

**The Rural Needs Act (NI) 2016**

**Rural Needs Impact Assessment – Reshaping Stroke Care: Saving Lives, Reducing Disability.**

**SECTION 1 - Defining the activity subject to Section 1(1) of the Rural Needs Act (NI) 2016**

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| **1A. Name of Public Authority - Department of Health** |

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| **1B. Please provide the official title/ description of the Strategy, Policy, Plan or Public Service document or initiative:** |

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| **TITLE: Reshaping Stroke Care - Saving Lives, Reducing Disability.**Stroke is a major health issue in Northern Ireland with around 2,800 people being admitted to hospital each year and 36,000 stroke survivors living in our communities. It is important that every opportunity is taken to secure excellent care for people after a stroke and give them the best possible chance of a good recovery. Opportunities exist across the entire pathway for improving stroke care and much is currently being done to raise awareness of stroke, prevent more strokes, invest in rehabilitation and review the long-term support for those with stroke.The consultation document outlines seven commitments to strengthen and improve both community and hospital-based stroke care. These are:1. Identify a regional model for TIA assessment by March 2020 for implementation by 2022 to deliver a 7 day service of specialist assessment within 24 hours of symptoms.
2. By 2022, remove the variance in the delivery of thrombolysis to ensure that patients across NI have timely access to the treatment.
3. Increase the availability of thrombectomy, moving to a Monday-Friday 8am-8pm service by December 2019 and a 24/7 service by 2022.
4. Reshape stroke services by 2022 to establish dedicated Hyperacute Stroke Units (HASUs) and Acute Stroke Units (ASUs) underpinned by regional service standards to deliver improved outcomes for stroke patients.
5. The recently published Stroke Association document ‘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.
6. The HSC will undertake a workforce review to identify the staffing and skill mix required to deliver effective stroke services.
7. We will extend the partnership with the charity AANI to enable the Helicopter Emergency Medical Service (HEMS) to provide a secondary response to incidents including strokes by 2022 to improve access to services, particularly from rural areas.

In line with commitment 4, six potential options have been identified for the provision of specialist emergency stroke care in Hyperacute Stroke Unit (HASU) sites, normally used for the first 72 hours of hospital care. These are:Five HASU Configuration * **Option A:** under this option, 5 HASUs would be located at Altnagelvin Area Hospital, Antrim Area Hospital, Craigavon Area Hospital, Royal Victoria Hospital and South West Acute Hospital. Acute Stroke Units (ASUs) would be co-located.

Four HASU Configurations* **Option B:** under this option, 4 HASUs would be located at Altnagelvin Area Hospital, Antrim Area Hospital, Craigavon Area Hospital and Royal Victoria Hospital. ASUs to be co-located, with consideration of a fifth ASU at the Ulster hospital.
* **Option C:** under this option, 4 HASUs would be located at Altnagelvin Area Hospital, Craigavon Area Hospital, Royal Victoria Hospital and South West Acute Hospital. ASUs to be co-located, with consideration of a fifth ASU at the Ulster Hospital.

Two Phased Approaches* **Option D:** under this option 4 HASUs would be located at Altnagelvin Area Hospital, Antrim Area Hospital, Craigavon Area Hospital and Royal Victoria Hospital with services removed from Antrim Area Hospital over time.
* **Option E:** under this option 4 HASUs would be located at Altnagelvin Area Hospital, Craigavon Area Hospital, Royal Victoria Hospital and South West Acute Hospital, with services removed from the South West Acute Hospital over time.

Three HASU Configuration * **Option F:** under this option 3 HASUs would be located at Altnagelvin Area Hospital, Craigavon Area Hospital and Royal Victoria Hospital, with additional ASUs located at the Ulster Hospital and Antrim Area Hospital.

It is recommended that acute stroke units for ongoing hospital care after 72 hours should be co-located with hyperacute stroke units if possible so that the valuable staff resource can be consolidated onto as few sites as possible. The order of options noted above is not a ranking and at this stage the Department has not identified a preferred option.  |

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| **1C. Please indicate which category the activity specified in Section 1B above relates to -**  |

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| Developing a: | Strategy |  | Policy |  | Plan |  |
| Adopting a: | Strategy |  | Policy |  | Plan |  |
| Implementing a: | Strategy |  | Policy |  | Plan |  |
| Revising a:  | Strategy |  | Policy |  | Plan |  |
| Designing a Public Service |  | X |  |  |  |  |
| Delivering a Public Service |  |  |  |  |  |  |

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| **1D. Please provide the aims and/or objectives of the Strategy, Policy, Plan or Public Service:**  |

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| The aim of this process is to reshape and improve community and hospital-based stroke care to improve the sustainability and effectiveness of stroke care, resulting in a reduction of avoidable deaths and disability and improvement in outcomes for stroke patients.  |

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| **1E. Which definition of ‘rural’ is the Public Authority using in respect of the Policy, Strategy, Plan or Public Service?:**  |

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Population Settlements of less than 5,000 (Default definition)

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| X |

Other Definition (Provide details and the rationale below)

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| The default definition cited above (Population Settlements of less than 5,000) is not useful in differentiating impacts in respect of this policy. People living in both large and small settlements would be similarly impacted by changes in the location of hospital stroke services.The following alternative definition, as suggested by DAERA, is proposed:**“Populations outside of a 30 minute drive time of Derry/Londonderry or Belfast”.**This definition is better able to distinguish between those who will be most impacted by additional travel times caused by proposed changes to services. It should be noted that the service under consideration is not provided within rural communities but provided inside a hospital environment. The benefits of enhancing these services would be experienced by both urban and rural dwellers. |

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A definition of ‘rural’ is not applicable[[1]](#footnote-1)

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| **SECTION 2 – Understanding the impact of the Policy, Strategy, Plan or Public Service** |

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| Yes | X | No |  |

**2A. Is the Policy, Strategy Plan or Public Service likely to impact on people in rural areas?** **Please explain:** The following issues were identified through extensive pre-consultation engagement; these are outlined under the categories of positive and negative, direct and indirect impacts. **POSITIVE IMPACTS***Direct***Outcomes:** Through ensuring that services are sustainable and staffed appropriately seven days a week, the quality of stroke services is expected to improve. Populations in urban and rural areas would be expected to experience improvements in stroke clinical outcomes. This will result in a shorter hospital stay for many stroke survivors.**NEGATIVE IMPACTS***Direct***Travel Times**: An increase in the time taken for some people to travel to hospital stroke units. Visits from friends and relatives were noted by stroke survivors to be an important support to the stroke recovery process. It is possible that increases in the time taken to visit friends or relatives in hospital stroke units, may impact upon the frequency of visits in some cases.**Financial Impacts:** Costs might be incurred with increased travel times to visit family members in hospital.*Indirect***Caring issues**: If people are discharged from hospital earlier after a stroke it is possible that a longer period of support from friends and/or relatives is required. There may be a need for additional social care support. However, this should be balanced with the expectation that many people would be discharged with less disability as a result of a better quality of hospital care.**Isolation**: During engagement people residing in rural settlements described the impact of isolation after stroke due in part to challenges in accessing transport, health services and stroke support services. Although this relates to the period after hospital discharge and is not directly impacted by the location of hospital services, it is noted to be an important issue facing rural dwellers.**Ambulance response**: People responding to the pre-consultation frequently identified that ambulance response times are a key concern in rural communities, as these people often live some distance from an ambulance base and might experience longer ambulance response times than those in urban settings. Ambulance response times are not directly affected by the specific location of hospital stroke services. |

**If the response is NO after entering explanation GO TO Section 3**

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| **2B. If the Policy, Strategy, Plan or Public Service is likely to impact on people in rural areas differently from people in urban areas, please explain how it will impact people in rural areas differently:**  |
| The key impact that differentially affects rural dwellers is likely to relate to travel times to hospital not only for the person admitted to hospital as a result of a stroke but also their family, friends or carers.The greater the number of sites providing stroke care, then there would be a fewer number of people experiencing longer journey times.All of the options outlined in the consultation document include the provision of hospital stroke care at the following sites: Altnagelvin Area Hospital, Craigavon Area Hospital and Royal Victoria Hospital. Therefore people currently living within the catchment areas for these three sites will not experience any increase in respect of travel times. However for those people living within the catchment area of hospitals who might not provide hospital stroke care in the future, they could experience an increase in travel time. Under the potential options, people living in the catchment areas for Causeway Hospital, Daisy Hill Hospital, and Ulster Hospital would experience an increase in journey time if taken to hospital after a suspected stroke. In addition to the above, implementation of options D, E or F (resulting in the removal of services from the Antrim Area Hospital and South West Acute Hospital) would mean that people living in those catchment areas would also be impacted, experiencing an increase in journey times if taken to an alternative hospital after a suspected stroke. |

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| **2C. Please indicate the rural policy areas the Policy, Strategy, Plan or Public Service is likely to impact on (see list at note 1):**  |

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| The key policy area affected is health and social care services for those in rural areas, namely access to specialist hospital based stroke care.It should be noted that the hospital period of care is often the shortest period of the stroke recovery process. An increasingly large amount of rehabilitation, specialist review and support is now provided within the community after leaving hospital. In order to support required changes, the community infrastructure has received significant investment between 2015 and 2019. As a result more support and rehabilitation is now available in the community than has ever been available before, ensuring that people stay in hospital for as short a time as possible. |

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| **SECTION 3 – Identifying the Social and Economic Needs of Persons in Rural Areas** |

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| **3A. Has the Public Authority taken steps to identify the social and economic needs of people in rural areas that are relevant to the Policy, Strategy, Plan or Public Service?**

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| X |
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**Yes**  **No Please explain:**  |

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| The HSC has completed an extensive public engagement exercise between June and September 2017 which included:* A pre-consultation exercise including public documents, a response questionnaire and over 40 public meetings using a range of accessible materials for the public such as easy reads concise guides, patient’s videos, animations and infographics;
* Engagement with communities and political representatives; and
* Ongoing engagement including representation of service users and stroke charities on the Design Group.

Further engagement, to include rural communities, is planned as part of the public consultation exercise. |

**If the response is NO please explain above and GO TO Section 4**

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| **3B. Please indicate which methods or information sources were used to identify the social and economic needs of people in rural areas (see note 2 for examples) and provide details including relevant dates, names of organisations, titles of publications, website references, details of surveys or consultations undertaken etc.:**  |

**Note 2**

**Examples of methods or information sources used (relates to question 3B):**

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| * Consultation with Rural Stakeholders
 |  | * Published Statistics
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| * Consultation with Other Organisations
 |  | * Research Papers
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| * Surveys or Questionnaires
 |  | * Other Publications
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| * Other Methods or Information Sources (include details)
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| 1. Annex 1 provides dates and times of engagement meetings and events and also details those organisations which responded to the pre-consultation.

Pre-consultation engagement with rural stakeholders included the following:* 1. In July 2017, 127 people with lived experience of stroke attended five survivor and carer workshops to participate in the future model of stroke services. Three of these events were held more than 30 minutes from Londonderry or Belfast: these were in Omagh, Lurgan and Ballynahinch.
	2. Between June and September 2017 public meetings were held in Enniskillen, Newry, and Downpatrick.
	3. Health and Social Care Board Local Commissioning Group public workshops were held in Newtownards, Omagh, Cookstown, Downpatrick and Ballymena.
	4. Correspondence was issued through the rural community network with invitations to meet, however these invitation were not taken up. It is assumed that this was due to the range of other opportunities available for local engagement.
1. Consultation with other organisations:
	1. Meetings took place with local councils in Downpatrick, Magherafelt and Enniskillen.

 * 1. A specific meeting was also arranged for political representatives across the entire region and was facilitated by Northern Ireland Chest Heart and Stroke.
1. Survey:
	1. A survey was designed to capture responses from the pre-consultation engagement; the findings were specifically analysed for references to matters relating to rural issues and travel times. A report summarising these findings was produced.
2. Published papers:
	1. Health inequalities report published by DoH [[2]](#footnote-2)
	2. DAERA statistics paper of rural needs (see Annex 2 and Annex 3).
	3. Extracted Information from NINIS[[3]](#footnote-3).
3. Research Papers:
4. Specifically commissioned research was undertaken by the Universities of Calgary and Exeter in relation to impacts in respect of travel times and to stroke outcomes for the NI population.
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| **3C. Please provide details of the social and economic needs of people in rural areas which have been identified:**  |

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| Using the prescribed definitions of ‘*Social and Economic need’* listedwithin guidance provided; two areas are identified in relation to ‘*Health and Social Care* *needs*’ and *‘economic needs.’**“A need can be considered as something that is essential to achieve a standard of living comparable to the population in general.”* Health and Social Care needs* The primary Health and Social Care *‘need’* of rural dwellers is identified as availability of timely and high quality acute stroke care with continued care and rehabilitation thereafter in the community. This includes a timely ambulance response and journey to hospital.

Economic needs* We considered an economic ‘*need*’ may relate to the cost of travel to visit family members in hospital or to attend follow up appointments.
* Some stakeholders have highlighted a potential economic impact on those employed with hospital services living in rural areas. They may work in hospitals that are currently providing stroke unit care but may not provide stroke unit care in future. These situations would be carefully addressed locally by employers with actions to take consideration of any work related travel costs and consideration of redeployment options.
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| **SECTION 4 – Considering the Social and Economic Needs of Persons in Rural Areas** |

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| **4A. Please provide details of the issues considered in relation to the social and economic needs of people in rural areas identified by the Public Authority:**  |

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| Consideration of the impacts and needs requires us to appropriately balance issues of population travel times, provision of high quality care and the sustainability of services. This section considers in more detail how the issues identified during engagement with rural stakeholders have been explored in relation to the potential options and defined needs.**Health and Social Care Needs****Impact on Travel Times**Further detailed analysis of the travel time impacts was commissioned to quantify impacts for journey time in each of the potential future scenarios.* The impact of diverting ambulances from Antrim Area Hospital to the Royal Victoria Hospital or Altnagelvin Area Hospital was found to be around 15 minutes to the mean travel time.
* The impact of diverting ambulances from Causeway Hospital to either the Royal Victoria Hospital or Altnagelvin Area Hospital was found to be an additional 34 minutes to the mean travel time.
* The impact of diverting ambulances from Causeway Hospital to either Antrim Area Hospital or Altnagelvin Area Hospital was estimated at an additional 29 minutes to the mean travel time.
* The impact of diverting ambulances from Daisy Hill Hospital to Craigavon Area Hospital was estimated at an additional 20 minutes to the mean travel time.
* The impact of diverting ambulances from the South West Acute Hospital to the nearest of either Craigavon Area Hospital or Altnagelvin Area Hospital was found to be an additional 41 minutes to the mean travel time.
* The impact of diverting ambulances from the Ulster Hospital to the Royal Victoria Hospital was estimated at an additional 10 minutes to the mean travel time.

**Outcomes**Additional research commissioned by the University of Exeter sought to understand the relationship between the location of units, travel times and relationship to stroke outcomes.Table 1 below shows current provision compared with the six options with outcomes calculated using a realistic future performance. The travel times shown in the analysis below are averages for the entire Northern Ireland population rather than the specific catchment areas.**Table 1 Comparative analysis of the number of Hyperacute Stroke Unit (HASU) sites and impact on clinical outcomes, sustainability and travel times compared to current services.**

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| **Option** | **Good outcomes (per 1000 admissions)** | **Number of Hyperacute Stroke Units** | **Average travel time (minutes)** | **Max travel time (minutes)** | **95% pop. travel time (minutes)** |
| Current | 16.5 | 8 | 20 | 59 | 43 |
| A | 33.8  | 5 | 25 | 66 | 51 |
| B | 33.5 | 4 | 28 | 106 | 63 |
| C | 33.7 | 4 | 27 | 75 | 54 |
| DPhased Approach | Stage 1: 33.5Stage 2: 33.5 | Stage 1:4 Stage 2: 3 | Stage 1:28Stage 2: 30 | Stage 1: 106Stage 2: 106 | Stage 1: 63Stage 2: 66 |
| EPhased Approach | Stage 1: 33.7Stage 2:33.5 | Stage 1:4Stage 2:3 | Stage 1: 27Stage 2: 30 | Stage 1: 75Stage 2: 106 | Stage 1: 54Stage 2: 66 |
| F | 33.5 | 3 | 30 | 106 | 66 |

Time spent travelling to hospital accounts for only a small proportion of the time between onset of stroke symptoms and hospital treatment. Stroke patient often take several hours to alert emergency services of their symptoms and often delays are experienced after arrival at hospital. The actual performance of a unit is the most important consideration when predicting outcomes for people after stroke. This is why the time and distance travelled by ambulances is not the only factor considered in decisions about providing stroke care. The primary factor affecting outcomes for people in either rural or urban populations is the ability get to a service that is able to provide a sustainable workforce and thus high quality services. **Rural Isolation**There is clearly an established role for the community and voluntary sector in providing support for people in their recovery after a stroke at home and for their carers and family members. These services are delivered in partnership with stroke charities and the consultation document makes a commitment to further develop and expand these services.re are further opportunities to be explored; exploiting the broader network of community based voluntary services.**Technology**The “Delivering Together” transformation of Health and Social Care is testing ways in which virtual communication can be used to support people with remote consultations to stay connected with their health teams. There is likely to be further opportunities to develop technologies to empower people and enhance their community rehabilitation experience after stroke.Virtual networks can also be used to provide a level of stroke expertise to sites which may not in future have stroke units based within them. |

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| **SECTION 5 – Influencing the Policy, Strategy, Plan or Public Service** |

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| **5A. Has the development, adoption, implementation or revision of the Policy, Strategy or Plan, or the design or delivery of the Public Service, been influenced by the rural needs identified?**

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**Yes**  **No Please explain:**  |

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| The development of potential options for the future stroke service configuration for Northern Ireland has considered at great length the needs of people living in rural populations.The design has sought to ensure better outcomes for both rural and urban dwellers. Additional research has been undertaken to detail the impact of hospital travel time as it was the most frequent issue cited by rural stakeholders.It has also been important to reflect on evidence from reconfiguration elsewhere which demonstrates that patients who are treated in a HASU have better outcomes because they get a faster diagnosis and specialist treatment. **Journey Times*** **Influence on Design**

The identification of best possible options for the population reflects the need to balance sustainability, improved outcomes and travel times.* **Proposed Actions:**
1. Ensuring hospital services are delivering high quality care, rather than local care, is the best means of providing better outcomes for both rural and urban dwellers.
2. Implementation of future hospital stroke units may include measures to improve access to visitors either through flexible visiting, technology, or assistance with transport if reasonable.
3. Explore how stroke telemedicine and networking of services to support regional delivery of stroke care should be fully realised.
4. Explore expanding the Helicopter Emergency Medical Service (HEMS) to ‘secondary response’ incidents where the aircraft would be dispatched to a designated site to meet a road ambulance coming either from an incident or from a hospital in order to provide rapid onward transport of the patient to a hospital.
5. Investigate the impact of a new Clinical Response Model for the NI Ambulance Service, similar to those introduced in recent years elsewhere in the UK. The new model would be designed to provide a more clinically appropriate ambulance response than the current approach by better targeting the right resources (clinical skills and vehicle type) to the right patients.

**Visiting Relatives in Hospital*** **Influence on Design**

Visiting relatives in hospital is noted to be helpful in emotional and psychological recovery after stroke. It is recognised that an increase in travel time to visit people in hospital may have an impact on family, friends and carers. That said, the benefits of reducing deaths and long term disability caused by stroke outweighs the short term impact for people visiting stroke patients in hospital.* **Proposed Action**

In implementing future changes to services, managers should consider how best to provide access to visitors through flexible visiting, technology and transport assistance etc.**Support in the Community*** **Influence on Design**

Hospital stroke care accounts for a relatively short proportion of a person’s journey in recovery after stroke. Changes in hospital services will be supported by investment in quality community follow up and rehabilitation that will benefit both those in urban and rural populations.* **Proposed Action**

Investment in community rehabilitation infrastructure and improvements in the voluntary and community support available to stroke services has been prioritised. |

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| **SECTION 6 – Documenting and Recording** |

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| **6A. I confirm that details of the Rural Needs Impact Assessment will be recorded on the Public Authority’s Annual Monitoring Return and the RNIA Template retained by the Public Authority (**please check box**)** |  |

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| X |

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| **Rural Needs Impact Assessment undertaken by:** |  **Dean Looney**  |
| **Position / Grade:**  | **G7** |
| **Division/Branch:** | **Hospital Services Reform Directorate** |
| **Signature:** |  |
| **Date:**  |  **22/03/19**  |
| **Rural Needs Impact Assessment approved by:** | **Alastair Campbell** |
| **Position / Grade:**  | **Director** |
| **Division / Branch:**  | **Hospital Services Reform Directorate** |
| **Signature:** |  |
| **Date:** | **22/03/2019** |

**Note 1**

**Rural Policy Areas (relates to question 2C):**

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| * Rural Businesses
* Rural Tourism
* Rural Housing
* Jobs or Employment in Rural Areas
* Education or Training in Rural Areas
* Broadband or Mobile Communications in Rural Areas
 | * Transport Services or Infrastructure in Rural Areas
* Health or Social Care Services in Rural Areas
* Poverty in Rural Areas
* Deprivation in Rural Areas
* Rural Crime or Community Safety
* Rural Development
* Other (Please specify)
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**Note 2**

**Examples of methods or information sources used (relates to question 3B):**

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| --- | --- | --- | --- |
| * Consultation with Rural Stakeholders
 |  | * Published Statistics
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| * Consultation with Other Organisations
 |  | * Research Papers
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| * Surveys or Questionnaires
 |  | * Other Publications
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| * Other Methods or Information Sources (include details)
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Annex 1 Details of engagement and organisations who responded

**TABLE 1: Table of Engagement Meetings and Events**

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| **List of Engagement Meetings and Events** |
| **Meeting/Event** | **Location** | **Date (2017)** |
| Southern LCG public | Dungannon | 15th June  |
| Belfast LCG Public | Belfast | 15th June  |
| Northern LCG meeting | Ballymena | 22nd June  |
| Survivor Stakeholder Event | Altnagelvin | 23rd June  |
| Survivor Stakeholder Event | Ballymena | 26th June  |
| Local Trust Promotion Stand | Craigavon/ Daisy Hill Area Hospital | 17th – 21st July  |
| Local Trust Promotion Stand | Causeway Hospital | 17th – 21st July  |
| Survivor Stakeholder Event | Belfast | 24th July  |
| Local Trust Promotion Stand | Ulster Hospital  | 24th – 28th July |
| Staff Engagement Event | Royal Victoria Hospital | 25th July |
| Staff Engagement Event | Antrim | 26th July |
| Staff Engagement Event | Coleraine | 27th July |
| Staff Engagement Event | Armagh | 27th July |
| Survivor Stakeholder Events | Ballynahinch | 28th July  |
| Survivor Stakeholder Events  | Lurgan | 31st July  |
| Council Meeting Mid Ulster | Magherafelt | 1st August |
| LCG Public Meetings | Newtownards/Downpatrick | 3rd August  |
| ICP Regional Leads | Internal Belfast | 2nd August |
| Local Trust Promotion Stands | Altnagelvin | 7th – 11th August |
| Staff Engagement Events | South West Acute Hospital | 7th August |
| LCG Public Meetings | Omagh | 9th August  |
| LCG Public Meetings | Downpatrick | 10th August |
| Staff Engagement Events | Ulster Hospital | 10th August |
| Council meeting | Downpatrick | 10th August |
| Staff Engagement Event | Enniskillen | 11th August |
| Local Trust Promotion Stand | Enniskillen | 14th -18th August |
| Local Trust Promotion Stand | Antrim Area Hospital | 21st – 25th August |
| Local Trust Promotion Stand | Downe Hospital | 28th August – 1st September |
| Local Trust Promotion Stand | Newry | 4th – 8th September |
| Council meeting | Enniskillen | 6th September |
| Public Events 6.30pm – 8.30pm | Derry / Londonderry | 4th September |
| Coleraine | 6th September |
| Belfast | 7th September |
| Omagh | 11th September |
| Newry | 12th September |
| Downpatrick | 13th September |

**TABLE 2: Organisations that responded to pre-consultation**

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| **Organisations who responded to pre-consultation** |
| **COUNCILS** |
|  | Fermanagh & Omagh District Council |
|  | Newry, Mourne & Down District Council |
| **GP FEDERATION** |
|  | South West GP Federation |
| **HEALTH & SOCIAL CARE TRUSTS** |
|  | Belfast Trust (BHSCT) Regional Neurosurgical Service  |
| **POLITICAL PARTIES** |
|  | DUP NI Assembly - East Londonderry Constituency |
|  | DUP NI Assembly - Fermanagh & South Tyrone Constituency |
|  | DUP NI Assembly - Foyle Constituency |
|  | SDLP - Fermanagh & South Tyrone Constituency |
|  | SDLP - Foyle Constituency |
|  | Sinn Fein Health Policy |
|  | UUP - Fermanagh Constituency |
| **PROFESSIONAL BODIES** |
|  | British Medical Association NI |
|  | British Dietetic Association (BDA NI) |
|  | Chartered Society of Physiotherapy NI |
|  | NIAS HQ |
|  | Patient & Client Council |
|  | Pharmacy Forum NI |
|  | Roche Diagnostics  |
| **STROKE ORGANISATIONS/ GROUPS** |
|  | Causeway Stroke Carers Group |
|  | Save our Stroke Services (SOSS) Fermanagh |
|  | Stroke Association |
| **UNION** |
|  | UNISON NI |
|  | UNISON Omagh & Fermanagh (SWAH) |
| **VOLUNTARY/COMMUNITY** |
|  | AF Association & Arrhythmia Alliance (A-A) |
|  | British Deaf Association  |
|  | Carers NI |
|  | Community Pharmacy NI |
|  | Down Community Health Committee |
|  | Marie Curie |
|  | NIPEC |
|  | RNIB NI |
|  | Rural Community Network |

Annex 2

DAERA Infographic - Rural Statistics[[4]](#footnote-4)



Annex 3

Most Deprived Rural Super Output Areas Within Northern Ireland – Northern Ireland Multiple Deprivation Measures 2017[[5]](#footnote-5)



1. *If a definition of ‘rural’ is not applicable, the policy is unlikely to fall under the scope of the Act and you should be able to screen out at this stage* [↑](#footnote-ref-1)
2. <http://www.health-ni.gov.uk/topics/dhssps-statistics-and-research/health-inequalities-statistics> [↑](#footnote-ref-2)
3. <http://www.ninis2.nisra.gov.uk/public/Home.aspx> [↑](#footnote-ref-3)
4. <https://www.daera-ni.gov.uk/sites/default/files/publications/daera/Rural-Urban%20Infographic_0.pdf> [↑](#footnote-ref-4)
5. <https://www.daera-ni.gov.uk/publications/rural-deprivation-infographic> [↑](#footnote-ref-5)