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Date: 6 February 2019

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Joint Committee of Clinical Commissioning Groups for Stroke Services

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

Sent electronically

Dear Mr Douglas and Ms Jones,

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely,

Jon Pitt

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

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

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

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

KENT AND MEDWAY STROKE REVIEW – CONSULTATION WITH THE JHOSC

MINORITY RESPONSE FROM THE MEDWAY COUNCIL REPRESENTATIVES ON THE JHOSC

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

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

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

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

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

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

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

PTO

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

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

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

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

Secondly,

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

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

Jon Gilbert - Enodatio Consulting Ltd

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

Opinion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.3.2 However, significant changes were made:

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

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

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

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

1.3.2.2 additional sub-criteria were included;

1.3.2.3 scoring keys were changed; and

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

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

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

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

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

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

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

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