COUNCILLOR PETER McCABE
(Labour, Ravensbury Ward)

Matt Hancock MP
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Dear Mr Hancock,

I am writing on behalf of the London Borough of Merton ("**the Council**") to make a formal referral to you of the decision proposed to be made by the Surrey Heartlands and South West London CCG ("**the CCGs**") as a result of the meeting of the Committee in Common of the CCGs at their meeting on 3 July 2020 to approve the Decision Making Business Case ("**DMBC**") for the reconfiguration of hospital services in CCGs' areas in accordance with the Improving Healthcare Together 2020 to 2030 ("**IHT**") programme.

This reference is made under Regulations 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("**the Regulations**"). The Council makes this report to the Secretary of State because it is considered that the CCG's consultation on the IHT has been inadequate in relation to content or time allowed, in the context of the increased demands on NHS resources as a result of the COV19 pandemic (and potential future pandemics), and because the Council considers that the proposed decision would not be in the interests of the health service in its area.

In accordance with Regulation 23(7)(a), the Council has notified the CCGs of its decision to make this referral which was taken by a majority decision at the Council's Heathier Communities and Older People Overview and Scrutiny Panel at its meeting on 21 July 2020. That Panel carries out the Council's health scrutiny functions. The matter was also considered by the Joint Health Scrutiny Committee (JHSC) established for that purpose by the London Boroughs of Croydon, Kingston upon Thames, Merton, Sutton and Wandsworth and Surrey County Council on 3 July 2020. The JHSC submitted comments to the CCGs but did not make any recommendations.

The full suite of documentation relating to the IHT can be found on the dedicated website, a link to which is set out below:
IHT website

The Council would draw the Secretary of State's particular attention to the following:

1. Submission from Merton Council
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.2.1-Merton-Council-Submissions.pdf

2. Siobhain McDonagh MP's July 2020 response to the consultation and submission to the CIC meeting on 3 July 2020
Siobhain McDonagh's response to consultation
Siobhain McDonagh MP's Submission to the CIC

3. Statement from Chris Grayling MP

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/07/2.-Chris-Grayling-MP_Written-statement.pdf

4. Submission from Dr Rosina Allin-Khan MP whose constituency includes St Georges Hospital and who also works there.
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.3.1-DrRosena-Allin-Khan.pdf

5. Submission from Sutton council
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.2.6-Sutton-Council.pdf

6. From Community Action Sutton
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/Community-Action-Sutton_CVS-Scheme_Report_FINAL_Apr-2020-2.pdf

7. From Merton Voluntary services
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/Merton-Voluntary-Services-Council_CVS-Scheme_Report_FINAL_Apr-2020.pdf

8. Submission from GMB union
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.4.1-GMB.pdf

9. Submission from Trades Council
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E42MER1.pdf

10. .Submission from Epsom and St Helier Unison branch
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.4.3-UNISON-Epsom-and-St-Helier-University-NHS-Trust.pdf

11. Submission on behalf of local campaigners (KOSH and KOEH)
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E51KEE1.pdf

10. Report from the Clinical Senate June 2019
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/06/Joint-clinical-

These documents detail the shortcomings of the proposals in full and explain the errors made in the documents and processes undertaken by the CCGs. This letter seeks to summarise key points but the Secretary of State is asked to consider these reports in full.

The Council invites the Secretary of State to refer the proposed decision to the Independent Reconfiguration Panel ("**IRP**"). The Council is confident that the IRP would conduct a proper analysis of the merits of the proposal and will see the obvious flaws in the approach taken by the CCGs. For the reasons set out below, the Council does not accept that there has been an adequate and thorough evaluation of the many criticisms made of the PCBC nor any opportunity for stakeholders to respond and engage with the DMBC. Further, there has been no proper evaluation of future health and social care needs notwithstanding the COV19 pandemic and the potential for future pandemics. The Council considers that anyone outside the CCGs and the Epsom and St Helier Hospitals NHS Trust ("**the Trust**") would inevitably reach the conclusion that this proposal is premature, does not represent the best option commanding the agreement of stakeholders and is not convincing as a robust and resilient solution to current and future requirements. It is detrimental to the interests of Merton residents and would result in (or introduce a substantial and unacceptable risk of) a substantially inferior health service for NHS patients generally.

The background.

There is a long history of proposals for radical change to the provision of healthcare in South West London going back to at least the 1990s when the Epsom and St Helier Trusts were merged. Each of these plans has presented differing rationales for changes to NHS acute services and each has offered different potential solutions to perceived problems.

At the end of 2000 the "Investing in Excellence" plan proposed downgrading services in Epsom to centralise acute services at St Helier Hospital, which is located within the area of Sutton Council. In the autumn of 2003 a Clinical services Review Team proposed closing Epsom's A&E and temporary centralisation at St Helier pending the building of a new critical care centre: the plan was abruptly dropped, but not before the Epsom MP had proposed the expansion of Epsom and the downgrade of St Helier as a counter proposal. This was followed by the 2003 consultation on "Better Healthcare Closer to Home" ("**BHCH**"), which involved the proposed closure of both Epsom and St Helier hospitals to be replaced by a new single site 500-bed 'Critical Care Hospital' at St Helier, Sutton or Priest Hill, and a group of ten local care centres which were said to facilitate a reduction in activity of up to 50%.

These proposals were rejected at the end of 2005 following strong local opposition. In January 2006 plans for a single site critical care hospital on the Sutton Hospital site collapsed, and the project director resigned. The Sutton Hospital site is actually in Belmont, which is within the administrative boundaries of the London Borough of Sutton but is south of Sutton town centre and close to the boundary with Surrey and therefore further away from the residents of Merton. For the purposes of this reference, the Sutton Hospital site will be referred to as "Belmont".

In 2009 with the future of services secured at Epsom Hospital after Surrey PCT dropped proposals to divert patients elsewhere, plans were approved for the complete refurbishment of St Helier hospital at a cost of £219m, and it was agreed that this would be government funded, and not paid for through the Private Finance Initiative. However it came to nothing.

After the election of the coalition government in 2010, another reconfiguration proposal, "Better Services, Better Value" ("**BSBV**"), was introduced in May 2011 and in effect killed off the refurbishment plans. BSBV was put forward as a clinical initiative led by local GPs and hospital clinicians, and included some of the original proponents of BHCH. Ostensibly its aim was to improve the quality of services in South West London and to contribute to the need to ensure financial sustainability in the wake of the financial crash and the Government's austerity policies. However, common to both BHCH and BSBV seems to have been an antagonism to the continuation of services on the St Helier site.

The next proposals were to break up the Epsom St Helier Trust, with St Helier to be merged with St George's and Epsom to be merged with Ashford and St Peter's in Surrey. Both of these proposed mergers collapsed in 2012 because of unresolved financial problems. Eventually in 2014 after much controversy BSBV plans were dropped after failure to present a compelling business case and to secure agreement across stakeholders in SW London and in Surrey. Just 3 months later a new 5-year "strategy" document was published by the South West London CCGs, now working together as "South West London Collaborative Commissioning," effectively cutting the links with Surrey Downs CCG. The Strategy proposed "vacating and disposing of" the Belmont site, but also called for "service changes ... across the provider landscape which would deliver financial savings while also making it easier to deliver the improved services Commissioners want to achieve for their patients." It proposed to expand Kingston Hospital and increase bed numbers at St George's.

By 2016, much of the "strategy" appeared to be forgotten or discarded because the new Epsom St Helier Chief Executive began promoting plans for a new 800-bed single site hospital. This hospital was proposed to replace the 1,162 beds provided in the existing Epsom and St Helier hospitals.

The most recent IHT proposals, formulated in 2017/18, have sought to overcome past problems by:

- narrowing the scope of proposals to three CCG areas rather than as a pan South West London solution
- cost shifting the impact of reducing local capacity to other providers, social care providers and community services;
- using the main argument that this is because staff cannot be recruited to support two A&E departments at St Helier and Epsom ,and,
- securing pre-approval from the Secretary of State for up to £500m of resources ear marked now in future capital spending rounds as an incentive to proceed quickly.

These announcements were made in the run up to the last election and thus there is legitimate public expectation that spending pledges will be fulfilled; albeit that the caveat was made that plans would be subject to business case approval. Many may be forgiven for thinking this is a minor technicality but in

reality it remains a significant hurdle, not least in that the financial case seems weak and stakeholders are fiercely divided on the legitimacy of the processes for selecting options to be shortlisted, on the adequacy of the analysis presented so far, the viability of the severely reduced scale of acute bed provision outlined in the preferred option, and for the selection of the preferred option for centralising major services at Belmont. These doubts have now been compounded by fears of inadequate capacity revealed by the COV19 pandemic and the need for the NHS to be ready to meet the demands of future pandemics.

IHT seeks to promote a preferred option of removing all major services (A&E services, maternity and paediatrics, emergency surgery and acute medicine) from both Epsom hospital and St Helier hospital to a site in Belmont where, in effect, a new hospital will be built. The pre-consultation business case ("**PCBC**") suggests there should be what are termed "district hospital services" based on the existing sites at Epsom and St Helier. This is a mis-use of language. The proposal does not intend to create the same range of services at Epsom and St Helier as would usually be provided at a "District General Hospital". The range of services at a "district hospital" will be substantially reduced because there will for example, be no A & E service , no consultant-led maternity service or access to emergency surgery, intensive care and other back up as would be expected at a District General Hospital. Specifically in relation to maternity services, there appears to be an assumption that more women will choose to have home births although there is little or no evidence to support this assumption.

The Council and other stakeholders have been led to believe this will be cheaper, safer and provide higher quality accommodation on a more sustainable basis, principally by being easier to recruit and retain staff. However, the Council remains unconvinced because the new model will treat fewer patients with a significantly reduced number of consultants. There are significant concerns about the complex, risky and expensive three site configuration proposed and the credibility of the claims for increased efficiency, cost savings and improved quality of services. In particular we note that significant savings are claimed for consolidation of A&E services which are not backed up by reference to the latest guidance from the Royal College of Emergency Medicine and was highlighted in the Clinical Senate report (R30 p25) in 2019.

There are equally some difficult issues around the proportion of qualified nurses required to cover the reduced number of acute beds and downgraded beds at Epsom and St Helier.

The CCGs have proceeded with public consultation quickly before establishing a broader understanding and agreement across stakeholders of the risks the NHS would be taking in making these changes without having secured the necessary support.

The nature of the Council's objections to the proposed CCGs decisions.

The Council has reached the view that the CCGs consultation on the IHT has not been adequate in relation to content or time allowed and that the proposed reconfiguration decision would not be in the interests of the health service in its area, for the reasons set out below.

1. **The decision fails to give effect to the NHS's commitment to tackle health inequalities.**

The Council is hugely sceptical about whether it is in the interests of the users of the health service in its area for acute services at Epsom and St Helier hospitals, in effect, to be amalgamated on a single site. The reasons for that scepticism are set out below. However, if the acute services at Epsom and St Helier hospitals are to be amalgamated on a single site, the Council considers that there is an overwhelming financial, clinical and legal case for that site to be St Helier Hospital as opposed to either Epsom Hospital or a new build on the Belmont site.

A proposal to locate acute facilities in Belmont would be yet another example of the NHS taking decisions to move acute care facilities away from lower socio-economic areas and to build them up in more affluent areas, despite the benefits of improved access for poorer people of developing service where those services are most needed.

The proposal to invest the bulk of £500M of public money to create a single major acute site at Belmont, the location of a new Specialist Emergency Care Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals involves moving substantial services away from St Helier Hospital and thus reducing the ability of poorer communities with higher levels of deprivation and greater health inequalities to access NHS services. The plans are redolent of thinking which has failed to learn lessons from the original Marmot Report into health inequalities in 2011 (which build on a series of earlier reports) and the recent Marmot review report in February 2020. The 2020 Report said:

> *"Life expectancy follows the social gradient – the more deprived the area the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010-12 and 2016-18 ....*
>
> *The national government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010"*

An approach which fails to give proper regard to health inequalities breaches the CCGS' duties under section 14T of the National Health Service Act 2006 ("**the NHS Act**"). Endorsing such an approach would breach the Secretary of State's duties under section 1C of the NHS Act.

The DMBC found:

> *"This analysis shows a clear and consistent association of higher rates of A&E attendance for those living in the more deprived communities" [p100]*

It then said:

> *"The IIA found that the planned changes to district services may lead to the enhancement of local service offerings which may in turn lead to improved health outcomes for those from deprived areas and bring about changes which may help to reduce health inequalities [p101]"*

The Council considers that the IRP will see the obvious flaws in that approach, namely that this wording appears to suggest that reductions in the range of Accident and Emergency Services at St Helier, which is the hospital serving the populations with the highest level of health inequalities, will "*help to reduce health inequalities*". That is an example of a conclusion being drawn before the evidence is considered. It is totally nonsensical because there is no evidence that a reduction in services to the poorest communities will or even has the capacity to reduce health inequalities.

The methodology used in the DMBC to analyse inequalities is also at fault. No proper age weighting appears to have been used for the analysis. One key aspect of health inequalities is that people in poorer populations suffer illnesses earlier in life than those in more affluent areas. That flaw is shown clearly in the DMBC at p113 where is says:

> *"Of note within the analysis overall is the increased rate of non-elective medical admissions for the Surrey Downs area per 1,000 residents in comparison with either the Merton area and Sutton area. This is largely attributable to the higher proportion of elderly residents in the Surrey Downs area. In terms of the association between lengths of stay in hospital and deprivation, there is no pattern of consistency"*

Thus, in assessing health inequalities, the DMBC made fundamental errors. The extent to which the DMBC has totally failed to understand or take account of health inequalities is demonstrated by the recommendation that further work should be undertaken on health inequality issues. Recommendations 12 and 13 were:

> *"12. Review district service provision against local health inequalities*
>
> *13. Re-assess accessibility issues for deprivation groups for preferred option"*

However the Council believes that this work ought to have been undertaken before the decision is made on location, not afterwards. In any case it is impossible to believe that any objective assessment could reach the conclusion that the relocation of services serving the most disadvantaged away from the location at which such persons live could be to their advantage when it is fully justifiable to develop those services on the site closest to those with greatest disadvantage. There are no compelling advantages that could not have been secured more directly otherwise e.g. by .training more staff.

This absence of due regard being had to health inequalities is shown in the list of "legal duties" to which the CCGs had regard as set out at page 31 of the presentation to the final decision making meeting. The key duty to tackle health inequalities was absent from this list.

The final integrated impact assessment recognised that socio-economic status and deprivation is directly linked to health inequalities [see p97]. That report noted:

"Of the 11 LSOAs in the top quintile, none are in Surrey Downs, four are in Merton, and seven are in Sutton. Sutton also has the LSOA with the most deprived population (in Beddington South)"

These LSOAs are substantially in the area around St Helier Hospital.

The report recognised that there was disadvantage to people in deprived areas of the chosen location for acute services, albeit that it suggested that other factors had a greater impact. However, as the IHT decision was only about acute services, the impact of other measures to tackle health inequalities was irrelevant unless it also contained detailed other proposals to tackle health inequalities, which it did not.

Thus the Report recognised that there were disadvantages for deprived communities in moving services away from locations where they could access them easily but the CCGs failed to take that into account when making this decision.

2. The failure to model the effect of displacing patients away from the Trust and towards other hospitals and social care.

The Council is concerned that, despite the considerable proposed investment, the plans will result in fewer doctors, fewer beds and an overall reduction in services for local people. That reduction is planned against the background of a historically low level of hospital beds to meet the needs of local people. The DMBC assumes a 2% per annum reduction in emergency admissions up to 2025/26 and a 3% per annum reduction in activity overall, with a 3% per annum bed savings by reducing length of stay. These are not only untested assumptions but the evidence from elsewhere in the NHS shows they have not been achieved. Overall the new configuration proposes a reduction of 80 acute hospital beds but this number is arrived at taking into account by "district" hospital beds which lack the necessary comprehensive support found in acute settings. The real cut in major acute beds is 452. The problem, from the Council's perspective, is that fewer hospital beds being provided in a less convenient location will lead to the following outcomes.

a) Merton residents will not seek emergency NHS treatment in Belmont, they will go to their nearest hospital which is likely to be another London hospital, notably St George's, Tooting. Thus downgrading St Helier will not result in patients relocating from St Helier to Belmont but from St Helier to St George's. That transfer will put additional pressure on St George's. There is no assessment as to whether St George's can absorb that additional work. However the movement away from "payment by results" means that (unless financial arrangements change) the St George's Trust will not be provided with further financial resources to fund this additional work, nor is the physical capacity available at St George's (and no expansion is planned or budgeted for);

b) There will be fewer patients attending the Belmont site and thus, in effect, the block payment to the Trust by the CCGs will fund services for significantly fewer more affluent patients. Whilst that may well be good news for the more affluent patients, it is really bad news for those with the highest level of health needs. They will find fewer services for them and less funding for those services; and

c) Fewer patients will be seen within acute hospitals, causing increasing strain on already overloaded community and social care services.

Thus Merton residents will not only find acute services harder to access as those services move away from them if this misguided decision is implemented but they will also have fewer services to access if they do seek to access services.

3. The Council refutes the suggestion that achievement of defined clinical standards make the best use of limited NHS and social care resources.

The Council challenges whether there is a proper evidence basis to support larger hospitals based on the achievement of clinical standards. The problem, in summary, is that clinicians have looked at the type of environment that works best from a clinician perspective within a hospital. That approach inevitably leads to larger and larger hospital units, which can only operate successfully if these larger units serve the needs of more and more patients. However there are serious questions about whether improved clinical standards do, in fact, come from larger hospitals. Fewer, larger, hospitals mean increased lengths of journey for patients and visitors, with the risk of creating a reluctance for patients or visitors to attend because of the distance and there is real doubt as to the evidence that, despite predictions "bigger is best" for health outcomes. This consultation was supposedly based on a desire to achieve these standards but the real question for debate should have been whether those standards were realistic, achievable and make the best use of limited NHS and social care resources. If the questions were posed in that way, the obvious answer is that a sole focus on achieving these standards does not make the best use of limited NHS and social care resources.

Indeed the CCGs appear to be saying that the most telling argument for reducing services is that it is not possible to train and recruit sufficient staff locally, not that there isn't a need for local services. The Council would like to see this problem addressed strategically rather than be asked to accept that services must be built around the contrived constraint of a shortage of clinical staff.

4. Learning the lessons of the Covid-19 pandemic.

Fourthly, the CCGs have moved too quickly and, as a result, will almost certainly have failed to learn the lessons of the Covid-19 pandemic. It is far too early properly to learn the entirety of the lessons from the pandemic, but the emerging evidence is that more hospital beds will be needed in the future, not less. The days of NHS hospitals being able to run at capacity rates of more than 95% ought to be over. If the CCGs had a combination of wisdom and humility, they would accept that this is not the time for the NHS to be making long-term decisions to reduce capacity further. The work that the CCGs have done to assess the impact of Covid-19 has been superficial and inadequate. In particular, no proper account has been taken of the emerging evidence that people from BAME communities have been disproportionately affected by Covid-19, both in terms of susceptibility to the virus and the seriousness of its impact. In fact, the 5 page document produced by the CCGs in seeking to assess the impact of the Covid-19 failed even to mention BAME

communities. This work came to the conclusion that the strains that the pandemic had put on the NHS in fact supported their plans. However that conclusion does not bear proper examination as it is frankly far too early to know how the pandemic will affect future NHS planning.

Thus the Council believes that the CCGs ought to have halted this consultation process, waiting until it was clear what lessons were being learned from the pandemic and then recommenced the consultation process. We consider that the need to learn lessons from the pandemic means that this was the wrong time to complete the consultation and thus the Secretary of State should set aside this decision under Regulation 23(9)(a).

5. The misrepresentation of the public voice in the DMBC

The DMBC substantially misrepresents the outcome of the consultation exercise. It misrepresents the views expressed by the public and misunderstands the way in which the public responded to the consultation process. The details of the errors are set out in the excellent and detailed report prepared by the local Member of Parliament, Ms Siobhan McDonagh which is annexed to this letter. We can do no better than to refer you to the details set out in that report which it makes it clear that in almost every aspect of the consultation responses there was overwhelming opposition to the Belmont option.

The way in which the CCGs explained how the public responded to the consultation has been indicative of the fact that this appears to the Council to be a reconfiguration project which has been "ego driven" by senior Trust managers who have used force of personality to drive forward the reconfiguration agenda rather than being an "evidence driven" process. Senior managers at the Trust have created a wholly artificial focus on the hospitals within the Trust instead of focusing the planning around the needs of health and social care more generally across South West London. As a result the NHS has developed plans which do not make any sense for the wider health and social care economy.

As a result, the plans are a colossal waste of tax-payers' money. There are far better ways to apply the substantial investment monies than those proposed in the DMBC, as the material provided by the Council to the CCGs has clearly demonstrated. However, once the NHS train was put on the track with the aim of creating, in effect, a new white elephant hospital in Belmont and down-grading the services at St Helier, no amount of evidence appears to have been able to persuade the CCGs that this was a crazy plan.

6. The money does not add up

The Trust is in significant financial deficit and requires support from NHS England to continue in operation. However, the plans are built on expectations of financial savings by the creation of new clinical models which have not worked elsewhere. An Independent expert review has cast doubt on the reliability and accuracy of the savings claimed and it is significant that the plans have not been assured by NHS London or NHE England finance professionals as is stipulated in guidance.

The Treasury, who approve all capital projects of more than £50m at the moment, issue the Green Book and the Guide to developing the Project Business Case. These lay down clear guidance for on the process involved in investment appraisal, particularly the options appraisal process and the

requirement to consider properly lower cost do-minimum options. Further guidance on multi –criteria analysis of the type deployed in the PCBC can be found in a manual issued by central government and the guidance on economic modelling issued in December 2019. This guidance does not appear to have been followed, with inadequate consideration of lower cost options and options involving behavioural changes which, taken together with some much needed capital investment in the existing buildings would reduce the need for such radical and expensive changes to buildings as a so-called solution to recruitment difficulties. Further detail of the flaws in the financial analysis and particularly the assessment of net present value can be provided in due course. It should be noted that in making the announcement of the funding for Epsom and St Helier capital development, you also said that future details of a new capital funding regime would be published before the end of 2019. It is still not clear either what that the future system will be; or the system for future funding of social care, again long promised.

Page 31 of the DMBC contains a long list of services that the Trust would like to see delivered in the community. But there is no agreed funding to expand community services to pay for those services. Hence the clinical model proposes moving services out of an existing hospital environment (where they are funded) to community locations (with no identified funding).

If funding is diverted to support all of the community services that are described in the DMBC, the proposal becomes unaffordable. However without that funding being part of the overall plan, it is unrealistic.

Overall, the Council does not consider that this proposed decision is well thought through or has been subject to the type of thorough analysis needed before major changes are made to NHS services. That so many other key stakeholders, including the staff, and many thousands of the public think similarly reinforces our position.

The consultation should not have continued through the Covid-19 pandemic and everyone should have stopped and asked themselves difficult questions about whether this was the right way forward. That was not done. The Council thus invites the Secretary of State to refer this matter to the IRP for a thorough analysis.

The matters set out in this letter and the attached documents are, by definition, at a high level. The Council will co-operate the IRP to develop the arguments and analysis.

I should be grateful if you would kindly acknowledge receipt of this letter.

Yours sincerely

Councillor Peter McCabe,
Chair, Healthier Communities and Older People Panel
London Borough of Merton

Cc Andrew Murray, SW London NHS Clinical Commissioning Group
Charlotte Caniff, Surrey Heartlands NHS Clinical commissioning Group
Sarah Blow, SW London Alliance
Matthew Tait, Surrey Heartlands