Neuropsychology for Community Stroke

Resource Pack

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Executive Summary

A stroke is sudden and shocking and can affect every part of a person's life. Stroke costs the NHS around 3 billion a year, with additional cost to the economy of £4 billion in lost productivity, disability and informal care. Up to 75% of stroke survivors struggle with their mental health and 90% experience at least one cognitive effect of stroke [1]. Getting support for the neuropsychological aspects of stroke has been found to be a top priority for stroke survivors[2]. If untreated, these difficulties can reduce the effectiveness of rehabilitation interventions resulting in a longer duration of rehabilitation, reduced independence, increased institutionalisation and long term care, even in the absence of post-stroke physical disability[3].

The National Stroke Service Model recognises the vital role clinical neuropsychology plays in supporting stroke patients recovery and has recommended that a clinical neuropsychologist is part of every community stroke team [4]. When commissioned as part of an integrated multidisciplinary team, neuropsychological services have been found to benefit patients and offer economic value for the NHS. The evidence recognises improved health related outcomes, community functioning and quality of life[5], financial savings by reducing the number of social care hours needed by increasing independence[6] and aiding patients in successfully returning to paid employment[7]. For example, the Liverpool Stroke Recovery Partnership project found that an initial 12-month investment of £308,000 in clinical neuropsychology support achieved healthcare cost savings of £913 000 over the same 12-month term, which as an overall return on investment of three to one[8].

Despite these recommendations and findings, access to a clinical neuropsychologist is far from guaranteed. Most multi-disciplinary stroke teams don't include a clinical neuropsychologist, meaning patients commonly don't receive the help they need to achieve their best possible recovery.

This resource pack aims to act as a practical guide to support the establishment and development of community-based neuropsychological care for people following stroke, and suggest ways they can implement evidence-based guidance and treatment. It provides a single resource to assist stroke providers and commissioners to design, implement or improve services in their locality.

[1] https://www.stroke.org.uk/lived-experience-of-stroke-report/chapter-1-hidden-effects-of-stroke

[2] Hill, G., Regan, S. and Francis, R. (2022). Research priorities to improve stroke outcomes. Lancet Neurology, Apr 21 (4), 312-313.

[3] Griffiths, M; Kontou, E and Ford, C (2023). Psychological support after stroke: unmet needs and workforce requirements of clinical neuropsychological provision for optimal rehabilitation outcomes. British Journal of Hospital Medicine, 84 (11).

[4] National Stroke Programme. National Stroke Service Model. Integrated Stroke Delivery Networks, May 2021

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[6] Turner-Stokes L, Paul S, Williams H. Efficiency of specialist rehabilitation in reducing dependency and costs of continuing care for adults with complex acquired brain injuries. J Neurol Neurosur PS. 2006;77:63–639

[7] Turner-Stokes L. Evidence for the effectiveness of multi-disciplinary rehabilitation following acquired brain injury: a synthesis of two systematic approaches. J Rehabil Med. 2008;40(9):691–701

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Introduction

This resource pack is intended for London community stroke and neurorehabilitation services and commissioning bodies to support them to commission and deliver services that meet the national clinical guidelines for stroke and ensure that a stroke survivor's neuropsychological needs are met.

The pack collates current evidence for best practice and provides information and resources that are intended to be supportive, giving suggestions for and working examples of good practice.

The pack includes:

- An outline of the different types of clinical psychology/neuropsychology and the scope of practice
- Outlines the difference between clinical psychology and other types of psychological interventions and services e.g. talking therapies
- Summaries of key national clinical guidance, standards, and related evidence
- Clinical psychologists role in vocational rehabilitation/supporting someone back to or into work following a stroke
- Examples of workforce planning

The information has been drawn from a number of key documents including:

- National Clinical Guideline for Stroke for the UK and Ireland. London: Intercollegiate Stroke Working Party; 2023 May 4. Available at: www.strokeguideline.org
- NICE Guideline: Stroke Rehabilitation in Adults (NICE, NG236, 2023)
- National Stroke Programme. National Stroke Service Model. Integrated Stroke Delivery Networks, May 2021
- National Stroke Programme. National service model for an integrated community stroke service February 2022 (PAR733)
- British Psychological Society Briefing Paper: Recommendations for Integrated Community Stroke Services: Service design, workforce planning & clinical governance requirements for a high-quality service and rehabilitation outcomes. Division of Neuropsychology Policy Unit, August 2022
- British Psychological Society. Guidelines for Commissioning NHS Neuropsychological Services, Division of Neuropsychology Policy Unit, November 2024
- British Society of Rehabilitation Medicine (2021). BSRM Standards for Specialist Rehabilitation for Community Dwelling Adults – update of 2002 standards
- Psychological care after stroke. Improving stroke services for people with cognitive and mood disorders, NHS Improvement, 2018

Queries regarding this document can be directed to england.cardiac-strokecnldn@nhs.net.

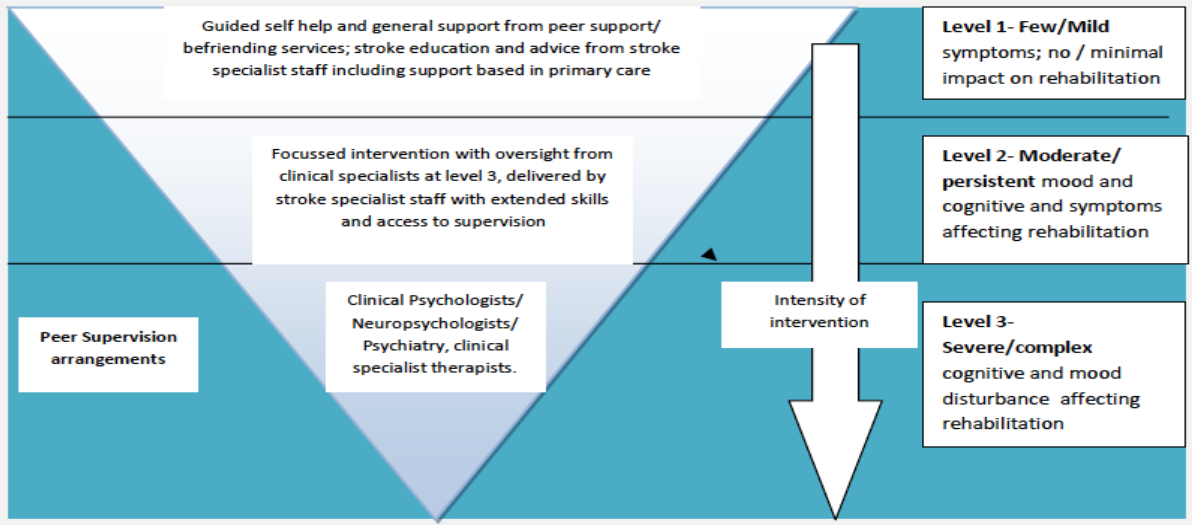
Role of a clinical psychologist/neuropsychologist

Within a stroke or neurorehabilitation team, psychological support may be provided by a clinical psychologist who has gained specialist expertise in stroke or working with neurological conditions (a specialist clinical psychologist in stroke/neurological conditions) or a clinical neuropsychologist. In the UK **clinical psychologists** work with a wide range of psychological difficulties in mental and physical health. They can then undertake further specialist training to become **clinical neuropsychologists**. This training makes them well prepared to work with individuals who have other neurological conditions in addition to stroke (e.g. stroke in addition to seizures, functional neurological disorder or Multiple Sclerosis) and provide specialist assessments and guidance if or when stroke survivors develop frailty, delirium, or dementia.

The day-to-day role of a neuropsychologist can include:

- Ensuring the delivery of psychologically informed care by all members of the rehabilitation team as part of a matched care model (recommended by the National Clinical Guideline for Stroke for the UK and Ireland). This requires all clinical staff to be aware of psychological and neuropsychological problems after stroke and have skills to manage these effectively.
- Developing and supporting effective screening for mood, cognitive and behaviour difficulties post stroke.
- Cognitive rehabilitation for problems affecting memory, perception, concentration and other aspects of intellectual functioning.
- Work assessments alongside relevant colleagues (e.g. occupational health, occupational therapy, physiotherapy) and supporting vocational rehabilitation.
- Psychological therapies to help emotional adjustment to neurological disorders.
- Risk assessment and liaison with mental health services to help manage co-morbidity (e.g. complex mental health disorder/drug and alcohol misuse/suicidality and self-harm).
- Behavioural interventions to help manage challenging behaviour.
- Educational and support groups for stroke survivors, family members or carers, focusing on understanding brain injury, providing cognitive strategies and supporting psychological adjustment.

Figure 1: Tiers of services within the interdisciplinary model of psychological service for stroke (NHS East of England, 2011).



National Service Models for Neuropsychological Rehabilitation in Stroke

National Stroke Service Model

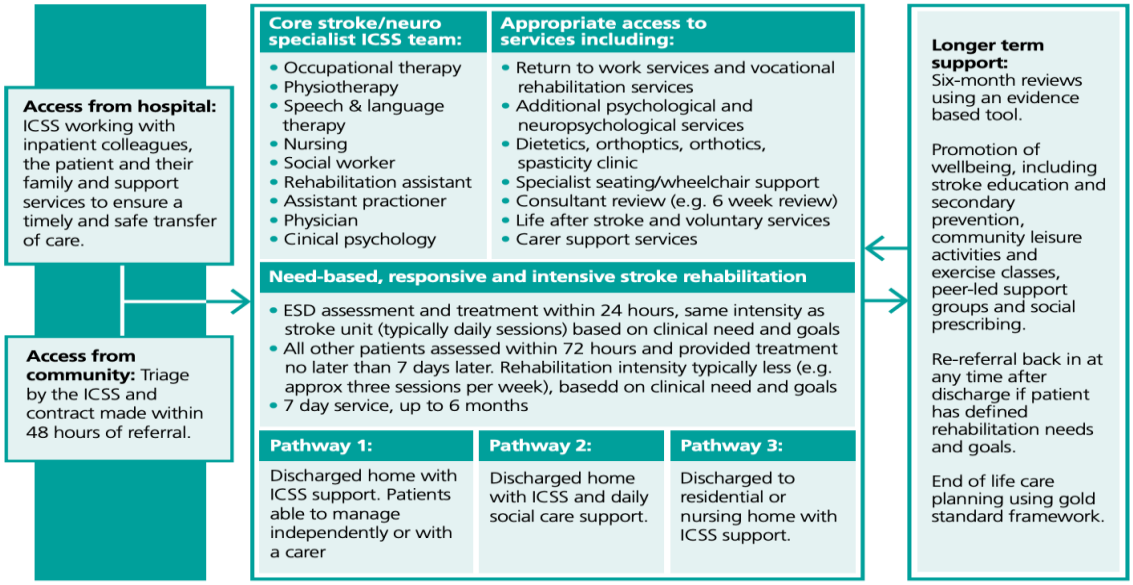
In May 2021, the National Stroke Service Model was proposed with integrated stroke delivery networks as a key vehicle for transforming stroke care across the country. Part of this delivery emphasised the need for an Integrated Community Stroke Service to help co-ordinate the transfer of care of stroke survivors from hospital and provide early, effective and community based specialist stroke rehabilitation and disability management to all stroke survivors leaving hospital who need it. They made the following key recommendations for meeting patients neuropsychological needs post stroke:

Key Recommendations:

1. **Psychological and neuropsychological rehabilitation** must be routinely available as part of the core service provision throughout the patient journey.
2. **The entire multi-disciplinary team must address the psychological, emotional, cognitive and neuropsychological effects** commonly experienced by stroke survivors. These can greatly impact a person's engagement with rehabilitation, their level of functioning, ability to return to work and ultimately quality of life.
3. **The patients psychological needs should be addressed** by clinicians and providers collaborating throughout care planning.

National Service Model for an Integrated Community Stroke Service (ICSS)

In February 2022, the National Service Model for an Integrated Community Stroke Service was published. This aimed to ensure that all discharged stroke survivors are seen in a timely way by an integrated multidisciplinary team including **clinical psychology.** They also recommend having timely access to appropriate extra support from other psychological/neuropsychological or psychiatric services (e.g. Talking Therapies, community mental health services, memory clinics/neuropsychology diagnostic assessment services, psychiatry and neuropsychiatry).



British Psychological Society: Recommendations for ICSS

In April 2023, the British Psychological Society presented a briefing paper that was developed with the NHS England National Stroke Programme, looking at how to support services to implement the ICSS recommendations for psychological care for stroke survivors. They made the following recommendations.

1. All people who have had a stroke should have their neuropsychological needs (i.e. changes in cognition, behaviour, and emotional state/ mental health) assessed routinely as part of their stroke care
2. Appropriate interventions should be available in a timely manner; accessible via a routine stroke care pathway; including access to stroke specialist practitioner psychology/ clinical neuropsychology professionals, to provide care support and formal treatments where needed
3. Stroke psychological care should follow a 'matched care' model and pathway i.e. where an individual's needs define the clinical care and contact accessed in a timely manner; not in response to clinical contact defined by rigid or inflexible stepped care criteria or systems.
4. The stroke neuropsychological care pathway should also accommodate patients having access to neuropsychological needs-assessment and stroke psychological care in the longer term where needed, recognising the progressive and chronic nature of many stroke survivor's support needs that may require clinical review over a term which may frequently lie outside of the usual community rehabilitation timeframe
5. Staffing levels for the stroke clinical neuropsychology team must be sufficient to support a broad range of clinical activity including direct and indirect activities supportive of client rehabilitation; providing clinical assessment and treatment, as well as clinical advice/consultation, training, and clinical supervision to MDT colleagues, and to wider health professionals involved in stroke care. Also providing routine contributions to MDT meetings and MDT care planning
6. The clinical neuropsychology team must be of a suitable grade mix and under a relevant, consultant practitioner psychologist-led clinical governance framework, to adequately support safe and high-quality care
7. The clinical neuropsychology team should also support wider psychological and emotional support services (such as those provided by IAPT and that might also be provided by third sector providers along stroke emotional support lines), and support wider mental health interventions, under collaborative working, where required for best patient outcomes
8. Under a local ISDN (Integrated Stroke Delivery Network) framework, a 'whole system' stroke psychological workforce plan should be defined – expanding upon the community stroke workforce in place – to support system delivery on stroke rehabilitation requirements outlined (and to support system resilience).

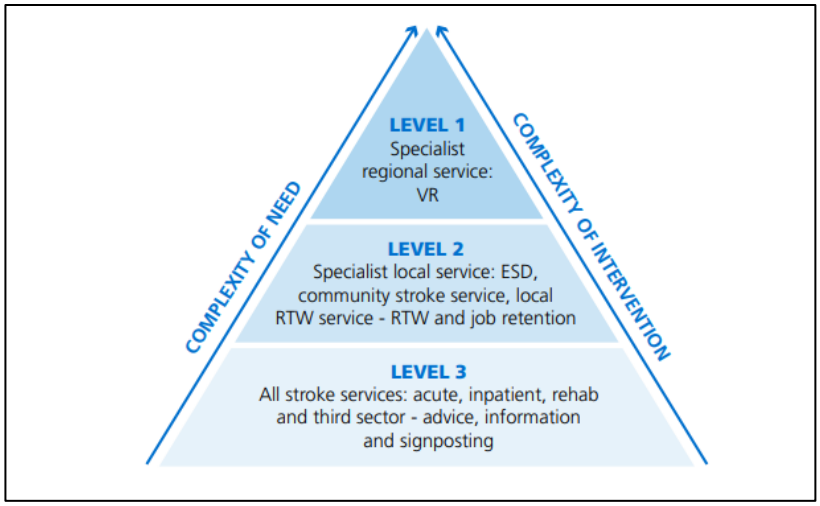
Vocational Rehabilitation

Vocational rehabilitation has been described as '*whatever helps someone with a health problem to stay at, return to and remain in work: it is an idea and an approach as much as an intervention or a service*'[9].

One in four strokes occur in people of working age[10]. Although return to work is often a key goal for the person with a stroke and important for maintaining quality of life and wellbeing, less than half of those in employment return to work after a stroke[11]. For those who do, their return is often complicated by residual 'invisible' symptoms that often reflect subtle cognitive or behavioural changes related to their stroke. These difficulties, if not identified, can often result in stroke survivors failing to sustain work even if they do manage their initial return. Clinical neuropsychologists play a key role in identifying these subtle changes and putting in place effective strategies to enable the person to have a successful return to work.

The NICE quality standard for stroke states that all adults who have had a stroke should be offered active management to return to work if they wish to do so[12]. Community rehabilitation services are required to provide Level 2 interventions that include a focus on return to work and job retention. The British Society for Rehabilitation Medicine notes that as stroke may result in a range of neurological impairments, a multidisciplinary team is required for vocational rehabilitation as with standard neuro-rehabilitation[13]. The recommended staffing for a population of 250,000 is 1.0 WTE Occupational Therapist, 1.0 WTE Clinical Psychologist and 2.0 WTE Rehabilitation Assistants (in addition to access to speech and language therapy, physiotherapy and physicians as required).

Figure 3: Model for stroke vocational rehabilitation.



[9] Waddell G., Burton A.K., Kendall N. Vocational Rehabilitation: What works, for Whom, and When? The Stationary Office; London, UK: 2008

[10] Stroke Association. State of the nation 2018. https://www.stroke.org.uk/sites/default/files/state_of_the_nation_2018.pdf

[11] Daniel K, Wolfe C, Busch M, McKevitt C. What are the social consequences of stroke for working-aged adults? A systematic review. Stroke 2009;40:431-40. https://doi.org/10.1161/STROKEAHA.108.534487

[12] National Institute for Health and Care Excellence. Stroke in adults. Quality standard. 2016 https://www.nice.org.uk/guidance/qs2/resources/stroke-in-adults-pdf-58292707525

[13] British Society of Rehabilitation Medicine. Vocational Rehabilitation Brief Guidance

NHS Talking Therapies services

What is the NHS Talking Therapies service?

- NHS Talking Therapies is a service that provides evidence based psychological therapy to people suffering with mild to moderate anxiety and/or depression.
- The staff that make up Talking Therapies services are usually specialists in delivering specific therapies such as guided self-help, cognitive behaviour therapy, eye movement desensitisation and reprocessing (EMDR), counselling and interpersonal therapy.
- NHS Talking Therapies are sometimes able to work with patients with long term health conditions and that can include those with a stroke or a neurological condition.

Making a referral to an NHS Talking Therapies service

It is often **appropriate** to consider a referral to Talking Therapies for people following a stroke or diagnosis of a neurological condition if:

- they are suffering with mild to moderate anxiety and/or depression
- any physical, cognitive or communication difficulties that they have do not impact on the ability to access a talking therapy approach

It is likely to be **less appropriate** to refer the patient to Talking Therapies service if the following is required:

- **Neuropsychological rehabilitation or MDT support:** Talking Therapy services do not offer neuropsychological rehabilitation or psychologically integrated care following stroke as part of a multi-disciplinary team.
- **Family/Carer support:** Although they can offer psychological therapy for carers, this would usually be on the basis that they require talking therapies for their own anxiety and/or depression, and they would not be able to work closely with family/carers to support the stroke survivor.
- **Adjustment disorder/Other psychiatric disorder:** Many Talking Therapy services are not trained or commissioned to provide treatment for diagnoses other than anxiety and/or depression. Individuals requiring support for other presentations (e.g. adjustment disorder following a stroke or neurological diagnosis) would usually not be offered treatment within these services.
- **Cognitive/Communication difficulties:** Talking Therapy services are not trained in working with people who have had a brain injury or suffer significant cognitive of communication difficulties. This could lead to difficulties in identifying the most appropriate psychological intervention to meet the person's needs. For example, a patient experiencing emotional lability with increased tearfulness following a stroke could be considered to be presenting with depression and receive treatment for the same, rather than strategies to help manage emotional lability post-stroke.
- **Home visits**: Although there is some variability across the UK, Talking Therapy services can struggle to offer domiciliary visits to patients. This can limit access to those who are not able to travel to be seen or access remote therapy.

Workforce Planning

This section describes some of the practicalities in implementing the national and professional guidance for clinical psychology/neuropsychology within a community neurorehabilitation setting.

- National and professional guidance indicates recruitment to a minimum of 0.4 WTE **qualified** clinical psychology/neuropsychology staff per 100 stroke referrals.
- The BPS guidance recommends a combination of Band 8 (a–b) and Band 7 practitioner **qualified** psychologists with suitable skills in addition to 0.2 WTE **unqualified** staff per 100 stroke referrals. They recommend oversight from a Consultant Practitioner Psychologist to ensure an appropriate clinical governance structure is in place[14].
- An additional 0.2 WTE of **qualified** staff per 100 referrals is likely to be required if the service accepts referrals for other neurological conditions in addition to stroke.

Figure 4. BPS Recommended Guidance for Community Stroke Workforce

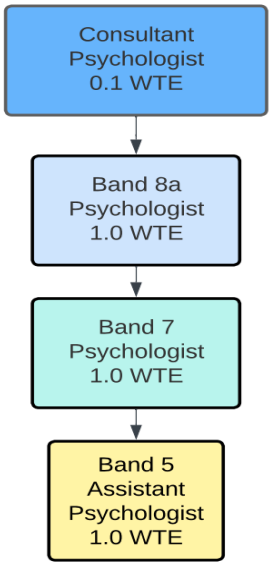
Table 1. Stroke neuropsychology team in community stroke rehabilitation staffing grade and threshold requirements

Staff requirements	Role	Grades	Staff number (whole time equivalent) per 100 referrals to the stroke multidisciplinary team
Qualified staffing requirements	Practitioner psychologists (with applicable and established neuropsychology skills, relevant to grade)	Bands 7–8b (grade mix defined according to stroke team size and local context)	0.4/100 referrals to multidisciplinary team
Additional psychology staff	Assistant psychologists/associate psychological practitioners/clinical associate psychologists	Grades 4–6	0.2/100 referrals to multidisciplinary team
Clinical governance assurances	Appropriate consultant-level psychologist (neuropsychology specialist) leadership	Bands 8c–d	Whole time equivalent inputs to be locally defined, under system requirements (Figure 1)

Staffing total: 0.6/100 referrals to multidisciplinary team. From British Psychological Society (2023)

[14] British Psychological Society. Recommendations for Integrated Community Stroke Services: Service design, workforce planning & clinical governance requirements for a high-quality service and rehabilitation outcomes. April 2023.

Example of psychology staffing for a community neurorehabilitation service with 500 stroke referrals

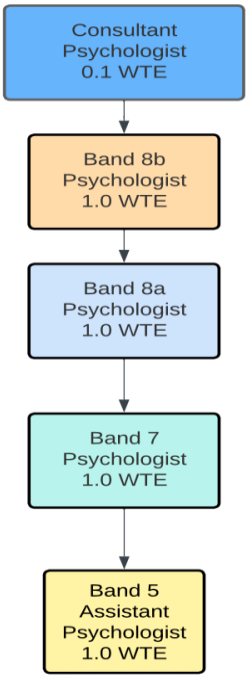


For a multidisciplinary community stroke team that may be expected to receive 500 stroke referrals a year, this would indicate the need for 2.0 stroke specialist practitioner psychologists and 1 assistant psychologist (or APP/ CAP) to be embedded within the community stroke team.

This includes appropriate consultant clinical psychology/clinical neuropsychology leadership and governance at band 8c.

Banding	Staffing costs (inc. oncosts)
Band 8c	£10,664
Band 8a	£77,713
Band 7	£67,817
Band 5	£45,913
TOTAL	**£202,107**

Example of psychology staffing for a community neurorehabilitation service with 500 stroke + 500 neurology referrals



For a multidisciplinary community stroke team that may be expected to receive 500 stroke referrals a year, and an additional 500 referrals for other neurological conditions, this would indicate the need for 3.0 stroke specialist practitioner psychologists and 1 assistant psychologist (or APP/ CAP) to be embedded within the community stroke team.

This includes appropriate consultant clinical psychology/clinical neuropsychology leadership and governance at band 8c.

Banding	Staffing costs (inc. oncosts)
Band 8c	£10,664
Band 8b	£90,531
Band 8a	£77,713
Band 7	£67,817
Band 5	£45,913
TOTAL	**£292,638**

Costings based on Agenda for Change 2024/25, not including HCAS.

Practical tips for optimising service delivery

If a service is unable to employ staff to the recommended standards due to budgetary constraints or labour market conditions, they should take intermediary steps to optimise the current service delivery, while developing a long term strategy towards the gold standard with the support of the ICB.

Top tips applied in London services

1. ***Pathway model:*** Services are structured to enable continuity of neuropsychology services for patients across the care pathway, from an acute unit to community rehabilitation team. Linking in with local hospitals that have existing psychology provision to hyper-acute/acute stroke units and or brain injury units may enable split-posts to be created across settings. These can be supported by service level agreements between Trusts and increase access to appropriate consultant psychology governance and leadership. Utilising the pathway model opens up opportunities for more full time posts, which can be easier to recruit into and provide a wider network of collaboration, reducing isolation in the roles.
2. ***Multiborough model:*** A larger catchment area can deliver economies of scale. This can be in combination of services provided by inpatient, community neurorehabilitation and community stroke teams. Also, an ICB-wide community multidisciplinary panel, incorporating a neuropsychologist, can deliver efficiencies by providing one-stop access to a team of stroke specialists and improve access to neuropsychology.
3. ***Use of rotational staff:*** Collaboration with wider services that have access to psychologists can open up development of rotational posts. This can support recruitment, optimise learning opportunities and increase access to cover for vacancies and/or maternity leave.
4. ***Trainee and honorary placements***. Offering trainee placements and/or honorary placements for assistant psychologists studying at university can increases the service provision with unqualified staff.
5. ***Peer support, access to CPD, sharing resources.*** Potential candidates should be able to see opportunities for their career progression and should be provided an appropriate level of clinical and professional supervision. Advanced qualification could be sought through completion of the Qualification in Clinical Neuropsychology (QiCN). Health Education England (HEE) can provide funding for eligible applicants to complete this training.

For detailed information about these, please contact england.cardiac-strokecnldn@nhs.net.

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Appendix 1

Guidance for recruitment to psychology

QUALIFIED STAFF:

Band 7

- Band 7 is the entry level for newly qualified practitioner psychologist. This is in contrast to other allied health care professionals where band 5 is the entry level for newly qualified staff (e.g. occupational therapy, physiotherapy and speech and language therapy).
- This difference is partly because, in the UK, a clinical psychologist must complete a minimum of 6 years of university training (including a clinical doctorate) in addition to obtaining relevant clinical experience prior to qualifying.
- As it is an entry level role, the supervision and development requirements for a band 7 are likely to be higher than a band 8a role.
- Progression from band 7 to 8a is usually expected to occur a few years after qualification.
- The role will often include supervision of trainee psychologists and/or assistant psychologists.

Band 7/8a Clinical Psychology Preceptorship[15]

- Clinical psychology preceptorships are band 8a posts that can be offered as a preceptorship which involves recruiting initially at a band 7 level (usually for a minimum of 18 months) before progressing to the band 8a level.
- The standard NHS personal development plans can be used to help structure their learning so that they move towards meeting the target of progressing to band 8a after 18 months.

Band 8a

- Band 8a psychologists would usually be expected to have a minimum of 18 months post qualification experience.
- The role would usually involve increased aspects of service development and supervision of qualified band 7 staff, trainee psychologists and/or assistant psychologists.

Band 8b

- These posts are more senior and they would usually have a number of years of experience working at a band 8a level.
- This banding usually places a greater emphasis on service leadership and development, risk assessment and management, supervision of qualified staff and having a supportive role to the band 8c psychology role.

Band 8c

- Band 8c consultant clinical neuropsychologists/psychologists will be required to provide senior support for psychologists working in a service and have responsibility for the overall clinical governance.
- Within a neuro-rehabilitation service, a band 8c role may not be embedded within the service and may contribute a session per week as part of their wider role.

[15] https://www.hcpc-uk.org/globalassets/resources/information/preceptorship/hcpc-principles-for-preceptorship.pdf

UNQUALIFIED STAFF:

As noted in the BPS guidance, additional support from unqualified staff (bands 4-6) can help to increase the delivery of the service. However, it is important to remember that these staff will require supervision from a qualified psychologist in order to practice safely and effectively in the service. Any gaps in recruitment to the qualified psychologist will have an impact on the service provision of unqualified staff.

Band 4 or 5 – Assistant Psychologist[16]

- Assistant Psychologists have an accredited undergraduate degree in psychology recognised by the British Psychological Society.
- They may be employed on Band 4 or Band 5. Within a neuro-rehabilitation setting, it is likely to be more appropriate to recruit at a Band 5 level, and to look for individuals with previous experience working with patients with neurological conditions and/or have a therapeutic qualification.
- Full time assistant psychologists should have access to at least two hours per week of supervision from a qualified practitioner psychologist[17]

Band 6 – Trainee Clinical Psychologist[18]

- Trainee Clinical Psychologists are paid via their training programme using centralised NHS funds. Placements are usually between 6 to 12 months long.
- Placements are offered through links with universities if there is an appropriate clinical psychology supervisor and the work covers their placement needs.
- In neuro-rehabilitation settings it may be helpful to consider taking second or third year trainees as they will have undergone basic foundational skills and training in their first year.

Band 6 – Clinical Associate Psychologist[19]

- Clinical associate psychologists are new roles which have been developed in the NHS to provide greater access to psychologically informed mental health services. clinical associate psychologist fill an identified skills gap between assistant psychologist and qualified clinical psychologists.
- They are able to practice autonomously with appropriate support, working within their scope of practice, under the supervision of a registered clinical psychologist.

[16] https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles/assistant-clinical-psychologist

[17] BPS Practice Guidelines_Third Edition, 2007

[18] https://acpuk.org.uk/what_is_a_trainee_clinical_psychologist/

[19] https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles-psychological-therapies/clinical-associate-psychology

Clinical Supervision and Line Management

- For general guidance on the clinical supervision requirements for psychologists please see BPS Division of Clinical Psychology Policy on Supervision[20].
- Psychologists can be provided with operational or line management supervision by non-psychologists within their service. This would likely focus on appraisal and monitoring of performance and is specifically concerned with operational issues and quality of service.
- Psychologists will also require clinical and professional supervision and the BPS recommend oversight from a consultant practitioner psychologist to ensure an appropriate clinical governance structure is in place.
- If the psychologist is being recruited to an isolated post, it would be necessary for them to have access to a more senior psychologist. This may be available via local arrangements made internally within the same NHS trust or externally sourced from senior psychologists working in local NHS Trusts in a similar geographical area.

Continued Professional Development

- Study leave is likely to vary depending on the service but the BPS recommends that a full-time worker should have a minimum of 10 days per year study leave, pro rata for part time workers[21].
- Many psychologists who would like to specialise in neuropsychology go on to complete the BPS Qualification in Clinical Neuropsychology (QICN) and join the BPS Specialist Register of Clinical Neuropsychologists (SRCN). Offering to support the training or at least part of the QICN training with study leave and/or financial support can help with recruitment and retention of psychology staff. Health Education England (HEE) can provide funding for eligible applicants to complete this training. For further information on fees/study leave requirements please see https://www.bps.org.uk/qualification-clinical neuropsychology.

[20] BPS Division of Clinical Psychology Policy on Supervision. May 2014

[21] Division of Clinical Psychology (2011c). Guidelines on CPD for Clinical Psychologists. Leicester: British Psychological Society.

Appendix 2

National Clinical Guideline for Stroke (2023)

The National Clinical Guideline for Stroke (2023) makes a number of recommendations with regard to supporting stroke survivors with the **psychological effects of stroke:**

A Healthcare professionals should select screening tools and assessments for psychological problems appropriate to the needs of the person with stroke, with a clear rationale regarding which tools are to be used in which circumstances. These tools and assessments should:

- be validated for use in people with stroke;
- include freely available training in their use for staff;
- cover the full range of potential impairments including attention, visual perception, memory, and executive functioning;
- be applied consistently along local stroke pathways;
- be completed with a speech and language therapist if the person with stroke has language difficulties;
- be conducted in the patient's first language, using an interpreter if required;
- be conducted in a quiet environment where distractions are minimised, at a time of day appropriate for the individual (particularly those with fatigue). [2023]

B All members of the stroke multidisciplinary team should be trained and engaged in supporting those with psychological problems following stroke. The team should have the stroke-specific knowledge and skills to support people with cognitive impairment after stroke in daily activities and reduce the impact on participation, including making any necessary adjustments to the rehabilitation approach. [2023]

C Stroke-skilled clinical psychology/neuropsychology should be available to multidisciplinary team members involved in the assessment and formulation of psychological problems people may have after stroke to provide training, clinical supervision, advice and support. [2023]

D Stroke-skilled clinical psychology/neuropsychology should be available for people with stroke who have complex or atypical psychological presentations, or specific issues affecting risk or safety. [2023]

E Following any screening or cognitive assessment, people with cognitive impairment after stroke and their family/carers should receive appropriate supporting information and education regarding the findings, implications, and recommended approach to their cognitive problems. [2023]

F People with cognitive impairment after stroke should be considered for moderate-intensity cardiorespiratory training programmes to improve cognitive function according to the person's needs, goals and preferences, as part of an overall treatment approach that also includes neuropsychological assessment and intervention. Cognitive impairment should not be considered a barrier to engaging with repetitive task training. [2023]

The National Clinical Guideline for Stroke (2023) makes the following recommendations with regard to supporting stroke survivors with the **cognitive effects of stroke:**

A People with cognitive problems after stroke should receive an in-depth cognitive assessment, including functional performance, using standardised and validated tools to determine the nature of their cognitive difficulties and to detect uncommon or subtle changes for which screening tests may lack sensitivity. [2023]

B Community stroke teams (including clinical psychology/neuropsychology) should be available to accept referrals for further cognitive assessment, identification of rehabilitation goals and assessment and management of risk, including when it is inappropriate for this to be conducted in the acute hospital setting. This should include contributing to mental capacity or safeguarding decisions and the assessment and management of people returning to cognitively demanding roles such as work or driving. [2023]

C Standardised cognitive assessments should be carried out by specialised assessors (e.g. occupational therapists with relevant knowledge and skills, or stroke clinical psychologists/neuropsychologists) with appropriate training and awareness of the properties and limitations of the various tests. [2023]

D People with stroke returning to cognitively demanding roles such as managing instrumental activities of daily living (e.g. finances, driving or work) should have detailed cognitive assessments performed by an appropriately skilled assessor. [2023]

E People with stroke who are unable to tolerate or adequately engage in standardised cognitive assessment should be assessed using appropriate functional tasks within a structured approach. [2023]

Appendix 3

NICE Guideline: Stroke rehabilitation in adults (NG236)

1.5 Cognitive functioning

1.5.1 Screen people after stroke for cognitive impairment. Where cognitive impairment is identified, carry out a detailed assessment using valid, reliable and responsive tools before designing a treatment programme. [2013]

1.5.2 Provide education and support for people after stroke, and their families and carers, to help them understand the extent and impact of cognitive impairment, recognising that these may vary over time and in different settings. [2013]

Memory function

1.5.5 Assess memory and other relevant domains of cognitive functioning (such as executive functions) in people after stroke, particularly where impairments in memory affect everyday activity. [2013]

1.5.6 Use interventions for memory and cognitive functions that focus on the relevant functional tasks, taking into account the underlying impairment. Interventions could include:

- increasing the person's own awareness of the memory impairment
- enhancing learning using errorless learning and elaborative techniques (making associations, use of mnemonics and internal strategies related to encoding. information such as 'preview, question, read, state, test')
- external aids (for example, diaries, lists, calendars and alarms)
- environmental strategies (using routines and environmental prompts). [2013]

Attention function

1.5.7 Assess attention and cognitive functions in people after stroke using standardised assessments. Use behavioural observation to evaluate the impact of any impairment on functional tasks. [2013]

1.5.8 Consider attention training for people with attention deficits after stroke. [2013]

1.5.9 Use interventions for attention and cognitive functions after stroke that focus on the relevant functional tasks. For example, by minimising distractions and providing prompts related to the task. [2013]

1.6 Psychological functioning

1.6.1 Assess the person after stroke for changes to:

- their emotional functioning, such as the onset of emotionalism
- their behaviour
- their mental health including the development of any signs that could indicate an increased risk of suicide (suicidality) such as suicidal thoughts, plans and actions, and suicide attempts
- the way they are adjusting and coping after stroke. [2013, amended 2023]

1.6.2 When choosing any intervention for problems with emotional functioning, take into account the type or complexity of the person's neuropsychological presentation and relevant personal history. [2013]

1.6.3 Support and educate people and their families and carers to help them make an emotional adjustment after stroke, recognising that their psychological needs may change over time and in different settings. [2013]

1.6.4 When new or persisting changes to mood or emotional difficulties are identified at the person's 6-month or annual stroke review, refer them to appropriate services for detailed assessment and treatment. [2013]

1.6.5 Manage depression or anxiety in people after stroke who have no cognitive impairment in line with NICE's guidelines on depression in adults with a chronic physical health problem and generalised anxiety disorder and panic disorder in adults. [2013]

1.6 Returning to Work

1.16.4 Identify any return-to-work issues for the person as soon as possible after stroke. Review these regularly and manage them actively, for example by:

- identifying the physical, cognitive, communication and psychological demands of the job (such as multi-tasking by answering emails and telephone calls in a busy office)
- identifying any problems that affect work performance (for example, physical limitations, anxiety, fatigue preventing attendance for a full day at work, cognitive impairments preventing multi-tasking, and communication problems)
- tailoring interventions (for example, teaching strategies to support multitasking or memory difficulties, teaching the use of voice-activated software for people with difficulty typing, and delivery of work simulations)
- providing information about the Equality Act 2010 and support available (for example, an access-to-work scheme)
- workplace visits and liaison with employers to make reasonable adjustments such as provision of equipment and phased return to work. [2013]

1.16.5 Consider a referral to a return-to-work programme for people who were working before they had a stroke. [2023]

1.16.6 Manage people's return to work or long-term absence after stroke in line with NICE's guideline on workplace health. [2013]

Appendix 4

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This document was collated by the Workforce Task and Finish Group within the London Stroke Clinical Network and ISDN. Advice and guidance was also provided by the BPS Division of Neuropsychology Co-Leads for Stroke.

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