges.

- For each of the four clinical models discussed in section 2 of the reviewed document, future expected outcomes are listed in each of the benefits frameworks. These are aspirational, and for which no baseline data is presented.

- The main quoted reference for clinical standards in the C4C is the London Quality Standards[4]. This excellent resource provides a wide range of standards over and above workforce recommendations, and the enhanced quality service that is the consequence of adequate consultant-led care and staffing, and that enables some of the key standards, could be more clearly described.

- The C4C does not identify the major areas of unwarranted variation in health outcomes, as will be identified in the RightCare data for the three CCGs.

- Data and sources that could be reviewed for quality and outcomes data include the following:
  - The JSNAs of the two relevant health and wellbeing boards.
  - RightCare for areas of unwarranted variation.
  - Standardised mortality rates (for each hospital if available).
  - Complication rates for a range of conditions.
  - Re-admission rates.
  - Specific CQC-highlighted outcomes and quality issues that need addressing (and by hospital site as well if available).
  - Any specialty-specific national comparative audit data that highlights areas for improvement (such as SSNAP for stroke care).
  - Cardiac arrest survival rates.
  - Comparative cancer survival and other cancer metrics (e.g. [5]).

4.5.3 Improving the health and wellbeing of the population

- Preventing ill health is key to a future sustainable local health system, and will be aligned with STP and health and wellbeing board strategies. The section (1.4.1) on prevention gives examples of excellent local strategies, but the importance and impact of effective prevention and public health measures could be strengthened. This should include more reference to the essential role of local authorities (housing, social care etc.) in a holistic, integrated approach.

- Mental health is referred to in section 1.2.2., but there is little in the rest of the document that addresses the challenge of the unmet need in both adult, child and adolescent services, both within the hospitals and in the community.

- How current health inequalities will be addressed is not discussed.

[4] London Quality Standards: acute emergency and maternity services. London Health Programmes, Feb 2013. https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf

[5] National cancer waiting time data: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

4.5.4 Estates

- Although the older infrastructure of St Helier is described, the implication is that facilities at Epsom are more modern (this in implicit in the data provided, that 57% of the EpStH estate was built before 1948, with 93% at St Helier, implying that Epsom and other sites are predominantly post-1948). A more balanced description of the estate would be appropriate.

4.5.5 Finance

- Although the current overspend is described in the C4C and Clinical Models document, the potential savings from reconfiguration and centralisation are not discussed, which weakens the financial case for the major changes proposed. The NIHR review of the drivers and evidence for service reconfiguration found an absence of evidence of cost savings from many previous major service changes[6]. In addition, reference should be made to the Nuffield Trust publication 'Shifting the Balance of Care: Great Expectations', which looks at the evidence for reduction in whole system costs from a range of current health care initiatives[7].

4.6. Provider focus of the C4C

- It is recognised that the case for change does not seek to address all the health and care issues of the population, and the focus is more on the provision of hospital services, but this focus should be made much clearer to avoid confusion of purpose, and ensure the content is directly relevant to the changes being proposed. Nonetheless, patient pathways in to and out of hospital are key, and such pathways would benefit from greater emphasis with examples.

[6] Insights from the clinical assurance of service reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed-methods study. Imison C et al. Health Serv Deliv Res 2015;3(9). https://www.ncbi.nlm.nih.gov/books/NBK280129/pdf/Bookshelf_NBK280129.pdf (e.g. see page 100).
[7] Shifting the balance of care: Great expectations. Imison C et al. Nuffield Trust March 2017. https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf

4.7. Evidence of public and patient engagement

- The level of public engagement in the production of the case for change and clinical models document is not clear enough. Most reference is made to the engagement exercise undertaken during 2017 by the EpStH trust in producing their strategic outline case, reported in the publication Epsom and St Helier 2020-2030, Your Views[8]. A more detailed summary of the proposals for which consultation were sought in that exercise should be provided, and the key messages that were received stated.

- That engagement exercise was presumably based primarily around the future of the hospital trust, whereas the current commissioner-led programme would likely have broader considerations of future healthcare of the three CCGs' populations.

- The nature of engagement and questions asked of the public would presumably therefore be different. It would therefore be helpful to show any additional views of the public received in any subsequent consultation work to date, and how that has been taken in to account and addressed in the current document. Feedback from patients and the public that is supportive of change is clearly of major importance in getting agreement for the changes being considered.

- There are likely to be different considerations from the public across the three CCGs' geography (e.g. Surrey residents may have different perspectives and concerns from those in SW London) and it will be important to demonstrate this as the programme moves forward, and to take account of such location-specific feedback.

[8] Epsom and St Helier 2020 – 2030: Your views. Epsom and St Helier University Hospitals NHS Trust 2017. https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jijm4n8161.pdf&ver=19815

5. Review of the clinical models

5.1. Comments on the overarching clinical model

5.1.1 Terminology and definitions

- Some of the usage of terms for services, groups of services and hospitals is confusing without clearer distinction between them. A review of terminology and definitions is recommended. Examples are as follows:
  - '**Emergency Department'**. Whilst this is a new term for A&E, the latter is in much more common parlance and is recognised by the public.

  - '**Major emergency department'** is used to describe the grouping of 'emergency department, acute medicine, emergency surgery and critical care' (see executive summary, section 2.2.1 and conclusions sections). Alternatively an alternative term should be used for the 'major emergency department', as it is not really a 'department' but a functional grouping of related services.

  - '**District hospital'**, '**district hospital services**' and '**district services'**. The terminology was found to be somewhat confusing, compounded by the fact that the current Epsom and St Helier Hospitals are 'district general hospitals'. The document would benefit from clear definitions of what district hospital/hospital services/services describes, unless alternative terminology is decided upon following continued engagement with your users and population.

  - '**Major acute hospital'**. It is not clear that this is a widely used and defined term in England, though does describe the essence of the proposed single site acute hospital for the trust. The terminology in this area is confused by the proposed terms in NHS England's 'Transforming urgent and emergency care services in England' review[9], which suggests Emergency Centres, and Major Emergency Centres (the distinction being the presence of specialist services in a MEC, leading to an alternative term of Specialist Emergency Centres', though this terminology has not taken root nationally to our understanding.

[9] Transforming urgent and emergency care services in England (NHS England, 2015). https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

5.1.2 Patient access, travel times and the impact on other providers in Surrey and SW London from single siting acute inpatient care

- **Potential changes to patient flows from single siting acute services.**
  - Patient flows and the potential for these to change if acute provision is based at a single site (e.g. the St Helier or Epsom site) are not considered in the document. There is an implied assumption that patients will continue to access EpStH Trust services in the way they do currently. The increased travel times to a centralised EpStH acute hospital may imply that acutely ill patients living more distant from that hospital should be taken another, nearer hospital.

  - Alternative acute models that take in patient pathways to other acute providers in Surrey or SW London are not acknowledged as a potential outcome of centralising acute care onto a single site, which would have a significant impact on EpStH Trust's activity and finances.

- **Comparative travel times from within the three CCGs to acute providers**
  We recognise there is likely to be further work on travel times and that might cover the following points which were raised:
  - The travel times from different parts of the three CCGs to a single EpStH hospital acute site are illustrated in Appendix 2, to demonstrate comparative travel times to different surrounding hospitals. This issue needs explicit reference, and strategic discussions with neighbouring trusts and the ambulance services, to understand future patient flows and activity.

  - Distances and travel times to any of the potential single acute hospital locations should be provided, including public transport access as well as ambulance and car travel times. This is important baseline information that grounds the discussion in the real world, and recognises the public's usual focus on access to healthcare.

- **Ambulance service considerations**
  There should be more reference to ambulance provision and capacity, and the wider impact on patient pathways from the proposed new models. The ambulance services are normally expected to take the patient to the nearest emergency department, unless the patient is on a specialist pathway, has an agreed care plan or there are other exceptional circumstances. Whilst discussions could be had with the ambulance services about mandating the transfer of patients to the EpStH single acute hospital site, the full quality and safety consequences of any longer conveyancing times must be fully discussed, understood and be part of the preparation of the PCBC.

5.1.3 The case for keeping acute inpatient care within the 3 CCGs' geography

- The rationale for keeping 'major acute services' within the CCGs' geography is not made sufficiently clear, even though it is stated as a given and used as one of the three initial tests to short list options (see section 3.4.2). Confirmation from the STPs and wider stakeholders outside of this geography of this requirement would help substantiate this assertion.

5.1.4 Consequences of centralising acute inpatient care on to one site

- **Making the scale of the proposed changes more explicit**
  - The 'do something' options all describe a single centre for A&E and emergency and acute inpatient care, and although this is described in each of the four specific clinical models, this major change in the trust's configuration is not stated in such clear terms and with the profile required within the document.

  - Given the scale of the proposed change, and the long previous history of discussions about the trust's configuration, previous attempts or alternatives to address the challenges without resorting to reconfiguration should be clearly outlined, to understand better the need for centralisation, and why the alternatives are not considered feasible.

- **Maintaining patient flow in the acute hospital**
  Good patient flow through the hospital and back to the community will be even more important with a single acute site and the need to maintain bed capacity to meet demand. More clarity on the pathways for long stay patients who cannot be discharged home, or could be repatriated to a community-based bed closer to home, should be provided.

- **Examples of pathways**
  The narrative would benefit from patient vignettes and exemplar pathways, which would be a potent and engaging way to demonstrate the perceived benefits of the new model.

- **Modelling inpatient capacity requirements**
  Inpatient bed modelling should be provided, both current capacity and forecast up to 2030. This is critical to understanding the feasibility of centralising acute inpatient services on to a single site, and in determining the financial consequences. This would have to take account of any change to the catchment area of the acute trust if as a result of centralisation patient flows for those living furthest from the chosen hospital change to some of the surrounding hospitals in Surrey or SW London.

5.1.5 Clinical co-dependencies

- The rationale for using the co-dependency case for single siting needs to be made more explicit and in a way that the public can relate to.

- The range of co-dependent services for the emergency department (A&E), acute medicine, emergency surgery, critical care, obstetric-led births and emergency and inpatient paediatrics is summarised on 2.2.1.1. The South East Clinical Senate's review of the clinical co-dependencies of acute hospital services provides more depth on the full range of clinical services recommended to be on the same site, particularly the medical specialties, as the label 'acute medicine' does not refer to these services[10]. Note that the link to this review on page 45 of the C4C document does not work.

5.1.6 'District hospitals' and 'district hospital services'

- **Description of the changes involved**
  - From the document, it appears there are in fact major changes planned for the 'district hospital', in line with the STPs' initiatives to deliver more care locally, to establish an augmented UTC on site, and use the district hospital beds differently as a way to maintain flow in the acute hospital and avoid admission. The following statement 'Given there is no case for major service change in district hospital services, the numerous existing district hospital services that are a key part of local strategies and objectives will continue to be developed without need for major changes to be considered.', does not therefore seem accurate, and it would seem better to accentuate the improvement in functions and facilities at a revamped district hospital site.

- **Staffing model**
  - As work on this model progresses, it will be important to have clarity on the clinical accountability and the duty of care for inpatients, policies and guidance for admissions and bed prioritisation.
  - There are opportunities for developing an integrated workforce model that does not necessarily depend on primary care generalists, and includes elderly care specialists outreaching from secondary care or on community-based contracts.
  - The staffing needs or such a community hospital will depend critically on the hours of opening (e.g. will they be 24/7, 12/7 or weekdays only).

[10] The Clinical Co-dependencies of Acute Hospital Services. South East Clinical Senate, Dec 2014. http://www.secsenate.nhs.uk/files/4015/0029/9866/The_Clinical_Co-dependencies_of_Acute_Hospital_Services_SEC_Clinical_Senate_Dec_2014_errata_grids_B_and_C_corrected.pdf

- **Bed capacity**
  As for the future single site acute hospital, activity and bed modelling should be provided to understand current and projected capacity requirements. The implication is that district hospital beds will form a major part of maintaining flow in the acute hospital (along with the expansion of out-of-hospital community services). This was not available.

- **Best practice and national guidance**
  The C4C narrative does not take account/expand and make best use of existing areas of best practice in community based acute care, particularly the Epsom Health and Care Alliance's Epsom Health and Care '@home' integrated service[11]. Reference should be made to the national guidance on urgent treatment centres as a key source in the development of and description of UTCs[12].

5.1.7 Implications for the SWLEOC if key co-dependent inpatient services are moved from the Epsom site

- The South West London Elective Orthopaedic Centre (SWLEOC) is planned to remain at the Epsom site, regardless of which of the shortlisted acute hospital configurations are finally selected. Whilst the SWLEOC has been described to us as a 'stand-alone' unit, there should be clarity about the clinical pathways for such elective patients who devlop urgent or complex needs post-operatively, particular those needing HDU or ICU care, for whichever of the future configuration options for major acute services is chosen.

5.1.8 Level of detail provided on each of the four clinical models

- For each of the individual clinical models that are being developed (urgent and emergency care, maternity, paediatrics and planned care), the descriptions were short and lacking in fine detail, and were more overviews. As such, the clinical senates were unable to comment about these in any detail, but were able to make general points, as provided in the next section.

[11] The Epsom Health and Care '@ Home' service. CSH Surrey. https://www.cshsurrey.co.uk/our-services/service-adults/epsom-health-and-care-home
[12] Urgent Treatment Centres – Principles and Standards. NHS England July 2017. https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards/

5.2. Urgent and emergency care (including A&E, acute medicine, acute surgery and critical care)

- There is almost no information about the clinical model at the proposed new single site acute inpatient hospital, other than figure 12. This contrasts with the extensive discussion in the section on the district hospital and the urgent care centre. This is currently an unbalanced section, and more detail should be provided as to what the new centralised hospital would look like, including likely activity, bed requirements, staffing issues (not just A&E consultants) and patient pathways and flows.

- It is not possible at present to comment on how the centralised inpatient service would deliver higher quality care, or a greater range of services than the 'as is' model, and this needs to be addressed. The benefits of a single site model needs better articulation, and it is therefore difficult to comment on how realistic the improved outcomes expected and summarised in the benefits framework (section 2.3.2) are. Reference could be made to the impact of closing type 1 EDs as described in a recent publication[13].

- The co-located services at the 'to be' acute inpatient hospital (as shown in figure 12) are all appropriate and consistent with the SECS co-dependency grid. An additional box could be added that represents the range of acute medical specialties (such as cardiology, respiratory, gastroenterology, elderly care, gastroenterology) which the box 'acute medicine' does not cover.

- It is not clear what the level of critical care at the non-acute, 'district hospital' site would be. In figure 12, there is no mention of an HDU. It will be important to clarify what this unit provides, and whether it would remain viable without the currently co-located ITU currently at Epsom. Have levels of critical care provided on the second site been fully explored with intensivists – could HDU be sufficient to support elective general surgery delivery at second site and accommodate any escalations from GP admissions?

- There are no references to ambulance triage, and the modelling would benefit from inclusion.

- Reference to relevant metrics, standards, and current baseline data should be provided, e.g. A&E performance, DTOC, current problems with two site working and splitting the trust's workforce.

[13] Closing five emergency departments in England between 2009 and 2011: the closed controlled interrupted time-series analysis. Knowles E et al. Health Services and Delivery Research. July 2017. https://www.ncbi.nlm.nih.gov/books/NBK513754/pdf/Bookshelf_NBK513754.pdf

- There should be an ambition described to achieve specified standards and targets, with timescales.

- Significant detail will be required to describe the patient pathways within the PCBC.

- There should be more information on workforce planning and assumptions, including the non-consultant (trainee) medical workforce and other staff groups. With a single site there would presumably be better staffed rotas across a wide range of specialties de livering UEC, which could deliver a number of important benefits, not least delivering seven day services, more consultant-delivered care, sub-specialisation, and recruitment and retention benefits.

5.3. Paediatrics

- There should be some data provided and modelling on the future demand, activity and capacity required for inpatient paediatric services up to 2030.

- An outline of the workforce plan is absent.

- The ambition to have a level 2 paediatric critical care unit at the main acute hospital site is stated. It would be helpful to define what types of patients would be treated in such a stand-alone unit in the absence of a co-located level 3 unit (which we understand is the usual configuration). Reference should be made to Healthy London Partnership's standards document, 'Paediatric critical care standards for London' in this section and when developing the model further[14]. Such plans will of course need to be agreed and coordinated with the paediatric networks in South London and Surrey, and with the South Thames Retrieval Service for critically ill paediatric patients.

- Greater clarity around the CAMHS provision is required. There are some broad generic comments made with limited narrative to validate the proposed approach which should be better explained, such as: 'CAMHS provided consistently', and 'support for community paediatrics'.

- The provision of better paediatric out of hospital care should be informed by the revised best practice guidelines produced by the Healthy London Partnership (Nov 2016)[15].

[14] Paediatric critical care standards for London. Healthy London Partnership. March 2016. https://www.myhealth.london.nhs.uk/sites/default/files/Healthy%20London%20Partnership%20-%20Paediatric%20Critical%20Care%20Level%201%20and%202%20Standards_0.pdf

[15] Out-of-hospital care standards for London's children and your people. Healthy London Partnership Nov 2016. https://www.healthylondon.org/wp-content/uploads/2017/10/Out-of-hospital-care-standards-for-children-and-young-people.pdf

5.4. Maternity

- Whilst the birth rates (per 1000 births) are quantified in figures 22 & 23, the actual numbers are not given (either for the two current hospitals ('as is') or with the planned centralisation of the MLU and obstetrician led unit. This data is essential for workforce planning, current and future activity levels and sustainability, and for capacity planning to 2030.

- A map of patient flows here and in the surrounding areas would be helpful in understanding how the maternity networks function and how patient flows operate.

- Reference to how the model aligns with the requirement to provide patient choice would be helpful.

- A direct reference to the LMS plans in respect to analysis and understanding of unwarranted variation /patient safety should be included.

- It would be helpful to include direct reference to data on quality metrics, including:
  - Outreach provision (for unexpected/unplanned home births).
  - Still birth rate.
  - Neonatal mortality.
  - Caesarean section rates.

- Reference should be made to the NHS England guidance Better Births: Improving outcomes of maternity services in England (NHS Feb 2016)[16] , and how the new proposed model is aligned with it.

- It is unclear how the proposed model fits together with the two relevant local maternity strategies for Surrey Heartlands[17] and for SW London[18].

- The C4C references an informal approach to developing the model without using the evidence or established groups available to support them (such as the LMS networks).

[16] Better Births: Improving outcomes of maternity services in England. NHS Feb 2016. https://www.england.nhs.uk/mat-transformation/implementing-better-births/mat-review/

[17] NHS Early Adopters in Maternity Services – Surrey Heartlands. https://www.england.nhs.uk/mat-transformation/early-adopters/

[18] South West Local Maternity System Maternity Transformation Delivery Plan 2017/18-2020/2021 January 2018. Weblink awaited.

- The C4C does not contain sufficient workforce planning details. What analysis is available is limited to high level consultant plans and does not reflect midwifery numbers. The consultant modelling, shown in table 10 (section 3.5.2.4) does not seem realistic. In particular, the plan to only run one obstetrics rota with potentially as few as 12 consultants needs review. The required numbers needs referencing. It is important that economies of scale from centralising the obstetrician-led service are recognised but more detail is required.

5.5. Planned Care

- There was an absence of activity and capacity modelling through to 2030 to comment on. This would determine the feasibility for achieving the stated outcomes aims in the benefits framework (reduced day case cancellations and reduced waiting times for treatment).

- It was not clear how the planned reduction in re-admission rates for surgical complications would be achieved from the information presented, and evidence of planned changes that would lead to this should be provided.

- The narrative indicates some 'good' ideas, but the absence of a clear evidence base is a cause for concern. We sense that there are some missed opportunities within this model to create a compelling evidence based case.

- Does the Royal Marsden Hospital have any augmented role and impact in the provision of planned care in any new model of care?

- Reference should be made to any national or regional guidance on standards and best practice in this area.

- There were no details on workforce planning, and how it would be integrated with the acute hospital site, to be commented on.

- The planned expansion of the one-stop shop approach and virtual clinics for outpatients is strongly supported.

- For detailed comments about the SWLEOC, refer to section 5.1.7.

6. Appendices

Appendix 1. Abbreviations

ASP(B) – Acute Sustainability Programme (Board). The programme set up by the three CCGs to take this programme of work forward

CCG – Clinical Commissioning Group

C4C – Case for Change

PCBC – pre-consultation business case

EpStH – Epsom and St Helier University Hospitals NHS Trust

CQC – Care Quality Commission

JSNA – Joint Strategic Needs Assessment

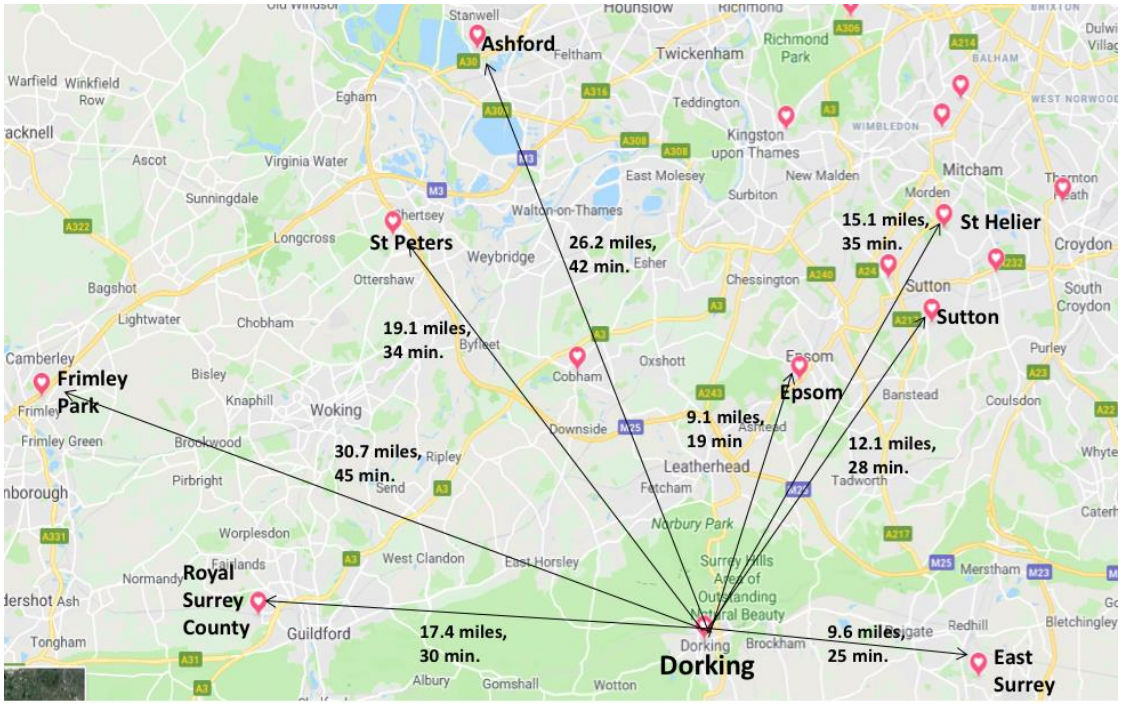
JHWS – Joint Health and Wellbeing Strategy

SWLEOC - The South West London Elective Orthopaedic Centre

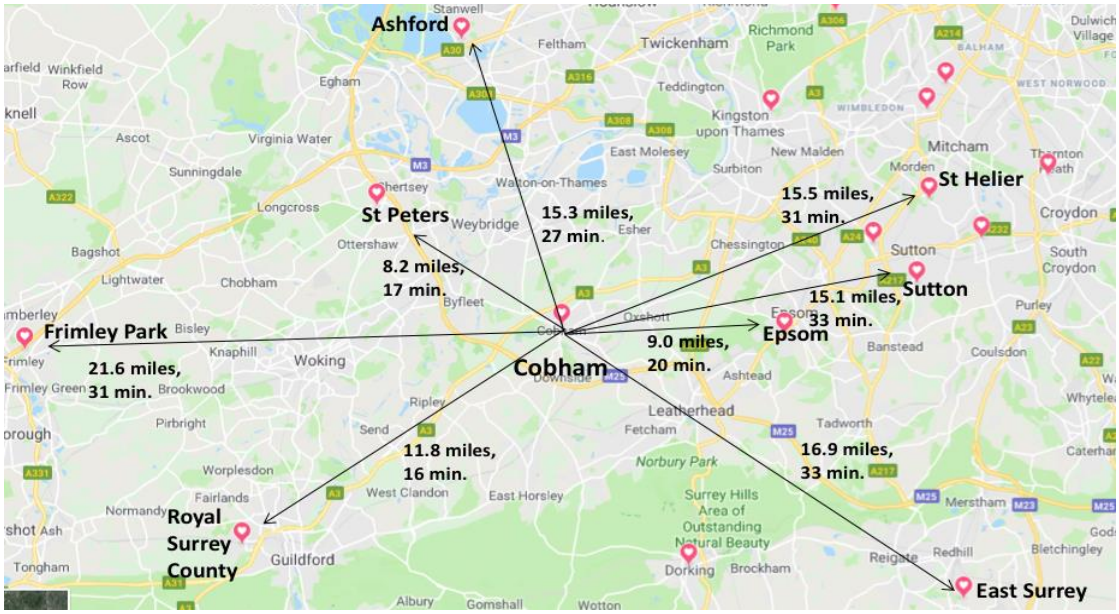
SECS – South East Clinical Senate

Appendix 2. Travel times between sites in Surrey Downs and SW London and nearest providers [*].

2.1. Travel distances, Dorking to St Helier and Surrey acute hospitals.

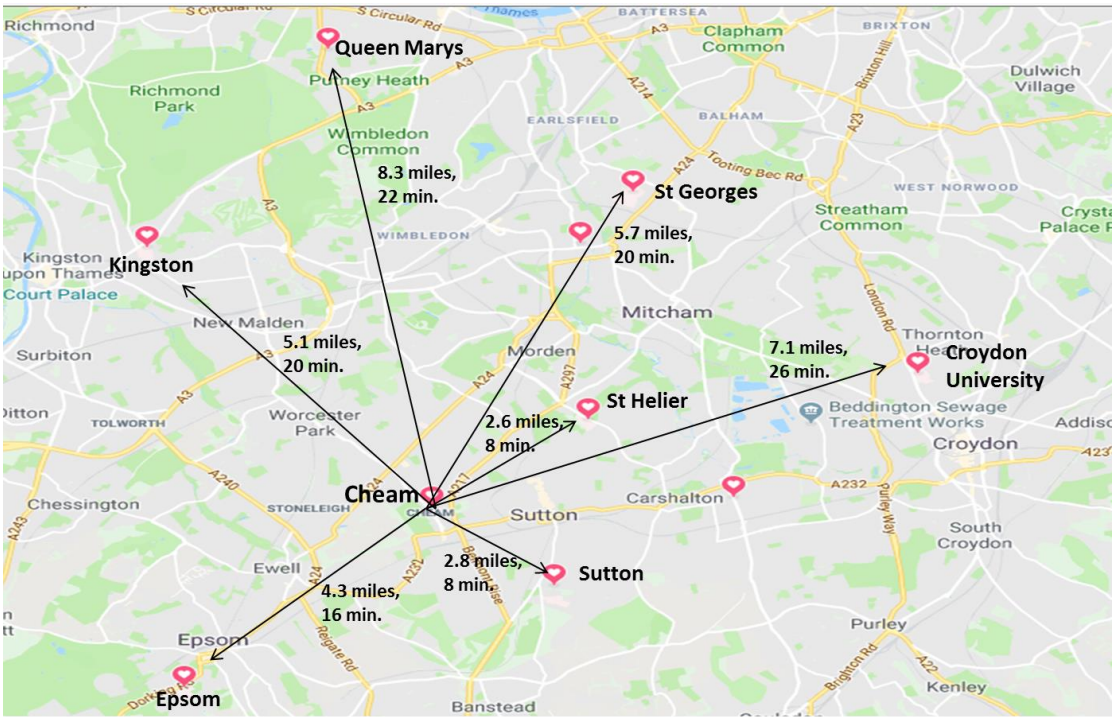


2.2. Travel distances, Cobham to St Helier and Surrey acute hospitals

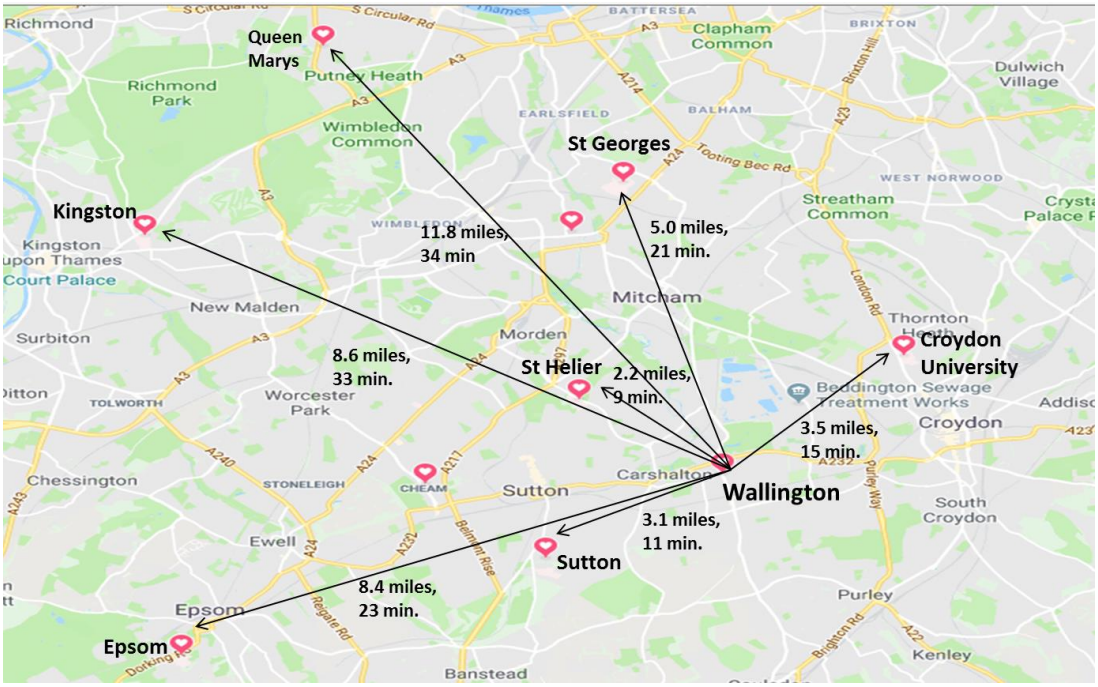


[*] Maps and distances produced by the clinical senates from Google, using car daytime travel time
This should be undertaken more formally in the PCBC using data including non-emergency and emergency ambulance transport data.

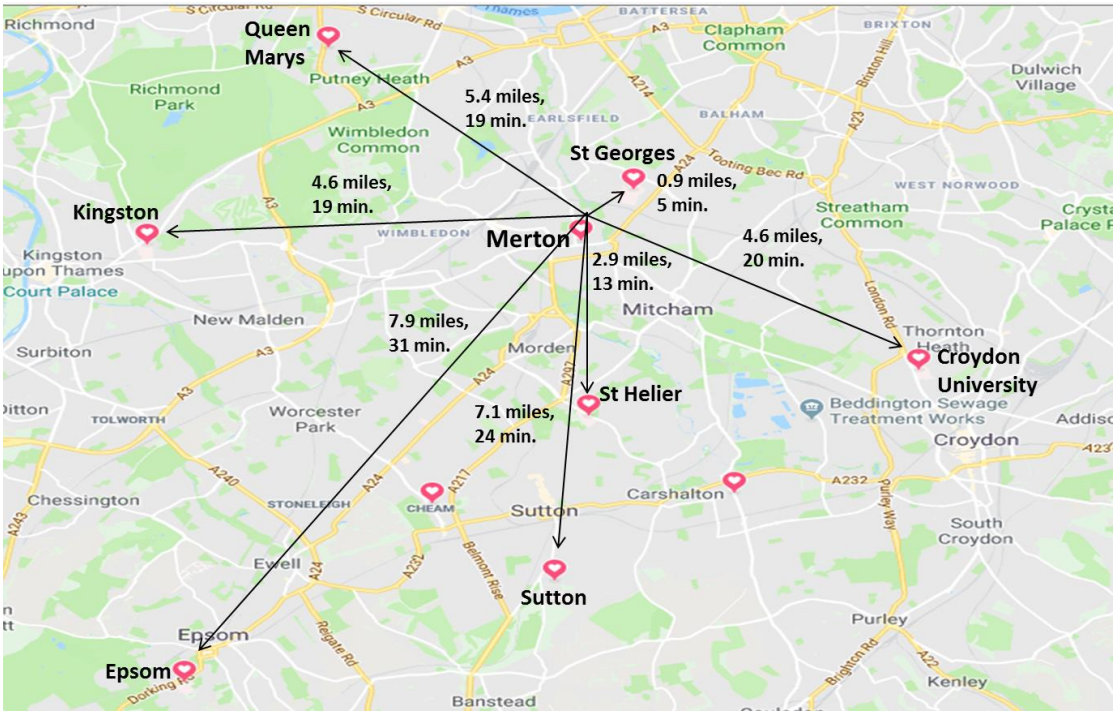
2.3. Travel distances, Cheam to Epsom, Sutton and SW London acute hospitals



2.4. Travel distances, Wallington to Epsom, Sutton and SW London acute hospitals



2.5. Travel distances, Merton to Epsom, Sutton and SW London acute hospitals



2.6. Table of travel distances from selected towns in Surrey Downs and SW London to other local acute hospitals*.

A) Surrey Downs CCG

Acute hospital:	Dorking		Cobham	
	Miles	Time (min)	Miles	Time (min)
St Helier	15.1	35	15.5	31
Sutton	12.1	28	15.1	33
Epsom	9.1	19	9.0	20
East Surrey	9.6	25	16.9	33
Royal Surrey County	17.4	30	11.8	16
Ashford	26.2	42	15.3	27
St Peters	19.1	34	8.2	17
Frimley Park	30.7	45	21.6	31
Croydon University	17.9	46	18.3	45

B) Sutton and Merton CCGs

Acute hospital:	Cheam		Wallington		Merton	
	Miles	Time (min)	Miles	Time (min)	Miles	Time (min)
St Helier	2.6	8	2.2	9	2.9	13
Sutton	2.8	8	3.1	11	7.1	24
Epsom	4.3	16	8.4	23	7.9	31
Croydon University	7.1	26	3.5	15	4.6	20
St Georges	5.7	20	5.0	21	0.9	5
Kingston	5.1	20	8.6	33	4.6	19
Queen Marys	8.3	22	11.8	34	5.4	19

* Maps and distances produced by the clinical senates from Google, using car daytime travel time
This should be undertaken more formally in the PCBC using data including non-emergency and emergency ambulance transport data.

Appendix 3. Table of Key Lines of Enquiry used at the two clinical senate council desktop review meetings

A. Case for Change: Key Lines of Enquiry:
1. Strategic Imperative for change
Have the key drivers for change, both internally (within the three CCGS' footprint) and externally been clearly articulated?
Is the case for change aligned with local, regional and national strategies (including those of the two relevant STPs)?
Is there sufficient evidence of learning from the various past reviews of healthcare provision in this geography?
Has the quality gap that needs addressing been comprehensively and convincingly described?
2. Health Inequalities, population and public health
Does the Case for Change (C4C) take into account the demographic profile, geography and the provider landscape, current outcomes, and address health inequalities?
Does the C4C demonstrate modelling and planning for sustainable healthcare provision through to 2030?
3. Evidence of patient-centered focus
Is there evidence of public and patient involvement in the development of this C4C, and in setting the expectations and ambitions for safe, effective and accessible care?
Do the broad plans and approach to address the current quality gap seem appropriate and sufficient?
4. Delivering high quality, safe and value based care.
Do the proposed clinical models appear to meet the needs of the combined populations of Sutton, Merton and Surrey Downs CCGs?
Is there sufficient clarity on which metrics and outcome measures will be used to demonstrate that the proposed changes will be successful?
Does the case for change adequately identify the major areas of unwarranted variation in health outcomes?
5. Configuration of acute services: critical co-dependencies.
Does the C4C take into account the co-dependent clinical services required to deliver high quality and safe care, and to meet any national requirements?
Are the benefits of centralising specific clinical services on to one hospital site (a consequence of any of the 'do something solutions'), adequately described?
6. Workforce, education training
Does the C4C provide a realistic assessment of the workforce availability, constraints and anticipated demands?

7. Ambition
Is there a compelling strategic narrative 'thread' that runs throughout the C4C that includes a clear vision of the desired future state?
B. Clinical Models: Key Lines of Enquiry:
8. Overarching questions applicable to all models:
Given that the document states that all the described services would need to be provided within the 3 CCGs' geographical footprint, have the implications for patient access and travel times been taken account of when these services are centralised on one of the three proposed sites?
Is the role of 'district hospital beds' in the patient pathways clear, and seem appropriate?
If critical care and other acute services are moved from the Epsom site, have the implications for the SWLEOC been anticipated (this would go in general surgery if that included orthopaedics)?
9. Proposed clinical models
9.1 Urgent and Emergency Department, (including A&E, acute medicine, acute surgery and critical care):
Has the clinical case for the proposed service reconfiguration been sufficiently described and evidenced; including the potential impacts (both benefits and risks).
Does the model address any relevant unwarranted variation that has been identified?
Does each of the clinical models adequately refer to any relevant national and local standards, clinical guidance and evidence based best practice?
Does the model have the capacity and flexibility to adapt to changes in demand or future service provision up to 2030?
Are the associated outline workforce plans considered realistic?
Any other comments about this clinical model?
9.2 Paediatrics:
Has the clinical case for the proposed service reconfiguration been sufficiently described and evidenced; including the potential impacts (both benefits and risks)?
Does the model address any relevant unwarranted variation that has been identified?
Does each of the clinical models adequately refer to any relevant national and local standards, clinical guidance and evidence based best practice?
Does the model have the capacity and flexibility to adapt to changes in demand or future service provision up to 2030?

Are the associated outline workforce plans considered realistic?
Any other comments about this clinical model?
9.3 Maternity:
Has the clinical case for the proposed service reconfiguration been sufficiently described and evidenced; including the potential impacts (both benefits and risks)?
Does the model address any relevant unwarranted variation that has been identified?
Does each of the clinical models adequately refer to any relevant national and local standards, clinical guidance and evidence based best practice?
Does the model have the capacity and flexibility to adapt to changes in demand or future service provision up to 2030?
Are the associated outline workforce plans considered realistic?
Any other comments about this clinical model?
9.4 Planned Care.
Has the clinical case for the proposed service reconfiguration been sufficiently described and evidenced; including the potential impacts (both benefits and risks).
Does the model address any relevant unwarranted variation that has been identified?
Does each of the clinical models adequately refer to any relevant national and local standards, clinical guidance and evidence based best practice?
Does the model have the capacity and flexibility to adapt to changes in demand or future service provision up to 2030?
Are the associated outline workforce plans considered realistic?
Any other comments about this clinical model?

Appendix 4. Clinical senate councils members contributing to this review and conflicts of interest *

Name	Roles
A) South East Clinical Senate	
Lawrence Goldberg	Chair of the South East Clinical Senate, and Consultant Nephrologist, Brighton and Sussex University Hospitals NHS Trust
Amanda Allen	Therapy Manager, Maidstone and Tunbridge Wells NHS Trust
Mandy Assin	Consultant Psychiatrist, Sussex Partnership NHS Foundation Trust
Alison Barnett	Deputy Centre Director, Public Health England South East
Helen Bell	Clinical Senate Programme Manager
May Bullen	Patient and Public Engagement Representative
Priscilla Chandro	Patient and Public Engagement Representative
David Davis	Paramedic; Clinical Programme Lead, Digital Urgent and Emergency Care, NHS England
Peter Green	Chief Clinical Officer, General Practitioner, NHS Medway CCG. General Practitioner. Representing Kent and Medway CCGs
Jackie Huddleston	Associate Director, South East Clinical Networks
Rachel Mackay	Pharmacist, Guildford & Waverley CCG
Ali Parsons	Associate Director, South East Clinical Senate NHS England South East (Kent, Surrey, Sussex).
Mansoor Sange	Consultant Anaesthetist and Intensivist, Kent Critical Care Clinical Group, Darent Valley Hospital, Dartford.
Alison Taylor	Deputy Medical Director, NHS South (South East), NHS England GP

* For full South East Clinical Senate Council membership, see http://www.secsenate.nhs.uk/clinical-senate-council/membership/
For full London Clinical Senate Council membership, see http://www.londonsenate.nhs.uk/senate-council/members/

B) London Clinical Senate	
Mike Gill	London Clinical Senate Council Chair, and Consultant, Homerton University Hospital NHS Foundation Trust. Medical Director, Health 1000: The Wellness Centre
Ian Abbs	Chief Medical Officer, Guys and St Thomas, NHS Foundation Trust
Somen Banerjee	Director of Public Health, London Borough of Tower Hamlets
Vin Diwakar	Medical Director, NHS England (London Region) London Clinical Senate Forum Co-Chair
Tim Edwards	Consultant Paramedic, London Ambulance Service NHS Trust
Katie Humphreys	Clinical Senate Senior Project Manager
Diane Jones	Chief Nurse/Director of Quality & Safety, North-West London Clinical Commissioning Groups
Sally Kirkpatrick	London Clinical Senate PPV Group Chair
Peter Littlejohns	Professor of Public Health, King's College London. Deputy Director, Collaboration for Leadership in Applied Health Research and Care (CLAHRC) South London
Myra Malik	Associate Medical Director, Faculty of Medical Leadership and Management. Patient Safety Fellow, Royal Marsden Hospital
Andy Mattin	Executive Director of Nursing and Quality, Central & North West London NHS Foundation Trust
Geeta Menon	Postgraduate Dean South London, Health Education England
Oliver Shanley	Regional Chief Nurse (London Region), NHS England and NHS Improvement. London Clinical Senate Forum Co-Chair
Mark Spencer	London Clinical Senate Council Vice Chair, General Practitioner, Care UK
Inder Singh Uppal	London Clinical Senate PPV Group Vice-Chair
Malti Varshney	Associate Director Clinical Networks and Senate, NHS England (London Region)
Edward Ward	Clinical Senate Manager

South East Clinical Senate Council members' declarations of interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Amanda Allen	None	None	None	None
Mandy Assin	None	None	None	None
Alison Barnett	None	None	None	None
May Bullen	None	None	None	None
Priscilla Chandro	None	None	None	None
David Davis	None	None	None	None
Peter Green	None	None	None	None
Lawrence Goldberg	None	None	None	None
Jackie Huddleston	None	None	None	None
Rachel Mackay	None	None	None	None
Ali Parsons	None	None	None	None
Mansoor Sange	None	None	None	None
Alison Taylor	None	None	None	None

London Clinical Senate Council members' declarations of interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Mike Gill	None	None	None	None
Ian Abbs	None	None	Executive director at GSTT, an organisation that may be affected by the commissioning changes proposed in SWL	None
Somen Banerjee	None	None	None	None
Vin Diwakar	None	None	None	None
Tim Edwards	None	None	None	None
Diane Jones	None	None	None	None
Sally Kirkpatrick	None	None	None	None
Peter Littlejohns	None	None	None	None
Myra Malik	None	None	Employed by the Royal Marsden Hospital	None
Andy Mattin	None	None	None	None
Geeta Menon	None	None	None	None
Oliver Shanley	None	None	None	None
Mark Spencer	None	None	None	None
Inder Singh Uppal	None	None	None	None
Malti Varshney	None	None	None	None