South East Clinical Senate

South East

Clinical

senate

Improving Clinical Communications Between Primary and Secondary Care Clinicians:

A review and recommendations for the Sussex and East Surrey STP

December 2017

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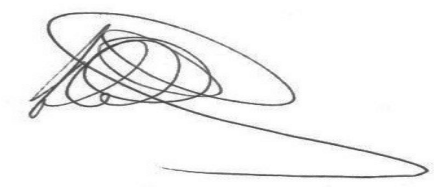
Preface

The way that clinicians work together in providing care to individual patients, and how they communicate with each other, is vital to providing an integrated, coordinated, patient-centred approach, and for delivering the best experience of care and outcomes for patients. Phone calls and conventional letters have been the default means of communication for decades, whilst over time technological changes, increasing specialisation, the need for every greater efficiencies, changing organisational and professional boundaries, and changing patient expectations, have ceaselessly evolved.

In recognition of this, the Sussex and East Surrey STP sought a clinical senate review of how patient-related communications between clinicians could be optimised across its footprint. The review's focus was on three primary means of communicating about patient care: telephone, email, and shared access to integrated health care records (formerly known as electronic patient records). Many of the findings and recommendations in this report relate simply to the better use of existing modes of communication, more reliable processes, and greater transparency and ease of access to each other. In addition, the importance of clear and timely discharge summaries and clinic letters, co-development of patient pathways, and more opportunities for GPs and consultants (in particular) to interact face to face, will result in higher quality care, a better understanding of each other's ways of working and needs, and a reduction in avoidable and time consuming supplementary requests for advice.

Whilst the review focussed on the inter-professional communications between primary and secondary care clinicians, many of the findings would equally apply to communications with community health care and social care professionals. Furthermore, whilst this review was undertaken for a specific STP, the issues identified, and the recommendations, can equally apply to other STPs across the country, though recognising that different areas and organisations have evolved their own ways of working, and may require different solutions and focus from others: one size certainly does not fit all. The benefits of STP-wide solutions and approaches to this issue should be emphasised, and would contribute to the shared clinical culture and practice that STPs can foster.

I would like to thank the members of the South East Clinical Senate working group, and the clinical senate council, for their time, expertise and passion in producing this report, which we hope will provide a valuable steer to clinicians, managers and commissioners.



Dr Lawrence Goldberg, South East Clinical Senate Chair.

1. Introduction and Context

Good, patient-centred healthcare must involve close collaboration between the range of multi-professional clinicians caring for individual patients, to ensure that such care is coordinated, appropriate, timely, avoids duplication or unnecessary interventions, and is cost effective. This is particularly important across organisational and professional boundaries, where currently there are many barriers (technical, cultural and financial) that impede effective communication about individual patients between clinicians.

The Sussex and East Surrey STP Clinical Board has recognised the significant opportunities that could result from improved clinical communication, particularly between primary and secondary care clinicians. To help provide the board and the wider STP with guidance for how this important agenda can be progressed, the South East Clinical Senate was asked to undertake an independent clinical review, to provide advice and recommendations.

The request to the clinical senate was:

What are the best mechanisms for improving clinical communication between primary and secondary care clinicians for both urgent and non-urgent clinical issues?

This review looks at the current barriers and enablers to better clinical communications, reviews some of the pertinent literature, single centre experiences, and technologies that have been used, and provides a range of recommendations for how this agenda can be taken forward. It should be noted that whilst the request was to focus on primary-to-secondary care links, many of the issues and recommendations are relevant to communications with community health care and social care professionals.

2. Methodology

The remit and scope of the proposed review was discussed and agreed by the South East Clinical Senate's council and STP Clinical Board chairs. A working group was set up, reporting to the council, to undertake the detailed work of the review. A literature review was conducted by the Brighton and Sussex Knowledge and Library Service (BSUH), supplemented by additional examples provided by the clinical senate council and working group members. The request from the STP clinical board to submit the report by the end of October 2017 resulted in a more focussed and narrower scope than would otherwise have been possible.

3. Scope of the review

The following were within the scope of the review:

- Communications about patient-specific, clinical issues (not managerial or social).
- Clinician to clinician communications only (with a clinician defined as any practicing healthcare professional).
- Communication across organisations (not within): Primarily between secondary care and primary care (with the understanding that many of the principles and recommendations developed could be extended to both community-secondary care and paramedic-secondary care).
- Across the range of clinical urgency (e.g. immediate, same day, same week), as determined by the clinical need of the requester.
- All clinical specialties, including mental health.
- The opportunities provided by technical solutions (without undertaking any detailed review of the currently available technologies)

The following were out of scope:

- Direct communications between patient and clinician, (though not to dismiss the huge potential opportunities afforded by telemedicine developments).
- Face to face meetings and joint educational events (though acknowledging the opportunities for relationship building and learning from such encounters).
- Interactions between health care and social care professionals, (though the principles established here can likely be adapted subsequently to such interactions).
- A review of specific electronic patient record (EPR) systems/products. However, the review will still outline the generic benefits from shared use of such records across organisations in enabling integrated clinical decision making.

4. The purpose and key aims of improving clinical communications

The following are considered the key aims for improving communications between primary and secondary care clinicians:

- To improve the timeliness and appropriateness of clinical decision making, and thereby the quality and safety of patient care, by better sharing of clinical information between clinicians working in different organisations.

- To reduce avoidable patient attendances in primary and secondary care settings by enhancing ways to provide specialist advice to primary and community care clinicians.

- To ensure streamlined, barrier-free access for primary care clinicians to specialist advice, and secondary care clinicians for advice and discussion with primary care colleagues, both within response times commensurate with the clinical need.

- To ensure any new methods of communication deliver better value (better patient outcomes for the resources expended) than current practice.

- To enhance the professional relationships between primary and secondary care clinicians.

5. Underlying principles

The following principles should be used to guide the development and implementation of new or improved approaches to clinician communications:

1. GP requests for advice should be met by a consultant (or if not, an alternative, experienced decision maker), to ensure high quality, definitive advice, consistent with GMC Good Medical Practice requirements[1].
2. Clinicians should be available to respond in a clinically appropriate and agreed time frame to maintain quality and safety of patient care (whether in minutes or hours for acute conditions, or days for less urgent issues). This may often require a team based approach both in primary and secondary care to ensure availability to respond, and to minimise disruption to other patient-facing activity (e.g. to ward rounds, clinics, GP surgeries).
3. Discussions about clinical cases should aim for clarity of purpose, be succinct in the provision of relevant information, and by default use a consistent format for both written and verbal contacts.
4. Following an inter-professional consultation, it should be clear between the clinicians involved who is responsible for any agreed actions, and this should be documented accordingly in the patient's record. Other clinicians involved in the patient's care should be notified of changes to the patient's management plan where it would alter the patient's care.
5. The maintenance of patient confidentiality and compliance with information governance requirements are essential. However, unnecessary or spurious barriers to effective communication, such as over-interpretation of legal guidance, should be avoided.
6. Every effort should be made to have a consistency of approach across the STP, to avoid the need for clinicians to use multiple systems and processes when interacting with clinicians across the range of NHS organisations within their networks.
7. Any new technologies made available for inter-professional communication should be reliable, accessible, easy to use and secure. They should enhance patient care and outcomes whilst being cost effective, i.e. they should add value over current practice.
8. The patient should normally be informed of the request for advice from another healthcare professional, and given an indication of when such advice is expected to be available and communicated to them.

[1] General Medical Council Good Medical Practice. Para 34: 'When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.'. http://www.gmc-uk.org/guidance/good_medical_practice/communicate_effectively.asp

9. Hospital clinicians should ensure prompt delivery of clinical letters and discharge summaries, to avoid unnecessary additional work for GPs and loss of care continuity for patients, as required in the acute provider national contract.
10. Clinical guidelines and pathways for the main clinical conditions across all specialties should be jointly developed and agreed (at STP level wherever possible), to minimise the need for patient-specific clinical queries about referral or management.

6. Enhancing telephone, email and video communications.

The main means of communication between clinicians that were explored in this review were those of telephone, email and video links. Whilst other technologies are being developed, these are unlikely to be available for implementation in the near future, but health systems should continue to horizon scan and find out about the benefits of such newer technologies.

In this section, we have identified many of the important barriers that get in the way of easier and better communication links between primary and secondary care clinicians, and provides practical recommendations for addressing them and unlocking the huge potential that more effective communication can deliver for improved and timely patient care.

6.1 Improving telephone communications

GP consensus is that direct phone access to a consultant (otherwise an experienced alternative senior clinician), rather than a junior trainee is the most valuable for getting definitive advice. Conversely consultants benefit from direct conversations with their patients' GPs. For both approaches, there are well-known obstacles to ready access, which need to be overcome.

A direct clinical discussion between primary and secondary care clinicians is generally used for one of three purposes: to arrange an admission or urgent hospital-based assessment for an acutely ill patient; to discuss clinical cases where there is uncertainty about the need for admission or hospital assessment; or for complex but less urgent cases where telephoning is considered more appropriate that written consultation.

6.1.2 Enhancing GP telephone contact with specialists

Barriers:

The causes of delays include:

- Waiting for a hospital switchboard response, and switchboard reluctance to use consultant mobile phone numbers for outside callers.
- Consultant is away or otherwise unavailable
- Consultant secretary away from their desk without call forwarding.
- Wi-Fi and mobile phone 3G/4G dead zones within hospitals impair reliability of mobile phone usage as the primary means of communicating.
- Unreliable and delayed response to bleeping of specialty SpRs. Bleep holder may be occupied, or not be at work and without an alternative responder in place.
- Uncertainty exists as to the best service across the health system to contact for an acute clinical issue.

Recommendations:

R1: Mobile phones should become the default means for GPs to make direct contact with hospital clinicians. Trusts should reach agreement with consultants to authorise this for their switchboards and their departmental administrative staff.

R2: Each specialty/department in acute trusts should have a single point of telephone access (available by direct dial to outside clinicians) that is administered during normal office hours, that can triage calls to the most appropriate and available specialist in the department.

R3: Hospitals should ensure Wi-Fi and 3G/4G availability throughout their sites to ensure mobile phone functionality.

R4: For urgent calls to on call specialists, trusts should ensure their telephony systems have a single point of access for GPs (and other clinicians), that enable seamless, guaranteed and prompt direct contact, 24/7. Hospitals should have bypass numbers made available to external clinicians to avoid delay. Various commercial options are available for connecting with specialist clinicians and can be considered if required, which should enable case conferencing, recording of the interaction, and auditing.

Commercial examples of telephony systems include:

- Consultant Connect[2,3], used extensively in North Essex, Bath, and more recently at Western Sussex Hospitals.
- GP Connect[4].
- Vocera clinical communications software[5].
- Skype for Business (which has a suite of tools and presence for identifying clinicians who are 'available' for contact), and is now in a partnership with NHS.net[6].

The use of DECT phones (Digital Enhanced Cordless Telecommunications) can facilitate such ready access to on call clinicians[7].

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[2] Consultant Connect homepage. https://www.consultantconnect.org.uk/

[3] Consultant Connect aggregated performance data. https://www.consultantconnect.org.uk/actual-numbers-actual-project/

[4] GP Connect. www.gpcare.org.uk/site/consultant_link/

[5] Vocera Clinical Communications software. https://www.vocera.com/products/secure-texting-collaboration

[6] Skype for Business http://support.nhs.net/skypeforbusinessintro

[7] As used by the acute medical team at BSUH NHS Trust.

R5: Bleeps should be phased out, and any new strategies and service developments should not consider them until all other alternatives have been exhausted. Until then, they should be role-specific ('baton bleep'), not person-specific, with the on duty bleep holder always holding it during the agreed hours of the service.

R6: Communication processes within health systems for urgent clinical issues should be streamlined through a single point of access. This will likely be provided by the updated 111/clinical advice hub model.

A call handling service armed with a Directory of Services (DoS) can triage call to the relevant, community based service, e.g. DVT or cellulitis pathways, or to the acute or mental health trust's internal single point of access.

6.1.2 Enhancing secondary care telephone access to GPs:

Barriers:

- Ringing standard GP practice phone numbers usually involves long delays waiting to get through answering automated messages before connecting to practice administrative staff.
- GP bypass numbers are not universally operational, and there is a lack of awareness of these numbers by hospital switchboards, and their clinicians and secretaries.

Recommendations:

R7: All GP practices should have functioning bypass numbers for hospital clinicians to access. These numbers should be made readily accessible in hospital PAS systems, to trust switchboards, and to trust clinicians.

R8: GPs if not immediately available for a consultation should ring the calling clinician back at the earliest opportunity, using the direct contact number provided by the caller.

6.2 E-consultations: email and other electronic text-based clinical communications

GPs and consultants need to be able to collaborate more effectively by written communications in the clinical management of patients who don't need urgent referral (which is best enabled by telephone discussion). The use of traditional dictated and typed letters sent by conventional mail for this purpose are in many places the norm, a practice that has not changed in spite of technological developments that are widely implemented and used in other sectors. This causes delays in clinical decision making that can affect patient outcomes, and potentially unnecessary or inappropriate referrals and investigations which creates inefficiencies, wasted time for patients and clinicians, and additional costs.

Requests for non-urgent advice from GPs to consultants can be divided in to two broad categories: a) for new referrals, and b) for patients already under active follow up, (usually patients with long term conditions). These are described separately, although integrated systems that cater for both are likely to be developed.

6.2.1 Advice consultation categories: New referrals and patients under active follow up

A) New referrals: the Advice and Guidance CQUIN

- NHS England is incentivising the set up and operation of Advice and Guidance (A&G) throughout 2017-19 with a national CQUIN (Commissioning for Quality and Innovation, indicator 6) [8]. The purpose is 'to improve GP access to consultant advice prior to referring patients in to secondary care', and is valued at 0.25% of the value of a trust's contract value.
- The guidance states that A&G support should be provided either through the e-Referral System platform of NHS Digital, or otherwise *via local solutions where health systems agree this offers a better alternative*. Other examples include Kinesis Advice and Guidance[9]. Full details of the A&G CQUIN are available in the well written Supplementary Guidance, which describes the scope, benefits, technical and implementation issues, and it is strongly recommended that clinical leaders and managers involved with improving clinical communications read it[10].

B) Advice for patients under active follow up:

- An efficient way for GPs and consultants to communicate electronically with each other about ongoing patient care is essential for the provision of timely and higher

[8] National CQUIN 2017-19 guidance. NHS England. https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

[9] Kinesis Advice and Guidance software platform. https://www.kinesisag.uk/

[10] Supplementary guidance for national CQUIN (2017-19) Indicator 6: Offering Advice and Guidance. NHS England. https://www.england.nhs.uk/wp-content/uploads/2017/08/offering-ag-supplementary-guidance.pdf

quality care. The prime means of such communication is likely to be by email (though various alternative commercial software solutions are available). A number of publications have evaluated the benefits of this approach, the specialties where it has been most used to date (including haematology, endocrinology, dermatology, cardiology and mental health), and the impact on health professionals (which includes a transfer of work from secondary to primary care)[11,12,13,14]. A large scale review was undertaken by Caffery and Smith in 2010[15].Currently in many health systems there are many hidden barriers to cross-organisational email-based discussions of patient care which are described below, with recommendations for how these can be addressed.

6.2.2 Communicating between NHS.net and nhs.uk email addresses

Barriers:

- Whilst all GPs use @NHS.net as their primary professional address, most acute trusts in the South East use @xxx.nhs.uk accounts and addresses. Whilst individual clinicians may set up their own NHS.net addresses, this is ad hoc and unpredictable (and requires a separate login to that of their trust email account as it is not integrated with their trust's Microsoft Outlook).
- Strict information governance requirements limit the communication of patient-identifiable information between NHS.net and non-NHS.net acute trust email addresses, and at least one of the sender or receiver should be an NHS.net address to ensure appropriate encryption. Anecdotally there is widespread uncertainty about what is acceptable practice and how encryption can be used, which inhibits usage.
- GPs and hospital clinicians do not have ready access to each other's email addresses, so are unable to easily initiate email conversations.

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[11] Electronic consultations (e-consults) to improve access to specialty care: A systematic review and narrative synthesis. Journal of Telemedicine and Telecare 2015, 323–330. http://journals.sagepub.com/doi/pdf/10.1177/1357633X15582108

[12] A retrospective study on how primary care providers manage specialists' recommendations after an e-consultation. Pecina J.L. SAGE Open Medicine 2016. http://journals.sagepub.com/doi/pdf/10.1177/2050312116682127

[13] Electronic Consultations to Improve the Primary Care-Specialty Care Interface for Cardiology in the Medically Underserved: A Cluster-Randomized Controlled Trial. Olayiwola J et al. Annals Family Medicine 2016133-140. http://www.annfammed.org/content/14/2/133.full

[14] Behavioral health integration at your fingertips: A descriptive analysis of electronic consultation from primary care to psychiatry. Gleason N. Journal of Gen Internal Med 2016. https://www.jmir.org/article/viewFile/jmir_v19i8e279/2

[15] A literature review of email-based telemedicine. Caffery L and Smith A. 2010. Stud Health Technol Inform. https://www.ncbi.nlm.nih.gov/pubmed/21191155 (abstract only).

- Concern from consultants that the expansion of email communications with GPs will increase workload without a reduction in other activity, and would not fit in to existing job plans.
- Concern from GPs that by increasing an advice service from consultants this will increase work and care undertaken in primary care, without additional resources to manage it.
- Lack of confidence in whether or when a response will be received to a request for advice.

Recommendations:

R9: Services should set up specialty-specific nhs.net email addresses that are administered to ensure that the request is directed to an appropriate and available clinician, who can respond within agreed response times. This will require consultants to agree rotas for this activity.

R10: Trust clinicians should have an NHS.net email address in addition to their trust address, to facilitate ad hoc patient-related communications with clinicians in primary care and other organisations.

R11: Trusts should provide online information and training to staff on ways to send patient-identifiable data to or from NHS.net addresses. NHS Digital has provided essential guides for how to do this[16].

R12: Directories of all clinicians' nhs.net email addresses should be created and shared between organisations in a way that enables easy access for clinicians.

R13: Primary and secondary care clinicians should include their email addresses (or at a minimum an agreed practice or specialty email address for internal triage) in correspondence with each other.

R14: Response times for the Advice and Guidance CQUIN for new referrals are within two working days of receipt. We recommend that the same standard applies to responses about patients known to the specialty and under active follow up.

R15: The likely activity per specialty should be modelled, based on current practice, and experience from providing these services elsewhere, and monitored during piloting and implementation. Trusts should be prepared to recognise in job plans any clear increase in such activity, but this may be counter-balanced by a reduction in clinic activity depending on the impact on referrals.

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[16] NHS Digital guides to sending patient-identifiable information by email.

NHSmail sharing sensitive information guide; NHSmail encryption guidance for senders; NHSmail encryption guidance for recipients

R16: The impact on the workload in primary care should be closely monitored, and funding should be considered for GP practices, such as through locally commissioned services (LCS) schemes, if it is clear that more activity is moving to primary care as a result of more remote specialist advice.

6.3 Video links

Video-communication between clinicians is not common practice in the NHS, though there are likely to be a range of potential benefits that should be tested and evaluated, including case conferences and MDTs, as well as including the patient in inter-professional discussions about their care. Visual enhancement of clinician conversations is likely to improve professional relationships.

Desktops, laptops, tablets and smartphones can all be used for videoconferencing if appropriate technology is utilised, appropriately configured and secured, and if W-Fi with the appropriate bandwidth is available.

Barriers:

- There is uncertainty of the benefit from face to face discussions between clinicians compared with telephone or written communication.
- It would be difficult to schedule joint availability of clinicians for video calls.
- There is a lack of available, reliable and secure technology that works across organisations in the NHS (Skype, FaceTime etc. are not considered secure).

Recommendations:

R17: Health systems should explore the potential for, then pilot the use of clinician-to-clinician videoconferencing. Calls could be coordinated and scheduled by respective administrators at each end.

Of note, Skype for Business in now available for all NHS staff with nhs.net accounts, and its peer-to-peer video calling (and web-conferencing) option is available (including licencing) for a combined £19 per user per year. This is about to be piloted in mid-Sussex, and the results of the early evaluation should be shared across the STP to consider the potential benefits from a wide roll out across organisations[17].

[17] Contact Tim Moore, Head of Digital for NHS Crawley and NHS Horsham & Mid Sussex CCGs at tim.moore5@nhs.net for more information.

7. Shared access to digital patient information across primary or secondary care

Currently primary care and hospital based electronic records do not readily share patient information, even though access to electronically stored information by all health and care professionals has innumerable benefits for integrated, effective and efficient patient care. The excellent Nuffield Trust's publication Delivering the benefits of digital health, provides an overview of this area and examples where successful pilots of integrated electronic patient records have taken place[18]. The Local Digital Roadmap for the Sussex and East Surrey STP has as a key domain that of shared health and care information, and the further development of a shared health and care record[19].

Whilst a fully integrated, patient-centred, single IDCR (previously known as electronic patient record, or EPR) remains a key goal for modern health systems (and the Sussex and East Surrey STP has recently confirmed its commitment to pursuing IDCR over the coming years), this seems to remain some way off, and other means of sharing clinical information are available now, and their potential realised. This can include read-only access to each other's digital patient records, or much more widespread use of the Summary Care Record.

7.1 The Summary Care Record (SCR)

Barriers:

- The SCR is potentially available to all clinical staff (unless a patient has opted out from consent), but awareness of it and its uses is low outside of A&E and hospital pharmacy teams.
- The SCR can be of most use if patients consent to their 'additional information' being uploaded (that includes diagnoses, vaccination records, end of life care wishes, Lasting Power of Attorney status, and the ProActive Care Plan - PACE). The toolkit is available on the NHS Digital website[20]

[18] Delivering the benefits of digital health. Imison C et al. Nuffield Trust 2016. https://www.nuffieldtrust.org.uk/files/2017-01/delivering-the-benefits-of-digital-technology-web-final.pdf

[19] Sussex and East Surrey STP Digital Road Map. Jan 2017. https://www.coastalwestsussexccg.nhs.uk/?action=download&item=10513.

[20] Additional Information in the SCR. Toolkit. NHS Digital. https://digital.nhs.uk/summary-care-records/additional-information

Recommendations:

R18: Trusts should ensure all relevant clinical staff are offered access to the SCR. Full details are available at the SCR home page[21].

R19: GPs and their practices should prioritise discussions with patients about adding 'additional information' to their SCR, particularly those with frailty or multiple morbidities, to enable all clinicians caring for these patients to have access to important clinical information about them and their wishes[22].

It should also be noted that SCR is available nationally, so where patients are away from the local area the information will still be available.

7.2 Shared access to Integrated Digital Care Records (IDCR)

Barriers:

- GP EPRs are highly developed, but generally inaccessible to secondary care, even on a read only basis
- Acute trusts do not all have comprehensive EPRs, or have multiple specialty-specific systems, which are not generally accessible to clinicians outside of the specialty or trust.

Recommendations:

R20: Organisations within the STP should work together to support the strategy for sharing health and care information described in the Local Digital Road Map.

There are now examples where integrated care records are being tested across the country. This includes the Hampshire Health Record[23], North West London and Great North Care Record.

R21: Ensure effective engagement with GPs to provide confidence to share patient information in a secure way which does not expose GPs or patients to unwarranted risk, in line with good IG practice.

R22: Secondary Care providers should aim for highly functional IDCRs that integrate key patient related data, either as single systems, or by integration and interoperability of their multiple databases.

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[21] SCR home page. https://www.digital.nhs.uk/summary-care-records

[22] Guidance for adding additional information to the SCR. https://www.digital.nhs.uk/summary-care-records/additional-information

[23] The Hampshire Health Record (now renamed the Care and Health Information Exchange) https://www.hantshealthrecord.nhs.uk

R23: Providers should ensure that the NHS number becomes the key clinical reference number to facilitate sharing outside of the trust. Where trusts have records that are isolated or solely paper based these should be targeted for digitalisation.

R24: Promote engagement and uptake of effective interim sharing solutions (e.g. SCR, ROCI) ahead of a broader IDCR. The benefits of accessing GP systems through existing solutions which have some level of deployment across the STP footprint should be explored.

Examples include:

- Read Only Care Information (ROCI) in use across Coastal CCG/WSHFT, Brighton & Hove CCG/BSUH
- TPP SystmOne Enhanced Data Sharing Model (e.g. sharing within SystmOne between GP practices and SCFT/ESHT Community,and access by renal specialists to SystmOne for joint management of patients with chronic kidney disease)[24].
- Patient Knows Best (inflammatory bowel disease patients in SASH/East Surrey)

7.3 Patient held electronic records

Barrier:

- Patient held electronic records, which have the potential to integrate their personal health and care information in one place, which if shared with their clinicians can enhance clinical communications, are under-developed.

Recommendation:

R25: The lessons to be learnt from current software solutions that are being developed and tested, should be explored for use within the STP.

Notable examples include Patient Knows Best, which has been used very successfully in a large group of patients with inflammatory bowel disease in East Surrey Hospitals NHS Trust[25], and for a wide range of patient groups elsewhere[26]. Patient View, developed in initially for renal patients, is piloting its use in other specialties[27].

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[24] Electronic patient records: bridging the gap between primary and secondary care. Stoves K and Connolly K. Royal College of Physicians Future Hospital Journal 2017. https://www.rcplondon.ac.uk/file/5580/download?token=-1rSsKyY (need to copy and paste link in to browser).

[25] Managing inflammatory bowel disease patients using Patient Knows Best software platform. Azhar Ansari.KSS AHSN case study. http://www.kssahsn.net/what-we-do/publications-and-resources/Documents/AHSN%20-%20case%20study%20-%20PKB%20Ansari%20-%20website.pdf

[26] Patient Knows Best case studies. https://www.patientsknowbest.com/case-studies.html

[27] Patient View software for patient held integrated records. https://www.patientview.org/#/

8. Fostering improved relationships between GPs and consultants

There are fewer opportunities than in the past for clinicians working in different organisations, particularly GPs and consultants, to meet. This reduces the potential for building understanding of each other's roles, sharing perspectives, and problem solving, which although difficult to quantify, are intuitively recognised by clinicians as very important.

Barriers:

- Difficulty creating opportunities to meet clinical colleagues as working days are usually fully timetabled in their own institutional settings, and finding mutually convenient times for joint meetings is very challenging.
- Lack of understanding between primary and secondary care clinicians about their ways of working, their competing demands and capacity.

Recommendations:

R26: Shared bulletins for primary and secondary care clinicians, that contains information of mutual relevance, should be initiated, to inform, develop shared understanding, and help improve a collaborative and integrated clinical culture.

R27: Clinical leaders across local health systems (whether at place based or STP level) should develop opportunities to improve inter-professional contact at shared events. These could include joint CPD meetings, 'speed dating' interactive events, and social events. In particular, offering or requiring consultant attendance at a GP clinic, or GP attendance at a hospital clinic or ward round, e.g. on an annual basis, would provide excellent learning and relationship building opportunities.

R28: Commissioning of specialists to work in community settings would enhance face to face contact with primary care colleagues and educational opportunities, and helps to build professional relationships and mutual understanding.

9. Commissioning, Implementation and Evaluation

9.1 Commissioning

The provision of more specialist advice and guidance to primary care is likely to lead to less hospital based activity (as outpatient and A&E attendances, and some hospital admissions, should reduce) but an increase in workload undertaken by primary care, and of requests for investigations (pathology, radiology and other diagnostics).

Acute trusts will be concerned about lost income from reduced outpatient activity, with inadequate current contractual mechanisms to pay for this different way of delivering integrated care. The potential increase in work for primary care needs to be anticipated, resourced and if required, funded.

Recommendations:

R29: Contractual incentives and levers will support and encourage improvement in clinical communications. Planned compliance with the current national Advice and Guidance CQUIN will generate trust income (0.25% of contract value) to enable this and other communication services and infra-structure to be piloted then rolled out

R30: Commissioners and providers need to agree contractual arrangements that recognise the anticipated clinical time commitment and its costs in both primary and secondary care, before implementing a more comprehensive advice and guidance service.

R31: For primary care, funding such as by a locally commissioned service (LCS) should be considered, using monies released from the anticipated reduction in traditional hospital activity.

R32: Local health systems will need to decide whether funding of acute trusts for an increase in advice services to GPs, should be by tariffs or by block contract. The Advice and Guidance CQUIN is likely to have a national tariff attached. Advice services for patients under ongoing follow up will need local agreement on the need for funding, and at what level.

9.2 Implementation and evaluation

The best solutions for enhanced clinical communications may vary from one specialty to another (which the evidence base bears out), and depends on the nature and urgency of the clinical issue: one size will not necessarily fit all. Careful pre-implementation planning that considers and anticipates the likely blocks and enablers (as summarised in previous sections), a staged approach, clinical engagement, iteration and evaluation, are all key.

Recommendations:

R33: NHS-approved, proven technologies should be used wherever possible, to minimise delays in acquisition and the risks of failed implementation from under-developed and under-tested systems. These include NHS.net for email communications, and NHS.net-associated products such as Skype for Business. For primary care systems, the GP 'System of Choice'[28] catalogue should be consulted.

R34: The wide range of potential benefits (cultural, clinical and financial) of improving communications between clinicians should be mapped and evaluated, using a benefits assessment framework, such as that proposed in Appendix 1.

R35: Evaluation of new approaches should not be undertaken too early, to allow time for bedding in and problem solving, but there should be inbuilt support for iterative improvements, based on user feedback.

R36: Regular reviews should be conducted of the types of requests for advice received, so that common themes and issues of clinical uncertainty can be identified, then addressed though revised pathways and guidelines, CPD events, and general feedback to GPs and consultants.

R37: The publication 'Ten steps to establishing an e-consultation service to improve access to specialist care'[29] is strongly recommended as a resource when initiating and implementing such projects, and the 10 steps are listed in appendix 2.

[28] GP Systems of Choice. NHS Digital. https://digital.nhs.uk/GP-Systems-of-Choice/GPSoC-Services

[29] Ten steps to establishing an e-consultation service to improve access to specialist care. Liddy C et al. Telemedicine and e-Health 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3850434/pdf/tmj.2013.0056.pdf

10. Improving clinical processes to reduce avoidable communication requests

10.1 Ensuring discharge summaries and clinic letters meet quality standards

Delays in communicating treatment plans though delays in discharge summaries or clinic letters arriving in to GP records, triggers avoidable need for advice or updates. Lack of accuracy, relevant detail or clarity in discharge summaries or clinic letters (with regard to medication changes, further investigations and treatments, and booked follow up appointments), and unwarranted requests to GPs for actions, drives additional and avoidable work and requests for information from the hospital.

The loss of regular consultant-specific firms (due to shift patterns, trainee rotations, and consultant of the week models and sub-specialisation for example) can lead to uncertainty for GPs as to which consultant is responsible for the patient's care, particularly following hospital discharge, and therefore who to contact in the event of needing further advice or information.

Recommendations:

R38: Hospital teams need to reconfigure to deliver on the new and clinically important national standards and contractual requirements for delivery times for discharge summaries (within 24 hours of discharge) and clinic letters (within 10 days currently, and within 7 days from April 2018)[30]. This is supported by the main national clinical professions' bodies[31].

R39: Consultant responsibility for ongoing care, and the patient follow up arrangements, must be made clear in discharge summaries and other patient related correspondence. Hospital clinicians should help avoid the unnecessary additional work for GPs (and knock on requests to the hospital for information) generated by delays in sending out discharge summaries and clinic letters, and by ensuring that subsequent investigations and results are followed through by the hospital team, in line with requirements agreed by the medical professional groups and the NHS[32,33].

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[30] National contract 2017/18 and 2018/19. NHS England. See para 11.5 and 11.18, pages 13-14. https://www.england.nhs.uk/wp-content/uploads/2016/11/2-service-conditions-fl.pdf

[31] The interface between primary and secondary care: key messages for NHS clinicians and managers. NHS England, July 2017. https://www.england.nhs.uk/wp-content/uploads/2017/07/interface-between-primary-secondary-care.pdf

[32] The interface between primary and secondary care: Key messages for NHS clinicians. https://www.england.nhs.uk/wp-content/uploads/2017/07/interface-between-primary-secondary-care.pdf

[33] NHS Standard Contract 2017/18 and 2018/19, Service Conditions, section 11 https://www.england.nhs.uk/wp-content/uploads/2016/11/2-service-conditions-fl.pdf

R40: Discharge summaries and clinic letters should be quality assured, primarily by the responsible consultant. Consultant teams will need to agree how this can be delivered within the contractual timescales for the sending out of this correspondence (see previous page).

This could be delivered by structured and regular reviews as part of trainee assessments in the workplace of the quality and accuracy of their correspondence with GPs as a means of raising standards and awareness. The Professional Records Standards Board (supported by the Academy of Medical Royal Colleges) is developing standards for health and social care records, and has detailed guidelines now in place for outpatient letters and discharge summaries (which are also being used as the basis for the consistent electronic interchange of information)[34].

10.2 Agreeing joint clinical guidelines and pathways

Local clinical pathways and guidelines are often designed primarily by specialists within single specialties, and do not always involve GPs, other specialties (to take account of the common co-morbid conditions patients suffer) and other health professionals in their development. This risks conflict with other national and local pathways, making them either impractical or inconsistent.

Clinical management guidelines, including referral criteria, may be under-developed, unclear, or not visible or accessible for GPs, which generates avoidable requests for advice.

Recommendations:

R41: The production of clinical pathways and guidelines co-designed by primary care, all relevant specialities and patient representation should be prioritised, which when made widely accessible on trust and CCG websites is likely to obviate the need for a significant proportion of patient-specific clinical advice requests.

R42: Clinicians responsible for patient pathways should agree referral criteria and management guidelines for a wide range of clinical presentations or conditions. This requires the establishment of multi-professional, cross-organisations clinical reference groups where they don't currently exist.

R43: GP systems should maximise the use of decision support tools that reference such clinical guidelines, to minimise the need for additional requests for advice.

[34] Professional Records Standards Body. Published standards (including for outpatient letters and discharge summaries). https://theprsb.org/standards

11. Information governance and patient consent

Information governance requirements provide significant challenges to the interchange of patient-identifiable information between clinicians working across different organisations (whether though emails, text based or video-enabled technologies).

Whilst the recording of explicit patient consent is currently required for the Summary Care Record (SCR), for health and care professionals involved in the 'direct care' of patients the common law duty of confidentiality specifies that information can be shared without patient consent where it is supporting a medical purpose and there is a 'reasonable expectation' for it to be shared[35]:

1. 'Direct care' is used to refer to activities related to the prevention, investigation and treatment of illness or suffering, and includes risk stratification for case finding purposes.
2. 'Secondary use' refers to activities outside of care delivery, e.g. commissioning or strategic planning, for which only non-identifiable data can be used.

GMC guidance (Confidentiality: good practice in handling patient information, 2017) is an important reference point as clarity is sought in progressing implementation plans[36].

Recommendations:

R44: Information governance (IG) and IT leads need to work in partnership with clinicians and managers to find the most effective and efficient communication solutions that can be embedded in clinical practices that are compliant with essential IG constraints.

R45: Obtaining patients' consent, where required, for the sharing of their clinical information electronically between the professionals involved with their care should be made a priority. This enables clinicians to better coordinate their care, reduce duplication, avoid unnecessary diagnostics and treatments, and to minimise the risk of adverse events.

[35] David Stone, Kaleidoscope Consultants. www.kaleidoscopeconsultants.com. Based on advice provided to the NW London Partnership on information sharing.

[36] Confidentiality: good practice in handling patient information, General Medical Council 2017. See paragraphs 13 and 27-29. http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

12. Conclusion

In this review, we have identified widespread benefits that can be achieved by providing enhanced means for clinicians to communicate about patient issues across organisations. These benefits arise from the facilitation of more integrated, informed and timely patient care, and improved clinical collaboration.

There are many barriers to progressing this change to how care is traditionally delivered that are described here, but all of these are surmountable if the ambition within health systems is agreed, and with strong clinical leadership, and support from managers, commissioners, information governance and information technology services, and organisations. A range of principles and practical recommendations are provided as a foundation for progressing this agenda within the STP.

New ways of working will be required from clinical and supporting administrative staff, that needs their engagement and involvement as plans are developed, implemented and iterated. Changes to financial flows and payments are to be expected, and trusts, commissioners and their clinicians must work together at all stages to anticipate and agree sensible and workable models.

Appendix 1. Summary of recommendations

Principles

The 9 principles stated in this report (see section 5) should be used as the foundation for transforming clinical communications between primary and secondary care, and can be used equally for patient-related interactions with community and mental health clinicians, and further developed for social care – health care professional interactions.

Recommendations

Number Ref.	Recommendations
Enhancing telephone, email and video communications.	
Improving telephone communications: Enabling GP contact with specialists:	
R1:	Mobile phones should become the default means for GPs to make direct contact with hospital clinicians. Trusts should reach agreement with consultants to authorise this for their switchboards, and departmental administrative staff. This includes the provision of the mobile number to the GP to ring or text the consultant directly.
R2:	Each specialty/department in acute trusts should have a single point of telephone access (available by direct dial to outside clinicians) that is administered during normal office hours, that can triage calls to the most appropriate and available specialist in the department.
R3:	Hospitals should ensure Wi-Fi and 3G/4G availability throughout their sites to ensure mobile phone functionality.
R4:	For urgent calls to on call specialists, trusts should ensure their telephony systems have a single point of access for GPs (and other clinicians), that enable seamless, guaranteed and prompt direct contact, 24/7. Hospitals should have bypass numbers made available to external clinicians to avoid delay. Various commercial options are available for connecting with specialist clinicians and can be considered if required, which should enable case conferencing, recording of the interaction, and auditing.
R5:	Bleeps should be phased out, and any new strategies and service developments should not consider them until all other alternatives have been exhausted. Until then, they should be role-specific ('baton bleep'), not person-specific, with the on duty bleep holder always holding it during the agreed hours of the service.
R6:	Communication processes within health systems for urgent clinical issues should be streamlined through a single point of access. This will likely be provided by the updated 111/clinical advice hub model.
Enhancing secondary care access to GPs:	
R7:	All GP practices should have functioning bypass numbers for hospital clinicians to access. These numbers should be made readily accessible to trust switchboards, and to their clinicians.

R8:	GPs if not immediately available for a consultation should ring the calling clinician back at the earliest opportunity, using the direct contact number provided by the caller.
Email and written communications about patient care:	
R9:	Services should set up specialty-specific nhs.net email addresses that are administered to ensure that the request is directed to an appropriate and available clinician, who can respond within agreed response times. This will require consultants to agree rotas for this activity.
R10:	Trust clinicians should have an NHS.net email address in addition to their trust address, to facilitate ad hoc patient-related communications with clinicians in primary care and other organisations.
R11:	Trusts should provide online information and training to staff on ways to send patient-identifiable data to or from NHS.net addresses. NHS Digital has provided essential guides for how to do this37.
R12:	Directories of all clinicians' nhs.net email addresses should be created and shared between organisations in a way that enables easy access for clinicians.
R13:	Primary and secondary care clinicians should include their email addresses (or at a minimum an agreed practice or specialty email address for internal triage) in correspondence with each other.
R14:	Response times for the Advice and Guidance CQUIN for new referrals are within two working days of receipt. We recommend that the same standard applies to responses about patients known to the specialty and under active follow up.
R15:	The likely activity per specialty should be modelled, based on current practice, and experience from providing these services elsewhere, and monitored during piloting and implementation. Trusts should be prepared to recognise in job plans any clear increase in such activity, but this may be counter-balanced by a reduction in clinic activity depending on the impact on referrals.
R16:	The impact on the workload in primary care should be closely monitored, and funding should be considered for GP practices, such as through locally commissioned services (LCS) schemes, if it is clear that more activity is moving to primary care as a result of more remote specialist advice.
Videolinks:	
R17:	Health systems should explore the potential for, then pilot the use of clinician-to-clinician videoconferencing. Calls could be coordinated and scheduled by respective administrators at each end.
The Summary Care Record (SCR):	
R18:	Trusts should ensure all relevant clinical staff are offered access to the SCR. Full details are available at the SCR home page[38].

[37] NHS Digital guides to sending patient-identifiable information by email.

NHSmail sharing sensitive information guide; NHSmail encryption guidance for senders; NHSmail encryption guidance for recipients

R19:	GPs and their practices should prioritise discussions with patients about adding 'additional information' to their SCR, particularly those with frailty or multiple morbidities, to enable all clinicians caring for these patients to have access to important clinical information about them and their wishes[39].
Shared access to Integrated Digital Care Records (IDCR)	
R20:	Organisations within the STP should work together to support the strategy for sharing health and care information described in the Local Digital Road Map.
R21:	Ensure effective engagement with GPs to provide confidence to share patient information in a secure way which does not expose GPs or patients to unwarranted risk, in line with good IG practice.
R22:	Secondary Care providers should aim for highly functional IDCRs that integrate key patient related data, either as single systems, or by integration and interoperability of their multiple databases.
R23:	Providers should ensure that the NHS number becomes the key clinical reference number to facilitate sharing outside of the trust. Where trusts have records that are isolated or solely paper based these should be targeted for digitalisation.
R24:	Promote engagement and uptake of effective interim sharing solutions (e.g. SCR, ROCI) ahead of a broader IDCR. The benefits of accessing GP systems through existing solutions which have some level of deployment across the STP footprint should be explored.
Patient held electronic records:	
R25:	The lessons to be learnt from current software solutions that are being developed and tested, should be explored for use within the STP.
Fostering improved relationships between GPs and consultants:	
R26:	Shared bulletins for primary and secondary care clinicians, that contains information of mutual relevance, should be initiated, to inform, develop shared understanding, and help improve a collaborative and integrated clinical culture.
R27:	Clinical leaders across local health systems (whether at place based or STP level) should develop opportunities to improve inter-professional contact at shared events. These could include joint CPD meetings, 'speed dating' interactive events, and social events. In particular, offering or requiring consultant attendance at a GP clinic, or GP attendance at a hospital clinic or ward round, e.g. on an annual basis, would provide excellent learning and relationship building opportunities.
R28:	Commissioning of specialists to work in community settings would enhance face to face contact with primary care colleagues and educational opportunities, and helps to build professional relationships and mutual understanding.
Commissioning, Implementation and Evaluation	
R29:	Contractual incentives and levers will support and encourage improvement In clinical communications. Planned compliance with the current national Advice and Guidance CQUIN will generate trust income (0.25% of contract value or approximately £xxx across the Sussex

[38] SCR home page. https://www.digital.nhs.uk/summary-care-records

[39] Guidance for adding additional information to the SCR. https://www.digital.nhs.uk/summary-care-records/additional-information

	and East Surrey STP) to enable this and other communication services and infra-structure to be piloted then rolled out.
R30:	Commissioners and providers need to agree contractual arrangements that recognise the anticipated clinical time commitment and its costs in both primary and secondary care, before implementing a more comprehensive advice and guidance service.
R31:	For primary care, funding such as by a locally commissioned service schemes should be considered, using monies released from the anticipated reduction in traditional hospital activity.
R32:	Local health systems will need to decide whether funding of acute trusts for an increase in advice services to GPs, should be by tariffs or by block contract. The Advice and Guidance CQUIN is likely to have a national tariff attached. Advice services for patients under ongoing follow up will need local agreement on the need for funding, and at what level.
Implementation and evaluation	
R33:	NHS-approved, proven technologies should be used wherever possible, to minimize delays in acquisition and the risks of failed implementation from under-developed and under-tested systems. These include NHS.net for email communications, and NHS.net-associated products such as Skype for Business. For primary care systems, the GP 'System of Choice'[40] catalogue should be consulted
R34:	The wide range of potential benefits (cultural, clinical and financial) of improving communications between clinicians should be mapped and evaluated, using a benefits assessment framework, such as that proposed in Appendix 1.
R35:	Evaluation of new approaches should not be undertaken too early, to allow time for bedding in and problem solving, but there should be inbuilt support for iterative improvements, based on user feedback.
R36:	Regular reviews should be conducted of the types of requests for advice received, so that common themes and issues of clinical uncertainty can be identified, then addressed though revised pathways and guidelines, CPD events, and general feedback to GPs and consultants.
R37:	The publication 'Ten steps to establishing an e-consultation service to improve access to specialist care'[41] is strongly recommended as a resource when initiating and implementing such projects, and the 10 steps are listed in appendix 2.
Improving clinical processes to reduce avoidable communication requests	
R38:	Hospital teams need to reconfigure to deliver on the new and clinically important national standards and contractual requirements for delivery times for discharge summaries (within 24 hours of discharge) and clinic letters (within 10 days currently, and within 7 days from April 2018)[42]. This is supported by the main national clinical professions' bodies[43].

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R39:	Consultant responsibility for ongoing care, and the patient follow up arrangements, must be made clear in discharge summaries and other patient related correspondence. Hospital clinicians should help avoid the unnecessary additional work for GPs (and knock on requests to the hospital for information) generated by delays in sending out discharge summaries and clinic letters, and by ensuring that subsequent investigations and results are followed through by the hospital team, in line with requirements agreed by the medical professional groups and the NHS[44,45].
R40:	Discharge summaries and clinic letters should be quality assured, primarily by the responsible consultant. Consultant teams will need to agree how this can be delivered within the contractual timescales for the sending out of this correspondence.
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R41:	The production of clinical pathways and guidelines co-designed by primary care, all relevant specialities and patient representation should be prioritised, which when made widely accessible on trust and CCG websites is likely to obviate the need for a significant proportion of patient-specific clinical advice requests.
R42:	Clinicians responsible for patient pathways should agree referral criteria and management guidelines for a wide range of clinical presentations or conditions. This requires the establishment of multi-professional, cross-organisations clinical reference groups where they don't currently exist.
R43:	GP systems should maximise the use of decision support tools that reference such clinical guidelines, to minimise the need for additional requests for advice.
Information governance and patient consent	
R44:	Information governance (IG) and IT leads need to work in partnership with clinicians and managers to find the most effective and efficient communication solutions that can be embedded in clinical practices that are compliant with essential IG constraints.
R45:	Obtaining patients' consent, where required, for the sharing of their clinical information electronically between the professionals involved with their care should be made a priority. This enables clinicians to better coordinate their care, reduce duplication, avoid unnecessary diagnostics and treatments, and to minimise the risk of adverse events.

[43] The interface between primary and secondary care: key messages for NHS clinicians and managers. NHS England, July 2017. https://www.england.nhs.uk/wp-content/uploads/2017/07/interface-between-primary-secondary-care.pdf

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[45] NHS Standard Contract 2017/18 and 2018/19, Service Conditions, section 11 https://www.england.nhs.uk/wp-content/uploads/2016/11/2-service-conditions-fl.pdf

Appendix 2. Potential benefits assessment framework

a) Potential impact on the patient

More timely care
Better advice
Less travel time and costs/clinic attendance
Fewer/more investigations?
Less face to face contact with a specialist

b) Potential impact on primary care clinicians

Time taken to obtain advice compared with current methods
Intrusiveness
Change in workload for primary care/ capacity issues
Changes in attribution of costs
How are joint decisions recorded?
Where does clinical responsibility lie?
CPD element

c) Potential impact on specialists

Additional time taken to provide advice outside of timetabled clinics: job planning
What kinds of advice would be offered (e.g. should there be defined restrictions?)
How are joint decisions recorded?
Where does clinical responsibility lie?
Improved relationships and understanding of primary care issues and constraints

d) Potential impact on organisations

Attributing costs to new ways of working.
Tariffs, or integrated system approach (one healthcare budget)
Costs of new communications IT hardware/software
Information governance issues
Training for any new way of working/new systems

Appendix 3.

Ten Steps to Establishing an e-Consultation Service to Improve Access to Specialist Care. (From Liddy C et al[46])	
Step 1.	**PARTNERS**:- Establish the key working partnerships: (clinical champions, regional support and technology partner).
Step 2.	**PLATFORM**:- Choose a platform for the e-consultation system.
Step 3.	**PILOT**:- Start small and build
Step 4.	**PRODUCT**:- Design the e-consultation form
Step 5.	**PRIVACY**:- Ensure privacy and security requirements are met
Step 6.	**PROCESS**:- Determine workflow
Step 7.	**PARTICIPANTS**:- Keep physician engagement simple
Step 8.	**PAYMENT**:- Determine payment and liability aspects (duty of care)
Step 9.	**PROVIDE FEEDBACK**:- Build in continuous quality feedback
Step 10.	**PLAN THE TRANSITION FROM PILOT TO SUSTAINABLE PROGRAM :**–Plan early for sustainability rather than afterthought

[46] Ten Steps to Establishing an e-Consultation Service to Improve Access to Specialist Care. Liddy C et al. Telemedicine and Telehealth. Dec 2013.

http://europepmc.org/articles/PMC3850434;jsessionid=5CBB2CCDDB4F9A5D917D2CEEF5BF3168?fromSearch=singleResult&fromQuery=%28TITLE:%22Ten+steps+to+establishing+an+e-consultation+service+to+improve+access+to+specialist+care.%22%29+AND+%28JOURNAL:%22Telemedicine+Journal+and+e-Health%22%29+AND+%28AUTH:%22liddy%22%29

Appendix 4. Clinical Senate Working Group Membership

Name	Roles
Lawrence Goldberg (Joint Chair)	Clinical Senate Chair Consultant Nephrologist, Brighton and Sussex University Hospitals NHS Trust
Larisa Han (Joint Chair)	General Practitioner, Merrow Park Surgery, Guildford
Mandy Assin	Consultant Psychiatrist, Sussex Partnership NHS Foundation Trust
Steve Barden	Consultant Physician, Brighton and Sussex University Hospitals NHS Trust
Michael Bosch	General Practitioner, Horley, Surrey
Charlotte Canniff	Clinical Chair, NW Surrey CCG
Priscilla Chandro	Patient and Public Engagement Representative
Peter Green	Clinical Chair NHS Medway CCG. General Practitioner.
Marianne Illsley	Consultant Clinical Oncologist, and Deputy Medical Director, Royal Surrey County Hospital Foundation Trust
Rachael Liebmann	Deputy Medical Director, Clinical Director of Pathology Services, Queen Victoria Hospital, East Grinstead. Consultant Pathologist
Tony Newman-Sanders	Clinical Director, Diagnostic Imaging Surrey and Sussex Healthcare.
Ali Parsons	Associate Director South East Clinical Senate, NHS England South East
Mark Watson	Digital programme director (Sussex and East Surrey)
Saloni Zaveri	Centre Consultant- Healthcare Public Health Public Health England South East

Appendix 5. Clinical Senate Council Membership

Lawrence Goldberg Clinical Senate Chair Consultant Nephrologist, Brighton and Sussex University Hospitals NHS Trust	
Amanda Allen Allied Health Care Professional Representative	**Larisa Han** GP, Merrow Park Surgery, Guildford
Sally Allum Nursing Director, NHS England South (South East)	**Timothy Ho** Medical Director, Frimley Health NHS Foundation Trust
Mandy Assin Mental Health Clinician	**Des Holden** Clinical Lead, Academic Health Science Network, Kent, Surrey, Sussex
Michael Baker Public Health England Deputy for Alison Barnett	**Jackie Huddleston** Associate Director, South East Clinical Networks,
Alison Barnett Deputy Centre Director, Public Health England South East	**Marianne Illsley** Deputy Medical Director, St Luke's Cancer Centre, RSCH
Michael Bosch GP	**Rachael Liebmann** Acute Provider Consultant, Kent & Medway
May Bullen PPE Representative	**Rachel Mackay** Pharmacist, Guildford & Waverley CCG
Charlotte Canniff Clinical Chair, NW Surrey CCG	**Hugh McIntyre** Consultant Physician, Conquest Hospital, East Sussex Healthcare Trust
Heather Caudle Director of Nursing – Improvement Nursing Directorate NHS England	**Liz Mouland** Community Nurse, First Community Surrey
Priscilla Chandro PPE Representative	**James Nicholl** Consultant Orthopaedic Surgeon, Maidstone and Tunbridge Wells NHS Trust
Peter Clarkson Lead Cardiologist, Frimley Heath NHS Foundation Trust	**Ali Parsons** Associate Director; Clinical Senate NHS England
David Davis Allied Health Care Professional	**Waqar Rashid** Consultant Neurologist, Hurstwood Park Neurological Centre
Graeme Dewhurst Postgraduate Dean, Health Education England, Kent, Surrey & Sussex	**Jonathan Richenberg** Consultant Radiologist, Royal Sussex County and Princess Royal Hospitals
Andrew Foulkes GP and Clinical Adviser, NHS England South (South East)	**Mansoor Sange** Consultant Anaesthetist and Intensivist at Darent Valley Hospital, Dartford
Tony Frew Dept of Respiratory Medicine, Royal Sussex County Hospital, BSUH	**Aneetha Skinner** Clinical Director of Adult Specialist Rehab Services Sussex Community NHS Trust
Peter Green CCG Collaborative Representative, Kent & Medway	**James Thallon (JT)** Medical Director, NHS England South (South East),