Department of Health
An Roinn Sláinte
Männystrie O Poustie
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RESHAPING STROKE CARE – SAVING LIVES, REDUCING DISABILITY

Consultation Questionnaire

26 March 2019

Prepared by:

Hospital Services Reform

Department of Health

Annexe 3

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https://consultations.nidirect.gov.uk/

RESPONDING TO THE CONSULTATION

You can let us know your views by completing our Consultation Questionnaire online via **https://consultations.nidirect.gov.uk/**

You can also complete our Consultation Questionnaire and submit the completed document to the Department by email or by returning a completed hard copy to the address below.

If this document is not in a format that suits your needs, please contact us and we can discuss alternative arrangements. Before you submit your response, please read the information at **Annex A** about the effect of the Freedom of Information Act 2000, the Environmental Regulations 2004, the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (EU) 2016/679 on the confidentiality of responses to public consultation exercises.

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https://www.health-ni.gov.uk/sites/default/files/publications/health/DoH-Privacy-Notice.pdf

Section 1 – Consultee Details

Name (Optional):	**Brendan Hegarty**
Organisation and job title (if applicable):	**Chief Executive** **Fermanagh and Omagh District Council**
Address:	**2 Townhall Street** **Enniskillen** **Fermanagh BT74 7BA**
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Are you responding on behalf of your organisation or as an individual?

Organisation	√	**(Please Tick)**
Individual		

If replying as an individual, please indicate if you do not wish for your identity to be made public.

Whilst not essential, it would assist the Department in analysing responses if responding on behalf of an organisation you could provide details of who your organisation represents and, where applicable, how the views of members were assembled.
This response was agreed by Fermanagh and Omagh District Council on 12 June 2019.

The last date for responses to this consultation is **19 July 2019.**

Responses should be sent to:

Email: **StrokeConsultation@health-ni.gov.uk**

By post: Hospital Services Reform
Department of Health
Annexe 3
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Belfast BT4 3SQ

Section 2 – Questions relating to Reshaping Stroke Care – Saving Lives, Reducing Disability in Northern Ireland

These questions should be read in conjunction with the proposals set out in the accompanying consultation document.

Question 1: Do you agree that stroke patients should be admitted as soon as possible to specialist centres to deliver the best possible outcomes? (Please Tick)	**Yes**	
	No	**√**

Please use this space to expand your answer.

Council does not support this proposal as it is predicated on an assumption that patients would be moved to regional comprehensive stroke centres rather than local primary stroke centres.

Patients experiencing a stroke, or a stroke mimic, should be admitted as soon as is possible to a high quality local and accessible Integrated Stroke Unit, which is capable of providing rapid assessment, imaging services and thrombolysis. Within the Fermanagh and Omagh District Council area, such a unit is already in existence at the South West Acute Hospital (SWAH), which is repeatedly rated as the best stroke unit in Northern Ireland with a top "A" rating from the Royal College of Physicians:

Hospital	**No of Patients**		**Overall Performance**			
	Admns.	Discharge	SSNAP Level	CA	Ac	Combined K1
Royal Victoria	172	146	**A**	**A**	**A**	**A**
Antrim Area	98	93	**C**	**A**	**A**	**C**
Causeway	64	46	**D**	**A**	**A**	**D**
Downe General	TFP	TFP	**X**	**E**	**X**	**X**
Ulster Hospital	118	114	**C**	**A**	**A**	**C**
Craigavon Area	78	70	**B**	**B**	**A**	**B**
Daisy Hill	31	34	**B**	**A**	**A**	**B**
Altnagelvin	55	57	**D**	**A**	**B**	**D**
SWAH	**65**	**53**	**A**	**A**	**A**	**A**

Source: SSNAP Oct-Dec 2018
Team-Centred results for Routinely Admitting Teams

It is clearly demonstrated that the South West Acute Hospital (SWAH) is one of the top performing centres in Northern Ireland, outperforming other centres named within the consultation document in several key areas, including high rates of thrombolysis, the fastest time in the UK for the delivery of clot busting treatments and very fast times for access to a Stroke Specialist Consultant.

Council is aware that the latest SSNAP Audi for Jan- Mar 2019 is due for publication in July 2019, and would stress that these results must also play a vital part in any consideration in relation to the Reshaping of Stroke Services. Any reconfiguration which results in patients being redirected from this "A" rated performing unit to increase the throughput at lesser performing units at Craigavon and Altnagelvin would be directly harmful by delaying both the delivery of lysis and access to a Stroke Specialist Consultant. Council recognises that the clot removal procedure 'thrombectomy' is a specialist service provided only at the Royal Victoria Hospital (RVH) site as it relies on other services that are only available at this regional centre for Northern Ireland. The treatment is currently available between Monday and Friday, 8.30 am to 5.30 pm and around 70 patients currently receive this treatment each year. It is known that a thrombectomy procedure is also much more effective when it is given quickly. Council would support the enhancement of the service at the Royal to provide 24 hours, seven days a week access to mechanical thrombectomy. However, it is important that patients should first have access to a fully resources Hyperacute Stroke Services Unit (HASU), such as that available in the SWAH, for a comprehensive local assessment, emergency treatment including treatment with clot buster interventions. Those who require thrombectomy should be urgently transferred to the RVH with early discharge back to the SWAH for ongoing local acute and subacute stroke care. This contention is supported by evidence from the Calgary report which clearly supports the premise for the retention of the local thrombolysis service at the SWAH and Altnagelvin hospitals, as models which direct patients away from the West without access to lysis result in poorer outcomes: "The maps for HSCB are shown in Fig. 4. These maps immediately show the reduced probability of good outcome when only looking at patients with a LAMS[1] greater than 3 compared to all stroke patients, which is because those patients who have a LAMS of more than 3 are the most severe patients, and typically have poorer outcomes. Additionally, there is a green band to the north where patients with LAMS >3 are more likely to benefit if transported directly to the CSC,[2] rather than to their nearest PSC[3]. However, despite these differences, the two models yield very similar locations of when the Drip and Ship or Mothership transportation option should be used. The maps show that there is an area to the north and south of the CSC in Belfast that should always transport directly to the CSC, and	

[1] Los Angeles Motor Scale is a simple and validated assessment of stroke severity.
[2] CSC – Comprehensive Stroke Centre
[3] PSC – Primary Stroke Centre

patients should always be transported directly to the two PSCs to the west of Northern Ireland prior to moving to the CSC". All the options should therefore contain RVH, Altnagelvin and the SWAH as the basic minimum for HASU care.		
Question 2: Do you agree that, to deliver an effective service, staff need the opportunity to build and develop their specialist expertise? (Please Tick)	**Yes**	
	No	**√**

Please use this space to expand your answer:

The clear implication from the consultation document is that building and developing expertise can only be achieved within larger units and that smaller volume units are unable to train staff appropriately.. It is important that such a contention is not used as a basis for justifying and movement of services away from the SWAH.

Council is not supportive of this idea which is not supported by a robust evidence base. Training and continuous skill updating must be available across all units and community teams in the future. Investing in training staff locally and regionally via networking, modern on-line video networking, e-learning and site rotation can successfully deal with any identified training and development issues.

Training and staff development can be delivered locally, and the evidence is there to prove it – the Stroke Unit at the SWAH regularly achieves an "A" rating, despite under resourcing.

A whole pathway approach to the provision of stroke services is crucial in order to maximise the clinical outcome for patients, their quality of life and experience of stroke services. The first 72 hours of care are vital to ensure the optimum clinical outcome or stroke survivors. This needs to be underpinned by an effective whole system pathway from Hyper Acute Stroke Unit admission to subsequent rehabilitation and longer-term support if applicable.

In order to deliver services in a sustainable / resilient fashion in rural areas the teams should be linked to a local stroke unit and not exist as stand-alone teams. The proposals will require local stroke consultant involvement support to the ESD team if patients are being directly discharged increasingly early from HASUs. An In-reach and out-reach model from a local combined HASU/ASU would best support skills maintenance and effective resourcing of sustainable weekend rotas. The community teams need direct access to social care to enable Early Supported Discharge – similar to Hospital at Home Care models. The critical importance of local accessibility to Hyper Acute and Acute Stroke Units is key to the delivery of an effective Early Supported Discharge System.

Question 3: Do you agree that delivering better outcomes should take priority over additional travel time? (Please Tick)	**Yes**	
	No	**√**

Please use this space to expand your answer:

These two objectives are inextricably linked and there is a significant evidence base referenced within the consultation which proves that increase in travel times and the consequential delay to acute intervention will obviously result in poorer outcomes for patients from within the Fermanagh and Omagh District Council area. Any increase in travel times will result in slower and lower rates of lysis being available, with delayed access to a Specialist Stroke Services Consultant.

Evidence shows Hyper Acute Stroke Units provide better outcomes, but rapid access and carer involvement are also imperative for physical and psychological rehabilitation. There is a large body of evidence which details the critical importance of the provision of accessible services, some examples of which are included below:

"Travelling 90 minutes or more to a specialist stroke centre offsets any survival benefits from the care provided, a retrospective US study has found[4]"

"The typical patient loses 1.9 million neurons each minute in which stroke is untreated…. For patients experiencing acute ischemic stroke, and for the physicians and allied health personnel treating them, every second counts."[5]

The "trend towards centralisation of trauma services pays too much attention to the advantages of centralisation and not enough to the extent to which delays in reaching hospital care contribute to preventable deaths'"[6]

"In the debate between local versus centralised healthcare provision, 77% of the included studies showed evidence of an association between worse health outcomes the further a patient lived from the healthcare facilities they needed to attend…. A distance decay effect cannot be ruled out, and distance/travel time should be a consideration when configuring the locations of healthcare facilities and treatment options for patients"[7]

The Consultation document references the reorganisation of Stroke Services in London and Manchester which recommended that the creation of Stroke Units with more than 600 admissions per year resulted in less death and disability after stroke. Council stresses that

[4] BMJ 2016; 354 i4168 (Published 28 July 2016)

[5] Saver JL. Stroke. 2006; 37: 263-266

[6] Rousseau et al centre for health services research

[7] Kelly C, Hulme C, Farragher T, et al. BMJ Oct 16

neither of these examples can provide robust comparative evidence to inform the delivery of stroke services within Northern Ireland and are particularly irrelevant to the West and the South West of the region. The authors of this report, also outlined particular weaknesses: [8]

"Firstly, the hospital episode statistics database does not include information on severity of stroke, which is an important predictor of mortality. Secondly, we were unable to assess the impact of the reconfigurations on other outcomes, such as quality of life, disability, or neurological and functional impairment, as these measures were not collected in the hospital episode statistics database. Thirdly, the hospital episode statistics database includes only patients admitted to hospital. It does not include any information about patients who died before they reached the hospital, nor does it include information on the time of stroke; hence our analyses of mortality were based on time from admission. Fourthly, length of hospital stay was measured as the difference between date of admission and date of discharge. We assumed that when patients were discharged from one hospital and readmitted to another hospital on the same day this was a transfer related to the original stroke, capturing the movement between components of the stroke care pathway (for example, between a hyperacute stroke unit and a stroke unit in London). Conversely, we assumed that when a subsequent admission occurred one or more days later after discharge this was a recurrent stroke".

The welfare of the Stroke patient should be at the heart of any potential reconfiguration of Stroke Services, and the importance of the emotional support given by families and friends during their stay in hospital cannot be over-estimated. The location of the Stroke Unit can clearly impact on the potential for family members to make such journeys, particularly if they are dependent on public transport. Currently SWAH has the fastest Stroke Consultant delivery in the UK (RCP SNAPP National Stroke Audit).

The proposals within the Consultation document use average travel times and a notional maximum travel time, but this is of little relevance to stroke patients and their families within the rural areas of Omagh and Fermanagh, who will be disadvantaged, and their recovery and outcomes actually harmed by any proposed configuration to move away from the high performing unit in the SWAH. In London, Manchester and Exeter, acceptable travel times were less than 45 minutes. There can be no justification for Northern Ireland extending an acceptable limit to more than 60 minutes, without any examination of the effects on the populations affected.

[8] BMJ 2014;349:g4757

Question 4: Would the availability of additional measures such as the availability of an air ambulance address your concerns about additional travel time? (Please Tick)	**Yes**	
	No	**√**

Please use this space to expand your answer:

The Council is supportive of partnership working and partnering with the Air Ambulance on key health issues will be extremely beneficial. However, the Council does have concerns about the use of an Air Ambulance in relation to patients who have had strokes and require urgent life-saving treatment. Air Ambulance transportation may also be unsuitable for some stroke patients due to the potential adverse impacts of differences in air pressure.

Council stresses that the Air Ambulance Service cannot provide Northern Ireland wide stroke cover. The limited evidence from analysis of similar services in UK, Europe and USA indicates that it cannot deliver better outcomes for patients, than those provided by access to a local high performing Stroke Unit. The current service depends totally upon charitable donations, so there is rightly concerns about sustainability of the service in the longer term.

The priority of the current Air Ambulance Service is to deal with incidences of trauma and a specialised trauma team is dispatched with the helicopter. As stroke patients require a CT scan prior to commencing treatment, transport by Air Ambulance will not bring forward the initial commencement of acute stroke care.

Within the Western Trust area alone, there are not infrequently 3-4 stroke or stroke mimic cases presenting at any one time – such need could not be met by the Air Ambulance Service alone. The Air Ambulance Service is funded by Charitable donations, and any further pressures on the service will inevitably fall to the voluntary sector, unless sustainable funding is provided by the Government. Taking into account the fact that the Air Ambulance cannot fly at night or in bad weather, and the inaccessibility of some rural areas in relation to a safe landing place, it cannot provide a realistic transport option for the vast majority of stroke patients in the South West.

It can however be used to land on the existing helipads at SWAH or Altnagelvin (AAH) to transport a patient to the RVH for thrombectomy, following urgent imaging and clot busting treatment provided by the local stroke team.

Question 5: Which of the options do you think delivers the maximum benefit for stroke patients in NI? (Please Tick)	**Option A**	**√**
	Option B	
	Option C	
	Option D	
	Option E	
	Option F	

Please use this space to expand your answer:

Council strongly supports Option A as the proposed five site model delivers maximum coverage and the best outcomes for the population of Northern Ireland. It indicates the best performance in relation to travel times, with 99% of the population having a travel time to a HASU site of 60 minutes or less and a maximum time of 66 minutes. The inclusion of additional units with lower volumes of patients does not equate to or indicate the potential for poorer outcomes or issues with sustainability, as clearly evidenced by the current "A" rated performance within the SWAH.

Question 6: Are there additional options that we have not considered? (Please Tick)	Yes	√
	No	

Please use this space to expand your answer:

As supported by the evidence considered in the Calgary paper, Council stresses the importance of the retention of the two stroke units in the Western Trust region, Altnagelvin and the SWAH, to meet the issues posed by geography and access needs. The units could be strengthened by closer linkages to form a single stroke service providing improved staff coverage on a rota basis and resulting in a stroke service volume of 500+ acute admissions. This would enhance sustainability of the service in terms of local stroke team expertise and skills training, providing coverage for a wide geographic area.

A further 5 site model which has not been proposed would comprise RVH, Causeway, Daisy Hill, Altnagelvin and SWAH as 5 HASU's. This configuration would give excellent travel time coverage for Northern Ireland as patients within the Antrim and Craigavon areas are able to access the motorways to RVH for thrombectomy if required and go to a comprehensive stroke centre.

Cross-Border Provision

The Consultation document fails to consider the potential of cross border service provision for the border communities and Council recommends that further consideration should be given to include the modelling of a CAWT initiative in service re-design.

The populations of the bordering Counties accessible to the Stroke Unit at the South West Acute Hospital to are set out below:

County	Date	Population
Donegal	2016	158,755
Sligo	2011	65,393
Leitrim	2011	31,798
Cavan	2016	76,092
Monaghan	2011	60,483

Hospital	Stroke Unit
Cavan General Hospital	Yes
Sligo University Hospital	Yes
Monaghan General Hospital	No
Letterkenny General Hospital	Yes
Donegal Town Community Hospital	No
Our Lady's Hospital, Manorhamilton, Co Leitrim	No

Section 3 – Equality and Human Rights

Section 75 of the NI Act 1998 requires departments in carrying out their functions relating to NI to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between person with a disability and persons without; and
- between persons with dependants and persons without.

You may wish to refer to the Equality Screening, Disability Duties and Human Rights Assessment Template at **https://www.health-ni.gov.uk/consultations**

Question 7: Are any of the options set out in the consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the 1998 Act? (Please Tick)	**Yes**	√
	No	

If yes, please state the group(s) and provide comment on how these adverse impacts could be reduced or alleviated in the proposals:

In relation to Models B, D, E and F which would result in the removal of both the inpatient acute service in the SWAH and the rehabilitation service in the Omagh Hospital, Council wishes to highlight the following adverse impacts which would ensue:

Age – Older People

Older stroke patients and their elderly relatives would be required to travel longer distances for treatment or to visit their family member. This would compound the disadvantage already experienced by this group in relation to measures of rural deprivation, including a poor rural transport network.

There is a body of evidence which shows that such patients have delayed recovery due to the isolation experienced by being isolated in distant hospitals, which also impacts on mental health.

It also can delay discharge of patients if there are no local stroke beds, thus adding to the emotional and mental health stress problems for elderly patients.

Disability

Patients with a disability who can access local services with their own transport will also be adversely impacted under these models.

The pressure which will be experienced on hyperacute beds in the larger units will inevitably result in patients with a high degree of disability being discharged without readily available access to appropriate rehabilitation and social care services. The proposals within the consultation do not consider any solution as to how this adverse impact could be mitigated.

Gender and Caring Status
The adoption of Models B, C, D, E and F present significant challenges to the provision of care both at distant units and back in isolated rural areas, without the support of local inpatient facilities or a Specialist Stroke Team. As women continue to provide the bulk of caring in our society, they are particularly adversely affected under these Models. The lack of agency domiciliary carers in rural areas adds to this burden and is neither acknowledged or addressed within the consultation.

Question 8: Are you aware of any indication or evidence – qualitative or quantitative – that any of the options set out in the consultation document may have an adverse impact on equality of opportunity or on good relations? (Please Tick)	**Yes**	**√**
	No	
If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact: In relation to Models B, D, E and F which would result in the removal of both the inpatient acute service in the SWAH and the rehabilitation service in the Omagh Hospital, Council wishes to highlight the following adverse impacts which would ensue: The loss of up to 25 beds and associated job losses or relocations from the Fermanagh and Omagh areas would have a significant economic and social impact upon the area. This would also affect recruitment to other health care disciplines as the closure of an "A" rated unit would seriously affect confidence in the longer-term sustainability of the hospital. Future trainees and staff would not commit to a hospital with a downgraded and reduced service profile.		

Question 9: Is there an opportunity to better promote equality of opportunity or good relations? (Please Tick)	**Yes**	√
	No	
If yes, please give details as to how: Council strongly supports Option A as the proposed five site model delivers maximum coverage and the best outcomes for the population of Northern Ireland. This option would result in good performance in relation to travel times, with 99% of the population having a travel time to one of the HASU sites of 60 minutes or less and a maximum travel time of 66 minutes. This would also minimise the mentality of who were the winners and who were the losers across the whole of Northern Ireland.		
Question 10: Are there any aspects of the proposals in the consultation where potential human rights violations may occur? (Please Tick)	**Yes**	√
	No	
If yes, please give details as to how: In relation to Models B, D, E and F which would result in the removal of both the inpatient acute service in the SWAH and the rehabilitation service in the Omagh Hospital, Council wishes to highlight the following potential Human Rights Violations which could ensue: Article 2 "The Right to Life" – For the population of Fermanagh and Omagh, there is a potential violation in relation to the resultant removal or reduction in local hyperacute services, the acknowledged increased travel times, and the delays to definitive therapy which will affect survival rates and recovery rates. Article 14 "Protection from Discrimination" – The adoption of these Models would result in a disproportionate adverse effect on the elderly, the disabled, carers and people living in rural areas.		

Section 4 – Rural Impact

The Rural Needs Act (NI) 2016 became operational on the 1 June 2017 and places a duty on public authorities, including government departments, to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services. A draft rural needs impact assessment has been prepared against these policy proposals.

Question 11: Are the actions/proposals set out in this consultation document likely to have an adverse impact on rural areas? (Please Tick)	**Yes**	**√**
	No	

If yes, please provide comment on how these adverse impacts could be reduced or alleviated:

In relation to Models B, C, D, E and F which would result in the removal of both the inpatient acute service in the SWAH and the rehabilitation service in the Omagh Hospital, Council wishes to highlight the following differential impacts on the rural community which would ensue:

- Poorer outcomes for the 90% of rural acute stroke cases not receiving thrombectomy.
- Lower level and unequal service provision
- The worsening of existing measures of rural disadvantage in relation to income levels, employment opportunities and access to services including transport. This is then amplified when you consider the condition of the road infrastructure within the District, some of which have been deteriorating for a long period of time – due to budget cuts and the lack of a Northern Ireland Executive.
- Resultant skills migration to urbans areas.

The delivery of Model A provides the optimum approach to addressing the adverse impacts on the rural community.

There is a need for a regional policy framework that responds to the special circumstances and requirements of the countryside. Services in rural areas are at great risk unless the 'rural premium' is taken into account when assessing service provision. The rural premium is the extra cost of delivery of services to people living in a rural area, compared to those who live in an urban area. This is already a fundamental problem affecting the availability of and access to a range of local services. It has been highlighted in the health and social care sector that the funding formula tends to favour urban areas and does not take into account the impact of providing services over a wider geographic area in rural areas. The decision to cut services in rural areas cannot be based simply on cost and the number of people using the service. Instead, commissioning bodies must undertake broader impact assessments, taking social impact into account.

Local service commissioners should have to respond to user indicators of quality so that they gain a clearer sense of what local people are saying they need. For many rural users standard measures of performance are less attractive than other measures of quality (such as proximity). There is a need to increase rural premiums in order to sustain services, not only because the services are valuable in themselves, but also because of their essential role in sustaining diverse and remote communities. Resource allocations should reflect the higher costs of delivery in rural areas, and other factors such as demography and dispersed population should be integral to the process.

Responses must be received no later than 5pm on 18 June 2019.

Thank you for your comments.

ANNEX A

Confidentiality and Access to information Legislation

The Department may publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be published or disclosed on request in accordance with information legislation; these chiefly being the Freedom of Information Act 2000 (FOIA), the Environmental Information Regulations 2004 (EIR), the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) (EU) 2016/679. The Department can only refuse to disclose information in exceptional circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The FOIA gives the public a right of access to any information held by a public authority, namely, the Department in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

If you do not wish information about your identity to be made public please include an explanation in your response. Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the DPA and the General Data Protection Regulation (EU) 2016/679. The Department is committed to building trust and confidence in our ability to process personal information. This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances.

For further information about confidentiality of responses please contact the Information Commissioner's Office on **0303 123 1113** or via https://ico.org.uk/global/contact-us/