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Response from the Stroke Strategy Implementation Project and the Northern Ireland Multidisciplinary Association of Stroke Teams (NIMAST) to "A Healthier Future" - A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025" DHSSPS NI

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The Stroke Strategy Implementation Project is a three year partnership project between the Northern Ireland Chest Heart and Stroke Association and the Eastern Health and Social Services Board and funded by the Big Lottery Fund. The aim of the project is to facilitate the implementation of the Northern Ireland Stroke Strategy within the EHSSB area and ensure processes are in place to review and develop stroke services from prevention through to ongoing care in line with best practice up to date evidence and the needs of service users and carers. The project is governed by a multi disciplinary steering group with representation from all trusts within the Eastern Board and service users and carers.

NIMAST is a Northern Ireland charity for professionals working in stroke care with the aim of providing a unified voice for professionals working in stroke care in Northern Ireland. They also aim to raise the profile of stroke care among professionals, commissioners of services, and the lay public.

The Stroke Strategy implementation project and NIMAST welcome the opportunity to comment on "A Healthier Future A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025". We recognise that the vision for health services in Northern Ireland set out by DHSSPS in this document will form the background for service developments in stroke in the coming years and as such will impact on the work we do and the models of working we adopt.

We offer our thoughts on a number of strategic themes laid out in this document which will impact on stroke services and hope that they are considered by the consultation team both for this twenty year vision and for subsequent short term strategy documents and implementation plans.

1(i) A Healthier Society (pg8)

Stroke is the third biggest killer in NI and as such we would like to see a greater profile for stroke throughout this document in line with the profile afforded to cancer and heart disease.

1.7 Smoking Kills and Injures (pg10)

The Stroke Strategy Implementation Project offers unequivocal support for option (iii) smoke free public places and work places as introduced in the south of Ireland.
Smoking is indicated in 12% of all strokes and passive smoking is we know from a large body of research also harmful. Implementation of smoke free workplaces in the south of Ireland has proved very successful and is the only viable and workable option if we wish to truly make a difference to the health of non-smokers and also to facilitate smokers to quit.

1(ii)Who is responsible? (pg12)

Health is the responsibility of all and we would advocate the inclusion of the voluntary sector within this section as they have a vital role to play in promoting health and are key players in partnership working.

Key Population Health Outcomes (pg13)

We welcome the focus on the common risk factors for ill health and in particular in relation to stroke, the emphasis on smoking, obesity and alcohol abuse. The targets in these areas are challenging however we are conscious that a focus on obesity may not be sufficient to reduce ill health, the emphasis needs to be placed on good nutrition.
Many people of a healthy weight are at risk of stroke due to a diet high in salt and saturated fat. Key outcomes must relate to the nutritional basis of our diet and not just obesity.

Hypertension and smoking are two of the main risk factors for stroke and as such should feature strongly in subsequent targets and implementation plans associated with this document.

1(iii)What are we doing about it? (pg15)

We welcome the health outcome related to stroke to "*reduce the death rate per 100,000 people under 80 years of age for stroke by 50% from 38 deaths for males in 2002 and 36 deaths for females to 19 deaths and 18 deaths respectively.*"

However in keeping with the preventative model of healthcare which we now work towards it would have much more impact and ensure much more change in service provision if the health outcomes focussed on prevention of stroke in Northern Ireland. It is estimated that as many as 40% of strokes could be prevented and action must be taken to raise awareness of stroke its warning signs, risk factors and to appropriately medicate those people at significant risk of stroke.

We also need to see key milestones put in place in subsequent short term plans which are published to ensure that services for stroke are a priority for all and that changes are implemented which will have a direct impact on patient care.

Targets need to be set based on evidence and in keeping with national standards for stroke including key indicators such as time spent on a stroke unit, early intervention from a range of allied health professionals, access to scanning within the recommended time frames and specialist community rehabilitation teams input.

1(iv) Partnerships across Government (pg16)

Stroke is an illness which leaves one in three patients with a residual disability affecting how they live their lives and also affecting their families. Their employment, financial and social opportunities will be greatly diminished and in order for full rehabilitation into the community services will need to be in place that cater for their needs across the range of Government departments.

Partnership working is essential to supporting stroke patients' recovery and we support the Health Impact Assessment approach.

1(v) Can our system cope? (pg20)

1.60 Stroke patients occupy 20% of all acute hospital beds A lack of community provision leading to delayed hospital discharges is a problem frequently experienced by stroke patients. This results in a long unnecessary stay in hospital and in other patients being denied access to stroke unit care which has been shown to save lives and reduce disability.

Specialised stroke units require greater investment and development to deliver a standard of care equivalent to those in other areas of the UK. Access to stroke units is still restricted and according to the Sentinel Audit 2004 only 62% of stroke patients in Northern Ireland were treated in a stroke unit.

Investment into specialist community stroke teams has been proven to increase patients' satisfaction, produce better outcomes and significantly reduce length of stay in hospital. Where these teams are in place capacity is an issue and a significant number of patients who would benefit are not currently receiving this service. There are many areas of Northern Ireland where this service is not available at all. The current situation demonstrates an inefficient way of working and an inequitable service. We would like to see investment in specialist community stroke care to address these issues.

Looking Ahead: A Changing World

2(i) Technology (pg28)

2.17 Stroke is a disease area which is particularly hampered by the lack of effective communication and information sharing between sectors of the HPSS. A stroke patient experiences care across all sectors of HPSS and suffers due to the lack of

partnership working through delays, repetition in some areas and a lack of communication and continuity in their care.
Investment in this area will reap rewards across the system and is the basis of increasing patients and health professional satisfaction and will make partnership working easier to achieve.

A province wide interactive stroke register and clinical information system which crosses all organisational and professional boundaries is essential to the understanding of the scale of stroke illness and for developing effective services. We would like to see the pilot stroke register (SAPPHIRE) currently running at the Ulster Hospital and part funded by DHSSPS rolled out and implemented across the province. This would provide a huge base of information for development of services and make for more effective audit of current service.

2(ii) Demographics and Lifestyle (pg29)

2.21 Stroke currently consumes 5% of the health service budget. Demographic changes will impact hugely on stroke and costs are set to increase by 30% in real terms in the next twenty years. Additional resource must now be channelled into both prevention of stroke and acute and community stroke care to reduce disability and save lives and provide quality ongoing care in the community which will in the long term reduce the costs associated with stroke.

2(iii) The Future Service (pg34)

2.29 There is a strong evidence base to support the need for specialist stroke services within the acute sector. We would highlight that there is an equally strong evidence base for specialist community stroke care. We note the emphasis on generalist services within the community but would point out that in relation to stroke this type of service would not support best practice, indeed the RCP Stroke Guidelines 2004 state that generalist community input for stroke is detrimental to recovery.

Responsive Integrated Services (pg48)

5.7 We are supportive of a chronic disease management approach for stroke. Stroke is a lifelong illness and many of the issues which service users report are due to a feeling of abandonment once the intensive physical rehabilitation period has come to an end. Almost 40% of stroke patients will have some residual disability and ongoing care and support is essential to improving quality of life both for patients and their families and carers. A chronic disease management approach should seek to address these feelings of abandonment and provide ongoing support through a needs led service.

5.17 Multi-skilled teams and networks are essential to develop a patient centred model of healthcare. Co-operative working, shared protocols and an understanding of the entire patient pathway will all impact on the care which each patient receives and ensure that a seamless service is available for all patients. A high level of input will be required in the set up phase and support must be provided to manage these networks, support the change in culture which these new models of working will bring about and also guidance to develop effective reporting and governance mechanisms.

5.31 Local clinical research and development must form a part of any forward thinking strategy. Developments in stroke services have in the past been stunted by the lack of research into effective interventions. This has been addressed to some extent and there is now clear evidence for many aspects of stroke care; dedicated stroke units, specialised teams and community stroke rehabilitation teams. However there is still a need for research into many aspects of care and in particular epidemiological information about the nature of stroke in the Northern Ireland population.

5(xii) People with Physical and Sensory Disability (pg76)

Given that stroke is the single biggest cause of adult disability we strongly support the promotion of independent living and reintegration into society outlined in this strategy. Appointment of a task force to address this issue would be welcomed and should be representative of all key stakeholders including stroke.

Conclusion

The Stroke Strategy Implementation Project and NIMAST are supportive of the vision which is laid out in this document. Prevention of illness through risk factor management, a focus on chronic disease with patients and carers at the forefront, development of technology within the HSPSS and a networking and partnership approach are all necessary to deliver the high quality effective and timely service which we deserve.

We hope that the vision which is laid out in this document will be translated into more specific actions with associated targets in an efficient and timely way and we look forward to inputting to those short term plans as appropriate.

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