Transforming health and social care in Kent and Medway

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APPENDIX J

Alan Jarrett
Medway Council
Gun Wharf
Dock Road
Chatham
ME2 4AU

4th January 2019

Dear Councillor Jarrett,

Re: Stroke Decision Making Business Case

Further to your letter to Ivor Duffy dated 8th November 2018 and his response dated 21st November 2018 I am following up on the issues you raised which Ivor directed to Glenn Douglas.

I think it's important to start by reiterating that all five of the options publically consulted on were believed to be viable and the Decision Making Business Case is designed to further test and develop one of those options recommended after a rigorous process of selection.

Your first concern is one of flow of patients from London and the ability for Kent and Medway units to cope with this in terms of clinical capacity. You will be aware that we have undertaken extensive travel time modelling and this was presented to the JHOSC in detail on 5th September 2018. This has also been repeated several times to make sure we are using the most up to date data at every point.

London has already reconfigured its stroke services into Hyper Acute and Acute Stroke units (HASU and ASU's) and therefore patients in the catchment area already have access to these units. In order to make sure we understood how having HASU/ASU's in Kent and Medway could impact London catchment patients on the borders with Kent we met with the South East Coast Ambulance service (SECAmb), the London Ambulance Service (LAS), South East London Commissioners, the South East London STP and executives from Darent Valley Hospital.

In summary commissioners from Greenwich, Lewisham and Bromley as well as LAS confirmed that all patients from those areas would continue to flow, as they do now, to the London hospitals that provide hyper acute stroke services. Bexley commissioners reconfirmed their expectation that those patients currently accessing stroke services in Kent would continue to do so. In light of this Bexley were included in the public consultation.
In addition any programme of this scale should consider increased flows beyond those predicted and I can confirm this has been done for stroke and it has been taken account of in the modelling for all of the sites, helpfully supported by Medway Public Health Intelligence Unit.

Thank you for your comments on the Deliverability Panel review process. There were a wide range of expert individuals on the panel and each of them evaluated independently. Those individual evaluations and comments were then bought together for review as a single panel for a consensus view. The evaluation included in final matrix was that which represented the view of the panel for each option and was their final and agreed output. The comments made by any member of the panel were all taken into account in arriving at their final evaluation.

The PRUH did not refuse to submit an implementation plan and the plan they did submit was reviewed and members of their senior leadership team were questioned by the Deliverability Panel.

The stroke programme is, and always has been, focussed on best serving the whole population of Kent and Medway. In different configurations varying numbers of K&M patients flow into or out of border hospitals, one of which is the PRUH. This was visible in the Pre Consultation Business Case and public consultation. We were asked to further consider the flows in and out of border hospitals and their ability to deliver by NHSE, as part of the Pre Consultation Business Case assurance review. When this was done it was clear that there was significant impact on the PRUH in all five options. In options A, B and E the flows would be reduced significantly and in options C and D they would be increased significantly.

In order to discharge our responsibility to the entire population it was vital that we further confirmed the ability of border hospitals to provide stroke services to K&M patients under the different options and/or to make sure current stroke services would not be destabilised. This was in no way to 'help out' a provider either within or on the borders of K&M, rather to ensure an improved service to all of our patients.

One of the core principles throughout this entire process has been that K&M patients will access their nearest HASU. This has been consistently and unanimously supported throughout. For some of our patients in some of the options that HASU would be the PRUH. During the second meeting with Medway Council this issue of redirecting patients away from the PRUH was raised by your council and I agreed to review this. I am pleased to confirm that has now been done. SECAmb have confirmed that, in situations where 2 services in different locations are very similar in terms of travel time (i.e. within 5 mins of each other), it would be reasonable for commissioners to indicate a preference. However, this is not reasonable in situations where 2 services are more than 5 minutes apart and, and specifically for emergency care, the patient would always be transferred to the closest available service.

I understand that the criteria were listed in the consultation document but it was clear that this was not any reflection of a priority order. For clarity, all criteria were equally weighted, i.e. all were as important as each other.

You quite rightly state that the Clinical Reference Group signed off the approach for the evaluation of the recommended preferred option. They did this in a dedicated meeting taking 2 hours to review the information and support the approach on the 7th September. The evaluation work shop took place the following week on the 13th

September so I am unsure why you would think it was the day after. It is also important to confirm that the first part of the evaluation work shop was solely dedicated to reviewing the evaluation methodology ahead of reviewing the full matrix in the second part of the meeting. All attendees supported the approach.

I would like to take this opportunity to assure you that we have, and continue to take, your concerns very seriously and I would be very happy to come and meet with you again if that would be helpful.

Yours sincerely

Rachel Jones
Director of Acute Strategy and Partnerships
K&M STP

Glenn Douglas
Reh Chishti MP
Kelly Tolhurst MP
Gordon Henderson MP
Ivor Duffy NHSE

Your ref:
Our ref: AJ/2019-1/Jones
Date: 24 January 2019

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Dear Ms Jones,

Thank you for your reply to my letter of 8 November 2018. I regret that I must say that I do not feel that you have addressed my questions adequately and in some cases your responses are not correct.

Regarding capacity your response is that patients from Greenwich, Lewisham and Bromley will continue to flow to London hospitals. Patients from areas in Bexley that currently flow to Kent will continue to do so. But you have not said how this will be ensured, for example you have provided no evidence of a protocol agreed with London Ambulance Service (LAS) to ensure that only patients from areas that currently use Kent hospitals will do so. You have also not said which specific areas (LSOAs) will be included. This latter point being extremely important in relation to modelling capacity and demand requirements for Kent Hyper Acute Stroke Units.

You state that increased patient flows beyond those predicted have been taken into account, supported by work performed by the Medway Public Health Intelligence team. We have not seen evidence of increased flows being taken into account. The work by the Public Health Intelligence team showed that the zero rate of growth in numbers assumed in the decision-making business case was not appropriate and that the number of strokes is expected to increase due to increasing numbers of older people. This work did not allow for any additional increase resulting from increased flows from Bexley or other areas outside of Kent. We have therefore still not been reassured that flows from South-East London will be managed to ensure that there is sufficient capacity at Darent Valley Hospital for patients from Kent and Medway.

Regarding the PRUH's implementation plan you said the "PRUH did not refuse to submit an implementation plan", however, they did not submit an implementation plan, they submitted a letter listing arguments against Options C and D. They ended their letter with "...we have not allocated resource to managing the implementation of stroke expansion. At present we have not identified the key activities that would be required to mobilise and **do not have a detailed implementation plan** and risk register for the project." This information is set out in correspondence provided to this Council by the Kent and Medway Stroke review team following our freedom of information request.

Regarding inclusion of the PRUH in Options C and D. You said that the PRUH was "visible" but it was not explicitly included in any of the options during the consultation and it was not clear in the consultation that any of the options depended on the PRUH. You also state that ambulance services will always take patients to the nearest location, but a key argument of the consultation was that, below one hour, travel-time is not important., It is the speed and quality of the processes within the HASU that are important. You have used this argument to justify patients from more deprived areas of Kent, e.g. Thanet, travelling up to an hour to their proposed HASU. We are quite concerned with this particular statement. You are we believe, well acquainted with the work of professor Michael Marmot. His review into health inequalities in England has informed government and NHS strategy. One specific principle of the Marmot review (accepted by the NHS) is the concept of proportionate universalism. Simply put, this means providing more support and input into disadvantaged groups/localities, than is provided to affluent populations/localities.

Using Marmot's principles, HASUs should be established in hospitals serving the most disadvantaged areas of Kent and Medway. This is because as you accept, these areas have populations with the highest risk factors for stroke. If the aspirations to reduce variation and health inequalities set out in the recently published NHS 10 year plan are to be achieved, how can it be acceptable for patients from the most deprived areas in Kent and Medway to have to travel for longer than patients from more wealthy areas closer to the north Kent border. The travel times from this area to two of the hospitals in option D will in fact be considerably less than one hour. This is why option D offers a better solution to address clinical variation and reduce health inequalities in Kent and Medway.

You state that the criteria were "not any reflection of a priority order" but this is not correct. It was stated explicitly in the consultation document that they were prioritised. Page 38, second paragraph states: "The final list of evaluation criteria we used is shown below **in the order of the importance** identified by stakeholders". Therefore our arguments that the most important criteria were neutralised still stands.

You have not answered several of my numbered questions. I have indicated in bold italics my assessment of your response:

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? ***Did not answer.***

2. Why was the Clinical Reference Group given so little time and information to review the changed approach to scoring the criteria? ***Did not answer why. Just reiterated that CRG had a two-hour meeting.***

3. Can NHS England please clarify whether or not the PRUH was part of Option D? ***Did not answer explicitly, said the PRUH was "visible".***

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? ***See 3 above.***

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). ***Denied that it refused to submit an Implementation Plan, however this is incorrect (see above).***

6. Why were the capital costs for the PRUH included in Options C and D when there was no plan for implementation? ***See 5.***

7. Why were the comments from the independent panel about Tunbridge Wells needing to consider other implementation plans ignored? ***Described process but did not address the question specifically.***.

8. Why were the comments from the independent panel about the quality of clinical leadership not considered appropriately and ignored in the final evaluation? ***See 7.***

9. What "further instruction" did NHS England give to the Kent and Medway Stroke review team regarding the inclusion of the PRUH? ***Answered: "We were asked to further consider the flows in and out of border hospitals and their ability to deliver by NHSE"***

Yours Sincerely

Councillor Alan Jarrett
Leader
Medway Council

c.c. Glenn Douglas
Rehman Chishti, MP
Kelly Tolhurst, MP
Gordon Henderson, MP
Ivor Duffy, NHSE

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28th January 2019

Dear Councillor Jarrett,

Re: Stroke Decision Making Business Case

Further to your letter dated 24th January 2019, I am sorry that you do not feel my response of 4th January 2019 answered the questions you raised. I will take your points in turn.

I have confirmed to you that the Bexley commissioners do not wish to make any changes to the services they commission for their patients. This means that patients will continue to flow exactly as they do now and there is no need for a new protocol with London Ambulance Service (LAS) as nothing is changing from the current protocols that have been in place for many years. LAS have also confirmed they would not routinely transport patients to Kent and Medway hospitals for any service and, if the PRUH is at capacity they would divert to one of the other HASUs in the London territory as per the current process. The establishment of HASUs in Kent and Medway will not impact the current process.

I can confirm that the numbers of patients attending Darent Valley Hospital (DVH) from Bexley for stroke conditions has remained stable over the last few years. Details on all of modelling are included in the Decision Making Business Case (DMBC) and the relevant appendices. If you require any further information please do come back to me.

As you are aware, Medway Public Health Intelligence Unit undertook the initial demand modelling and then supported us in reviewing the assumptions made. The modelling that was undertaken reviewed stroke admissions - regardless of geography - related to a predicted growth of the ageing population. These assumptions are therefore applicable to the demand on HASU/ASUs in Kent and Medway based on current activity which includes the Bexley population. This work correlates with the much wider Burden In Europe study and I can confirm that Bexley does not have a disproportionate proportion of older people relative to Kent and Medway.

The final Decision Making Business Case (DMBC) demonstrates that an additional 14 beds could be made available at DVH to manage any significant increase in activity all of which is now explained in the narrative in response to the question raised by the South East Coast Clinical Senate. The stroke review encompasses all patients who use/will use HASU/ASUs in Kent and Medway not just those with a Kent and Medway postcode.

My response regarding the submission of a plan from the Princess Royal University Hospital (PRUH) is correct. I understand that you are not happy with what was contained within their submission however, that is a different issue and not one that I am able to respond to as it was the submission they made. The DMBC and relevant appendices contains the detail regarding all of the Trust submissions and the scrutiny the Deliverability Panel gave to those. I have already clarified that, following the public consultation, NHS England required us to test the ability of the PRUH to cope with the potential increases as described in the public consultation document.

I disagree that the possible scale of patient flows to and from hospitals bordering Kent and Medway were not visible or that the impact was not recognised. It is for that reason both Bexley and East Sussex were included in the consultation and councillors from those areas joined the Joint Health Overview and Scrutiny Committee in February 2018, prior to consultation. We were very clear within our consultation materials that a small number of patients from surrounding areas in south east London and East Sussex might be affected by our proposals and we made a concerted effort within those areas to engage local people during the consultation period as our consultation analysis demonstrates. We have ensured that questions about border areas raised by JHOSC members during meetings and briefings have been addressed over the past year and included significant information on these issues in our updates and presentations to you.

The principles that have formed the basis both of the review and specifically the multiple evaluation processes have been tested and retested throughout the process and you are aware that the Marmot principles were not part of the criteria at any point. We are confident that the principles and guidelines that we have adhered to during the review have provided us with the rigour required to create a robust and well-evidenced final DMBC for stroke services in Kent and Medway. In addition, we believe that our plans are in tune with the objectives set out in the NHS Long Term Plan which says, "sustainability and transformation programmes and integrated care systems to reconfigure stroke services into specialist centres" and "Areas that have centralised hyper-acute stroke care into a smaller number of well-equipped and staffed hospitals have seen the greatest improvements in patient care."

As we have repeatedly said the significant improvements in the outcomes for stroke patients are driven by the rapid diagnostics and treatment achieved by consolidating services in a HASU/ASU model. In this way the skilled workforce and wider environment is available consistently 7 days a week. You are aware of national best practice in stroke medicine, the evidence presented by our leading clinicians in this area and the examples of other areas of the country (all of which are supported by Medway Foundation NHS Trust) tells us that health inequalities directly related to poor stroke outcomes are reduced by implementing a HASU/ASU model of care. We also know that primary prevention, developed and delivered by public health, has a very significant positive impact on health inequalities as the risk factors related to stroke are also related to a number of other long term health conditions and mortality.

In relation to the priority order you are correct that the stakeholder feedback suggested a priority based on their views however, whilst that was considered, the PCBC and DMBC

clearly demonstrates that differential weighting was not applied to criteria and therefore all were treated equally during the evaluation processes.

The amendments to the criteria were driven by feedback and guidance and as such were evidenced. The criteria used to agree the five options had to be refined to allow for further differentiation between the options in order to arrive at a preferred option. The amendments that were made did offer that differentiation and therefore I disagree that the changes made it less easy to distinguish the options. As we have said before, going from five possible options to one preferred option was always going to be a challenging step in the process. All the options had the very real potential to improve stroke care, and there was little to differentiate between them. The purpose of the post-consultation evaluation was to look closely at the fine differences between the options and identify which option was the 'best of the best'.

In my previous response I indicated the time the Clinical Reference Group (CRG) had to consider the information in order to reassure you that reasonable time was allowed however, for the avoidance of doubt, the CRG were comfortable that they had enough time to consider the information and signed it off. This was repeated in the evaluation workshop and again supported by the attendees. I therefore do not agree that not enough time was allowed for the review of revised criteria.

I can confirm that border hospitals were considered in every option.

I can confirm again that the PRUH did submit a plan to the Deliverability Panel, clarifying the impact on them and their ability to respond. As previously stated, I understand that you are not happy with the content of that plan however that the process did continue as with all other providers.

The comments from the Deliverability Panel were not ignored. The final assessment that was presented was a rounded and final view, agreed by all members of the panel, and the individual comments were all taken into account as part of the process in reaching a unanimous view for each option. To avoid any further confusion, I can confirm that none of the individual comments were ignored.

My response to point 9 in your letter remains as per my previous letter.

Yours sincerely

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