**RESHAPING STROKE CARE – SAVING LIVES, REDUCING DISABILITY**

**Consultation Questionnaire**

**26 March 2019**

**Prepared by:**

**Hospital Services Reform**

**Department of Health**

**Annexe 3**

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[**https://consultations.nidirect.gov.uk/**](https://consultations.nidirect.gov.uk/)

**RESPONDING TO THE CONSULTATION**

You can let us know your views by completing our Consultation Questionnaire online via [**https://consultations.nidirect.gov.uk/**](https://consultations.nidirect.gov.uk/)

You can also complete our Consultation Questionnaire and submit the completed document to the Department by email or by returning a completed hard copy to the address below.

If this document is not in a format that suits your needs, please contact us and we can discuss alternative arrangements. Before you submit your response, please read the information at **Annex A** about the effect of the Freedom of Information Act 2000, the Environmental Regulations 2004, the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (EU) 2016/679 on the confidentiality of responses to public consultation exercises.

For further information about how we process your information please see the following link which will take you to the Departmental Privacy Notice:

[**https://www.health-ni.gov.uk/sites/default/files/publications/health/DoH-Privacy-Notice.pdf**](https://www.health-ni.gov.uk/sites/default/files/publications/health/DoH-Privacy-Notice.pdf)

**Section 1 – Consultee Details**

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| **Name (Optional):** | **Paul Cooper** |
| **Organisation and job  title (if applicable):** | **Royal College of Occupational Therapists** |
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Are you responding on behalf of your organisation or as an individual?

|  |  |  |
| --- | --- | --- |
| **Organisation** | **X** | **(Please Tick)** |
| **Individual** |  |

**If replying as an individual, please indicate if you do not wish for your identity
to be made public.**

N/A

**Whilst not essential, it would assist the Department in analysing responses if responding on behalf of an organisation you could provide details of who your organisation represents and, where applicable, how the views of members were assembled.**

The Royal College of Occupational Therapists (RCOT) is pleased to provide a response to this consultation. RCOT is the professional body for occupational therapists and represents over 33,000 occupational therapists, support workers and students from across the United Kingdom. There are currently 1,256 RCOT members in Northern Ireland of which 1,083 are professional members (RCOT, June 2019). Occupational therapy enables people of all ages to participate in daily life to improve health and wellbeing. The philosophy of occupational therapy is founded on the concept that occupation (participating in activities) is essential to human existence and good health and wellbeing.

Occupational therapists are regulated by the Health and Care Professions Council (HCPC), and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties. Occupational therapists in Northern Ireland work in trusts, across health and social care services. They deliver services across housing, schools, prisons, the voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists consider the relationship between what a person does every day (occupations), how illness or disability impacts upon the person and how a person’s environment supports or hinders their activity. Using this approach, we help people to continue or re-engage with participating fully in daily life, including work, social activities and maintaining roles and responsibilities.

Occupational therapists address the physical, cognitive and psychological challenges brought on by a stroke, and can help stroke survivors regain their ability to engage in daily activities through using evidence based methods. Occupational therapists work with people who have a stroke in primary, secondary and social care settings. The range of interventions includes:

* Specialist assessment and intervention for people with visual, perceptual, physical and cognitive dysfunction.
* Recommendation of specialist equipment and adaptations for the home to assist a person to complete functional tasks.
* Evaluation of the home environment for safety hazards to reduce falls.
* Build a person’s physical endurance and strength through using therapeutic activity
* Offer targeted therapy to facilitate a return to work.
* Support carers by reducing the person’s care needs.

When people cannot do the activities they need or want to do as a result of having a stroke, their health and wellbeing will be affected. Occupational therapists are skilled in activity analysis and help people to overcome barriers to return to their optimal level of performance to enable people to get the most from life.

The last date for responses to this consultation is **2 August 2019.**

Responses should be sent to:

**Email**: **StrokeConsultation@health-ni.gov.uk**

**By post**: Hospital Services Reform

Department of Health

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**Section 2 – Questions relating to Reshaping Stroke Care – Saving Lives, Reducing Disability in Northern Ireland**

These questions should be read in conjunction with the proposals set out in the accompanying consultation document.

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| **Question 1: Do you agree that stroke patients should be admitted as soon as possible to specialist centres to deliver the best possible outcomes? (Please Tick)** | **Yes** | x |
| **No** |  |
| *Please use this space to expand your answer.*Yes. We note that it states in the consultation document that *“only around half of people with strokes are admitted to stroke units-despite admission to a specialist unit being the single most important treatment for stroke patients”* (page 19) so it would seem imperative that stroke patients be admitted as soon as possible to specialist centres to deliver the best possible outcomes. It is vital these centres are staffed with the specialist staff required. We believe that people should receive the most appropriate care as soon as possible in order to achieve better long term outcomes and improve chances for more rehabilitation potential. A big challenge in Northern Ireland is the rural and dispersed nature of the communities - getting the location of the Hyperacute Stroke Units (HASU’s) and Acute Stroke Units (ASU's) is critical but similarly the Early Supported Discharge (ESD) and community teams need to be considered at the same time.We would echo the Allied Health Professions Federation Northern Ireland (AHPFNI) statement that the role of Allied Health Professionals (AHPs), including occupational therapists be recognised within the rehabilitation process and in the prevention stage. Occupational therapists are skilled in preventative approaches to health and work across all sectors. We would ask that workforce development acknowledges the scope and variety of occupational therapy practice and utilises the skills in the system fully in support of best outcomes for stroke care. In common with the Stroke Association, we believe that there should be better long-term support for people to rebuild their lives after stroke, whether this be from professionals in the system, or community support for people to return back to their meaningful daily activities. Advice and guidance for people and their carers is essential in order that they receive the right level of support and to ensure that people can develop greater self-management ability.In line with the Stroke Association comments, we believe that greater public awareness of the signs and symptoms of stroke and TIA will greatly improve more timely intervention. However raising awareness must also be assured by an appropriate response by services.  |  |
| **Question 2: Do you agree that, to deliver an effective service, staff need the opportunity to build and develop their specialist expertise? (Please Tick)** | **Yes** | **X** |
| **No** |  |
| *Please use this space to expand your answer:*We would agree that there is a need for staff to build their skills within stroke care. We would like to make some additional comments based on feedback from our members.**We are pleased to see that one of the proposals is a minimum requirement that at any future location throughout Northern Ireland delivering Hyperacute Stroke Care includes a ‘highly skilled stroke multidisciplinary team’ and that included as part of this team are AHPs, 24 hours a day (page 27). A**HPs, including occupational therapists, should be a key part of the teams of HASUs/ASUs as they contribute to the assessment and treatment of patients with acute stroke providing acute management and early rehabilitation and provide substantial support in enabling discharges to ESD teams and community services. We agree that to deliver an effective service, staff need the opportunity to build and develop their specialist expertise. **On page 26, specialist nursing and medical staff is mentioned. This should also include occupational therapists and AHPs with specialist knowledge. As shown in the** [Advanced AHP Practice Framework](https://www.health-ni.gov.uk/sites/default/files/publications/health/AHP-Framework.pdf)**, there is great deal of potential with expert AHP practitioners to support stroke care. This could be alongside, or instead of, medical and nursing staff. We could also learn from what is happening elsewhere in the wider provisions of stroke services.****Occupational therapy-led stroke unit** NHS Grampian has two stroke units, one led by a consultant occupational therapist and the other follows a medical model. In 2014, the median length of stay in the consultant occupational therapist- led unit was 28 days and 55 in the other. In 2015 a similar result: 27 and 59 days. The consultant occupational therapist is now responsible for some of the beds on the second unit in order to support a similar person-centred rehabilitation process, which has an impact on the effectiveness and efficiency of services. Patients have reported increased satisfaction and improved ability to engage in their chosen occupations, including ability to return to roles at home, at work and socially. (RCOT, 2016) Having the right workforce with the right skills is critical to any new model. There are not many details on the section on ‘Workforce Development’. It does mention that when the proposals are approved that the following consultation, a detailed workforce implementation plan, will be produced. We hope this will be aligned to the Health and Social Care Workforce Strategy 2026 and workforce reviews. With a change such as this, the workforce also needs to feel valued and supported. We had member opinion that while the proposals aim to concentrate expertise into fewer sites, this is based upon the assumption that healthcare professionals will all willingly relocate to the proposed implementation sites and that this may not be the case. In the HASU's there is no mention of seven day working for AHP's. Our members felt it was important to consider this prior to development of these services. S of occupational therapists and the wider AHP ensures good flow of people through services.There has also been concern raised about existing challenges of recruitment and retention of specialised AHP staff, particularly in rural areas of Fermanagh and Tyrone. In addition, concern about the impact any move to specialist units might have, such as on service delivery within local hospital sites. If trained, experienced staff are to move from local stroke units to other HASU / ASU centres, workforce skill and expertise will be lost from the local hospitals. An example given was that the neurological stroke occupational therapy team may not only see stroke patients but also a range of other complex neurological patients such as head injuries. Therefore, this loss of skill must be considered.As stated later in the document, we would ask that all staff are consulted and at every stage in order to ensure that any new units have the most appropriate staff to meet people’s needs.Whilst in this document, Commitment 5 states that *“alongside the reshaping of hospital services, we are committed to driving improvement in rehabilitation and long-term support and will use the Stroke Associations analysis and recommendations as a blueprint to drive that improvement”,* RCOT do not believe this is sufficient and the proposals must outline clearly how this is to happen. It should also be necessary to review all the stroke survivors’ needs and assess functional change as required by the stroke survivor and/or their carer.In the document, it says that following hyper acute care, around 40% of patients should be discharged home to community stroke services. The remaining 60% of patients would continue to receive care in an ASU. It would be beneficial to outline how these needs will be met.The Regulation and Quality Improvement Authority Review of Stroke Services in Northern Ireland 2014 identified several areas of unmet need within community stroke services (page 35). It would be important to look at this aspect of delivery and what is intended as services are reshaped.There is also an opportunity to build into this document more about the role that occupational therapists and other AHPs can do in support of self-management during the rehabilitation and life after stroke. Within this context, this document should also include support that should be offered to people of working age to return/maintain work. In Commitment 6, it refers to undertaking a workforce review to identify staffing and skill mix required to deliver effective stroke services. This work has already been done in England and staffing ratios exist for nursing and AHP's which might be a helpful starting point.Our member at South-West Acute Hospital (SWAH), has pointed to her service delivering access to HSAU/ASU immediate therapy with early AHP interventions, specialist Stroke Nurse and Stroke Consultants and how its associated with better outcomes. They have highlighted that the SWAH Stroke Unit is “*consistently delivering on all these domains which is clearly demonstrated in the SSNAP results”.* We are happy to make further links with this service, should this prove useful. The document does reference the importance of providing support for long-term, post-stroke support. However, our membership has questioned whether this should have a unique element in the pathway, perhaps called ‘**Life after Stroke’.**References:*Health and Social Care Workforce Strategy 2026. Delivering for our people.* Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-workforce-strategy-2016.pdf> [Accessed 22.07.19]RCOT (2016) *Reducing the pressure on hospitals. A report on the value of occupational therapy in Northern Ireland*. Available at: <https://www.rcot.co.uk/file/3211/download?token=HKLAsDSR>. [Accessed 22.07.19]*The Regulation and Quality Improvement Authority Review of Stroke Services in Northern Ireland 2014*. Available at: <https://www.rqia.org.uk/RQIA/files/b8/b8f067de-3bf7-40c6-9297-b21a41a31811.pdf> [Accessed 22.07.19] |

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| **Question 3: Do you agree that delivering better outcomes should take priority over additional travel time? (Please Tick)** | **Yes** | **X** |
| **No** |  |
| *Please use this space to expand your answer:*In general yes, however our members have requested that there be a greater level of evidence in the proposals about what an increasing travel time might mean on large sections of the community, particularly in rural communities. We have received comments from a member relating to the proposals and this includes travel time. Due to the level of detail, we have attached this as an appendix.There have been a number of concerns from a few members about the support given by family and friends and how there is much to be gained in the less acute phase from greater family and carers involvement. Our members have commented that, with greater distance between care setting and their homes, it may limit input from family and carers. We would ask that carers be enabled to input into these proposal being considered, given the importance they play in every stage of a person’s care, rehabilitation and in supporting a person’s self-management.In addition, some of our members have expressed concern that people in the acute phase of treatment may be disadvantaged in the psychological support from their families and friends, if there is a greater distance and care provided so far from home. |
| **Question 4: Would the availability of additional measures such as the availability of an air ambulance address your concerns about additional travel time? (Please Tick)** | **Yes** | **X** |
| **No** |  |
| *Please use this space to expand your answer:*Yes, this would be good addition in order to ensure that people get timely access in the acute emergency phase. We hope that there would be ongoing commitment for the Air Ambulance to perform this important task in the acute phase, especially in rural localities. There needs to be sufficient funds and environments, within hospital settings and rural areas, to ensure smooth transfers of care. For example; will it be able to be used at night or in bad weather with inaccessibility of many rural areas making landing impossible? Members have questioned how priorities for this service will be put in place. For example; will incidence of major trauma take precedence? In addition, we would support our AHPFNI paramedic colleagues and question whether there is to be more first response teams and vehicles.  |
| **Question 5: Which of the options do you think delivers the maximum benefit for stroke patients in NI? (Please Tick)** | **Option A** |  |
| **Option B** |  |
| **Option C** |  |
| **Option D** |  |
| **Option E** |  |
| **Option F** |  |
| *Please use this space to expand your answer:*The Royal College recognises the work that has gone into looking at the various models and agrees that there needs to be reorganisation, however comments from members suggest there are flaws with each of the models that have been put forward.These relate to:* Concern that comparison to London and Manchester models is not like for like as these are large, urban areas which are non-comparable to the more dispersed and largely rural population in Northern Ireland.
* Travel times may differ from those in the document, the degree of risk may be shifted and be greater for those travelling on difficult, country roads.
* Population needs and demographics may vary across Northern Ireland and this should be examined.
* Performance as measured by the Stroke Sentinel National Audit Programme (SSNAP). The sites for the relocation do not seem to necessarily correspond with those preforming well. This is not just in relation to the comments about the South West Acute Services and questions of sustainability but other sites performing well without clear examination being considered in the overall reconfiguration and how are the presently poorer preforming suggested options to improve standards.
* The reshaping of services will be also be dependent on professionals who have the appropriate skills and expertise relocating to proposed implementation sites.
* If stroke services are relocated, will the new models be able to cope with the additional patients annually being redirected to them. An example given was from the Ulster Hospital to the Royal.
* Information on Acute Stroke Units in the document is not very detailed. It is mentioned that proposals envisage that in future, all stroke specific rehabilitation would be delivered within Specialist Acute Stroke Units and generally the proposed HASU and ASU on page 33 are co-located apart from a possible ASU also at the Ulster Hospital included in all but one option.
* It is included that the regional Acquired Brain Injury Unit at Musgrave Park Hospital which offers specialist rehabilitation to a small group of complex stroke patients will continue. Member concern relates to how this will work alongside Acute Stroke Units. It says on page 35, “*it is more important that patients are taken to the place they will receive the best care’ however what is meant by ‘best care’”*. In the modelling provided as extra evidence from the University of Exeter on the Department of Health’s website, it says that *“the modelling described here focusses on the Hyper Acute Stroke Unit phase of stroke care and does not extend to organisation of ongoing step-down care in local stroke units, or after discharge home”* (Allen 18/19). RCOT would like to see rehabilitation, community care and review considered as part of the overall reconfiguration and reorganisation.

As stated, there has been concern raised from our membership that each of these options has a travelling time of 60 minutes. As detailed in the attached, we would echo concerns about the need to ensure that greater travel time does not lead to poorer outcomes for people. From all member responses, there was a general request that evidence base around transfer time and the impact this would have on outcomes be factored in. Finally, we believe strongly that whatever changes are decided on, they must include and involve occupational therapists, and indeed the wider AHP team given the importance they play in the rehabilitation process and for ongoing prevention. Reference:Allen Dr M.et al (February 2019) Northern Ireland hyper-acute stroke care modelling: Maximising sustainability of services and clinical benefit from thrombolysisAnd thrombectomy.  |
| **Question 6: Are there additional options that we have not considered? (Please Tick)** | **Yes** | **X** |
| **No** |  |
| *Please use this space to expand your answer:*Has the use of telemedicine/teleradiology to support clinical decision making, as mentioned on page 38 in the supporting evidence, been considered>In therapy-led stroke units as previously mentioned. This is about where HASUs and ASUs are situated; we would like the wider provision of services and rehabilitation to be considered in options. |

**Section 3 – Equality and Human Rights**

Section 75 of the [NI Act 1998](http://www.legislation.gov.uk/ukpga/1998/47/contents) requires departments in carrying out their functions relating to NI to have due regard to the need to promote equality of opportunity:

* between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
* between men and women generally;
* between person with a disability and persons without; and
* between persons with dependants and persons without.

You may wish to refer to the Equality Screening, Disability Duties and Human Rights Assessment Template at [**https://www.health-ni.gov.uk/consultations**](https://www.health-ni.gov.uk/consultations)

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| **Question 7: Are any of the options set out in the consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the 1998 Act?  (Please Tick)** | **Yes** |  |
| **No** | **X** |
| *If yes, please state the group(s) and provide comment on how these adverse impacts could be reduced or alleviated in the proposals:* |
| **Question 8:  Are you aware of any indication or evidence – qualitative or quantitative – that any of the options set out in the consultation document may have an adverse impact on equality of opportunity or on good relations? (Please Tick)** | **Yes** |  |
| **No** | **X** |
| *If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact:* |  |  |
| **Question 9: Is there an opportunity to better promote equality of opportunity or good relations? (Please Tick)** | **Yes** |  |
| **No** | **X** |
| *If yes, please give details as to how:* |  |  |
| **Question 10: Are there any aspects of the proposals in the** **consultation where potential human rights violations may** **occur? (Please Tick)** | **Yes** |  |
| **No** | **X** |
| *If yes, please give details as to how:* |  |  |

**Section 4 – Rural Impact**

The Rural Needs Act (NI) 2016 became operational on the 1 June 2017 and places a duty on public authorities, including government departments, to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services.  A draft rural needs impact assessment has been prepared against these policy proposals.

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| **Question 11: Are the actions/proposals set out in this consultation document likely to have an adverse impact on rural areas? (Please Tick)** | **Yes** | **X** |
| **No** |  |
| *If yes, please provide comment on how these adverse impacts could be reduced or alleviated:*Please see above for some concern related to this area. In addition there have been concerns raised about the impact on the far north-east and far south-west areas.  |

**Responses must be received no later than 5pm on 2 August 2019.**

**Thank you for your comments.**

**ANNEX A**

**Confidentiality and Access to information Legislation**

The Department may publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be published or disclosed on request in accordance with information legislation; these chiefly being the Freedom of Information Act 2000 (FOIA), the Environmental Information Regulations 2004 (EIR), the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) (EU) 2016/679. The Department can only refuse to disclose information in exceptional circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The FOIA gives the public a right of access to any information held by a public authority, namely, the Department in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

If you do not wish information about your identity to be made public please include an explanation in your response. Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the DPA and the General Data Protection Regulation (EU) 2016/679. The Department is committed to building trust and confidence in our ability to process personal information. This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances.

For further information about confidentiality of responses please contact the Information Commissioner’s Office on **0303 123 1113** or via <https://ico.org.uk/global/contact-us/>