

Appendix 1 - Letter from the Leader of Medway Council to NHS England

Please contact:
Your ref:
Our ref: RC/RDM
Date: 08 November 2018



Mr Ivor Duffy
Director of Assurance & Delivery
NHS England (KSS)
Wharf House
Wharf Road
Tonbridge
TN9 1RE

Councillor Alan Jarrett
Leader
Medway Council
Gun Wharf
Dock Road
Chatham
Kent, ME2 4AU
Telephone: 01634 332514
Alan.jarrett@medway.gov.uk

Dear Mr Duffy

I am writing to you to express my deep concern about the decision to select Darent Valley, Maidstone and William Harvey Hospitals as the locations of the three HASUs in Kent and Medway.

My fellow councillors and I have concerns about the recommendation that the Joint Committee of CCGs made and the process by which they were led to the recommendation. I have enclosed my letter to the South East Clinical Senate (SECS) and the reply that we received from the SECS. In this letter I will not repeat the concerns expressed previously, but will provide additional justification for our concerns.

As you will be aware, the NHS consulted on five options, each consisting of three hospitals.

This Council believes that the decision to select Darent Valley, Maidstone and William Harvey Hospitals (Option B) is not in the interest of the health service in Medway, nor indeed, more widely the health service across Kent.

Our first concern is regarding capacity. We understand that ambulance services take patients to the hospital that has the shortest travel time and for many patients outside of Kent and Medway this will be Darent Valley Hospital. As there appears to be no way to limit the number of patients being brought from out-of-Kent and Medway we need to see evidence that this will not lead to patients from South East London overwhelming Darent Valley Hospital, should it become a HASU, resulting in insufficient beds for patients from Kent and Medway.

As well as capacity we are concerned by the observations of the independent assessment panel, and the way these were scored. The panel felt that Maidstone Hospital was "slightly insular looking" and "did not consider the whole of Kent and Medway or how they would work with other trusts." They also noted that there was "reliance on past progress and current performance as a marker of future success rather than a robust plan to deliver the new model of care", and yet Maidstone Hospital received the highest score of all the hospitals. Darent Valley "didn't tackle key



workforce and quality issues” and the panel had “concerns about the current level of clinical leadership in the Trust for the stroke programme”. Nevertheless Darent Valley received a neutral score.

For Medway Maritime Hospital the panel noted the “impressive clinical leadership, experienced in this change.” Whilst we acknowledge that they noted that a stronger plan was needed, this was also true of Maidstone Hospital; MMH received a negative score as a result, while Maidstone received a plus. It is hard to understand why Medway Maritime Hospital was scored so negatively given that it has the kind of clinical leadership and experience that is needed to create a successful HASU.

The observations of the independent panel lead us to believe that Maidstone and Darent Valley hospitals lack the leadership and attitude to deliver a HASU service for the population of Medway (and for the population of Kent).

Our concern regarding the process is that it appears that the decision was made to include Darent Valley Hospital (DVH) to assist the struggling Princess Royal University Hospital (PRUH) and the way the options were evaluated was modified to ensure that the Joint Committee of CCGs would be led to choosing an option that included DVH. The consultation was based on five criteria, each with sub-criteria:

1. Quality of care
2. Accessibility
3. Workforce
4. Feasibility
5. Finance

which were scored¹ through a series of engagement exercises resulting in a consensus score for each criterion. After the consultation period had ended the criteria remained the same, however, the mechanism for scoring the criteria was changed.

The NHS has claimed that this was necessary to help discriminate between the five options and argued that this is not a change in the process; however, it has substantially changed the assessment of the criteria. It is like saying that age is the criterion used to determine when someone can legally drink alcohol, and then changing the threshold at which this is permitted - (e.g. a “+” for over 18 becomes a “-“). The criterion has remained the same, but the way of using the criterion has changed.

The five criteria were ranked in order of importance in the consultation document² and the new approach to scoring the criteria meant that the first two, the two most important criteria, were neutralised, with all options having the same score whereas previously these criteria helped to discriminate between the options. This is the exact opposite of the rationale given for changing the way the criteria were scored. The new approach was signed-off by the Clinical Reference Group (CRG), however, the CRG was only given part of the information about the new approach to scoring the criteria one day before the meeting and further information at the meeting. During this meeting

¹ As ++, +, /, -, --

² Page 38, paragraph 2.

concerns were raised that this new approach neutralises the first two criteria, however with little time to properly consider the impact of this the group agreed to the approach. The CRG also did not see the impact of the approach on the remaining criteria.

I am puzzled by the lack of evidence behind the JCCG's assertion that William Harvey and Darent Valley can demonstrate better workforce mitigation compared to Medway Maritime Hospital. They share a workforce with on call consultant rotas and the shortages of relevant specialists affect all equally, a point made many times during the consultation and before.

With the first two criteria neutralised the recommendation was driven by criteria 4 and 5: feasibility and finance. In the public consultation reference was made to the PRUH however it was not explicitly included as part of any of the options. After the consultation period the PRUH was included in two options: C and D; the options that did not include DVH.

This meant that along with hospitals included in the options in the consultation, the PRUH was also required to submit a plan to demonstrate how it would expand to allow for patients from Kent and Medway for whom the PRUH would be the nearest HASU. The PRUH declined to do so, which substantially adversely affected the feasibility scores for options C and D.

It is now unclear to this Council whether the PRUH was or was not a part of Option D. If the PRUH is not willing to expand to accommodate Kent and Medway patients, then it should have been excluded from options C and D because ambulance crews would not be able to take patients to the PRUH. A fundamental aspect of the consultation was that patients should not travel more than one hour to get to a HASU; this is the justification for residents of Broadstairs, for example, being served by a HASU at William Harvey Hospital, approximately one hour away. Kent patients on the border would be within 45 minutes travel of Tunbridge Wells Hospital and Medway Maritime Hospital, two hospitals in Option D, and could therefore be taken safely to either of these hospitals. Therefore it seems irrefutable that Option D should only have included Medway, Tunbridge Wells and William Harvey hospitals.

The feasibility of option D was also adversely affected by the duration of implementation for Tunbridge Wells Hospital. This was noted as being excessively long by the independent review panel and could have been reduced. It is worth noting that during the consultation period a representative of Maidstone and Tunbridge Wells Trust (MTW) had stated that the Trust preferred the HASU to be at the Maidstone site rather than the Tunbridge Wells site.

The final criterion was finance. Option D increased substantially in costs from those in the consultation document, primarily due to a large increase in the costs to build a new education centre and car park at the Tunbridge Wells site. Option D also included increased costs for the PRUH, which as shown above, should have been excluded from Options C and D as the PRUH had no intention of taking additional Kent and Medway patients. With respect to Tunbridge Wells Hospital, the independent review panel "felt that all options hadn't been explored fully in the estates solution...meaning other plans should have been considered" and it is possible that other plans for Tunbridge Wells and the removal of the costs at the PRUH would have brought Option

D below the financial threshold, as well as being implemented in a reasonable timeframe.

Further support to our belief that the recommendation had been made to select Option B as the preferred option before the meeting of the Joint Committee of CCGs was provided in a meeting between the NHS and councillors and council officers on 25 October 2018. When explaining why little had changed as a result of the consultation, as evidenced by the consultation report, yet the way the criteria were evaluated had changed considerably, including the inclusion of the PRUH, the NHS team stated that they "had further instruction from NHS England about the PRUH" after the consultation.

I would therefore ask NHS England to respond to the following questions:

1. Can NHS England explain why the scoring of the criteria was changed in a way that reduced the ability to distinguish between the options for the most important criteria when the objective was to provide greater distinction between the options?
2. Why was the Clinical Reference Group given so little time and information to review the changed approach to scoring the criteria?
3. Can NHS England please clarify whether or not the PRUH was part of Option D?
4. Why was the PRUH included in Options C and D in the final evaluation but not formally included in these options in the consultation documents?
5. Why was the PRUH included in Options C and D in the final evaluation when it has refused to submit an implementation plan? (It should have been excluded and patients from Kent on the border could have been diverted to Tunbridge Wells and Medway hospitals).
6. Why were the capital costs for the PRUH included in Options C and D when there was no plan for implementation?
7. Why were the comments from the independent panel about Tunbridge Wells needing to consider other implementation plans ignored?
8. Why were the comments from the independent panel about the quality of clinical leadership not considered appropriately and ignored in the final evaluation?
9. What "further instruction" did NHS England give to the Kent and Medway Stroke review team regarding the inclusion of the PRUH?

This Council is convinced that the process by which the CCGs were led to choosing Option B was flawed and that this option is not in the best interests of the health service in Medway and Kent more widely. We will also be pursuing our concerns through the statutory Joint Health Overview and Scrutiny Committee which may ultimately involve a referral to the Secretary of Health.

A timely response to this letter would be appreciated to enable us to prepare for the Joint HOSC discussions. Certainly we do not believe a final decision on the configuration of hyper acute and acute stroke services in Kent and Medway can be taken until these flaws in process have been addressed and a proper decision-making process put in place.

Medway Council reserves the right to seek further redress in this matter as it thinks necessary.

Yours sincerely



COUNCILLOR ALAN JARRETT
Leader
Medway Council

Encls.

cc: Reh Chishti MP, Gillingham and Rainham
Kelly Tolhurst MP, Rochester and Strood
Gordon Henderson MP, Sittingbourne and Sheppey

Appendix 1 - Reply from NHS England



By Email

Councillor Alan Jarrett
Leader
Medway Council
Gun Wharf
Dock Road
CHATHAM
ME2 4AU

NHS England South East
(Kent, Surrey & Sussex)
Wharf House
Medway Wharf Road
Tonbridge
Kent
TN9 1RE

Email: ivor.duffy@nhs.net
Tel: 0113 8248575

21 November 2018

Dear Councillor Jarrett

Stroke Services Consultation – Kent and Medway

Thank you for your letter with regard to the Stroke Services consultation in Kent and Medway. Apologies for the delay in responding but I only received an electronic copy of the letter this morning.

I have reviewed the letter and the questions you pose are within the responsibility of the Clinical Commissioning Groups (CCGs) not NHS England. I have forwarded your letter to Glenn Douglas, Accountable Officer for the CCGs in Kent and Medway, to provide a response.

NHS England's role in service reconfiguration and transformation is that of assurance. It is the CCGs' role to consult on any proposed changes and to consider in their decision making the outcomes from the consultation. It is also their role to draw together the options and any shortlisting criteria. It is not NHS England's role to step in and influence a consultation and subsequent decision making process and it would be inappropriate for us to do so.

Kind regards.

Yours sincerely

Ivor Duffy
Director of Assurance and Delivery
NHS England South (Kent, Surrey & Sussex)

Copy To:

Rehman Chishti MP, Gillingham and Rainham

Kelly Tolhurst MP, Rochester and Strood

Gordon Henderson MP, Sittingbourne and Sheppey

Felicity Cox, Director Commissioning Operations, NHS England (Kent, Surrey, Sussex)

Glenn Douglas, Accountable Officer, Kent and Medway CCGs