



Commissioning concise guide for stroke services 2016

This concise guide brings together key recommendations, extracted from the National Clinical Guideline for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. It is meant to guide those responsible for commissioning the entire pathway of stroke care other than primary prevention (in the recommendations below, the term ‘commissioner’, which has a specific meaning in the NHS in England, is used to refer to all those responsible for planning and acquiring services for the populations they serve e.g. Health Boards in Wales). Clinical teams can only provide services that are commissioned and paid for. The recommendations in the National Clinical Guideline for Stroke will not provide the anticipated benefits for people with stroke if the organisations that commission healthcare do not support their implementation.

The recommendations for commissioners contained in this guide are derived directly from the clinical and organisational recommendations made elsewhere in the guideline. In practice, commissioning organisations often do not include people with expertise in specific areas of clinical practice such as stroke care and close collaboration and the sharing of expertise between commissioners and healthcare providers is vital. Service specifications need to take account of best practice contained within expert guidelines, and commissioners can reasonably expect that the services they obtain for people with stroke will deliver all the recommendations outlined in the full guideline www.strokeaudit.org/guideline. Commissioners have a critical part to play in the wider implementation of the full guideline and the achievement of its aim to improve the care of all people with stroke.

Overall structure of stroke services

6.1.1A Commissioning organisations should ensure that their commissioning portfolio includes the whole stroke pathway from prevention (including neurovascular services) through acute care, early rehabilitation, secondary prevention, early supported discharge, community rehabilitation, systematic follow-up, palliative care and long-term support.

6.1.1B Stroke services should be commissioned based upon an estimate of the needs of the population served, and derived from the best available evidence locally and nationally.

6.1.1C Commissioners should commission services which ensure that:

- > people with suspected stroke or TIA are diagnosed and treated urgently, using

evidence-based treatments;

- > adequate provision is made for people with stroke with long-term disability covering the full range of their needs (e.g. nursing, therapy, emotional support, practical support, family/carer support);

- > people with stroke who live in care homes or are unable to leave their own home have equivalent access to specialist stroke services;

- > people with stroke can re-access specialist stroke services when necessary;

- > people dying with stroke receive end-of-life (palliative) care from the acute stroke service and whenever possible in their own homes.

6.1.1D Commissioners should commission a public education and professional training strategy to ensure that the public and emergency personnel (e.g. staff in emergency call centres) can recognise when a person has a suspected stroke or TIA and respond appropriately. This

should be commissioned in such a way that it can be formally evaluated.

6.1.1E Commissioners should require that all those caring for people with stroke have the knowledge, skills and attitudes to provide safe, compassionate and effective care, especially for vulnerable people with restricted mobility, sensory loss, impaired communication and cognition and neuropsychological problems.

6.1.1F Commissioners should ensure that there is sufficient information provided to people with stroke and their family/carers about which services are available and how to access them at all stages of the pathway of care. All information should be provided in a format accessible to those with communication disability.

6.1.1G In commissioning services for people with stroke along the whole pathway of care, commissioners should ensure that there are:

- > protocols between healthcare providers and social services that enable seamless and safe transfers of care without delay;
- > protocols in place that enable rapid assessment and provision of all equipment, aids (including communication aids) and structural adaptations needed by people with disabilities after stroke.

6.1.1H Commissioners should require the stroke services they commission to participate in national audit, auditing practice against the recommendations made in this guideline.

6.1.1I Commissioners should require the stroke services they commission to regularly seek the views of those who use their services, and use the findings to design services around the needs of the person with stroke.

6.1.1J Commissioners should ensure that the stroke services they commission are monitored and evaluated regularly in terms of the process of care, the patient experience and person-centred outcomes.

Commissioning acute stroke services

6.2.1A Ambulance services, including call handlers, should be commissioned to respond to every person with a suspected acute stroke as a medical emergency.

6.2.1B Commissioners should commission acute stroke services in accordance with the recommendations in this guideline to provide:

- > urgent brain imaging for patients with suspected acute stroke;
- > treatment with alteplase for patients with acute ischaemic stroke;
- > an endovascular service for patients with acute ischaemic stroke;
- > a neuroscience service to admit, investigate and manage patients referred with subarachnoid haemorrhage, both surgically and with interventional radiology;
- > a neuroscience service delivering neurosurgical interventions for intracerebral haemorrhage, malignant cerebral oedema, and hydrocephalus;
- > direct admission of patients with acute stroke to a hyperacute stroke unit providing active management of physiological status and homeostasis within 4 hours of arrival at hospital;
- > an acute neurovascular service for the diagnosis and treatment of people with suspected TIA;
- > an acute vascular surgical service to investigate and manage patients with TIA and non-disabling stroke due to carotid artery stenosis.

6.2.1C Commissioners of acute stroke services should ensure the active participation of people with stroke and their family/carers in the planning and evaluation of acute stroke services.

Commissioning secondary prevention services

6.3.1A Commissioners should ensure that healthcare providers enact all the secondary stroke prevention measures recommended in this guideline, through a process of regular audit and monitoring.

6.3.1B Commissioners should commission stroke services in accordance with the recommendations in this guideline to:

- > identify and treat modifiable vascular risk factors as soon as possible, including symptomatic carotid artery stenosis;
- > provide all people with stroke or TIA with information and advice on treatments and lifestyle changes to reduce their risk of stroke, tailored to the needs of the individual;
- > liaise with and support general practitioners in the long-term management of risk factors in people with stroke or TIA.

6.3.1C Commissioners should support the lifestyle recommendations for stroke prevention made in this guideline through:

- > providing smoking cessation services;
- > working with other organisations to make it easier for people with disabilities to participate in exercise;
- > supporting healthy eating;
- > supporting people who drink alcohol in excess to abstain or maintain their intake within recommended limits.

Commissioning rehabilitation services

6.4.1A Commissioners should commission stroke rehabilitation services in accordance with the recommendations in this guideline to provide:

- > an inpatient stroke unit capable of providing stroke rehabilitation for all people with stroke admitted to hospital;
- > a specialist early supported discharge service to enable people with stroke to receive rehabilitation at home or in a care home;
- > specialist rehabilitation services capable of meeting the specific health, social and vocational needs of people with stroke of all ages;
- > services capable of delivering specialist rehabilitation in out-patient and community settings in liaison with in-patient services.

6.4.1B Commissioners should ensure that they specify within a stroke rehabilitation service, or commission separately, services capable of meeting all the needs of people with stroke identified by members of the specialist team (e.g. orthotics,

specialist seating, equipment provision, continence, vocational rehabilitation, family/carer support).

6.4.1C Commissioners should ensure that people with stroke whose mental capacity is impaired can access independent specialist advice and support in relation to advocacy.

Commissioning long-term services

6.5.1A Commissioners should commission services that provide:

- > routine follow-up of people with stroke six months after hospital discharge and annually thereafter;
- > reassessment and further treatment of people with stroke who are no longer receiving rehabilitation. Services should be accessible from primary or secondary care, social services or by self-referral.

6.5.1B Commissioners should ensure that, between health and social services and other agencies, people with stroke can:

- > receive the practical (e.g. housing, employment) and emotional support they need to live with long-term disability;
- > access suitable social and leisure activities outside their homes;
- > receive maintenance interventions (e.g. provision of exercise programmes and peer support) to enhance and maintain health and well-being.

6.5.1C Commissioners in health and social care should ensure that the carers of people with stroke:

- > are aware that their needs can be assessed separately;
- > are able to access the advice, support and help they need;
- > are provided with information, equipment and appropriate training (e.g. manual handling) to enable them to care for a person with stroke;
- > have their need for information and support reassessed whenever there is a significant change in circumstances (e.g. if the health of

the carer or the person with stroke changes).

6.5.1D Commissioners should ensure that advance care planning and community palliative care services are available for people with stroke with limited life expectancy, and their family/carers where appropriate.

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