

## STATEMENT FROM MEDWAY COUNCIL TO THE KENT AND MEDWAY STROKE REVIEW JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC)

### 1. Summary

- 1.1 Medway Council believes that the proposed sites that have been selected for the provision of HASUs (Darent Valley, Maidstone and William Harvey, Ashford) are not in the best interests of the health service in Kent and Medway. Furthermore, Medway Council believes that there were flaws in the way that the Joint Committee of Clinical Commissioning Groups was led to choose the selected sites. This invalidated the criteria used on the public consultation documents and failed to provide evidence to support the evaluation criteria.
- 1.2 Medway Council has significant concerns in relation to the selection of option B (as further detailed in 2.2 below) and does not consider that Option B represents the best option for the health service in Kent and Medway and its residents.
- 1.3 Medway is also concerned about the phased approach now being proposed to achieve the delivery of HASUs and the detrimental effect that this could have on patients in East Kent as the HASU at the William Harvey would not open until 2021 while the HASUs at Darent Valley and Maidstone would open in 2019/20. In particular, we are concerned about how and where patients will be cared for if they are unable to return home after their initial period of intensive treatment in the HASU.
- 1.4 Medway is asking the JHOSC to consider the questions raised by Medway and to refer the concerns set out below and in the external expert opinion to the Joint Committee of CCGs. Medway also asks that the Joint HOSC requests that a decision-making business case is produced in relation to Option D.
- 1.5 Responses have yet to be received to a number of questions previously raised by Medway Council in a letter, dated 8 November 2018, from Medway Council's Leader, Cllr Alan Jarrett, to NHS England (Appendix 2). Ivor Duffy, Director of Assurance and Delivery at NHS England South had forwarded the letter and questions to Glenn Douglas, Accountable Officer for the CCGs in Kent and Medway, for a response to be provided.
- 1.6 Medway is concerned that the NHS is not planning to repeat the public consultation. It has previously been requested that the public consultation be repeated in view of the significant changes since the original consultation had been undertaken, particularly that the Princes Royal University Hospital (PRUH) had not been explicitly included in the options consulted upon. Medway also considers that the consultation findings were misrepresented at the Joint meeting of CCGs held on 13 September 2018 and is also concerned that for the question within the consultation that asked respondents to indicate their preferred option, mean figures had been calculated to indicate levels of public support for each option.<sup>1</sup>

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<sup>1</sup> Respondents had been asked to rank the five, three site options, in order of preference from 1 to 5 with their most favoured option as number 5.

## 2. External Expert Opinion

- 2.1 Medway has commissioned an external expert to undertake an external review of the preferred option, the full findings of which are set out in Appendix 1.
- 2.2 Medway does not consider that Option B represents the best option for the health service in Kent and Medway and its residents for the following reasons:

- 1) Option B may be unable to meet the expected increases in demand for stroke services in the future.

Work commissioned by the NHS and discussed in the Clinical Reference Group meeting on 11 December 2018 has identified that the preferred option would need to accommodate an additional four HASU beds by 2025 to keep the occupancy at 80%, eight additional HASU beds by 2030, and 15 additional HASU beds by 2040. In addition, up to 30 extra ASU beds will be required by 2040 unless the Acute Stroke Unit (ASU) length of stay can be reduced. The table below shows the occupancy rates for 36 HASU beds and 93 ASU beds (the planned model).

Year	HASU occupancy	ASU occupancy
Baseline	79.0%	90.0%
2020	83.5%	95.1%
2025	89.7%	102.1%
2030	97.9%	111.4%
2040	113.1%	128.8%

The DMBC aims to keep occupancy at 80% in the HASU and 90% in the ASU. ASU occupancy can be mitigated by reducing length of stay in the ASU, but to keep levels to 90% by 2025 the system would need to achieve an average length of stay of 11 days. For the HASUs, extra capacity will be needed after 2030.

Beyond 2040, it may prove impossible to mitigate the requirement for extra ASU beds through making further reductions to the length of stay. In this case, Option B will need to accommodate a further 2-3 extra beds (HASU/ASU) each year. Darent Valley Hospital (DVH) (part of Option B) is a Private Finance Initiative hospital and is unlikely to have the additional capacity to provide these additional beds, whereas Medway Maritime Hospital (Option D) would be able to provide the additional capacity. Medway Council therefore considers that Option D would provide a more sustainable solution in the long-term interest of the population of Kent and Medway. The JHOSC should explore this further with the NHS to assure itself of the sustainability of the proposed provision.

- 2) Option B carries the substantial risk that existing bed capacity will be taken up by the population of SE London.

There is a substantial risk that existing bed capacity will be taken up by the population of South East London, at the expense of residents in Kent and Medway. This issue will be compounded by the expected increase in the number of admissions over the next 20 years. Because DVH is located close to the county boundary, there is a concern that this service would be used by a significant number of residents from South East London when DVH becomes a HASU. This risk was recognised by the Stroke Programme Board and an agreement was reached with commissioners from South

East London in August 2018 that would ensure that that local ambulance services would continue to use London hospitals. Medway would like assurance of how binding this agreement is. However, this will not prevent residents in South East London from using the service themselves.

### 3) Option B unnecessarily and disproportionately effects areas of higher deprivation

As stated in the Integrated Impact Assessment for the proposed changes, “People from the most economically deprived areas of the UK are around twice as likely to have a stroke and are three times more likely to die from a stroke than those from the least deprived areas. This is due to the strong association between deprivation and stroke risk factors such as higher levels of obesity, physical inactivity, an unhealthy diet, smoking and poor blood pressure control.”

The draft DMBC recognises that people from the most deprived quintile will be disproportionately impacted by the proposed option in terms of travel and access, compared to the general population.

## 2.3 Other key issues identified by Medway’s expert are summarised as follows:

### **Changes to the Criteria and Evaluation Methodology**

Between the publication of the consultation feedback (in June) and the Evaluation Workshop (in September), a number of significant changes were made to the evaluation criteria and evaluation methodology which materially impacted upon the evaluation process. Changes should not be made to the criteria or evaluation process without good reason. This has been recognised by the JCCCG.

- **The criteria’s priority order was removed**

While the criteria used to shortlist options at the PCBC stage were not formally weighted, they did have an order of priority. This order of priority had been determined by clinicians, patients and patient representatives who took part in the development and testing of the criteria in July and August 2017. The order of prioritisation was removed from the criteria following the PCBC. No prioritisation or weighting was applied when selecting a preferred option for the DMBC and there were no reasonable grounds for removing this prioritisation.

- **Additional sub-criteria were included**

The JCCCG, Stroke Programme Board and Clinical Reference Group noted the feedback received through the consultation process which had been undertaken following the PCBC. Reflecting upon this feedback, it determined that no changes were required to the evaluation criteria. However, despite this, a number of changes were made to the sub-criteria. These changes had a material impact on how the criteria were evaluated and affected the selection of a preferred option for DMBC.

- **The scoring keys were changed**

Scoring keys for each sub-criterion were used to determine the scoring for each site. (E.g. ‘-’ is awarded if capital costs exceeding £45m.) The scoring keys were updated for several sub-criteria between the shortlisting (at the PCBC stage) and the selection of a preferred option (for the DMBC stage). These changes provided an unwarranted advantage to Options A, B and C and a disadvantage to Options D and E.

- **The methodology for combining individual site scores into a ‘whole option’ score was replaced**

When evaluating each sub-criterion, the scoring for individual sites must be combined to determine the ‘whole option’ score. The methodology used to do this at the PCBC stage was developed iteratively during workshops. The agreed methodology was then recorded alongside each sub-criterion for transparency. However, this evaluation methodology was not used for the selection of a preferred option at the DMBC stage. It had been replaced with a ‘standard methodology’ which failed to identify nuances between sub-criteria and placed undue importance on standardisation. The effect of replacing this evaluation methodology was substantial and created a significant inconsistency between the PCBC evaluation methodology and the DMBC evaluation methodology.

- **Process by which changes were agreed**

The process by which these changes were agreed was inadequate and papers were not served with sufficient time before meetings to allow due consideration of the proposed changes.

## 2.4 **Application of the revised criteria and evaluation methodology**

The way that the revised criteria and evaluation methodology were applied to the shortlisted options was incorrect. The impact of the PRUH was not handled correctly for Options C and D in relation to the ‘ability to deliver’ sub-criteria. The PRUH should not have been included as part of the evaluation of Option C and D.

**Jon Gilbert** - Enodatio Consulting Ltd

Jon is a procurement and contracts expert with over 15 years' experience. He has extensive experience running multi-million pound tenders for the public sector and has provided advice across a range of projects to local authorities, NHS trusts, Public Health England and the private sector. He is a non-practising solicitor.

## 3. **Concerns Previously Raised to NHS England and the South East Clinical Senate**

- 3.1 Medway has previously raised a number of concerns about the NHS preferred option in letters to the NHS (see Appendix 2) and the South East Clinical Senate (see Appendix 3). These concerns include that the decision fails to recognise that Medway is the largest and fastest growing urban area outside of London and that a larger proportion of stroke admissions in Medway are under the age of 75 than in Kent. The location of the HASUs outside of Medway will increase health inequalities. Nationally, there is clear evidence of inequalities in stroke incidence and outcomes, with higher rates in more deprived areas.
- 3.2 Secondly, Medway has raised concerns about capacity. It is understood that ambulance crews take patients to the nearest hospital, and it will not be possible to limit the number of patients that may come from outside of Kent and Medway to Darent Valley Hospital. Assurance is yet to be provided that there will be sufficient capacity for Kent and Medway patients in this scenario.
- 3.3 The independent review panel highlighted concerns about clinical leadership at two of the selected hospitals, and praised the clinical leadership at Medway hospital.

- 3.4 The changes appear to have been made to provide assistance to areas outside of Kent and Medway, in particular the Princess Royal University Hospital (PRUH), even though the NHS in Kent and Medway has said that the HASUs are being established to improve quality of care “*for local people.*”
- 3.5 The PRUH was included in some options but not others, after the public consultation, and then failed to deliver an implementation plan. This meant that any option that included the PRUH was penalised severely. As the PRUH had no intention of providing an implementation plan it should have been excluded from the evaluation of these options; the Kent and Medway patients that would have been affected by this could then have been reallocated to one of at least two other hospitals in Kent and Medway that are well within the desired travel-window.

#### **4. Recommendation**

- 4.1 Taking into account the concerns set out above and in the attached documents, Medway Council recommends that the Joint HOSC:
- i) Refers the very serious concerns raised about the methodology used for the process to reach a decision on the selection of the preferred option, together with the supporting statement from Medway and the opinion obtained from Jon Gilbert at Enodatia Consulting Ltd, to the Joint Committee of CCGs.
  - ii) Asks the JCCCGs to produce a decision-making business case for Option D, which would secure provision of HASUs at Medway Maritime, Tunbridge Wells and William Harvey Hospitals on the basis that Option D would provide a more sustainable solution in the long term interest of the population of Kent and Medway and that this would have emerged as the preferred option if changes to the selection criteria and methodology had not been made at the tail end of the review process.

#### **Appendices**

- Appendix 1: Review of the Kent and Medway Stroke Review Preferred Option and Selection Process
- Appendix 2: Letter from the Leader of Medway Council to NHS England and the reply
- Appendix 3: Letter from the Leader of Medway Council to the South East Clinical Senate and the reply
- Appendix 4: Freedom of Information request to NHS after September 2018 meeting at which Option B was selected and responses from the NHS. (Excluding pack of papers and scores/summary scores referenced in questions 1 and 2 of FOI request)

PLEASE NOTE THAT APPENDICES 2-4 ARE ALREADY ATTACHED AS APPENDICES 1-3 TO THE MAIN CABINET REPORT SO ARE NOT REPRODUCED HERE.

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**REVIEW OF  
THE KENT AND MEDWAY STROKE REVIEW PREFERRED OPTION  
AND SELECTION PROCESS**

**Date:** 12 December 2018

**Version:** 1.2

## **1 EXECUTIVE SUMMARY**

- 1.1 Joint Committee of CCGs for Kent and Medway (“JCCCG”) has undertaken a review of stroke services. This review considered a number of options as the preferred locations for hyper-acute stroke units (“HASU”) in Kent and Medway.
- 1.2 Following an evaluation process, JCCCG selected ‘Option B’ as its preferred option, with locations at Darent Valley Hospital, Maidstone General Hospital and William Harvey Hospital.
- 1.3 Medway Council has significant concerns regarding the selection of Option B. It does not consider that Option B represents the best option for the residents of Kent and Medway. This is because:
  - 1.3.1 it does not provide sufficient bed capacity in the long term to meet the growing demand for stroke services;
  - 1.3.2 there is a substantial risk that existing bed capacity will be taken up by the population of South East London, at the expense of residents in Kent and Medway; and
  - 1.3.3 it does not sufficiently address the disproportionate adverse effects on residents from areas of higher deprivation, who have greater need for stroke services.
- 1.4 Medway Council considers that ‘Option D’ (Medway Maritime Hospital, Tunbridge Wells Hospital and William Harvey Hospital) addresses these concerns and represents the best option for the residents of Kent and Medway.
- 1.5 In addition, Medway Council considers that there were a number of procedural flaws in the process used to select the preferred option, which erroneously led to Option B being selected. If these procedural flaws were to be remedied and the options re-evaluated, Medway Council considers that Option D would be correctly selected as the best option for the residents of Kent and Medway.

## **2 BACKGROUND AND SUMMARY**

- 2.1 In late 2014, Kent and Medway commenced a Stroke Review process. The Case for Change was published in Autumn 2015 and a number of options were put forward as the future potential locations of HASUs for the Kent and Medway population. An extensive process of engagement was undertaken with stakeholders to develop and test the criteria (and sub-criteria) which would be used to shortlist those options. These criteria were not formally weighted but were placed in the order of priority as indicated by feedback from patients and the public. The criteria (and sub-criteria) are set out below:

Criteria	Sub-criteria
1 Quality of care for all	<ul style="list-style-type: none"> <li>Stroke co-adjacencies</li> <li>Co-adjacencies for mechanical thrombectomy</li> <li>Requirements for MEC</li> </ul>
2 Access to care for all	<ul style="list-style-type: none"> <li>Blue light proxy</li> <li>Private car, peak</li> </ul>
3 Workforce	<ul style="list-style-type: none"> <li>Gap in workforce requirements</li> <li>Vacancies</li> <li>Turnover</li> </ul>
4 Ability to deliver	<ul style="list-style-type: none"> <li>Time to deliver</li> <li>Trust willingness to deliver</li> </ul>
5 Affordability and vfm	<ul style="list-style-type: none"> <li>Net present value, 10 years</li> </ul>

- 2.2 In September 2017, an Optional Approval Process was undertaken which shortlisted five out of 13 options. These shortlisted options were:
- 2.2.1 Option A: DVH, MMH, WHH
- 2.2.2 Option B: DVH, MGH, WHH
- 2.2.3 Option C: MGH, MMH, WHH
- 2.2.4 Option D: TWH, MMH, WHH
- 2.2.5 Option E: DVH, TWH, WHH
- 2.3 In January 2018, the Pre-Consultation Business Case (“PCBC”) was published, setting out those options and the basis on which those options had been shortlisted. Between February and April 2018 an extensive consultation process was undertaken to inform the selection of the preferred option and the development of the Decision Making Business Case (“DMBC”). As part of this, residents were invited to say how important various factors were to the decision-making process and to highlight key areas of concern.
- 2.4 On 30 May 2018, a meeting of the Stroke Programme Board (“SPB”) was advised that the evaluation process for the DMBC would “be the same as for the PCBC to maintain consistency but criteria may be weighted depending on feedback from the consultation”.
- 2.5 In June 2018, feedback from the consultation process was published. From the responses received, it was clear that respondents felt that the two most important questions to ask when deciding between the options was (i) whether it would ‘improve the quality of care’ and (ii) whether it would ‘improve access’ to services. It also highlighted concerns regarding travel times to access the HASUs and the disproportionate effect this may have on deprived areas.
- 2.6 The Joint Committee of CCGs (“JCCCG”) held an evaluation workshop on 13 September 2018 to reach a consensus on the preferred shortlisted option for the HASUs (“Evaluation Workshop”). The workshop considered the inputs from the Clinical Reference Group (“CRG”) and the Finance and Modelling Group (“FAM”) which had evaluated the five shortlisted options using a set of criteria and evaluation methodology. On this basis, the JCCCG selected Option B as the preferred option.
- 2.7 The Clinical Senate conducted a clinical review of the preferred option in November 2018 and made a number of observations and recommendations.
- 2.8 On 4 December 2018, the draft DMBC was published, which confirmed Option B as the preferred option and the basis for its selection.



- 2.9 Medway Council has significant concerns regarding Option B. It does not consider that Option B represents the best option for the residents of Kent and Medway. These concerns are set out in detail below.

### 3 UNABLE TO MEET FUTURE DEMAND

- 3.1 It is vital that the selected option can meet the current and future demands for stroke services in Kent and Medway.
- 3.2 To try to ensure that this is achieved, a detailed modelling exercise was undertaken at the PCBC stage. The CRG reviewed the bed occupancy rates on 4 December 2017. They agreed that the selected option would be based on an occupancy rate of 80% for HASU and 90% for an acute stroke unit (“ASU”). It was decided that a lower rate was required for HASU occupancy due to the small bed numbers and the fluctuation in numbers of people presenting.
- 3.3 Medway Council Public Health had also undertaken a review in 2015 into the number of admissions for first stroke. This work concluded that, based on previous activity, the number of first stroke admissions was unlikely to significantly increase in the next ten years (based on CCG data, not taking into account inflows). Having considered this review, the Stroke Programme Board proposed that no growth assumptions would be applied to the stroke activity baseline.
- 3.4 In November 2018, the Clinical Senate questioned the validity of the assumption made by the Stroke Programme Board.
- 3.4.1 Firstly, it considered that the apparent absence of an increasing incidence rate may be misleading. The apparent reduction in stroke incidents could have been caused by a better understanding and diagnosis of stroke, resulting in a reduction in the number of hospital events being classified as stroke.
- 3.4.2 Secondly, it considered recent publications by Kings College London which forecast that, between 2015 and 2035, there would be a rise in the total number of stroke events (i) across Europe of 34%, and (ii) across the UK of 44%. The Clinical Senate suggested that the increasing proportion of elderly people in Kent and Medway, together with the increase in the overall population, is “likely to result in an actual rise in the total number of stroke cases per year, even if the age-related stroke incidence remains the same”.
- 3.4.3 The Clinical Senate recommended remodelling the activity levels and also recommended a re-examination of data for under 75s in relation to health inequalities and areas of deprivation.
- 3.5 The NHS commissioned a review of these matters and this was then discussed in the Clinical Reference Group meeting on 11 December 2018. The review noted a number of points:
- 3.5.1 It noted that the original review in 2015 had provided a forecast of *first-ever* stroke incidence rather than total admissions. This helps to explain why the use of a zero growth rate assumption for the *total* future stroke activity was inappropriate.
- 3.5.2 It conducted a fresh review to ascertain how the total number of stroke admissions was expected to change up to 2040. It used ONS data projections for the growth in the population aged 65+ and the crude rate incidence of stroke admissions. Based upon this, it predicted that there would be an increase of 43.1% in stroke admissions across Kent and Medway between 2016/17 and 2040/41.

3.5.3 This would result in an increase in stroke admissions from 3,054 (at the baseline) to 4,371 (by 2040).

3.5.4 It considered how this would impact upon the occupancy in the HASU and ASU wards. In order to maintain 80% occupancy on HASU wards and 90% occupancy on ASU wards, an increase in the number of beds would be required:

Year	Strokes	TIAs	Mimics	HASU beds	ASU beds	Total beds
Baseline	3,054	305	764	36	93	129
2020	3,228	323	807	38	98	136
2025	3,465	346	866	40	105	146
2030	3,782	378	946	44	115	159
2040	4,371	437	1,093	51	133	184

3.5.5 It considered the effect on occupancy if the number of beds was not increased beyond what is currently proposed (36 HASU and 93 ASU). It determined that occupancy levels on HASU wards is forecast to be 90% by 2025 and will approach 100% by 2030. Occupancy on ASU wards would rise above 100% as early as 2025.

Year	HASU occupancy	ASU occupancy
Baseline	79.0%	90.0%
2020	83.5%	95.1%
2025	89.7%	102.1%
2030	97.9%	111.4%
2040	113.1%	128.8%

3.5.6 It noted that the effects on ASU occupancy could be mitigated through a reduction in the length of stay (from 15 days to 11 days by 2040). No mitigate was proposed for HASU occupancy (where the length of stay is much shorter: 2-3 days).

Year	HASU occupancy	ASU occupancy	ASU LOS
Baseline	79.0%	90.0%	15
2020	83.5%	95.1%	15
2021	84.6%	96.3%	15
2022	85.8%	91.1%	14
2023	87.0%	92.4%	14
2024	88.3%	87.1%	13
2025	89.7%	88.5%	13
2030	97.9%	89.1%	12
2040	113.1%	94.4%	11

- 3.5.7 It concluded that more beds would be required to maintain the desired occupancy levels on HASU and ASU wards.
- 3.6 In light of this work, it is clear that the preferred option would need to accommodate an additional four HASU beds by 2025 to keep the occupancy at 80%, eight additional HASU beds by 2030, and 15 additional HASU beds by 2040. In addition, up to 30 extra ASU beds will be required by 2040 unless the ASU length of stay can be reduced. Beyond 2040, it may prove impossible to mitigate the requirement for extra ASU beds through making further reductions to the length of stay. In this case, Option B will need to accommodate a further 2-3 extra beds (HASU/ASU) each year.
- 3.7 DVH (part of Option B) is a PFI hospital and is unlikely to have the additional capacity to provide these additional beds, whereas MMH (Option D) would be able to provide the additional capacity.
- 3.8 Medway Council therefore considers that Option D would provide a more sustainable solution in the long term interest of the population of Kent and Medway.

#### **4 INSUFFICIENT BED CAPACITY DUE TO SOUTH EAST LONDON PRESSURES**

- 4.1 There is a substantial risk that existing bed capacity will be taken up by the population of South East London, at the expense of residents in Kent and Medway. This issue will be compounded by the expected increase in the number of admissions over the next 20 years.
- 4.2 Because DVH is located close to the county boundary, there is a concern that this service would be used by a significant number of residents from South East London when DVH becomes a HASU.
- 4.3 This risk was recognised by the Stroke Programme Board and an agreement was reached with commissioners from South East London in August 2018 that would ensure that that local ambulance services would continue to use London hospitals. However, this will not prevent residents in South East London from using the service themselves. It was noted by the Stroke Programme Board on 29 August 2018 that, despite the agreed operational guidance, there is the possibility for a fundamental shift to happen over time which could place substantial extra burden on DVH. The full extent of this risk has not been modelled. However, even assuming that the local ambulance service continues to use London hospitals, the draft DMBC (p138) estimated that DVH will see around 200 strokes each year which are currently seen at the PRUH. This alone equates to 8 beds out of the 34 HASU/ASU beds available at DVH (23.5%).
- 4.4 As MMH is not located as close to a county boundary, this risk would not apply if Option D were selected. Instead, the Kent and Medway resources would be available for Kent and Medway residents.

#### **5 DISPROPORTIONATELY AFFECTING AREAS OF HIGHER DEPRIVATION**

- 5.1 As stated in the Integrated Impact Assessment for the proposed changes, "People from the most economically deprived areas of the UK are around twice as likely to have a stroke and are three times more likely to die from a stroke than those from the least deprived areas. This is due to the strong association between deprivation and stroke risk factors such as higher levels of obesity, physical inactivity, an unhealthy diet, smoking and poor blood pressure control."
- 5.2 Medway Council is concerned that the phased approach being proposed to achieve the delivery of HASUs for Option B could have the detrimental effect on patients in East Kent as

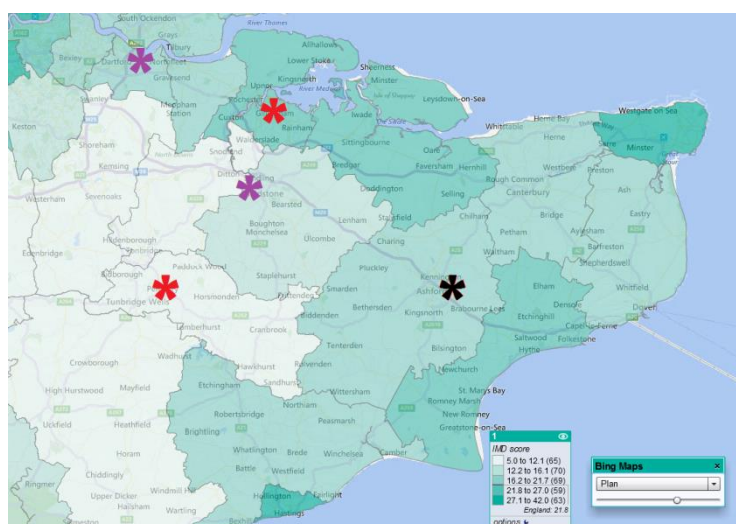
the HASU at the WHH would not open until 2021 while the HASUs at DVH and MGH would open in 2019/20.

- 5.3 Moreover, the draft DMBC recognises that people from the most deprived quintile will be disproportionately impacted by the proposed option in terms of travel and access, compared to the general population. This is shown below:

	Preferred Option - Within 30 minutes %	Percentage point change from baseline	Preferred Option- Within 45 minutes %	Percentage point change from baseline
Population overall	69.6%	-19.9%	92.4%	-7.4%
Females aged 16-44	71.5%	-17.9%	93.2%	-6.7%
Population with LLTI	66.2%	-22.2%	89.9%	-9.8%
Most deprived quintile	61.8%	-22.9%	81.3%	-18.7%
Population aged 65 and over	65.1%	-22.8%	90.5%	-9.1%
Males	69.7%	-19.7%	92.5%	-7.3%
BAME population	78.0%	-13.4%	94.5%	-5.4%

Source: Basemap travel time data, UK Census 2011/ MYE 2016/IMD 2015

- 5.4 This situation is compounded by evidence (noted by the Clinical Senate’s review in November 2018) that patients from lower socioeconomic groups have strokes around seven years earlier than the highest, so the incidence of stroke is likely to be higher in deprived areas within the under 75 age group.
- 5.5 The Integrated Impact Assessment which was undertaken in relation to the preferred option, did not produce comparative data in relation to the other four shortlisted options. However, Medway Council considers that Option D would represent a better option because the location of its sites would mitigate those effects.
- 5.6 The map below shows the Index of Multiple Deprivation (2015) and shows how the Option D sites (shown in red & black) compare to the Option B sites (shown in purple and black):



- 5.7 As Medway Maritime Hospital is clearly located within an area of higher deprivation, it is apparent that Option D would reduce the disproportionate effect on travel times for people within areas of higher deprivation, when compared against Option B.

## 6 PROCEDURAL FLAWS

- 6.1 Medway Council considers that there were a number of procedural flaws in the process used to select the preferred option. These procedural flaws erroneously led to Option B being selected as the preferred option.

- 6.2 These procedural flaws are set out below:
- 6.2.1 unwarranted changes were made to the criteria and evaluation methodology;
  - 6.2.2 the process for agreeing those changes was inadequate; and
  - 6.2.3 the revised criteria were not applied correctly.
- 6.3 If these procedural flaws were to be remedied and the options re-evaluated, Medway Council considers that Option D would be correctly selected as the best option for the residents of Kent and Medway.

## **7 PROCEDURAL FLAWS: CHANGES TO THE CRITERIA AND EVALUATION METHODOLOGY**

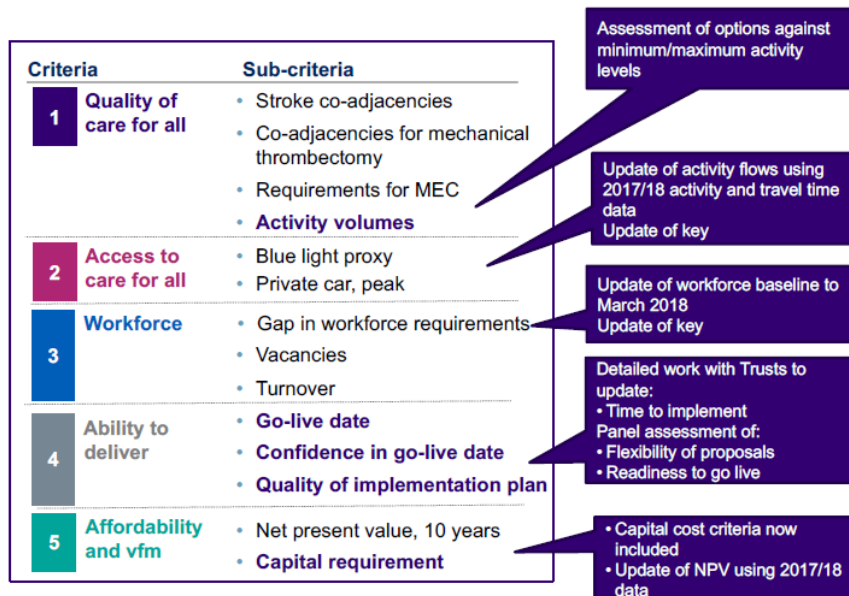
- 7.1 Between the publication of the consultation feedback (in June) and the Evaluation Workshop (in September), a number of significant changes were made to the evaluation criteria and evaluation methodology which materially impacted upon the evaluation process.
- 7.2 Changes should not be made to the criteria or evaluation process without good reason. This was recognised by the JCCCG, which set out the following five overarching principles for evaluation:
- 7.2.1 The aim of the options evaluation is to differentiate between the options in order to determine a preferred option
  - 7.2.2 The evaluation criteria used within the PCBC will be applied to maintain consistency
  - 7.2.3 Additional evaluation criteria will only be added if it should emerge from the consultation
  - 7.2.4 The evaluation criteria will be weighted to differentiate between options
  - 7.2.5 The evaluation will reflect the current status of services delivered and not future aspirations
- 7.3 The more extensive the changes made to the criteria and/or evaluation methodology, the greater the risk that the evaluation process is compromised. This is because:
- 7.3.1 it undermines the extensive consultation process undertaken before the PCBC (which helped to formulate the criteria);
  - 7.3.2 it undermines the basis by which the 5 options were shortlisted;
  - 7.3.3 it calls into question whether other options from the medium-list (of the 13 options) should not have been excluded or should be reintroduced;
  - 7.3.4 it undermines the consultation process conducted following the PCBC (save where changes are made in light of feedback received from that consultation process).
- 7.4 Significant changes were made to the criteria and evaluation methodology:
- 7.4.1 the criteria's priority order was removed;
  - 7.4.2 additional sub-criteria were included;
  - 7.4.3 scoring keys (used to determine the scoring of various sub-criteria) were changed; and
  - 7.4.4 the methodology for combining individual site scores into a 'whole option' score was replaced.

## **7.5 The criteria's priority order was removed**

- 7.5.1 While the criteria used to shortlist options at the PCBC stage were not formally weighted, it appears that they did have an order of priority (shown in paragraph 2.1). This order of priority had been determined by clinicians, patients and patient representatives who took part in the development and testing of the criteria in July and August 2017.
- 7.5.2 The PCBC indicates that due regard was given to this order during the evaluation meetings: "These [evaluation] meetings considered feedback from extensive patient and public engagement on the evaluation options which consistently put quality, access and workforce as the highest priority areas for consideration."
- 7.5.3 However, the order of prioritisation was removed from the criteria following the PCBC. No prioritisation or weighting was applied when selecting a preferred option for the DMBC.
- 7.5.4 There were no reasonable grounds for removing this prioritisation. It is clear from the consultation process undertaken after the PCBC that patients and the public still prioritised 'quality' and 'access' as the two most important factors (followed by 'workforce').
- 7.5.5 The decision to remove the prioritisation also appears to contradict the fourth overarching principle agreed by the JCCCG (see paragraph 7.2.4) which required that the evaluation criteria would be weighted to differentiate between options.
- 7.5.6 The removal of prioritisation was material to the evaluation process. Option D (which had the highest 'quality' score at the PCBC stage) stood to be the most disadvantaged by the removal of prioritisation. Options B and C scored lowest in relation to the 'quality' criterion and gained the most from the removal of the prioritisation. In addition, the removal of the prioritisation had the effect of increasing the relative weighting of the 'ability to delivery' and 'affordability and vfm' criteria which significantly improved the overall evaluation of Options B and A, while negatively impacting Options C and D.

## **7.6 Additional sub-criteria were included**

- 7.6.1 The JCCCG, SPB and CRG noted the feedback received through the consultation process which had been undertaken following the PCBC. Reflecting upon this feedback, it determined that no changes were required to the evaluation criteria. However, despite this, a number of changes were made to the sub-criteria. These changes had a material impact on how the criteria were evaluated and affected the selection of a preferred option for DMBC.
- 7.6.2 The sub-criteria were updated as shown below:



7.6.3 The ‘activity volumes’ sub-criterion (under ‘quality’) should not have been introduced as it did not support evaluators in differentiating between options: all five options were awarded ‘++’. In addition, this had the effect of diluting the relative importance of the other three ‘quality’ sub-criteria. This negatively impacted Option D (which had scored highest across those three sub-criteria at the PCBC stage) and positively impacted Options B and C (which had scored joint-lowest across those three sub-criteria).

7.6.4 The changes to the sub-criteria for ‘ability to deliver’, materially changed the basis on which this criterion was assessed. In particular, Options C and D were evaluated not only on the basis of the three Kent and Medway sites. They were also assessed on the PRUH’s ‘ability to delivery’.

At the PCBC stage, the PRUH’s ‘ability to deliver’ had been considered for just one sub-criterion. At the selection for the DMBC stage, the PRUH’s ability to deliver was included in all three sub-criteria. This significantly negatively impacted on the scoring of Options C and D.

Moreover, it is understood that Options C and D were not dependent on the PRUH’s ability to deliver. While the existence of a HASU at the PRUH would have lightened the burden on the Kent and Medway sites, the coverage of those sites would have extended to the borders of Kent and Medway even without the PRUH. On this basis (and in light of the fact that the PRUH had indicated that it did not intend to establish additional capacity), the evaluation of Options C and D should not have included an assessment of the PRUH’s ability to deliver. (Further analysis is required in relation to the updating of the catchment areas.)

7.6.5 The ‘capital requirements’ sub-criteria should not have been included under ‘affordability and vfm’. This is because it had been considered and rejected in September 2017 when the criteria were been developed for the PCBC. (This was because ‘capital investment requirements’ is already considered as part the calculation of the ‘net present value’ sub-criterion and would therefore be duplicative.)

However, it is understood that the rationale for its inclusion was not to provide an assessment of the affordability of each Option. Instead, it was reintroduced because, following the Investment Committee in December 2017, it was understood that there would be an impact on timescales if capital investment was greater than £38m. On this basis, if this sub-criterion were to be introduced, it should therefore have been assessed under 'ability to deliver' and considered alongside each Option's proposed go-live date. Where capital investment exceeded £38m then the confidence in the go-live date should have been downgraded – but only where this funding delay would have impacted on the mobilisation dates.

## **7.7 The scoring keys were changed**

- 7.7.1 Scoring keys for each sub-criterion were used to determine the scoring for each site. (E.g. '- -' is awarded if capital costs exceeding £45m.)
- 7.7.2 The scoring keys were updated for several sub-criteria between the shortlisting (at the PCBC stage) and the selection of a preferred option (for the DMBC stage).
- 7.7.3 These changes increased the differentiation of options under the 'affordability and vfm' criterion by accentuating any differences between the scores awarded for each option (i.e. it 'stretched the field'). However, no changes were made to increase the differentiation of options for 'quality'. The net effect of this was to increase the relative importance of 'affordability and vfm' sub-criteria when compared against 'quality' sub-criteria, despite feedback from the consultation process indicating that 'quality' was a far more important criterion for differentiating options. This provided an unwarranted advantage to Options A, B and C and a disadvantage to Options D and E.

## **7.8 The methodology for combining individual site scores into a 'whole option' score was replaced**

- 7.8.1 When evaluating each sub-criterion, the scoring for individual sites must be combined to determine the 'whole option' score. The methodology used to do this at the PCBC stage was developed iteratively during workshops. The agreed methodology was then recorded alongside each sub-criterion for transparency. However, this evaluation methodology was not used for the selection of a preferred option at the DMBC stage. It had been replaced with a 'standard methodology' which applied across all sub-criteria.
- 7.8.2 The reason given for changing the evaluation methodology to the 'standard approach' was that the previous methodology had 'caused some confusion'. In addition, it was felt that the 'standard approach' would allow greater differentiation of options by highlighting those options with sites that had scored a '- -'.
- 7.8.3 Overall, the effect of replacing this evaluation methodology was significant. Taking this change in isolation across the nine sub-criteria used at both the PCBC and DMBC selection stages, it reduces the score of Option A by 1, Option B by 2, Option C by 2 and Option D by 4. Further detailed analysis is required to fully quantify the effect on the scoring in light of the other changes to the criteria and evaluation methodology set out above. However, it is worth noting that two of the reduced scores for Option D were against a 'quality' criterion (which had the highest priority at the PCBC stage).



- 7.8.4 The adoption of the ‘standard approach’ placed undue importance on standardising the methodology across all sub-criteria. The ‘standard approach’ fails to identify nuances between sub-criteria and then fails to handle those differences appropriately through its ‘one-size-fits-all’ calculation. (For example, for one sub-criterion it may be more appropriate for one site’s score to be compensated by the scores of the other sites; whereas this may be less appropriate for other sub-criteria.) These nuances had been identified and handled on a point-by-point basis by the evaluation methodology which had been iteratively developed for the PCBC evaluation. The adoption of the ‘standard approach’ was driven by a desire for consistency but it created a far more significant inconsistency between the PCBC evaluation methodology and the DMBC evaluation methodology.
- 7.8.5 In addition, while the ‘standard approach’ had sought to allow greater differentiation between options, in some cases it achieved the exact opposite. In particular, it levelled the scoring across two of the sub-criteria used to assess ‘quality’ (which respondents to the consultation had identified as the most important criterion for differentiating options). The previous approach allowed evaluators to develop a tailored methodology for each sub-criterion which could draw out differences between the options more effectively.

## **8 PROCEDURAL FLAWS: PROCESS BY WHICH CHANGES WERE AGREED**

- 8.1 The process by which these changes were agreed was inadequate and papers were not served with sufficient time before meetings to allow due consideration of the proposed changes.
- 8.2 One important example is the CRG meeting on 7 September 2018 which reviewed the ‘quality’, ‘access’ and ‘workforce’ evaluation inputs. This evaluation was key to the decision making process as it formed the basis of the JCCCG’s Evaluation Workshop for those three criteria. Papers for this meeting were only circulated to members of the CRG on 6 September 2018 (the day before the meeting). The meeting itself was only scheduled for 2 hours, which also required time for a discussion and confirmation of the recommended model of care for rehabilitation. (We understand that the time allocated for the meeting was insufficient and it overran by 30 minutes.)
- 8.3 At this meeting, CRG members were presented with the ‘standard approach’ methodology (as described in paragraph 7.8 above) and invited to agree this methodology. It is understood that copies of the scoring matrix (setting out the 70 different combinations of individual site scores and how they correlate to the ‘whole option’ scores) were only handed out for the first time during that meeting and collected back in at the end of the meeting.
- 8.4 It appears from the minutes that the relative merits and drawbacks of changing the evaluation methodology were not discussed or considered in that meeting. Instead, the importance of ‘consistency’ in evaluating sub-criteria appears to have been presented as the overriding principle. No questions appear to have been raised by any member of the CRG about the effects of the new methodology before it was accepted by the group, implying that the full ramifications had not been appreciated. This calls into question the CRG’s conclusion that the ‘standard approach’ was “sound and appropriate for the process”
- 8.5 Given the importance of the proposed changes to the evaluation methodology, greater time and consideration should have been given to the proposed changes to the evaluation methodology.

## 9 PROCEDURAL FLAWS: APPLICATION OF THE REVISED CRITERIA

- 9.1 The way that the revised criteria were applied to the shortlisted options was incorrect.
- 9.2 As stated above (see paragraph 7.6.4), the impact of the PRUH was not handled correctly for Options C and D in relation to the 'ability to deliver' sub-criteria. The PRUH should not have been included as part of the evaluation of Option C and D. While the expansion of the HASU at the PRUH could have lightened the burden on the Kent and Medway sites, the coverage of those sites would have extended to the borders of Kent and Medway even without the PRUH. On this basis (and in light of the fact that the PRUH had indicated that it did not intend to establish a HASU), the evaluation of Options C and D should not have included an assessment of the PRUH's ability to deliver.

## 10 CONCLUSIONS

- 10.1 Medway Council has significant concerns regarding the selection of Option B. It does not consider that Option B represents the best option for the residents of Kent and Medway.
- 10.2 In addition, Medway Council considers that there were a number of procedural flaws in the process used to select the preferred option, which erroneously led to Option B being selected.
- 10.3 If these procedural flaws were to be remedied and the options re-evaluated, Medway Council considers that Option D would be correctly selected as the best option for the residents of Kent and Medway.

## 11 SITE ABBREVIATIONS

DVH	Darent Valley Hospital
MGH	Maidstone General Hospital
MMH	Medway Maritime Hospital
PRUH	Princess Royal University Hospital
TWH	Tunbridge Wells Hospital
WHH	William Harvey Hospital

Review of the selection process conducted by: Enodatio Consulting Ltd