



London Clinical Senate



South East Clinical Senate

Kent Surrey and Sussex

South East Clinical Senate & London Clinical Senate

**Joint Clinical Senate Review of the Improving
Healthcare Together 2020-2030 Pre-
Consultation Business Case, for Surrey
Downs, Sutton and Merton CCGs**

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FINAL**

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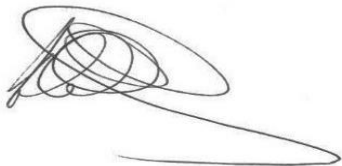
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Foreword

The South East (Kent, Surrey and Sussex) and London Clinical Senates were asked to jointly review the 'Improving Health Together' (IHT) pre-consultation business case (PCBC) and its proposals for health services in the three clinical commissioning groups (CCGs) of Surrey Downs in Surrey, and Sutton and Merton in South West London. The proposals underpin a substantial change programme to provide sustainable hospital services in South West London and Surrey Downs. A multi-disciplinary independent review panel of health and care professionals with a wide range of experience and representatives of service users and carers was brought together to review the PCBC.

That panel after hearing from the IHT team worked to develop the recommendations in this review. We would like to commend the IHT team for their drive and initiative in developing an innovative solution to their key challenges of workforce, estate and financial sustainability. Such innovative solutions do require great scrutiny; hence we have made multiple recommendations. Some of them cover similar issues in the different sections. Many of our recommendations are also clarifications and suggestions to improve the case and make it clearer to the reader.

We would like to thank the IHT team for their work in presenting the case to the review team and answering questions. Thanks also to the review panel for agreeing to contribute to the review and for their thoughtful questioning and review of this document. Finally, a thank you to the support teams of both senates for coordinating the review and bringing the report together.



Dr Lawrence Goldberg
South East Clinical Senate Chair



Dr Michael Gill
London Clinical Senate Chair

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1. Executive summary

Background

The three Clinical Commissioning Groups (CCGs) of Surrey Downs, Sutton and Merton, leading the programme 'Improving Healthcare Together 2020-2030' (IHT), have concluded with their stakeholder partners that the acute trust within their combined geographies, the Epsom and St Helier NHS Trust (ESH Trust), needs to radically change the way it provides its services to be sustainable in the coming years. The challenges are summarised as relating to the workforce for acute care, aging estates and financial sustainability.

A detailed draft pre-consultation business case (PCBC) has been produced, which summarises the case for change, the proposed clinical model, and then detailing those shortlisted options for the future configuration of hospital services. Whilst option 1 would continue to have the major acute services on both the current sites of Epsom Hospital and St Helier Hospital, options 2, 3 and 4 involve centralising these services (including the emergency department (A&E), acute medicine and surgery, critical care, inpatient obstetrics and inpatient paediatrics) on a single site (either at Epsom, St Helier or Sutton).

A key element of the proposals is to set up two 'district hospitals' (DH), one at Epsom and one at St Helier (whatever the final agreed acute hospital location). These district hospitals would contain an urgent treatment centre (UTC), outpatients, diagnostics, day case elective surgery, and a large number of 'district hospital beds' that would be for lower acuity patients requiring admission but who don't need to be in an acute hospital setting.

The IHT programme board requested a joint independent clinical review of the draft PCBC, before it was finalised, from the South East (Kent, Surrey and Sussex) and London clinical senates. The request was to review the clinical aspects of the PCBC, and to focus primarily on urgent and emergency care, paediatrics, maternity and planned care. The remit did not include a review of the process for shortlisting the four options, nor the financial modelling or assumptions.

The two clinical senates established an independent clinical panel, which met to review the draft PCBC and supporting appendices. From this review, 94 recommendations have been produced. Many of the recommendations relate to the DHs and the patient pathways in to and out of them, particularly for the DH on a separate site from the acute hospital. This is an innovative model for reconfiguration, where very careful planning, and anticipation of the challenges to ensuring safe and high quality care, is required prior to implementation.

The key themes and recommendations in this report are summarised below.

Framing of the PCBC, and the shortlisted options

- The PCBC should be re-framed to more clearly articulate its purpose. The primary driver for change is to ensure the sustainability of ESH Trust, through centralisation of the major acute services on to one site, supported by two district hospitals and the range of planned community based services. There are significant benefits to the centralisation of the major acute services on to one site that are under-emphasised in the PCBC. These include the provision of a wider range of 7/7 and in some cases 24/7 services for which there are currently inadequate staff when spread across two sites; improvements in training opportunities for the full range of clinical staff; and the potential for enhanced recruitment and retention.
- For the four shortlisted options, two issues were highlighted. For option 4 (the acute hospital at Sutton) more detail is required. This option requires a major new build on a site without an acute hospital at present: how this would link with the current or future planned changes to the Royal Marsden Hospital on site should be clearer. A fuller description of the implications of delivering inpatient care on three sites in this option (and with the two UTCs on a different site from the acute hospital) will be essential.
- The ability of the surrounding acute hospital trusts to take the additional activity resulting particularly in option 2 with Epsom as the acute hospital (where the most activity would be transferred to other trusts) is not stated, and this re-assurance is required if such options are being formally proposed.

Demographic change, and activity and bed modelling

- The expected demographic changes should be provided up to 2030 (it is currently only up to 2025/26), and with more detail on the methodology used. The associated activity and bed modelling should take more account of the uncertainties of such modelling, and ranges rather than precise numbers would be more realistic. The future bed modelling needs to take account of the different anticipated average length of stay of patients in acute hospital beds compared with those in DH beds. More confidence in the modelling is required on how the ratio of acute to DH beds has been arrived at, specifically projections of the number of step up, step down and direct admission to the DH beds. This should also take account of the community bed capacity across the combined geography of the three CCGs, as well as a consideration of the potential of discharging more patients directly home rather than to a DH bed.

District Hospitals

- DHs will by nature not have the range of expertise and facilities to care for acutely ill patients above a certain clinical threshold. It will be essential therefore to ensure that patients are admitted to the right hospital (acute or district) first time for their clinical needs. Therefore, great care will be required in triaging those patients needing admission, and the criteria for acute or DH admission in particular should undergo further review by the trust's clinicians. This will need to take account of the staffing and services that will be in place in the DHs. This is particularly important for the DH that is not co-located with the acute hospital, where they will not have on site access to the more extensive range of services and workforce associated with the acute hospital. This asymmetry between the DHs within the model should be more fully articulated, and any associated clinical risks mitigated.
- The staffing model for the DH inpatient wards needs further detail. This includes the numbers of staff required, and particularly the competencies necessary to take responsibility for a wide range of diagnoses and acuities implied by the admission criteria for these beds. The interface clinician in particular must be sufficiently trained in the care of hospital inpatients. It is not clear at present that this role could be fulfilled by general practitioners, as proposed in the PCBC. It is recommended that at implementation of the DH model, there is a level of over-skilling and over-staffing, and potentially a limitation in the acuity of patients admitted, to gain confidence in the quality and safety of the care that can be provided in this new way of working before expanding the remit of the DH to that described. It will be essential to provide a 7/7 liaison psychiatry service for the DH hospitals, in addition to that which is planned for the acute hospital.
- Seamless digital links across the Trust between the DHs and the acute hospital sites and services will be essential. This includes ready access to laboratory, imaging and other investigation results, clinical correspondence (e.g. previous discharge summaries and clinic letters), and any electronic patient records the Trust has or plans to implement.

Urgent treatment centres and ambulatory care

- The urgent treatment centres (UTCs) are expected to reduce demand on the planned single consolidated emergency department (ED). This impact is not currently quantified, and needs to be, with a clearer outline of the types of cases that would be diverted and credible methodology provided for such quantification. The definition and role of 'ambulatory care' needs more clarity, and if this is 'ambulatory emergency care' how this would be staffed and delivered on more than one site.

Ambulance services

- The ambulance services will be significantly impacted by the proposed changes. They will be at the front line in deciding whether to transfer patients to the acute hospital ED or UTC, or to the off-site UTC, and they will need clear clinical criteria to help make such decisions. They will be required to transfer patients stepping down from the acute hospital to the off-site DH, or for the urgent transfer of deteriorating patients in the off-site DH to the acute hospital. A better understanding of the impact on the ambulance services and the increased capacity required should be provided.

Paediatrics

- The required future paediatric bed capacity across the four options needs to be distinguished from the adult bed requirements, as these are currently aggregated within the PCBC. The role of the UTCs and medical investigation units in paediatric assessment as a clinically appropriate alternative to the single planned paediatric ED should be made clearer, and whether the required paediatric competencies and diagnostics can be realistically provided across more than one site. There should be more detail of the current and planned community paediatric services, which will help to avoid the need for attendance and assessment in hospital (as has been described for adult community services).

Maternity

- The consolidation of hospital based delivery services on to one site has many advantages as outlined in the PCBC. This includes a likelihood of more women choosing midwifery led care with the back up of on site full obstetric services if required. Further detail about how the maternity led unit would support home births would be helpful.
- The trends in birth rates up to 2030, and how these impact on the stated future birth numbers in the maternity units across the four options, should be provided.
- Option 2 involves centralising the hospital based birthing services at Epsom, and would result in a much smaller maternity unit than in the other options, with just 2,900 births per year. There may be challenges in recruiting to and staffing such a small unit to provide the level of consultant obstetrician led care on the labour ward and supporting consultant anaesthetics and these would need to be recognised and addressed.
- The ability of St Georges and Croydon University Hospitals to take the additional activity in this option would need to be confirmed.
- Alignment with the local maternity systems' strategies should be made explicit, to confirm the shared vision and consistency in the planning of services.

Elective surgery

- Whilst acute and complex surgery that requires overnight stay would be centralised on the acute hospital site (as it currently is at St Helier), elective day case surgery is planned to take place at both of the DH sites in DH beds. Whilst the projected activity at the two DH sites is forecast to be similar across the four options, this should be reviewed, as it is likely that higher risk or more complex day case patients would undertake their surgery in the DH co-located with the acute site rather than at the stand alone site.
- There is also a discrepancy between the variable projected non-elective activity and beds across the options which relates to their different catchment areas, and the similar projected elective activity and elective beds required across the options. This discrepancy is currently unexplained.
- There needs to be more detail on the anaesthetic provision required at the DHs, and an estimate of number of potential urgent transfers to the acute hospital for patients with post-operative complications requiring assessment and overnight admission.

Conclusion

There has been extensive, detailed work undertaken in constructing the draft PCBC, with evidence of substantial clinical engagement and involvement. There are strong arguments for centralising the major acute services on to one site, and a number of trusts across the country have or are in the process of following this course. The overall model of having two DHs is innovative. However, it raises a number of issues about admission criteria, clinical competencies required, and clinical pathways for more acutely ill patients, at the DHs. These need to be considered in more detail to ensure that safety and quality of care would be maintained.

It is hoped that the range of recommendations in this report will help the IHT to ensure that their proposals are clear, supported by the evidence provided, address quality and safety requirements, and are shown to improve the quality of care for the three CCGs' populations as they finalise their proposals prior to public consultation.

2. Context and remit for the clinical senate review

2.1 Context

The three CCGs of Surrey Downs in Surrey, and Sutton and Merton in South West London, working together on the programme 'Improving Healthcare Together (2020-2030)', have concluded that current configuration of hospital based services (that is primarily provided across the two acute hospitals of Epsom in Surrey, and St Helier in SW London) for their populations are not sustainable, this is based on three key challenges: insufficient trained workforce to manage two acute hospitals; aging buildings and estates needing upgrading; and finance.

The two clinical senates of London and of the South East (Kent, Surrey and Sussex) were previously commissioned to provide a review of the draft case for change and the outline clinical models for a number of services, which was submitted to the IHT programme board in September 2018¹. This report helped to inform the draft pre-consultation business case (PCBC) for major service reconfiguration in the geography of the three CCGs. The two clinical senates have been subsequently requested to review this draft PCBC, prior to formal NHS England assurance and public consultation.

The PCBC details the case for the centralisation of the major acute services on to a single site at either Epsom, St Helier or Sutton, with two 'district hospitals' (DHs) sited at both the Epsom and the St Helier sites. The PCBC describes the four options for service reconfiguration that have been shortlisted after a rigorous process that includes an option that maintains Epsom and St Helier both as acute hospitals (see table 1).

Table 1. Summary of the four shortlisted options for service reconfiguration

	Option 1 (no change)	Option 2	Option 3	Option 4
Major acute site(s)	Epsom and St Helier	Epsom	St Helier	Sutton
District hospital sites	Epsom and St Helier	Epsom and St Helier	Epsom and St Helier	Epsom and St Helier

The major acute hospital would house the emergency department (ED), acute medicine and surgery, critical care, inpatient paediatrics and the obstetrician and midwifery led birthing unit. The district hospital would provide 'district hospital beds' (taking lower dependency patients who are not anticipated to need critical care), together with a UTC, and a variety of other services such as outpatients, diagnostics and therapies. The range of services to be provided by the major acute hospitals is shown in table 2.

¹ Joint clinical senate review of the case for change and clinical models for Surrey Downs, Sutton and Merton CCGs. South East Clinical Senate and London Clinical Senate. Submitted to the Improving Healthcare Together Programme Board Sept 2018.

Table 2. Planned distributions of services across the major acute hospital and district hospital sites in the short-listed options².

Site	Urgent and Emergency Care	Paediatrics	Maternity	Planned Care
Major acute site	ED (A&E) 24/7	Paediatric ED	Midwifery led birthing unit	Inpatient beds
	Ambulatory care	Medical investigation unit	Obstetrician led birthing unit	Inpatient surgery
	Acute medical unit 24/7	Day cases	Emergency surgery	
	Surgical assessment unit 24/7	PAU	Critical care	
	Observation ward	CAMHS	Interventional radiology	
	Acute medicine	Inpatient medicine	Post-natal ward	
	HDU and ITU	Inpatient surgery	Cots	
	Inpatient wards	POSCU	Neonatal critical care L1	
	Emergency surgery	Paediatric critical care L2		
	Full diagnostics	Neonates		
District hospital sites	UTC	UTC	General antenatal services (assessments and scans)	Outpatient clinics
	Ambulatory care	Outpatient clinics		Day case surgery
	Beds: step up	CAMHS		Chemotherapy
	Beds: step down	Medical investigation unit		Endoscopy
	Beds: direct admission	Community paediatrics		Renal dialysis
	Imaging			
Other			Home births	South West London Elective Orthopaedic Centre (SWLEOC)

² Extracted from Appendix 20, figures 62, 64, 66 and 68 (see PCBC pgs. 260-263)

2.2 Remit

The agreed terms of reference for this joint clinical senate review was to review the clinically related aspects of the draft PCBC, that includes the shortlisted options and their associated clinical models, focusing on (but not limited to):

- Emergency and acute care (inclusive of critical care)
- Paediatrics
- Maternity
- Planned care.

What this clinical senate review did not consider was:

- The process by which the shortlisted options for reconfiguration were arrived at
- Financial modelling

Our report and recommendations focus on the reconfiguration of the ESH Trust services, and the major acute hospital – district hospital model. Whilst the community based services are key to supporting and enabling the effectiveness of this new model of hospital based care, they were not the major focus of this review.

3. Methodology

The two clinical senates assembled a broad based panel of senior clinicians and professionals, who provided their own time and expertise to the review. The panel membership is listed in appendix 9. Great care was taken to avoid conflicts of interest, and those are also shown in appendix 9.

The December 2018 draft PCBC and multiple appendices were provided to the clinical senates' teams on 17th December 2018. The relevant appendices for the clinical senate review were filtered by the clinical senate chairs (see appendix 6 for the list of materials provided), and key lines of enquiry (KLOE) were developed. The PCBC, relevant appendices (see appendix 6 of this report) and key lines of enquiry (KLOEs, see appendix 7) were shared with the panel, prior to a teleconference pre-meet of the panel which was conducted one week in advance of the main panel meeting, to orientate the members, discuss the KLOEs and address any questions.

The all-day panel meeting was held on 24 January 2019. The morning session was shared with the IHT programme board and senior clinicians from the CCGs and ESH Trust, who presented summaries of the PCBC and took detailed questions from the panel. The afternoon session was for the panel alone to consider their response and recommendations. The full agenda for the panel day is shown in appendix 8, and the IHT presenting team in appendix 10.

The notes from the meeting and comments made were synthesised in to a first draft, which was circulated to the panel for comment. The final draft was then prepared for submission to the IHT programme board for matters of accuracy on 22 February 2019, and for review, comment then sign off by the two clinical senate councils.

4. General themes

4.1 PCBC focus

The primary case for change as presented in the PCBC is the sustainability of the ESH Trust, in terms of workforce, estates and finance. This has driven the planned reconfiguration to one acute hospital; networked with two DH's each with UTC and lower dependency (district) beds. The model will be supported by the innovative community based care initiatives to deliver care closer to home and avoid unnecessary attendance at and admission to hospital.

R1. Re-frame the PCBC around the primacy of sustaining the acute trust, and the associated benefits to the population, with the district hospital model and innovations in community care as enablers for this new model.

The panel recognised the benefits of centralising the major acute services on to one site, given the Trust's challenges, and the many clinical benefits that can ensue. That the Trust's sustainability is the key driver for this PCBC could be presented more clearly in the way the case for change is written. It would be helpful to highlight succinctly and in a way the public can relate to, the benefits to patient care, outcomes and experience that will result from the trust's proposed reconfiguration. Such benefits as described are somewhat scattered around the PCBC, and could be brought together to demonstrate the benefits to the population of the changes being proposed.

R2. Describe the potential clinical risks of the district hospital model, and the mitigations for these risks.

Given that the proposed district hospital elements of this model of care are somewhat innovative, the PCBC should explicitly consider the potential implications for patient safety and quality of care associated with this clinical model, including those when transitioning to this new model of care. Any such potential clinical risks will need to be addressed, and this report provides numerous recommendations in this regard.

R3. Justify more clearly the rationale for maintaining the major acute services within the three CCGs' geography.

As raised in the prior clinical senate review of the Case for Change (C4C), there remains a need to present a clearer rationale for maintaining all the major acute services within the three CCGs' geographies. Test 1 for shortlisting (PCBC 9.1.2.1) is 'Does the potential solution maintain major acute services within the combined geographies?'. The explanation given is that: 'We have each, as commissioners of services for our local populations, publicly committed to continuing to deliver major acute services from within our combined geographies'. It is important to provide a fuller justification based on, for example, patient journey times, inability of surrounding trusts to absorb ESH Trust's activity, patient and public

surveys etc. and as to how it meets the strategic needs of the population, rather than to just make the assertion.

4.2 Demographics, bed and activity modelling across the four shortlisted options

4.2.1. Demographic change and associated activity projections

R4. Provide more clarity and detail about the expected demographic changes.

One of the key recommendations in the earlier clinical senate review of the C4C was that ‘a more detailed analysis of the demographic changes up to 2030 would be helpful to understand future healthcare demand and capacity requirements’. The methodology provided in the PCBC³ does not currently provide that detail required to have confidence in the projections.

R5. Extend the demographic and activity modelling through to 2030.

The activity projections are only taken up to 2025/26 not to 2030 (in spite of the IHT programme’s title), especially since the implementation of the reconfiguration would not likely become operational before 2021/22 at the earliest, and presumably at least 10 year capacity planning is required.

R6. The provision of ranges rather than specific numbers for long term demographic and activity projections should be provided.

This would take account of the uncertainties of these estimates, and providing risk mitigations should the forecasts turn out to be underestimates would be reassuring.

4.2.2. Catchment areas and populations in relation to the different options

R7. The current catchment population of the ESH Trust needs stating.

It is not mentioned in the PCBC. There is reference to the combined commissioning population of the three CCGs of 720,000, but an unspecified proportion of that would be within other trusts’ catchments.

R8. The catchment populations for each shortlisted option should be clearly stated.

The four options have significantly different catchment areas, based on the maps provided⁴ (and shown in Appendix 2) which leads to the variations in projected activity and beds required across the options provided in the PCBC (see our summary in Appendix 3). Given that the activity and bed modelling is so contingent on the population served by the reconfigured trust, the catchment populations are essential information.

³ The methodology is referred to in PCBC section 10.2.1.2, and page 44 of PCBC appendix 9.

⁴ PCBC figures 38, 40, 42 and 44

R9. Describe the differential impact across the four options on acute hospital and district hospital beds.

There is little difference in the number of district hospital beds required across the four options, yet significant differences in the number of non-elective and elective beds, relating to the relative catchment areas. It is not clear why there is this discrepancy. We have presumed the following assumptions are being made, but if these and others are the case, they should be made more explicit:

- The lower acuity patients requiring step up or direct admission to a district hospital bed may be admitted to their closest DH, rather than the non-ESH Trust responsible for their acute hospital catchment area.
- Similarly, step down patients being discharged from acute care in neighbouring hospitals could be repatriated to their nearest (ESH Trust) DH rather than remaining in a non-ESH Trust bed. Therefore the catchment area for DH beds in the trust would be larger than that for acute beds across the options.

4.2.3. Impact of demand management on ED attendances and non-elective admissions, and bed modelling⁵

R10. Review the projections for future emergency department activity.

Without demand management measures, a 1.2-1.3% annual increase in A&E attendances is projected, with an 8.8% increase over the six years 2019/20 – 2025/26. This is significantly less than national trends in recent years, where there was a 2.0% increase in attendances from 2015/16 to 2016/17 (against a 0.8% population growth in England), and 22% increase in attendances over the nine years 2007/8 to 2016/17⁶.

R11. Estimate the projected level of activity in the UTCs that will contribute to the reduction in ED demand.

Over 2019/20 – 2025/26, demand management is projected to reduce projected A&E activity by 11.4%, giving a net reduction over that time of 2.7% from current baseline. It was accepted that there are local initiatives which may have led to the lower increases in A&E attendances. It is not clear what proportion of this reduction is to be achieved by attendance at a UTC rather than at the emergency department (ED) in the future, as opposed to demand reduction from the numerous community based initiatives described. Such information will be essential for planning the required capacity in both UTCs and the main ED. The QIPP initiatives listed do not break down the expected relative contribution of the various demand management initiatives.

⁵ Ref PCBC Appx 9, pg. 66

⁶ Hospital Accident and Emergency Activity 2016-17. NHS. <https://files.digital.nhs.uk/pdf/m/4/acci-emer-atte-eng-2016-17-rep.pdf>

R12. Provide more confidence in the timeline for the impact of new community care initiatives on demand.

The further development of community and primary care capacity and extended functions is critical to reducing ED and non-elective demand. The community based vanguards and other initiatives across the three CCGs are very promising, and are already showing an impact on admission avoidance (though their impact on ED attendance is not shown). The spread of these models across the geography will maximise their impact, and have been factored in to the QIPP assumptions.

4.2.4. Length of stay assumptions

R13. Predicting reductions in overall length of stay in the Trust's beds need to consider acute and DH beds separately before they are aggregated.

The projection is to reduce overall length of stay in ESH Trust beds to meet the national top quartile, which equates to a 25% reduction from current LoS. There are many planned initiatives described in the PCBC to deliver this. These include: more consultant-delivered acute care; more comprehensive co-location on one site of acute admissions with supporting clinical services, separation of elective from non-elective work; improved estates and facilities; and the promising impact (already seen on the vanguard sites) of Epsom's Community@home scheme in the over-65s, and Sutton's Red Bag scheme for nursing homes.

The modelling provided however does not distinguish the LoS reductions that would occur in acute beds and DH beds separately, but considers them in aggregate. The LoS in district hospital beds is likely to be very different from acute beds given the different criteria for admission and issues that require admission or transfer to these respective sites.

Those who are admitted through genuine need of an acute hospital bed are likely to have a longer LoS, as the less ill make up a smaller *proportion* of those inpatients in future (due to the other options to acute hospital bed admission that will be in place). This could increase the average LoS of those admitted to these acute beds.

The following statements about the status of DH beds need to be clarified:

*'District hospital services: Offering district hospital beds as part of a two-tiered model means both 'step-up' and 'step-down' beds are available, enhancing patients flow through hospital to reduce overall lengths of stay.'*⁷

'District hospital beds enable patients to be treated closer to home, enhance the flow through hospitals (reducing length of stay) and reduce demand for major acute services. A reduction in the length of stay is achieved through the step up (prevention of deterioration that could lead to an admission to hospital) and step down pathway from major acute services. As a result, it has been estimated that England needs

⁷ PCBC 6.2.3.1

double the current capacity for district beds to meet demand. The areas with the highest bed use have been found to have longer lengths of stay for patients who were in hospital while transitioning between home and a place that meets their current health and care needs. District hospital services may enable this transition and thereby reduce overall length of stay.⁸

DH beds are part of the acute trust's total bed base, and not interchangeable with the definition of 'intermediate beds' based on the wide range of admission criteria proposed for DH beds. Therefore LoS in these beds is as important in bed modelling as that for acute beds, but needs to be calculated separately before combining the two.

R14. Steps to anticipate and avoid the risk of increased length of stay arising from transfers of care between the acute hospital and the district hospital should be taken.

Whilst patients stepping down from acute care, who may no longer need the acute hospital's services, may have a reduced LoS in a care setting more suitable to their discharge planning, the transfer to another ward, team, and even hospital in the DH can cause disruption to the patient pathway (with the new team having to become familiar with the patient and their needs, and referrals made to rehabilitation and other services). Steps taken to minimise the impact of such transfers on LoS must be clearly described.

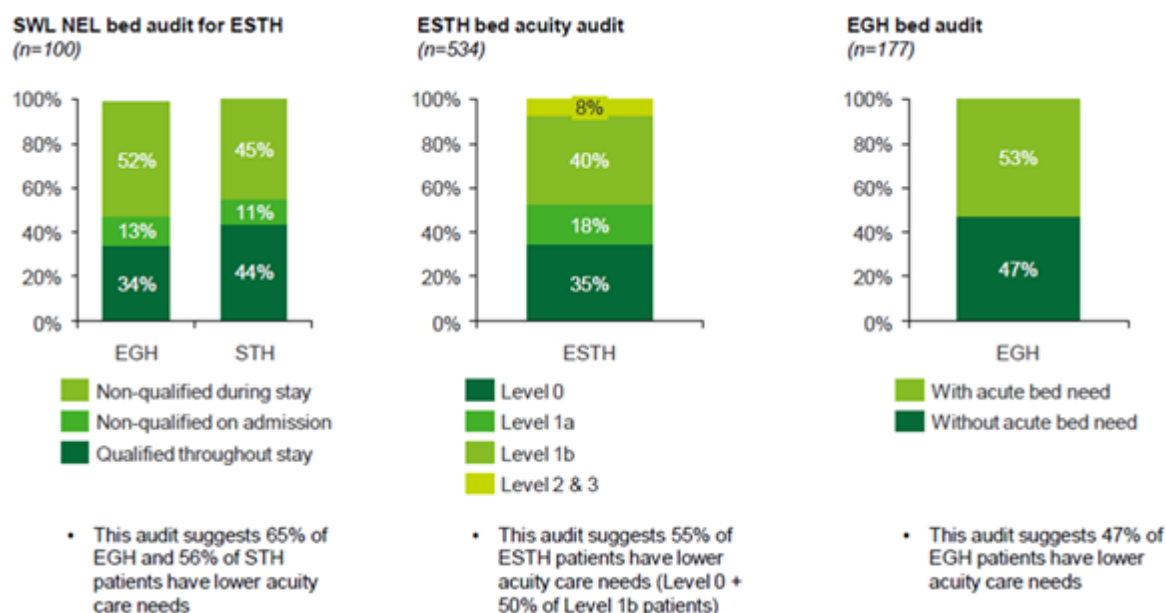
4.2.5. Determining the number of district hospital beds required

R15. Greater clarity on the methodology and assumptions used to determine the ratio of acute to district hospital beds and total bed numbers is required.

The bed modelling appears to be based on the three trust audits of the acuity of inpatients (see figure 1).

⁸ PCBC 6.2.3.2

Figure 1. Results of three separate audits of patient acuity and needs in ESH Trust beds (from PCBC fig 22)



An issue with interpreting this data is that they are snapshots at a particular time, and risk not taking account of the very heterogeneous patient journeys this summary data represents. For example, in the graph showing the SW London NEL bed audit for ESH Trust, the 11-13% of patients deemed 'non-qualified on admission' would presumably be appropriate for 'direct' or 'step up' admissions to a DH bed. However for the 45-52% of the 'non-qualified during stay' patients (and the lower acuity patients represented in the other two audits shown), is it being assumed that all of those would be suitable for transfer to a DH bed? The risk of such an assumption is that patients' clinical condition is fluid, and they can deteriorate during admission, and move from non-qualified to qualify for an acute bed.

This is an inexact science, but some explanation for the assumptions made here in bed modeling would clarify how the numbers have been arrived at. Future such bed audits should take account of the status of the capacity for step down in to the community as well as to a district hospital beds, when evaluating the potential for step down from (or admission to) an acute bed.

R16. Provide more specific modelling for the impact of community-based care and community beds on the DH bed numbers required.

Many of the criteria for DH admission describe 'intermediate care' needs⁹, typically provided by community hospitals. The only reference to community beds in the PCBC is that: 'Some community beds will move in to ESH Trust as a result of the clinical model', which is estimated

⁹ Intermediate Care, highlights. Social Care Institute for Excellence.
<https://www.scie.org.uk/prevention/independence/intermediate-care/highlights>

to be 62 across the trust by 2025/6 (PCBC section 10.2.1.3, table 38). It is not clear in what way this category of beds is distinguished from the 'district hospital beds'.

The current and planned community bed capacity across the geography is not specified in the PCBC. A fuller understanding of the community care bed-based strategy, and the overall needs and capacity within the system now and what is planned is essential for integrated planning purposes, and for understanding what should be located within the DH as opposed to elsewhere.

The requirement for DH beds, for both step up and step down patients, will be very dependent on delivering the capacity and function of the range of planned community based services and initiatives described in the PCBC, that will enhance admission avoidance and enablement of discharge home.

4.3 The model of one acute and two district hospitals

4.3.1. Other examples of the acute/district hospital model

R17. The direct relevance of the quoted Northumbria model should be made clearer, along with any other examples.

The proposal to have district hospital beds (as described in the PCBC) off site from the acute hospital, is not widespread, and detailed reference to Northumbria in the PCBC figure 19¹⁰ implies that the IHT reconfiguration plan is based on this (though this reference is not linked to the text within the PCBC so it is unclear as to its true relevance). If it is this should be made more explicit, and with more detail given about the model, pathways, admission criteria (or types of patients admitted) to the beds in the two district hospital sites, and outcomes.

Note the Health Foundation analysis of the first year of the Northumbria implementation¹¹ showed an increase in A&E attendances, and an uncertain impact on admissions and lengths of stay. The report highlights that reconfiguring NHS services takes time to generate the intended results and that robust, repeat evaluation can help to inform decisions and improvement. This lag factor should be built in to the assumptions.

¹⁰ Northumbria Healthcare Emergency Care website referenced in PCBC pg. 94:

<https://www.northumbria.nhs.uk/our-services/emergency-care/emergency-care/>

¹¹ Briefing: The impact of redesigning urgent and emergency care in Northumberland. Health Foundation Dec 2017. Dec 2017 <http://healthfoundation21wauernoew.devcloud.acquia-sites.com/sites/default/files/IAUNorthumberland.pdf>

4.3.2. Terminology for the different hospitals

R18. Consider changing the term ‘district hospital’ to ‘local hospital’ or ‘local general hospital’.

There is potential for the term ‘district hospital’ to be equated to ‘district general hospital’ in the public’s mind, which risks inadvertently misleading the public as to the range of services at a DH site, which will not be the same as a typical DGH (whose services include an ED, critical care and acute medicine). The term ‘local hospital’ or ‘local general hospital’ is proposed as an alternative.

R19. Consider changing the term ‘major acute hospital’ to ‘acute hospital’.

For the hospital in which ‘major acute services’ are centralised, it would seem sufficient to call it the ‘acute hospital’ rather than the term used throughout the PCBC of ‘major acute hospital’, which is a term not used elsewhere in England. Many tertiary services will not be provided from this hospital (and are not currently by the trust) but are from other surrounding trusts, so it is not clear what the term ‘major’ adds to the definition.

R20. Consider whether the acute and district hospital wards on the same site would be distinct hospitals.

Whilst the acute hospital will have co-located district hospital beds, it is not clear in what way these DH beds could be described as being in a hospital that is distinct from the acute hospital. Will they be in a separate ‘district hospital’ building, or will they simply be a group of wards designated for these lower acuity patients? If the latter, then calling this a district hospital may be misleading, and an alternative term should be found. It would appear that the term ‘district hospital’ should apply only to the standalone facility, not that based on the acute hospital site.

4.3.3. Site dependent differences in the district hospitals

R21. Make more explicit the differences between the district hospital co-located with the acute hospital, and those which are stand alone.

The DH on the same site as the acute hospital will by nature have access to the full range of other acute and diagnostic clinical services that the acute site provides, which will not be the case for the stand alone DH site. Currently all DHs are portrayed as being equivalent.

4.3.4. The Sutton acute hospital option

R22. Provide more detail about the advantages of the Sutton acute option.

The description of the Sutton option (option 4) is generally short on detail at present. It would also be helpful to describe in more detail any potential synergistic working with the Royal Marsden as a major specialist cancer hospital.

R23. In option 4, clarify if there would there be two or three UTCs.

In PCBC section 10.4.2.1 none of the DH services, including a UTC, would be at the Sutton site. However in PCBC section 11.3.2 it clearly states that Sutton would have a UTC (making three in total across the trust). This should be clarified.

4.4 Improvements in population health following the planned reconfigurations

R24. The PCBC would be significantly strengthened by more emphasis on the improvements in health outcomes for the population that should arise from the reconfiguration.

This approach would add more impact with patients and the public, rather than making the case mainly on securing the ESH Trust's viability, and using process and proxy measures, such as staffing, waiting times and co-dependencies. Connecting these more directly to the impact on population needs, patient outcomes and patient experience would provide greater impact to the case.

R25. The rationale for the trust reconfiguration could be re-cast as an organisational strategy which addresses local health needs and improves outcomes.

Although the scope for improvement in some key quality metrics are shown (PCBC section 6.2.3 table 28), it is not made clear enough how the centralisation of acute services would lead to these improvements.

R26. The future health needs of the population could be more clearly described.

A significant number of facts have been presented, but a clearer picture of *future* health needs of the population should be shown. For example, the Surrey Joint Strategic Needs Assessment includes modelling of future incidence of frailty and multi morbidities for Surrey Downs.

4.5 Workforce strategy and issues

4.5.1. Acute hospital workforce

R27. Highlight that the challenges to staffing the major acute services across two sites is a shared problem across the country.

The trust is grappling with workforce challenges relating to their major acute services that are far from unique across the country, and many other trust reconfigurations that involve centralising acute inpatient services on to one site are being driven by the same pressures. It would help to paint this national picture, so that it is clearly seen as a shared problem and a well recognised solution.

R28. Describe more fully the workforce pressures across the non-medical workforce, and how the reconfiguration can address these.

Acknowledging that workforce is one of the key drivers for reconfiguration in the case for change, more detail on the total workforce required across all disciplines and sites is required, over and beyond the medical workforce. This would include nurses, midwives, and the range of the main AHP professions.

R29. Make a stronger case for the benefits to staff recruitment and retention from the reconfiguration.

The new centralised model of acute care is likely to attract staff to the trust, and the PCBC could make a stronger case for the ensuing benefits, whilst describing the current negative factors for recruitment and retention with the current two acute site model. The advantages of working in a bigger, 'hotter' site should be outlined. These include: being part of larger clinical teams, and the provision of additional sustainable specialist 24/7 on call consultant rotas that aren't currently in place, that might include the acute physician medical take, on site emergency endoscopy, cardiology, paediatrics, critical care and other services.

R30. ED consultant requirements should be updated to take account of the latest guidance from the Royal College of Emergency Medicine.

The Royal College of Emergency Medicine (RCEM) updated guidance (Sept 2018) should be consulted to establish if the PCBC's consultant workforce requirements now meet these¹² (currently the PCBC quotes the 2010 guidance). These guidelines categorise an ED as 'small' if <60,000 attendances per year, 'medium-sized' if 60,000-100,000 attendances per year, 'large' if >100,000 attendances per year and 'very large' if >150,000, and recommend the range of consultants required, along with the various key roles these consultants undertake. The projected ED attendances and consultants required across the four options is shown in table 3.

Table 3. Projected ED annual attendances across the four options, and consultant numbers required. Based on RCEM 2018 guidelines.

Option	Predicted ED attendances	Consultant numbers required*
1 (ED at Epsom and St Helier)	Epsom 57,400, St Helier 90,200 147,000 (across the two EDs)	36-50: (18-25) + (18-25)
2 (ED at Epsom)	129,500	25-36
3 (ED at St Helier)	135,200	25-36
4 (ED at Sutton)	151,300	34-48

¹² RCEM Workforce Recommendations 2018. Consultant Staffing in Emergency Departments in the UK.
[https://www.rcem.ac.uk/docs/Workforce/RCEM_Consultant_Workforce_Document_\(revised_Feb_2019\).pdf](https://www.rcem.ac.uk/docs/Workforce/RCEM_Consultant_Workforce_Document_(revised_Feb_2019).pdf)

The ED consultant workforce requirements add to the case for a single consolidated ED department, which needs greater emphasis. The projected numbers are significantly greater than the 20 which are currently planned for in the PCBC. These total numbers should not be seen in isolation, without considering the additional requirement for weekend consultant rotas in ED and the expectation that there will be an on-site consultant presence at least 16/7. For weekend on call rotas ED consultants should work on the basis of 1 in 8 according to the RCEM guidelines. In a two ED model for the trust (option 1) this can only be met by the much larger total number of consultants as shown in the table above.

4.5.2. Staffing the district hospitals and their wards

R31. For the district hospitals, the total clinical staffing required, for each of the four options, should be outlined, and aligned with the projected DH bed and ward capacity.

The ability to recruit staff (medical, nursing and AHP) to work in the DH wards and sites is unclear, as is the total manpower required for these beds. This is contingent on the bed numbers on each site and in each option, and the variable and unpredictable level of acuity of patients in these beds. Understanding the projected staffing numbers, skill mixes and competencies required will help to reality check the challenge of recruiting to these posts.

R32. Initial staffing of the district hospitals wards should be by senior and experienced staff to gain confidence in the new model of care.

The range of acuities of patients in DH beds in the proposed model is broad, and there are risks particularly in relation to the stand alone DHs with regard to the on-site competencies required. It will be important therefore, in order to mitigate any potential clinical risk and gain confidence when it is introduced, to employ experienced and highly skilled staff from the outset. As confidence is gained, the opportunities for different staff competencies can be explored.

R33. Consider alternatives to GPs fulfilling the described roles in the district hospitals.

The GP manpower requirements to staff the various services within the DH (UTC, DH beds etc.) may need to be tempered with the national shortage of GPs, the new national GP contract, and local and national plans to expand community based services. Confidence in the ability to recruit to these hospital based posts and mitigations for if there are insufficient applicants, should be stated.

4.5.3. Training

R34. The enhanced training opportunities in acute care from centralising acute services on to one site should be emphasised.

This applies to all the inpatient healthcare professions. Examples of opportunities include:

- Bigger teams with more opportunities for teaching, training and support, including via expansions in consultant on call rotas in more specialties.
- Higher activity levels in the single acute site with more varied and specialist case mix
- Developing new ways of working and training in extended roles (upskilling and competency development through integrated training) across the nursing and AHP workforce. The workforce strategy would be strengthened by having increased emphasis on upskilling and competency development of existing staff (across medical, nursing and AHP professionals), along with plans to train and deploy advanced care practitioners, nurse associates and physician associates.
- There is the potential for developing a novel, expanded generalist role at the DHs, but the role needs to be more clearly defined than is currently articulated in the PCBC.

R35. The opportunities and risks to training from the proposed new trust model should be recognised.

The implications for clinical training of having a large number of DH wards (whether on the acute site or stand-alone) need to be fully considered, and discussed with the post-graduate deans, HEE and other clinical training leads. The clinical experience and learning opportunities will be very different from the acute wards and their current wide range of acuities and issues, and separating out lower and higher dependency patients so explicitly and geographically has implications for training programmes and rotations. There may well be opportunities and benefits from trainee rotations across these different clinical areas, but it will be essential that the supervision arrangements for trainees working at the less acute sites is in place in the same way as is required in the acute hospital environment.

4.6 Level of clinical engagement

R36. Describe in more detail the level of clinical engagement about the case for change and the proposed reconfiguration of the ESH Trust.

In verbal responses to the panel, there was strong evidence that engagement has been thorough with medical and nursing staff within the acute trust, with apparent widespread consultant support for changes. The engagement with other clinical professions in the trust included an online survey of staff (July-Oct 2018) with more than 200 responses. What is less clear is that engagement with health and care professionals outside of the trust, including with GPs, mental health clinicians, district nurses and health visitors, homeless services, social

service professionals, and voluntary organisations. The ambulance trusts appear only to have been engaged on a process level and not with respect to the clinical model and the potential of enhanced paramedic roles. If this is not the case then reference to their input and the workforce opportunities should be emphasised.

4.7 Digital strategies

R37. Describe in more detail how clinical information will be shared effectively across the hospital sites and teams.

It was presumed that the trust, with a long history of delivering acute and elective care across two sites, had integrated health informatic systems (radiology/PACS, pathology results, correspondence, electronic patient record), but this isn't described in the PCBC. Shared and readily available access to electronically stored and transmissible patient information is essential for delivering safe, timely and efficient care. The current status and the plans for future should be summarised, and should include any plans to integrate or share information across primary, secondary, community and mental health care, and with social care.

Improving clinical communications between clinicians working across sites and organisations (e.g. acute hospital, district hospitals, GP, mental and community health) is key to efficient and timely patient centred care. The recommendations within the South East Clinical Senate's review of this topic are a resource to consider and reference¹³.

R38. Alignment with the two STPs' digital strategies and that of the new NHS Long Term Plan should be demonstrated.

These strategies are not referenced in the PCBC.

4.8 The impact on neighbouring hospitals

R39. Can the neighbouring acute trusts support the consequences of all four of the shortlisted options?

The impact on some of the neighbouring acute providers is significant, depending on which reconfiguration option is selected¹⁴. Have the neighbouring acute trusts confirmed that they would be able to provide for any projected increases in activity resulting from each of the options (taking account of any of their own potential reconfiguration or development plans)? There are clearly significant implications for some in terms of increases in A&E conveyancing,

¹³ Improving clinical communications between primary and secondary care clinicians. South East Clinical Senate, Dec 2017.

http://www.secsenate.nhs.uk/files/8315/1559/3599/Improving_clinical_communications_between_primary_and_secondary_care_clinicians_SE_Clinical_Senate_Dec_2017.pdf

¹⁴ See PCBC section 10.2 and PCBC appendix 9 pages 30-33.

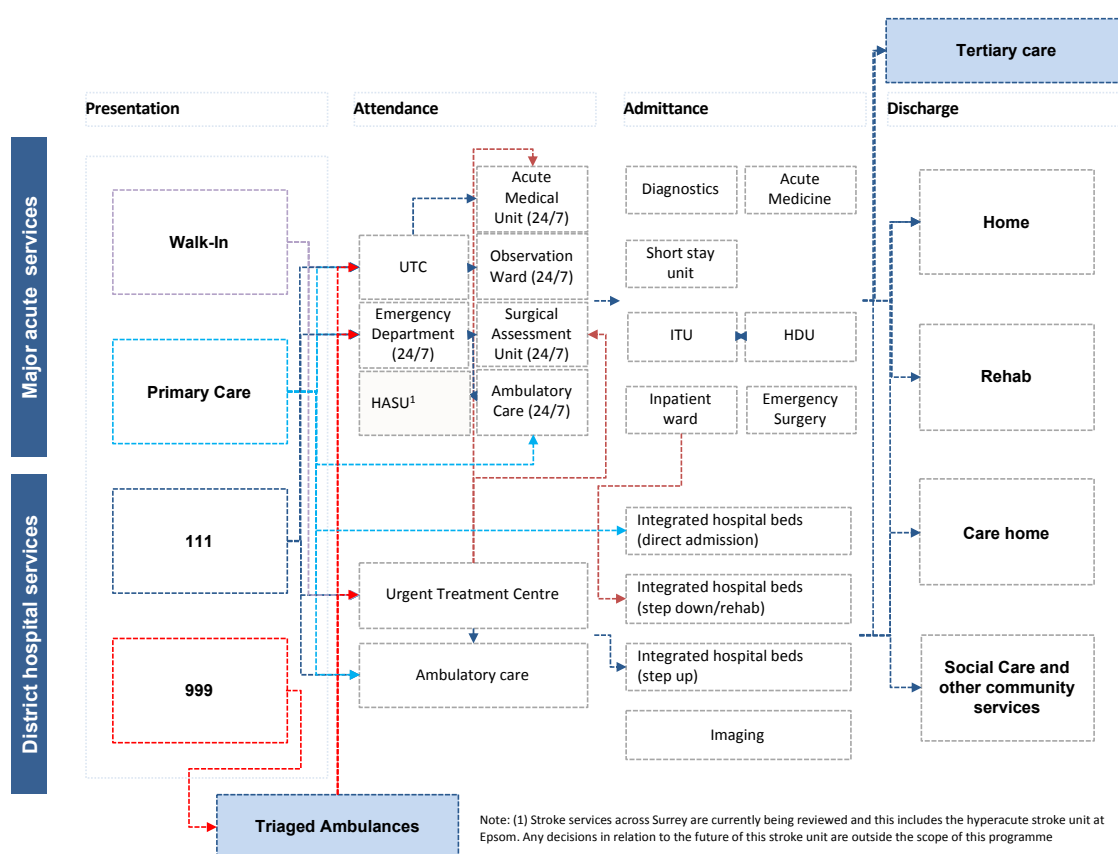
bed capacity required, and increases in demand for the whole range of acute services (including maternity).

R40. The current and planned provision of tertiary services for the CCGs' population should be presented.

There should be more detail about where tertiary services and specialist pathways that serve the three CCGs' population are provided. Many are not currently provided by the ESH Trust (other than renal services), and transparency at this stage to raise awareness will reduce the risk of misunderstanding of what is changing with the reconfiguration options. Examples that should be referenced are vascular surgery, major trauma centre (we have assumed that ESH Trust is and would remain a 'trauma unit' but that is not stated in the PCBC), interventional cardiology, hyper-acute and acute stroke services, specialist cancer, and paediatric cancer.

5. Urgent and emergency care pathways and services

Figure 2. Outline pathway for urgent and emergency care proposed in the PCBC.



5.1 Urgent treatment centres

R41. The full implications of having a UTC on a different site from the acute hospital, and how any risks will be mitigated, should be described.

All four of the proposed options have two urgent treatment centres (UTCs): in option 1 each is co-located with an acute hospital, in options 2 and 3 one will be on the acute hospital site and one on the district hospital site, and in option 4 both would be at the DH sites and neither co-located with the acute hospital.

There is a long history of minor injuries units/level 3 A&Es as standalone units, but urgent treatment centres (UTCs) that will see a wider range and higher acuity of patient are more recent conceptions, and there are now national specifications for their configuration and

function¹⁵. Many service re-designs are considering having these co-located with an acute hospital, though this is not mandated in the national guidance:

‘There are advantages if they can be co-located alongside hospital A&E departments to allow the most efficient flow of patients to the service that best serves their need but this will be determined by geographic distribution of urgent care sites and patient flows.’

Therefore care must be taken in ensuring the quality and safety of patient pathways for patients assessed at a standalone UTC who do not have a clear diagnosis and who may be unstable or at risk of rapid deterioration (which may be unforeseen when first assessed). The stand-alone UTCs may need clearly defined criteria for which acutely ill patients they accept via GPs, paramedics or 111 referral, and which they direct to the acute site for primary assessment.

R42. Anticipate the increased use of the UTC co-located with the acute hospital.

It is quite probable that patients will gravitate over time to the UTC on the same site as the major acute hospital as a site where more facilities and links to the acute hospital are available. This should be considered when projecting future activity and capacity.

R43. Clear operational guidance will be required for patients needing UTC assessment near closing times.

The opening hours of the UTCs will impact on the out of hours activity of the acute hospital ED. A 12/7 model is planned, with an additional two hours ‘shoulder time’ to complete management of patients arriving near the closing time for new attendees. Clear protocols must be in place for patients who are unlikely to complete their assessment by closing time, as these patients cannot be left stranded mid-assessment. Diversion or transfer to A&E or the acute medical unit at the acute hospital might be required, and this needs to be carefully managed to ensure the patient comes to the right place first time whenever possible at these watershed times.

R44. Specific clinical examples of the types of conditions a UTC might treat rather than an ED would be helpful.

Such conditions might include exacerbation of heart failure, exacerbation of COPD, pneumonia, cellulitis, UTI, and DVT. The South East Clinical Senate’s report on out of hospital care should be reviewed in this regard¹⁶, though there is significant potential overlap with ambulatory emergency care.

¹⁵ Urgent treatment centres – principles and standards. NHS England 2017. <https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres-principles-standards.pdf>

¹⁶ Reducing avoidable hospital based care: re-thinking out of hospital clinical pathways. South East Clinical Senate Nov 2016. Refer specifically to chapter 4 and the associated tables. http://www.secsenate.nhs.uk/files/4114/7947/4980/Reducing_avoidable_hospital_based_care_-_re-thinking_out_of_hospital_clinical_pathways._South_East_Clinical_Senate_report_Nov_2016.pdf

5.2 Ambulatory care

R45. Clarity about what the ambulatory care service is on each site should be provided.

The PCBC states that ‘ambulatory care’ will be available at the district hospital sites. It is not clear what the term refers to here and what specific types of care would be provided. In more common use is the term ‘ambulatory emergency care’ (AEC, referring to emergency care delivered without an overnight stay), which the new NHS Long Term Plan (LTP) proposes is re-named as ‘same day emergency care’ (SDEC). The LTP states that: ‘Under this Long Term Plan, every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care’¹⁷.

These units would normally be run by trained hospital physicians and nurses, and would need rapid access to diagnostics etc. They would have specific staffing requirements that are not detailed in the PCBC, and whether such units in the stand alone DHs could be realistically provided distant from the acute hospital and their acute specialist teams and support, is not established. Further background information on AEC can be found in the footnote references below¹⁸.

If however ‘ambulatory care’ in the PCBC refers to an alternative service that is not AEC as described above, then its function and patient group should be made much clearer.

Whichever of these definitions of the service is intended, there are likely to be challenges in staffing this service across multiple sites.

5.3 Initial assessment of acutely ill patients and triage to the right inpatient setting

R46. High quality clinical triage will be essential to ensure patients are assessed in the right setting, first time.

The model involves a range of the trust locations where acutely ill patients could be assessed. These include the UTC (one of two sites), an ambulatory care unit (one of two sites), or the ED at the acute hospital. High quality clinical triage, whether by primary care, 111, or the ambulance and paramedic service, must be assured to ensure that patients are directed to the most suitable place for the assessment and initial management of their acute condition. This will be challenging.

¹⁷ NHS Long Term Plan, paras 1.28 – 1.30, pages 21-22. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf>

¹⁸ Reducing avoidable hospital based care: re-thinking out of hospital clinical pathways. South East Clinical Senate Nov 2016, page 12, and see hyperlinked references 6-12 on that page. http://www.secsenate.nhs.uk/files/4114/7947/4980/Reducing_avoidable_hospital_based_care_-_re-thinking_out_of_hospital_clinical_pathways_South_East_Clinical_Senate_report_Nov_2016.pdf

The criteria for admission to district vs acute bed needs further clarification, and is discussed in the district hospital beds section of this report. For patients with urgent care needs, a key exclusion criterion for the district beds is 'patients who require acute care'. This is too broad a term, and should be better defined, to align with the available skills and 24/7 facilities available at the acute site. This is discussed further in section 6.

5.4 Critical care

R47. The capacity and workforce for critical care and outreach should be clarified.

Experts on the panel were concerned the critical care bed numbers stated appeared low. This may be an issue of definition. A clearer description of critical care capacity including High Dependency Unit (HDU) beds and step down is recommended with some flexibility built in for any potential increase in demand. This can then link to the workforce required including critical care consultants to support this outreach.

5.5 Liaison psychiatry and mental health

R48. Clarify the provision of liaison psychiatry to the district hospital inpatients.

The plans to deliver a 24/7 liaison psychiatry service to the acute hospital is strongly supported. It was not clear to what extent there would be such a service for the district hospital inpatients, many of whom will have long term or acute psychiatric co-morbidities needing mental health care input in that setting.

R49. Expand on the joint planning with and pathways to primary mental health services.

Explicit reference to joint planning with the mental health trusts covering the geography would be re-assuring. More detail on the pathway in to the mental health service and its beds from the acute hospital is required.

5.6 Ambulance triage, transfer and capacity issues

R50. Provide details of the increased capacity likely to be required of the two ambulance services and patient transport services.

With a single ED in the three CCGs' geography, the net average travel times will inevitably be longer, whether transferring to that ED or to a neighbouring hospital responsible for the changed catchment area. In addition, there will be a large increase in inter-hospital journeys, for step down patients from acute to stand alone district hospital, patients needing admission following UTC assessment in the stand alone DH, urgent transfer of inpatients who deteriorate in the stand alone DH, and for inpatients needing diagnostics that might only be available at the acute site. The additional capacity required of the two ambulance services (staff and fleet) will need to be worked through, the resources identified, and the appropriate

contract agreed. Non-blue light conveyances need to be accounted for in addition to blue light.

There should be a distinction between hospital commissioned patient transport service (PTS) and statutory emergency ambulance service parts of the pathway, and which will be responsible for what (e.g. step down and step up admissions to DH beds).

R51. Develop clear clinical criteria for conveyances to the local UTC or the acute hospital's ED.

For the ambulance services these criteria would need to be clearly articulated, or the default position may be to transport patients to the acute hospital (whether their UTC or ED). The paramedics would need to have confidence that the receiving centre has the clinical competencies to manage the patient, otherwise the default would be to take the patient direct to the acute hospital.

R52. Ensure ED capacity of ESH Trust and neighbouring hospitals is sufficient to avoid adverse impact on the ambulance services.

The additional activity resulting from centralising the ESH Trust ED on to one site, and to changes in catchment areas across the shortlisted options, risks increasing ambulance handover times and delays, unless capacity is sufficient.

6. District hospital beds

District hospital (DH) beds are to be located at both of the district hospital sites (at both Epsom and St Helier hospitals in all four options – see table 1 in the Introduction section). There are five categories of patients described in the PCBC for potential admission to the DH beds:

- ‘Step up’, from the community MDT, for patients with short term escalating medical need.
- ‘Step down’, from the acute hospital for patients no longer requiring the high intensity of major acute services but still requiring short term medical care.
- ‘Direct admissions’ from the UTC or GP for patients ‘who do not require major acute services’.
- Inpatient rehabilitation
- End of life care

The district hospital beds will be co-located with a UTC, outpatients, a range of diagnostics, and a variety of other services, as shown in table 2 (see Introduction). The criteria for admission to a DH or an acute hospital bed are set out in PCBC section 5.3.3, which is also shown tabulated in Appendix 4 of this report.

R53. The definition of patient suitability for a district hospital bed should be reviewed.

The definitions provided of patients suitable for DH beds is that they ‘do not require critical care and/or services on which critical care depends’, and that ‘this patient cohort does not need *any* [our italics] of the services offered at the major acute site’. This seems too broad a definition and would exclude many services that would be available (including specialist in-reach). The clinical co-dependency grids in the South East Clinical Senate’s co-dependencies review should be referred to in order to help sense check the above definitions¹⁹.

Admission to a DH bed is also defined in the PCBC as for when ‘care needs to be provided from a bedded facility with access to ‘generalist’ input suited to patient requirements’. This is a loose definition, its meaning is not sufficiently clear, and would benefit from greater specificity.

¹⁹ The clinical co-dependencies of acute hospital services. South East Clinical Senate Dec 2014. See grids pages 30-32. 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

6.1 Pathways and potential clinical risks depending on co-location with the acute hospital

R54. The differential clinical risks to patients in stand-alone district hospital beds, and the mitigations for those risks, need clearer articulation.

There are very important potential distinctions between the DHs that are located alongside the acute hospital, and those DHs that are stand alone. The acute site is potentially a safer site for patients in a co-located DH bed (and will be seen as such), particularly for those whose condition deteriorates and who need rapid clinical assessment, diagnostics and more specialist treatment, who would not need an ambulance transfer to the acute site.

Appropriate detailed criteria and case selection for admission, and clear and effective pathways for managing acutely deteriorating patients, will be vital for the safety of this model of care. A full risk assessment of this model is required. Any lessons from the PCBC's quoted Northumbria model that would provide re-assurance would be helpful.

6.2 Ensuring the district hospital is suitable for step up and direct admission patients

R55. Patients for admission need a detailed clinical assessment before deciding if a district hospital bed is suitable and safe.

Step-down patients will have come from acute hospital care following a thorough secondary care assessment and with diagnoses and a management plan fully established, and recovering from the initial acute cause of their admission. This is quite different from step-up admissions and direct admissions to a DH bed, in whom the diagnosis may be unclear, and who will need a thorough clinical assessment before assuming that their care is suitable for DH admission.

These patients will have a range of acute or sub-acute conditions that caused their deterioration that requires admission, and serious illness may not be immediately apparent at the UTC, or initial GP and community based assessment. They need accurate and prompt diagnosis, and great care must be taken to align the admission criteria to a DH bed with the DH's capacity to provide the acute clinical care required (assessments, diagnostics and treatment), to ensure that the patient gets to the right place, first time, to deliver safe and effective care.

How this assessment prior to or at DH admission is made must be carefully considered, as it is a significant clinical risk if the patient is admitted to the wrong hospital for their clinical condition. Review of such patients by the physician team responsible for the DH beds for example in the UTC setting, before acceptance of admission, would add a layer of quality and safety to care, and so that the patient isn't 'lost' on one of the DH wards before a clear management plan is in place.

6.3 Implementation

R56. Consider a phased implementation of the model starting with lower acuity step down and step up patients.

It may be safer to plan a transitional implementation, gradually increasing the level of acuity of patients, with staged evaluations and risk assessments, that is less ambitious in terms of clinical case mix for the standalone DH beds at the start. Confidence can thereby be built up and the model progressively iterated towards the full aspirations of the model and intended patient base.

6.4 Providing for sufficient level of care for inpatients

R57. The level of available medical and nursing skills and facilities must be sufficient for and adaptable to the potentially wide range of clinical conditions and acuity of inpatients, 24/7.

Patients without clear diagnoses, or who are not clinically stable (but not sick enough to qualify for direct admission to or transfer to an acute hospital bed) will require a level of assessment and monitoring that is quite different from the cohort that is stable and simply awaiting discharge planning to be completed. A significant number of DH inpatients will be frail with multiple co-morbidities and have unstable medical conditions, and clear robust and safe pathways are required for these patients.

For patients who deteriorate whilst in a DH bed, there needs to be assurance that there will be an adequate clinical response. In an acute hospital there will be the 'crash team' for cardiac arrests, and a 'medical emergency team' (MET). In the event of a cardiac arrest or a severe and acute deterioration of the patient in a DH bed, what response will be available?

In particular, how would emergency airway management be provided? If there is no readily available on site/on call anaesthetist or airway-proficient professional 24/7, then such patients would require a 999 response and urgent transfer to the acute hospital A&E, whilst potentially having a quality of resuscitation inferior to one on the acute hospital site.

R58. Agree pathways, protocols and contracts for emergency transfer to the acute hospital with the ambulance services.

If the ambulance service is being relied upon for the transfer of deteriorating patients to the acute site, there may be delays when the ambulance service is under pressure as the DH might be considered to be a 'safe place' to maintain the patient. Protocols should be developed and assured, and agreed with the ambulance services, that ensure the best available care is provided whilst waiting for transfer.

6.5 Specialist in-reach

R59. Ensure sufficient job planned time is provided to undertake specialty in-reach.

Patients in district hospital beds will be under the direct care of the 'interface physician', but may have or develop more specialist issues that need a specialist opinion. The provision of specialist consultant ward rounds is appropriately built in to the ward cover arrangements, and would be supplemented by direct access 24/7 to specialist advice by telephone and other digital links with the acute hospital to ensure advice is always available for acutely ill patients.

Given the large number of patients and wards designated as 'district hospital' (whether on the acute site or standalone – the total number of DH beds is projected to be 227-239 across two sites), such specialist outreach will be very important to maintain the quality of care and reduce the need for patient transfer to (or back to) the acute site. The job planning implications (for consultants and senior trainees) of this in-reach care should not be underestimated, and full visiting ward rounds across a range of specialties (which will need to be agreed) will need to be appropriately resourced.

6.6 Liaison psychiatry

R60. Ensure there is 7/7 liaison psychiatry provision for the district hospital inpatients.

A liaison psychiatry service for the DH beds is not mentioned, but this will be essential, assuming that a significant proportion of the inpatients will be elderly patients with dementia and other mental health needs. Further discussion would be required with Surrey Borders Partnership NHS Trust and South West London and St George's Mental Health NHS Trust.

6.7 Diagnostics

R61. Confirm the range of diagnostics available and anticipated hours of provision.

A sufficient range of diagnostics for inpatients as well as outpatients must be provided at the DHs, to minimise the need for patient transfers to the acute site. Whilst XR, CT, MRI and endoscopy are listed as services that will be available in the DH (and presumably ultrasound which was omitted from the list), there needs to be sufficient equipment, radiographer, radiologist and endoscopist staffing to run the service. If any diagnostics are not available overnight or on weekends, the implications for urgent patient transfer at these times needs to be recognised.

6.8 Pathology

R62. Ensure that there is rapid access to pathology testing.

The reference to pathology implies that there will be an on-site laboratory, so that at least the common blood tests will be processed rapidly without the need to courier samples to the acute hospital. If that was required it would inevitably increase the time to make assessments and plan the patient's management. Rapid access to laboratory results is essential for prompt clinical decision making.

6.9 Pharmacy

R63. Confirm that an on-site hospital pharmacy will be present on the standalone district hospital sites.

An on-site pharmacy would be essential to minimise delays in treatment and discharge planning. Whether there would be one is not mentioned in the PCBC.

6.10 Digital integration with the acute hospital

R64. Ensure digital links to the acute hospital are seamless.

There must be ready access to laboratory and imaging results, archived hospital correspondence, and any electronic patient records that the trust uses for patient care.

6.11 Maximising the opportunities for getting patients back out to the community

R65. More emphasis should be placed on ways to discharge patients directly home from an acute hospital bed.

The alternative for many patients who no longer need to be in the acute hospital setting is to discharge to the community with 'wrap around' health and care services, rather than to another inpatient bed (even if in a lower intensity setting). The 'Discharge to Assess' model²⁰ is one programme for doing this, but only has one minor reference in the PCBC: 'we are enhancing discharge to assess to maintain hospital flows'. There should be more emphasis on the opportunities of this and related programmes, as this could avoid the need for step down transfer to the district hospital, and help reduce the physical deconditioning and increasing dependency associated with prolonged hospital stays. These strategies will need to link in with the evolving capabilities of the primary care networks and the range of community services that are being developed and spread.

²⁰ Discharge to Assess: Quick Guide. DH, NHS England and ADASS. <https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf>

R66. Ensure sufficient capacity and resourcing of community services to deliver the proposed model and ESH Trust bed capacity assumptions.

Maintaining flow from the DH beds back out to the community will be as important as it is for an acute hospital. The capacity of the community based services is therefore a key consideration. The three CCGs have described their range of innovative and increasingly impactful initiatives (such as the @home programme in Epsom, and the Sutton Homes of Care vanguard), and their spread and full implementation across the geography will help to prevent delays to getting patients out of the acute and the district hospitals. This will of course require adequate funding to establish and maintain these community services at the capacity required.

R67. Describe any gap in current and anticipated social services and how this would be addressed.

Given the essential role of adult social services in helping people to stay or get home from hospital, more information of the social care needs of the system and how these would be addressed in the new models would add credibility to the models of care and demand management of hospital based activity. The national shortages of domiciliary care workers and care home places are particular issues. Full and meaningful engagement and alignment with the councils and their social care departments and strategies is essential for this, and it would be helpful to refer to this in more detail.

R68. Consider how discharge planning from the time of initial admission would be delivered.

Discharge planning should begin from the day of admission for complex or frail patients. How would this work across sites, particularly for patients being transferred between multiple sites and from different local authority areas?

6.12 The staffing model for the district hospital inpatients²¹

R69. The initial staffing of these sites should be at a more senior level than may be required in the long term.

It is essential to build confidence in the model, ensure safety, identify and resolve operational and clinical issues from the go live date, and building in a high level of expertise and competence at launch is strongly recommended. We recommend that the clinical teams, HEE and the IHT programme continue to work closely together to refine the model so that there is full confidence that it is fit for the intended purpose. Once the DH model is fully developed, this may be an attractive setting to support recruitment, and the positive aspects of roles in these settings could prove important 'selling points' for the workforce.

²¹ See PCBC section 5.3.3.4

R70. Further define the competencies and qualifications required for the interface clinician role.

The PCBC outlines the requirements for staffing the district hospital beds (section 5.3.3.4). The nature and required skills and training of the proposed 'interface clinician' is not clear enough here (nor when comparing tables 22 and 23 in the PCBC, where table 22 shows consultant numbers required, but table 23 does not specify that). It states that the role should be undertaken by a 'senior medical clinician at consultant/GP level'. These two professions are not interchangeable. If a GP, this would mean that hospitalised patients may be under the direct care of a clinician without post-graduate qualifications in the medical care of hospital inpatients. Whilst this might be sufficient for patients just needing intermediate care, the criteria for DH bed admission are much broader than that. Patients would have a wide range of acute medical conditions (even if not of an acuity or complexity requiring an acute hospital bed), many of which might not be fully diagnosed at the time of admission, and specific skills and training must be able to meet the needs of these patients.

The qualifications and training required to undertake this role, if not a hospital trained physician, needs to be clearly understood and agreed. This might include the need for the MRCP, or a validated training scheme and certification, which we are not aware currently exists. Preparing for this role would likely benefit from rotation through the acute hospital for spells to increase skills in acute care, and the trust could consider identifying and starting training now with interested professionals. Whilst the interface clinicians will be 'supplemented by COTE physicians', that does not equate to the prime clinical responsibility residing with those clinicians.

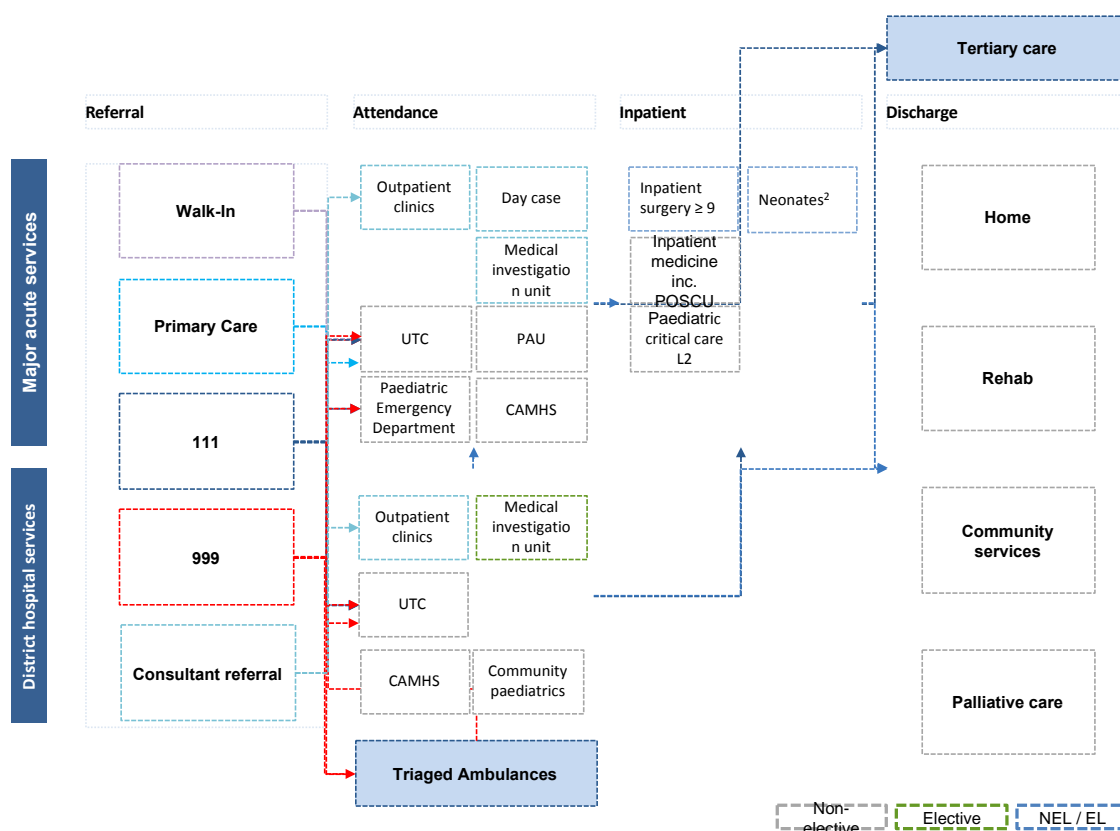
R71. Consider if there would be a sufficient GP workforce to fulfil the interface clinician role.

Given the national shortage of GPs, and the uncertain attraction and training needs of these posts, the assumption that these roles will be filled by GPs is questioned. The total number required is not given in the PCBC. The numbers would be significant given the number of DH beds the Trust is planning for.

7. Paediatrics

There were just three pages on the acute paediatric service in the PCBC so a detailed review of the pathway and issues was not possible.

Figure 3. The future paediatric pathway



Note: (1) POSCU and CAMHS both have direct referral to admission. (2) Neonatal pathway defined by maternity subgroup.

7.1 Bed requirements

R72. Specify the current paediatric bed base of the trust, and the projected need across the four options, at ESH Trust and the surrounding trusts.

We could not locate specific reference to the number of projected paediatric beds required across the options, as they seemed to be amalgamated with the adult bed base. Separate bed modelling is needed to understand the capacity required. This will of course need to take account of the projected population growth for the ages 0-18.

The potential impact of increased activity (paediatric ED and beds) on neighbouring trusts arising from the four different options and the different catchment areas needs to be clearer.

7.2 The out of hospital components of the pathway

R73. Provide more information on the out of hospital community paediatric services.

The full integrated pathway for paediatrics including the out of hospital services (e.g. community medical and nursing paediatrics, health visitors and social care services) needs more detail to demonstrate the range of services that can help avoid attendance or admission to a hospital setting, in the way that has been presented for adult community services. Any future intentions to augment these services should also be presented.

7.3 Critical care

R74. Make clear what the additional case mix the planned level 2 paediatric critical care unit would provide for.

The plans show that the service will augment from two level 1 units to a single level 2 unit on the acute site. The PCBC should outline the additional clinical cases that could remain within the trust, for information, and as a positive consequence of centralisation.

7.4 Surgery

R75. Make clearer the minimum age for surgery in the trust, and any aspirations to reduce it.

The reason for the minimum age of nine for paediatric surgery in the trust was reported to us to be for historical reasons, and reflects the skill sets and competence currently within the trust. It would be helpful for this to be clearer in the PCBC so that the public are aware of the current limitations and where younger children go currently and will do in the future, so that there is no misunderstanding of the future plans.

7.5 UTCs

R76. Outline the role of the UTC as an alternative to the paediatric ED.

There will need to be clarity as to what level of care and range of conditions the local UTC would provide as opposed to the paediatric ED on the acute hospital site. Would there be any age cut off at the UTC?

The co-located services for the UTC on the acute hospital site will be very different from the stand alone UTC, with the likelihood that self-referrals (and potentially GP/111/paramedic referrals) would gravitate to the acute site, reducing the viability and relevance of a paediatrics-competent off-site UTC.

The proposed patient pathways between the off-site UTC to the paediatric ED and PAU needs to be more fully described in a way that is clear to families and the public, and the risks and any mitigations articulated.

Similarly, how urgent or emergency transfers would be undertaken should be articulated more clearly.

R77. State the planned skill mix at the UTCs.

What are the staffing and planned skill mix for the assessment of children and young people's care at the UTC? What are the staffing plans for paediatric assessment at the UTCs? For example, will there be a requirement for paediatric nurses?

7.6 Medical investigation units

R78. Explain the role and viability of two medical investigation units.

There will be two paediatric 'medical investigation units', with one on the stand alone site. What is the purpose of these units, and will it be possible to staff two of them with the required skills? Paediatric radiology (e.g. USS) would presumably be a necessary diagnostic test, but there was concern that it might not be possible to spread the relevant workforce across more than one site on a 7/7 (or even 5/7) basis.

7.7 Safeguarding

R79. Acknowledge the need for staff working in any facility caring for children to have undertaken safeguarding training.

All staff caring for paediatric patients would need the appropriate level of safeguarding training and certification. Is this considered feasible for all the UTCs and MIUs and other services in the DH sites caring for children?

7.8 CAMHS

R80. Describe the planned CAMHS service for the UTCs and the paediatric emergency department, and liaison psychiatry for the inpatients.

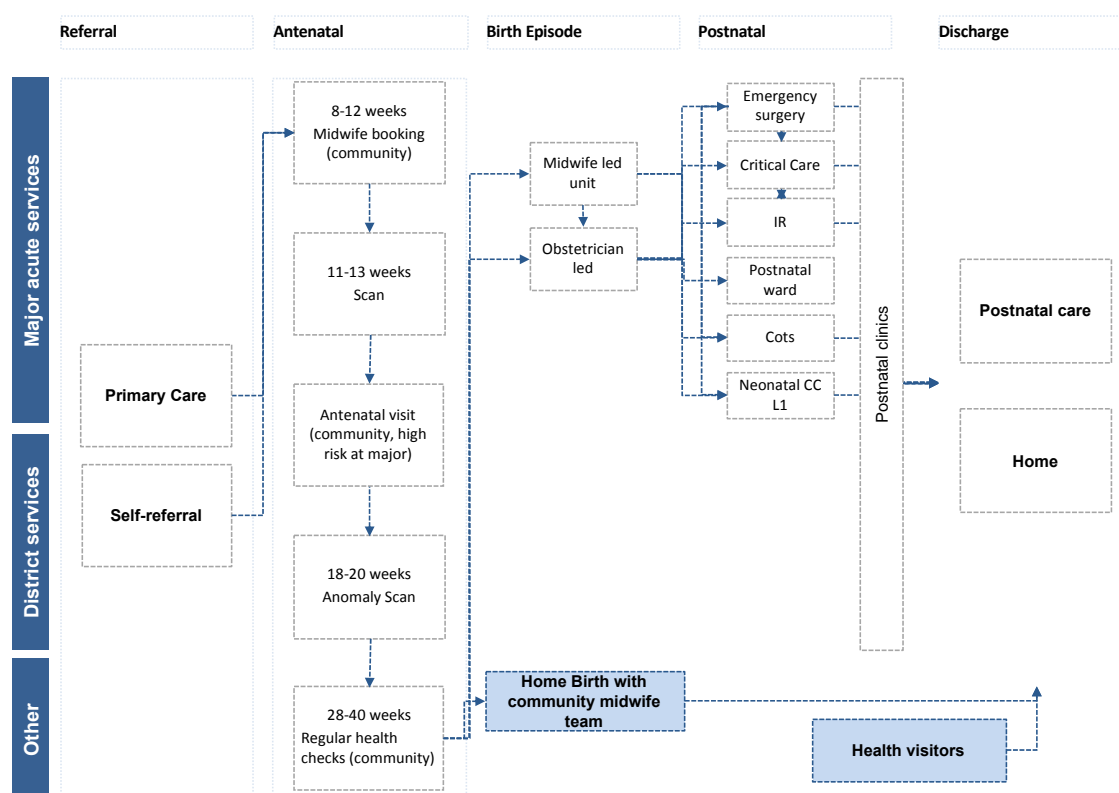
7.9 Workforce

R81. Provide more detail about the multi-professional staffing requirements for the trust's future paediatric service.

There is little detail about staffing requirements other than for consultant numbers (PCBC section 11.3.3). Further detail relating to other required staff, e.g. advanced paediatric nurse practitioners and paediatric AHPs, should be provided.

8. Maternity

Figure 4. The future maternity pathway



8.1 Centralisation of the MLU and OLU on the acute hospital site

The planned birthing pathway that co-located both midwifery led and obstetrician led units, on the acute hospital site, was considered robust and the panel supported the general model and rationale provided. The case made for centralising the inpatient obstetric service on one site is fully supported. On site availability of the neonatal service, interventional radiology, gynaecology and critical care are essential requisites for safe and modern obstetric care.

The co-location of both these units may encourage women to choose a midwife-led birth in the confidence that support is available on site if subsequently they need obstetric input.

R82. There could be more clarity as to how the maternity led units will support home births.

8.2 Birthing activity modelling

R83. Make clearer the local birth rate trends to justify the projected future activity.

The expected trends in the birth rate across the three CCGs should be provided, to better understand the activity modelling that has been undertaken.

R84. Describe the impact of the four options on the size of the resulting obstetric units.

The impact on annual birthing numbers within the trust and the consequent changes in the catchment areas for the different options should be spelt out. It would appear from the supporting information provided that the Epsom option could result in a reduction in the total number of births in the trust (from the current 4,900 to 2,900) as women choose the closer locality of Croydon or St Georges. This would result in a 'small obstetric unit' (by national categorisation) which has inherent challenges. By comparison, the other options would result in 3,800-4,900 births.

8.3 Consequence of a small obstetric unit at Epsom

R85. Recognise the additional challenges of staffing the small obstetric unit that would result from Option 2.

Small units will have difficulty attracting sufficient trainees for safe staffing, and would still need consultant presence at least 12 hours every day to ensure that acutely unwell maternity patients were seen by a consultant within 14 hours of admission. The London Quality Standards for Maternity (2013)²² suggested that all obstetric units should have 168 hours per week of obstetric consultant presence on the labour ward, with appropriate consultant obstetric anaesthetist presence. In the subsequent RCOG guidelines (2016)²³ it was recognised that providing 24/7 consultant obstetric presence was unrealistic, but nonetheless there is a drive to provide at least 84 hours per week, every week. The London Quality Standards are going through a refresh, and the draft guidance is that all units should provide 12 hours dedicated consultant obstetric presence every day with plans to increase to 14 hours per day. This makes a 'small' unit hard to sustain.

²² London quality standards: acute emergency and maternity services. London Health Programmes 2013. <https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf>

²³ Providing quality care for women: obstetrics and gynaecology workforce. Royal College of Obstetricians and Gynaecologists 2016. <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/providing-quality-care-for-women-obstetrics-and-gynaecology-workforce/>

Both St George's and Croydon University hospitals would need to cater for the additional activity resulting from this option and their views on the deliverability of this should be sought.

8.4 Workforce

R86. Demonstrate that the planned consultant obstetric numbers will meet the clinical standards.

The required number of obstetricians for each site is provided in PCBC section 11.3.3 table 70. This suggests a requirement of 20-22 for each of the options. The current consultant numbers in the trust could not be found in the PCBC, so the gap was not clear. It is now recommended that all obstetric units should be able to provide consultant presence for at least 12 hours per day so that all sick women can be seen within 14 hours of admission. The outcome of the impending Maternity Workforce Strategy of Health Education England (due for launch in March 2019) will also be very relevant.

R87. Separate gynaecology and obstetrics consultant rotas are recommended.

Will there be a separate gynaecology on call consultant rota, or will a single rota cover both gynaecology and obstetrics? If the latter, what contingencies would be put in place if there are simultaneous demands on the single consultant. With the expected levels of births annually, separate rotas should be the ambition, and this is one of the draft recommendations from the proposed revised 2018 London Quality Standards²⁴.

R88. Describe the midwifery staffing requirements and retention strategy following centralisation.

More detail is required about midwifery staffing requirements and how the organisation plans to address midwifery workforce retention following relocation of services.

8.5 The SW London and the Surrey Local Maternity Systems

R89. Demonstrate alignment with the strategies and plans of both the LMS's.

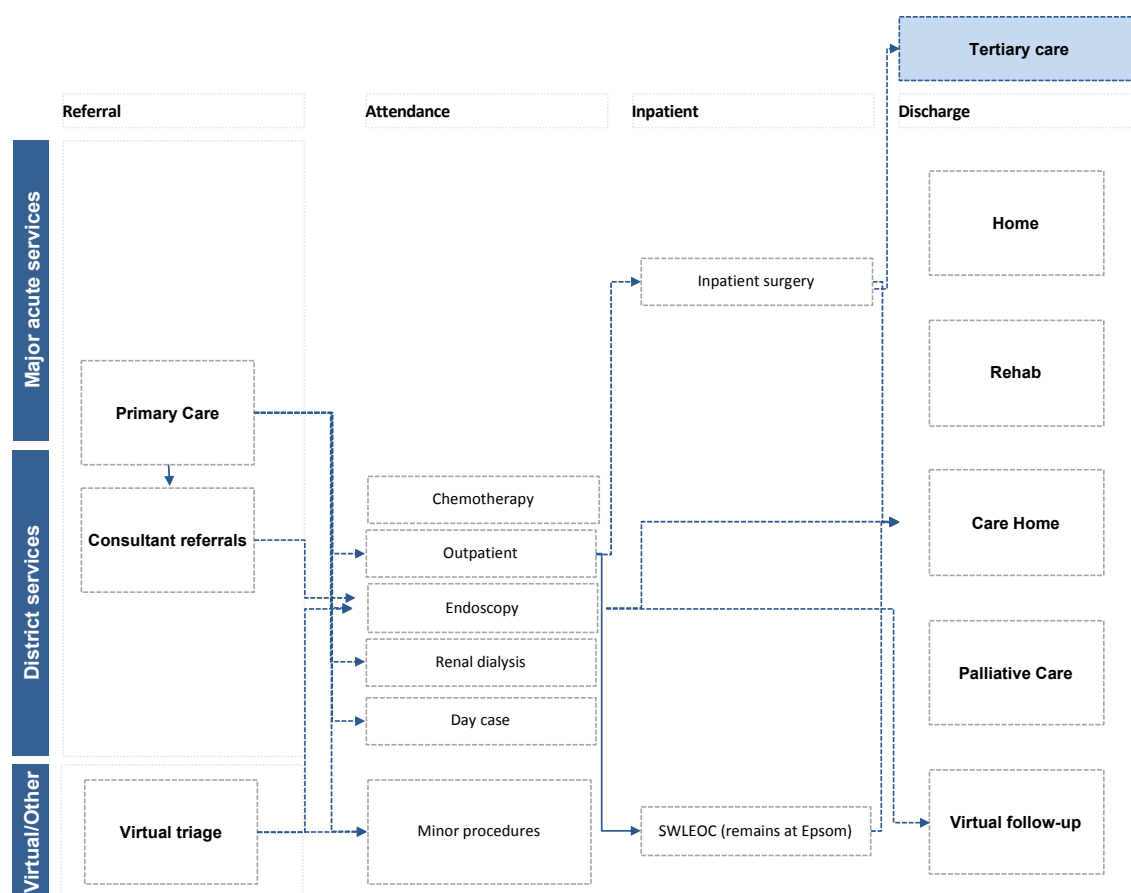
There is no mention of the two LMS strategies and plans, and how the IHT future pathway is aligned with them. Such alignment (assuming it is the case) should be made explicit. This would help provide assurance to women choosing care from different providers within both of the LMS's.

²⁴ London maternity intrapartum quality standards engagement paper. NHS London Clinical Networks 2018. <http://www.londonscn.nhs.uk/wp-content/uploads/2015/06/mat-intrapartum-qs-engagement-paper-032018.pdf>

9. Planned care (elective surgery)

This review focused on aspects of elective surgery (day case and overnight), and not the other aspects of planned care (outpatients, procedures, diagnostics, non-surgical treatments).

Figure 5. The future planned care pathway



We understand that the centralisation of emergency surgery on to one site took place around 10 years ago, and the model is well embedded and accepted. Many consultant surgeons have job plans that span both current sites. This makes the acceptance of a continuation of multi-site working in all shortlisted options highly likely by staff and the public.

9.1 Planned activity and bed requirements across the four options

R90. Clarify the reason for the disparity between elective and non-elective activity and beds across the four options.

The projected elective activity and bed requirements for the four options are shown in table 4 (activity) and Appendix 3.4 (beds). There is a disparity between these (particularly for day

case surgery), which are very similar across the four options, and the large differences in non-elective beds across the four options (associated with their different catchment areas). Is there an explanation for this discrepancy between elective and non-elective activity and beds?

Table 4. Elective activity forecast (2025/26) for the three hospital sites in the four shortlisted options²⁵

Option	Epsom ¹	St Helier	Sutton	Total
Option 1 (acute at Epsom and St Helier)	Not specified	Not specified	NA	54,900
Option 2 (acute at Epsom)	28,400	23,900	NA	52,300
Option 3 (acute at St Helier)	23,500	23,000	NA	53,400
Option 4 (acute at Sutton)	23,500	23,900	6,300	53,800

¹ It is not clear if the numbers include SWLEOC activity

9.2 The distribution of elective surgical services across the trust's hospitals

R91. Review the balance of day case surgery at the district hospital co-located with the acute, and at the stand alone district hospital.

Elective surgery will take place in the acute hospital's beds if patients are complex, higher risk or needing an overnight stay. Less complex, lower risk day case surgery would take place in one of the two DHs in each of the options. However, where one of the DHs is on the same site as the acute hospital it may be acceptable to undertake higher risk day case surgery at that DH, and not at the stand alone site (given the 24/7 on call availability of anaesthetists and MET call teams). If this is validated by the trust's surgeons and anaesthetists, then the bed and theatre modelling would need to take account of the different respective elective surgical activity that could be safely undertaken in the three possible hospital sites for operating (not including the SWLEOC).

Listing the main day case procedures and considering what proportion would be suitable for which location, would be one approach. Previous audits (from the ESH Trust or other trusts) may well be available to inform this work²⁶.

²⁵ From PCBC section 10.2.2.

²⁶ East Sussex is a recent example where all high-risk procedures were moved to a single site and the learning from there could be drawn-on (though both sites have EDs, critical care facilities and acute medical services).

9.3 Pathway for post-op patients needing escalation in care

R92. Estimate the number of patients who may need transfer to the acute hospital after their day case surgery off site.

Understanding the likely proportion of patients who will deteriorate or have complications following their day case surgery, and needing transfer to the acute hospital, is important for inter-hospital transfer planning with the ambulance services, and for understanding demand on acute hospital beds and critical care. Has this been reviewed?

9.4 Anaesthetics

R93. More detail is required on the planned anaesthetic provision for each site.

This should include the rotas and manpower required. Also what is the planned approach to the provision of anaesthetic cover for elective patients with post-operative complications on the stand alone DH site?

9.5 The range of surgery the trust provides

R94. Clarify which types of surgery will not be provided in the trust.

Surgery that is not currently performed, and will not be performed in the future, should be listed, to raise awareness and inform the public and others, and avoid any future misunderstandings about what the trust provides. This would presumably include vascular, specialist cancer and neurosurgery.

10. Appendices

Appendix 1: Abbreviations

AHP – Allied Health Professionals

CAMHS – Child and Adolescent Mental Health Services

CCG – Clinical Commissioning Group

C4C – Case for Change

CQC – Care Quality Commission

DH- District Hospital (as defined in the PCBC and not equivalent to a ‘district general hospital’)

ED – Emergency Department

ESH Trust – Epsom and St Helier University Hospitals NHS Trust

HEE – Health Education England

IHT –Improving Healthcare Together

JSNA – Joint Strategic Needs Assessment

JHWS – Joint Health and Wellbeing Strategy

KLOE – Key lines of enquiry

LoS – Length of Stay

NEL – Non-elective activity (i.e. urgent or emergency)

PCBC – pre-consultation business case

QIPP – Quality, Innovation, Productivity and Prevention programme is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care.

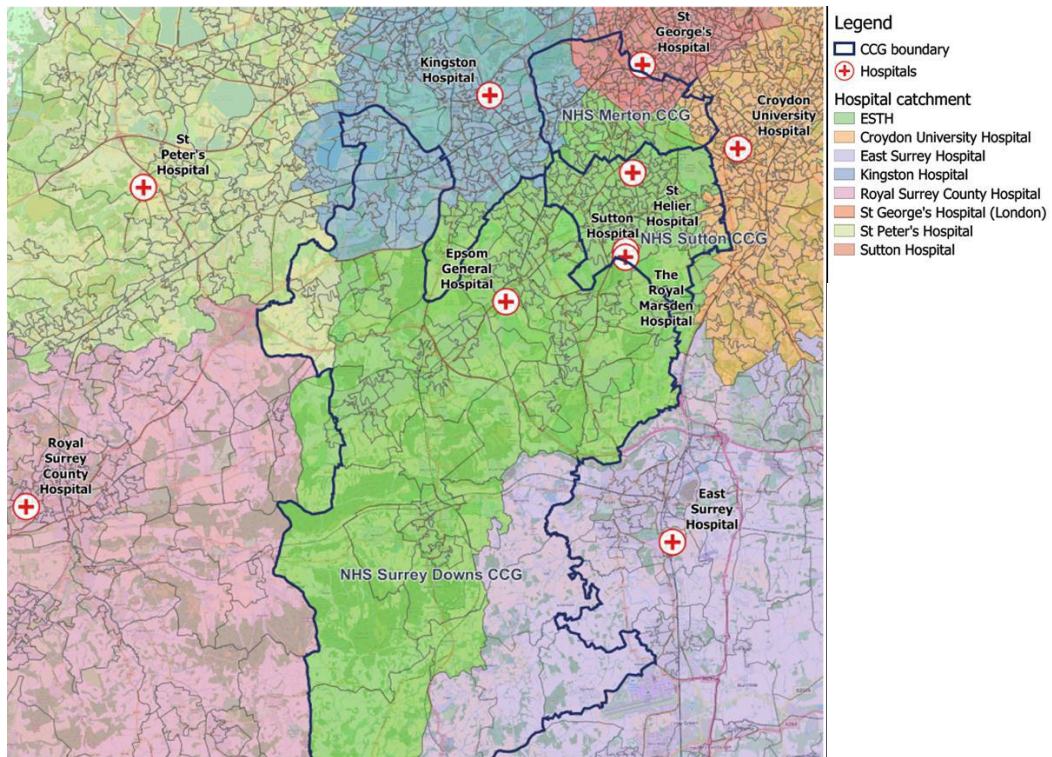
RCEM – Royal College of Emergency Medicine

SWLEOC - The South West London Elective Orthopaedic Centre

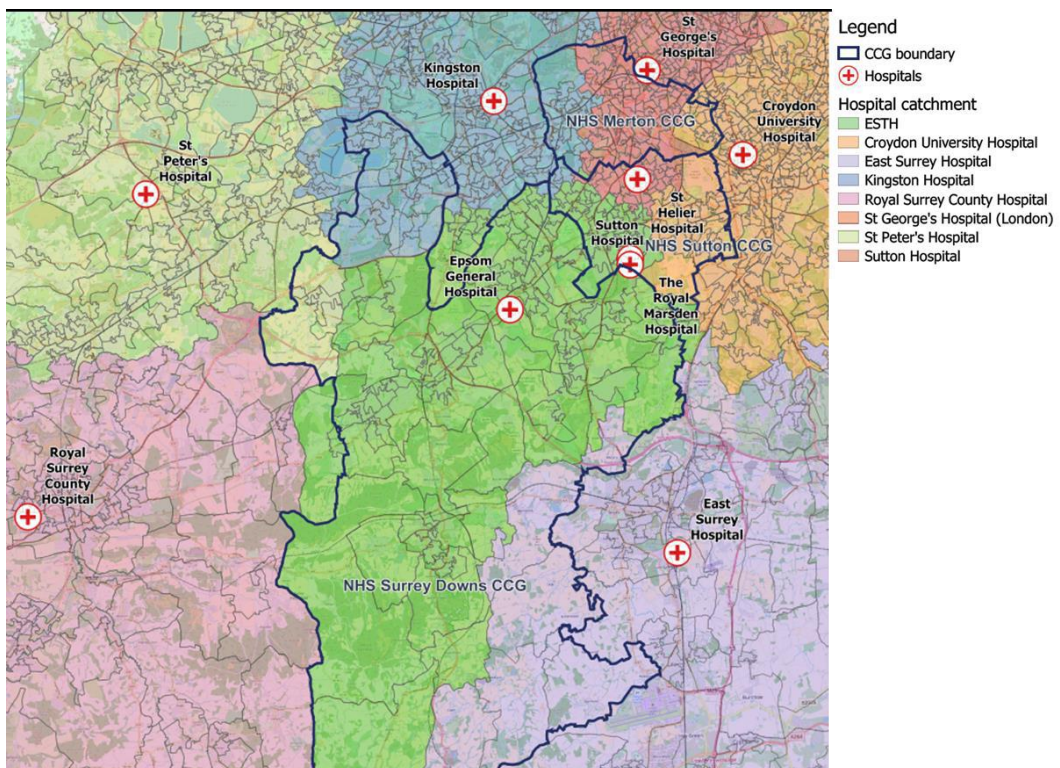
SECS – South East Clinical Senate (Kent Surrey & Sussex).

Appendix 2: Maps of the four options' catchment areas

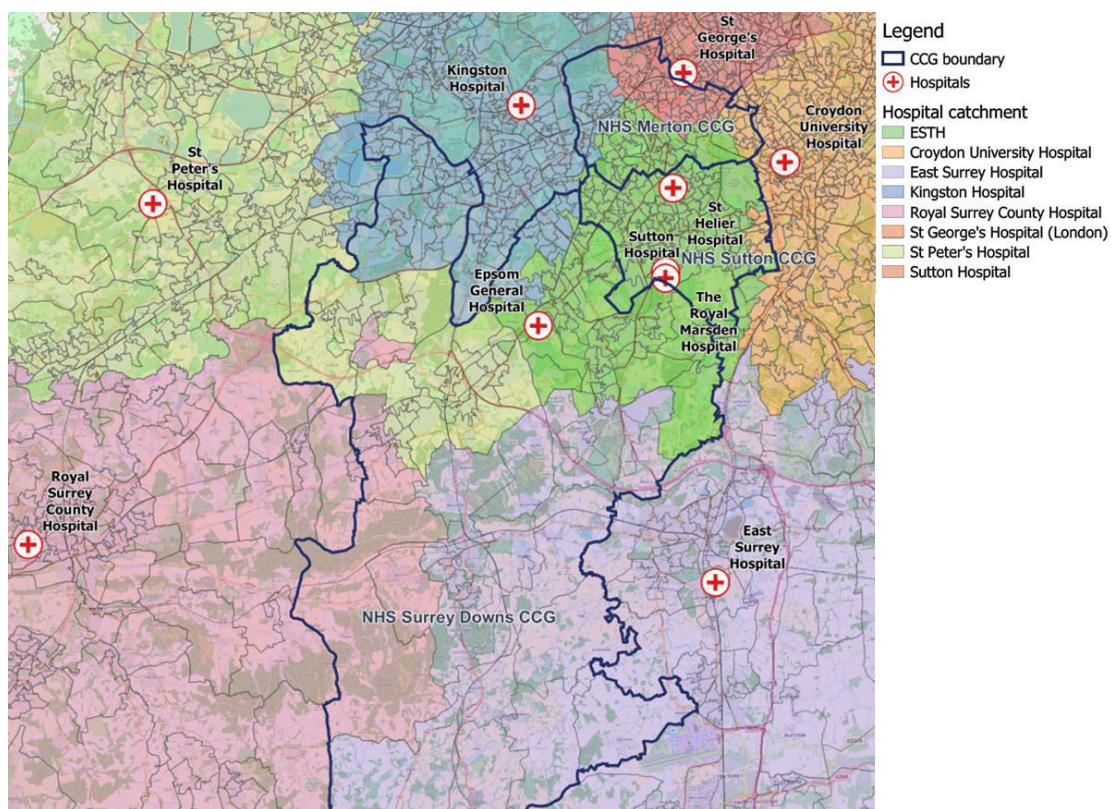
1. ESTH Catchment Area Population - Current



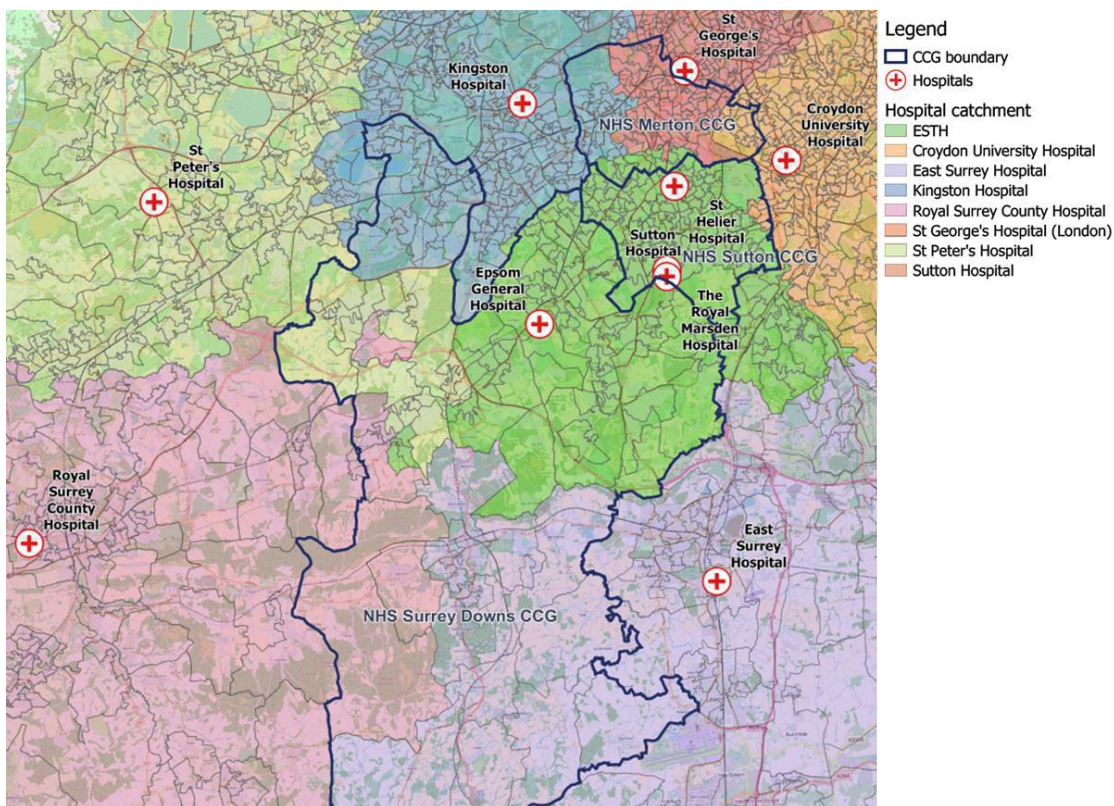
2. ESTH Catchment Area Population - Epsom as a major acute site



3. ESTH Catchment Area Population – St Helier as a major acute site



4. ESTH Catchment Area Population – Sutton as a major acute site



Appendix 3: Summary of projected bed requirements and activity for each of the four options.

Data provided from within the PCBC.

A3.1. Bed requirements in each option, 2025/26 (assuming reduced LoS and QIPP)

	Acute site(s)	Total beds	Outflow	Inflow	Additional LoS benefit
Option 1	Epsom & St Helier	1091			
Option 2	Epsom	848	252	39	31
Option 3	St Helier	975	86	0	31
Option 4	Sutton	1011	134	84	31

A3.2. A&E Attendances 2025/26 (000's)

	Acute site(s)	Epsom	St Helier	Sutton	Total
Option 1	Epsom & St Helier	57.4	90.2	0	147.6
Option 2	Epsom	66.1	63.5	0	129.5
Option 3	St Helier	32.7	102.6	0	135.2
Option 4	Sutton	32.7	63.5	55.2	151.3

A3.3. Maternity: Births 2025/26 (000's)

	Acute site(s)	Epsom	St Helier	Sutton	Total
Option 1	Epsom & St Helier	2.0	2.9	0.0	4.9
Option 2	Epsom	2.9	0.0	0.0	2.9
Option 3	St Helier	0.0	3.8	0.0	3.8
Option 4	Sutton	0.0	0.0	3.8	3.8

A3.4. Detailed bed requirements by category, and by reconfiguration option

(Date from PCBC Appendix 17, pages 20-23)

Bed Category	Option 1				Option 2				Option 3				Option 4			
	Epsom	St Helier	Sutton	Total	Epsom	St Helier	Sutton	Total	Epsom	St Helier	Sutton	Total	Epsom	St Helier	Sutton	Total
NEL (overnight)	100	261	0	362	215	0	0	215	0	296	0	296	0	0	328	328
EL (overnight)	17	26	0	43	27	0	0	27	0	34	0	34	0	0	37	37
Critical Care	9	14	0	22	13	0	0	13	0	18	0	18	0	0	21	21
NEL (day)	16	23	0	38	23	0	0	23	0	31	0	31	0	0	33	34
EL (day)	41	57	0	98	43	53	0	95	39	58	0	97	39	53	5	97
District Beds	117	121	0	239	112	115	0	227	112	115	0	227	112	115	0	227
Community Beds	47	15	0	62	47	15	0	62	47	15	0	62	47	15	0	62
Contingency District	0	0	0	35	0	0	0	35	0	0	0	35	0	0	0	35
SWLEOC	75	0	0	75	75	0	0	75	75	0	0	75	75	0	0	75
Private Patients	24	0	0	24	24	0	0	24	0	24	0	24	0	0	24	24
Maternity	32	61	0	94	51	0	0	51	0	76	0	76	0	0	73	73
TOTAL	479	578	0	1091	630	183	0	848	273	667	0	975	273	183	520	1011

Appendix 4: Currently defined criteria for admission to an acute or district bed²⁷

Acute bed	District hospital bed
Medically unstable or at risk of becoming unstable	Medically stable 'step down'- when the primary complaint has been 'arrested, controlled or is stable'.
Requires access to immediate medical cover 24/7 of on-site senior medical opinion	There is a need to further refine a treatment and further management of co-occurring conditions but not meeting eligibility for acute care
Patient needs cardiac monitoring, arterial blood gas measured, needs central line insertion	Where access to diagnostics such as blood monitoring, X-ray and ultrasound is required
Needs observations (blood pressure/pulse/urine output) at least 4 hourly; and/or oxygen saturations or neurological observations.	Medically stable 'step up': where there is a need for bed-based care and investigations requiring access to multidisciplinary assessment and diagnostics as provided within the district services model
Requires access to 24/7 diagnostics	For the patient with difficulties completing activities of daily living, including transfer, mobility and safety and where care cannot be managed via home support or in existing community hospitals
Needs access to escalation to HDU/ITU	Exclusion criterion: patients who require acute care
Needs specialist medical / surgical input	Exclusion criterion: those whose needs are entirely social care or could be managed at home

²⁷ PCBC section 5.3.3.1 figure 23. Patient Criteria

Appendix 5: Summary table of recommendations

REC. NO.	RECOMMENDATION
General themes	
PCBC Focus	
R1.	Re-frame the PCBC around the primacy of sustaining the acute trust, and the associated benefits to the population, with the district hospital model and innovations in community care as enablers for this new model.
R2.	Describe the potential clinical risks of the district hospitals clinical model, and the mitigations for these risks.
R3.	Justify more clearly the rationale for maintaining the major acute services within the three CCGs' geography.
Demographics, bed and activity modelling across the four shortlisted options	
R4.	Provide more clarity and detail about the expected demographic changes.
R5.	Extend the demographic and activity modelling through to 2030.
R6.	The provision of ranges rather than specific numbers for long term demographic and activity projections should be provided.
R7.	The current catchment population of the ESH Trust needs stating.
R8.	The catchment populations for each shortlisted option should be clearly stated.
R9.	Describe the differential impact across the four options on acute hospital and district hospital beds.
R10.	Review the projections for future emergency department activity.
R11.	Estimate the projected level of activity in the UTCs that will contribute to the reduction in ED demand.
R12.	Provide more confidence in the timeline for the impact of new community care initiatives on demand.
R13.	Predicting reductions in overall length of stay in the Trust's beds need to consider acute and DH beds separately before they are aggregated.
R14.	Steps to anticipate and avoids the risk of increased length of stay arising from transfers of care between the acute hospital and district hospital should be taken.
R15.	Greater clarity on the methodology and assumptions used to determine the ratio of acute to district hospital beds and total bed numbers is required.
R16.	Provide more specific modelling for the impact of community-based care and community beds on the DH bed numbers required.

The model of one acute and two district hospitals	
R17.	The direct relevance of the quoted Northumbria model should be made clearer, along with any other examples.
R18.	Consider changing the term 'district hospital' to 'local hospital' or 'local general hospital'.
R19.	Consider changing the term 'major acute hospital' to 'acute hospital'.
R20.	Consider whether the acute and district hospital wards on the same site would be distinct hospitals.
R21.	Make more explicit the differences between the district hospital co-located with the acute hospital, and those which are stand alone.
R22.	Provide more detail about the advantages of the Sutton acute option.
R23.	In option 4, clarify if there would there be two or three UTCs.
Improvements in population health following the planned reconfigurations	
R24.	The PCBC would be significantly strengthened by more emphasis on the improvements in health outcomes for the population that should arise from the reconfiguration.
R25.	The rationale for the trust reconfiguration could be re-cast as an organisational strategy which addresses local health needs and improves outcomes.
R26	The future health needs of the population could be more clearly described.
Workforce strategy and issues	
R27.	Highlight that the challenges to staffing the major acute services across two sites is a shared problem across the country.
R28.	Describe more fully the workforce pressures across the non-medical workforce, and how the reconfiguration can address these.
R29.	Make a stronger case for the benefits to staff recruitment and retention from the reconfiguration.
R30.	ED consultant requirements should be updated to take account of the latest guidance from the Royal College of Emergency Medicine.
R31.	For the district hospitals, the total clinical staffing required, for each of the four options, should be outlined, and aligned with the projected DH bed and ward capacity.
R32.	Initial staffing of the district hospitals wards should be by senior and experienced staff to gain confidence in the new model of care.
R33.	Consider alternatives to GPs fulfilling the described roles in the district hospitals.
R34.	The enhanced training opportunities in acute care from centralising acute services on to one site should be emphasised.

R35.	The opportunities and risks to training from the proposed new trust model should be recognised.
Level of clinical engagement	
R36.	Describe in more detail the level of clinical engagement about the case for change and the proposed reconfiguration of the ESH Trust.
Digital Strategies	
R.37	Describe in more detail how clinical information will be shared effectively across the hospital sites and teams.
R38.	Alignment with the two STPs' digital strategies and that of the new NHS Long Term Plan should be demonstrated.
The impact on neighbouring hospitals	
R39.	Can the neighbouring acute trusts support the consequences of all four of the shortlisted options?
R40.	The current and planned provision of tertiary services for the CCGs' population should be presented.
Urgent and emergency care pathways and services	
R41.	The full implications of having a UTC on a different site from the acute hospital, and how any risks will be mitigated, should be described.
R42.	Anticipate the increased use of the UTC co-located with the acute hospital.
R43.	Clear operational guidance will be required for patients needing UTC assessment near closing times.
R44.	Specific clinical examples of the types of conditions a UTC might treat rather than an ED would be helpful.
R45.	Clarity about what the ambulatory care service is on each site should be provided.
R46.	High quality clinical triage will be essential to ensure patients are assessed in the right setting, first time.
R47.	The capacity and workforce for critical care and outreach should be clarified.
R48.	Clarify the provision of liaison psychiatry to the district hospital inpatients.
R49.	Expand on the joint planning with and pathways to primary mental health services.
R50.	Provide details of the increased capacity likely to be required of the two ambulance services and patient transport services.
R51.	Develop clear clinical criteria for conveyances to the local UTC or the acute hospital's ED.

R52.	Ensure ED capacity of ESH Trust and neighbouring hospitals is sufficient to avoid adverse impact on the ambulance services.
District hospital beds	
R53.	The definition of patient suitability for a district hospital bed should be reviewed.
R54.	The differential clinical risks to patients in stand-alone district hospital beds, and the mitigations for those risks, need clearer articulation.
R55.	Patients for admission need a detailed clinical assessment before deciding if a district hospital bed is suitable and safe.
R56.	Consider a phased implementation of the model starting with lower acuity step down and step up patients.
R57.	The level of available medical and nursing skills and facilities must be sufficient for and adaptable to the potentially wide range of clinical conditions and acuity of inpatients, 24/7.
R58.	Agree pathways, protocols and contracts for emergency transfer to the acute hospital with the ambulance services.
R59.	Ensure sufficient job planned time is provided to undertake specialty in-reach.
R60.	Ensure there is 7/7 liaison psychiatry provision for the district hospital inpatients.
R61.	Confirm the range of diagnostics available and anticipated hours of provision.
R62.	Ensure that there is rapid access to pathology testing.
R63.	Confirm that an on-site hospital pharmacy will be present on the standalone district hospital sites.
R64.	Ensure digital links to the acute hospital are seamless.
R65.	More emphasis should be placed on ways to discharge patients directly home from an acute hospital bed.
R66.	Ensure sufficient capacity and resourcing of community services to deliver the proposed model and ESH Trust bed capacity assumptions.
R67.	Describe any gap in current and anticipated social services and how this would be addressed.
R68.	Consider how discharge planning from the time of initial admission would be delivered.
R69.	The initial staffing of these sites should be at a more senior level than may be required in the long term.
R70.	Further define the competencies and qualifications required for the interface clinician role.

R71.	Consider if there would be a sufficient GP workforce to fulfil the interface clinician role.
Paediatrics	
R72.	Specify the current paediatric bed base of the trust, and the projected need across the four options, at ESH and the surrounding trusts.
R73.	Provide more information on the out of hospital community paediatric services.
R74.	Make clear what the additional case mix the planned level 2 paediatric critical care unit would provide for.
R75.	Make clearer the minimum age for surgery in the trust, and any aspirations to reduce it.
R76.	Outline the role of the UTC as an alternative to the paediatric ED.
R77.	State the planned skill mix at the UTCs.
R78.	Explain the role and viability of two medical investigation units.
R79.	Acknowledge the need for staff working in any facility caring for children to have undertaken safeguarding training.
R80.	Describe the planned CAMHS service for the UTCs and the paediatric emergency department, and liaison psychiatry for the inpatients.
R81.	Provide more detail about the multi-professional staffing requirements for the trust's future paediatric service.
Maternity	
R82.	There could be more clarity as to how the maternity led units will support home births.
R83.	Make clearer the local birth rate trends to justify the projected future activity.
R84.	Describe the impact of the four options on the size of the resulting obstetric units.
R85.	Recognise the additional challenges of staffing the small obstetric unit that would result from Option 2.
R86.	Demonstrate that the planned consultant obstetric numbers will meet the clinical standards.
R87.	Separate gynaecology and obstetrics consultant rotas are recommended.
R88.	Describe the midwifery staffing requirements and retention strategy following centralisation.
R89.	Demonstrate alignment with the strategies and plans of both the LMS's.

Planned care (elective surgery)	
R90.	Clarify the reason for the disparity between elective and non-elective activity and beds across the four options.
R91.	Review the balance of day case surgery at the district hospital co-located with the acute, and at the stand alone district hospital.
R92.	Estimate the number of patients who may need transfer to the acute hospital after their day case surgery off site.
R93.	More detail is required on the planned anaesthetic provision for each site.
R94.	Clarify which types of surgery will not be provided in the trust.

Appendix 6: Resource material provided to the independent review panel

Document Name	
1.	IHT Pre-Consultation Business Case
2.	Appendix 8:- Clinical Evidence Review
3.	Appendix 9:- Draft Finance Workbook v1
4.	Appendix 10.1:- Baseline Travel Analysis
5.	Appendix 11:- Deprivation Impact Analysis
6.	Appendix 16.1:- Equality Impact Assessment
7.	Appendix 17:- Additional Bed Data
8.	Details of Future Demographic Trends
Supplementary Resources	
9.	Maps: Hospital catchment areas for the four options
10.	Maps: Inclusive of travel times between current acute hospitals
11.	Bed Modelling: Supplementary paper
12.	Joint Clinical Senate Review: IHT Case for Change
13.	South East Clinical Senate Acute Services Co-Dependency Grids
14.	South East Clinical Senate Review Report: Reducing Avoidable Hospital Based Care: Re thinking out of hospital clinical pathways

Appendix 7: Key lines of enquiry (KLOEs)

General KLOEs
Are the projections for changes in demand up to 2030 realistic?
How will the planned reconfigurations improve health outcomes for the populations of the three CCGs?
Is there a coherent and realistic workforce strategy that takes account of the full range of the clinical workforce and the opportunities provided by new roles and ways of working?
Are there plans for the necessary digital clinical information sharing across the trust, and alignment of the digital strategies of the two relevant STPs?
Are there any major inconsistencies in the proposed reconfiguration of services with the new NHS Long Term Plan?
Has the breadth and depth of clinical engagement been sufficient?
KLOEs relating to the shortlisted options for future hospital configuration
Across the three options for service reconfiguration (acute major hospital at Epsom, St Helier or Sutton, and district hospital services and beds at both Epsom and St Helier for all three options), are there option-specific issues that need highlighting?
Is the impact on neighbouring hospitals clearly described for each option, and are there any associated issues of concern not described in the PCBC?
Is the impact on surrounding acute trusts clear for each of the options (including specialist/tertiary services)? Consider UEC, paediatrics and maternity for each.
Urgent and Emergency Care
General comments on the patient pathways (refer to the relevant pathway diagram)
Is the patient pathway between a separately sited UTC and ambulatory care service, and the major acute hospital, clear and sound (including overnight pathways when the UTC may be closed)?
Are there clear and sound criteria for admission to a district vs acute hospital bed?
Is there confidence that the ambulance triage and transfer pathways and capacity issues have been sufficiently addressed?
Ambulance triage and transfer issues
Are the benefits and risks (including mitigation) of centralising the various major acute services on to one site clearly articulated?
Will the co-location of the various key clinical support specialties and services support the proposed models?
Is there a clear and deliverable workforce plan?
Are there additional clinical standards beyond those referenced (see PCBC references 127 and 128, pg. 110) that are relevant to delivering high quality of care UEC?
Will the current and planned community based services and initiatives (see PCBC section 5.3) be of sufficient efficacy and capacity to deliver the new UEC pathway?
Have the specific issues with option 4, where both district hospitals, with their district beds and UTCs, would be located on a different site from the acute hospital (at Sutton), been addressed?
Paediatrics
General comments on the patient pathways (refer to the relevant pathway diagram)
Is the patient pathway between a separately sited UTC and the paediatric ED and PAU at the major acute hospital, clear and clinically sound?

Will the co-location of the various key clinical support specialties and services support the proposed model?
Is the interface and pathways between the acute hospital and paediatric service and the community paediatric service (paediatricians and paediatric nurses) described (so that unnecessary transfers to hospital can be avoided)?
Is there a clear and deliverable workforce plan?
Are there sufficient published clinical standards referenced in the PCBC?
Is the paediatric surgical pathway clear and sound?
Is the paediatric medical inpatient pathway clear and sound?
Are there any issues in relation to paediatric critical care capacity and the network?
Maternity
General comments on the configuration of birthing pathways (refer to the relevant pathway diagram), esp. centralisation to one hospital of the MLU and OLU?
Will the co-location of the various key clinical support specialties and services support the proposed model?
Is there a clear and deliverable workforce plan?
Is the neonatal pathway clear and sound?
Are there sufficient published clinical standards referenced in the PCBC?
Are the plans aligned with both the SW London and the Surrey Local Maternity Systems (LMS) and strategies?
Planned Care
Comments on the distribution of elective surgical services
Pathway for post-op patients needing escalation in care/critical care if on different site from the major acute hospital.
Are the workforce challenges relating to multiple site surgical services addressed?
Will the co-location of the various key clinical support specialties and services support the proposed model?
Will the planned capacity for elective surgery (beds, theatres, critical care) be sufficient?
District Hospital beds
Are the criteria for admissions sufficiently described?
Is there a clear and sound pathway for patients that deteriorate in a district hospital bed?
Will there be sufficient capacity in the community to discharge patient and maintain flow?
Is there clarity about the bed modelling across the trust for district and acute hospital beds (refer to the capacity and bed modelling assumptions, appx 17)?
How is clinical risk to be managed and owned for these patients not in an acute hospital?
Is the staffing model for district hospital wards sufficient and appropriate (see PCBC section 5.3.3.4) including the new role of the 'interface physician', the availability of 'specialists', and the out of hours cover?
Is the staffing model for district hospital wards clear and appropriate?
Will there be sufficient on site supporting clinical services at the district hospital from the major acute hospital?

Appendix 8: Agenda for the independent panel day

London and South East Clinical Senates:
Joint Review of the Pre-Consultation Business Case for Surrey Downs, Sutton and Merton CCGs
 24th January 2019, 9.30am-5pm
 Convocation Hall, Church House, Dean's Yard, Westminster, London SW1P 3NZ

Item	Time	Item	Lead
1.	9.30	Arrival, registration and refreshments	
2.	10.00	London and South East Clinical Senate Expert Review Panel pre-meet	LG/MG
	10.30	Improving Healthcare Together (IHT) team join the meeting	
3.	10.30	Introductions, context and approach to the review	LG
4.	10.40	Improving Health Together presentation Presentation from the IHT team, briefly summarising the case for change, purpose of the proposed reconfiguration, criteria for options shortlisting and summary of the options	TBC
5.	11.00	Discussion between the clinical senate panel and the CCG team, relating to the strategic approach, overarching themes and shortlisted options (Q&A).	LG
6.	11.30	Clinical Models and Pathways presentations and discussion Major acute services: Each model presentation to be followed by Q&A Review of the four clinical models and pathways, including any issues with each of the four shortlisted options. <ul style="list-style-type: none"> • Urgent and emergency care, with reference to the use of community beds and the supporting community services: (Presentation 15 mins: Q&A 15 mins) • Paediatrics: (Presentation 10 mins: Q&A 10 mins) • Maternity: (Presentation 10 mins: Q&A 10 mins) • Planned care: (Presentation 5 mins: Q&A 10 mins) • District hospital services: (15 min presentation followed by 10 min Q&A) • Review of the clinical models and pathways, including any issues with each of the four shortlisted options. • Model of care (Inc. UTC, district beds, ante/post-natal, dialysis and chemotherapy, Out Patient and day case, imaging and diagnostics) • District hospital beds • Delivery model (services by site) • Benefits 	
	1.30	Close of joint meeting and lunch	
7.	2.15	Clinical senate review panel only: Panel discussion, conclusions and development of recommendations	MG
8.	4.50	Summing up and next steps	MG/LG
9.	5.00	Meeting close	

Appendix 9: Independent Review Panel membership and Declarations of Interest

Name	Roles
Caroline Alexander	Acute Trust Nurse, Barts Health NHS Trust
Amanda Allen	Occupational Therapist, Maidstone and Tunbridge Wells NHS Trust
Alison Barnett	Director Public Health (South East)
Professor Richard Beale	Consultant Intensivist and Associate Medical Director, Guys and St Thomas' NHS Foundation Trust Professor of Intensive Care Medicine, Kings College London
Chetan Bhan	General Surgeon, Whittington Health NHS Trust
Aileen Buckton	Director of Adult Social Care, London Borough of Lewisham
May Bullen	PPE (South East)
Graeme Dewhurst	Health Education England (Kent, Surrey and Sussex)
Katrina Erskine	Obstetrician, Homerton University Hospital NHS Foundation Trust
Andrew Foulkes	GP, NHS England (South East)
Mike Gill	London Clinical Senate Chair
Lawrence Goldberg	South East Clinical Senate Chair Consultant Nephrologist, Brighton and Sussex University Hospitals NHS Trust
Professor Fares Haddad	Consultant and Orthopaedic Surgeon, University College Hospital
Deepak Hora	Clinical Lead Planned Care, Camden
Nicola Kingston	PPE (London)
Rachel Landau	A&E Consultant, Whittington Health NHS Trust
Jaqui Lindridge	Paramedic, Consultant Paramedic Committee
Sunil Lobo	STP Clinical Lead for Acute Medicine in East Kent
Hugh McIntyre	Acute Geriatrician, East Sussex Healthcare
Lisa Page	Acute Psychiatric Liaison, Brighton and Sussex University Hospitals NHS Trust
Ali Parsons	Associate Director, South East Clinical Senate
Vivek Patil	Deputy Medical Director, Sussex Community Foundation Trust
Jessica Read	Regional Maternity Lead, NHS England (London)
Jonathan Richenberg	Consultant Radiologist, Royal Sussex County Hospital
Edward Ward	Programme Lead, London Clinical Senate

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Caroline Alexander	None	None	None	None
Amanda Allen	None	None	None	None
Alison Barnett	None	None	None	None
Professor Richard Beale	None	None	None	None
Chetan Bhan	None	None	None	None
Aileen Buckton	None	None	None	None
May Bullen	None	None	None	None
Graeme Dewhurst	None	None	None	None
Katrina Erskine	None	None	None	None
Andrew Foulkes	None	None	None	None
Mike Gill	None	None	None	None
Lawrence Goldberg	None	None	None	None
Professor Fares Haddad	None	None	None	None
Deepak Hora	None	None	None	None
Nicola Kingston	None	None	None	None
Rachel Landau	None	None	None	None
Jaqui Lindridge	None	None	None	None
Sunil Lobo	None	None	None	None
Hugh McIntyre	None	None	None	None
Lisa Page	None	None	None	None
Ali Parsons	None	None	None	None
Vivek Patil	None	None	None	None
Jessica Read	None	None	None	None
Jonathan Richenberg	None	None	None	None
Edward Ward	None	None	None	None

Appendix 10: Improving Healthcare Together presentation team

Name	Roles
Tammy Angel	Consultant, Geriatric Medicine, Epsom and St Helier University Hospitals NHS Trust
Sarah Blow	Accountable Officer for South West London
Ruth Charlton	Deputy Chief Executive and Joint Medical Director Epsom & St Helier University Hospital NHS Trust
Dr Jeff Croucher	Clinical Chair - Sutton Clinical Commissioning Group
Andrew Demetriades	Joint Programme Director for Improving Healthcare Together
Daniel Elkeles	Chief Executive, Epsom & St Helier University Hospitals NHS Trust
Stephen Farrington	Technical Expert, Improving Healthcare Together
Ramesh Ganapathy	Clinical Director for Women's Services, Epsom & St Helier University Hospitals NHS Trust
Amir Hassan	Clinical Director Emergency Medicine, Epsom & St Helier University Hospitals NHS Trust
Dr Russell Hills	Clinical Chair - Surrey Downs Clinical Commissioning Group
Gaun Lim	Consultant, Epsom Health and Care
James Marsh	Deputy Chief Executive and Joint Medical Director, Epsom & St Helier University Hospitals Trust
Dr Andrew Murray	Clinical Chair - Merton Clinical Commissioning Group
Matthew Tait	Joint Accountable Officer for Surrey Heartlands Health and Care Partnership
Arlene Wellman	Chief Nurse, Epsom and St Helier University Hospitals NHS Trust

