Appendix 2 - Letter from the Leader of Medway Council to the South East Clinical Senate

Please contact: Julie Keith (01634 332760)
Your ref:
Our ref: JK/Stroke Review
Date: 12 October 2018

Mr Lawrence Goldberg,
Chair,
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Councillor Alan Jarrett
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Dear Mr Goldberg,

Review of hospital-based urgent stroke services for people in Kent and Medway

I am writing to you on behalf of Medway Council, ahead of the South East Clinical Senate meeting on 18 October where you will be reviewing the decision making business case for the preferred option for reconfiguration of hyper acute stroke services across Kent and Medway. As you know the preferred option (B), published by the NHS in Kent and Medway on 17 September 2018, is to have hyper acute stroke units, alongside acute stroke units at Darent Valley Hospital in Dartford, Maidstone Hospital and William Harvey Hospital in Ashford.

At a meeting of Medway Council on 11 October 2018 the Councillors present resolved unanimously to ask me to make representations to you seeking a robust review by the Clinical Senate, of the methodology and evaluation process used to inform the selection of the preferred option for HASUs in Kent and Medway (taking into account the Council's concerns).

You will appreciate our very grave disappointment and concern that Medway Maritime Hospital does not feature in the preferred option despite being included in three of the five options under consideration and given the outcome of two pre-consultation impact analysis exercises completed by Mott MacDonald Group Ltd and by the Medway Public Health Intelligence Team which indicated that Option D (Tunbridge Wells Hospital, Medway Maritime Hospital and William Harvey Hospital) would have the greatest positive impacts and the least negative impacts for equality and travel and access. The NHS consultation material also clearly indicated the strength of Option D.

The Council's Health and Adult Social Care Overview and Scrutiny Committee met on 3 October with senior NHS Kent and Medway representatives present to explore how the methodology used had delivered a preferred option excluding Medway Maritime Hospital.

Very regrettably our request to NHS Kent and Medway on 18 September for access to the un-amended selection workshop documentation had been refused, forcing us to submit a request under Freedom of Information legislation, which had not been

responded to in time for our Overview and Scrutiny Committee meeting. This impeded the ability of Overview and Scrutiny Councillors to fully scrutinise the process and to formulate key lines of enquiry ahead of the meeting to test how an outcome has emerged which we believe will have a detrimental impact on health inequalities and outcomes for the population of Medway. We are concerned at this lack of transparency in relation to a process affecting a population in Medway of 280 000 people (with expected growth to 330 000 people by 2035) and a wider population of 500 000 people if you factor in the impact across Medway and wider North Kent. These concerns have also been expressed by Members of Parliament for Rochester and Strood, Gillingham and Rainham and Sittingbourne and Sheppey.

At the Overview and Scrutiny Committee meeting on 3 October the Members were advised of the rationale for the changes made to the evaluation sub-criteria ahead of the workshop on 13 September where the preferred option was chosen and the further work underway on mitigations relating to deprivation, journey times and rehabilitation.

However, Members of that Committee did not feel they received the assurances they were looking for in relation to the evaluation process and underpinning methodology. In particular, Members were concerned this process has failed to take into account the specific impact of disadvantage in Medway. Given Medway has higher rates of hospital admissions for stroke and TIA, in residents aged under 75, this is of concern.

An offer of a fuller in depth briefing has been made by the NHS but this could not be arranged before the Clinical Senate deadline for submission of the decision making business case, which has prompted us to ask for your support in testing the methodology underpinning the preferred option evaluation process.

Our Overview and Scrutiny Members will also be taking our concerns forward to the Joint Health Overview and Scrutiny Committee when it meets and potentially to the Secretary of State for Health under the power we have to contest and refer substantial health service changes.

There is a strong sense that after a review exercise taking 4 years the final stage of the process is being rushed resulting in an outcome that is not in the interests of the health service in Medway. For example, at the Joint HOSC meeting on 5 September Medway Councillors pointed out that the figures in the paperwork relating to the percentage of patients who would be able to access a hospital providing stroke services within a 30 or 45 minutes travel time, varied significantly for Option E compared to the percentages published during the consultation period. The effect of this was to move Option D from its position of offering the best travel times overall. This was of particular concern in view of the fact that the percentages for the other options had not changed significantly. Neither NHS colleagues, nor Carnall Farrar representatives were able to explain the discrepancies and after the meeting reported back that there had been a typographical error and that corrections needed to be made. We are now also being told that the final decision may be taken by the JCCG in December which provides little time for the full decision making business case to be scrutinised by the Joint HOSC in contravention of the legal obligation to allow adequate time for this.

All this together with last minute changes to the preferred option evaluation sub criteria and the refusal to provide us with timely access to the un-amended evaluation workshop documentation has undermined our confidence in the rigour, the fairness and frankly the bona fides of the process.

It is incomprehensible to Medway Council how methodology has been developed which has resulted in Medway Hospital being excluded as a site for a HASU given that it is serving the largest urban area in the South East outside London, with a population at greater risk of stroke due to the large number of elderly residents, high levels of deprivation and higher than average numbers of smokers. Medway Maritime Hospital is the only one of the seven hospitals in Kent and Medway that regularly treats over 500 stroke patients a year. Our hospital already has a wide range of supporting services needed to support stroke services making it ideally placed to become a hyper acute stroke service. On that basis it is not clear to Medway Council how any reasonable decision-maker could choose an option that does not include Medway Maritime Hospital as one of the HASUs. We understand, the Trust is itself is seeking feedback on how it has failed to be selected.

The particular questions we would ask the South East Clinical Senate to review when it meets on 18 October are as follows:

1. The time allowed for each of the Groups involved in the development of the evaluation criteria to assess and properly consider the last minute changes to sub criteria (ie the Evaluation Criteria working Group, Stroke Programme Board, Stroke Clinical reference Group and the JCCCG).
2. The rationale for changes made to the sub criteria and the impact these changes had on the capacity of the process to generate Option D as a preferred outcome – given Option D had been independently assessed as having the greatest positive impacts and the least negative impacts for equality and travel and access.
3. Why the preferred option selection process was allowed to proceed without an implementation plan from PRUH. It was argued previously that PRUH would experience a large flow of Kent and Medway patients if Options C or D were selected and an assurance was provided to the Joint HOSC on 5 September that PRUH would be required to present a plan to the Deliverability Panel.
4. How the estimated capital costs for Option D escalated from £36million (as published in the consultation documentation) to £49.7million at the workshop evaluation stage taking Option D to a place outside of the financial envelope of £38 million. This was an increase of nearly 38%. Option B also moved from being the fourth most expensive option at consultation stage to the least expensive in capital investment terms (reducing by £7.7 million). It is also mystifying how the NPV for Option B has increased by 208% since the consultation was launched but for Option D we see an improvement of only 17%. These massive shifts and discrepancies bring into the question the efficacy of the original options and also brings into question a selection methodology which has delivered an outcome which conveniently represents the least expensive in capital investment terms and most beneficial in terms of NPV (noting that at consultation stage Option B ranked fourth and fifth respectively for those factors).
5. The likely impact on the health service in Medway, and the wider population of North Kent, of an option being implemented which does not include Medway Maritime Hospital as one of the sites for a HASU in the context of deprivation. NHS Kent and Medway have stated they are working to mitigate risk arising from deprivation but are also publicly saying there is no evidence linking deprivation to prevalence of stroke. This latter statement flies in the face of the strong evidence that links socio-economic variation to stroke and poorer outcomes for disadvantaged populations in England[i] .

NHS Kent and Medway colleagues have acknowledged that the evaluation process is an art not a science and that there will be a degree of subjectivity. Medway Council would ask the South East Clinical Senate to rigorously review this process and to take into account the concerns we have for health equalities and outcomes for our population.

Please can this letter be provided to all members of the Senate before the meeting on 18 October and formally placed on record.

I look forward to hearing from you further.

Yours sincerely

COUNCILLOR ALAN JARRETT
Leader
Medway Council

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[i] Bray D, Paley L, et al (2018). Socioeconomic disparities in first stroke incidence, quality of care, and survival: a nationwide registry-based cohort study of 44 million adults in England. The Lancet Volume 3, ISSUE 4, Page 185-193, April 01, 2018. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30030-6/fulltext.
Accessed 2nd October 2018.https://doi.org/10.1016/S2468-2667(18)30030-6

South East Clinical Senate

Kent Surrey and Sussex

15 October 2018

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Dear Councillor Jarrett

Re: Forthcoming South East Clinical Senate review of the Kent and Medway stroke service reconfiguration draft decision making business case on 18 October 2018

Thank you for your letter of October 12th regarding the South East Clinical Senate's (SECS) forthcoming independent clinical review of the decision making business case (DMBC) for future stroke services in Kent and Medway due on October 18th. In your letter you outline two broad concerns through five questions you have posed to us, which I might summarise as:

- The process followed by the Kent and Medway stroke programme board in reaching the preferred option that does not include Medway NHS Trust as one of the three HASU/ASUs (relating to your questions numbered 1-4).
- Your concerns about the impact on the changes on the health service in Medway and the wider population of North Kent in the context of deprivation if Medway NHS Trust is not one of the three HASU/ASUs (your question 5).

In answering you, it is important for me to clarify the role of the clinical senate here, as against NHS England and its formal assurance role in service change (and as set out in NHS England's guidance document 'Planning, Assuring and Delivering Service Change for Patients', March 2018)[1]. Clinical senates exist to provide independent clinical advice and recommendations to healthcare commissioners and health systems. The clinical senate (composed of senior clinicians providing their clinical experience and expertise on a voluntary basis) is not constituted, skilled or tasked to review questions of process, nor of finance. When their input is invited, they can provide an independent, clinically focussed review of proposals for service change taking a population based approach that considers the health impacts of any planned change, with a focus on the coherence of clinical and patient pathways, the planned improvements in quality and outcomes, and the evidence base (where evidence exists).

[1] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

For this specific clinical senate review of the draft DMBC for the preferred option for future hyper-acute stroke units (HASUs) alongside acute stroke units (ASUs) in Kent and Medway, we agreed terms of reference with the requesting body, which was the STP's Clinical Board. The agreed aim was for 'the SECS to provide its advice on the final preferred option for stroke services configuration as part of the draft DMBC'. The review was 'to be of the draft DMBC, before the final DMBC is submitted for NHS England and NHS Improvement assurance', and the SECS 'will focus on the clinical elements of the DMBC'. On this basis, the SECS will be reviewing the various clinical aspects of the preferred option as described in the draft DMBC, not the process by which the preferred option was arrived at. It would be for NHS England to consider these as part of their formal assurance role.

In getting to this point in Kent and Medway's planning for stroke services, the SECS has provided input in the past through:

a) Review of the Case for Change for Stroke Services in Kent and Medway (June 2015)[2]

b) A review of the STP's draft proposals for future acute stroke services in Kent and Medway (Jan 2018). This was an independent clinical review of the draft pre-consultation business case

(PCBC), in which our recommendations were considered by the programme board before the PCBC was finalised and then went to public consultation. Our review of the draft PCBC was made available on line by the Kent and Medway team during the public consultation, and can be obtained from the K&M stroke programme team.

On the basis of our remit and role described above, your questions 1-4, that relate to process issues (Q1-3) or finance (Q4), are out with of the clinical senate's scope to answer or address. You may wish to consider referring these queries directly to NHS England- South East - Kent Surrey and Sussex.

In response to your fifth and important question, regarding the likely health impact on the population of Medway and North Kent in the context of the level of deprivation, if Medway NHS Trust does not provide a HASU/ASU service:

I can assure you that part of the forthcoming SECS review will include the consideration of access to high quality stroke services for the whole population of Kent and Medway, taking account of travel times and levels of deprivation their location. In that regard, thank you for sharing the recent Lancet Public Health article that shows the association of levels of deprivation with incidence of stroke and its risk factors[3]. The SECS has also previous provided an independent clinical review entitled 'Hospitals without Acute Stroke Units: a review of the clinical implications, and recommendations for stroke networks' (Jan 2016)[4], which although conducted for the Surrey clinical commissioners, it was a generic report relevant to any stroke reconfiguration, including that in Kent and Medway. I hope that will give you others confidence that we will be looking at the impact on hospitals and their local populations that do not have a HASU/ASU.

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[2] http://www.secsenate.nhs.uk/files/3914/4118/1216/SECS_Kent_and_Medway_Stroke_Services_Review_Report_June_2015.pdf

[3] Socioeconomic disparities in first stroke incidence, quality of care, and survival: a nationwide registry-based cohort study of 44 million adults in England. Bray B et al. Lancet Public Health 2018. https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(18)30030-6.pdf

[4] http://www.secsenate.nhs.uk/files/3814/5503/1676/Hospitals_without_acute_stroke_units__implications_and_recommendations._South_East_Clinical_Senate_Jan_2016.pdf

With kind regards

Yours sincerely

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Cc Ali Parsons, Associate Director, South East Clinical Senate