Reshaping Stroke Care: Saving Lives, Reducing Disability
Consultation Response from Fermanagh and Omagh District Council
[Department of Health]

Brief Background to the Fermanagh and Omagh District Council Area

The District Council area is home to 114,992 people, approximately 52,500 jobs and 7,175 businesses. The District Council area is Northern Ireland's largest region in terms of land mass - approximately 3,000km² (or 20% of NI) - and is the smallest in terms of population. As a result, the population density of approximately 41 people per km² is the sparsest in Northern Ireland. This is a key feature of the district but presents challenges in terms of accessibility and service delivery.

Consultation Response

Fermanagh and Omagh District Council (Council) welcomes the opportunity to respond to the Department of Health (DoH) on the recently published 'Reshaping Stroke Care: Saving Lives, Reducing Disability' document.

In terms of this consultation there are several proposals with which the Council has concerns; however, these will be explored fully within this response document. Council notes that the conclusions drawn from both the Calgary and Exeter reports do not reflect the Department of Health's proposals but have been interpreted in a way which the Council does not agree with.

The Council's specific responses to the individual proposals (or options) are set out in the Consultation questionnaire; however, Council wishes to address critical issues which will have a huge impact on service location separately as it is felt these are not adequately covered within the questionnaire.

1. Performance of the South West Acute Hospital

The consultation document (on page 8) refers to the 'reports' and 'audits of performance' which are carried out by RQIA, the Royal College of Physicians (RCP) and London School of Economics – which show that services are falling short:

> The single most important factor in delivering better outcomes for stroke patients is the quality of care provided in a stroke unit. Evidence ranging from RQIA reports to audits of performance carried out by the Royal College of Physicians (RCP) and London School of Economics demonstrate that services are falling short.

However, the Council stresses that this is not the case for all stroke units in Northern Ireland, nor has it been for several years.

For a considerable period of time, the South West Acute Hospital has been outperforming other centres in Northern Ireland in relation to stroke care – and the Council feels that this is not reflected in any of the Consultation Documentation. By

not reflecting this within the documentation, the public are being misled into thinking that all stroke services being delivered in Northern Ireland are inadequate.

The Sentinel Stroke National Audit Programme (Kings College London) was referenced in the Department's previous pre-consultation (2017), however it has been omitted from this document. This recent report ('Stroke Care in England, Wales and Northern Ireland') demonstrates that the South West Acute Hospital in Enniskillen is the best performing centre in Northern Ireland.

South West Acute Hospital achieves category 'A' (highest standards for almost all patients) in the following areas:

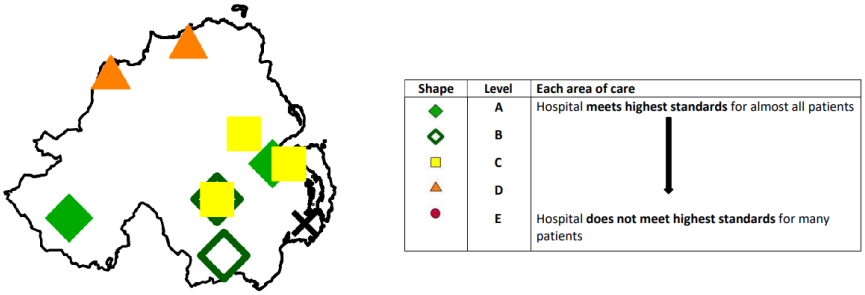
- SSNAP level.
- SSNAP participation.
- Brain scanning.
- Stroke Unit.
- Thrombolysis (Clot Busting Treatment).
- Specialist assessments.
- Occupational Therapy.

Category B level is achieved for areas including

- Physiotherapy (no centre in Northern Ireland achieved Category A level in terms of physiotherapy).
- Speech and Language Therapy.
- Team working (highest ranked centre in Northern Ireland).
- Standards by Discharge.

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.

The SWAH (overall) was the highest rated hospital in Northern Ireland and the **only** hospital to receive an overall Category A Grade - as demonstrated in the below image:



(Source: **Stroke Care in England Wales and Northern Ireland - October to December 2018** (Kings College London – Sentinel Stroke National Audit Programme [SSNAP])

This performance is not only reflected in recent statistics/reports – the SWAH also performed very well in previous reports (December 2016 – March 2017) when it was recognised as the highest performing hospital in Northern Ireland at this point as well.

Therefore, considering its current (and previous) performance, the Council strongly recommends that the SWAH is developed as a Centre of Excellence – it clearly meets (and exceeds) the criteria for assessing the sustainability of services which are set out in the Bengoa Report entitled 'Systems not Structures'.

Whilst the Council accepts that there is a need to provide safe, modern, sustainable and affordable stroke services, however this should be done in a manner that makes optimum use of the significant capital expenditure already invested within the SWAH as well as reflecting on the level of performance and expertise provided within SWAH.

The Council is also adamant that it is inequitable for services to be located away from the rural West – leaving individuals with further travel distances and time before receiving treatment.

Irrespective of the model of care which is adopted, it is imperative that the performance of the South West Hospital is recognised. The Hospital received an initial investment of £276m and it is vital that Stroke Services are retained, not only in recognition of their demonstrable quality, but also because of the impact on the sustainability of other services within the hospital.

2. Importance of Timely Access to Stroke Services and Specialist Centres

When read in the context of the proposals contained within the Consultation document, Council does not support that proposal as it is predicated on an assumption that patients would be moved to regional comprehensive stroke centres rather than local primary stroke centres. The document also indicates that smaller volume units are unable to train staff appropriately. The Council does not agree that small units, like the one in the SWAH, cannot develop specialist expertise, as is evidenced by the consistently high SSNAP Clinical Audit results

There is substantial research and evidence that demonstrates the importance of HASUs in providing better outcomes for individuals. Although, HSAUs are vitally important, the issues of rapid access and carer involvement for full physical and phycological rehabilitation are also key.

The large body of evidence details the critical importance of providing quick access to services with 'every second counting'. Some examples are included below:

> A BMJ report published in 2016 stating that '..travelling 90 minutes, or more, to a specialist stroke centre offsets any survival benefits from the care provided'.
>
> '…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…' (Saver JL).

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…'(Rosseau et al).

'…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…' (Kelly, Hulme, Farragher et al).

In line with the Council's response to other consultations (particularly health related consultations), the welfare of the individual should be at the heart of any reconfiguration or change process. Therefore, timely access should be reflected in all proposals and, in this instance, timely access is not being reflected fully.

Timely access to services will not only ensure that patients received life-saving treatment as soon as possible, but it will also ensure that patients can receive as much emotional support as possible (from family and friends) during their stay in hospital. The importance of this emotional support cannot be overestimated and placing additional pressures on families at times when their loved ones require the best possible support is not beneficial nor recommended.

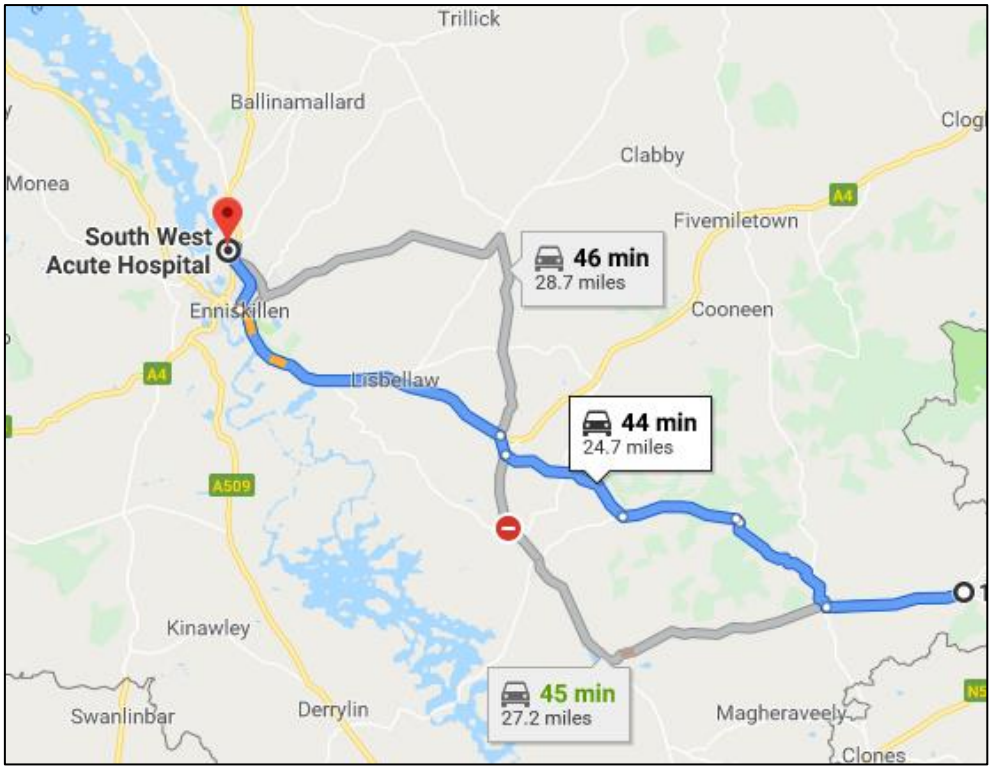
Examples of potential journeys faced by individuals within the Council area who wish to visit loved ones in other locations are included in Appendix 2. The Council believes that placing additional travel/journey times on a patient's family/friends, will only create additional stresses, pressures and ultimately costs.

3. Delivery of Outcomes vs Additional Travel Time

The Council does not agree with the perception that better outcomes can be delivered, if patients must travel further to receive treatment.

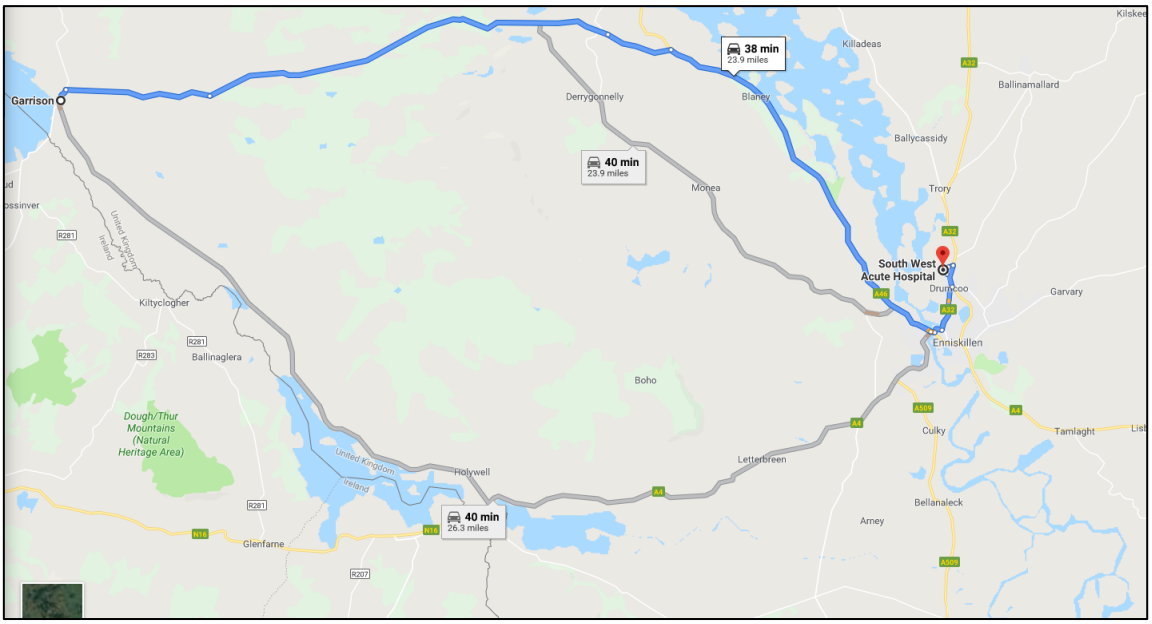
As stated previously within this consultation response – there is substantial expert/academic research which demonstrates that 'travel time' and 'better outcomes' are often interlinked.

Within the present system patients in many rural parts of Fermanagh already have a considerable journey to receive treatment in the SWAH – for example, patients living in Rosslea must travel for at least 44 minutes before they reach the SWAH – it is worth noting that this does not take into account the ambulance response time – potentially another 40 mins before it reaches the patient. This potentially leaves a patient waiting for 1 hour 24 minutes before they reach the SWAH at present.



(Rosslea to SWAH Journey)

The same issue is relatable across western parts of Fermanagh – anyone living in Garrison must travel for at least 38 minutes at present, before they reach the SWAH. Taking into account Ambulance Response Times, a patient will have to wait for over an hour.



(Garrison to SWAH Journey)

When dealing with patients who have suffered a stroke, the Council believes that time is precious – every minute that passes by a patient potentially loses up to 1.9

million neurons. Therefore, it is vital that patients receive the life saving treatment as soon as possible, reducing travel/journey time to a minimum.

The Council feels strongly that by removing stroke services from the SWAH, it would be impractical to transport patients to other centres for treatment – particularly when they would be driving past the SWAH – which has outperformed all other centres in Northern Ireland for several years.

4. Options Outlined Within Consultation Document

The Council believes that Option A is the most suitable option outlined. The full reasoning for this is outlined in the below paragraphs. The Council

Council comments on each of the six options to reshape hospital-based care (as outlined within the Consultation Document)

Option A: HASUs situated at Altnagelvin, Antrim, Craigavon, Royal Victoria and South West Acute hospitals. ASUs would be co-located.

The Council feels that this option is the fairest option outlined within the Consultation Document. Whilst it is acknowledged that four of the five of the HASUs will be below recommended admission levels, Council would stress that this occurs for the vast majority of centres (apart from the Royal Victoria Hospital) for all six options.

The Council also notes the fact that the Consultation Document, when outlining Option A, is very complimentary of the performance of the South West Acute Hospital – stating '…the SWAH's performance is not one that can be easily replicated elsewhere'. Therefore, there is strong reasoning within this Option for retaining a HASU within the SWAH – given the difficulty in replicating this performance standard elsewhere.

In terms of travel time, this option also proves fair for patients across Northern Ireland with the maximum travel time for anyone being estimated at 66 minutes. It is worth noting that this does not take into account issues such as roads infrastructure, ambulance response time, etc.

Option B: HSAUs located at Altnagelvin, Royal Victoria, Craigavon and Antrim Hospitals

The Council strongly opposes the introduction of Option B. Firstly, on the basis of fairness and equality, rural residents are being indirectly discriminated against.

The Consultation Document estimates that 94% of the population of Northern Ireland is within a 60-minute travel time of a HASU.

The Council feels it is entirely inappropriate for the vast majority of the Fermanagh and Omagh District (particularly residents in western areas of County Fermanagh) all of whom will have to travel for 60 minutes or longer – before taking into account other issues like: roads infrastructure, ambulance response time, etc.

The Council also questions the impact of introducing this proposal when the Department would be extending a patient's potential travel time by 40 minutes – a patient who is already very ill and in the majority of cases needing life-saving care.

Option C: HASUs located at the Royal Victoria, Altnagelvin, Craigavon and South West Acute Hospitals, with ASUs co-located and the consideration of a fifth at Ulster Hospital.

The Council believes that Option C is slightly fairer model that that which is outlined in Option B. However, in terms of travel time alone – it does not appear to be as fair as Option A, providing a lesser service for the overall population in terms of coverage and accessibility.

Although there is no differential impact (to Option A) for the Fermanagh and Omagh District, there is potentially an additional 15-minute travel time for patients/individuals in other areas of Northern Ireland.

Option D: Initially 4 HASUs at Royal Victoria, Altnagelvin, Craigavon and Antrim hospitals with services to be removed from Antrim Hospital over time.

The Council feels that this phased approach is entirely unacceptable. Altnagelvin Area Hospital is consistently being rated as poor performance standards in comparison to the South West Acute Hospital, which is not even proposed as an ASU site.

During the first phase (4 HASUs) 6% of the Northern Ireland population will live over 60 minutes from a HASU, with this figure rising to 7% when the HASU sites are reduced to three.

The Council also notes that no map has been included within Option D to illustrate potential travel times for other areas of Northern Ireland.

Option E: HASUs located at Royal Victoria, Altnagelvin, Craigavon and South West Acute hospitals with services to be removed from the South West Acute Hospital over time.

Again, the Council would strongly oppose the introduction of Option E. The travel times, when compared to Option A, are not adequate particularly when the number of HASUs are reduced to three.

Individuals in rural areas will be particularly adversely impacted upon. A full comparison of travel times between Option E and Option A are:

	Option E (phase 2)	**Option A**
Population % within 60 mins of a HASU	93%	99%
Estimated maximum travel time	106 mins	66 mins

Option F: HASUs located at Royal Victoria, Altnagelvin and Craigavon hospitals. ASUs will be co-located with additional ASUs at Ulster and Antrim hospitals.

The Council acknowledges this option as the poorest of the six outlined within the Consultation Document.

In terms of travel time, 7% of the Northern Ireland population would live more than 60 minutes from a HASU, with the maximum travel time being 120 mins – 60 minutes longer than that outlined in Option A.

Services at the Royal Victoria Hospital could potentially be over the recommended maximum threshold, placing patients at risk of mis-treatment.

5. Adverse Impacts on Equality and Rurality

Rural communities face particular challenges with regard to access to services. Nowhere is this more apparent than in the area of health and social care where the differences between urban and rural communities must be recognised and models of care to meet diverse rural needs must be explored. Health service planning needs to more accurately reflect deprivation indicators across rural areas. Equity and equality across Northern Ireland must apply to healthcare provision. Rural communities seeking 'elective treatment' have shown their willingness to travel long distances. However, 'emergency treatment' is something totally different and Council feels that accessibility is vital in the field of healthcare.

Self-evidently, patients and visitors living furthest from the healthcare setting incur higher travel and time costs than local residents. The condition of the roads is also a direct consideration for patients and their carers e.g. A32 connection Omagh and Enniskillen patients with chronic conditions that affect their ability to work, their reduced income amplifies the financial burden of access costs. Chronic illness could further impact household budgets through increased heating bills and related expenditures. Whilst patients will rarely miss appointments to save money, they may have less disposable income for food and nutrition, and money related stress concerns may be detrimental to their overall health and recovery.

It is vital that equity and equality is applied to all individuals across Northern Ireland, regardless of their location/home. Several proposals outlined within the consultation document will result in individuals within the District incurring higher travel and time costs.

There can be no comparison between the best practice models of other areas and what is required in rural Northern Ireland (i.e. vast areas of the Fermanagh and Omagh District). Indeed, the needs of the District are vastly different to the other areas of Northern Ireland – with many individuals having several stroke centres closer to their doorstep.

The Department of Health, and the regional Health and Social Care Trusts, have a duty to provide healthcare services to everyone in Northern Ireland, regardless of geography, or any other consideration. These services can not be centralised as it

would be done so at the detriment of a vast amount of people – particularly those living in rural and/or isolated areas, many of whom could be classed as 'at risk' because of their standard of life or circumstances.

The Council believes that the Department has a duty to ensure that a Hyperacute Stoke Unit is located in areas of most need and risk – therefore services at the South West Acute Hospital should be retained. If they are not retained here, it will cause victims travelling further and longer before they receive vital (in many cases lifesaving) treatment. Consequences of this could result in death or reducing an individual's quality of life after the event.

In remote areas the lack of access to services has a disproportionately large impact on the quality of life of particular groups. This is essentially a social justice argument: the most vulnerable groups are disadvantaged most, those most likely to lack influence over service design and provision. There is a clear imperative to tackle the exclusion of vulnerable individuals and families simply because of where they live.

6. Commitments within the Consultation Document

The Council believes it is important to pass comment on other areas of the consultation document which are not included elsewhere within the questionnaire. On page 11 of the consultation Document, the Council notes the seven commitments which will be used to drive improvement and comments upon each below.

Commitment One: We will Identify a regional model for TIA assessment (by March 2020) and implement that model by 2022 to deliver a 7-day service of specialist assessment within 24 hours of symptoms.

National Clinical Guidelines for Stroke were published in 2016, stating that:

- Patients with a suspected TIA should be assessed urgently by a neurological specialist, or an acute stroke unit.
- Patients with a confirmed TIA should receive specific treatment to reduce the risk of a full stroke.

The Council believes that without locating the HASU in the South West Acute Hospital, the Department (and HSC) would not be compliant with these clinical guidelines. The service can be delivered locally at the SWAH/Omagh Hospitals Complex over a five-day week, with two regional clinics being identified and resources to provide the service at weekends and Bank Holidays.

The Department must ensure that proper, and sustainable, resources (human and financial) are made available to ensure that the seven-day service is sustainable, without having an adverse impact on the service availability Monday-Friday.

Commitment Two: By 2022 we will remove the variance in delivering Thrombolysis to ensure that patients across NI have timely access to the treatment

Thrombolysis is a treatment that uses drugs to break down and disperse a clot for people who have had an ischaemic stroke. It is estimated that clot-busting drugs increase the chance of a good outcome by up to 30%.

However, the State of the Nation (Stroke Statistics) states that within Northern Ireland (as well as England and Wales), 12% of stroke cases are eligible to receive thrombolysis. However, only 85% of those who are eligible receive it.

Therefore, even though the treatment increases the chance of a good outcome, there is still a substantial number of individuals who are not receiving thrombolysis treatment despite being eligible.

In the most recent report by Kings College London (as referenced elsewhere in this consultation response) the South West Acute Hospital was the only stroke unit that received a Category 'A' grade for delivering Thrombolysis - outperforming every other centre in Northern Ireland. Therefore, the Council is troubled as to why there are several options which discuss closing the best performing centre in Northern Ireland.

Table 4 in the document produced by the University of Exeter "Northern Ireland hyper-acute stroke care modelling: Maximising sustainability of services and clinical benefit from thrombolysis and thrombectomy" clearly outlines the excellent performance of the South West Acute Hospital, with an obvious correlation with the achievement of excellent outcomes for patients in Fermanagh and Omagh, and from other catchment areas. Such benefits would be severely impacted if a Model was selected which removed the Stroke Services from the SWAH.

Table 4: Current door to needle times and thrombolysis use rates

Hospital	Current door to needle (minutes)	Thrombolysis use (% all patients)
Royal Victoria	40	18.4
Ulster	48	13.3
Daisy Hill	47	12.5
Antrim Area	53	12.2
Altnagelvin	31	13.4
Causeway	57	7.4
Craigavon Area	43	8.6
South West	**18**	**20.9**

Other issues which should also be considered with this commitment is travel time. It is widely recognised that thrombolytic medicines should be administered within the first 30 minutes of arriving at the hospital and within three hours of the patients first symptoms. When taking into account the timeframes already experienced by residents within the District (i.e. ambulance response times and travel times, without

taking into account the time taken from experiencing the 'first symptoms' to alerting the emergency services) is already unacceptable. By adding additional travel time patients within the District are being further discriminated against in comparison to those who live in more rural areas.

During the reform of stroke services in another area (Sussex) the South East Clinical Senate Review (of Proposals for Future Stroke Services), it was recommended that "travel times between home and the HASU should seen in the context of 'overall time' between onset of the stroke and the delivery of thrombolysis for those suitable.' The recommendations go further to suggest that travel time should be limited to 45 minutes, aligning this with slick assessment and scanning procedures and achieving a 'call to needle' time of 120 minutes for most suitable patients.

A similar approach should be adopted in Northern Ireland and the SWAH would play a huge role in this approach given its location (servicing much of western Northern Ireland), local infrastructure, etc.

Commitment Three: We will continue to invest in the growth of Thrombectomy increasing hours of operation to Monday-Friday 8am – 8pm service by December 2019, and moving to 24/7 service by 2022

Although a relatively small number of patients are eligible for the treatment, it is shown to provide significant benefits, increasing the chance of a good outcome by up to 50%.

The Council acknowledges that at present the Royal Victoria Hospital is the only centre in Northern Ireland which offers Thrombectomy. However, the current hours of work do not permit all stroke patients to have access to the important treatment and the Council welcomes the extension to a 24/7 services.

The Calgary report 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 patients should always be transported directly to the two PSCs to the west of Northern Ireland prior to moving to the CSC".

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

Commitment Four: We will reshape stroke services by 2022 to establish dedicated hyperacute and acute stroke units underpinned by regional service standards to deliver improved outcomes for stroke patients.

Council notes that despite the poor figures for Northern Ireland with only half of people with strokes being admitted to stroke units, the South West Acute Hospital is one of only two centres in Northern Ireland meeting the SSNAP target of '90% of patients being admitted to a stroke unit'. This reflects the relatively poor performance of other centres across Northern Ireland.

Council recognises that enabling people to reach specialist care quickly allows them to benefit from the newest treatments becoming available and to have a better chance of making a good recovery. The longer a patient waits for appropriate treatment the longer the bleeding into their brain will continue and the potential for more damage, and/or worsening their chances of making a good recovery.

Council is concerned to note that the regional standards to which reference is made are based on the reorganisation that was implemented within Manchester and London. They have not been assessed through a co-production process and are not supported by empirical evidence from rural populations within Northern Ireland.

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. However, it is important to note that Stroke Units which meet this criterion are not necessarily in receipt of the best grades in the SSNAP Clinical Audit. Council stresses that 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:[4]

> "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

[4] BMJ 2014;349: g4757

admission occurred one or more days later after discharge this was a recurrent stroke".

While in large metropolitan areas, such as London and Manchester, it is possible to provide hyper-acute stroke care that maintains at least 600 admissions in all units, with all patients within 30 minutes of their most local unit, achieving both objectives is not possible in mixed urban and rural environments. It is necessary to consider best compromises between the competing objectives of unit volume and rapid access. The most important objective under any reconfiguration model should be that no patient will be offered a lesser service than is currently available locally.

Commitment 5: Struggling to recover' makes six recommendations to improve services. Alongside the reshaping of hospital services, we are committed to driving improvement in rehabilitation and long-term support and will use the Stroke Association's analysis and recommendations as a blueprint to drive that improvement.

Council is supportive of this commitment and stresses the importance of local service delivery. If community teams are not linked to a local stroke unit such as the one in the SWAH with the expertise which is readily available there, the sustainability of such teams in relation to recruitment and retention will be severely impacted.

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.

Council is supportive of this proposal but stresses that, 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 HASDU/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.

Commitment 6: The HSC will undertake a workforce review to identify the staffing and skill mix required to deliver effective stroke services.

Whilst supportive of this commitment, Council is also concerned about the inevitable time lag of up to seven years to produce a qualified practitioner. The fact that this review is only now being planned raised concerns about the availability of a suitable trained and experienced workforce who would be critical to the successful implementation of any fundamental reconfiguration process.

Commitment 7: We will extend the partnership with the charity AANI to enable the Helicopter Emergency Medical Service (HEMS) to provide a secondary response.

Experience of the invaluable service provided by Air Ambulances in many areas indicates that the priority is inevitably assigned to incidences of major trauma and conditions such as cardiac arrest where the diagnosis and treatment needs are easily identifiable. Any additional pressures would have an inevitable impact on the sustainability of the service which is dependent upon voluntary and charitable donations. In relation to acute stroke illness, most patients will require access to imaging expertise and assessment, such as that available in the SWAH, prior to any confirmatory diagnosis. In Northern Ireland as a whole, there can be as many as four to seven acute strokes occurring on any given days with an additional 40% stroke mimics. HEMS would not be able to provide a response at this level, leaving aside issues of physical accessibility of the service in rural areas, the ability to fly at night or in poor weather conditions, and the suitability of the service for a patient with a stroke.

Conclusion

The Council acknowledges the importance of all HASUs and ASUs in the delivery of stroke services throughout Northern Ireland as well as their location. However, it is extremely worrying that the highest performing centre (South West Acute Hospital) in Northern Ireland is only included (as a permanent HASU) within two of the six options outlined. Guidance from the Royal College of Physicians recommends that HASU's should ideally admit more than 600 stroke admissions per year. This number is suggested as the minimum size to attract a large cohort of specialist staff and sustain specialist rotas 24 hours a day, seven days a week. The only unit in NI currently admitting more than 600 stroke patients is the Royal Victoria hospital in Belfast, so it is against this background that the excellent performance of the Stroke Unit at the SWAH must be recognised and built upon.

Reliance on reports such as those prepared by the Universities of Exeter and Calgary, and the research on the experience of reconfiguration in London, cannot have direct relevance to a predominantly rural area such as in the Fermanagh and Omagh District Council area. Some elements of the studies can be logically applied, e.g. the Calgary report 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. However, many of the options within the consultation document do not follow the rationale contained within the reports.

The SWAH is a proven Centre of Excellence within Northern Ireland and as such should be retained – providing an excellent model for other HASUs in Northern Ireland to learn from and follow. This approach can also result in a more effective use of resources across the whole health and social care system, through strokes avoided, shorter length hospital stays and reduced disability costs. It is also important to recognise the valuable and essential contribution to the overall health care offering for stroke patients through the availability of the rehabilitation beds at the Omagh Primary Care Complex.

The Council was disappointed to note that, in reference to the pre-consultation exercise, there is reference to “3,000 template responses being received” and would strongly recommend that appropriate weighting should be given to such responses as they represent the views of **all** the people who submitted them.

The Council totally opposes any potential diminution of the services provided in the South West Acute Hospital and the Omagh Primary Care Complex which will further exacerbate health inequalities, particularly for the most disadvantaged people in the council district.

Appendix 1: Average journey times to hospitals from the Fermanagh and Omagh District

Town/area	Average travel time to **South West Acute Hospital (Enniskillen)**	Average travel time to **Omagh Hospital and Primary Care Complex**	Average travel time to **Altnagelvin Hospital (Derry/Londonderry)**	Average travel time to **Craigavon Area Hospital**
Ballinamallard	**7 minutes** (4.4 miles)	**39 minutes** (22.1 miles)	**1 hour 23 minutes** (49.2 miles)	**1 hour 14 minutes** (57 miles)
Garrison	**39 minutes** (26 miles)	**1 hour 1 minute** (41.6 miles)	**1 hour 35 minutes** (59 miles)	**1 hour 47 minute** (85.8 miles)
Belleek	**39 minutes** (25.7 miles)	**54 minutes** (37.6 miles)	**1 hour 28 minutes** (54.9 miles)	**1 hour 41 minute** (81.7 miles)
Boho	**18 minutes** (9 miles)	**1 hour 1 minute** (36.1 miles)	**1 hour 40 minutes** (60.4 miles)	**1 hour 29 minutes** (67.9 miles)
Brookeborough	**22 minutes** (13.3 miles)	**39 minutes** (23 miles)	**1 hour 31 minutes** (56.8 miles)	**57 minutes** (48.9 miles)
Enniskillen	**5 minutes** (2 miles)	**43 minutes** (27.5 miles)	**1 hour 30 minutes** (54.1 miles)	**1 hour 11 minutes** (59.8 miles)
Derrygonnelly	**18 minutes** (10.9 miles)	**1 hour 1 minute** (38 miles)	**1 hour 41 minutes** (63.2 miles)	**1 hour 29 minutes** (69.7 miles)
Teemore	**29 minutes** (17.5 miles)	**1 hour** (37.5 miles)	**1 hour 54 minutes** (69.6 miles)	**1 hour 18 minutes** (63.2 miles)
Donagh	**30 minutes** (17.1 miles)	**54 minutes** (32.5 miles)	**1 hour 46 minutes** (66.6 miles)	**1 hour 12 minutes** (58.5 miles)
Enniskillen	**5 minutes** (2 miles)	**43 minutes** (27.5 miles)	**1 hour 30 minutes** (54.1 miles)	**1 hour 11 minutes** (59.8 miles)
Kinawley	**24 minutes** (12.5 miles)	**1 hour 1 minute** (33.7 miles)	**1 hour 47 minutes** (64.6 miles)	**1 hour 22 minutes** (63 miles)
Irvinestown	**11 minutes** (7.6 miles)	**33 minutes** (19.5 miles)	**1 hour 15 minutes** (45.1 miles)	**1 hour 13 minutes** (58 miles)
Kesh	**17 minutes** (12.3 miles)	**35 minutes** (21.1 miles)	**1 hour 7 minutes** (39.9 miles)	**1 hour 18 minutes** (64.8 miles)

Town/area	Average travel time to **South West Acute Hospital (Enniskillen)**	Average travel time to **Omagh Hospital and Primary Care Complex**	Average travel time to **Altnagelvin Hospital (Derry/Londonderry)**	Average travel time to **Craigavon Area Hospital**
Lisbellaw	**14 minutes** (6.9 miles)	**43 minutes** (24.6 miles)	**1 hour 36 minutes** (59.4 miles)	**1 hour 3 minutes** (54.9 miles)
Lisnarick	**13 minutes** (9.1 miles)	**38 minutes** (23.6 miles)	**1 hour 11 minutes** (43.3 miles)	**1 hour 20 minutes** (60.7 miles)
Lisnaskea	**23 minutes** (13.5 miles)	**46 minutes** (28.8 miles)	**1 hour 42 minutes** (63.7 miles)	**1 hour 6 minutes** (54.8 miles)
Maguiresbridge	**18 minutes** (10.2 miles)	**43 minutes** (26 miles)	**1 hour 33 minutes** (59.6 miles)	**1 hour 1 minutes** (52 miles)
Newtownbutler	**33 minutes** (19.5 miles)	**56 minutes** (35 miles)	**1 hour 49 minutes** (69.1 miles)	**1 hour 15 minutes** (61 miles)
Rosslea	**43 minutes** (26.5 miles)	**55 minutes** (30.7 miles)	**1 hour 49 minutes** (64.8 miles)	**1 hour 7 minutes** (39 miles)
Tempo	**14 minutes** (9.2 miles)	**32 minutes** (18.8 miles)	**1 hour 24 minutes** (53.6 miles)	**59 minutes** (49.8 miles)
Beragh	**44 minutes** (28 miles)	**11 minutes** (5.8 miles)	**1 hour 8 minutes** (41.9 miles)	**44 minutes** (40 miles)
Omagh	**37 minutes** (24.9 miles)	**6 minutes** (1.6 miles)	**57 minutes** (34.1 miles)	**51 minutes** (46 miles)
Clanabogan	**31 minutes** (22.6 miles)	**15 minutes** (5.7 miles)	**1 hour** (37 miles)	**58 minutes** (49.1 miles)
Dromore	**24 minutes** (16.2 miles)	**19 minutes** (10.4 miles)	**1 hour 9 minutes** (42.4 miles)	**1 hour 2 minutes** (49.9 miles)
Drumnakilly	**47 minutes** (31.2 miles)	**10 minutes** (4.8 miles)	**1 hour 2 minutes** (37.3 miles)	**53 minutes** (40.8 miles)
Drumquinn	**32 minutes** (21.7 miles)	**22 minutes** (11.5 miles)	**54 minutes** (31.6 miles)	**1 hour 5 minutes** (54.8 miles)
Mountjoy	**41 minutes** (28.4 miles)	**16 minutes** (6.7 miles)	**49 minutes** (31 miles)	**59 minutes** (50.1 miles)

Town/area	Average travel time to **South West Acute Hospital (Enniskillen)**	Average travel time to **Omagh Hospital and Primary Care Complex**	Average travel time to **Altnagelvin Hospital (Derry/Londonderry)**	Average travel time to **Craigavon Area Hospital**
Fintona	**31 minutes** (20.1 miles)	**15 minutes** (8.6 miles)	**1 hour 11 minutes** (42.7 miles)	**49 minutes** (43.1 miles)
Gortin	**56 minutes** (34.8 miles)	**20 minutes** (10.7 miles)	**39 minutes** (24.6 miles)	**1 hour 6 minutes** (47.8 miles)
Omagh	**37 minutes** (24.9 miles)	**6 minutes** (1.6 miles)	**57 minutes** (34.1 miles)	**51 minutes** (46 miles)
Killyclogher	**41 minutes** (26.9 miles)	**7 minutes** (2 miles)	**55 minutes** (33.9 miles)	**53 minutes** (46.4 miles)
Seskinore	**35 minutes** (23 miles)	**14 minutes** (6.2 miles)	**1 hour 6 minutes** (41 miles)	**46 minutes** (41.3 miles)
Greencastle	**54 minutes** (37 miles)	**19 minutes** (11.8 miles)	**50 minutes** (31.9 miles)	**55 minutes** (40.4 miles)
Sixmilecross	**47 mins** (30 miles)	**16 minutes** (8.5 miles)	**1 hour 10 minutes** (44.4 miles)	**43 minutes** (34.8 miles)
Carrickmore	**56 minutes** (35.1 miles)	**19 minutes** (10.5 miles)	**1 hour 2 minute**s (39.4 miles)	**44 minutes** (35.6 miles)
Trillick	**18 minutes** (10.2 miles)	**29 minutes** (16.6 miles)	**1 hour 14 minutes** (47.8 miles)	**1 hour 6 minute** (51.4 miles)

Return Journeys for Residents to Altnagelvin and Craigavon Area Hospitals

Altnagelvin

	Enniskillen	Garrison	Belcoo	Kinawley	Teemore	Roslea	Omagh	Sixmilecross	Carrickmore	Beragh
Distance to Altnagelvin in miles.	53.7	65.5	64.7	64.2	69.50	64.4	33.8	43.4	40.1	41.5
Total return car journey	2 hours 50 mins	3 hours 6 mins	3 hours 26 mins	3 hours 30 mins	3 hours 40 mins	3 hours 34 mins	1 hour 42 mins	2 hours 18 mins	2 hours 8 mins	2 hours 12 mins
Bus journey to Altnagelvin	3 hours 50 mins	4 hours 31mins	4hours 12 mins	4 hours 5 mins	4 hours 19 mins	3 hours 39 mins	1 hour 51 mins	2 hours 38mins	2 hours 33mins	2 hours 33 mins
Return journey from Altnagelvin	3 hours 3 mins	3 hours 30 mins	4 hours 47 mins	4 hours	4 hours 45 mins	4 hours 47 mins	1 hour 43 mins	2 hours 2 mins	2 hours 15 mins	2 hours
Total bus journey travelling time	6 hours 53 mins	8 hours 1 min	8 hours 59 mins	8 hours 5 mins	9 hours 4 mins	8 hours 26 mins	3 hours 33 mins	4 hours 40 mins	4 hours 48 mins	4 hours 30 mins

Example 1 – Roslea to Altnagelvin via public transport:

There is only one bus from Roslea at 07.32am, this is not direct and the passenger would need to wait 41 minutes in Maguiresbridge to get a second bus to Londonderry via Ballygawley, time of arrival would be 11.12am.

The bus depot in Londonderry on Foyle Street is 2.2miles from Altnagelvin hospital, a 44 minute walk or a 9 minute car journey.

Visiting times at Altnagelvin Area Hospital

3.00pm – 4.00pm and 7.00pm to 8.30pm. Neither of the visiting times would be suitable to a friend, family member or carer travelling from Roslea.

Return Journey

There is only one bus in operation from Londonderry to Roslea (via Belfast) which departs at 2.00pm. In total the journey home would take 4 hours and 47 minutes, 4 different buses and a wait time of 42 minutes in between buses. Overall the travelling time for this journey is 8 hours and 26 minutes.

Craigavon

	Enniskillen	**Garrison**	**Belcoo**	**Kinawley**	**Teemore**	**Omagh**	**Roslea**	**Sixmilecross**	**Carrickmore**	**Beragh**
Distance to Craigavon in miles	56.8	78.3	70.6	62.1	62.6	45.1	38.8	33.8	34.7	39.5
Total return car journey	2 hours 18 mins	3 hours 30 mins	3 hours	2 hours 42 mins	2 hours 36 mins	1 hour 36 mins	2 hours 8 mins	1 hour 22 mins	1 hour 24 mins	1 hour 26 mins
Bus journey to Craigavon	3 hours 2 mins	3 hours 41 mins	2 hours 51 mins	4 hours 36 mins	4 hours 56 mins	1 hour 26 mins	3 hours 21 mins	2 hours 41 mins	2 hours 45 mins	2 hours 29 mins
Return Journey from Craigavon	3 hours 45 mins	3 hours 45 mins	3 hours 27 mins	3 hours 49 mins	3 hours 55 mins	1 hour 30 mins	3 hours 27mins	3 hours 33 mins	2 hours	3 hours 30 mins
Total bus journey travelling time	6 hours 47 mins	7 hours 26mins	6 hours 18 mins	8 hours 25 mins	8 hours 51 mins	2 hours 56 mins	6 hours 48 mins	6 hours 14 mins	4 hours 45mins	5 hours 59 mins

Example 2 – Garrison to Craigavon Area Hospital via public transport:

There is no direct bus from Garrison to Craigavon. There is a bus from Garrison to Enniskillen at 12.17pm, this bus takes 39 minutes. The next bus from Enniskillen to Craigavon departs at 2.00pm and takes 3 hours and 2 minutes, arriving in Craigavon at 5.02pm.

Visiting times at Craigavon Area Hospital:

3.00 - 4.00pm and 6.45 – 8.15pm. The only suitable return bus journey leaves less than 40 minutes after arrival at 5.40pm, therefore the family member, friend or carer would be unable to adhere to either of the visiting times.

Return Journey

There is only one return bus journey from Craigavon at 5.40pm from Rushmere shopping centre via Belfast arriving back to Enniskillen at 9.25pm. There is no public transport from Enniskillen to Garrison after 9.25pm. Overall the travelling time for this journey is 7 hours and 26 minutes.

Example 3 – Kinawley to Craigavon Area Hospital via public transport:

There is no direct bus from Kinawley to Craigavon. The earliest bus from Kinawley departs at 09.55am via Enniskillen and Dungannon and arrives in Craigavon at 2.31pm. The latest bus for the return journey departs at 2.35pm therefore the family member, friend or carer would not have sufficient time to visit the hospital.