APPENDIX 2

Medway COUNCIL
Serving You

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

Rt Hon Matt Hancock MP
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Ministerial Correspondence and
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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

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[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

Medway 20
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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

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[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

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[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

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[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

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[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

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[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.

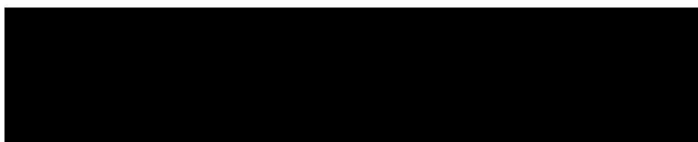
iii) Require the IRP to consider whether consideration should be given to the development of a HASU in Medway by instructing that a decision-making business case should be produced in relation to Option D of the public consultation, which would secure provision of HASUs at Medway Maritime, Tunbridge 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