Please contact: Jon Pitt (01634 332715)
Your ref:
Our ref:
Date: 27 March 2019

Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care
Ministerial Correspondence and
Pubic Enquiries Unit
Department of Health and Social Care
39 Victoria Street
London SW1H 0EU

Democratic Services
Gun Wharf
Dock Road
Chatham
Kent ME4 4TR

Main switchboard: 01634 306000
Email jon.pitt@medway.gov.uk

Dear Minister,

Report from Medway Health and Adult Social Care Overview and Scrutiny Committee – NHS proposal to reconfigure urgent stroke services in Kent and Medway

I am writing in my capacity as the Chairman of Medway Council's Health and Adult Social Care (HASC) Overview and Scrutiny Committee on behalf of Medway Council ("**the Council**") pursuant to the Council's powers under Regulation 23 of the Local Authority (Public, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("**the Regulations**") to report to you that the Council considers that the decision taken on 14 February 2019 ("**the Decision**") by the Clinical Commissioning Groups covering Kent and Medway ("**the CCGs**[1]") to make a substantial variation to the NHS stroke services is not in the interests of the health service in Medway or the wider population of Kent and Medway.

What is the Council asking you to do?

We request that you exercise your powers to make an urgent referral, relating to the Decision, to the Independent Reconfiguration Panel ("**IRP**"), in order to undertake an objective evaluation as to whether the Decision is in the best interests of the health service. We also ask you to take the other steps set out at the end of this letter. The Council is confident that, for the reasons set out below, the IRP will recommend that substantial changes are made to the Decision which, in due course, we would invite you to make pursuant to your powers under the Regulations.

What have the CCGs decided?

The CCGs have been working over an extended period to examine proposals for changes to the arrangements for treating patients in the Kent and Medway area who

[1] The relevant CCGs are Ashford CCG, Canterbury and Coastal CCG, Dartford, Gravesham & Swanley CCG, Medway CCG, South Kent Coast CCG, Swale CCG, Thanet CCG, West Kent CCG

suffer from a stroke. The Council has been co-operating with this work and supports the CCGs in considering that there is a good medical case to make changes to the current arrangements.

A consensus has been reached that services should be organised around the development of three Hyper-Acute Stroke Units ("**HASUs"**) to serve the patients of Medway and Kent. The Council supports that proposal. The key issue is not whether the NHS should develop HASUs for NHS patients in Medway and Kent but where those HASUs should be located.

The CCGs prepared a Decision Making Business Case ("**the DMBC**") which proposed the establishment of HASUs at Darent Valley Hospital ("**DVH**") in Dartford, Maidstone Hospital and the William Harvey Hospital in Ashford. – This was "Option B" in the document that the CCGs put out to public consultation.

Stroke Services are currently provided at six acute hospitals in Kent and Medway - Darent Valley Hospital, Maidstone Hospital, William Harvey Hospital, Medway Maritime Hospital, Queen Elizabeth, the Queen Mother ("**QEQM**") Hospital in Margate and Tunbridge Wells Hospital.

Establishment of three HASUs for Kent and Medway would result in the removal of acute stroke services from Medway, QEQM and Tunbridge Wells hospitals.

On 14 February 2019, the CCGs met and decided to adopt Option B. As a result, the CCGs are proposing not to establish a HASU at Medway Maritime Hospital.

The Council's view

The Council considers that this is a deeply flawed decision which will have substantial adverse impacts on the population in Medway.

For the reasons set out below, the Council's view is that implementation of the Kent and Medway Stroke Review consultation Option D, would be in the overall best interests of the population of Kent and Medway. Option D would see the establishment of HASUs at Medway Maritime Hospital, Tunbridge Wells and William Harvey Hospitals.

A Summary of the reasons why Option B is the wrong decision

The Council considers that Option B is the wrong decision because Option D was a fully deliverable option. The Decision to prefer Option B over Option D was the wrong decision because:

1. The Decision was reached by following a flawed methodology which biased the decision making process in favour of a pre-determined outcome.
2. The Option has not properly (or at all) taken into account the inevitable additional pressure which will arise on services from patients who live outside Kent and Medway on the services within Kent and Medway, and thus has not properly modelled the effect of patient flows.
3. The Decision adversely and disproportionately impacts on health inequalities for patients in the Medway area and will disproportionately benefit patients who already have better health outcomes. Impact analysis exercises completed by Mott MacDonald Group Ltd and by the Medway Public Health Intelligence Team, demonstrated 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.

4. There was substantial public support for Option D as a result of public consultation and yet the CCGs took a decision which was failed properly to reflect public views.

The background

Medway Hospital serves a population of 500,000 people (including Swale). It thus serves the largest urban area in the South East outside London.

The Medway population is at greater risk of stroke due to a range of population risk factors. These include high levels of deprivation, obesity and smoking prevalence.

Medway Maritime Hospital is the only one of the seven hospitals in Kent and Medway that regularly treats over 500 stroke patients a year. Medway hospital already has a wide range of co-adjacent services needed to support stroke services. Medway hospital is ideally placed to become a hyper acute stroke service.

Over a period of three and half years this potential reconfiguration has been the subject of NHS consultation with a Joint Health Scrutiny Committee ("**Joint HOSC**" or "**JHOSC**") initially involving two local authorities; Kent County Council ("**KCC**") and Medway Council with a combined population of 1.8 million people.

During 2017, the NHS decided to include two neighbouring local authorities (East Sussex County Council and the London Borough of Bexley) in the consultation process because the proposal had the potential to be a substantial variation to the health service in their areas, although a relatively small population across both these areas is affected. This required a new Joint HOSC to be established involving all four authorities with a membership of four KCC Councillors, four Medway Councillors and two each from Bexley and East Sussex.

At the end of the Joint HOSC process, only two of the KCC Councillors and the four Councillors representing East Sussex and Bexley voted to recommend the four Health Overview and Scrutiny Committees to support the proposal. The four Medway Councillors and one KCC Member on the Joint HOSC (i.e. the majority of Councillors representing the area most affected by the stroke service review) voted against the proposal and in favour of a proposal from Medway to contest the reconfiguration. In effect the views of the two local authorities with population sizes least affected by the proposed changes have prevailed in the Joint HOSC process. If these Councils had not been included in the Joint HOSC process then the majority view of the Committee would have been to recommend referral of this proposal to you. At a meeting of the KCC HOSC on 22 March 2019 the committee raised serious concerns about the impact on health inequalities of the proposed location of HASUs and called for a response from the NHS. It is due to meet again to consider the NHS response and decide whether or not to make a referral.

I enclose Medway's submission to the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee meeting of 14 December 2018, as well as a Minority Response to the JCCCG. This was agreed by the Medway Members of the JHOSC at a meeting on 1 February 2019. The Minority Response was submitted to the JCCCG on 6 February 2019, in advance of the JCCCG meeting on 14 February that took the decision to approve the implementation of Option B.

The Minority Response requested that the JCCCG should delay taking a decision to implement Option B and further requested that the JCCCG develop a Decision Making Business Case in relation to Option D.

I also enclose a copy of the report considered by Medway HASC Overview and Scrutiny Committee on 12 March 2019, which provides the background to the proposed reconfiguration and the very serious concerns raised by Medway Councillors via the Joint Kent and Medway Health Overview and Scrutiny Committee.

You will understand that Medway Council is extremely concerned that in view of the concerns it has raised, with supporting evidence, that a decision has been made to proceed with a reconfiguration of stroke services.

The reasons why the CCGs have come to the wrong decision

The reasons why the Council believes that the CCGs have come to the wrong decision are supported by the Integrated Impact Assessment: Pre-Consultation Report – Stroke Services, produced by Mott MacDonald and by the independent expert opinion of Jon Gilbert, who was commissioned by Medway Council to analyse the preferred option identified by the NHS and the decision making process. These documents, or links to them are enclosed with this letter.

However, in summary, the reasons are as follows:

1) Health Inequalities

Implementation of Option B would result in residents from areas of higher deprivation, who have the greatest need for stroke services, being disproportionately adversely affected, especially with regards to travel times. This failure to adequately address health inequalities appears not only to be a breach of the CCGs' duties under section 14T of the National Health Service Act 2006, but also to be at odds with the NHS Long Term Plan which talks about taking a more concerted and systematic approach to reducing health inequalities and ensuring that programmes are focused on health inequality reduction.[2] The Preferred Option would achieve the opposite of this. The Decision Making Business Case (DMBC)[3] claims that residents from more deprived areas will disproportionately benefit.

This analysis fails to address the real issues arising out of the options. The Council accepts that people from more deprived areas, such as Medway and Thanet, are likely to access HASU services more than those who are less deprived simply because they will have more strokes and thus more need for the services. However, that is an argument for the creation of HASUs (which the Council supports) not an argument for the reconfiguration of HASUs. Individuals and their families from lower socio-economic groups will find it disproportionately harder to access services that are located away from their homes than those from higher socio-economic groups who have more access to their own transport and so do not have to rely on public transport.

The report submitted by the Stroke Programme team to the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee meeting (JHOSC) on

[2] NHS Long term plan, January 2019, page 39
[3] Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (JHOSC) meeting agenda, 1 February 2019 meeting agenda p87

1 February 2019 states that “evidence from all other implementations have [sic] demonstrated a reduction of health inequalities.” Medway has been unable to find any such evidence to support this assertion and when asked at the 1 February and 12 March 2019 meetings, the NHS Stroke Review team was unable to provide any evidence to support this statement.

The Joint Committee of CCGs has also been unable to provide evidence to support the claims that populations in deprived areas have benefitted more than those in more affluent areas from reconfigurations undertaken elsewhere. Instead, they argue that better outcomes for all as a consequence of improved stroke services will address health inequalities. At best, this will perpetuate the existing health inequalities because there is no suggestion that there will be better outcomes for people from more deprived areas, and at worst, health inequalities will increase because the HASUs will not be in the most deprived CCG areas. While a prevention work stream has been offered as a means of reducing health inequalities, this was offered in the closing days of a process that has taken over four years. There is as yet no associated business case and prevention work is not budgeted for in the DMBC. There is no specific commitment to provide funds for this at this point.

There is also no indication that any peer reviewed, academic evidence has been presented to either the Stroke Clinical Reference Group or to the Stroke Programme Board to support the assertion made with regards to disproportionate benefit.

The duty under section 14T means that decisions about where to locate HASUs must be targeted at the geographic areas with the greatest need and where those individuals would face barriers in accessing services located at a greater distance from their homes.

The Option approved by the JCCCG will not place HASUs in these areas. Data presented to the JHOSC[4] shows that the HASUs will be located in the **least** deprived CCG areas in Kent and Medway, with between 3.6% and 12.4% of the CCG populations in the most deprived quintile. The corresponding figure for Medway CCG is 20.1%, while Thanet CCG, which would not host a HASU under any of the three site options consulted on, has the highest level at 35.9%. In comparison to Option B, Option D would, overall, locate HASUs in more deprived areas. The Mott MacDonald pre-consultation report also found that Option D would have the greatest positive impacts and the least negative impacts in terms of equality.

There is also a risk that implementing the three HASUs in two phases, as proposed in the DMBC, will further impact areas of higher deprivation which would only receive a HASU in the second phase. Recent peer reviewed evidence published in January 2019 into patient outcomes following a two-phased implementation in Manchester, compared to a single phase implementation in London, identified clear negative outcomes for stroke patients in Manchester. Medway acknowledges that a commitment has been made to give phasing of the implementation further consideration but it is concerning that this was not fully considered prior to the JCCCG making its decision.

2) Bed Capacity

There is an important element to the CCGs planning which has led to this decision which, in the view of the Council, is plainly against the best interests of NHS patients

[4] JHOSC meeting agenda, 1 February 2019 - p96

in Medway. In its capacity planning, the CCGs have projected that 100% of Bexley residents who are currently seen at the Princess Royal University Hospital **("PRUH")** or DVH will now be included within the HASUs included in this reconfiguration exercise. The DMBC states that around 200 strokes, 8 out of 34 HASU/ASU beds at DVH (23.5% of capacity) will immediately start to be taken up by patients currently seen at the PRUH.[5] The review failed to take account of patient flows from outside the Kent and Medway area, despite the fact that this will reduce the services available for Kent and Medway based patients. Thus, under the preferred option chosen by the CCGs, there will be significantly less HASU capacity for Kent and Medway based patients as compared to other options (which would see patients from outside Kent and Medway continue to be treated at hospitals outside the Kent and Medway area.) However, the CCGs have not proposed any overall increase in the number of HASU beds to take account of those beds at Kent and Medway hospitals that will be used for non-Kent and Medway based patients. The CCGs have primary responsibility for making commissioning decisions for the benefit of the patients for whom they have commissioning responsibility. The CCGs in Kent and Medway have no commissioning responsibility for the patients from South-East London. It is thus, plainly erroneous for the CCGs to prefer an option which provides fewer beds (and thus fewer services) for those patients for whom they have commissioning responsibility as compared to other options which would have provided a larger number of beds (and thus a better level of services) for the CCGs' own patients.

This problem is particularly acute under Option B. Adopting that option may well result in bed capacity in HASUs being quickly outstripped by growth in demand. Capacity would also be taken by residents of South East London, resulting in there being fewer beds available for the population of Kent and Medway.

There is a predicted increase of 43% in stroke admissions up to 2040/41. In order to maintain the required capacity thresholds, an additional four HASU beds & 12 ASU (Acute Stroke Unit) beds would be required by 2025; eight HASU and 22 ASU beds would be needed by 2030 and; 15 HASU and 40 ASU beds would be needed by 2040. The provision of additional capacity and a reduction in the average length of patient stay can help mitigate this up to 2030. However, capacity will remain an issue.

Under Option B, all Bexley resident stroke patients who are currently seen at the PRUH in Bromley, which already has a HASU, would instead be taken to a hospital in Kent and Medway. This is further evidenced by page 8 of Appendix D of the Business Case (Changes to the activity and travel time analysis). This states that '100% of Bexley CGG patients currently seen in DVH and PRUH would be included in the scope for the K&M catchment'. Page 15 of this appendix shows that, under Option B, the PRUH would see no stroke patients from Kent and Medway.

Capacity at Darent Valley will be further taken up due to population increases resulting from home building due to take place in south-east London. The London Borough of Bexley, for example, aims to deliver 31,500 new homes by 2050, 80% of which would be in the catchment area of Darent Valley Hospital.[6]

The combined effect of an increase in demand and choosing locations closer to the borders of Kent and Medway will mean that capacity is taken up by an increasing number of South East London residents at the expense of residents in Kent and

[5] JHOSC meeting agenda, 1 February 2019 – p223
[6] JHOSC meeting agenda, 1 February 2019 – p14

Medway. Establishing a HASU at Darent Valley Hospital, within 15 miles (approximately 22 minutes' drive) of the PRUH, would help short-term capacity issues at the PRUH but would not be in the long-term best interests of the NHS as a whole. This is because the new HASU would provide disproportionate support to South East London and West Kent rather than spreading the HASUs more evenly across the Kent and Medway region.

Capacity deficit issues have been addressed very late in the development of the DMBC via last minute work on population and housing growth, which brings into question the validity of the basis on which the options were initially developed. Action to address capacity shortfall relies on driving down length of stay, which is aspirational at this point and if unachievable could mean that the model will provide insufficient capacity as early as 2023.

The IRP has considerable expertise in analysing these complex issues. The Council is confident that the existing analysis relied upon by the CCGs will not stand scrutiny by any independent evaluator. We invite you to refer the matter to the IRP to enable that scrutiny to take place.

3) Evaluation Process

The Council considers the evaluation process used to select Option B as the preferred option to have been flawed. Significant changes were made between the Pre-Consultation Business Case (PCBC) / consultation stage and publication of the DMBC. The Council does not consider that the evaluation criteria and process should have been changed without good reason, given that the more changes that were made, the greater the risk that the consultation process and shortlisting process would have been undermined.

However, significant changes to the criteria and process were made, as follows:

i) The criteria's priority order was removed. The CCGs claimed that the criteria were never prioritised but the DMBC sets out how they were created and makes it clear that those involved in developing the evaluation criteria prioritised the criteria that were most important in determining how options should be evaluated.[7] This was repeated at the consultation stage and so the public and stakeholders were led to believe that the criteria were prioritised. This would, therefore, have had an impact on the responses to the public consultation. No prioritisation or weighting was applied when selecting a preferred option for the DMBC and 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'. Clearly, this brings into question the validity of the consultation process. The decision to remove the prioritisation also appears to contradict the fourth overarching principle agreed by the JCCCG which required that the evaluation criteria would be weighted to differentiate between options. 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. Option B and Option C (Maidstone, Medway and William Harvey hospitals) 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

[7] JHOSC meeting agenda, 1 February 2019 – p141

relative weighting of the 'ability to deliver' and 'affordability and value for money' criteria. This significantly improved the overall evaluation of Options B and A (Darent Valley, Medway and William Harvey), while negatively impacting Options C and D.

ii) 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 the DMBC.

iii) Scoring keys were changed - scoring keys for each sub-criterion were used to determine the scoring for each hospital site (e.g. a double negative score, '- -' was awarded where capital costs exceeded £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.

Overall, the changes to the criteria and process provided an advantage to Options A, B and C and a disadvantage to Option D and Option E (Darent Valley, Tunbridge Wells and William Harvey hospitals).

There is more than a suspicion amongst those who have observed this process that changes were made to the methodology by those running the process because there was a concern that operating the existing methodology would produce the "wrong" result. Hence the rules of the evaluation process appear to have been changed, with the result that the process produced an outcome favoured by those who were involved in the process. The IRP has considerable expertise in scrutinising the ways that changes have been made to evaluation processes and ensuring that this type of "gerrymandering" does not occur.

Had these unwarranted changes not been made, it is unlikely that Option B would have been identified as the preferred option. Option D became unviable after public consultation due to escalating capital costs at Tunbridge Wells and the late consideration of the impact of the Princess Royal University Hospital (PRUH). It is arguable that disproportionate weight has been given to the needs of the population of South London compared to the needs of the population of Kent and Medway and that the public consultation was misleading.

The DMBC now envisages that the HASU due to be built at the William Harvey Hospital could, subject to further consultation, be relocated to the Kent and Canterbury Hospital in Canterbury.[8] As this highly significant change was not considered in the evaluation process, it further undermines the selection process.

4) Further work required in key areas

Decisions made by the JCCCG on 14 February 2019 included agreeing the establishment of a Transport Advisory Group to look at concerns about travel times; to confirm that a review of long term financial sustainability will be undertaken as part of implementation; to agree that a business case for stroke rehabilitation services is needed as a matter of urgency and will be presented to the JCCCG not later than

[8] JHOSC meeting agenda, 1 February 2019 – p222

spring 2019; and to agree that a prevention business case will be presented to the JCCCG as soon as possible.

Whilst these decisions were intended to provide some reassurance, it is both unlawful and illogical to take final decisions on the preferred option before making proper assessments as to whether the obvious disadvantages and adverse health inequality impacts of the preferred option can be properly ameliorated (and/or how much it would cost to do so).

The Council considers that the Decision Making Business Case should not have been signed off as a final decision before it was clear whether and how it could be successfully implemented.

Decision to report to the Secretary of State

In summary, the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) is seeking to secure the provision of a HASU at Medway Maritime Hospital as it believes that the development of a service configuration that does not include the provision of a HASU in Medway would not be in the interests of the health service in Medway or in the wider best interests of the population of Kent and Medway. Medway also considers that Option D, which would see the provision of HASUs at Medway Maritime Hospital, Tunbridge Wells Hospital and William Harvey Hospital, would address the concerns highlighted and would represent the best overall option for the residents of Kent and Medway.

Implementation of Option D would focus service provision on areas of higher deprivation (Medway and Swale), with there being shorter travel times for those most in need. Bed capacity would be focused on the residents of Kent and Medway, all of whom would be able to reach one of the Option D HASUs within required Call to Needle times. Capacity would be freed up in the short term and HASU sites for Option D can be expanded to provide additional capacity in the longer term. The Consultation feedback report demonstrates that respondents to the consultation tended to consider Option D to provide the best geographic spread of provision. The report states that “Option D is generally seen as offering the best balance geographically.”[9] As previously stated, the Mott MacDonald pre-consultation report also found that Option D would have the greatest positive impacts and the least negative impacts in terms of equality.

The Committee is extremely concerned that, from an NHS perspective, the viability of Option D was significantly adversely affected by the escalating capital costs of providing a HASU at Tunbridge Wells. The Independent Review Panel noted that for Tunbridge Wells “The panel felt that all options hadn’t been explored fully in the estates solution” (JCCCG evaluation workshop document, page 25). The capital costs of Option D increased post-consultation, from £36 million to £49 million. The viability of Option D has also been affected by consideration of the impact on the PRUH. This has contributed to the selection of Option B, which includes Darent Valley, in order to mitigate the impact on the PRUH.

In accordance with the requirement to ensure that practicable steps have been taken to reach agreement if there is disagreement between the health scrutiny body and the NHS where the health scrutiny comments include a recommendation, a number of steps have been taken to satisfy this requirement. Since the NHS preferred option

[9] Public Consultation on Proposed Changes to Urgent Stroke Services, Research Analysis Report, DJS Research, Summer 2018, p80

was announced on 17 September 2018, Medway Council's concerns have been discussed with the Stroke Review team on several occasions; at a special meeting of the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) on 3 October 2019, at an informal briefing for Medway Councillors on 25 October 2018 and at three Joint HOSC meetings held on 14 December 2018 and 1 and 26 February 2019. The Stroke Review team was invited to and attended the Medway HASC Overview and Scrutiny Committee on 12 March 2019.

The Committee discussed its concerns with the NHS representatives in attendance. However, the Committee did not consider that the serious concerns, raised previously to the JHOSC and to the JCCCG and further discussed at HASC, had been adequately addressed. The Committee continues to take the view that the development of a service configuration that does not include a HASU at Medway Maritime Hospital would not be in the interests of the health service in Medway or in the interests of the wider population of Kent and Medway. At the Committee meeting on 12 March the NHS categorically stated they would not be prepared to undertake any additional work to determine whether the costs and risks attributed to the proposed reconfiguration (Option B), particularly in relation to bed capacity, could be better mitigated by Option D. The NHS also stated they would not be prepared to revisit the decision to proceed with Option B and look at alternatives to the current model that would better meet the needs of Medway residents; specifically Option D.

Recommendation of the Medway Health and Adult Social Care Overview and Scrutiny Committee

At its meeting on 12 March 2019, the Committee unanimously agreed to exercise the power to report to the Secretary of State for Health about the proposed establishment of Hyper Acute Stroke Units (HASUs) at Darent Valley Hospital, Dartford, Maidstone Hospital and William Harvey Hospital, Ashford (consultation Option B) and resulting removal of acute stroke services from other hospitals in Kent and Medway, including Medway Maritime, for the reasons set out in the committee report and outlined in this letter and on the basis that the requirement to take practical steps to reach agreement with the NHS on this matter has been met.

Your intervention is requested to:

i) Refer this matter for the urgent consideration of the IRP;

ii) Pending a decision by the IRP, require the CCGs to pause the development of all work relating to the implementation of the decision to progress with Option B (Darent Valley, Maidstone and William Harvey Hospitals), on the grounds that there is a strong case that this option is not in the overall best interests of the health service in Kent and Medway in view of the following:

- It would locate all three HASU's in CCG areas with relatively low levels of deprivation. This is of significant concern in the context of the new NHS Long Term Plan which makes a commitment to a concerted and systematic approach to reducing inequalities and ensuring that programmes are focused on health inequality reduction.
- There are serious issues in relation to the process used to select the preferred option for Kent and Medway.

- The capacity of the three preferred HASU's will be significantly impacted given the flow of patients from South East London into Darent Valley hospital.
- A decision has been made even though further work is still required in key areas, such as travel times, financial sustainability and the development of rehabilitation services.

iii) Require the IRP to consider whether consideration should be given to the development of a HASU in Medway by instructing that a decision-making business case should be produced in relation to Option D of the public consultation, 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 interests of the population of Kent and Medway.

This report is not a step we have taken lightly. It is a reflection of the grave concerns we have about the proposals that have been presented to us. Medway members believe it is incumbent on us to make these representations to you, to secure the best outcomes possible for users of hyper-acute stroke services across Kent and Medway.

Access to the complete set of records relating to the Overview and Scrutiny process can be provided to you via Jon Pitt, Democratic Services Officer at Medway Council. His contact details appear at the top of this letter.

I look forward to hearing from you.

Yours sincerely,

Councillor David Wildey

Chairman of the Health and Adult Social Care Overview and Scrutiny Committee

Enclosures

Appendix A – Medway Council submission to JHOSC, 14 December 2018, which includes external expert opinion and the letters listed below*

Appendix B – Stroke Review Joint HOSC Minority Report, 6 February 2019, which includes updated external expert opinion

Appendix C – Agenda of Medway Health and Adult Social Care Overview and Scrutiny Committee (excluding appendices), 12 March 2019

Appendix D – Draft Minutes of Medway Health and Adult Social Care Overview and Scrutiny Committee, 12 March 2019

Appendix E – Letters between Medway Council Leader and Senior Responsible Officer, 4 January, 24 January and 28 January 2019

*Letters included in 14 December submission to JHOSC (Appendix A)

Letter from Leader of Council to Ivor Duffy, NHS England, 8 November 2018
Response from NHS England to Leader of Council, 21 November 2018
Letter from Leader of Council to Dr Lawrence Goldberg, South East Clinical Senate, 12 October 2018
Response from South East Clinical Senate to Leader of Council, 15 October 2018
Response to Freedom of Information (FOI) follow up request, 29 November 2018

Links to Background Documents

Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee
https://democracy.kent.gov.uk/ieListMeetings.aspx?CId=909&Year=0

Kent and Medway NHS Joint Overview and Scrutiny Committee
https://democracy.kent.gov.uk/ieListMeetings.aspx?CId=757&Year=0

Kent and Medway Stroke Review – Decision Making Business Case
https://kentandmedway.nhs.uk/stroke/dmbc/

Medway Health and Adult Social Care Overview and Scrutiny Committee
12 March 2019
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=4366&Ver=4
3 October 2018
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=4313&Ver=4
11 August 2015
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3255&Ver=4

Papers for Stroke JCCCG Meeting – 14 February 2019
https://kentandmedway.nhs.uk/latest-news/jcccg-papers-14-feb-19/

NHS Long term plan
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Public Consultation on Proposed Changes to Urgent Stroke Services, Research Analysis Report, DJS Research, Summer 2018
https://kentandmedway.nhs.uk/wp-content/uploads/2018/06/Stroke-consultation-analysis-FINAL-for-web-compressed.pdf

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.[1]

[1] 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 disproportionally 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 Enodatio 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)

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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

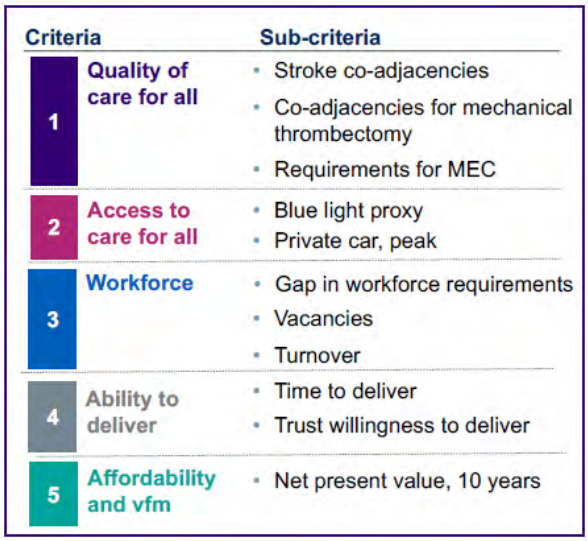
1.3.3 it does not sufficiently address the disproportionate adverse effects on residents from areas of higher deprivation, who have greater need for stroke services.

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:



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 disproportionally 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').

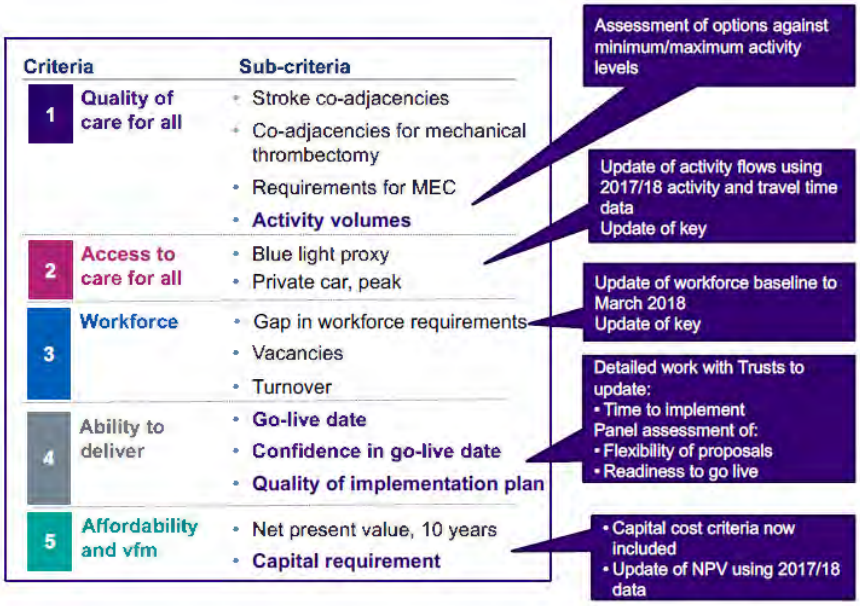
7.5.5 The decision to remove the prioritisation also appears to contradict the fourth overarching principle agreed by the JCCCG (see paragraph 7.2.4) which required that the evaluation criteria would be weighted to differentiate between options.

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

Appendix 2 - 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 over-whelming 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 scored[1] 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 document[2] 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 CCCGs 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 2 - 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

Appendix 3 - 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,
South East Clinical Senate,
York House,
18-20 Massetts Road,
Horley,
Surrey,
RH6 7DE

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

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

Councillor Alan Jarrett
Leader, Medway Council
Gun Wharf, Dock Road
Chatham, Kent ME2 4AU

South East Clinical Senate
York House
18-20 Massetts Road
Horley RH6 7DE

Email lawrencegoldberg@nhs.net
england.clinicalsenatesec@nhs.net

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.

---

[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

Dr Lawrence Goldberg MB ChB MD FRCP
Chair, South East Clinical Senate

Cc Ali Parsons, Associate Director, South East Clinical Senate

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Appendix 4 - Freedom of Information request and response

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Ref: FOI/GS/ID 4996 review

Please reply to:
FOI Administrator
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

29 November 2018

Mr J Pitt
Jon.pitt@medway.gov.uk

Dear Mr Pitt

Freedom of Information Act 2000

I am writing in response to your request for a review of the information from Kent and Medway STP made under the Freedom of Information Act 2000 in relation to STTP Stroke JCCG workshop papers and associated information.

Original request	**Follow up 25/10**	**STP Response**
A full and un-amended copy of the documentation provided to those in attendance at the workshop and a copy of the power point presentation	This was not responded to appropriately as the Council would have expected this to have been formally provided to the person making the FOI request.	Thank you for your feedback. We have now sent a copy of these materials directly to Ms Keith.
The scores for each of the criteria and sub-criteria for each option and the summary scores that were generated from these;	Complete, however as per request 1, this was not sent to the person who made the request.	As above.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>Full details of the methodology used to derive summary scores for each option, including any summary sheets of combinations of options, e.g. the matrix;</td><td>Incomplete. The materials do not provide full details used to derive summary evaluations, e.g. how three pluses are summarised as a plus, and one plus with two neutral evaluations also equates to a plus. Please explain the rationale followed to derive the combined evaluations.</td><td>
Each of the five shortlisted options comprised three hospital sites. Individual sites were evaluated against each of the sub-criteria and assigned an evaluation ranging from double positive to double negative:


Individual site evaluations were then combined to give an overall ‘whole option’ evaluation.

At the PCBC stage, to identify the shortlist, this was done iteratively and in conversation during workshops attended by clinical and commissioning leaders from across Kent and Medway, as well as patient representatives and local councillors. However, this approach caused some confusion and there was concern that this might not always be consistent.

To ensure consistency at the post-consultation stage, a standard approach was developed. The Stroke Clinical Refence Group reviewed this standard approach and agreed it was a sound basis for combining individual site evaluations. They also specifically considered where this might be different to the evaluation in comparison for that done for the PCBC.

The approach agreed by the Clinical Reference Group was as follows:

If two or more of the sites within an option are assessed as double negative then the overall option is evaluated as a double negative
If one site within an option is assessed as a single negative then the overall option cannot be evaluated as double positive
If all sites are evaluated as single positives the overall evaluation cannot be double positive
A neutral evaluation cannot add or detract from the overall evaluation (i.e. two neutrals and one positive would equal a positive evaluation)

The impact of this standardised approach was that a double negative evaluation applied to a site within an option had more of an impact on the overall option evaluation than other evaluations. The rationale for this was to make explicitly clear in the overall evaluation matrix where options included a site with a double negative evaluation.

It is also important to note that for the overall option evaluations (as opposed to individual site evaluations) when two values were within 5% of each other, they were evaluated the same.

The table below shows where the standardised approach to evaluation, as opposed to any other factor such as refreshed data or new evaluation criteria, impacted the evaluation of an option.
<table>
<tr><th>Criteria</th><th>Option A

DVH, MMH, WHH</th><th>Option B,

DVH, MGH, WHH</th><th>Option C

MGH, MMH, WHH</th><th>Option D

TWH, MMH, WHH</th><th>Option E

DVH, TWH WHH</th></tr>
<tr><td>Quality of care</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
</table>

		Stroke co-adjacencies	No impact	No impact	No impact	Changed from ++ to +	No impact
		Co-adjacencies for mechanical thrombectomy	No impact	No impact	No impact	Changed from ++ to +	No impact
		Requirements for MEC	No impact	Changed from + to /	Changed from + to /	No impact	No impact
		Activity volumes	Not applicable – amended sub-criteria				
		Access to care					
		Blue light proxy	No impact	No impact	No impact	No impact	No impact
		Private car	No impact	No impact	No impact	No impact	No impact
		Workforce					
		Workforce gap	No impact	No impact	No impact	No impact	No impact
		Vacancy rates	Changed from / to -	No impact	No impact	Changed from - to - -	No impact
		Turnover rates	No impact	Changed from / to –	Changed from + to /	Changed from + to /	No impact
		Ability to deliver					
		Go live date	No impact	No impact	No impact	No impact	No impact
		Confidence in go live date	Not applicable: new sub-criteria				
		Quality of implementation plan	Not applicable: new sub-criteria				
		Value for money					
		Net present value	No impact	No impact	No impact	No impact	No impact
		Capital requirement	Not applicable: new sub-criteria				
The names of the groups that agreed this methodology and the amount of time they were given to review the methodology	Incomplete. To clarify this request, please advise how much time did participants in meetings that approved the standard approach	Please see below a table setting out the dates of each of the meetings referred to in the original email, the date papers for those meetings were circulated and the length of the meeting.					

Meeting date	Papers circulated on	Meeting length
Clinical Reference Group		
27 July	26 July	2 hours
7 August	6 August	2 hours

before agreeing to it.	have to review the new approach to combining the individual site evaluations?	7 September	6 September	2.5 hours
		Stroke Programme Board		
		27 June	25 June	2 hours
		25 July	25 July	2 hours
		29 August	24 August	2 hours
		Stroke Joint Committee of CCGs		
		28 June	25 June	3 hours
		2 August	1 August	3 hours
		28 August	24 August	3 hours
		Evaluation workshop		
		15 September	N/A – papers were not circulated before the meeting	3 hours

If you are not content with the outcome of your complaint you may apply directly to the Information Commissioner for a decision. Generally the Information Commission cannot make a decision unless you have exhausted the complaints procedure provided by the Chief Executive's Office. The Information Commissioner can be contacted at:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Yours sincerely

Gail Spinks
Head of Information Governance

FOI Applicant Feedback

Maidstone & Tunbridge Wells NHS Trust constantly reviews the services that we provide in order to ensure that we deliver the highest quality possible to our service users. In order to assist with this process we would ask you please to take a couple of minutes to provide us with some feedback with regard to the FOI service that you have been provided.

FOI Request reference Number	
Did you find it easy to make a request for information?	Yes / No
Did you receive an acknowledgement within a reasonable timeframe?	Yes / No
Are you satisfied that your request was dealt within a timely manner?	Yes / No
Did the response content address the requirement of your request?	Yes / No
What if anything do you feel the Trust could do differently to improve the FOI service for the benefit of our service users?	

Please send this completed form to:

Mtw-tr.foiadmin@nhs.net or

G Spinks
Head of Information Governance
Maidstone & Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

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APPENDIX B

Medway Council

Serving You

Please contact: 01634 332715
Your ref:
Our ref: JP – Stroke Review Minority Response
Date: 6 February 2019

Democratic Services
Gun Wharf
Dock Road, Chatham
Kent ME4 4TR

Switchboard: 01634 306000
Email: democratic.services@medway.gov.uk
www.medway.gov.uk

Joint Committee of Clinical Commissioning Groups for Stroke Services

C/O: Glenn Douglas, Accountable Officer for the Kent and Medway CCGs;
Rachel Jones, Senior Responsible Officer for the Kent and Medway Stroke Review
Kent and Medway Sustainability and Transformation Partnership
2nd Floor, Magnitude House,
New Hythe Lane, Aylesford, ME20 6WT

Sent electronically

Dear Mr Douglas and Ms Jones,

Stroke Review – Minority Response from Medway Council representatives on the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee

As you are aware, a meeting of the Kent and Medway Stroke Review – Joint Health Overview and Scrutiny Committee (JHOSC) took place on 1 February 2019. The purpose of this meeting was for the JHOSC to comment both on the final version of the Decision Making Business Case and on NHS preferred option, Option B, ahead of the Joint Committee of Clinical Commissioning Groups for Stroke Services (JCCCG) meeting on 14 February 2019 that is due to make a decision on the NHS preferred option.

At the JHOSC meeting, Councillor Wildey, the Vice-Chairman of the JHOSC and Chairman of the Medway Health and Adult Social Care Overview and Scrutiny Committee, moved a proposal to the JHOSC that it should recommend that the JCCCG delay taking a decision to implement Option B (which would see the development of Hyper Acute Stroke Units and Darent Valley Hospital, Dartford, Maidstone Hospital and William Harvey Hospital, Ashford) and further recommend that the JCCCG develop a decision making business case for Option D (Medway Maritime, Tunbridge Wells and William Harvey hospitals).

Upon being put to the vote, the proposal was not agreed by the JHOSC. An alternative proposal was then moved and upon being put to the vote, was agreed by the Joint HOSC. The four Medway Members abstained from this vote.

The Terms of Reference of the Kent and Medway Stroke Review Joint HOSC (as agreed by Medway Council, Kent County Council, East Sussex County Council and the London Borough of Bexley), allow for the submission of a minority response under the following circumstances:

The formal response of the JHOSC will be reached as far as is reasonably practicable by consensus and decided by a majority vote. If the JHOSC cannot agree a single response to a proposal under consideration then a minority response which is supported by the largest minority, but at least two Members, may be prepared and submitted for consideration by the NHS body or a relevant health service provider with the majority response.

In accordance with the JHOSC Terms of Reference, Councillor Wildey moved that his proposal, supported by the reasons outlined to the JHOSC and by the expert opinion of Jon Gilbert, commissioned by Medway Council and presented to the JHOSC, be submitted for consideration by the JCCCG as the JHOSC Minority Response.

The four Medway Council Committee Members of the JHOSC voted in favour of this proposal. In accordance with the Terms of Reference of the JHOSC, please accept the attached report as the Committee's Minority Response to the JCCCG ahead of its meeting on 14 February 2019.

The full text of the proposal is set out in the enclosed JHOSC Minority Response.

Please confirm that the Minority Response will be provided to the JCCCG members in advance of 14 February to enable it to be fully taken into account during the decision making process.

Please also note that the expert opinion included in the Minority Response has had some footnotes added since the JHOSC meeting in order to address related questions raised at the JHOSC. It is otherwise as provided to the JHOSC.

Yours sincerely,

Jon Pitt, Democratic Services Officer, on behalf of the Medway Council Members of the Kent and Medway Stroke Review JHOSC

Enclosures:
Kent and Medway Stroke Review JHOSC Minority Response to the JCCCG

Copy to:
Rehman Chishti, MP;
Tracey Crouch, MP;
Kelly Tolhurst, MP;
Ivor Duffy, NHSE;
Stuart Jeffery, NHS Medway CCG

REPORT TO MEETING OF THE JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS FOR STROKE SERVICES (JCCCG) - 14 FEBRUARY 2019

KENT AND MEDWAY STROKE REVIEW – CONSULTATION WITH THE JHOSC

MINORITY RESPONSE FROM THE MEDWAY COUNCIL REPRESENTATIVES ON THE JHOSC

1. This minority response is submitted for the following reasons:

1.1 We have listened carefully to the NHS's rationale for the proposed configuration of hyper acute services across Kent and Medway and have listened to the answers provided to our questions.

1.2 Whilst we all agree the principle of developing new hyper acute stroke units to deliver high quality stroke services, Medway remains unconvinced that the proposed locations for the three Units is in the interests of the health service across the whole of Kent and Medway.

1.3 Medway has three principal reasons for recommending that the NHS should reconsider the location of the HASUs:

1.4 Firstly, health inequalities – HASUs should be located in more deprived areas. We are not persuaded that the NHS can deliver disproportionate benefit for stroke patients from deprived areas unless stroke patients from these areas are given preferential access to the service on arrival at a HASU over patients from more affluent areas. Clearly this will never happen. Neither can we find evidence to support claims by the NHS that populations in deprived areas have benefitted more than those in more affluent areas from reconfigurations elsewhere.

1.5 Secondly we are concerned about capacity – the NHS is recommending expenditure of £39 million on a HASU model where bed capacity will be quickly outstripped by growth in demand. 100% of Bexley residents currently seen at the PRUH or Darent Valley will now flow to provision in Kent and Medway, immediately absorbing 23% of the capacity at Darent Valley. With significant future growth planned in South East London over the next twenty years, capacity at Darent Valley is likely to be taken up meeting this demand, at the expense of residents from Kent and Medway itself.

1.6 Thirdly, we believe the evaluation process to have been flawed as has been set out by our expert. We remain convinced that had the changes not been made to methodology option B would not have been selected and the NHS may now be considering an option to locate a HASU in Medway. There is also a big question mark over the validity of the business case for Option B if the location of one of the HASUs is to move from Ashford to Canterbury which will affect travel times, patient access across Kent and Medway not to mention workforce and capital costs.

PTO

2. RECOMMENDATION TO THE JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS FOR STROKE SERVICES (JCCCG)

2.1 That the Joint Committee of CCGs (JCCCG) consider the following recommendations as the Minority Response from the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee:

i) The JCCCG should delay taking a decision to implement Option B, the NHS preferred option, on the basis that it is not in the interests of the health service across Kent and Medway to pursue an option which locates all three HASU's in CCG areas with relatively low levels of deprivation. This is of significant concern in the context of the new NHS Long Term Plan which makes a commitment to a concerted and systematic approach to reducing inequalities with a promise that action on health inequalities will be central to everything the NHS does. There also remain concerns that:

- There are serious issues in relation to the process used to select the preferred option for Kent and Medway which is open to challenge.
- The capacity of the 3 preferred HASU's will be significantly impacted on given the flow of patients from South East London into Darent Valley hospital and;

Secondly,

ii) That the JCCCG develop a decision making business case for Option D, which would locate the third HASU at Medway Maritime Hospital which serves one of the most deprived CCG areas in Kent and Medway (see Figure 3 on page 16 of the decision making business case) recognising that there is now a prospect of the HASU which serves the population of East Kent being located at Kent and Canterbury hospital (see page 142 of the final decision making business case for Option B)

PTO

3. EXPERT OPINION FROM JON GILBERT, COMMISSIONED BY MEDWAY COUNCIL IN RELATION TO THE KENT AND MEDWAY STROKE REVIEW

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.

Opinion

1 I have reviewed Medway Council's concerns regarding the selection of Option B as the Preferred Option and I do not consider that it represents the best option for the residents of Kent and Medway. This is because:

1.1 **bed capacity** will be quickly outstripped by growth in demand, and will be taken up by the population of South East London, at the expense of residents in Kent and Medway:

1.1.1 There is a predicted increase of 43% in stroke admissions up to 2040/41.

1.1.2 To maintain the required capacity thresholds, an additional 4 HASU beds & 12 ASU beds would be required by 2025 (8 HASU & 22 ASU beds by 2030; 15 HASU & 40 ASU beds by 2040). The provision of additional capacity and a reduction in the length of stay can help mitigate this up to 2030. However, capacity will remain an issue.

1.1.3 Under the Preferred Option, 100% of Bexley residents who are currently seen at the PRUH or DVH will now be seen within K&M.[1] As a result, 8 out of 34 HASU/ASU beds at DVH (23.5% of capacity) will immediately start to be taken up by patients currently seen at the PRUH.

1.1.4 This capacity will be further taken up by residents of South East London, with Bexley Council's ambition to deliver 31,500 new homes by 2050 (p14) – 80% of which within the DVH catchment. The impact of these new developments has not been modelled (contrary to p78), as the modelling work was based on ONS predictions (rather than the K&M Growth & Infrastructure Framework) (see p2 of Appx EE).

[1] See p223 of the meeting pack (p143 of DMBC) which states: "it is expected that around 200 strokes (eight beds) of strokes that are currently seen at the Princess Royal University Hospital (which is already a HASU) will be seen at Darent Valley Hospital once it is established as a HASU/ASU". This is further evidenced by Appx D (Changes to the activity and travel time analysis) in the DMBC, where page 8 states "100% of Bexley CGG patients currently seen in DVH and PRUH would be included in the scope for the 'K&M catchment'". Page 15 of this Appx shows that, under Option B, the PRUH will see zero strokes and provide zero beds for the K&M catchment.

1.1.5 The combined effect of an increase in demand and choosing locations closer to the K&M borders will mean that capacity is taken up by increasing number of South East London residents at the expense of residents in Kent and Medway.[2]

1.2 residents from areas of **higher deprivation** (who have greater need for stroke services) will be disproportionately adversely affected – especially regarding travel times:

1.2.1 The NHS 10-year plan makes a commitment to a concerted and systematic approach to reducing inequalities with a promise that action on health inequalities will be central to everything the NHS does. The Preferred Option achieves the opposite of this.

1.2.2 The DMBC (p87[3]) suggests residents from more deprived areas will disproportionally benefit. This is at best misleading. The only way people from more deprived areas, such as Medway and Thanet, could benefit more than people from less deprived areas, such as West Kent, is if they were somehow given preferential access on arrival in a HASU. Also on page 76 of the meeting pack the NHS states that "evidence from all other implementations have demonstrated a reduction of health inequalities", but I have been unable to find any such evidence to support this assertion. No peer reviewed, academic evidence appears to have been presented to either the Clinical Reference Group or the Stroke Programme Board in support of this to date.

1.2.3 The service should be targeted on those who need it most. The Preferred Option does not place HASUs in those areas of greatest need. Figure 3 on page 96 of the meeting pack shows that the HASUs will be located in the least deprived CCG areas.

1.2.4 There is also a risk that adopting a two-phased approach will further impact areas of higher deprivation, that would only receive a HASU in phase 2. Recent peer reviewed evidence published in January 2019 into patient outcomes following a two-phased implementation in Manchester, compared to London which was single phase, identified clear negative outcomes for stroke patients in Manchester.

1.3 the **evaluation process** in selecting the Preferred Option was flawed:

1.3.1 The evaluation criteria and process should not have been changed without good reason. The more changes that are made, the greater the risk that the consultation process and shortlisting process are undermined.

1.3.2 However, significant changes were made:

1.3.2.1 the criteria's priority order was removed. (The NHS argues the criteria were never prioritised but p141 sets out how they were created and makes it clear that participants prioritised the criteria that were most important in determining how options should be evaluated. This was

[2] Placing another HASU at DVH, within 15 miles (c.22 minutes' drive) of the PRUH, would help short-term capacity issues at the PRUH but would not be in the long-term best interests of the NHS as a whole. This is because it would provide disproportionate support to South East London and West Kent rather than spreading the HASUs more evenly across the Kent and Medway region.

[3] Page 87 of the meeting pack / Page 15 of the DMBC.

repeated at the consultation stage and so the public and stakeholders were led to believe that the criteria were prioritised);

1.3.2.2 additional sub-criteria were included;

1.3.2.3 scoring keys were changed; and

1.3.2.4 the methodology for combining individual site scores into a 'whole option score' was replaced.

1.3.3 Each of these changes improved the scoring of the Preferred Option. Had these unwarranted changes not been made, the Preferred Option is unlikely to have been selected.

1.3.4 Also, the DMBC now envisages that the WHH HASU could, subject to further consultation, be relocated to the Kent and Canterbury Hospital (p222). As this highly significant change was not considered in the evaluation process, it further undermines the selection process.

2 I support Medway Council in its view that 'Option D' (MMH, TWH and WHH) addresses these concerns and represents the best option for the residents of Kent and Medway:

2.1 It focuses service provision on areas of higher deprivation (Medway and Swale) with shorter travel times for those most in need.

2.2 Bed capacity is focused on the residents of Kent & Medway – all of whom can reach a K&M HASU within required Call To Needle times. This focus frees-up capacity in the short term, and HASU sites for Option D can be expanded to provide additional capacity in the longer term.

2.3 In the Consultation feedback, Option D was "generally seen as offering the best balance geographically".

2.4 If no unwarranted changes had been made to the evaluation process, Option D is likely to have been selected as the Preferred Option at the Evaluation Workshop.

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Health and Adult Social Care Overview and Scrutiny Committee

A meeting of the committee will be held on:

Date: Tuesday, 12 March 2019

Time: 6.30pm

Venue: Civic Suite - Level 2, Gun Wharf, Dock Road, Chatham ME4 4TR

Membership: Councillors Wildey (Chairman), Purdy (Vice-Chairman), Aldous, Bhutia, Clarke, Fearn, McDonald, Murray, Opara, Price, Vacancy and Vacancy

Co-opted members without voting rights:
Margaret Cane (Healthwatch Medway CIC Representative) and Shirley Griffiths (Medway Pensioners Forum)

Agenda

1 Apologies for absence

2 Urgent matters by reason of special circumstances

The Chairman will announce any late items which do not appear on the main agenda but which he/she has agreed should be considered by reason of special circumstances to be specified in the report.

3 Disclosable Pecuniary Interests or Other Significant Interests and Whipping **(Pages 5 - 6)**

Members are invited to disclose any Disclosable Pecuniary Interests or Other Significant Interests in accordance with the Member Code of Conduct. Guidance on this is set out in agenda item 4.

4 Outcome of NHS Consultation on Acute and Hyper-Acute Stroke Services in Kent and Medway (Pages 7 - 196)

This report advises Members of the decision made by the Joint Committee of CCGs for Stroke Services (JCCCGs) on 14 February 2019 to locate Hyper Acute Stroke Units (HASUs) at Darent Valley Hospital in Dartford, Maidstone Hospital and the William Harvey Hospital in Ashford. Acute stroke treatment in Kent and Medway is currently provided at these three hospitals as well as at Medway Maritime Hospital, Queen Elizabeth, the Queen Mother Hospital in Margate and Tunbridge Wells Hospital. Development of the NHS agreed option will result in the removal of treatment of stroke patients from these hospitals.

The Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (JHOSC) met on 26 February 2019 and recommended the relevant committees of the four partaking authorities to support the decision of the JCCCGs, subject to the NHS making an undertaking to review the provision of acute and hyper acute units, should demographic changes require it.

This Committee is invited to consider whether to accept the JHOSC recommendation or to report the matter to the Secretary of State for Health. A report can be made to the Secretary of State where the Committee is not satisfied that the NHS consultation with the Joint Overview and Scrutiny Committee has been adequate in relation to content or time allowed or where the Committee considers that the proposal would not be in the interests of the health service in its area.

For further information please contact Jon Pitt, Democratic Services Officer on Telephone: 01634 332715 or Email: democratic.services@medway.gov.uk

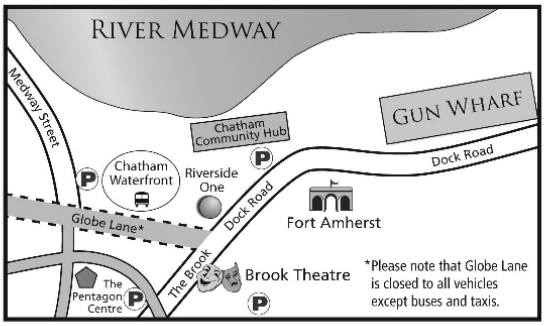
Date: 4 March 2019

Reporting on the meeting: Members of the press and public are entitled to report on this meeting except where the public are excluded, as permitted by law. Reporting includes filming and recording of the proceedings and use of the internet and social media such as tweeting and blogging to report the proceedings. Guidance for people wishing to exercise this right is available on the Council's website and in the public seating area at the meeting.

It is helpful if people wishing to film the proceedings could contact the Council's media team in advance on 01634 332736 or by email to pressoffice@medway.gov.uk. Please sit in the front row or other designated area if you wish to report on the meeting. If you are attending and do not wish to be filmed or recorded please sit at the back of the public seating area.

http://www.medway.gov.uk/thecouncilanddemocracy/reportingonmeetingsguidance.aspx

Please note that parking is available at Gun Wharf from 5pm



This agenda and reports are available on our website
www.medway.gov.uk

A summary of this information can be made available in other formats from **01634 333333**

If you have any questions about this meeting and you want to speak to someone in your own language please ring **01634 335577**

বাংলা	331780	ગુજરાતી	331782	ਪੰਜਾਬੀ	331784	كوردي	331841	اردو	331785	Русский	332374
中文	331781	हिंदी	331783	Polski	332373	এছহৎশফব	331786	فارسی	331840	Lietuviškai	332372

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Declarations of Disclosable Pecuniary Interests and Other Significant Interests

a) Disclosure at meetings

If you know you have a Disclosable Pecuniary Interest (DPI) or Other Significant Interest (OSI) (*see below for definitions*) in a matter to be considered at a meeting, you must disclose, at the start of the meeting or when the interest becomes apparent, the existence and nature of the interest.

Even if a DPI has already been registered you must still disclose it at the meeting.

Where you disclose an interest at a meeting which is not entered on the Council's register of interests, or the subject of a pending notification, you must notify the Monitoring Officer in writing of that interest within 28 days from the date of disclosure at the meeting.

b) **Participation in Meetings**

Where you have a DPI or OSI in a matter to be considered at a meeting you must, unless a dispensation has been granted:

I. **not** take part in any discussion of the matter
II. **not** take part in any vote on the matter
III. **leave** the meeting room (including the public gallery).

c) Bias and Pre-Determination

You must also be aware of and act within the rules on predetermination and bias. Avoidance of bias or predetermination is a principle of natural justice. Even if you do not have a DPI or OSI you may cause a decision to be invalid if you participate while predetermined or biased.

You should not participate in decisions where you are actually biased or give the appearance of being biased. The test is whether a fair minded and informed observer, having considered the facts, would conclude that there was a possibility that you as the decision maker are biased.

There is a distinction between predetermination, which rules out participation in decision-making and predisposition, which does not. It is acceptable for you as a Member to be predisposed towards a particular policy or viewpoint and that does not

…continued

prevent you from taking part in decision-making. However, if you take a stance which indicates that you have finally closed your mind on a matter and that nothing that you hear at Committee will alter your position then you will have moved on to becoming predetermined and, in that case, you should not participate.

d) Whipping

The Council's constitution also requires any member of the Committee who is subject to a party whip (ie agreeing to vote in line with the majority view of a private party group meeting) to declare the existence of the whip.

Definitions

Disclosable Pecuniary Interests - *are those interests set out in Schedule One to the Code of Conduct. You will have a DPI in a matter being considered at a meeting where the DPI is closely aligned to the business of the agenda item and where the interest is:*

(a) your interest or

(b) an interest of your spouse or civil partner, a person with whom you are living as husband and wife, or a person with whom you are living as if you were civil partners and provided you are aware that the other person has the interest.

Other Significant Interests – *you will have an OSI where your interest is closely aligned to the business of the Council agenda item and where the business affects the financial position or well being of the following to a greater extent than most inhabitants of the area affected by the decision:*

I. you;

II. a member of your family or friends or any person with whom you have a close association;

III. any person or body from whom you have accepted or received any gifts or hospitality as specified in Schedule Two of the Code;

IV. any outside body or group specified in Schedule Two of the Code of which you are a member or in a position of general control or management (as relevant).

And *where a member of the public with knowledge of the relevant facts would reasonably think that your interest is so significant that it would be likely to prejudice your judgement of the public interest.*

Medway Council
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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

12 MARCH 2019

OUTCOME OF NHS CONSULTATION ON ACUTE AND HYPER-ACUTE STROKE SERVICES IN KENT AND MEDWAY

Report from: James Williams, Director of Public Health

Author: Julie Keith, Head of Democratic Services
David Whiting, Consultant in Public Health
Jon Pitt, Democratic Services Officer

Summary

This report advises Members of the decision made by the Joint Committee of CCGs for Stroke Services (JCCCGs) on 14 February 2019 to locate Hyper Acute Stroke Units (HASUs) at Darent Valley Hospital in Dartford, Maidstone Hospital and the William Harvey Hospital in Ashford. Acute stroke treatment in Kent and Medway is currently provided at these three hospitals as well as at Medway Maritime Hospital, Queen Elizabeth, the Queen Mother Hospital in Margate and Tunbridge Wells Hospital. Development of the NHS agreed option will result in the removal of treatment of stroke patients from these hospitals.

The Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (JHOSC) met on 26 February 2019 and recommended the relevant committees of the four partaking authorities to support the decision of the JCCCGs, subject to the NHS making an undertaking to review the provision of acute and hyper acute units, should demographic changes require it.

This Committee is invited to consider whether to accept the JHOSC recommendation or to report the matter to the Secretary of State for Health. A report can be made to the Secretary of State where the Committee is not satisfied that the NHS consultation with the Joint Overview and Scrutiny Committee has been adequate in relation to content or time allowed or where the Committee considers that the proposal would not be in the interests of the health service in its area.

1. Budget and Policy Framework

1.1 Medway Council has delegated the function of health scrutiny to the Health and Adult Social Care Overview and Scrutiny Committee and the Children and Young People Overview and Scrutiny Committee. This includes the power to report contested NHS service reconfigurations to the Secretary of State.

1.2 Medway's vision for Adult Social Care is '*We will support the people of Medway to live full, active lives, to live independently for as long as possible, and to play a full part in their local communities'*.

1.3 Our vision for Adult Social Care supports the delivery of Council Plan priorities, in particular 'Supporting Medway's people to realise their potential'; 'Older and disabled people living independently'; and 'Healthy and active communities'.

1.4 The proposed changes will impact on the delivery of stroke services for the residents of Medway.

1.5 The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services.

2. Background

2.1 The Kent and Medway Hyper Acute and Acute Stroke Services Review started in December 2014. Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers to consult affected local authorities about any proposal which they have under consideration for a substantial development of or variation to the health service. Where more than one local authority area is affected the regulations require the establishment of a Joint Health Scrutiny Committee comprising representation from each area and only that Committee may comment on the proposal, require the provision of information about the proposal and require NHS bodies and health service providers to attend to answer questions.

2.2 Between January and November 2016 the Stroke Review was initially under consideration by the Kent and Medway NHS Joint Overview and Scrutiny Committee. In November 2017 both Bexley Council and East Sussex County Council were formally advised by the NHS of the proposals relating to the reconfiguration of stroke services across Kent and Medway. The Health Overview and Scrutiny Committees for both these authorities deemed the proposals to constitute a substantial change/variation to the health service for their areas as a number of their residents access stroke services in Kent and Medway.

2.3 This generated a requirement to set up a new Joint Health Scrutiny Committee for the next stages of the NHS consultation with the

affected local authorities on Stroke Services, comprising of Members from Medway Council, Kent County Council, East Sussex County Council and Bexley Council. This Joint Committee was established in early 2018.

2.4 The terms of reference of the Joint Committee are attached at Appendix A. All four local authorities agreed that the power to refer the matter to the Secretary of State for Health should not be delegated to the Joint HOSC. This is a matter for each local authority to determine separately. For Medway this is a decision for the Health and Adult Social Care Overview and Scrutiny Committee.

2.5 In January 2018 the NHS produced a pre-consultation business case and options for change to Stroke Services (https://kentandmedway.nhs.uk/wp-content/uploads/2018/01/180124-Stroke-PCBC-vFINAL.pdf). In February 2018 the NHS launched a formal public consultation exercise on the proposal to establish hyper acute stroke units; whether three hyper acute stroke units is the right number; and five potential options for their location as follows:

	Hyper Acute Stroke Unit Options:
A	Darent Valley Hospital Medway Maritime Hospital William Harvey Hospital
B	Darent Valley Hospital Maidstone Hospital William Harvey Hospital
C	Maidstone Hospital Medway Maritime Hospital William Harvey Hospital
D	Tunbridge Wells Hospital Medway Maritime Hospital William Harvey Hospital
E	Darent Valley Hospital Tunbridge Wells Hospital William Harvey Hospital

2.6 Medway Council's Cabinet considered the matter on 10 April 2018. Based on an analysis from Mott MacDonald Group Ltd and Medway Public Health Intelligence Team, the Leader and Cabinet concluded that Option D would provide the best outcomes for people requiring urgent stroke services and responded to the public consultation accordingly. A copy of the response is attached at Appendix B. The same view was reached by Medway's Health and Wellbeing Board (HWB) at its meeting on 17 April 2018. The HWB also sent its own response to the public consultation expressing a preference for Option D.

2.7 On 5 July 2018 the Joint HOSC met to receive a post-consultation update from the NHS. This included a stroke consultation analysis report, a stroke consultation activity report, the options evaluation principles and a workforce update.

2.8 On 5 September 2018 the Joint HOSC met to receive a further update. This included additional information requested by the Committee on travel times, particularly to the Thanet area and an update on the rehabilitation pathway.

3. Identification of Preferred Option, development of Decision Making Business Case (DMBC) and further consideration by Medway

3.1 On 17 September 2018 the NHS in Kent and Medway published its preferred option for three new specialist hyper acute stroke units. The preferred option was to have hyper acute units alongside acute stroke units at Darent Valley Hospital in Dartford, Maidstone Hospital and William Harvey Hospital in Ashford (i.e. Option B). A copy of the statement published by the NHS in Kent and Medway and the accompanying FAQs are attached at Appendix C.

3.2 The preferred option had been selected at an evaluation workshop held in private on 13 September 2018. The workshop involved representatives from all Clinical Commissioning Groups (CCGs) across Kent and Medway, East Sussex and South East London, including GPs, commissioners and patient representatives. The Chairmen of the Health Scrutiny Committees for Kent, Medway, Bexley and East Sussex were invited to attend as observers. The Chairman and Vice-Chairman of this Committee both attended.

3.3 A special meeting of this Committee took place on 3 October 2018, following the selection of the NHS preferred option and in consideration of the fact that this option did not include the provision of a HASU at Medway Maritime Hospital. The meeting provided Members of the Committee with the opportunity to understand the reasons for the preferred option, and to express views and raise questions which could be taken forward to the Joint HOSC by the four Medway Members of that Committee. Representatives of the Stroke Review Team attended this meeting. It was agreed that a Member briefing would be held once the documentation from the evaluation workshop held on 13 September 2018 had been received, for representatives of the review team to give a more detailed explanation of the results of the evaluation process. This briefing took place on 25 October 2018 and was attended by the four Medway Members of the Joint HOSC.

3.4 **Council – 11 October 2018**

A motion in relation to the Stroke review was agreed at the meeting of Medway Council on 11 October 2018. The motion was carried as follows:

3.5 “This Council notes the critical role Medway Maritime Hospital plays in the delivery of stroke treatment for over 500,000[1] people across Medway and Swale, currently caring for the largest number of stroke patients in Kent and Medway. This Council further notes that new proposals made by Kent and Medway NHS would exclude Medway Maritime from becoming one of three new 24/7 hyper acute stroke units (HASU), despite the hospital’s inclusion in three of the five options initially presented for consultation. Council formally opposes any proposal which would not see Medway Maritime Hospital become a HASU, on the grounds that:

- Representations from Medway Council made at multiple levels and including formal responses to the consultation, submitted in order to represent the interests of Medway’s residents, have been given insufficient weight;
- The likelihood that removing all specialist stroke services from Medway Maritime Hospital, will contribute to increasing health inequalities in Medway. This is in light of the mortality rate for cardiovascular disease deemed preventable in Medway (for persons aged under 75) is statistically worse than the England average (53.7 deaths per 100,000 population Medway, 46.7 deaths per 100,000 population England);
- The probability that removing all specialist stroke services from Medway Maritime Hospital, will put lives at risk. Medway has one of the largest and fastest growing populations in the South East. Local residents will need to be transported to one of the 3 HASUs in Kent. Given that every second is crucial when it comes to initial treatment of stroke, and bearing in mind the specific and distinct geography of Medway, with its river and additional constraints transporting Medway residents who have had a stroke, or suspected stroke to HASUs will be challenging;
- It is unacceptable, and undermines this Council’s agenda to improve health inequalities, that services designed to provide for residents across Kent and Medway will not see a single site placed within Medway itself.

3.6 Council therefore resolved to:

- Write to the Kent and Medway NHS leadership responsible for commissioning stroke services to encourage serious reconsideration of the current proposals;
- Write to the three Medway MPs to ask that they join the Council in opposing the current proposals;
- Ensure this issue is thoroughly discussed and debated within all appropriate forums to protect the interests of all present and future patients treated at Medway Maritime Hospital – including, but not limited to, the Medway Health and Wellbeing Board and the Kent and Medway Joint Health and Wellbeing Board.

[1] 500,000 is the approximate combined population of Medway and Swale and not the number of strokes in these areas

- Request the Leader to make representations to the Chairman of the South East Clinical Senate, 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 this Council's concerns)."

3.7 **Health and Wellbeing Board - 6 November 2018**

The following recommendation was agreed by the Board:

The Board:

i) Noted that Option B had been published by the NHS in Kent and Medway as the NHS preferred option of the NHS for the location of three Hyper Acute Stroke Units (HASUs) across Kent and Medway at Darent Valley Hospital in Dartford, Maidstone Hospital and William Harvey Hospital in Ashford;

ii) Considered the potential risks to the population of Medway as a result of the proposed option that would not award HASU status to Medway Maritime Hospital;

iii) Supported the position of Medway Council in opposing the proposed option (B) and strongly supported continuing to press for its own preferred option D.

3.8 **Kent and Medway Joint Health and Wellbeing Board – 14 December 2018**

The Joint Board agreed the following:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the questions raised by Medway and commented on the likelihood that option D (which would locate HASUs at Medway Maritime, Tunbridge Wells and William Harvey Hospitals), would have emerged as the preferred option had questionable changes to the methodology and selection criteria not been introduced at a late stage in the process.

b) requested that the concerns raised be taken into account by the Joint Committee of CCGs before a decision is made.

3.9 The NHS produced a Decision Making Business Case (DMBC) in support of Option B (https://kentandmedway.nhs.uk/stroke/dmbc/). This was presented to the JHOSC on 14 December 2018. It had been anticipated that the JHOSC would formally comment on the DMBC and for these comments to be submitted to the Joint Committee of Clinical Commissioning Groups for Stroke Services ahead of it making a decision on whether to proceed with the implementation of Option B. However, the NHS advised during the JHOSC meeting that the DMBC

document under consideration was not the final version. It was, therefore, agreed that a further meeting of the JHOSC would take place to enable it to comment on the final DMBC.

3.10 Medway Council submitted a report to the 14 December JHOSC meeting on the basis that the Council did not consider that Option B was in the best interests of the health service in Kent and Medway. This also set out the view that Medway considered there to have been flaws in the way that the Joint Committee of Clinical Commissioning Groups was led to choose the selected sites.

3.11 Medway commissioned an external expert, Jon Gilbert, to analyse the NHS preferred option and the decision making process. The report and expert opinion submitted to the 14 December meeting are attached as Appendix D.

4. Proposal to Joint HOSC

4.1 On 1 February 2019, the Joint HOSC met to consider and comment on the final Decision Making Business Case (https://kentandmedway.nhs.uk/stroke/dmbc/). Councillor Wildey, in his capacity as Vice-Chairman, moved a recommendation, which was seconded by Councillor Murray, to request that the Joint HOSC ask the JCCCG to delay taking a decision to implement Option B and to develop a Decision Making Business Case in support of Option D, which would see the establishment of HASUs at Medway Maritime Hospital, Tunbridge Wells Hospital and William Harvey Hospital in Ashford.

4.2 The full text of this recommendation was as follows:

I propose that the Joint HOSC should agree to recommend the following to the Joint Committee of CCGs (JCCCGs) on 14 February 2019:

i) The JCCCGs should delay taking a decision to implement Option B, the NHS preferred option, on the basis that it is not in the interests of the health service across Kent and Medway to pursue an option which locates all three HASU's in CCG areas with relatively low levels of deprivation. This is of significant concern in the context of the new NHS Long Term Plan which makes a commitment to a concerted and systematic approach to reducing inequalities with a promise that action on health inequalities will be central to everything the NHS does. There also remain concerns that:

- there are serious issues in relation to the process used to select the preferred option for Kent and Medway which is open to challenge
- the capacity of the 3 preferred HASU's will be significantly impacted on given the flow of patients from South East London into Darent Valley hospital and;

Secondly,

ii) The Joint HOSC should further recommend that the JCCCGs develop a decision making business case for Option D, which would locate the third HASU at Medway Maritime Hospital which serves one of the most deprived CCG areas in Kent and Medway (see Figure 3 on page 16 of the decision making business case) recognising that there is now a prospect of the HASU which serves the population of East Kent being located at Kent and Canterbury hospital (see page 142 of the final decision making business case for Option B)

4.3 Upon being put to the vote, Cllr Wildey's proposal was not agreed by the Joint HOSC. The terms of reference of the JHOSC allow for the submission of a minority response where the JHOSC cannot agree a single response to a proposal under consideration, subject to the minority response being supported by at least two members of the committee. In accordance with the Terms of Reference, it was agreed that the proposal put forward by the four Medway Members of the Committee, as set out above, and incorporating an updated expert opinion from Jon Gilbert, should be submitted to the JCCCG as the JHOSC Minority Response.

4.4 The Joint HOSC agreed the following recommendation as its formal recommendation, with the four Medway Members abstaining from the vote:

The NHS are asked to pass on the comments of the JHOSC to the Joint Committee of Clinical Commissioning Groups (JCCCG) and to report back to the Joint Stroke HOSC and ask that the JCCCG prepare and consider an analysis of how population growth in North Kent, specifically Medway and the Thames Gateway, and East Kent has been taken into account in the proposals, particularly in relation to the number of HASUs being proposed.

4.5 The formal recommendation and the Minority Response were each submitted by the JHOSC to the JCCCG, ahead of the JCCCG making a decision on the preferred option on 14 February. The Minority Response is attached as Appendix E.

5. Joint Committee of Clinical Commissioning Groups for Stroke Services and Final JHOSC meeting

5.1 At its meeting on 14 February 2019, the Joint Committee of Clinical Commissioning Groups for Stroke (JCCCG) made the decision to proceed with the development of Option B for Hyper Acute Stroke Units (HASUs) to be established at Darent Valley Hospital – Dartford, Maidstone Hospital and William Harvey Hospital - Ashford. The Chairman, Vice-Chairman and Opposition Spokesperson of this Committee all attended this meeting as observers. However, due to interruptions from some members of the audience the meeting was

adjourned. When the meeting reconvened, the Medway Members were not present and were, therefore, not in the room when the decision was made. It was possible to listen to the meeting live via an audio webcast.

5.2 The full decision of the JCCCG was as follows:

Taking into account all of the evidence that has been made available to JCCCG members, the JCCCG agree the following resolutions on the basis that, taken together, they represent the most effective way of providing high quality acute stroke care for patients in, and residents of, Kent and Medway:

1) To agree and adopt the acute stroke service models with 3 HASU/ASUs as described in Section 3 [of the report].

2) To agree the establishment of these joint HASU/ASUs at Darent Valley Hospital, Maidstone General Hospital and William Harvey Hospital as described in section 6.4.

3) To agree that when the HASU/ASUs are operational that acute stroke services will no longer be commissioned at Medway Hospital, Tunbridge Wells Hospital, Queen Elizabeth, the Queen Mother Hospital and Kent & Canterbury Hospital.

4) To note the integrated impact assessment of the preferred option as set out in Section 8.4 and agree the establishment of a Transport Advisory Group to make recommendations on travel issues as part of implementing the plans.

5) To agree the current financial impact and confirm a review of long term financial sustainability will be undertaken as part of implementation.

6) To agree the key performance benefits set out in Section 10.4 and agree to set up the benefits monitoring system outlined in Section 10.5.

7) To agree that a business case for stroke rehabilitation services is needed as a matter of urgency and will be presented to the JCCCG not later than spring 2019.

8) To agree the adoption of the governance model and resourcing plan set out in Section 9.3.

9) To agree that a prevention business case will be presented to the JCCCG as soon as possible.

5.3 A further Stroke Review Joint Health Overview and Scrutiny Committee took place on 26 February to consider the decision of the JCCCG and

to make a recommendation to the health scrutiny committees of Medway, Kent, Bexley and East Sussex as to whether they should consider referring the decision regarding a substantial variation to stroke services to the Secretary of State for Health. The final decision as to whether to refer is a matter for each of these committees to consider individually as the power to make a referral to the Secretary of State has not been delegated to the JHOSC.

5.4 Councillor Wildey, in his capacity as Vice-Chairman, moved a recommendation, which was seconded by Councillor McDonald, to request the following:

5.5 That the Joint HOSC acknowledges the concerns raised by Medway Council that the proposed location of three HASU's in Kent and Medway, which excludes Medway Maritime Hospital as one of those sites, is not in the interests of the health service in Kent and Medway. This is based on the evidence previously provided by Medway relating to health inequalities, insufficient capacity and flaws in the methodology used for selection of the preferred option. It is of grave concern that the Decision Making Business Case for Option B has been signed off with key workstreams relating to prevention, rehabilitation and financial sustainability incomplete.

5.6 The Joint HOSC therefore agrees that the four relevant committees consider that the proposed reconfiguration of hyper acute stroke services across Kent and Medway should be referred to the Secretary of State for Health and to call on him to ask for an evidence based review of the concerns raised by Medway with particular emphasis on the scope of Option B to deliver a reduction in health inequalities as opposed to Option D.

5.7 Upon being put to the vote, Medway's proposal was not agreed.

5.8 The Joint HOSC then agreed the following recommendation as its formal recommendation, with the four Medway Members abstaining / voting against:

The Committee recommends that the relevant committees of the partaking authorities support the decision of the Joint Committee of CCGs subject to the NHS making an undertaking to review the provision of acute and hyper acute units, should demographic changes require it.

6. Advice and Analysis

6.1 The JHOSC has agreed to recommend to the four participating local authorities that the decision made by the JCCCG should not be referred to the Secretary of State for Health. However, the Committee will note that Medway has been unequivocal to date in opposing the development of Option B on the grounds that it does not consider that this option would be in the best interests of the health service of either Medway or of Kent and Medway as a whole. The right of referral to the

Secretary of State sits with this Committee and it is therefore the decision of this Committee as to whether to make such a referral.

6.2 The Medway Members on the Joint HOSC believe that this Committee should report to the Secretary of State for Health. Should the Committee decide to make a referral to the Secretary of State, detailed reasons will be set out in the referral letter. These are summarised as follows:

i) **Health Inequalities** – Implementation of Option B would result in residents from areas of higher deprivation, who have the greatest need for stroke services, being disproportionately adversely affected, because the HASUs will be located in some of the least deprived CCG areas in Kent and Medway. This is contrary to the NHS Long Term Plan which makes a commitment to a concerted and systematic approach to reducing inequalities with a promise that action on health inequalities will be central to everything the NHS does. The Joint Committee of CCGs has been unable to provide evidence to support claims in the DMBC that populations in deprived areas have benefitted more than those in more affluent areas from reconfigurations undertaken elsewhere. Instead they argue that better outcomes for all as a consequence of improved stroke services will address health inequalities. At best this will perpetuate the existing health inequalities because there is no suggestion that there will be better outcomes for people from more deprived areas, and at worst health inequalities will increase because the HASUs will not be in the most deprived CCG areas. While a prevention work stream has been offered as a means of reducing health inequalities, this was offered in the closing days of a process that has taken over four years. There is as yet no associated business case and prevention work is not budgeted for in the DMBC. There is no specific commitment to provide funds for this.

ii) **Bed Capacity** - Delivery of Option B could result in bed capacity in HASUs being quickly outstripped by growth in demand. Capacity would also be taken by residents of South East London, resulting in there being fewer beds available for the population of Kent and Medway. Capacity deficit issues have been addressed very late in the development of the DMBC via last minute work on population and housing growth, which brings into question the validity of the basis on which the options were initially developed. Action to address capacity shortfall relies on driving down length of stay, which is aspirational at this point and if unachievable could mean that the model will provide insufficient capacity as early as 2023.

iii) **Evaluation Process –** Medway has previously raised concerns that it considers the evaluation process used to select Option B as the preferred option to have been flawed. This was on the basis that significant changes were made between the Pre-Consultation Business Case (PCBC) / consultation stage and publication of the Decision Making Business Case. Had these changes not been made, it is considered likely that Option D (Medway, Tunbridge

Wells and William Harvey) would have been identified as the NHS preferred option rather than Option B. In particular, Option D became unviable after public consultation due to escalating capital costs at Tunbridge Wells and the late consideration of the impact of the Princess Royal University Hospital (PRUH). It is arguable that disproportionate weight has been given to the needs of the population of South London compared to the needs of the population of Kent and Medway and that the public consultation was misleading.

iv) **Further work required in key areas –** Decisions made by the JCCCG on 14 February included agreeing the establishment of a Transport Advisory Group to look at concerns about travel times; to confirm that a review of long term financial sustainability will be undertaken as part of implementation; to agree that a business case for stroke rehabilitation services is needed as a matter of urgency and will be presented to the JCCCG not later than spring 2019 and; to agree that a prevention business case will be presented to the JCCCG as soon as possible. Whilst these decisions provide some reassurance, it is concerning that the success of the reconfiguration appears to rely on further work being undertaken and reducing length of stay and that the Decision Making Business Case was signed off and a decision made to implement Option B in view of this uncertainty.

6.3 A referral to the Secretary of State for Health can be made on the following grounds:

(i) The local authority is not satisfied there has been adequate consultation with the relevant HOSC or Joint HOSC in terms of content or time allowed.

(ii) Where a consultation was not possible because of a risk to the safety of welfare of patients or staff, it is considered the reasons given for the lack of consultation were inadequate.

(iii) The local authority considers that the proposal would not be in the best interests of the health service in its area.

6.4 Medway has previously been clear that the principle of developing HASUs is accepted on the basis of clinical evidence that the centralising of acute stroke services and the provision of hyper acute stroke units will lead to better overall outcomes for patients across Kent and Medway. If the Committee was to determine that a referral to the Secretary of State should be made, this would be to challenge the proposed location of the HASUs rather than the principle of their establishment.

6.5 There has been some suggestion at the Joint HOSC that consideration should be given to establishing a fourth HASU in Kent and Medway. The NHS has stated that this would not be viable currently as it would result in workforce challenges and some of the HASUs not seeing

enough stroke patients in order for specialist expertise to be sufficiently maintained. Notwithstanding this, it is recommended that the Committee does not consider the need for a fourth HASU as a reason for referral as it is considered likely that any fourth HASU would be located in East Kent and not in Medway. The Joint HOSC was also advised that the HASU at William Harvey could be relocated to Canterbury should a new hospital be built in the longer term.

6.6 The Committee should also be aware that a referral to the Secretary of State, could, depending upon the response from the Secretary, lead to a delay in the implementation of HASUs in Kent and Medway.

7. Consultation

7.1 NHS commissioners and providers have duties in relation to public involvement and consultation and local authority consultation. The public involvement and consultation duties of commissioners are set out in Section 13Q of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and Section 14Z2 of the NHS Act 2006 for CCGs.

7.2 NHS Trusts and Foundation Trusts are also under a duty to make arrangements for the involvement of the users of health services when engaged in the planning or provision of health services (Section 242 of the NHS Act 2006). The range of duties for commissioners and providers covers engagement with the public through to full public consultation.

7.3 Where substantial development or variation changes are proposed there is a separate requirement to consult the affected local authority.

8. Risk management

8.1 In 2016 the South East Clinical Senate published a review of the potential clinical implications for local hospitals not designated a HASU in any stroke reconfiguration. The evidence from this review highlighted a number of specific risks to the population of Medway as a result of the decision not to award HASU status to Medway Maritime Hospital.

8.2 Key risks include:

8.2.1 **Diagnosis and Treatment** - All specialist stroke physicians and nurses will be transferred from Medway Martime Hospital to a HASU. This could impact on the initial treatment and care patients receive. Good practice in managing stroke requires all patients with symptoms of an acute stroke, to be urgently assessed and then discussed with the HASU. This initial triage requires maintenance of the appropriate clinical skills amongst the medical and nursing staff in the receiving specialties of the local hospital (mainly in A&E, acute medicine and elderly care).

8.2.2 **Early supported discharge** (ESD) - The aim of a HASU is to ensure appropriate treatment and care is provided in the acute phase of a stroke. Once patients are stabilised and deemed fit for discharge, they need to be transferred either home or suitable community setting for recovery. Medway social care teams will need to establish a mechanism to facilitate ESD for Medway residents at all three HASUs. This may impact on social care capacity to facilitate ESD within Medway Maritime and other Hospitals, for non-stroke patients.

8.2.3 **Rehabilitation** - The South East Clinical Senate review recommended that the provision of high quality, fully staffed and skilled specialist stroke rehabilitation services, is essential for good stroke care and patient outcomes. The new configuration of HASU's and movement of stroke care away from Medway Maritime Hospital, is likely to have an impact on Medway Council social care pathways for long term recovery (care home placement and supported living).

8.2.4 **Workforce** - Removing specialist stroke services, may impact on Medway Maritime Hospital's ability to recruit clinical and therapy staff. This is in turn could destabilise remaining services (e.g. elderly care and therapies). This would have a negative impact on council social care services and performance, for example Delayed Transfer of Care (DToC) targets.

8.2.5 **Family and carers** - It is anticipated there will be increased travel requirements for Medway families visiting relatives in a HASU. Additional travel costs will have a disproportionate impact on people from the most disadvantaged communities who may not be a position to pay fuel, taxi, public transport costs. The NHS has undertaken to look at this and establish a transport advisory group.

9. Financial Implications

9.1 There are no financial implications for Medway Council arising directly from the contents of this report.

10. Legal implications

10.1 A Joint Health Overview and Scrutiny Committee of Kent County Council, Medway Council, East Sussex County Council and Bexley Council (Joint HOSC) was established to meet the requirements of health scrutiny legislation in relation to consultation by the NHS with these local authorities on proposed changes to Hyper Acute and Acute Stroke Services in Kent and Medway and it was this Joint HOSC that commented on the outcome of the consultation exercise (Regulations 23 and 30, Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013).

10.2 The Joint HOSC has recommended to the health scrutiny committees of each council that they do not refer the decision to the Secretary of State for Health. However, the decision as to whether to refer is a matter to be determined individually by each health scrutiny committee.

Details of the background resulting in the establishment of the Joint HOSC and the grounds for referral to the Secretary of State are set out in the body of the report.

10.3 Current Local Authority health scrutiny guidance issued by The Department of Health states that when exercising the power to make a referral to the Secretary of State Local Authorities should ensure they are in a position to satisfy the relevant requirements under Regulation 23 to include certain explanations and evidence with the referral and in particular a requirement to ensure that practicable steps have been taken to reach agreement if there is disagreement between the health scrutiny body and the NHS where the health scrutiny comments include a recommendation. This would be a matter for each Council to demonstrate prior to making a referral.

10.4 In order to satisfy this requirement, since the NHS preferred option was announced on 17 September 2018 the Council's concerns have been discussed with the Stroke Review team on several occasions; at a special meeting of HASC on 3 October, at an informal briefing for Medway Councillors on 25 October and at three Joint HOSC meetings held on 14 December 2018 and 1 and 26 February 2019. The Stroke Review team has also been invited to attend this Committee meeting.

11. Recommendations

11.1 The Committee is asked to consider the report and either:

a) To agree the recommendation of the Joint HOSC to support the decision of the Joint Committee of CCGs subject to the NHS making an undertaking to review the provision of acute and hyper acute units, should demographic changes require it.

OR

b) Decide to exercise the power to report to the Secretary of State for Health about the proposed establishment of Hyper Acute Stroke Units (HASUs) at Darent Valley Hospital, Dartford, Maidstone Hospital and William Harvey Hospital Ashford (consultation Option B) and resulting removal of acute stroke services from other hospitals in Kent and Medway, including Medway Maritime, for the reasons set out in paragraph 6.2 and on the basis that the requirement to take practical steps to reach agreement with the NHS on this matter have been taken, as set out in paragraph 10.4.

11.2 If b is agreed, to:

i) Delegate authority to the Director of Public Health and Head of Democratic Services (who is the Council's Designated Scrutiny Officer) to take the necessary steps to produce and submit the report to the Secretary of State for Health, based on the rationale set out in paragraph 6.2, in consultation with the Chairman, Vice-Chairman and Opposition Spokesperson of this Committee.

ii) To formally notify the Joint Committee of Clinical Commissioning Groups for Stroke Services of the decision to report to the Secretary of State.

Lead officer contacts

James Williams, Director of Public Health
Telephone: 01634 338564 Email: james.williams@medway.gov.uk

Julie Keith, Head of Democratic Services
Telephone: 01634 332760 Email: julie.keith@medway.gov.uk

Appendices

Appendix A	Kent and Medway Stroke Review JHOSC Terms of Reference
Appendix B	Response to public consultation on Stroke Services agreed by Medway's Cabinet on 10 April 2018 (excluding appendices)
Appendix C	Preferred option and associated FAQs published by NHS Kent and Medway on 17 September 2018
Appendix D	Statement from Medway Council to Kent and Medway Stroke Review Joint HOSC, 14 December 2018
Appendix E	Minority Response from Medway Council representatives on the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee, 6 February 2019
Appendix F	Papers for JCCCG meeting, 14 February 2019
Appendix G	Draft Minutes from JCCCG meeting, 14 February 2019
Appendix H	Response from JCCCG to Joint HOSC, 26 February 2019
Appendix I	Population Modelling Undertaken following request by JHOSC, February 2019
Appendix J	Further correspondence between Medway Council and NHS, January 2019 (Note – Some previous letters are included as part of Appendix D)

Background papers

Agenda and minutes of:

Health and Adult Social Care OSC - 11 August 2015 and 3 October 2018
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3255&Ver=4
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=4313&Ver=4

Council – 11 October 2018
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=122&MId=4086&Ver=4

Health and Wellbeing Board - 6 November 2018
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=408&MId=4095&Ver=4

Kent and Medway Joint Health and Wellbeing Board – 14 December 2018
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=510&MId=4248&Ver=4

Kent and Medway Joint HOSC 2016-2018
https://democracy.kent.gov.uk/ieListMeetings.aspx?CId=757&Year=0

Kent and Medway Stroke Review Joint HOSC 2018-19
https://democracy.kent.gov.uk/ieListMeetings.aspx?CId=909&Year=0

Kent and Medway Stroke Review Pre-Consultation Business Case, 24 January 2019
https://kentandmedway.nhs.uk/wp-content/uploads/2018/01/180124-Stroke-PCBC-vFINAL.pdf

Decision Making Business Case for the Review of Urgent Stroke Services in Kent and Medway, 22 January 2019
https://kentandmedway.nhs.uk/stroke/dmbc/

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Medway Council

Meeting of Health and Adult Social Care Overview and Scrutiny Committee

Tuesday, 12 March 2019

6.40pm to 8.45pm

Record of the meeting

Subject to approval as an accurate record at the next meeting of this committee

Present: Councillors: Wildey (Chairman), Purdy (Vice-Chairman), Aldous, Bhutia, McDonald, Murray, Opara and Price

Co-opted members without voting rights

Margaret Cane (Healthwatch Medway CIC Representative) and Shirley Griffiths (Medway Pensioners Forum)

Substitutes: None.

In Attendance: Laura Caiels, Legal Advisor
Steph Hood, STP Communications and Engagement
Rachel Jones, Senior Responsible Officer, Kent and Medway Stroke Review, Kent and Medway STP, Kent and Medway STP
Julie Keith, Head of Democratic Services
Chris McKenzie, Assistant Director - Adult Social Care
James Pavey, Regional Operations Manager, South East Coast Ambulance Service
Jon Pitt, Democratic Services Officer
Ray Savage, South East Coast Ambulance Service
Dr David Sulch, Medical Director, Medway NHS Foundation Trust (left the meeting at approximately 7:30pm)
Dr David Whiting, Consultant in Public Health
James Williams, Director of Public Health

872 Apologies for absence

Apologies for absence were received from Councillors Clarke and Fearn.

873 Urgent matters by reason of special circumstances

There were none.

874 Disclosable Pecuniary Interests or Other Significant Interests and Whipping

Disclosable pecuniary interests

There were none.

Other significant interests (OSIs)

There were none.

Other interests

There were none.

875 Outcome of NHS Consultation on Acute and Hyper-Acute Stroke Services in Kent and Medway

Discussion

The Director of Public Health introduced the report, summarising Medway's concerns in relation to the NHS chosen option for the Kent and Medway Stroke Review.

The report set out the outcome of the Kent and Medway Stroke Review Joint HOSC (JHOSC) meeting on 26 February 2019 that had considered the outcome of the review. This had followed the meeting of the Joint Committee of Clinical Commissioning Groups for Stroke (JCCCGs) on 14 February. This had selected Option B, which would locate Hyper Acute Stroke Units (HASUs) at Darent Valley Hospital in Dartford, Maidstone Hospital and the William Harvey Hospital in Ashford.

Medway Members of the JHOSC did not consider that Option B was in the best interests of the population of Kent and Medway. A motion was put to the JHOSC requesting that it recommend that the individual health scrutiny committees of Medway, Kent, Bexley and East Sussex consider referring the decision to the Secretary of State for Health. This motion was not agreed. The JHOSC then recommended that the individual committees do not make a referral. The Medway Health and Adult Social Care Overview and Scrutiny Committee needed to determine whether the decision to select Option B warranted referral to Secretary of State for Health in view of the issues identified in relation to it.

Medway had relatively high levels of deprivation with some of the population living in areas amongst the most disadvantaged communities in England. Medway Maritime Hospital served a population of approximately 500,000 from Medway, Swale and elsewhere in Kent. Evidence from the Sentinel National Stroke Audit programme that monitors outcomes for people who have had a stroke showed that people from more disadvantaged communities had worse outcomes if they had a stroke.

The proposed HASUs set out in Option B were located in some of the more affluent CCG areas in Kent and Medway. The JCCCG had been told that Option B would reduce health inequalities but Medway Council had seen no evidence that this would be the case and none had been presented to the CCGs. Furthermore, Option B would increase the likelihood of health inequalities persisting in Medway and disadvantaged parts of Kent.

Mitigation work had been undertaken by the NHS to ensure that Option B would provide sufficient bed capacity. However, under Option B, bed capacity would be insufficient by 2023 without further action as the proposed mitigations were based on the assumption that patient length of stay could be reduced in order to free-up beds.

The Council had commissioned an independent review of the Stroke Review decision making process. This had identified that the weighting of additional factors, not considered at the consultation stage, had resulted in Option D not being identified as the preferred option. Had these factors not changed, it was considered likely that Option D would have been selected.

A range of issues had been identified by the NHS that needed to be resolved in order to make the stroke system work effectively post HASU implementation. The JCCCGs had said that a transport advisory group should be established to consider how people would travel to and from the HASUs. The financial sustainability of Option B also needed to be further reviewed and work was required to mitigate against the impact of health inequalities. Work was also needed to ensure that the prevention workstream reduced the likelihood first strokes or repeat events.

The Senior Responsible Officer for the Kent and Medway Stroke Review responded to the concerns highlighted. Work had taken place during the previous two months to address these concerns. In relation to health inequalities, HASUs would result in all Kent and Medway stroke patients having improved outcomes, regardless of where they lived. The existing stroke units in Medway and Thanet were amongst the worst rated in the country with there being too many units for the number of staff available in Kent and Medway. The Joint Committee of CCGs (JCCCGs) had recognised that improvements delivered by HASUs would not address the gap in health inequalities and had, therefore, made a commitment to focus on this with the development of a prevention Business Case having been requested. Prevention of stroke would help to address health inequalities.

Significant work had been undertaken in relation to bed capacity although it was difficult to mitigate this challenge. A commitment had been made to reducing the average length of hospital stay for stroke patients by three days over a five-year period. This would make length of stay at the Kent HASUs similar to that of existing HASUs and Acute Stroke Units (ASUs) elsewhere in the UK. Should this reduction not be achieved, 22 additional beds would be provided to ensure sufficient capacity was available. This would include 14

beds at Darent Valley Hospital, four at Maidstone and four at William Harvey Hospital.

In relation to the evaluation criteria for identifying the preferred option, the criteria had not been weighted, with each criterion having been considered equally. The Deliverability Panel had scrutinised the process following advice received that external scrutiny was required. This had included consideration of ability to deliver and go-live plans. Work would continue in relation to transport for patients and their families.

The following questions were raised by members of the Committee and were responded to by the health representatives present:

Rating of Medway Maritime Hospital Stroke Unit – In response to a question asking how much the Stroke unit at Medway Hospital would improve from its current E rating, on an A to E scale with A being the best, in the event that it became a HASU, it was confirmed that all HASUs would be expected to achieve an A rating within six months of go-live.

Health inequalities – The NHS had previously stated that people from more deprived areas would benefit disproportionately from the establishment of HASUs but this claim was no longer being made with frailty now being presented as an important factor in the citing of HASUs. It was questioned what specific evidence was available in relation to the impact of the development of HASUs on health inequalities as improving outcomes for all was not the same as reducing inequalities and the renewed focus on prevention was also not relevant to this. The concept of disproportionate benefit had not been included in the public consultation. Consideration of inequalities and their impact on the consultation options should have been included. It was the NHS that had first made the assertion that the preferred option would reduce health inequalities.

The Senior Responsible Officer (SRO) said there was clear evidence that the development of HASU / ASUs would result in improved outcomes for all patients. It was reiterated that some Kent and Medway residents were currently served by stroke units that were among the worst performing in the country. The development of HASUs would result in all stroke patients receiving an improved service. In terms of health inequalities, prevention made the most significant difference which was why the JCCCGs had asked for a business case to be developed. Inequalities had not been included in the original business case as outcomes would improve for everyone. The SRO said that, latterly, consideration had been given to inequalities as this had been raised by the Stroke Review Joint Health Overview and Scrutiny Committee.

Scoring of options – In response to a question asking how consultation option B had scored higher than the other options, the SRO confirmed that five options, A to E, had been consulted upon. These options were further evaluated in order to identify a preferred option. This had included assessment against deliverability and implementation. Option D had evaluated less favourably than Option B at this stage.

Inclusion of the PRUH and consultation evaluation – A Committee Member commented that the Princess Royal University Hospital in Orpington had not been included in the public consultation, while another Member said that the results of the consultation had been completely disregarded at the September 2018 meeting that had identified the preferred option. The STP Communications and Engagement representative said that the impact of the PRUH on neighbouring hospitals had been considered but that it had not been part of Option D. Some Committee Members said they disagreed with this.

Data to be provided to the Committee – In the event that Option B was implemented, there would be an expectation that the Committee would be provided with quarterly reports from the Sentinel Stroke National Audit Programme (SSNAP) showing outcomes for Medway patients. The data to be provided would also include mortality reports, broken down by quintile of deprivation across Kent and Medway, for before and after the establishment of HASUs as well as data on hospital length of stay. The SRO confirmed that this data would be provided.

Impact of the consultation on decision making – The STP Communications and Engagement Lead said that the consultation had been undertaken across 10 clinical commissioning groups, including Medway. This covered a population of 2.2 million across Kent and Medway and the boundary areas of East Sussex and South East London. The consultation had gathered insights, views and concerns and provided an understanding of support for the consultation options. The JHOSC had agreed that the consultation was robust. The results of the consultation had been given in-depth consideration by the JCCCGs as had other considerations, such as workforce and finance. The JCCCGs had considered the raw consultation data as well as the consultation feedback report. A significant period of time had been spent analysing the feedback and compiling the Decision Making Business Case. In response to a further Committee Member question, it was confirmed that the consultation had followed the same format at all public meetings. Any data that had been anonymised for events held in Medway would have been anonymised elsewhere.

Confidence in process – A Member said that people in Medway lacked confidence in the consultation process and did not feel that their views had been properly considered. It was questioned whether the Stroke Review team felt the process to have been flawed given that Medway Maritime Hospital had been included in three of the consultation options but was not in the final chosen option. The Communications and Engagement Lead said that Medway and all other areas had been listened to. Common themes had been identified, such as concern about travel arrangements for relatives of stroke patients.

Bed Capacity – Independent analysis had identified risks in relation to the bed capacity of Option B and that Option D could have better capacity. A Member asked whether additional work would be undertaken to consider whether risks attributed to Option B could be better mitigated by Option D, whether detailed risk modelling had been undertaken for the other options, besides Option B and

whether work on the Decision Making Business Case (DMBC) had intended to make Option B appear stronger.

The SRO said that work had been undertaken in relation to potential increases in demand. She noted that the DMBC had forecast that demand would not increase significantly. However, the South East Clinical Senate had referred the Stroke Review team to evidence suggesting that demand could increase due to an aging population. The Senate had, therefore, requested that modelling work be undertaken in relation to bed capacity. Significant work had been undertaken with Medway Public Health to look at capacity needs over the next 20 years. Robust mitigations had been put in place relating to length of stay and bed capacity. Mitigation work had only considered Option B. There was no expectation that similar work would be completed for the other options. This work had not been undertaken to strengthen Option B but rather to answer the questions and concerns raised about Option B.

Acuity of patients – A Committee Member said that there was evidence that patients in Medway tended to be sicker than patients elsewhere before they would be admitted to hospital. Another Member highlighted that people from deprived backgrounds tended to have lower recognition of the importance of symptoms and were therefore more poorly when an ambulance was called.

The Regional Operational Manager of South East Coast Ambulance Service said that ambulance responses were driven by an assessment of the condition of the patient with geographic location having no bearing on the response. His experience did not indicate that people from deprived backgrounds called ambulances later and ambulances attended patients in deprived areas more frequently. There had been a successful campaign to help the public recognise stroke symptoms which had led to an increase in calls.

The Director of Public Health advised that a national stroke survey had found that people in deprived areas were less likely to recognise symptoms and therefore likely to be in worse state when they called ambulance. This same review using data from the national Stroke Sentinel Survey, found people living in areas of deprivation were also more likely to have a stroke, than those living in more affluent areas.

Transport Advisory Group – A Member asked when the decision had been made to establish a Transport Advisory Group, how it would help Medway and what representation Medway residents would have.

The SRO said that three groups had been established across Kent and Medway, including one for Medway and Swale. Initial meetings had taken place with the Medway and Swale Group having agreed to focus on patient discharge from hospital and associated transport and access arrangements. Suggestions made by each group would be submitted directly to the JCCCGs for consideration. Membership of the groups included a number of volunteers with the roles having been advertised. A list of those who had attended the Medway and Swale Group would be provided to the Committee. A Member said that they had not seen adverts for public participation in the Group.

It was requested that details of the membership of the existing Patient and Public Advisory Group be provided to the Committee. This group was part of existing NHS infrastructure and had been established three to four years ago. The Group had considered the stroke review proposals and consultation activity and it was confirmed that there was Medway representation on this Group. The Public Health Consultant highlighted that the Stroke Programme Board meeting on 30 January had talked about the establishment of a Patient Advisory Group, which suggested that the Group was being newly established. The SRO suggested that this was an error and that the reference should have been to the Transport Advisory Group. She undertook to clarify this point.

Consultation Process – A Member asked, whether, in view of inconsistencies in the consultation process, the decision to select Option B would be reconsidered and alternatives to the current model, that would better meet the needs of Medway, be considered. The SRO said that the decision would not be reconsidered as Option B had been the preferred option identified from full analysis of the consultation findings and all other relevant information.

Importance of Rehabilitation – A Committee Member said that rehabilitation would become even more important for Medway if it did not host a HASU. No clear information had yet been provided about rehabilitation, such as the locations of these services or the structure of these services. The SRO advised that rehabilitation services would be close to patient homes and aligned with community hubs. Medway and Swale already had strong community facilities that some other parts of Kent did not. An audit had been undertaken to provide an understanding of existing provision. A draft business case would be completed in early April with the expectation being that this would be finalised by the end of May. The Business Case would not be put forward to the JCCCGs until there was confidence of local support.

Outcomes in relation to journey times – In response to a Member statement that longer journey times to a HASU would lead to worse patient outcomes, the Regional Operations Manager accepted that this would be the case if everyone could be taken to a specialist centre as close as possible to their location. However, there was exceptionally strong evidence that taking patients to a HASU would result in a better outcome than a shorter journey to a non-HASU site.

Stroke rehabilitation Pathway – In response to a Member question about how the rehabilitation pathway would work and why rehabilitation had not been considered earlier in the Stroke Review, the SRO said that there would be several different pathways. Some patients would be well enough to go home directly from a HASU, with rehabilitation taking place in their home or in an outpatient facility close to their home. Medway had two good community hospitals with it being envisioned that these could be used. The focus of the stroke review had initially been on acute provision as this was the key to saving lives and reducing disability. However, outcomes would be better if acute provision and rehabilitation were integrated. It had not originally been intended that new rehabilitation provision would go live at the same time as acute provision but there had been feedback that the provision of acute stroke care

would be compromised without there being appropriate rehabilitation provision in place. (It was later clarified that Medway Community Health Care currently provide stroke rehabilitation which is not currently delivered via a community hospital model in Medway). Details of the planned rehabilitation facilities in Medway would be provided to the Committee. In Thanet, consideration was being given as to whether to provide rehabilitation services within the acute hospital. This was something that could be considered in Medway if there was a local appetite.

Workforce requirements – A Committee Member asked whether the workforce needs of each HASU had been finalised, how many staff would be needed, where they would be based and what action would be taken if it was not possible to obtain sufficient staff. The SRO said that the provision of HASUs would result in there being full specialist cover at all sites 24/7, which was not the case for existing non-HASU stroke units. It was anticipated that the equivalent of 7.1 consultants would be provided at Maidstone Hospital, 7.1 at Darent Valley Hospital and 9.6 at the William Harvey Hospital. Staffing levels would be over and above those specified in national guidance. Staff would move between the three HASUs when required but would have a base hospital. It was anticipated that staffing requirements would be met and it was noted that simply meeting, rather than exceeding, the national standard would enable three HASUs to operate.

Workforce evaluation – A Committee Member said that the evaluation of the workforce at each of the potential HASUs had been inconsistent. At the start of the consultation, workforce factors at each hospital site had been considered to be similar and would therefore not have a significant impact on the option chosen. However, following the consultation, Medway had been evaluated less strongly than other sites and it was difficult to identify what had changed. This appeared to have then changed again, with the papers considered by the JCCCGs on 14 February suggesting that workforce considerations had not had a significant impact on the option selected. The consultation had been in relation to stroke services and not about wider workforce considerations at each hospital but the Member felt that these wider issues had been considered subsequently in order to support the decision made to select Option B.

The SRO said that the way in which workforce requirements had been evaluated had not changed during the process. Factors considered had included the gap between the current workforce and the workforce required to provide a HASU and levels of staff vacancies and turnover. Implementation of a HASU would be a boost to the host hospital in terms of wider recruitment. Consequently, these factors were considered in the evaluation. The three hospitals in Option B had evaluated more strongly against these metrics.

Staff morale – In response to a Member question, the Committee was advised that decisions were communicated to staff immediately in order not to unnecessarily harm morale. There had been a number of meetings with staff at the existing stroke units. All staff had been assured that they would have a job following the implementation of HASUs. Morale would be boosted by

implementation of the HASUs as soon as possible. Any delay also risked staff being lost to neighbouring areas that already had HASUs.

Rollout of HASUs – It was confirmed that the existing stroke units would remain open until after the HASUs had become operational. The HASUs at Maidstone and Darent Valley would be ready to open earlier than the unit at the William Harvey Hospital. The preference of the Clinical Reference Group was for Maidstone and Darent Valley to open first, followed by William Harvey rather than waiting until all three units could open simultaneously. Concerns had been raised at a meeting of the JHOSC about the inequality of the William Harvey HASU opening later than Darent Valley and Maidstone. A workshop event would be arranged to give further consideration to the phasing of the implementation. A Committee Member suggested that the phasing of HASUs would not be fair on patients who would not be taken to a HASU while patients elsewhere in Kent and Medway would. The Stroke Review team noted that there was currently an inequitable service for all of Kent and Medway and that there were already HASUs in East Sussex and London but it was acknowledged that the phasing decision was a difficult one.

Changing the decision – A Committee Member asked if anything would make the JCCCGs reconsider its decision. The SRO said that this would not happen unless there was intervention by the Secretary of State for Health.

Closing comments – A Member said that this challenge was being made to save lives rather than because there was any desire to hold up the process. It was considered that there were inconsistences in the consultation and review process.

The SRO said that the review had tried to listen to concerns raised and answer questions as best as it was able in order to select the best option for the population of Kent and Medway as a whole.

A Member said that there had not been a preconceived idea that a HASU would be located in Medway and asked what evidence there was to support the claim that HASUs would save a life a fortnight in Kent and Medway. The SRO advised that this was based upon expected improvement to the service once HASUs had been implemented and upon the current number of strokes treated and patient outcomes. This had been evidenced by work with researchers at University College London. The supporting methodology would be shared with the Committee.

Another Committee Member said they were not only considering the needs of Medway as they considered that Option D was in the overall best interests of the health service in the whole of Kent and Medway.

Decision

The Committee agreed:

i) To exercise the power to report to the Secretary of State for Health about the proposed establishment of Hyper Acute Stroke Units (HASUs) at Darent Valley Hospital, Dartford, Maidstone Hospital and William Harvey Hospital Ashford (consultation Option B) and resulting removal of acute stroke services from other hospitals in Kent and Medway, including Medway Maritime, for the reasons set out in paragraph 6.2 and on the basis that the requirement to take practical steps to reach agreement with the NHS on this matter have been taken, as set out in paragraph 10.4.

ii) To Delegate authority to the Director of Public Health and Head of Democratic Services (who is the Council's Designated Scrutiny Officer) to take the necessary steps to produce and submit the report to the Secretary of State for Health, based on the rationale set out in paragraph 6.2, in consultation with the Chairman, Vice-Chairman and Opposition Spokesperson of this Committee.

iii) To formally notify the Joint Committee of Clinical Commissioning Groups for Stroke Services of the decision to report to the Secretary of State.

Chairman

Date:

Jon Pitt, Democratic Services Officer

Telephone: 01634 332715
Email: democratic.services@medway.gov.uk

APPENDIX E

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

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Medway Council

Serving You

Your ref:

Our ref: AJ/2019-1/Jones

Date: 24 January 2019

Councillor Alan Jarrett
Leader
Medway Council
Tel: 01634 332514
E-mail: alan.jarrett@medway.gov.uk

Rachel Jones
Director of Acute Strategy and Partnerships
K&M STP
2nd Floor
Magnitude House (D)
New Hythe Lane
Aylesford Kent
ME20 6WT

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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Transforming health and social care in Kent and Medway

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

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

Rachel Jones
Director of Acute Strategy and Partnerships

K&M STP

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