



Developing High Quality Trauma and Stroke Services for London

Response from the College of Occupational Therapists

Introduction

The College of Occupational Therapists is pleased to provide a response to the consultation Developing High Quality Trauma and Stroke Services for London, which has been assisted by COT's Stroke Forum, part of COT's Specialist Section – Neurological Practice.

The College of Occupational Therapists is the professional body for occupational therapists and represents over 28,000 occupational therapists, support workers and students from across the United Kingdom. Occupational therapists work in the NHS, Local Authority social care services, housing, schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists are regulated by the Health Professions Council, and work with people 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 that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, caring for themselves and others, working, learning, playing and interacting with others. Being deprived of or having limited access to occupation, for example as a result of stroke, can affect physical and psychological health.

General

The College of Occupational Therapists (COT) welcomes Healthcare for London's plans to develop new high quality major trauma and stroke services for London. The COT views the efforts which are being made to reduce risk of mortality and impairment for patients through rapid response times and provision of specialised care immediately following major trauma or stroke as very positive. The COT also appreciates the attempt to tackle variations in service, and to ensure that people living in London will be within 45 minutes ambulance journey of a major trauma centre and within 30 minutes journey of specialised treatment for stroke. Although it is appreciated that the strategy is for both major trauma and stroke, most of this response is concerned with the impact the strategy will have on occupational therapy for clients with stroke.



In order to ensure that the new strategy brings about a comprehensive improvement in outcomes, it is important that all parts of the care pathway, from the acute phase to long term rehabilitation, are considered. In terms of service provision for stroke, occupational therapy has an important role to play in the acute phase within the first 48 hours, through intensive rehabilitation including early supported discharge, to long term rehabilitation and social care (Logan 2007). In the light of this, the COT would like to draw attention to a number of concerns.

1. Ensuring an adequate number of occupational therapy posts

The report mentions that '200 additional therapists will be needed in order to deliver the new stroke services' (p44), and it is appreciated that a detailed review of the stroke workforce is underway. It is unclear however, how this figure, for all therapists, has been derived, given that the results of the workforce review are not yet known. Additionally, it would be helpful if the figure of '200 additional therapists' to be broken down by profession.

The COT is concerned that whilst the options for the geographical location of stroke services (including hyper-acute units, stroke units and transient ischaemic attack services) appears to have undergone considerable testing prior to this consultation (including scrutiny by an expert panel plus engagement with clinicians, charities and members of the public), the workforce implications of the proposed changes have received less attention. This comes at a time when the problem of inadequate staff numbers for stroke services in England is being highlighted. A survey of 140 stroke units in England, conducted for the Health Workforce Bulletin (March 2009) has shown that:

- Patients are receiving low levels of nursing and therapy time, with wide variation in provision.
- 75% of patients receive less than one hour of therapy per day and 25% receiving less than half an hour in every 24 hours.
- The survey estimates that to provide an optimal service, 435 additional occupational therapists would be needed in England.

If the new strategy is to be successful in reducing the impact of stroke, then commissioning for adequate and appropriate staffing levels would appear to be a basic requirement. This needs to be given full and serious consideration. For information, minimum staffing levels per stroke patient are given in the 2007 document 'Occupational Therapy Following Stroke'. The recommendations state, for example, that in the intensive rehabilitation phase of the pathway, at least one Band7 occupational therapist is needed for every five patients (Logan 2007). Currently, members from COT's Stroke Forum are reporting that the staff patient ratio is 1:10 on some units.

Whilst the strategy appears to acknowledge to a certain extent that more rehabilitation staff will be needed for successful implementation, it also needs to be appreciated that the starting point is currently one of under provision of those staff. This problem will need to be addressed, as well as the additional staffing which the strategy will require.



COT's Stroke Forum has pointed out that there is frequently an assumption that the need for occupational therapy will predominantly occur during the rehabilitation stage of the pathway. Whilst there is certainly a need for occupational therapists at this stage, the occupational therapy requirements at the hyper-acute and acute stages should not be under-estimated. Occupational therapists need to be available at the hyper-acute stage, for example for cognitive and perceptual screening, positioning and to check for deficits which may have an impact on discharge.

The acute phase is the starting point for rehabilitation. Clients should have access to daily rehabilitation. Arrangements for early supported discharge should be being made with appropriate clients and there is usually a high demand for occupational therapy home assessments at this stage. Home visits are essential for many clients with stroke, because the stroke usually represents a sudden and major decline in functioning. However, they take a significant amount of occupational therapy time and also mean that occupational therapists are not available on site to be working with other clients whilst carrying out those visits. These factors need to be taken into consideration when determining staffing levels, to ensure that there is adequate occupational therapy cover.

2. Recruitment and Training

In addition to planning for adequate numbers of occupational therapy and rehabilitation posts, Healthcare for London needs to be aware that COT members are reporting severe difficulties recruiting to Band 7 posts in the London area. In one area of London, a vacancy rate of 25-50% has been reported by members of COT's Stroke Forum. Further reports suggest that in North East London, for example, there are Band 7 vacancies in five out of 12 inpatient and community units (North East London Cardiac and Stroke Network 2009). The situation becomes more complex when it is realised that some previously advertised positions have been filled by downgrading them to Band 6 positions, and that some vacancies are not being advertised. This has implications for quality of care, since clients with stroke require specialised and intensive rehabilitation, particularly at the early stages of recovery

The reasons for the difficulty in recruiting to higher grades are not clear but may be related to occupational therapists being unable to attend post qualification training and/or being unable to gain the supervision and experience necessary to progress to the higher grades. Whilst occupational therapists have basic skills in rehabilitation, building up expertise in stroke rehabilitation takes time and supervision from suitably experienced senior staff. The strategy appears to represent a good opportunity to address the need for on-going training and experiential learning, but it must be appreciated that this can only happen over time.

COT's Stroke Forum has been working to improve training opportunities through running the 'Starting Out in Stroke' road show. To date, 220 therapists have attended this training, and there have been numerous requests for further courses to take place. However, there is also a need for experience to be gained through 'on



the job' training, and this can only be provided if there are adequate posts and adequate staff in those posts to provide supervision, training and mentoring.

The COT welcomes fact that there will be 'an approved training and development programme for stroke professionals' (p44), but points out that there needs to be more information about what this training will entail. What aspects of occupational therapy will be included, and what provision will be made to ensure that staff are able to take time out from their clinical caseloads to pursue this training? If the training provided is not appropriate for occupational therapy, there must be provision to allow occupational therapists to pursue their own continuing professional development.

3. Attention to long term stroke rehabilitation and care

This aspect has been partly covered in point one, above, in that adequate attention needs to be given to the whole of the patient pathway rather than focusing mainly on the acute stage. Two related concerns are:

- a. The report mentions that, 'Improved acute care will mean that more people survive from stroke and require rehabilitation. However, the severity of disability and dependency is actually likely to reduce'(p44). This will have implications for occupational therapy, in that the focus of intervention is likely to change, but is not likely to be reduced. For example, rehabilitation for a client who has a high level of impairment following stroke is likely to focus on optimising independence in activities of daily living and possibly communication, social and leisure activities. For a client with a lower level of impairment, training for independence in activities of daily living may need to be addressed but other issues such as vocational rehabilitation, re-training for social roles and outdoor mobility/transport may also be a priority. Thus the role for occupational therapy may change, but is unlikely to be reduced.
- b. The proposed new strategy will have an impact on social services based occupational therapy provision. Workforce planning was highlighted in the COT's response to the Stroke Strategy (2007). To quote from this consultation: 'Occupational therapists work across sectors. For many years, the numbers of local authority social serviced employed occupational therapists has been excluded from health services workforce planning. Commissioning of undergraduate training places has been underestimated and as a result there has been an ongoing shortage of occupational therapists in the NHS. Workforce planning must take into account employment opportunities outside the NHS if it is to maintain staff numbers. This will be of increasing importance as more services are commissioned to non-NHS providers' (COT 2007). The College recommends consultation with the local authority departments in order to ensure that the new proposals are fully integrated.



4. Training in emergency care

Although occupational therapists receive basic life support training, this does not currently include specific training on what to do in the event of a suspected TIA or stroke. Given that the strategy aims to reduce response times for these events, it would seem prudent to provide this training for all occupational therapy staff, regardless of whether they work in a specialised stroke service or not.

Summary

Whilst the COT welcomes the efforts being made to reduce risk of mortality and impairment for patients suffering major trauma or stroke, it recommends that further attention be given to:

- The importance of **considering the occupational therapy role along the whole pathway for stroke care**. This includes the role in the hyper-acute units and the importance of occupational home assessments during the acute stage.
- **Staffing levels:**
 - Current inability to recruit to higher grades, such as Band 7, in some areas.
 - The starting point is one of under-staffing for some units, which has implications for quality of care and the ability of occupational therapists to improve their skills.
 - In long term rehabilitation, although overall severity of disability for patients may be reduced, the need for occupational therapy will still be present.

It would be helpful if explanation of how an additional workforce requirement of 200 therapists has been derived, as well as a breakdown of that figure, so that the numbers of therapists from each profession are known.

- **The role of occupational therapists in local authority social services departments** and the impact the strategy will have on those departments.
- **Training:**
 - Need for occupational therapists working with stroke patients to have access specialist training and other learning opportunities to ensure quality of care.
 - Need for all occupational therapists to have training on how to respond to suspected TIA or stroke.

For further information, please contact Amy Edwards, Professional Affairs Officer - Long Term Conditions, College of Occupational Therapists, e-mail amy.Edwards@cot.co.uk



References

College of Occupational Therapists (2007) *Towards a Stroke Strategy: Consultation Response Proforma*. College of Occupational Therapists. Available at www.baot.org.uk Accessed 08.04.2009

Health Workforce Bulletin (31.03.2009) *Survey shows inadequate staff numbers in stroke services* Online News. Available at <http://secure.littoralis.com/hwf/shopping-cgi/ppv.cgi?raw=w20090331.094330> Accessed 08.04.2009

Healthcare for London (2009) *The shape of things to come – major trauma and stroke services* Healthcare for London.

Logan, P (2007) *Occupational therapy following stroke* College of Occupational Therapists Specialist Section - Neurological Practice Consensus statement for Department of Health Stroke Strategy 2007. Available at http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Stroke/DH_081389 Accessed 15.04.2009

North East London Cardiac and Stroke Unit (2009) - informal communication 22.04.2009

Many thanks to the COT's Specialist Section - Neurological Practice Stroke Forum for their assistance in producing this consultation response.



Appendix 1

The role of the occupational therapist in the treatment of people who have had a stroke

The main occupational therapy interventions with people who have had a stroke are described as:

1. Assessment, to determine the degree of limitation in activities of daily living.
2. Goal setting, with patient and carer to develop a patient specific treatment programme.
3. Treatment, to help the patient achieve maximum functional ability:
 - a. - functional activities of daily living, e.g. washing, dressing, bathing, toilet,
 - b. - kitchen skills, eating and drinking
 - c. - sexual intercourse
 - d. - physical ability e.g. upper limb movement and function
 - e. - management of spasticity through splinting
 - f. - posture and positioning
 - g. - cognitive and perceptual ability
 - h. - wheelchair requirements
 - i. - vocational rehabilitation, work roles, voluntary jobs
 - j. - driving and outdoor mobility, walking and using electric scooters
 - k. - leisure activities, hobbies
 - l. - community reintegration.
4. Getting out of hospital:
 - a. Pre-discharge home visits
 - b. Early supported discharge/intermediate care
 - c. Provision of assistive devices, home adaptations
 - d. Liaison with community services e.g. home care, social services, meals at home, benefit advice, mobility centres, equipment centres.
5. Psychological support and counselling for the patient, family, carers and professionals.
6. Education for the patient, family, carers and professionals.
7. Long-term support, falls prevention advice, stroke clubs, day centres, and night-sitters.
8. Return to work.

Evidence for occupational therapy specific treatments listed above can be found in the document *Occupational Therapy Concise Guide for Stroke* (Logan 2007).