Reshaping Stroke Care

Rural Community Network
SUPPORTING RURAL COMMUNITIES

Response to the Department of Health consultation by

Rural Community Network

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Background to RCN

Rural Community Network (RCN) is a regional voluntary organisation established in 1991 by local community organisations to articulate the voice of rural communities on issues relating to poverty, disadvantage, equality, social exclusion and community development. Our vision is of vibrant, articulate, inclusive and sustainable rural communities across Northern Ireland contributing to a prosperous, equitable, peaceful and stable society. Our mission is to provide an effective voice for and support to rural communities, particularly those who are most disadvantaged.

RCN is a membership organisation with 250 members across Northern Ireland. Its Board is representative of its membership base with more than half of its representatives (12) elected democratically from the community. The remaining representatives are a mix of organisations that provide support or have a sectoral interest within rural communities. RCN's aims are:

- to empower the voice of rural communities
- to champion excellence in rural community development practice
- to develop civic leadership in rural communities
- to actively work towards an equitable and peaceful society
- to promote the sustainable development of rural communities

Response to the Consultation

Rural Community Network welcomes the opportunity to respond to the consultation.

Commitment 1

RCN supports, in principle, the commitment to identify a regional model for TIA assessment to deliver a 7-day service of specialist assessment within 24 hours of symptoms. RCN is interested in giving its views on any proposed regional model and to assess how accessible it will be to rural citizens particularly those living in more remote rural areas.

Commitment 2

RCN supports, in principle, the commitment to remove the variance in delivering thrombolysis to ensure patients have timely access to the treatment. Under the current system only 4 in 10 patients are admitted to stroke ward in the first 4 hours. The consultation document should have included a breakdown of this statistic across all stroke units, an analysis of reasons why patients were not admitted (percentage presenting outside 9-5 Mon-Fri, % who were not brought to hospital in time as they lived alone etc.).

Headline statistics on rates of Thrombolysis and time variations are presented but again no breakdown is provided across the 8 locations and no analysis is presented on the reasons for the variations.

Commitment 3

RCN supports the commitment to invest in the growth of thrombectomy and acknowledges that due to its complexity it is likely that this will only ever be provided at a single regional centre. The consultation should have included some detail on the current pathway for patients from rural areas who are treated in ASUs currently are diagnosed and transferred for thrombectomy and data should have been provided on outcomes for those people who transfer from other stroke units for thrombectomy.

Commitment 5

RCN supports the commitment to improve rehabilitation and long-term support services. The Stroke Association report's findings quoted in the consultation document are damning and point to the urgent need to improve rehabilitation and support services for stroke survivors and their families.

Commitment 6

The HSC commits to undertaking a workforce review to identify the staffing and skill mix required to deliver effective stroke services. This section of the consultation document acknowledges some of the most prominent workforce issues. It doesn't state whether any pre-

consultation discussions have taken place with staff or their trade union representatives. It does not identify the additional challenge for staff if services are consolidated and their positions are re-located. RCN accepts that those discussions can only take place when a draft model of services has been agreed but the Department must acknowledge that this will prove difficult for staff and may impact on the quality of delivery of stroke services in any newly reconfigured model. The shortage of consultants is identified as a problem, but no proposal is put forward as a potential solution.

Reshaping Hospital Care

Commitment 4

This commitment to re-shape stoke services from 11 locations to a network of dedicated hyperacute and acute stroke units was always going to be the most controversial part of the proposals.

RCN agrees that non-acute hospital care should be provided inside specialist stroke units as supported by research and stroke clinical guidelines.

Proposals to consolidate health services which, in effect, extend travel times for citizens to access acute care are always controversial. RCN finds it difficult to make informed comment on any of the proposed models for hospital-based care due to the difficulties with the evidence presented in the consultation document.

Travel time evidence based on Google maps travelling at 5am to represent an ambulance journey with lights and sirens is only a starting estimate of travelling time. Citizens at the public consultation meeting in Newry queried travel times presented in the consultation document with their lived experience. This flawed evidence undermines the Department's case for change. We would suggest that the Department should have invested in an independent assessment of travel times from a range of locations at a range of times in the day across NI to provide real world evidence. It is impossible to model all traffic and weather conditions but at least some attempt should have been made to have a realistic travel time estimate as a benchmark.

The consultation does not give any breakdown of the number of stroke patients who arrive by ambulance compared to those who arrive by private car. Travel to hospital by private car will inevitably involve a longer journey time than by ambulance.

Commitment 7

The consultation refers to the "potential expansion" of the Helicopter Emergency Medical Service (HEMS) and the development of a new Clinical Response Model for the NI Ambulance Service as options to minimise travel time within the new model of care.

The HEMS could play an important role in facilitating rapid access to HASUs from more remote rural areas. RCN believes more detail is needed to assess whether this is a realistic proposal. Our understanding is that the HEMS is currently a charity which depends on fund-raising for most of its income. It currently has one helicopter with a back-up helicopter and had 886 taskings between July 2017 to May 2019. It is operational 7 days a week between 7am and 7pm. No evidence is provided in the consultation of the average number of hours per tasking and RCN is unable to comment on whether the use of the HEMS will make any difference to rural citizens from remote rural areas accessing HASUs in a way that will make a significant difference to their outcome. RCN would have preferred to see some analysis on how the HEMS would enhance access to acute stroke care and how much that would cost.

RCN has no knowledge of the consultation on the new clinical response model proposed for the NIAS. If the proposals can reduce the proportion of patients receiving the highest level of response and identifies category 1 patients earlier than is currently the case, then hopefully NIAS resources can be targeted more efficiently. This may have a positive impact on travel times for rural citizens reaching HASUs. RCN is concerned, however, that no detail is provided in the consultation on current ambulance response times in rural communities. We are aware of difficulties in some remote rural communities with ambulances being delayed due to traffic or road conditions or unable to find addresses/incidents. This would enable a more informed consideration of the contribution of ambulance services to facilitating timely access to rationalised HASU services.

The consultation does not provide any analysis of current pinch points or obstructions in the NI road network which will slow access to HASUs. A realistic appraisal of the state of the current strategic road network and a commitment to address key pinch points would alleviate some of the concerns of rural citizens about access to a rationalised acute/hyper-acute stroke care service. To achieve this the Department should have engaged with the Department for Infrastructure to discuss any planned improvement work on the strategic road network before the proposals were brought to public consultation.

RCN is concerned that the consultation makes no reference to the potential for provision of cross border stroke care. This issue was raised several times at the Newry public consultation session. It may not have made any material difference to the proposed models for hospital care but it should have been considered and evidence of the current numbers of cross border patients could have easily been included in the consultation. Given the prevalence of discussions of Brexit and its potential impacts it is surprising that the issue of cross border access was ignored in the proposals. Knowing the reciprocal arrangements that are currently in place there is an imperative to consider what will happen to patients who currently make use of services on a cross border basis. It is concerning that there does not appear to have been any attempt to discuss the potential for development of stroke care services on a cross border basis. Cross border provision of acute stroke services in SWAH and Daisy Hill could be provided on a similar basis to the North West Cancer Centre at Altnagelvin. Without any data on the

current and potential use of services by patients from the Republic of Ireland we have no idea of the impact of this change of people in the Republic or the viability of services if such populations were taken into account. In RCN's view this is a serious oversight by the Department.

Rural Proofing

The Department has prepared a detailed Rural Needs Impact Assessment of the proposed change in Public Service Design. RCN would make the following comments on the RNIA:

1E: The Department uses an alternative definition of rural (as suggested by DAERA) "Populations outside of a 30 minute drive time of Derry or Belfast". Whilst this is reasonable RCN is surprised that no reference was made to this definition in the assessment of the advantages and disadvantages of the various models of location of HASUs.

2A: The RNIA does identify the increase in travel time taken for some people to travel to hospital stroke units as a direct negative impact. It should also clearly state that timeliness of accessing treatment is a key factor influencing patient outcomes.

3A: The RNIA states that further engagement to include rural communities is planned as part of the public consultation exercise. RCN would be interested to know more details of further engagement the Department has planned with rural communities.

3B point 1: We note that in July 2017 the Department held a series of five survivor and carer workshops as part of its pre-consultation process**.** It highlights that three of these workshops were held more than 30 minutes from Derry or Belfast in Omagh, Lurgan and Ballynahinch. Travel time from Ballynahinch to the Royal Victoria Hospital is just inside the thirty minute travel time to Belfast according to Google maps but obviously will vary significantly depending on traffic conditions. Travel time from Lurgan to Craigavon hospital is less than ten minutes. It would have been more informative for the Rural Needs Impact Assessment to schedule some of these workshops in more remote rural locations.

3C: Rightly identifies the importance of a timely ambulance response and journey to hospital as a key health and social care need when accessing acute stroke care.

5A: Journey times to any reconfigured model of acute stroke services is rightly identified as a key concern. Citizens at the public consultation meeting in Newry queried travel times presented in the consultation document with their direct lived experience. This flawed evidence undermines the Department's case for change. We would suggest that the Department should have invested in an independent assessment of travel times from a range of locations across NI to provide real world evidence. It is impossible to model all traffic and weather conditions but at least some attempt should have been made to have a realistic travel time estimate as a benchmark.

The expansion of HEMS and a new clinical response model for the NIAS are both referred to but no actual evidence is presented as to how any of these options will realistically impact on travel times for rural citizens trying to access acute stroke services.

Comment on the Public Consultation meeting in Newry:

RCN's Policy Officer attended the public consultation session organised by the DoH on Tuesday 2 July in the Canal Court Hotel in Newry. The format of the consultation meeting was deeply flawed. No information was given to the public in advance of how the consultation meeting would be conducted. Some consultees turned up with lengthy contributions to read out and were informed by the moderator they wouldn't be allowed to speak beyond a few minutes. This had the effect of further irritating a large number of people in the audience. Ten minutes was wasted in an argument between the moderator and the audience on how long one contributor would be permitted to speak.

No meaningful data was presented on:

- The current rate of admissions to the stroke unit in Daisy Hill hospital
- The breakdown on outcomes for those who present with stroke symptoms outside 9-5 Monday to Friday compared with those who present when stroke unit is operational across all stroke units.
- Comparison of data on patient outcomes between part time stroke units and the 24/7 stroke unit in RVH which would have been useful to inform the debate.
- Ambulance response times in Newry, Mourne and Down area and how ambulance service is performing.
- The number of patients diagnosed with stroke who arrive by ambulance compared to those driven to hospitals by family members, co-workers etc.
- Consideration of cross border stroke care and whether stroke care for patients South of the Border could facilitate development of a HASU in Daisy Hill.

Some time needed to be set aside for this detailed presentation of evidence. My impression was that the Department assumed that all those who attended the meeting had read the consultation document in detail.

Panel members who were there avoided some audience members questions which further annoyed people who were already upset that Daisy Hill was not considered as part of any of the proposed options for reconfiguration of acute stroke care. The moderator of the session didn't press panel members to answer questions fully or even ask them to clarify whether they didn't have the information to answer those questions. She frequently moved onto ask for new questions before an answer had been given to the previous question asked – this caused further frustration to consultees.

Unrealistic data was presented on travel times. The Department needs to invest in real time modelling of travel times to be able to present a realistic picture of what rationalisation of

services will mean for access times to consolidated services. If people who live in these communities and know the time it takes to drive to hospitals are told that drive times are considerably shorter then it isn't surprising that they suspect that this is a cost cutting measure.

Citizens need their concerns acknowledged in an open way. The Department of Health talks quite a bit about co design and co-production and the employment of community development methodologies – none of these approaches were evident at this session. The Department needs to learn from this process and invest in doing it better as this is only one service of dozens that will go through the "consolidation process" if the Bengoa reform agenda is to be implemented.