Stroke Association response to the Reshaping Stroke Care consultation

Overall position

The Stroke Association welcome the consultation into reshaping stroke care in Northern Ireland. Change is long overdue and we must do better to improve outcomes for those affected by stroke. We believe that reshaping, improving and investing in our stroke services will save lives, reduce disabilities and ensure that everyone affected by stroke gets timely access to the best treatment and care.

It is vital that this process isn't just about changing hospital stroke units. It must include investment in and improvement of the whole stroke pathway, from prevention to acute care to long-term support to help people rebuild their lives following stroke. We welcome the seven commitments made by the Department of Health but feel there are some issues which must be addressed as a matter of urgency in order for reform to be a success and to achieve the best outcomes for patients. In particular, the Department must:

- Address public concerns about ambulance response times by publishing more details on how NIAS will be resourced to cope with additional demand;
- Publish and implement plans on how they intend to address the huge workforce challenges in stroke;
- Urgently address gaps in inpatient rehabilitation and the post code lottery of access to Early Supported Discharge;
- Invest in better long-term support for people rebuilding their lives after stroke*; and*
- Carefully plan and implement the new regional model of stroke care without further delay in an open and transparent way and in partnership with staff, the voluntary sector and people affected by stroke.

Commitment 1: Regional TIA assessment model

A transient ischaemic attack or TIA is the same as a stroke, except that the symptoms last for a short amount of time. Although the symptoms may not last long, a TIA is still very serious and can be a major warning sign that a person is at risk of a more serious stroke. Both RCP and NICE guidelines recommend that suspected TIA patients should be urgently assessed by a specialist physician within 24 hours.

- We welcome the commitment to implement seven day specialist assessment services for patients with TIA in Northern Ireland and that assessment will take place within 24 hours of symptoms. A seven day model will ensure that

people are assessed and treated quickly which will reduce their risk of further stroke.

- Patients who have experienced a TIA should be provided with information, advice and support to enable them to make lifestyle choices to reduce their risk of stroke and signposted to the Stroke Association or Northern Ireland Chest Heart and Stroke for further support.
- We call on partners in Health and Social Care to work with people affected by stroke and the voluntary sector to improve public awareness of the signs and symptoms of stroke and TIA. This should include the continued roll-out of the successful FAST campaign.
- More needs to be done to detect other stroke risk factors such as high blood pressure and atrial fibrillation, particularly given that many people do not experience any symptoms for either condition.

Commitment 2: Remove variance in thrombolysis

NICE guidelines state that the clot-busting drug thrombolysis should be administered within 4.5 hours of onset of stroke symptoms in a well organised stroke service with staff trained in delivering thrombolysis and monitoring for any complications associated with the procedure.

- We welcome the commitment from the Department of Health to remove the variance in delivering thrombolysis to ensure that every patient across Northern Ireland has timely access to the treatment.
- The Stroke Association believe that every patient who is eligible for thrombolysis should be able to access the treatment, regardless of where and when they have their stroke. However to achieve this, patients must have 24/7 access to a hyper acute stroke unit where they can be quickly assessed, diagnosed and treated.
- We call on the Department of Health to ensure that learning and best practice from some of the top-performing units in terms of thrombolysis is shared across Northern Ireland to support all stroke units to meet the required standards of care, and to put in place protocols for assessing patients who self-present at hospitals without stroke services to ensure that they are treated at the nearest specialist stroke unit.

Commitment 3: Invest in the growth of thrombectomy

Thrombectomy is a game-changing, clot-retrieval procedure that reduces the severity of disability that a stroke can cause. Evidence shows the procedure is highly effective at reducing disability, extremely cost-effective and just as safe as other treatments. The most recent NICE guidance suggests that thrombectomy can be administered up to 24 hours after the onset of stroke symptoms in some cases.

- Northern Ireland has a relatively well-developed thrombectomy service in comparison to the rest of the UK, with over 100 procedures carried out here last year. However, the current restricted hours for the procedure in Belfast (Monday to Friday, 8.30am to 5.30pm) means that the full potential of thrombectomy to reduce deaths and disability is limited.
- We therefore welcome the commitment to move to a 24/7 service by 2022 as this will significantly improve the number of patients who can access and benefit from this revolutionary procedure.
- However, thrombectomy can only effectively operate in a properly and efficiently organised regional 24/7 service, hence the need to reshape how acute services are delivered.
- Providing this service 24/7 will also require a significant increase and investment in the specialist staff who can perform the procedure.
- However, not every patient is eligible for thrombectomy or thrombolysis so the best way to improve outcomes for all stroke patients is through the establishment of 24/7 specialist units.

Commitment 4: Reshape acute stroke services

Both NICE and RCP guidance recommends that every patient with suspected stroke should be admitted directly to a hyper acute stroke unit (HASU) where they can be quickly assessed by a specialist stroke physician. There is a wealth of evidence showing that direct admission to a stroke unit remains the most important intervention we have for acute stroke and that patients are more likely to survive and be able to live independently. Research from elsewhere in the UK (London, Manchester and Northumbria) shows that reorganising stroke care and creating HASUs can save lives and reduce length of hospital stay. HASUs are specialist centres that are suitably staffed, with expert teams available 24/7 and that have the specialist equipment needed to diagnose and treat stroke patients.

- We support this commitment as recent audit figures show that under half of stroke patients in Northern Ireland are being admitted to a stroke unit within four hours of admission.
- However, our engagement with members of the stroke community over the past few months has highlighted the following concerns about the proposals:
    - The impact on rural areas, in particular travel times;
    - Longer travel times for families and carers which could place a financial burden on them and restrict how often they can visit their loved one in hospital;
    - The ability of the Northern Ireland Ambulance Service (NIAS) to cope with additional demand and longer travel;
    - The workforce challenges in providing 24/7 specialist care; and
    - Whether acute stroke units will have the capacity to provide longer term inpatient rehabilitation for some patients.
- While we recognise that, in most cases, longer travel times to a HASU are often offset by quicker assessment and treatment when you arrive, these are understandable concerns and must be addressed by the Department of Health in order to enhance public confidence in the proposals and ensure that reconfiguration will be successful.
- On consideration of the evidence, the Stroke Association do not have a preferred model of locations of hospital-based stroke care in Northern Ireland. The modelling research conducted by the University of Exeter shows that each of the options presented by the Department have the potential to offer significantly better outcomes for patients than our current configuration of stroke services.
- Whatever option the Department of Health choose, we urge them to plan and implement it carefully in partnership with the stroke community and without further delay, as evidence from elsewhere shows that a phased approach to change is not as effective.
- Staying as we are is not an option and a lack of progress in reconfiguration puts lives and recoveries at risk.
- It is important that when reconfiguration is implemented, there is significant additional investment in inpatient rehabilitation (including speech and language therapy, physiotherapy, occupational therapy, psychological and emotional support, orthoptist services and dieticians) to ensure that people affected by stroke have the support they need to rebuild their lives. It's also important that inpatient rehabilitation beds are protected so that patients

requiring longer hospital stays are cared for in an appropriate therapeutic setting.

Commitment 5: Improve rehabilitation and long-term support

Over the last ten years there have been significant advances in hospital stroke treatment. However, rehabilitation services and post-hospital support have long been identified as the 'Cinderella' services of stroke care. The 2008 Stroke Strategy recommended that all stroke patients should have access to specialist community stroke care, including physiotherapy, speech and language therapy and support for carers. The 2014 RQIA review of stroke services highlighted that communication with stroke survivors about what support is available needs to improve, while the 2017 pre-consultation on reshaping stroke care identified long-term support and emotional support for those affected by stroke as particular areas of need. Despite this, there has not been adequate investment in these services over the past decade and many people affected by stroke still struggle to recover as a result.

- There are currently no Early Supported Discharge (ESD) services in two of the five trust areas creating a totally unacceptable post code lottery of treatment. This should be addressed as a matter of priority to ensure that money committed to ESD is not lost and that every patient who is eligible has access to this service.
- We welcome the commitment from the Department of Health to use our *Struggling to Recover* report as a blueprint to drive improvements in long-term support and rehabilitation.
- Our report highlighted six areas where improvement is needed:
    - The length and intensity of post-hospital rehabilitation;
    - Sign-posting to information and support in the community;
    - Psychological and emotional support for people affected by stroke;
    - Support for carers;
    - Support for younger stroke survivors who may wish to return to work; and
    - Public awareness and understanding of the impact of stroke.
- It is vital that this process is about reshaping the whole pathway. Adequate, recurrent, ring-fenced investment in improvement of post-hospital, long-term care in the community is urgently required to help people make the best possible recovery from stroke.

Commitment 6: Workforce review

National clinical guidelines are clear that an appropriately staffed and skilled stroke workforce is essential to ensure the best possible care of people with stroke. Research shows that patients who are cared for on a stroke unit by a team of doctors, nurses and therapists who specialise in looking after stroke patients are more likely to survive and be living independently one year after their stroke. However, there are major workforce challenges across the UK. In Northern Ireland, there are currently four vacant stroke consultant posts as well as gaps in the nursing and allied health professional workforces. Stroke care is spread too thin which means that smaller units struggle to attract and retain stroke specialist staff and recent graduates. These units also provide less opportunities for staff to develop and maintain clinical expertise in stroke care.

- The Stroke Association believe that every person who has had a stroke should be cared for by people with the right skills and knowledge to meet their needs across the whole stroke pathway.
- In Northern Ireland, we need a stroke workforce of sufficient numbers and skills to deliver the highest standard of care to all stroke patients and survivors, both in hospital and in the community.
- We welcome the Department's commitment to undertake a workforce review as part of plans to reshape and improve stroke care. However, we are concerned that this has not already happened, particularly given that the Department aim to implement the new regional model of stroke services by 2022. It takes years to adequately train staff to care for stroke patients so we urge the Department to complete the review as soon as possible and urgently invest in the stroke workforce to ensure that it is sufficient and ready for reform.
- The workforce review should consider all professionals who play a role in stroke care including paramedics, stroke consultants and nurses, interventional neuro-radiologists, psychologists and allied health professionals such as speech and language therapists, physiotherapists, occupational therapists, orthoptists and dieticians.
- The workforce review must also consider and plan for the possibility that some current professionals working in stroke care may choose not to move to a HASU and instead focus on another speciality such as elderly care. The Department should make efforts to encourage and support existing stroke specialists to move to the new HASUs so as to support reform.

Commitment 7: Extend Helicopter Emergency Medical Service

Stroke is a medical emergency. To ensure that all stroke patients have the best possible chance of surviving and making a good recovery, it is vital that they are taken to a specialist stroke unit where they can access the treatment they need as quickly as possible, in an appropriate vehicle such as an ambulance. With stroke, the focus is on getting the patient to the right hospital – one with a stroke unit - rather than just the closest. In some cases, it is more beneficial for the stroke patient to travel further in order to receive the best treatment.

- While an additional air ambulance would of course be welcome, we are concerned about the feasibility of such an approach. Our concerns include the ability of the air ambulance to fly at night or in bad weather and the primary function of the air ambulance as a trauma service, which may reduce its' availability for stroke patients. There is also no landing pad at the Royal Victoria Hospital which means that a road ambulance would still be required after landing to transport the patient to hospital.
- Given the high cost that an additional air ambulance would incur and the small number of patients that it would likely be suitable for, the Stroke Association believe that the Department's priority should be investing in additional road-based ambulance resources, such as staff and equipment.
- We call on the Department of Health and the Northern Ireland Ambulance Service to roll-out the new clinical response model, which they consulted on in 2018, and which has been shown elsewhere to improve emergency responses to stroke patients.