Royal College of Physicians

Commissioning concise guide for stroke services 2012

This concise guide contains specific recommendations on commissioning stroke services which are included in the *National clinical guideline for stroke*, fourth edition, 2012. These recommendations will be beneficial for commissioning organisations which often do not include people with expertise in specific areas of clinical practice, such as stroke care, and therefore it is important that there is close collaboration between commissioners and providers.

The recommendations are given below with their number (eg 2.1.1) and letter (eg A, B), so that they can be found in the main guideline.

2.1.1 Structure – global cover

A Commissioning organisations should ensure that their commissioning portfolio encompasses the whole stroke pathway from prevention through acute care, early rehabilitation and initiation of secondary prevention on to palliation to later rehabilitation in the community and long-term support.

B The stroke services commissioned should be based upon an estimate of the needs of the population covered, derived from the best available evidence locally and nationally.

C Commissioners need to be satisfied that all those caring for stroke patients have the required knowledge and skills to provide safe care for those with restricted mobility, sensory loss, impaired communication and neuropsychological impairments.

D Commissioners should also commission to ensure that:

- people dying with stroke receive palliative care from the acute stroke service or where possible in their own homes
- people with stroke who are in care homes or are unable to leave their own home have full access to specialist stroke services after discharge from hospital
- adequate support services are available to patients with long-term disability covering the full spectrum of needs (eg nursing, therapy, emotional support, practical support, carer support)
- patients can re-access specialist services long after stroke.

E A public education and professional training strategy should be devised and commissioned to ensure that the public and emergency contact healthcare professionals (eg in emergency call centres) can recognise when someone has a potential stroke and know how to respond. This should be commissioned in such a way that it can be formally evaluated.

F Commissioners should ensure that there is sufficient information provided to patients and their carers covering what services are available and how to access them at all stages of the pathway. All information – both stroke related and other – should be written in an accessible form that benefits both those with communication disability and others.

G Commissioners should require participation in national audit, for the services they pay for, auditing practice against the specific recommendations made in the *National clinical guideline for stroke*, fourth edition, 2012.

H Health commissioners should ensure that there are:

- formal protocols between health organisations and social services that facilitate seamless and safe transfers of care at the appropriate time
- protocols in place that facilitate rapid assessment for and provision of all equipment, aids (including communication aids), and structural adaptations needed by patients with a disability, especially but not restricted to patients in hospital awaiting discharge and those in care homes.

2.2.1 Commissioning acute stroke services

A Ambulance services, including call handlers, should be commissioned to respond to every patient presenting with a possible acute stroke as a medical emergency.

B Acute services should be commissioned to provide:

- imaging of all patients in the next slot or within 1 hour if required to plan urgent treatment (eg thrombolysis) and always within 12 hours
- thrombolysis in accordance with the recommendations in the *National clinical guideline for stroke*, fourth edition, 2012
- active management of physiological status and homeostasis
- completion of all investigations and treatments to reduce risk of stroke for transient ischaemic attacks and minor strokes within 1 week or within 24 hours for high-risk cases
- an acute vascular surgical service to investigate and manage people with neurovascular episodes in ways and in timescales recommended in the *National clinical guideline for stroke*, fourth edition, 2012
- a neuroscience service to admit, investigate and manage all patients referred with potential subarachnoid haemorrhage, both surgically and with interventional radiology
- a neuroscience service delivering neurosurgical interventions as recommended for major intracerebral haemorrhage, malignant cerebral oedema, and hydrocephalus.

C The commissioning of acute services should:

- ensure active involvement of specialist rehabilitation services with patients from the time of admission, wherever they are admitted, and
- ensure patients are seen by at least one member of the specialist rehabilitation team within 24 hours for assessment and by all team members within 5 days for treatment.

D An acute neurovascular service should be commissioned to assess and manage any patient presenting with a transient neurovascular episode in accordance with the recommendations made by the National Institute for Health and Clinical Excellence, and in the *National clinical guideline for stroke*, fourth edition, 2012.

2.3.1 Commissioning secondary prevention services

A Commissioners should ensure that every provider enacts all the secondary prevention measures recommended, and this should be the subject of regular audit or monitoring by commissioners.

B Commissioners should commission acute hospital health services to:

- identify and initiate treatment for all treatable risk factors as soon as possible
- give all patients written information and advice on lifestyle changes that reduce the risk of stroke, tailored to the needs of the individual person
- liaise with general practitioners about the long-term management of any identified risk factors for each patient.

C Commissioners should facilitate the lifestyle recommendations made through:

- supporting smoking cessation
- working with other organisations to make it easier for people with disability to participate in exercise
- supporting healthy eating
- supporting those with an alcohol problem to abstain or maintain their intake within recommended limits.

2.4.1 Commissioning rehabilitation services

A Commissioning organisations should commission:

- an inpatient stroke unit capable of delivering stroke rehabilitation as recommended in the *National clinical guideline for stroke*, fourth edition, 2012 for all people with stroke admitted to hospital
- early supported discharge to deliver stroke specialist rehabilitation at home or in a care home
- rehabilitation services capable of meeting the specific health, social and vocational needs of people of all ages
- services capable of delivering specialist rehabilitation in outpatient and community settings in liaison with inpatient services, as recommended in the *National clinical guideline for stroke*, fourth edition, 2012.

B In addition to commissioning an overall stroke rehabilitation service, commissioners should ensure that they specify within it, or commission separately, services capable of meeting all needs identified following assessments by members of the specialist stroke teams.

C Commissioners should ensure that patients who have had a stroke can gain specialist advice and treatments in relation to:

- driving
- work
- advocacy.

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2.5.1 Commissioning in relation to the long-term consequences of stroke

A Healthcare commissioners should commission a system that provides:

- routine follow-up of patients 6 months post discharge and annually after a stroke
- reassessment and where appropriate offers further treatment for patients no longer receiving rehabilitation. Referral should be considered from primary or secondary health services, social (adult) services or by self referral.

B Healthcare commissioners should ensure that, between health and social services and other agencies:

- patients receive the practical (eg housing, employment) and emotional support they need
- patients at home can access suitable social opportunities outside their homes if they want, usually through voluntary organisations
- patients receive ongoing maintenance interventions (eg provision of specialist stroke exercise programmes and peer-support programmes) needed to enhance and maintain well-being.

C Commissioners in health and social care should ensure:

- carers are aware that their needs can be assessed separately and carers are able to access the support and help they require
- carers are provided with written information and given appropriate instruction (eg manual handling) to enable them to provide care for someone following a stroke.

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