



Department of
**Health, Social Services
and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

IMPROVING STROKE SERVICES IN NORTHERN IRELAND

Consultation Response Questionnaire

November 2007

[13th February 2008]

College of
Occupational Therapists



CONSULTATION RESPONSE QUESTIONNAIRE

You can respond to the consultation document by e-mail, letter or fax.

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

Responses should be sent to:

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I am responding: as an individual on behalf of an organisation

(please tick a box)

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“Improving Stroke Services in Northern Ireland”

Response from the College of Occupational Therapists

1. Introduction

The College of Occupational Therapists (COT) is pleased to provide a response to the Department of Health, Social Services and Public Safety draft strategy entitled, “Improving Stroke Services in Northern Ireland”. The response to this consultation has been done in partnership with the College of Occupational Therapists Specialist Section – Neurological Practice – Regional Group, Northern Ireland.

The COT represents over 29,000 occupational therapists, students and support workers across the United Kingdom, of which over 900 are either working or studying in Northern Ireland. Occupational therapists (OTs) in Northern Ireland work in the NHS in Acute and Community Trusts, the voluntary and independent sectors, schools, primary care settings, and a wide range of vocational and employment rehabilitation services including palliative care settings.

Occupational therapists are regulated by the Health Professions Council, and work with individuals of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties. The philosophy of occupational therapy is founded on the concept of occupation as a crucial element of health and well-being. Practice is based on holistic, client centred care.



Q1. This document makes a total of 14 Recommendations, as set out in Table 1 below. Please indicate whether you agree or disagree with each of the recommendations. If you disagree with any of the recommendations please provide, in the space provided, detail of your reasons. We would also ask that you provide detail of any additional suggestions you may wish to make.

Recommendation	Y/N
<p>1. Delivery of a regional public awareness campaign for the recognition of early signs and symptoms of TIA and stroke, and the prevention of stroke, working in collaboration where appropriate with the Cardiovascular Disease awareness campaign. (Page 14)</p>	<p>Y</p>
<p>Comments: An ongoing regional public awareness campaign around stroke to inform the public about prevention and symptoms and what to do if they or someone else has a stroke will be essential.</p> <p>The College of Occupational Therapists (COT) is pleased that stroke is to be treated as a medical emergency. Is it intended to achieve “ A change in public perception so that acute stroke symptoms are recognised and seen as an emergency...”(bullet point one, page sixteen) through this public awareness campaign also?</p> <p>Consideration will need to be given to how any awareness campaign will be delivered to various groups in society to ensure the information reaches everyone and is delivered in the right format, for example, those at high risk, with specific needs, from different cultures, minority groups, disadvantaged groups and for whom English is not a first language.</p> <p>Improving healthcare professionals’ awareness will require more specialist training, education and support.</p>	
<p>Recommendation</p>	<p>Y/N</p>
<p>2. By April 2011 all acute stroke patients will be appropriately assessed and, if applicable, will receive thrombolysis within 3 hours of stroke onset. (Page 16)</p>	<p>Y</p>
<p>Comments: There will need to be careful consideration of the factors that impact on the delivery of thrombolysis. This has major implications; public awareness needs addressed, ambulance control, paramedics, and A&E staff education will be crucial. These are in addition to the more obvious necessities, such as CT scanner access, medical and nursing staffing and availability of ‘ring fenced’ acute stroke beds.</p> <p>Consideration will be needed to ensure all services are easily accessible regardless of whether people live in rural or urban areas.</p>	



Recommendation	Y/N
<p>3. That a working group will be established to bring forward proposals for the implementation of thrombolysis for acute stroke patients, where appropriate, to meet the target date in Recommendation 2 above. (Page 16)</p>	Y
<p>Comments: This recommendation will be crucial if the 2nd recommendation is to be achievable</p>	
Recommendation	Y/N
<p>4. That by 2010 70% and by 2011 90% of all confirmed TIA patients at high risk of early stroke (ABCD2 score 6 or 7), are fully investigated in a specialist neurovascular clinic, and a plan of management put in place within a maximum of 7 days of the event. (Page 18)</p>	Y
<p>Comments: Patients who have had a TIA or minor stroke should be immediately referred for an urgent specialist assessment, and we believe the assessment should be provided by a multi- disciplinary team of professionals who are appropriately skilled in stroke care to meet the needs of each individual patient.</p> <p>All patients need screening for neurological / cognitive / perceptual / visual / executive functioning problems. These can often be subtle problems that could be missed if the patient has no access to an occupational therapist at a neurovascular clinic.</p> <p>Early identification of cognitive and / or perceptual problems by an occupational therapist will help to inform the rest of the multi disciplinary team so they can adapt their approach to the patient e.g. amend their communication methods, and thereby improve the outcomes of their own interventions so they are more responsive and cost effective.</p> <p>Referral protocols between primary and secondary care will be essential to ensure that there are effective care pathways and resources that follow the patients.</p>	
Recommendation	Y/N
<p>5. That by 2010 80% of stroke patients should spend the majority of their hospital stay in a specialist stroke unit as defined by British Association of Stroke Physicians Service Specification (at least Level 2) and with the expectation that by 2012 this should be available to all patients. (Page 20)</p>	Y
<p>Comments: The College of Occupational Therapists (COT) support this recommendation which would promote quality care of stroke patients.</p>	



<p>However, occupational therapists in Northern Ireland report concerns regarding the staffing of stroke units. Throughout the province occupational therapy cover to stroke units varies greatly including multidisciplinary teams (MDT). Very often the occupational therapist who works in a stroke unit only does so as part of her workload and in consequence does not provide dedicated cover. This mixed caseload can make the prioritisation of patients very difficult. In an environment of target driven discharges, occupational therapists are faced daily with prioritisation between the rehabilitation of stroke patients and urgent facilitation of discharges of non stroke patients</p> <p>In reality when a therapist has a mixed caseload, rehabilitation of stroke patients is not seen as a priority when the focus is on discharging patients. This type of staffing can even occur in designated, geographically defined units, (i.e. level 1, 2 and 3) and occupational therapists in Northern Ireland feel this has a negative effect on the care of all stroke patients.</p>	
<p>Recommendation</p>	<p>Y/N</p>
<p>6. That by 2009 all Trusts should have a Specialist Early Supported Discharge service in place? By April 2010 50% of all stroke patients discharged from each stroke unit and for whom Specialist Early Supported Discharge is appropriate should have access to it. Do you consider the target dates and percentage appropriate? (Page 20)</p>	<p>Y</p>
<p>Comments:</p> <p>It is the experience of occupational therapists in Northern Ireland that the community stroke teams, where available and staffed well, provide stroke patients with invaluable support. They facilitate discharge home and help provide a less traumatic and more seamless transition back to community living.</p> <p>Throughout the province however occupational therapists are finding that the schemes are no longer being used solely to facilitate early discharge, as the document would indicate. The schemes could be said to be 'victims of their own success' and where available they are more frequently used as standard follow up for many discharges, not just the 'early supported discharges'. This will have implications for the schemes and their capacity.</p>	
<p>Recommendation</p>	<p>Y/N</p>
<p>7. That by April 2009 the RCP Transfer of Care Document or Northern Ireland equivalent should form the basis for the patients discharge plan? That a recognised specialist stroke co-ordinator should be available to support this process, as outlined in the Standard for Discharge Planning. (Page 21)</p>	<p>Y</p>
<p>Comments:</p> <p>Any consistent Transfer of Care documentation is to be welcomed and will help ensure a continuity of care from hospital to home.</p>	



<p>The position of specialist stroke co-ordinator is essential to ensure a seamless transfer and occupational therapists in Northern Ireland would like to see these positions being open to applications from the profession. Their expertise, skills and knowledge should be utilised with regard to enabling stroke survivors to return to their home environment.</p>	
<p>Recommendation</p>	<p>Y/N</p>
<p>8. That by 2010 every stroke patient should have access to stroke specialist assessment, advice, support and intervention in community settings in response to individual need. (Page 23)</p>	<p>Y</p>
<p>Comments: The concept of a specialist stroke review in response to ongoing individual need is entirely positive. Access to a specialist consultant either in a hospital review clinic or in a community setting is essential. Such review clinics need the support of a full multidisciplinary team, which includes an occupational therapist who plays a crucial role in such teams.</p> <p>Ideally, it is necessary to review all the stroke survivors' needs and assess functional change annually or as required by the stroke survivor and / or their carer. Clear links through working arrangements, referral routes, communication and skill sharing is required across sectors. For example, for access to work there needs to be clear care pathways across from health to occupational health and vocational rehabilitation services; for those with mental health issues, post stroke, there need to be clear care pathways giving access to mental health services provided by people with an understanding of the needs of stroke survivors.</p>	
<p>Recommendation</p>	<p>Y/N</p>
<p>9. That by April 2009 75% and by April 2010 95% of all stroke/TIA patients should have undergone a Primary Care Review at 6 weeks, 6 months, and one year after onset or discharge from a Specialist Stroke Unit. (Page 24)</p>	<p>Y</p>
<p>Comments: Whilst it is beneficial for all patients to be seen routinely by GPs after a CVA, the GP needs a clear referral route to his primary care team and a good knowledge of their skill set. The primary care team should have access to the specialist multidisciplinary stroke team when necessary which should include occupational therapists.</p> <p>Occupational therapists in a stroke rehabilitation setting may potentially have input in the following areas:</p> <ul style="list-style-type: none"> ❖ Seating ❖ Upper limb rehabilitation ❖ Perceptual screening and retraining ❖ Cognitive testing and rehabilitation 	



<ul style="list-style-type: none"> ❖ Mobility and transfer training ❖ Independence training in all areas of activities of daily living (ADL), personal care, toileting and self-care. ❖ Visual screening ❖ Aids and adaptations to promote independence at home ❖ Fatigue management ❖ Falls Prevention ❖ Splintage ❖ Carer advice and caring strategies ❖ Vocational retraining and return to work ❖ Return to community living, including driving. ❖ Multidisciplinary team (MDT) training <p>Whilst standard community occupational therapists will also have skills in all these areas, they will not necessarily be specialists in stroke care, and crucially, will have a primary directive to attend to equipment and adaptation needs as a priority. Therefore any referrals generated from newly formed primary care stroke clinics should be forwarded to the Community Stroke Schemes (not generic teams) This may have an impact on the capacity of such schemes and their staffing.</p>	
<p>Recommendation</p>	<p>Y/N</p>
<p>10. That by April 2010 psychological screening and treatment for both cognitive impairment and mood disorders and promotion of long term psychological adjustment should be available for all stroke survivors and their carers. (Page 24)</p>	<p>Y</p>
<p>Comments:</p> <p>The recommendation for psychological support following stroke must be appropriate to meet peoples' individual needs including their psychosocial, emotional and occupational needs using a variety of techniques provided by a diverse range of specialist therapists that includes occupational therapists.</p> <p>Occupational therapists in Northern Ireland feel their skills are currently the mainstay of cognitive assessment and rehabilitation of most stroke patients. Occupational therapists have dual training in the areas of mental health and physical functioning, and have an understanding of the psychological impact and cognitive sequelae of stroke. However very often, psychological interventions are very time intensive and will draw on the resources of any occupational therapy department. This should be looked at as a workforce planning issue.</p> <p>In addition occupational therapists in Northern Ireland would welcome the support of Clinical Neuropsychology input, which is currently under resourced and difficult to access. This undoubtedly negatively affects stroke patients.</p>	



Recommendation	Y/N
<p>11. That by April 2009 each Trust should have established effective means of providing information to stroke patients and carers in a manner tailored to suit individual needs. (Page 25)</p>	<p>Y</p>
<p>Comments: Stroke patients can have visual, perceptual, cognitive, communication and attentional problems. These can have a major impact on a person's ability to absorb and assimilate information. The solutions needed to ensure effective communication are very individual, and need to be tailored to reflect patients' specific clinical needs.</p> <p>There is a tendency to assume that if a leaflet has been issued, the topic has been covered, and this kind of thinking occurs in a time pressured environment, where sitting down to explain a topic thoroughly, in a client centred way, can require a period of time that staff simply do not have.</p> <p>In addition carers need to be involved in the giving of information with treatment from an early stage (as indicated in the RCP guidelines). The timeliness of communication and the repetition of it at regular intervals is important if information is to be retained.</p> <p>Again the implication of individual, timely, repeated information, given to both patients and family, based on assessment of clinical and communication needs, has many time implications for therapists and all staff working in this area. Services must be designed to allow for effective communication, which puts demands on therapists' time, and will have implications in a target driven workplace.</p>	
Recommendation	Y/N
<p>12. That by April 2010 the DHSSPS should put in place a regional managed approach to the integration and delivery of stroke services to ensure equity of access across the region. (Page 26)</p>	<p>Y</p>
<p>Comments: The '...significant service re organisation and redesign....' mentioned in paragraph two, page twenty six, will be very necessary and there must be adequate representation of occupational therapists to ensure that health care professionals involved in the planning and delivery of services play an equal part in developing effective, integrated services.</p> <p>Only a regional approach will ensure equity of services with improved workforce & service planning.</p>	



Recommendation	Y/N
<p>13. That the Department of Health should work with relevant agencies to develop a competency and skills framework for stroke which will inform workforce planning for specialist stroke teams. (Page 27)</p>	Y
<p>Comments: The College fully endorse any proposals for plans for any competency and skills frameworks to underpin 'a skilled, dedicated (and) specialised workforce'. We have noted that the document has not considered the whole MD team, only mentioning medical and nursing staff. (page twenty seven, paragraph two). We felt it was disappointing that the wider skill set of the entire multidisciplinary team was not addressed.</p> <p>Perhaps it is also worth noting that to date the impact of agenda for change (AFC) on skill mix has yet to be realised. Essentially therapists will only be graded over two bands. We have effectively "lost" that intermediate band of senior two staff that historically tended to form the backbone of many stroke units and schemes.</p> <p>With this potential flattening of the therapy work force into two bands, the needs of the service user could be addressed further by consideration of the potential development of the roles of clinical specialist therapists or consultant occupational therapists.</p> <p>We feel work needs to be done with regard to succession planning, supervision, and the development and maintenance of a workforce that comprises MDTs of specialist staff for stroke rehabilitation.</p> <p>Continuing professional development for Allied Health Professionals (AHPs), including occupational therapists should be factored into workforce planning and commissioned services.</p> <p>Workforce development will be a huge consideration in making this vision work. Stroke survivors should be able to expect that all staff they come in contact with are equipped with the qualities, competencies, knowledge and skills required by their individual position.</p>	
Recommendation	Y/N
<p>14. That by April 2010 a regionally agreed fundamental hospital based stroke register should be in use across the province. (Page 27)</p>	Y
<p>Comments: It has been to the detriment of research and development of stroke services in general that there has been no stroke register to date. Every effort should be made to ensure one is established.</p>	



Q2. What do you consider to be an appropriate number of acute Stroke Units to meet the needs of the population of Northern Ireland and their preferred location?

Response:

We do not feel we have the necessary information to hand to answer this question. However the following points are pertinent to stroke unit location and size:

- ❖ all residents of a geographical area should be able to access an acute stroke unit in a time window that allows consideration of thrombolysis treatment
- ❖ incidence of stroke within the local population
- ❖ accessibility to essential medical diagnostic tests and other essential services
- ❖ appropriate staffing levels (medical, nursing and all therapies/services)
- ❖ a geographically distinct unit, with specific staff who do not have a mixed caseload.

Equality implications

Q3. Do you think the Recommendations are likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals

Yes No

Response:

Religion- will access to a stroke unit in a time frame to allow consideration for thrombolysis be geographically dependant? If so, in the context of Northern Ireland, if this follows religious affiliation this could be considered as discriminatory.

Political opinion- as above, by inference.

Racial group- language barriers will impact on differing racial groups. Services should be provided by individuals and teams with the skills to recognise and respect the values, beliefs, customs and language of Northern Ireland's increasingly culturally rich and diverse population. Awareness campaigns and information should be in a suitable format.

Age- stroke services should not have an age criteria but many stroke units are situated in recognised elderly care areas in hospital and with a growing number of younger adults suffering CVAs this needs some consideration.



Marital status-

Sexual orientation

Gender- availability of hospital beds are often drawn against single sexed bays in stroke units. For instance, the unavailability of say a 'male' bed could be said to unfair and discriminatory.

Disability -Awareness campaigns and information should be in a suitable format.

With /without dependants

Q4. Are you aware of any evidence, qualitative or quantitative, that the proposals may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

Yes No

Response:

If any of the skills of the staff groups involved in the implementation of the strategy were not recognised and utilised, this could be denying stroke survivors or carers services that could benefit them.

Q5. Could the proposals better promote equality of opportunity or good relations? If yes, please give details as to how.

Yes No

Response:

If improved stroke services were implemented equitably across all communities within Northern Ireland, this should help promote equality of opportunity.

Q6. Do you have any other comments on the recommendations or any suggestions that you would like to make to improve the promotion of equality of opportunity and/or good relations or human rights?

Yes No

Response:

[13th February 2008]

College of
Occupational Therapists



Please find attached the AHPF response to the Stroke Strategy in England, which provides a range of evidence based practice for all Allied Health Professionals, which may assist the development of stroke services in Northern Ireland.
Please do not hesitate to contact us for further details or if we can be of further help

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