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

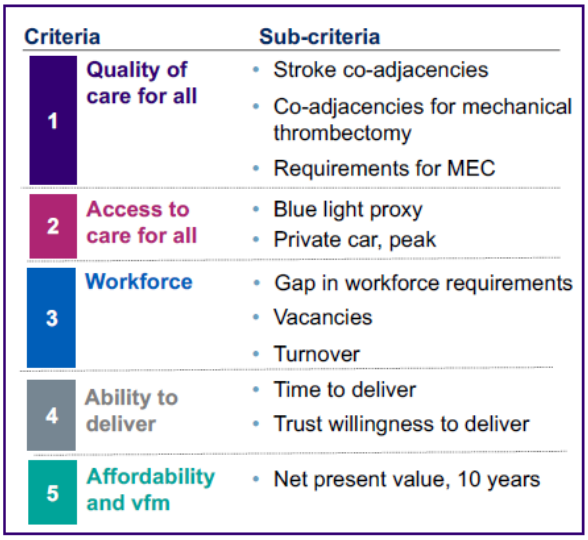
1.3.3 it does not sufficiently address the disproportionate adverse effects on residents from areas of higher deprivation, who have greater need for stroke services.

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:



Criteria		Sub-criteria
1	Quality of care for all	• Stroke co-adjacencies • Co-adjacencies for mechanical thrombectomy • Requirements for MEC
2	Access to care for all	• Blue light proxy • Private car, peak
3	Workforce	• Gap in workforce requirements • Vacancies • Turnover
4	Ability to deliver	• Time to deliver • Trust willingness to deliver
5	Affordability and vfm	• Net present value, 10 years

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:

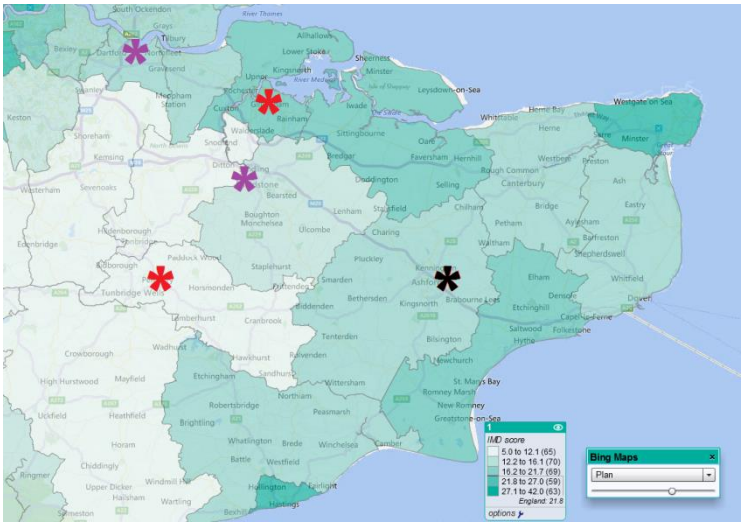
	Preferred Option - Within 30 minutes %	Percentage point change from baseline	Preferred Option- Within 45 minutes %	Percentage point change from baseline
Population overall	69.6%	-19.9%	92.4%	-7.4%
Females aged 16-44	71.5%	-17.9%	93.2%	-6.7%
Population with LLTI	66.2%	-22.2%	89.9%	-9.8%
Most deprived 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').

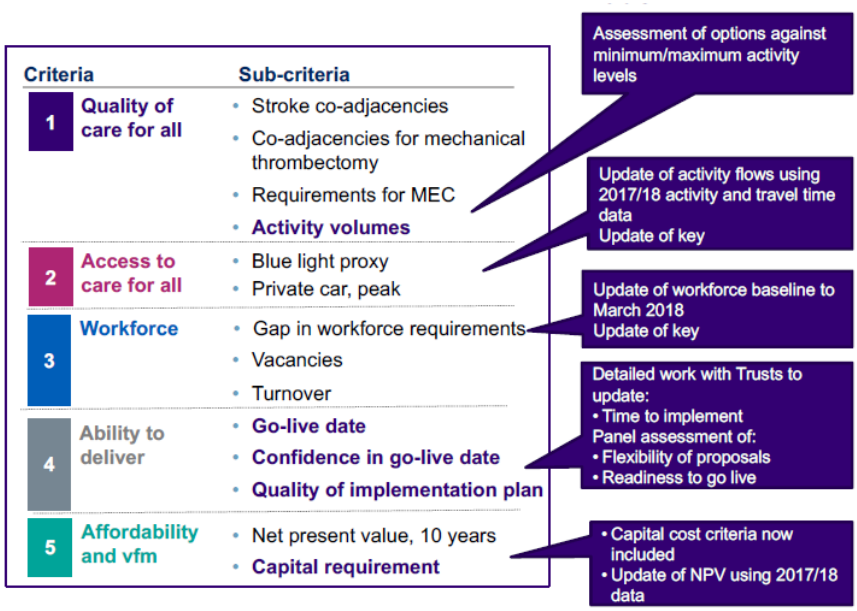
7.5.5 The decision to remove the prioritisation also appears to contradict the fourth overarching principle agreed by the JCCCG (see paragraph 7.2.4) which required that the evaluation criteria would be weighted to differentiate between options.

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
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TN9 1RE

Councillor Alan Jarrett
Leader
Medway Council
Gun Wharf
Dock Road
Chatham
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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

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[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

[redacted]

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
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ME2 4AU

NHS England South East
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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,
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York House,
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Horley,
Surrey,
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Councillor Alan Jarrett
Leader
Medway Council
Gun Wharf
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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
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Chatham, Kent ME2 4AU

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Dear Councillor Jarrett

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

With kind regards

Yours sincerely

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

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.

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;	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.	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. **Criteria** | **Option A** DVH, MMH, WHH | **Option B,** DVH, MGH, WHH | **Option C** MGH, MMH, WHH | **Option D** TWH, MMH, WHH | **Option E** DVH, TWH WHH Quality of care

		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