# Peer review report

**Participating organisations**

All known specialist professional organisations in the UK and Ireland were invited to participate and the following responded:

Association of British Neurologists
Association of Chartered Physiotherapists in Neurology (ACPIN)
Association for Palliative Medicine of Great Britain and Ireland (APM)
Association of Clinical Psychologists UK (ACP-UK)
Brain Injury Matters (NI)
British and Irish Association of Stroke Physicians (BIASP)
British and Irish Orthoptic Society
British Cardiovascular Society (including British Cardiovascular Intervention Society)
British Psychological Society
British Society of Gerodontology
British Society of Physical and Rehabilitation Medicine (BSPRM)
Chest Heart & Stroke Scotland
British Dietetic Association
Different Strokes
Irish Association of Physical and Rehabilitation Medicine
Irish Heart Foundation, Council on Stroke
Irish Institute of Clinical Neuroscience
National Imaging Academy Wales
Northern Ireland Multidisciplinary Association for Stroke Teams
Northern Ireland Stroke Network
Restorative Dentistry-UK
Royal College of Nursing
Royal College of Occupational Therapists - Specialist Section Neurological Practice
Royal College of Physicians of Ireland Clinical Advisory Group
Royal College of Radiologists Wales
Royal College of Speech and Language Therapists
Scottish Intercollegiate Guidelines Network (SIGN)
The British Association of Prosthetists and Orthotists
The Irish Heart Foundation
The Stroke Association
United Kingdom Clinical Pharmacy Association (UKCPA)
Welsh Association of Stroke Physicians
Wales Stroke Allied Health Professional Forum

**Submitting comments**

Organisations invited to participate nominated an individual to respond to the peer review survey and submit comments on their behalf. The peer review survey was open to responses from 28 November 2022 and closed on 9 January 2023.

**Public consultation**

In addition to inviting organisations to peer review, non peer reviewers also had the opportunity to review the draft guideline update in order to maximise exposure of the draft to corrections and adjustments. The Guideline Development Group (GDG) only committed to responding to and publishing public consultation comments when they covered an important point not otherwise covered in peer review. No such comments were received.

**Process**

Further details about the process for the peer review and public consultation exercises are described in the methodology overview found in the guideline appendices.

**Peer review pre survey question responses**

| Organisation | First name | Surname | Job title | Declarations of interest (How might the draft 2023 National Clinical Guideline for Stroke affect your organisation's functions/status/productivity?) |
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| RD-UK | Martin | Ashley | Consultant in Restorative Dentistry | RD-UK and its members have no conflict of interest to declare and the 2023 Guidelines will not affect RD-UK's functions, status or productivity |
| Irish Institute of Clinical Neuroscience | Professor Simon | Cronin | Consultant Neurologist | The IICN is Ireland's Professional Society for Neurologists including Vascular Neurologists, Neurosurgeons and related disciplines. It is the equivalent of the ABN in the UK. The IICN functions to support education in Neurology and the development of Neurology services. IICN Clinician members provide a mix of acute and consulting care to patients with stroke and TIA in Ireland. |
| Different Strokes | Austin | Willett | CEO | I don't believe this guideline will specifically affect our work - we have supported stroke survivors for many years and we will continue to do this. However, we are namechecked in a couple of places which I don't believe we have been previously, so this may lead to an increase in referrals to our organisation |
| Royal College of Nursing | Jonathan | Beebee | Professional Lead for Neuroscience | The RCN has produced a UK career framework for stroke nurses. This framework will need to be reviewed in line with the updated guideline. |
| British Cardiovascular Society (including British Cardiovascular Intervention Society) | Neil | Swanson | Cardiology consultant | No direct impact on these society's, although our members may well have additional activity based on the recommendations made through increased NHS activity. |
| British Psychological Society | Hannah | Farndon | Practice Team Manager | The guideline would have little to no effect on our organisation as a whole but could affect a portion of our members who work in the area. |
| British Society of Physical and Rehabilitation Medicine (BSPRM) | Sivaraman | Nair | Consultant Neurologist with special interest in disability management, Chair, Research and clinical standards | Neurorehabilitation remains at the heart of what most of our members do in their everyday clinical practice, and we have a strong clinical and academic background in the field of rehabilitation. Our embers are involved in stroke rehabilitation. Early input from a rehabilitation medicine specialist help to reduce the disabilities and promote recovery. Our input also help to support and promote recovery of the survivors of stroke who are |

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| | | | Committee of BSPRM | often left with significant disabilities. These clinical guidelines do have a significant effect on commissioning of the services. BSPRM is concerned that these guidelines on stroke do not consider input from Rehabilitation medicine as an important aspect of stroke rehabilitation. We are , by training and experience experts in managing complex disabilities of stroke survivors. Near complete exclusion of our specialty from the proposed criteria for staffing for stroke teams will have an adverse impact on care of people with neurological disabilities. We request the Guideline development group to reconsider this decision and include Rehabilitation medicine specialist as an integral part of the stroke team |
| Association of Clinical Psychologists UK (ACP-UK) | Alexandra | Garfield | Consultant Clinical Neuropsychologist | No direct effect.<br>Representing the views of professionals working in stroke services both acute and community. |
| Chest Heart & Stroke Scotland | Joanne | Graham | Director of Services | The individual submitting this review has been involved in the update of the guideline as a topic group member and as such will coordinate responses on behalf of CHSS only but will not peer review sections relating to the topic group in which I was involved. |
| British and Irish Orthoptic Society | Lauren | Hepworth | Academic Lead Stroke and Neuro Rehab Clinical Advisory Group | This 2023 guideline draft will provide strengthened support for the development of orthoptic stroke services, which will be used by the BIOS Stroke and Neuro Rehab Clinical Advisory Group to support our members to maintain and improve their services if they are in the fortunate position to have an existing service in place. However, for those stroke services without current orthoptic provision or with adhoc orthoptic provision these updated guidelines will underpin the business cases needed to take services to a standard and appropriate level. |
| Royal College of Speech and Language Therapists | Lorna | Baxter | Professional Guidance Manager | N/A |
| Association for Palliative Medicine of great Britain and Ireland (APM) | Kirsten | Baron | Honorary Secretary APM; Consultant in Palliative Medicine | N/A.<br>Many of our members will care for people affected by stroke |
| The Stroke Association | Rubina | Ahmed | Associate Director (Systems Engagement) | The Stroke Association provides a number of life after stroke and other services that support the mental and physical wellbeing of stroke survivors. The charity provides information and support for stroke survivors through our Helpline, through information included on our website, and through conversations between stroke coordinators and stroke survivors. The 2023 National Clinical Guidelines for Stroke will guide and influence practice within these services. The Stroke Association also acts as a system influencer, pushing for improvements across the UK using the guidelines to demonstrate what stroke care should look like. |
| Northern Ireland Stroke Network | Fiona | Quigg | Deputy Commissioning Lead/ NI Stroke Network Coordinator | The 2023 National Clinical Guideline for stroke will provide a standard for stroke services in Northern Ireland. It will inform the work programme of the NI stroke network, as it revises protocols, service delivery targets and recommended staffing compliments for HSC Trusts delivering stroke assessment and treatment. |
| Scottish Intercollegiate Guidelines Network | Ailsa | Stein | SIGN Programme Manager | SIGN is a partner organisation in the development of the guideline. The guideline will be the national clinical guideline for stroke in Scotland. |
| British and Irish | Michelle | Dharmasiri | BIASP Clinical Standards Chair | No DOI regarding the statement above. |

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| Association of Stroke Physicians (BIASP) | | | and Stroke Consultant | Members of the BIASP executive and clinical standards committee who are guideline development group members have not actively taken part in this review. Those who are topic group members have only provided peer review of sections that were not within the scope of their own topic group's questions. |
| The Irish Heart Foundation | Helen | Gaynor | Head of Community Services | The Irish Heart Foundation supports approximately 15% of stroke survivors being discharged in Ireland and offers our services to community-dwelling stroke survivors at any stage post-stroke, but with a particular emphasis on recently discharged stroke survivors who have returned home and are in need of support at that stage of their recovery.<br><br>We envisage that these evidence-based guidelines would enhance our delivery of community support services to people post-stroke. We would also welcome the knowledge and awareness of best practices for each stage of recovery but with specific emphasis on the recommendations for return to work, younger stroke survivors, psychological interventions, and exercise after stroke as we offer specific support interventions in these areas. |
| NIMAST | Katy | Pedlow | Lecturer in Physiotherapy | Provides direction for care at all levels, informs our professional members about their practice and provides a platform to build research in our region based on recommendations. |
| British Society of Gerodontology | Mili | Doshi | Consultant in Special Care Dentistry | Raise the profile of how to maintain good oral health for people who had had a stroke |
| Irish Association of Physical and Rehabilitation Medicine | John | Macfarlane | Consultant in Rehabilitation Medicine | Our speciality has historically been responsible for rehabilitation of individuals after stroke. These guidelines might affect the functions and status of the speciality |
| British Dietetic Association | Eleanor | Williams | Stroke & Rehab Dietitian | Provide recommendations and guidance for dietetic practice in stroke care. |
| RCR Wales | Anita | Pandey | Consultant Radiologist, Regional Chair & Consultant Radiologist at ABUHB | The new draft will not affect the RCR per se. However it will have an impact at HB level where on one hand there will be clarity and standardisation in management of Stroke patients across wales. On the other hand, there will be capacity issue in delivering the recommendations. |
| Brain Injury Matters (NI) | Jonathan | McCrea | Head of Service | The current and future guidelines provide a sound evidence base and direction for our third sector / voluntary organisation as we deliver for people with stroke and their families. We currently evaluate our service delivery based on the current guidelines and will update any relevant parameters when this update is published. |
| Association of British Neurologists | Tom | Hughes | Neurologist | They should help us become more evidence based and efficient |
| Welsh Association of Stroke Physicians | Tom | Hughes | Consultant Stroke Physician | By making us more evidence-based in our practice and by standardising practice across the country. |
| Wales Stroke Allied Health Professional Forum | Niki | Turner | National Allied Health Professional Lead for Stroke in Wales | Guide and influence individuals' professional practice and service delivery |
| National Imaging Academy Wales | Phillip | Wardle | Director | This may steer NIAW's training in Acute Stroke Imaging interpretation for Radiologists, Stroke Physicians and other appropriate Clinical Professionals.<br>As a Hub for Medical Imaging in NHS Wales, there are Service, Workforce and Education challenges which NIAW |

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| | | | | may be involved.<br>Contributor's comments are restricted to those pertinent to Medical Imaging. |
| United Kingdom Clinical Pharmacy Association (UKCPA) | Paresh | Parmar | Lead Pharmacist for stroke and older people | The Draft will acknowledge/highlight the role and contribution that specialist stroke pharmacists have within the multidisciplinary team. Specialists pharmacists have a vital role from ensuring accurate medication histories, oral medication amending for ensuring safe swallowing for dysphagic patients, assessing medication management through empowering through person centred care, and ensuring transfer of care for medication management across sectors. By recognising the pharmacists role, it will increase the status of the pharmacy profession within stroke and celebrate the contributions pharmacist make in patient care. |
| The British Association of Prosthetists and Orthotists | Nicky | Eddison | Vice Chair of BAPO / Consultant Orthotist / Associate Professor | The guideline will impact BAPO members and their patients |
| Association of Chartered Physiotherapists in Neurology(ACPIN) | Adine | Adonis | Chair ACPIN + Clincial Specialist Neurophysiotherapy | The 2023 NCG for stroke will support physiotherapists in being able to impact patient treatment |
| Royal College of Occupational Therapists - Specialist Section Neurological Practice | Lorinda | Sharkey | Engagement Officer | Occupational therapists are integral members of multi-disciplinary teams supporting people to manage and recover from the physical, cognitive and psychological effects of stroke. They work within acute and community health settings, as well as in social care and vocational rehabilitation services. As such, the National Clinical Guideline for Stroke has significant implications for occupational therapy practice. |
| Irish Heart Foundation, Council on Stroke | Rachael | Doyle | Consultant Physician and Geriatrician | Nothing to declare |
| Royal College of Physicians of Ireland Clinical Advisory Group | Sinéad | Coleman | Programme Manager, National Clinical Programme for Stroke | The Irish national clinical programme for stroke is frequently asked for its' guidance on aspects of stroke care or what is the national guideline on a topic of stroke management. Being party to the genesis of and approval of an intercollegiate guideline on stroke for the island of Ireland and UK allows reference to such guidance and saves both administration time and professional time in research and development of answers to such requests. In this regard the draft 2023 National Clinical Guideline for Stroke will enhance the efficiency of our stroke programme in the republic of Ireland. Having a representative intercollegiate guideline will also provide the Irish national clinical programme for stroke with a clinical template by which to measure provision of service against expected clinical standards and better help our annual service planning and budgetary submissions to the department of health. |

**Peer review survey question comments received and Guideline Development Group (GDG) responses**

| # | Section | Organisation | Comments received | GDG responses |
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| 1 | Q8. Section 2.3 Transfer to acute stroke services | Irish Institute of Clinical Neuroscience | Regarding: "I. Patients with acute neurological symptoms that resolve completely within 24 hours (i.e. suspected TIA) should be given aspirin 300 mg immediately and assessed urgently within 24 hours by a stroke specialist clinician in a neurovascular clinic or an acute stroke unit." This implies that TIA assessments should be available over a weekend, for example. A chief time-critical function of a TIA service is recognition of symptomatic carotid stenosis. Safe provision of such a service over weekends by Stroke Physicians would assume availability of carotid imaging for TIA, specifically over the weekend. We agree this would be ideal; however it will require availability of appropriate arterial imaging to implement. Therefore, an accompanying recommendation should state that carotid imaging is required over weekends for TIA and minor stroke. | Thank you for this comment. The guidelines have been explicit that acute stroke care should be available 24 hours a day, 7 days a week [See Evidence to Recommendations 2.3] and this would include access to both brain and carotid imaging.<br><br>Recommendation 3.3 E endorses the need for carotid imaging within 24 hours of assessment and it is implicit that this is regardless of the day of admission.<br><br>A new statement has been included within the 3.2 Implication section stating that patients with suspected TIA are assessed, and diagnosed urgently 7 days a week [Line 1103] |
| 2 | | Royal College of Nursing | The recommendations appear sound. The implications and limitations to local services are well acknowledged. | Thank you for this comment. |
| 3 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | We welcome the document, in particular the increased emphasis on the use of stroke thrombectomy.<br><br>55 2.3B Patients with acute stroke should "have access to a designated thrombectomy centre". This assumes transfer on to the centre offering thrombectomy if the initial hyperacute stroke centre does not. Here it should specify that this should be a 24/7 service and perhaps accessible within a particular time frame – ie 1 hour as per Coughlan 2021?<br><br>Is there a definition of a "designated thrombectomy centre" which will continue to be relevant for the lifespan of this clinical guideline. Is it synonymous with a CSC, line 125 or one that fulfils the service specification?)<br><br>Line 88 2.3 Perhaps alluding to the conflicting results of the many studies that have looked at this rather than starting from RACECAT - a single negative study - would paint a better picture of the 'Drip and Ship' versus 'Mothership' model. It is clear that even within the UK the more beneficial strategy for organisation of | Thank you for this comment.<br><br>Thank you for this comment and this has now been edited to specifically highlight access to a 'designated thrombectomy centre 24 hours, 7 days a week' [Line 55]<br><br>A thrombectomy centre is defined as a centre that specifically delivers mechanical thrombectomy for stroke. The GDG have not considered adopting the nomenclature 'Comprehensive Stroke Centre' as synonymous with a thrombectomy centre as the GDG wanted to ensure the terminology is in kilter with our five nation colleagues.<br><br>Thank you for this comment. The Guideline Development Group (GDG) wanted specifically to ascertain whether there was any robust evidence from randomised controlled trials in the first instance for redirection of patients with potential large vessel |

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| | | | services is likely to differ region to region. | occlusion and have acknowledged that a UK approach will undoubtedly involve a variety of models [secondary transfer or redirection] dependent upon local geography, travel times and population density. The GDG considered the RACECAT trial as the only robust trial evidence to date to base the findings in the evidence to recommendation section. |
| 4 | | British Psychological Society | Clarification is important around the RACECAT study – the paragraph currently states that a multicentre cluster RCT did not demonstrate benefits of redirection to a thrombectomy centre, but suggests that whether this is done regardless "depends on local and regional services and the population served". More detail about where and in which populations it would be appropriate to do this would be useful, to support clinicians' decision-making.<br><br>There are observations and evidence about cultural biases towards treating people from diverse cultural backgrounds. Throughout the document, Equality, Diversity and Inclusion principles need to be included to raise awareness in the context of care & rehab delivery. | Thank you for this comment and we acknowledge that further research is specifically required to explore in more detail, what population and geographical factors as well as time metrics are important for different models as highlighted in the evidence to recommendation section [2.3]<br><br>Thank you for this comment. We acknowledge that the delivery of stroke care will affect a wide range of patients from different cultural and ethnic backgrounds. It is the role of every clinician to understand the context (personal, family and societal) into which their treatments and advice will be received (Sweeney's third level of significance) and this has been articulated in Chapter 1. |
| 5 | | Chest Heart & Stroke Scotland | [2.3B This implies that patients should be admitted directly to a Thrombectomy centre using the mothership pathway as opposed to the drip and ship pathway in place in Scotland]<br><br>2.3 A&B (49-56) both mention transfer to a Hyperacute stroke centre. Caveat may need to be added (to include acute stroke unit) as hyperacute stroke units are not available in every region in Scotland. | Thank you for this comment. Recommendation 2.3 B stipulates that patients admitted directly to a hyper-acute centre should have access to a designated thrombectomy centre rather than specifically endorsing a mothership approach.<br><br>Thank you for this comment. The GDG considered that the nomenclature of hyper acute stroke care was sufficiently recognised to be used across the five nations. |
| 6 | | Royal College of Speech and Language Therapists | Page 2, line 49-52 – The RCSLT agrees with this, but this is very challenging to achieve. It is important to note that staff should be trained using a minimum standard training package as well as trained in stroke mimics to help reduce transfers. More research is needed into models of services supporting large geographical areas with mixed urban/rural economies.<br><br>Some of the language used in this section does not align with the rest of the guidance. For example, hyperacute stroke centre should be 'comprehensive stroke centre' - this language is used in section 2.4. | Thank you for this comment which has already been acknowledged in section 2.3 Implications statement<br><br>Thank you for this comment and refer to Section 2.4 summarising the key components of Comprehensive and Acute Stroke Centres |

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| | | | | for which hyperacute units are a key component of. |
| 7 | | The Stroke Association | We welcome Recommendation A. The current median time from symptom onset to stroke unit time is 11 hours and 1 minute across England, Wales and Northern Ireland (https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx). Patients have the best chance of survival the quicker they are taken to a stroke unit. Training should be through the use of validated tools like FAST. This training should not just be one off but embedded in their training as part of continuous professional development. Additionally, communication training should be provided so that community medical services and ambulances services can manage patients with aphasia. The Stroke Specific Education Framework is available to assist with this and can be used by paramedics and health care assistants. The website stroke-awareness.com has been endorsed by the Prehospital Stroke Consensus Group and can be adopted by pre-hospital clinicians to improve their understanding of stroke and its symptoms.<br><br>We also welcome Recommendation B. Stroke patients have the best chance of surviving and making a good recovery when they're taken to a hospital stroke unit for specialist medical treatment as soon as possible. In 2020/21 nearly 80% (5,889) of patients in England who needed a thrombectomy missed out. Thrombectomy is very time-sensitive but ambulance response times, lengthy handovers, and delayed interhospital transfers from a stroke unit to the thrombectomy centre pose logistical challenges and cause some patients who need to have the treatment to miss out. Thrombectomy is more effective the quicker it happens. A well-functioning ambulance service and pathway is essential to quickly transfer patients to the thrombectomy centre, usually via a local stroke unit. | Thank you for this comment which the GDG endorses.<br><br>Thank you for this comment. Please refer to 2.3 Implications section highlighting the need for configuration of stroke services in order to deliver time sensitive treatments as rapidly as possible. |
| 8 | | Scottish Intercollegiate Guidelines Network | The Royal College of Physicians of Edinburgh (RCPE) welcomes these recommendations as optimal but understands there will be obvious resource implications in terms of both training for community medical and ambulance staff and especially in terms of thrombectomy capacity given concerns about its availability, particularly in Scotland. The RCPE agrees strongly that there must be robust governance infrastructure in place to monitor the quality of stroke services delivered. | Thank you for this comment. |
| 9 | | British and Irish Association of Stroke Physicians (BIASP) | Page 2 line 48 2.3 recommendations. Good to see awareness of training needed for primary care to start aspirin immediately and arrange an urgent referral.<br><br>Page 4 line 95 "urgent need for research addressing this question that is directly | Thank you for this comment.<br><br>Thank you for this comment and this has been to include 'Health |

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| | | | applicable to the NHS" Suggest "directly applicable to NHS and Health Service Executive Ireland." Similarly, research is required in Ireland to determine the effectiveness and potential negative impact of any service change involving the redirection or patients.<br><br>Page 4 line 163 "Patients with acute neurological symptoms that resolve completely within 24 hours (i.e. suspected TIA) should (MAY) be given aspirin 300 mg immediately (suggest add WHERE APPROPRIATE) and assessed urgently within 24 hours by a stroke specialist clinician in a neurovascular clinic or an acute stroke unit. [2023]"<br><br>In some circumstances brain imaging may be indicated before considering anti-platelet treatment (e.g. patients taking an anticoagulants). | Service Executive Ireland' [Line 95]<br><br>Thank you for this comment. The term 'unless contraindicated' has been inserted into the text. [Line 164]<br><br>Thank you for this comment which has been already reflected in the Recommendation 3.2 E. |
| 10 | | The Irish Heart Foundation | The focus group contained several stroke survivors under 65 years old- these individuals all commented that their initial symptoms were dismissed by their GP as stroke symptoms because they did not present with typical FAST symptoms.<br><br>They suggested that more education and public awareness of uncommon stroke symptoms as well as the inclusion of BEFAST (Balance and eyes) would be beneficial in these guidelines.<br><br>Furthermore, those over 65 years discussed improving understanding and public awareness of TIA symptoms and the increased risk of a stroke TIA patients have.<br><br>As mentioned in the implications, it was strongly agreed that a focus should be made on access to the appropriate acute care, in a timely manner, across Ireland, to obtain the maximum benefit to the population. | Thank you for this comment. The specific question around the selection of different stroke warning tools to identify stroke is beyond the scope of this particular guideline. |
| 11 | | RCR Wales | Agree A & B are essential – there is not the capacity to transfer all stroke cases direct to thrombectomy centres. | Thank you for your comment. We have not specified that all stroke cases should be transferred directly to a thrombectomy centre but have access to such a centre if mechanical thrombectomy is being considered. |
| 12 | | Association of British Neurologists | Page 3<br>Line 94<br>There is an urgent need for research addressing this question that is directly applicable to the NHS ….<br><br>Comment | Thank you for this comment. The GDG considered the relevant evidence from the extensive searches and focused on the randomised controlled evidence available to date. |

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| | | | One study from NW London showed no difference in terms of functional independence between the drip and ship and Mothership organisational paradigm (D'Anna et al., Stroke Vasc Interv Neurol.2020;e000690; http://doi.org/10.1161/SVIN.122.000690 https://www.ahajournals.org/doi/10.1161/SVIN.122.000690<br><br>Page 4, line 165. "…24 hours by a stroke specialist clinician in a neurovascular clinic or an acute stroke unit …consider adding "including consideration for dual antiplatelet therapy if favourable after balancing the bleed risk (Am J Cardiol 2021;Aug 15;153;129-134 doi:10.1016/j.amjcard.2021.05.028)<br><br>The second point may be addressed in later sections of the guideline. | Thank you for this comment. This point has been endorsed by Recommendation 3.2 A and 3.3 B with relevant evidence to recommendations supporting this statement. The GDG agreed that aspirin was recommended for suspected TIA, and where eligible and appropriate, DAPT was recommended for confirmed TIA. [Line 164] |
| 13 | | Welsh Association of Stroke Physicians | Will the recommendation for patients with a suspected stroke to be admitted to an acute stroke unit lead to a large number of mimics entering stroke services? Is the recommendation for direct admission? The labelling of patients as "stroke" may lead to a delay in the initiation of the correct diagnostic process, and the correct treatment. | Thank you for this comment. The recommendation is for direct admission to such units acutely. It is inevitable that stroke mimics will initially be admitted to hyperacute or acute stroke unit settings given the high rate of such diagnoses which vary nationally. |
| 14 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 15 | | United Kingdom Clinical Pharmacy Association (UKCPA) | Agreed | Thank you for your comment. |
| 16 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations A and B appear appropriate | Thank you for your comment. |
| 17 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | We suggest adding that partners of people who have had a stroke are taught how to recognize symptoms and what to do as part of the stroke survivor management plan.<br><br>should recommendation A read 'community health services' therefore including other disciplines who may pick up and recognise new stroke | Thank you for your comments. Training for partners of people with stroke was beyond the scope of the update of this guideline.<br><br>We have changed the word medical to health. |
| 18 | | Irish Heart Foundation, Council on Stroke | ''There is an urgent need for research addressing this question that is directly applicable to the NHS'. add and HSE ( Health Service Executive which is the republic of Ireland's equivalent of the NHS' the same issues are also applicable to the HSE. | Thank you for this comment which has now been amended. |

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| 19 | | Royal College of Physicians of Ireland Clinical Advisory Group | Recommendation B consider "should be admitted directly to a hyperacute stroke unit unless clinically requiring other more urgent specialist ward management" Outcome of the LVO bypass being trialled in Dublin will be important. Access to LVO bypass should be informed by local evidence.<br>Some patients may need to be admitted to an alternative high dependency unit/ITU if need necessitates. | Thank you for this comment. It is implicit that if patients require further specialist involvement (e.g. in a HDU or ITU environment), then this would be appropriate and the editors felt that this was not necessary to state this. The implications of redirection and secondary transfer for mechanical thrombectomy has been highlighted in the evidence to recommendations and implications section [2.3]. Adoption of these pathways will depend on local geography, travel times, population density and current service provision. |
| 20 | Q9. Section 2.4 Organisation of acute stroke services | Royal College of Nursing | Support these recommendations and evidence | Thank you for your comment. |
| 21 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | Line 184 2.4 'clinicians in high-risk clinical areas (e.g. cardiology or renal wards, cardiothoracic units) should have a high level of awareness acute stroke…' ;<br><br>We would recommend additions here of '…and the time sensitive nature of interventions to improve outcome' (this to avoid deferral of decisions or onward referral until the morning or next working day).<br><br>Similarly, we would recommend changing 'including how to directly admit patients to a hyperacute stroke unit' to 'including how to immediately contact a stroke specialist for advice, imaging and transfer'. We feel a recommendation simply for a transfer to an ASU is unfortunately unrealistic.<br><br>1380 Mechanical thrombectomy<br><br>The important updated recommendation for all anterior and posterior circulation large vessel occlusion strokes presenting within 6 hours to undergo thrombectomy, with bridging IVT, and those up to 24-hours, including wake up strokes to have thrombectomy according to imaging criteria has major workload implications. An idea of anticipated numbers (pmp) to allow calculation of workforce levels for equitable 24/7 provision would be helpful. The number of trained operators required for imaging and intervention could be alluded to or suggested here. | Thank you for this comment. This statement has been added this to the stated text [Line 186].<br><br>Thank you for this comment. This statement has been added this to the stated text [Line 188].<br><br>Thank you for this comment. It is an important question regarding the workforce capability/capacity to deliver mechanical thrombectomy nationally over 24/7. The specific question regarding how many interventional operators are required is beyond the scope of this particular update of the guideline. The references by Ford et al, [2022] and Mortimer et al [2021] highlight the potential resource implications |
| 22 | | British Psychological Society | Recommendation 'E' – in our members' experience, acute settings are already good at ensuring scans are performed when stroke is suspected. Problems can | Thank you for this comment. The standard pathway to access brain imaging when stroke is suspected is through the acute stroke |

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| | | | arise in the community when patients presenting with slow onset symptoms call their GP and wait for an appointment or 'call back'. These people can later have an emergency when it may be too late for treatment but in fact, their presenting symptoms would be flags for stroke. Training for GP staff who triage calls and a flagging system for these cases would be useful and provide prevention. Those with very sudden/severe symptoms tend to be better at reaching emergency care.<br>Similarly, following discharge after stroke, if people become unwell again GPs and services differ in how they respond to new symptoms in the community. Some trusts have a 'deteriorating patient' standard operating procedure, which is locally derived and held; often Early Supported Discharge (ESD) services – if involved, are alerting services. Again, some form of standard would be helpful. | service pathway. Recommendation 2.3 F supports public and professional education. |
| | | | Recommendation I is helpful but could usefully go further to recommend screening TIA and minor stroke patients for emotional and cognitive changes. Cerebrovascular events are associated with emotional and cognitive sequelae for which patients may not receive support unless seen in a suitable clinic. For example, TIA is associated with depression (Kahlon & Nasrallah, 2019), anxiety and PTSD. A meta-analysis (9 studies, N=1138) found that 1 in 4 stroke or TIA survivors develop significant PTSD symptoms due to stroke or TIA (Edmondson et al. 2013). A large-scale study in Scotland found that nearly a third of TIA patients developed anxiety and a fifth developed depression (Broomfield et al. 2014). Work disruption has been linked with cognitive difficulties up to 2 years after TIA (Hallevi et al. 2020). | Thank you for this comment which has been acknowledged but the issue reflecting the long term cognitive and mental health complications after TIA is outside the scope of the updated guideline. |
| | | | Kahlon, C. K., & Nasrallah, H. A. (2019). Bidirectional relationship between transient ischemic attacks and depression: A review. Annals of Clinical Psychiatry: Official Journal of the American Academy of Clinical Psychiatrists, 31(3), 214-220.<br>Edmondson, D., Kronish, I. M., Shaffer, J. A., Falzon, L., & Burg, M. M. (2013). Posttraumatic stress disorder and risk for coronary heart disease: a meta-analytic review. American heart journal, 166(5), 806-814.<br>Broomfield, N. M., Quinn, T. J., Abdul-Rahim, A. H., Walters, M. R., & Evans, J. J. (2014). Depression and anxiety symptoms post-stroke/TIA: prevalence and associations in cross-sectional data from a regional stroke registry. BMC neurology, 14(1), 1-9.<br>Hallevi, H., Molad, J., Kliper, E., Seyman, E., Niry, D., Bornstein, N. M., & Assayag, E. B. (2020). Working status is related to post stroke/TIA cognitive decline: data | These sources are out of scope of the literature searches. |

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| | | | from the TABASCO study. Journal of Stroke and Cerebrovascular Diseases, 29(9), 105019. | |
| 23 | | Chest Heart & Stroke Scotland | [Scottish Stroke Care Audit (SSCA) guidance states Neurovascular clinic assess within 4 days]<br>I – no mention of dual anti-platelet therapy (although is mentioned later on in the document). This has been determined by ABCD2 score until now. | Thank you for this comment and the dual antiplatelet statement has been recorded [Line 164]. The GDG agreed that aspirin was recommended for suspected TIA, and where eligible and appropriate, DAPT was recommended for confirmed TIA. |
| 24 | | Royal College of Speech and Language Therapists | Page 5, line 192 – The RCSLT agrees that we need to reflect the stroke imaging pathway. | Thank you for the comment. The National Optimal Stroke Imaging Pathway has been referenced in the 3.4 Evidence to Recommendation Section [Line 1296], NHS England 2021. |
| 25 | | Northern Ireland Stroke Network | Lines 126& 127 – are we moving away from terms HASU and ASU? If yes, this should be clarified<br><br>Section I, line 165 - what is the clock start for 24hrs? Symptom onset? | Thank you for this comment. The GDG acknowledge that the nomenclature and terminology is required to be consistent and reflective of practice across the 5 nations of the UK, hence the definitions of ASC and CSC incorporating both hyperacute and acute stroke units.<br><br>Thank you for this comment. '24 hours from symptom onset'. This has been added to recommendations. [Line 163] |
| 26 | | Scottish Intercollegiate Guidelines Network | The RCPE generally supports these recommendations but would highlight the obvious and often significant challenges in ensuring recommended staffing levels are consistently met given ongoing staffing challenges at all levels.<br><br>Recommendation I - should be given DAPT or aspirin depending on whether 'high risk' or 'low risk' as per POINT, CHANCE and THALES studies. If giving aspirin only, then specialist review should be within 12 hours to allow DAPT (when needed) within an evidence based time frame | We acknowledge the challenges presented by the current workforce issues.<br><br>Thank you for this comment. This statement has been amended to include the consideration of dual antiplatelet therapy as stated more specifically in Recommendation 3.3 B. Dual antiplatelet therapy should be considered after assessment by stroke specialist within 24 hours after the initial delivery of 300 mg Aspirin. CHANCE, THALES and POINT delivered dual antiplatelet therapy within 12-24hrs and as such the GDG have taken the pragmatic and practical approach to reflect what can be delivered in UK practice and is still reflective of the evidence. |
| 27 | | RCR Wales | There is growing evidence that CT and CTA in late presentation stroke is non-inferior to CT perfusion. Has the data from the CLEAR study in JAMA neurology and the MR CLEAN - LATE study been reviewed in making this recommendation. CT perfusion may not be needed as a core imaging modality.<br><br>From radiology department point of view, there are constraints in providing continuous access to brain imaging, including CT or MRI angiography and | Thank you for this comment. Data from the CLEAR study was considered, however MR CLEAN LATE is yet to be published, the results of which have implications of determining the principal imaging modality to be used in the late time window.<br><br>Thank you for this comment which has been acknowledged by the GDG. |

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| | | | perfusion. Although those services could be provided most of the time, continuity cannot be guaranteed due to lack of trained personnel and scanner time. This is particularly problematic out of normal working hours and on weekends. | |
| 28 | | Welsh Association of Stroke Physicians | · 2.4 Missing the rehab facilities/accommodation aspect – can this be emphasised? as bedside rehabilitation is the push financially and space-wise which isn't as effective as using specific rehab facilities. To be as efficient as possible and deliver group work etc. therapists need access to accommodation & facilities. Also consideration of the very sensitive discussions and treatment sessions that stroke patients need, private spaces are also vital.<br><br>· Resources/staffing levels – with the prospect of delivering a minimum of 3 hours combined therapy a day, the staffing levels do not correlate with this<br><br>· How will 3 hours/day of direct therapy and the 6 hour/day of activity be measured? Given that most health boards fail to deliver 45 minutes it feels over-ambitious with regards to the staffing levels outlined in 2.19. Despite working efficiently/group work etc. it's still a big ask on a small resource who also have non-clinical, workforce-based commitments.<br><br>3 hours of combined therapy – if a patient only has physio needs does this mean physio need to deliver 3 hours every day? Not possible with staffing resource given | Thank you for the comments.<br><br>Whilst we recognise this as an important issue, rehabilitation facilities and accommodation were beyond the scope of the update.<br><br>We have clarified that achieving the recommendations in section 4.2 (Intensity of therapy) will also require use of unregistered support workers and rehabilitation assistants.<br><br>Additional detail relating to the recommendation of 3 hours of combined therapy has been provided in section 4.2. Therapy provided to individual patients should be tailored to individual needs and goals. |
| 29 | | National Imaging Academy Wales | E - definition of continuous would be helpful on the required services as workforce is such a challenge, both Radiographer and Radiologist, particularly for advanced imaging interpretation; 24 hour CT access is a given, but MR is a difficult ask and seems unnecessary from the remainder of the documentation (Acute stroke services should have continuous access to brain imaging including CT or MR angiography and perfusion when necessary and should be capable of undertaking<br>immediate brain imaging when clinically indicated.)<br>Recommendations - access to brain perfusion imaging and interpretation is a significant challenge.<br>Nil to add otherwise. | Thank you for this comment. 'Continuous' implies that such imaging modalities should be accessible 7 days per week where clinically required. |
| 30 | | United Kingdom Clinical Pharmacy Association | Agreed | Thank you for your comment. |

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| | | (UKCPA) | | |
| 31 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We welcome the clarity on definitions of the organisation of acute stroke services. However we wonder whether it is confusing to incorporate point c) a stroke rehabilitation unit providing inpatient rehabilitation only under the heading Organisation of acute stroke services. As there is a push to use more standardised terminology in respect to the timeline, acute there refers to just the first week. In practice, the acute wards are often seen differently from the rehabilitation wards and we query whether collectively grouping all these together aids confusion. This also applies when it says that acute services should be based in a hospital that can investigate and manage complications which doesn't apply to some off-site bespoke stroke rehab units. We suggest that perhaps the title for this section could just be Organisation of stroke services. This would bring things in line with Chapter 3 where acute does refer to the first few days only.<br><br>Additionally Line 255: We wanted to challenge whether we could really accept having a stroke rehab unit that cares "predominantly" for people with stroke? Should it not be for stroke patients only, to offer some protection to beds, especially with reconfiguration? | Thank you for your comments.<br><br>We have changed the title of section 2.4 to Organisation of inpatient stroke services<br>(replace 'acute' with 'inpatient')<br>We have also changed the title of section 2.5 Resources: inpatient stroke services<br><br>'Should predominantly care for people with stroke' aligns with the definition of stroke specialist care, which remains the same as 2016 as this was not under review for the 2023 update. It also allows for inpatient settings caring for stroke and neurology patients. |
| 32 | | Royal College of Physicians of Ireland Clinical Advisory Group | Recommendation E Agree – 24 hour access to these neuro imaging modalities is essential and requires funding<br><br>Recommendation I – 24 hours for TIA assessment at weekends – necessitates 7/7 stroke service with access to urgent imaging diagnostics at weekends also | Thank you for this comment<br><br>Thank you for this comment. The guidelines have been explicit that acute stroke care should be available 24 hours a day, 7 days a week [See Evidence to Recommendations 2.3] and this would include access to both brain and carotid imaging.<br><br>A new statement has been included within the 3.2 Implication section stating that patients with suspected TIA are assessed, and diagnosed urgently 7 days a week [Line 1103] |
| 33 | Q10. Section 2.5 Resources: acute stroke services | Royal College of Nursing | Agree with recommendation B. The RCN's Nursing Workforce Standards may be a useful addition here. These were designed in acknowledgement of there being no legislation in England for safe nursing levels, and that outside of bed based services numbers can be difficult to prescribe, so provides 14 areas to consider for safe, effective, well governed nursing practice. | Thank you for this suggestion. Whilst this is useful resource, it is beyond the scope of the guideline update to add additional information about nursing practice. The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group. |

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| | | | Agree with recommendations I, J, K, L, N and evidence to the recommendations.<br><br>Agree with implications. In recognition that there are tasks that could be done by unregistered staff perhaps the number of unregistered nursing staff in the WTEs could be higher. There could perhaps be an additional focus here on the implications to the patient if there is not sufficient access to specialist support, and the financial implications of extended dependence without timely intervention. | Thank you for your comment.<br><br>The Guideline Development Group endorsed an updated recommendation regarding staffing levels of registered staff on inpatient stroke units expressed as whole-time equivalents (WTE) in table 2.5. These recommendations take into account therapy delivered across seven days.<br><br>The evidence to recommendations section now suggests that these staffing levels are augmented by the use of support workers or therapy assistants. It is beyond the scope of the guideline update to add additional information about financial implications. |
| 34 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 35 | | British Psychological Society | We welcome the highlighted need for increased (neuro) psychology provision in stroke services.<br><br>It would be helpful to clarify the grade (banding) of psychology staff. This would need to be delivered by a qualified practitioner psychologists with specialist knowledge in stroke or neuropsychology (usually Band 8a or above).<br><br>The workforce numbers outlined in table 2.5 would benefit from being outlined as staff wte numbers by 100 referrals to the stroke units (rather than per 5 beds), to aid comparison to other workforce guidance papers and to support comparability consistency of workforce wte recommendations within this revised guideline (which described wte levels per 100 referrals later on in the document)<br><br>In our members' experience, psychology in acute services is often offered as a liaison service. It is important that this is not the case for stroke as an exclusive, imbedded psychology role on the ward is much more integrative, carrying out direct, indirect and systemic work. It would be good if this were explicit within the guidelines to create the best level of service for patients. | Thank you for your comment.<br><br>These are clinical guidelines that outline minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>The approach taken with regard to presenting WTE per bed aligns with the 2016 clinical guidelines on which recommendations are built.<br><br>Clinical neuropsychology/clinical psychology is listed as a core member of the multidisciplinary team |

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| | | | References to Clinical Psychology would be better with an inclusive title such as "Practitioner psychology" or "Registered Psychology". Although Clinical psychologists work in Stroke services, other domains of psychology, such as Counselling and Health, also work within stroke and could be inadvertently disadvantaged by this guidance. Neuropsychology is a specialist role with additional qualifications so it is correct to continue to be explicit about this service. We would be happy to liaise with you to help with the nuances of this if that would be helpful. | Clinical Psychology is a recognised term that was used in the 2016 guideline - it is important we remain consistent, – as the current update is a partial update. |
| 36 | | British Society of Physical and Rehabilitation Medicine ( BSPRM) | Response: B- Table 2.5 Recommended staffing levels: It should include a consultant in rehabilitation medicine leading twice weekly ward rounds in stroke rehabilitation units.<br>Recommendation J- A stroke rehabilitation unit should have a single MDT including specialist in: Rehabilitation medicine specialist is missing from the list of the members of Multi-disciplinary team. The stroke rehabilitation team should have a rehabilitation medicine specialist.<br>People with spinal cord stroke will require input from a spinal injury unit team.<br>Recommendation K: Please add A stroke rehabilitation unit should have access to a Consultant in Rehabilitation medicine with a weekly consultant led ward rounds.<br>Recommendation L: Stroke rehabilitation units with non-medical consultant leadership should have access to a Consultant in Rehabilitation medicine with a weekly session to support the team with difficult to manage patients such as those with agitated behaviour, complex cognitive impairments, uncontrolled seizures or pain, severe spasticity and difficult best interest decisions.<br>Rehabilitation Medicine consultants are also trained to deliver interventions such as botulinum toxin injections and peripheral nerve blocks.<br>Evidence to recommendations: Rehabilitation medicine specialists have skills and knowledge to assess, prevent and alleviate disabilities due to neurological illness. Their training differs from other medical specialists as the focus of training is on bio-psycho-social recovery They work within specialist multidisciplinary teams and practice rehabilitation medicine as their main activity. They have received specialist training and continuing education in rehabilitation. They are essential for management of patients with complex disabilities, such as those with more severe strokes, and younger patients needing support to return to high levels of function such as return to work and social/family roles. The evidence of role of rehabilitation medicine specialists and the value they add to stroke rehabilitation | Thank you for this comment.<br><br>Consultants in Rehabilitation Medicine are covered by the term 'Consultant level practitioner' in table 2.5.<br><br>We have now added access to Rehabilitation Medicine in Recommendation J.<br><br>It is beyond the scope of this guideline update and the evidence that was reviewed in the guideline process, to comment on Rehabilitation medicine specialists as outlined here. |

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| | | | is not considered in the current strategy. BSPRM request the GDG to reconsider this and include Rehabilitation medicine specialists as an integral part of the stroke team<br>References:. Turner-Stokes L, Williams H, Bill A, Basset P, Sephton K Cost-efficiency of specialist inpatient rehabilitation for working-aged adults with complex neurological disabilities: a multicentre cohort analysis of a national clinical dataset .BMJ Open 2016 http://doi.org/10.1136/bmjpoen-2015-010238 Turner-Stokes L, Dzingina M, Shavelle R, Bill A, Williams H, Sephton K Estimated Life-time savings in the cost of ongoing care following specialist rehabilitation for severe traumatic brain injury in the united kingdom. J head trauma rehabilitation 2019 http;//doi.org/10.1097/HTR.000000000000473.<br>Implications: Lack of expert rehabilitation medicine input for the stroke patients, especially those with enduring disabilities leads to increased patient morbidity in the longer term with higher burden of disability and loss of functional potential. Proactive medical management of complications of disability, sign-posting to appropriate specialist therapy teams and resources and longer term coordination of care and advocacy, in addition to the therapy are required, and are standard elements of rehabilitation medicine practice. This includes provision of rehabilitation prescription, spasticity management, administration of botulinum toxin injection, selection of patients for surgical interventions for foot drop and hand. Currently these patients are lost in the system and experience significant enduring disabilities which limit their participation in family life, society and vocation. Such joint working will require a much greater integration of specialist rehabilitation services and consultants in Rehabilitation Medicine with existing stroke services. This is particularly relevant to those areas of the country which do not currently have access to a Rehabilitation Medicine Consultant | |
| 37 | | Association of Clinical Psychologists UK (ACP-UK) | Table 2.5 – Recommended levels of staffing for hyperacute, acute and rehabilitation units lists psychology input at 0.28 wte per 5 beds. This recommendation is listed as being evidenced from observed staffing levels in London. Being based on observed staffing does not necessarily equate to what should be provided in order to provide comprehensive and holistic care to all patients. The whole-time equivalence figure for psychology is likely to equate to one qualified psychologist. This will mean no access to psychology when the member of staff is on leave (Annual, sickness, maternity).<br><br>How do these recommendations relate to the British Psychological Society guidance (2010 Stroke) that for a general district hospital with a catchment are of | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>These are clinical guidelines that outline minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications, which may include increased staffing if deemed |

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| | | | approximately 500,000 adequate staffing would be two whole time equivalent qualified psychologists and one whole time equivalent assistant psychologist?<br><br>The proposed recommendation for staffing is below what we consider is needed to provide sufficient staffing levels to meet all the needs of the recommendations in this guideline.<br><br>The staffing levels make no distinction for the provision to HASU/ ASU and stroke rehabilitation beds. Although psychology is needed across the patient pathway, it would be expected that increased provision is needed at the stroke rehabilitation bed, when people are starting to recover from cognitive difficulties or distress.<br><br>I, page 7, line 255 – clarification that patients with a diagnosis of subarachnoid haemorrhage should also be included on the stroke pathway<br><br>J, page 7, line 258 – a stroke rehabilitation unit should also have access to psychiatry or liaison psychiatry. Lack of access can result in patients having to be transferred back to acute care.<br><br>2.5 Implications page 9, line 342 – it is identified that qualified therapists should ensure time is available for clinical duties, however nowhere in the staffing recommendations does it have administration staff recommendations that are needed to support clinical staff | appropriate.<br><br>The suggested additions are beyond the scope of this guideline update and the evidence that was reviewed in the guideline process.<br><br>The following recommendation addresses the need for administrative management.<br>Section 2.5 Line 289 N Sufficient administration and management (including data management) support should be commissioned as part of the specialist stroke service. [2023]<br><br>There is also this text in the evidence to recommendations section.<br>Section 2.5 Line 333 Sufficient administrative and management support (including data management) is essential to the efficiency and governance of the core stroke unit team and should also be included. [2023]<br><br>Regarding clarification that patients with a diagnosis of subarachnoid haemorrhage should also be included on the stroke pathway – Subarachnoid haemorrhage is a recognised subtype of stroke and so this is tacit that the recommendation would apply to patents with this condition where applicable and appropriate. |
| 38 | | British and Irish Orthoptic Society | B<br>This table is really useful to support service planning. However, it would be vital to include the minimum staffing levels for orthoptists in a hyperacute unit, acute and rehabilitation units which are recommended in section 4.48. Orthoptists are the only profession listed as part of the stroke MDT in section 2.5 – J who are hospital based that are not included in the staffing levels table. It has to be recognised that not everyone will read the whole guideline but will hone in on tables like this. Therefore it is imperative that this table should provide the recommended staffing FTE for orthoptists alongside the other professions listed, so these vision services are not overlooked. | Thank you for these comments.<br><br>Staffing levels for orthoptists are referred to in section 4.48. The contents of table 2.5 was agreed through consensus by the Guideline Development Group. A footnote has been added to the table referring readers to section 4.48. |
| 39 | | Royal College of Speech and Language Therapists | Page 6, line 219 – The RCSLT believes this section is helpful, especially in terms of helping demonstrate the need for appropriate staffing levels. | Thank you for your comments and confirmation that this guidance aligns with recommendations in the RCSLT mapping exercise. |

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| | | | Staffing levels have been recommended for hyperacute and acute units. The RCSLT carried out an extensive mapping exercise looking at variation in the number of speech and language therapists per 10 beds and identifying best practice. Our recommendation is 1 speech and language therapist per 10 beds, or 0.5 speech and language therapists per 5 beds, which is broadly in line with the new Guidance.<br><br>Page 6, line 219 - The WTE of different professions is interesting. Currently, all therapies (e.g. OT and physio) are expected to deliver the same amount of therapy (45 mins daily) as per the guidelines. However, the Sentinel Stroke National Audit Programme (SSNAP) has shown that consistently, speech and language therapy does not hit this target and also does not operate a seven-day service across the majority of services. This indicates that speech and language therapy may need more resource. What is important to note is that the majority of stroke units across the UK have a speech and language therapy workforce below the recommended staffing level. The consequence is that the ability of speech and language therapists to meet the SSNAP, NICE and other national targets is seriously impacted. Work needs to urgently happen to bolster the speech and language therapy workforce to ensure all people with a communication or swallowing need post stroke can access vital speech and language therapy.<br><br>Page 6, line 219 – What is the rationale for not having therapy assistants as a separate entity as in the Fisher guidelines for ICSS? It is unclear as to what definition of stroke is used. The implication of this section is that the pipeline for registered staff recruitment needs to be considered due to availability of staff required for recommendations. It is concerning that without specifying assistant workforce there is a risk that skill mixing will go too far in the unregistered direction. This will dilute specialist skills. Recommendations for skill mixing are needed.<br><br>Page 6, line 219 – The RCSLT held two stroke study days with members to dive into the policy and practice realities of delivering stroke services across the country. We found that many stroke services across the country do not operate at the recommended speech and language therapy staffing level. At the study day we discussed the move to a 7-day service, which nationally speech and language therapists are struggling to meet compared to other allied health | Thank you for your comments suggesting that the majority of stroke units across the UK have a speech and language therapy workforce below the recommended staffing level. We hope that these guidelines can be used to highlight this in local efforts to address workforce challenges.<br><br>Table 2.5 outlines staffing levels of different disciplines of registered staff. This has been made clearer in the evidence to recommendations section.<br><br>These guidelines can be used flexibly as required by the local context, enabling the use of therapy assistants delivering rehabilitation under the supervision of a registered therapist.<br><br>For additional guidance we have stated that SSNAP data (2021-22) indicates that for suitable patients, up to a third of physiotherapy and occupational therapy is currently being delivered by unregistered rehabilitation assistants<br><br>It is beyond the scope of this guideline update to comment on AHP |

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| | | | professionals.<br><br>The therapy workforce recommendations need to be reviewed to account for a 7-day working week with achievable weekend rotas and skill mix. Also, rehab assistant interventions only come after qualified assessments – the majority of the work on hyperacute is qualified assessment. AHP job plans and case managers have not been mentioned but they also play a role and should be included in this. Furthermore, social work needs to reflect the different models of social services integration with acute - not always a dedicated social worker.<br><br>Page 6, line 219 – Recommended 'uplift' does not significantly increase staffing levels for speech and language therapy and will not help deliver gold standard therapy as expected by SSNAP. This uplift is not enough. Old recommendations Hyper Acute Stroke Unit (HASU) 0.81 per 10 beds – new ones 0.96 per 10 beds, Acute Stroke Unit (ASU) old – 0.81 per 10 beds and new – 1.12 per 10 beds. SSNAP data uses the calculation that 50% of patients are considered eligible for speech and language therapy. However clinical practice shows that speech and language therapists might see 85-90+% of patients on both HASU and ASU. These new figures account for a 7-day working week and non-clinical work.<br><br>Members continue to raise concerns about the scope of 'non-clinical' time, and their ability to deliver direct therapy (section 2.5). Members have suggested that band 7 have 40% of their working week as non-clinical and band 6 is 30%. It is important that there are adequate staff to allow full engagement with multidisciplinary teams (MDTs), including an increase in SLT staff. | job plans.<br><br>The following recommendation relates to 'non-clinical' time and support.<br>Section 2.5 Line 289 N Sufficient administration and management (including data management) support should be commissioned as part of the specialist stroke service. [2023]<br><br>There is also this text in the evidence to recommendations section.<br>Section 2.5 Line 333 Sufficient administrative and management support (including data management) is essential to the efficiency and governance of the core stroke unit team and should also be included. [2023] |
| 40 | | Association for Palliative Medicine of great Britain and Ireland (APM) | Need to add "A stroke rehabilitation unit should have access to specialist palliative care services to offer advice about direction of care, symptom control, emotional support to patients and their families, support care of the dying and rapid discharge to die at home for those who request it and to provide education and support staff in the core stroke MDT, ." Evidence for deaths on stroke units being poorly managed without SPC services; Cowey E, Schichtel M, Cheyne JD, Tweedie L, Lehman R, Melifonwu R, Mead GE. Palliative care after stroke: A review. Int J Stroke. 2021 Aug;16(6):632-639. doi: 10.1177/17474930211016603. Epub 2021 May 17. PMID: 33949268; PMCID: PMC8366189. | This is addressed for all stroke services in section 2.15. |
| 41 | | The Stroke Association | In reference to Recommendation J and lines 268-268, we welcome the inclusion of access to information, advice and support for people with stroke and their family/carers in the acute setting. However, we believe greater clarity on who | Thank you for these comments.<br><br>To ensure life after stroke services are highlighted we have added |

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| | | | could provide this should be included in this guidance to enhance clinicians' ability to implement the recommendation. This is part of the life after stroke service offer; as stated in the NSSM, 'LAS services should be available to all people affected by stroke from the very acute phase onwards'. | the following in relation to disciplines and services patient should have access to.<br>'life after stroke services providing information, advice and support for people with stroke and their family/carers. [2023]' |
| 42 | | Northern Ireland Stroke Network | Recommendations:<br>J – Are Orthoptics required as part of a core rehabilitation unit team? Rehabilitation units should have timely access to orthoptic services, if not core team component<br><br>N - include 'The administration/ data management staffing compliment should be such to minimise time requirement for registered staff to support this'<br>Evidence<br>It would be helpful if evidence review could clarify (where possible) the evidence base for different types of stroke unit. | Thank you for these comments.<br>Section 2.5 J – Orthoptists are listed as members of the multidisciplinary team<br>Recommendations for administrative support is already addressed: Section 2.5 Line 289 N Sufficient administration and management (including data management) support should be commissioned as part of the specialist stroke service. [2023]<br>It is beyond the scope of this guideline update to discuss the evidence base for different types of stroke unit. |
| 43 | | Scottish Intercollegiate Guidelines Network | The RCPE supports these recommendations and agrees that these will require a considerable increase in the provision of some specialties in stroke services. | Thank you for these comments.<br><br>We acknowledge the challenges presented by the current workforce issues. |
| 44 | | British and Irish Association of Stroke Physicians (BIASP) | P6 table 2.5. WTE Table - a non-consultant doctor WTE must be incorporated as essential team members and documented within the WTE table. Also, the requirement for 24:7 medical on call cover. Similarly, admin is crucial and again a specified WTE would be optimal.<br><br>P6 table 2.5. It's good to see the table of recommended staffing levels in there: it would be helpful if that could include something for junior/middle grade doctor cover as well +/- nurse practitioners/physicians associates?<br><br>P 7 line 270. Recommendation K – we recommend change to "minimum" of twice weekly ward rounds.<br><br>The recommendations in this guideline update have substantial implications for workload at a time of workforce crisis. This is a comment that is pertinent to the whole guideline. | Thank you for your comments.<br><br>The recommended staffing levels and scope of table 2.5 was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>Following editorial review the text was considered sufficient and not amended |
| 45 | | NIMAST | Do the whole time equivalent workforce numbers reflect the recommended increase in AHP input to minimum of 3 hours per day? | Thank you for these comments. |

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| | | | | The Guideline Development Group endorsed an updated recommendation regarding staffing levels of registered staff on inpatient stroke units expressed as whole-time equivalents (WTE) in table 2.5.<br><br>These recommendations take into account therapy delivered across seven days. Achieving the recommendations in section 4.2 Rehabilitation and Recovery – Intensity of therapy will also require the use of unregistered support workers and rehabilitation assistants delivering rehabilitation under the supervision of a registered staff. |
| 46 | | Irish Association of Physical and Rehabilitation Medicine | There is no mention of the benefit of referring patients to specialist neurological rehabilitation especially those with severe disability and those with profound disability (e.g. Locked-in Syndrome).<br>Evidence - "Rehabilitation services Medical rehabilitation in 2011 and beyond" Report 2010 - Nov A joint report between the Royal College of Physicians and the British Society of Rehabilitation Medicine | Thank you for these comments.<br><br>We have added Rehabilitation medicine to the list of disciplines to which patients should have timely access to. |
| 47 | | British Dietetic Association | Page 6, line 219 (Table 2.5):<br><br>Pleased to see dietitian staffing recommendations increased from levels recommended in the 2016 guidelines, reflecting the growing recognition of the importance of nutrition and hydration in acute stroke care. I note that the 2023 version states that 'WTE figures include non-clinical time (such as supervision and CPD) as well as non face-to-face clinical activity. Does the increase from 0.15 to 0.21 per 5 beds represent an actual increase in staffing recommendations, or just in recognition of the addition responsibilities above? The BDA paper that the 0.15wte was taken from for the 2016 guidance was very old and from before the hyperacute / stroke unit model. Is there greater dietetic input needed on acute stroke unit & stroke rehabilitation unit rather than HASU as per PT, OT, SLT? For example, Dietetic time in the support of consideration for long term enteral feeding including MDT meetings and family discussions, patient education, handover of care to community teams etc is likely to be time consuming on acute stroke unit / stroke rehabilitation unit and therefore require increase in dietetic time.<br><br>BDA Safe Staffing, Safe Workload recommendation for patient contacts in acute | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>The updated recommendations are an increase in staffing levels. Recommended staffing levels in the 2016 guideline also included non-clinical time.<br><br>These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>The evidence to recommendations section clarifies that these recommendations take into account therapy delivered across seven days.<br><br>We have amended text in section 2.5 evidence to recommendations to clarify recommendations in table 2.5. |

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| | | | setting: "The safe number of patient contacts (new and follow up) in the acute setting per W.T.E per week is likely to be 36**. To allow for 20% absence, over a year this figure would average out as 29 per week and equates to an average of 1498 contacts per dietitian per year." (https://www.bda.uk.com/uploads/assets/53c343b0-c925-4513-a5d6d08b9b24ba2a/Safe-Staffing-Workload-Guidance.pdf) It is likely that dietetic consultations with patients requiring additional support with communication etc may take longer and stroke survivors may need more regular reviews than patients in a different acute clinical setting to e.g. due to changes in swallow recommendations etc.<br><br>It would be useful to include banding guidance for WTE for service delivery including number of staff required to safely manage caseload and development. This is currently variable across the country and impacts on level of care provided.<br><br>Staffing levels per WTE based on beds on hyper-acute, acute and rehabilitation units, however in some hospitals stroke specialist Dietitians are caring for patients with diagnosed stroke not on a specialist stroke unit. Suggestion whether staffing levels could these be considered per diagnosed stroke?<br><br>The consensus from the feedback from Dietitians on behalf of the BDA was a further increase in staffing recommendations would be welcomed to support the provision of specialist dietetic care throughout stroke survivors journey in both acute and community care settings.<br><br>Page 8, line 324:<br><br>Table 2.5 is not clear whether these WTE recommendations are based on 5-day or 7-day service. Evidence to recommendations suggests this is based on 7 day working. Suggestion for this to be made clear in table 2.5.<br><br>Page 8, line 330-332:<br><br>A significant increase in WTE required to deliver specialist care over 7 day working. E.g. 1 WTE for 30 bedded unit based on recommended staffing levels would be unfeasible for 7 day working. | The Guideline Development Group endorses an updated recommendation regarding staffing levels of registered staff on inpatient stroke units expressed as whole-time equivalents (WTE) in table 2.5. These recommendations take into account therapy delivered across seven days. |

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| | | | Consensus from Dietetic feedback meeting was that current staffing recommendations are insufficient to provide specialist dietetic cover, particularly if looking at 7 day service. | |
| 48 | | Wales Stroke Allied Health Professional Forum | AGREE and rare that there is sufficient therapy space within the acute (and often rehab) stroke setting<br>It would be helpful if admin support including data management staffing was listed as a minimal staffing requirement with appropriate banding. Band 3 perhaps<br>The WTE increase for therapy staffing still does not seem high enough to be delivering the expected 3 hours of therapy daily.<br>How will 3hours/day of direct therapy and the 6 hour/day of activity be measured? Given that most services fail to deliver 45 minutes it feels over-ambitious with regards to the staffing levels outlined in 2.19. Despite working efficient/group work etc. it's still a big ask on a small resource who also have non-clinical, workforce-based commitments.<br>3 hours of combined therapy – if a patient only has physio needs does this mean physio need to deliver 3 hours every day? Not possible with staffing resource given. | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>Table 2.5 outlines staffing levels of different disciplines of registered staff. This has been made clearer in the evidence to recommendations section.<br><br>These guidelines can be used flexibly as required by the local context. The evidence to recommendations section now suggests that these staffing levels are augmented by the use of support workers or therapy assistants delivering rehabilitation under the supervision of a registered therapist to achieve the intensity and dose of therapy recommended in section 4.2 Rehabilitation approach – intensity of therapy.<br><br>For additional guidance we have stated that SSNAP data (2021-22) indicates that for suitable patients, up to a third of physiotherapy and occupational therapy is currently being delivered by unregistered rehabilitation assistants.<br><br>These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>The following recommendation highlights the need for admin support.<br>Section 2.5 Line 289 N Sufficient administration and management (including data management) support should be commissioned as |

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| | | | | part of the specialist stroke service. [2023] |
| 49 | | National Imaging Academy Wales | This is worthwhile, but I wonder if there has been any calculation on the implication of the WTE Radiologist/Radiographer or equivalent for the suggested increased imaging capacity required to achieve the numbers for all queries regarding stroke. This would be useful for education and workforce planning for robust and sustainable service provision. | Thank you for these comments.<br><br>It is beyond the scope of this guideline update and the evidence that was reviewed in the guideline process, to comment on WTE of Radiologist/Radiographer. |
| 50 | | United Kingdom Clinical Pharmacy Association (UKCPA) | B- inclusion of specialist pharmacists for hyperacute stroke units and stroke units. HASU beds are level 2 monitored high dependecy beds, so as per specialist pharmacist staffing - atleast band 8a 0.1wt per 2 level2 beds e.g so for 20 HASU beds = 1wt band 8a pharmacist (https://ukclinicalpharmacy.org/wp-content/uploads/2017/07/Core-Standards-for-ICUs.pdf )<br><br>J- include specialist pharmacist not just pharmacy | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development group.<br><br>Timely access to 'specialist' pharmacy has now been included. |
| 51 | | The British Association of Prosthetists and Orthotists | At BAPO we see the provision of orthotic services as key to assisting early mobilisation and aiding the rehabilitation guideline. Without acknowledging this in the staffing levels expert orthotic provision will be omitted.<br><br>Orthotic provision should be assessed for and provided at this early stage and discussed and facilitated by an MDT. We see an orthotist as a key member of the MDT and not a timely access (Golding-Day, Walker, Whitehead. Orthotic intervention following stroke: a survey of physiotherapist, occupational therapist and orthotist practice and views in the UK. Int J Ther Rehabil. 2022;29(6). | Thank you for these comments.<br><br>Timely access to orthotics services is recommended.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>The source identified is a survey of practice rather than staffing levels. |
| 52 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We recommend the focus on leadership and culture and wish to emphasise that there also needs to be a bottom-up approach, not just a top-down approach as highlighted in Turner et al 2016. This will require strong MDT leadership to encourage this so that all working on the stroke unit is able to ensure they deliver the best care.<br><br>Whilst we welcome the inclusion of consultant-level practitioner ward rounds, we query how come this level of practitioner has not been included separately in the staffing levels especially as these roles have a strong rehabilitation focus.<br><br>Whilst we welcome the recommendation around staffing levels in table 2.5 and are encouraged by the review of the recommended levels of staffing for inpatient services (table 2.5).: We strongly urge greater transparency about how these figures were calculated. The lack of transparency around calculating these levels | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>The figures from the previous 2016 guideline have been uplifted to reflect a 7 day service.<br><br>Table 2.5 outlines staffing levels of different disciplines of registered staff. This has been made clearer in the evidence to recommendations section. |

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| | | | hinders the discussion and detracts from ensuring best care. The physiotherapy staffing recommendation is lower for a hyperacute unit given the work involved in new patient assessments, early mobilisation and a potential increased need for respiratory physiotherapy. It looks like the figures from the previous 2016 guideline have been uplifted to reflect 7/7 rather than 5/7 service cover, but the recommendations are otherwise unchanged. The clarity around what is included (i.e. non clinical activity) and that these figures include rehabilitation assistant time is helpful - as this had been missing previously.<br><br>We query whether any work has been done to ensure that these recommendations are sufficient to deliver the new recommendations on rehabilitation intensity? Having adequate workforce is integral to achieving the intensity recommendations, and there is a missed opportunity if this is not addressed within the guideline.<br><br>Table 2.5 – Staffing levels – Within clinical practise in a large teaching hospital the old RCP recommendations for 5 days were utilised with an interpretation that this was purely for qualified staff and did NOT include supervision, and non-clinical time. Within clinical practice through benchmarking and establishment reviews over the last 3 years, the impact of these new guidelines will reduce our staffing levels despite the expectation that they are for 7 days of intervention. SSNAP records face-to-face time in line with this interpretation. The new guidelines should exclude non-clinical/supervision time and should exclude non-qualified staff numbers. It is recognised within a large teaching hospital that non-clinical time allocation is dependent on grade and this is locally driven. If non-qualified staffing levels and non-clinical time are to be a part of the guidelines the levels should be significantly increased.<br><br>The implications section 2.5 : Patterns of work need to be reviewed to deliver sufficient direct therapy by removing some administrative duties and ensuring that time is not spent by registered therapists on tasks that could be done by unregistered staff, is at odds with the recommended staffing levels and lack of skill mix for physiotherapy as identified above.<br><br>The need for protected time for staff to remain skilled to the required specialist level is important to ensuring best practice is implemented. Currently reports from physiotherapy teams based on hyper-acute, acute and rehabilitation stroke | These guidelines can be used flexibly as required by the local context. The evidence to recommendations section now suggests that these staffing levels are augmented by the use of support workers or therapy assistants delivering rehabilitation under the supervision of a registered therapist to achieve the intensity and dose of therapy recommended in section 4.2 Rehabilitation approach – intensity of therapy.<br><br>For additional guidance we have stated that SSNAP data (2021-22) indicates that for suitable patients, up to a third of physiotherapy and occupational therapy is currently being delivered by unregistered rehabilitation assistants. |

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| | | | units indicate that this isn't possible due to short staffing. Often units are very dependent on agency staff which dilutes the specialism of the units. Whilst welcome the suggestion that patterns of work would need to be reviewed, would this consideration also apply to the working patterns of staff such as speech and language therapists? Physiotherapists are reporting that some units do not have funding for weekend or bank holiday SLTs which impacts care even if the staffing levels are considered adequate.<br><br>The use of clinical data demonstrates that at least 50% of non qualified time is utilised to work alongside qualified therapists in treating heavier patients requiring 2 or more therapists to treat. We strongly recommend that non qualified staffing levels should be set separate to qualified levels. Including them under the therapy specific areas will lead to a decrease in the number of qualified therapy staff. This indicates a lack/decreased of recognition and insight into the skills, abilities and contributioin of physiotherapy staff. We strongly urge the consideration of a specified ratio of qualified to non-qualified physiotherapy staff similar to the nursing staffing to help ensure adequate skill mix? | The only available data is observational data from SSNAP. The Guideline Development Group did not wish to go beyond the existing amended uplift for transition from 5 to 7 days, plus a description of the observational data. |
| 53 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | As part of the resources, it would be helpful to include the ability to take part in or support research studies for all staff.<br><br>Could examples be provided of the sorts of roles that are suitable for Rehab Assistants/ unregistered staff, with suitable training? In practice, the remit of the RA and relevant competencies vary significantly across services. Some standardisation or direction around suitable tasks would support those services who are not close to 30% of therapy being delivered by unregistered staff. e.g., admin tasks/ onward referrals/ completing cognitive screening, blood pressure readings? e.g., providing and assessing with equipment?<br><br>Are there further recommendations on how social work provision would be provided in a Community Neuro Rehab Service? Challenges on the ground are that Social Workers are primarily employed by social services/ council services not NHS. Do you propose/ suggest SW would be employed by NHS and sit directly within the CNRS service? If so, how would they access supervision and support from peers? Would an in-reach model from a social service employed social worker meet the needs of this patient group? In many cases, NHS and social services do not use the same computer systems. This makes communication, information sharing, and joint working more difficult. More | Thank you for your comments<br>We have added 'Take part or support research' in section 2.18<br><br>This detail is beyond the scope of the current guideline update and the evidence that was reviewed.<br><br>It is beyond the scope of the guideline, and the evidence reviewed, to provide details about how services are provided as suggested here. These guidelines should be used with an understanding of the local context to inform more detailed service specifications and models of working across health and social care. |

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| | | | specific guidance on how this recommendation should be achieved would help local systems and service managers to look at improving systems/employment contracts as this is not something an individual CNRS service could likely implement themselves.<br><br>B- make title clearer to include 7 day working | Nursing and medical staffing levels have always referred to 7 days. For specifying the 7-day therapy staffing levels, this has been added to the footnote*. |
| 54 | | Irish Heart Foundation, Council on Stroke | All<br>Table 2.5.Acute and Rehabilitation units are merged together. The distinction is unclear.<br>Patients in rehabilitation units may require more therapy in many cases and may be in a fitter state to receive more prolonged therapy than those in an acute unit..<br><br>Nursing<br>No distinction is made between the different in nursing e.g. ANP or CNS and the number of patients they may be assigned to.<br>SLT<br>p.5 L205: The culture and tone "from the top" reflects a style less reflective of current interdisciplinary and MDT models of person-centred care. There is risk that this language undermines the ethical responsibility of autonomous HSCPs. SLTs for example cannot "plead higher" in a fitness to practice case. As CORU (Irelands multi profession health regulator) Registered professionals, holistic and compassionate care is a core element of our professional and ethical responsibility re; conduct, performance, and ethics - per CORU Code of Ethics (2019).<br>IASLT suggests that the language in the Implications section be ameliorated to be more inclusive of and professionally respectful to HSCPs. HSCPs are skilled, autonomous, registered professionals (CORU Codes of Professional Conduct and Ethics, 2019).<br>IASLT recommends reviewing and updating the evidence underpinning staffing recommendations and allocation of 45 minutes of SLT input only for patients with multiple (non-overlapping) impairments requiring SLT input for communication and swallowing. Communication is the essential medium through which people direct their own care. SLTs play an important role in ensuring people with acquired communication disabilities can be involved in informed | Thank you for your comments. Recommendations for the provision of inpatient stroke rehabilitation services are featured in section 2.5. The Guideline Development Group endorsed an updated recommendation regarding staffing levels of registered staff on inpatient stroke units expressed as whole-time equivalents (WTE) in table 2.5. Specific types of stroke rehabilitation unit involved will vary across nations and be dependent on local context.<br><br>These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding. The evidence to recommendations section now suggests that these staffing levels are augmented by the use of support workers or therapy assistants.<br><br>Reference to culture and tone relate to the organisational culture and leadership, rather than individual practice.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group. The Guideline Development Group endorses an updated recommendation regarding staffing levels of registered staff on inpatient stroke units expressed as whole-time equivalents (WTE) in table 2.5. These recommendations take into account therapy delivered across seven days. Achieving the recommendations in |

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| | | | decision making and enabled to direct their own care, which is their human and legal right ICP (2022), Assisted Decision Making and Capacity Act (2015) which is due to commence in 2023 and Decision Support Service (2020).<br><br>Historic staffing recommendations in the Irish context refer to the context of a 5/7 working week across all Stroke units for SLTs. If the recommendation is to progress to 7/7 SLT staff cover - then staffing figures will need to be amended to reflect same.<br><br>It should also be noted that for HSCPs non face to face clinical time extends beyond activities of supervision and CPD so perhaps these should not be named in isolation.<br>IASLT appreciates that much SLT work in a Hyperacute stroke unit is in keeping with a Clinical Specialist grade.<br><br>IASLT additionally note the following: The existing RCP guidance that all stroke patients should have access to swallow screening within first 4 hours of their admission and prior to commencing oral intake, and the continued expansion of swallow screening services across units and working hours, is likely to continue to generate increasing volumes of urgent referrals for SLT swallow assessment. These referrals are often for people who are nil by mouth and require urgent SLT assessment to allow safe management of nutrition, hydration and medications. Extending swallow screening services without sufficient SLT staffing to meet the referrals generated by the screening presents a clinical risk.<br><br>Furthermore, the RCP guidance that people with stroke with suspected aspiration or who require tube feeding or dietary modification should be considered for instrumental assessment (videofluoroscopy or fiberoptic endoscopic examination of swallowing has implications for SLT resource in terms of staffing, training needs, and equipment needs, and these demands must be reflected in staffing ratios.<br><br>Dietetics<br>The staffing ratio here for dietetics is wholly inadequate at 0.21/5beds.<br>There is little evidence behind staffing figures quoted. This ratio for dietetics does not reflect the complex hyperacute, acute and rehabilitation needs of the stroke population covering dysphagia management, malnutrition support, enteral | section 4.2 Rehabilitation and Recovery – Intensity of therapy will also require the use of unregistered support workers and rehabilitation assistants delivering rehabilitation under the supervision of a registered staff.<br>Section 4.2 Rehabilitation and Recovery includes updated guidelines on the intensity and dose of recommended therapy.<br>Section 4.26 Swallowing has also been updated.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group. The main justification for increased therapy staffing levels (intensity and |

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| | | | feeding both acute and medium to longer term interventions in the post-acute period i.e. PEG & RIG, and the often complex co-morbidities that stroke patients have requiring dietetics intervention i.e. AKI, CKD, Diabetes.<br>Of note, the National Stroke Strategy 2020-2025 made recommendations for all HSCP members with specific recommendations for each hospital. Overall, the recommended dietetic staffing for acute stroke care was 0.37 WTE per 5 beds. This is<br>significantly different to the recommended staffing levels in this document. Paired with these guidelines suggesting intervention time be increased above the minimum of 45 minutes, a staffing level of the suggested 0.21/5 beds in this document would prove a high risk for patient safety. We would suggest that as a minimum the staffing figure be set at as per the Irish National Stroke Programmes 2019 Recommendations for the Management of Nutrition and Hydration in Patients with Stroke – A Guidance Document " 0.71 Senior WTE dietitian/10acute beds. Due to the mixed hyper acute, acute and rehab nature of units in Ireland it is expected that a higher staffing ratio would be required to implement the various nutritional interventions across the stroke journey.''<br>Evidence to recommendations<br>The document states that 'staffing recommendations also include non-clinical time (such as supervision and CPD) as well as non-face-to-face clinical activity such as environmental visits, family contact and equipment ordering.....'.<br>Sufficient administration and management support (including data management ) is essential to the efficiency and governance of the core stroke unit team and should also be included (2023).<br>Comment:<br>From experience as senior dietitians in acute and rehabilitation stroke at the staffing ratio outlines in the document for dietetics this will not allow for any of the above to be undertaken, the entire time commitment will be taken over by the limited direct patient care and no time for non-clinical or non-patient direct contact. This would encompass educating families and carers on optimising modified diets and nutrition support o discharge, attending care planning meetings, organising and undertaking patient and family education and training on home enteral feeding pre discharge. All these tasks are undertaken by the dietitians in Ireland. This may result in dietitians will not be able to prioritise care meaning that some clients will not receive optimal care impacting their recovery, i.e., oral dysphagia management, oral nutrition support and management of co-morbidities will be deprioritised over enteral nutrition support. (This may differ | dose) is explained in the evidence to recommendations section. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate. |

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| | | | from the UK if tasks are undertaken by others)<br><br>Implications<br>The staffing ration outlined for dietetics will not only negatively impact patient care (direct and indirect) but also make the post unattractive and recruitment difficult. The staffing ration outlines, if followed would make it impossible to meet the dietetic interventions recommendations in this document and would prove a significant risk to patient care.<br><br>Physiotherapy<br>Staff required for acute and rehabilitation beds are not the same.<br><br>Occupational Therapy<br>Table 2.5 need to specify whether these figures relate to 7 day service?<br>Why specify staffing levels for HASU and ASU/SRUs here and not ESD teams and community stroke teams.<br>Need to include a recommendation for MSW and Therapy Assistant posts.<br>Staffing levels should not be the same across hyper acute, acute and rehabilitation stroke unit, greater Medical and nursing input needed in hyper acute units, but greater therapy cover is needed in sub-acute and rehabilitation units – the needs of the stroke patient are not the same across all three levels of service and recommendation re staffing need to reflect this.<br>What is the rationale for a lack of parity between OT and PT staffing? All patients with a confirmed stroke require OT input and any stroke survivor with physical impairments are going to experience an impact on their ADL. In addition, OTs are involved with stroke survivors with non-physical impairments related to cognitive, visual, perceptual and psychological functioning.<br>Figures for therapy need to be revised upwards – how effectively can PT, OT, SLT, Dietetics, & Psychology provide adequate cover to stroke patients over 7 days when most are staffed at less than one full time equivalent/5 beds and most HASUs have 5 beds.<br>WTE of 1.18 PT, 1.13 OT, 0.56 SLT, 0.28 Psychology, and 0.21 Dietetics per 5 beds would seem completely inadequate to provide 7 day service.<br>Terminology – in Republic of Ireland Health and Social Care Professions (HSCP) is the collective grouping name that includes the therapies, this terminology should be reflected in the guidelines. | Specific types of stroke rehabilitation unit involved will vary across nations and be dependent on local context.<br>The figures from the previous 2016 guideline have been uplifted to reflect a 7 day service.<br>Staffing levels for community stroke teams are provided in Section 2.8<br><br>Table 2.5 outlines staffing levels of different disciplines of registered staff. This has been made clearer in the evidence to recommendations section. The evidence to recommendations section now suggests that these staffing levels are augmented by the use of support workers or therapy assistants delivering rehabilitation under the supervision of a registered therapist to achieve the intensity and dose of therapy recommended in section 4.2 Rehabilitation approach – intensity of therapy. For additional guidance we have stated that SSNAP data (2021-22) indicates that for suitable patients, up to a third of physiotherapy and occupational therapy is currently being delivered by unregistered rehabilitation assistants. |

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| | | | Clinical Psychology<br>Table 2.5: WTE increase for Clin Psych / Neuropsych from 0.28 from 0.2 per 5 beds across acute/rehab services: while any increase is welcome, this is wholly inadequate for inpatient rehabilitation, especially for Level 1 rehab services with the highest complexity of patient need. The British Society for Rehabilitative Medicine guidelines have since 2009 recommended an absolute minimum of 1.5 to 2 WTE clinical psychologists per 20 beds, depending on level of complexity, so almost double this rate for high complexity rehab. In both brain injury and complex stroke rehabilitation, the psychologist is required to address mood and cognitive (complex neuropsychological assessment and rehabilitation), behaviour support, family support, mental capacity questions, etc.<br>Also, since Ireland's stroke strategy differentiates levels of rehabilitation service, it is inappropriate to provide one figure for acute and all types of rehabilitation service.<br>342: This does actually not represent a significant increase since previous document, although undoubtedly many services haven't yet achieved the 2016 benchmark.<br>437: ESD: The specified WTE for disciplines is welcome. Can't speak to the appropriateness of this rate, but since ESDs also carry higher proportion of 'walking wounded' patients with minimal physical impairments but potentially disabling higher level cog/comm deficits that are a barrier to work and relationships and would benefit from greater psychology input<br><br>Medical Social Worker<br>There should be a mention of interdisciplinary work rather than just multi-disciplinary. Stroke specialised HSCP teams in Ireland are working from an interdisciplinary way of working also and this should be reflected in the clinical guidelines.<br><br>Table 2.5.<br>It is extremely disappointing to see no Medical Social Work included on the recommended staffing levels for hyper-acute stroke unit, acute stroke Unit and stroke rehabilitation.<br>Medical social workers essential members of the stroke MDT and are skilled to assist with adjustment to illness/disability, providing emotional support, assistance with alcohol reduction, carer advice and support, assisting with practical matters (financial issues, accessing necessary community supports) and | The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>These guidelines can be used flexibly as required by the local context.<br><br>Section 2.8 - Community stroke rehabilitation. This section outlines minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications, which may include increased staffing if deemed appropriate. |

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| | | | assisting in crisis intervention. Medical social workers are often pivotal in coordinating a safe discharge for the stroke survivor and coordinating the necessary services for this. We recommend that Medical Social Work is accurately represented and included on staffing level recommendations for Hyper acute unit, Stroke unit and for rehabilitation.<br><br>Medical<br>Lines 322-335.smaller rehabilitation units may not be able to provide a 7 day therapy service | Discussion relating to interdisciplinary working was beyond the scope of the current update of this section of the guideline.<br><br>Section 2.5 Recommendation J states that A stroke rehabilitation unit should have a single multidisciplinary team including specialists in: - and lists Social Worker.<br><br>The following paragraphs are included in Section 2.5 Evidence to recommendations section<br>"An understanding of the local context, together with these recommendations, will be required to inform more detailed service specifications (including banding) which may include increased staffing if deemed appropriate".<br><br>"Units with a small bed base may need to consider revisions to these staffing levels to ensure adequate registered staffing cover across the week, taking account of rotas and days off for weekend working". |
| 55 | | Royal College of Physicians of Ireland Clinical Advisory Group | Agree – needs to be fully staffed – a long way to go – if we agree , what is implication /funding<br>In Ireland safe staffing levels have been introduced do not include hyperacute stroke units | Thank you for your comments. Discussion about funding implications is beyond the scope of the guideline update.<br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline development group. These guidelines should be used with an understanding of the local context to inform more detailed service specifications. |
| 56 | Q11. Section 2.8 Transfers of care from hospital to home: community stroke | Different Strokes | I would like to see more in here about linking with the voluntary/community sector. Voluntary/community sector organisations provide support to stroke survivors and these services can complement statutory services, but there is little here that references this. The Different Strokes 2022 beneficiary survey showed that only 20% of respondents had heard about Different Strokes from a | Thank you for these comments and we agree that joint working with the voluntary / community sector is important.<br>The updates made in this section reflect the evidence reviewed in relation to specific questions included in this partial guideline update process. |

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| | rehabilitation | | healthcare professional so I believe that more needs to be done to improve such links. | Addition to G – 'collaboration' and 'the voluntary sector' |
| 57 | | Royal College of Nursing | Agree with all recommendations.<br>For F should there be consideration of the role of nursing support workers? Perhaps include this where it states rehabilitation assistants.<br>Agree with evidence for the recommendations. Perhaps there needs to be acknowledgement that there can be a delay and shortage in achieving social care packages which can delay discharges. Stroke care needs to be planned and commissioned appropriately across health and social care provisions | Thank you for these comments.<br>We have added to section 2.5 evidence to recommendations, and included reference to support workers:<br><br>The Guideline Development Group endorses an updated recommendation regarding staffing levels of registered staff on inpatient stroke units expressed as whole-time equivalents (WTE) in table 2.5. These recommendations take into account therapy delivered across seven days. Nursing support workers are included in the table as unregistered staff. Achieving the recommendations in section 4.2 Rehabilitation and Recovery – Intensity of therapy will also require the use of unregistered support workers and rehabilitation assistants delivering rehabilitation under the supervision of registered staff. |
| 58 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 59 | | British Psychological Society | Recommendation A – In our member's experience, in some areas ESD exists without an established neuro rehab team. In some cases the budgets are for certain services and service specifications rather than being seen as a whole pathway model. If the document could separate out these different parts particularly in terms of workforce planning it would again help as a guide and make it clear for those commissioning services. For example workforce in 1. Acute setting. 2: ESD (based on time up to 6weeks post stroke) 3. Neuro community (based on need) 4. Nursing home.<br><br>Recommendation D - the intensity aspect of therapy can include self directed activity. The intensity of input is very much determined by the clinicians and based on meeting goals and is a mixture of face to face, phone and self directed therapy. This could be made clearer. (Please also note typo "be provide")<br><br>Recommendation E – it would be meaningful to include close family in these discussions too as appropriate. It is recommended that family are involved in rehab planning later when discussing rehabilitation (Rec B, p49) so this would be | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was based on the research evidence reviewed and agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>These are clinical guidelines that outline staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>Rehabilitation intensity is discussed in section 4.2 Rehabilitation approach – intensity of therapy.<br><br>E 'and their family/carers' has been added |

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| | | | useful for consistency<br><br>Recommendation F - Whilst it is appreciated that there is significant variation in psychological staffing within community stroke, the recommended levels are not sufficient to incorporate the work of a psychologist highlighted and recommended in later sections of the guidance. These workforce recommendations ignore the professionally endorsed workforce recommendation levels that were advised within the National Stroke Programme.<br><br>It is also concerning that the skill-mix is not better defined. Assistant Psychologists cannot work independently in a team without a qualified Practitioner Psychologist. Rehabilitation assistants are not included within recommended therapies staffing establishments and it is unclear why assistant psychologists are considered differently.<br><br>We recommend a 0.4 wte practitioner psychologist (with established neuropsychological expertise) Band 7-8b per 100 referrals; plus 0.2wte band 4-6 assistant psychologist/ associate psychological practitioner/ clinical associate psychologist per 100 referrals; plus necessary clinical supervision and clinical leadership from a consultant psychologist (neuropsychology specialist) (British Psychological Society, 2022).<br><br>Line 440-441: The recommendation for timely access to IAPT and community mental health services needs to be qualified. The national IAPT curriculum used to train IAPT therapists does not cover the brain, stroke, the psychological impact of stroke or the evidence base for psychological therapies after stroke, which does not support CBT (the main intervention provided by IAPT) that has not been augmented to take stroke into account. To include IAPT or community mental health services in this recommendation it would need to be qualified to: Appropriate administration and management (including data management) support with timely access to: psychological and neuropsychological services (e.g. including input from therapists within Improving Access to Psychological Therapies [IAPT] and community mental health services who have received stroke-specific training and who have supervision from a Clinical Neuropsychologist or Stroke Specialist Practitioner Psychologist". | The recommendation staffing levels (including those relating to psychological staffing) align with NHS England policy.<br><br>Thank you – the typo has been corrected.<br><br>We have added 'with stroke-specific training and appropriate supervision' in relation to access to IAPT and community mental health services<br><br>It is beyond the scope of this guideline update and the evidence |

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| | | | Recommendation M: In addition to the medical diagnosis, patients should be provided with a comprehensive and integrative formulation about the nature of their stroke. A formulation goes beyond a diagnosis to include the sharing of the understanding of the impact of the stroke on brain functioning, and neuro-psychological processing, which may have led to residual neuro-cogntive symptoms, psychological dysregulation and other psycho-social adjustment factors. This means that the person has a much greater understanding of their condition.<br><br>Evidence to the recommendations<br>Substantial evidence and recommendations collated through the national stroke programme rehabilitation and workforce workstreams have been ignored in reaching these recommendations outlined in the paper for psychology; ignoring practice-based evidence and professional consensus recommendations in doing so.<br><br>Line 550 - 554: We would also recommend consideration of carer wellbeing alongside training needs. Caregiver "burden" is a known issue for some caring for people with stroke, and a developing literature highlights impacts of neuropsychiatric symptoms on caregiver wellbeing and consequent effects on the cared-for individual. Isik et al.'s (2019) paper is useful illustration in Alzheimer's, for example, and is worth consideration given overlap in some symptoms.<br><br>British Psychological Society (2022) Recommendations for integrated community stroke services. Leicester: Author. Available at: Recommendations for integrated community stroke services \| BPS<br>Isisk, A, T., Soysal, P., Solmi, M. and Veronese, N. (2018) Bidirectional relationship between caregiver burden and neuropsychiatric symptoms in patients with Alzheimer's disease: A narrative review. Special Issue: Treating neuropsychiatric symptoms of Alzheimer's disease: An update Volume34, Issue9, Pages 1326-1334 https://doi.org/10.1002/gps.4965 p | that was reviewed in the guideline process, to add additional suggested text for Recommendation M and in the evidence to recommendations section.<br><br>The evidence to recommendations section states that carer's needs should also be assessed.<br><br>The source identified is an opinion source only. The population for the second source is people with Alzheimer's – not stroke. |
| 60 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Recommendation B: Patients who are not being offered immediate rehabilitation from an Early Supported Discharge Team should have an alternative rehabilitation plan/prescription negotiated which is documented alongside their medical needs on discharge.<br>Patients with stroke affecting the spinal cord stroke should be referred to a spinal | Thank you for these comments.<br><br>It is beyond the scope of this guideline update and the evidence that was reviewed in the guideline process, to add this suggested text. |

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| | | | injuries unit for on going rehabilitation.<br>Recommendation E: The community stroke rehabilitation team should have access to a rehabilitation medicine consultant to decide on type, duration and intensity of interventions<br>Recommendation F; The MDT service should have a core team which includes a consultant in rehabilitation medicine<br>Recommendation G: Access to a rehabilitation medicine consultant for management of complex disabilities and provision of interventions like botulinum toxin injections. Recommendation N: People with stroke who are discharged from hospital with complex disabilities should have continued access to a consultant led rehabilitation medicine service | Recommendations for a physician as part of the core multidisciplinary team allows flexibility with regard the speciality of the physician involved. |
| 61 | | Association of Clinical Psychologists UK (ACP-UK) | The community psychology staffing levels have clearly been lifted from the National Service Model for an Integrated Community Stroke Service document. However, there are concerns that the recommendation grossly underestimates the needed level of provision. The remit of what unqualified staff are able to provide in the community is more limited, with less direct supervision to qualified staff as in inpatient settings.<br><br>Staffing for Clinical Psychology guidance BRE56 Recommendations for Integrated Community Stroke Services_Nov_2022.pdf (bps.org.uk)<br><br>2.8 Recommendations F page 10- Line 441-442 With the adequate provision of psychology within stroke services there would not be the need to have access to neuropsychology departments. It should be that people with stroke then have access to other psychological services such as IAPT and community mental health services.<br><br>2.13 page 17 723 – There is a lot of evidence in the literature and clinical experience of considerable post-stroke gains in cognition and emotional disturbance beyond the first six months post event. This should be recognised as part of follow up | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was based on the research evidence reviewed and agreed through consensus by all relevant professionals simultaneously in the Guideline development group.<br><br>These are clinical guidelines that outline minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>The text featured in section 2.13 is a copy of that featured in section 5.27 Further rehabilitation and serves to sign post the reader to this section. We have added the following to highlight the importance of a holistic review.<br><br>This review should consider physical, psychological and social needs (including relationships and work, where applicable), related to adjusting to life after stroke. Whilst limited, there is evidence to suggest that for some people improvements in communication, arm function, walking, physical fitness and ADL can be achieved |

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| | | | | with interventions more than 6 months after stroke (Palmer and Enderby, 2007, Duncan et al., 2011, Ferrarello et al., 2011, Veerbeek et al., 2014b, Lohse et al., 2014, Ward et al., 2019). The provision and timing of appropriate, person-centred follow-up rehabilitation, holistic structured reviews and long-term support after stroke are discussed in more detail in Sections 5.27 Further rehabilitation, and 5.28 Social integration and participation. [2023] |
| 62 | | Chest Heart & Stroke Scotland | 2.8 A (412-414) stipulates that 'Hospital inpatients with stroke who have mild to moderate disability should be offered early supported discharge, with treatment at home beginning within 24 hours of discharge.' Again caveat may need to be added here to say 'wherever possible treatment at home beginning within 24 hours of discharge' as depending on day of discharge (e.g. Friday) weekend may delay access to treatment at home starting on the following Monday' | Thank you for these comments.<br><br>Treatment should begin within 24 hours regardless of the day of the week. |
| 63 | | Royal College of Speech and Language Therapists | Page 10, line 419-420 – The guideline suggests that early supported discharge should be provided at the same intensity as if the person was on the stroke unit. Further work is required in this area. A true early supported discharge is not a realistic expectation at the current time given recruitment difficulties and the nature of travel within urban vs rural areas and services which cover a large geographical area. More recommendations are needed for services which are limited in this way.<br><br>Page 11, line 432 – The RCSLT is concerned about the staffing levels suggested. We have raised this on a number of occasions with colleagues in NHS England as they developed their stroke rehabilitation pilots. We understand that the staffing ratios are based on the ISDN specification and the work in Greater Manchester Community Stroke Model and Service Specification. Why is speech and language therapy so much lower than the other therapies? More clarification is needed around the definition of 100 referrals per year. Currently, referrals are often calculated per profession and so exactly how this would relate to an early supported discharge team would be helpful. The guideline states that the staffing is a minimum structure (line 538). However, our evidence and mapping shows that speech and language therapy provision to early supported discharge and community stroke rehabilitation teams is below this level. Work needs to happen to increase speech and language therapy provision into these community-based teams. We recommend future monitoring of community stroke services to see if they actually achieve these recommended staffing levels. We are aware that NHS | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was agreed based on the research evidence reviewed and through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>We acknowledge the challenges presented by the current workforce issues with regard recruitment and retention of staff, however these are beyond the scope of the current guideline update.<br><br>The guidelines align with NHS England policy and the Integrated Community Stroke Service model. However these guidelines have also been developed so that they can also be used by the devolved nations. |

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| | | | England is working towards recommending workforce ratio levels for the community rehab workforce. This could be helpful in the future.<br><br>Page 12, line 482 – A transition package is a good recommendation in principle but will need careful consideration and planning to ensure adequate/increased beds and staffing to ensure a positive outcome.<br><br>Page 12, line 489 – Written information of their eating and drinking plan/recommendations is also needed.<br><br>Page 12, line 501 onwards – The RCSLT suggests aligning this section with the new ICST model, which should be one pathway alongside routine intervention in integrated community teams. There is no mention of the role of Ambulatory care to ICSTs to prevent admission.<br><br>General 2.8 recommendations – The RCSLT agrees with the recommendations, although this is dependent on adequately funded and staffed services.<br><br>General section 2.8 – Decisions around eating and drinking with acknowledged risks should be clearly documented within the guidance of an established policy. See RCSLT Eating and drinking with acknowledged risks guidance: https://www.rcslt.org/members/clinical-guidance/eating-and-drinking-with-acknowledged-risks-risk-feeding/#section-2 | Recommendations for eating and drinking are covered in detail in Section 4.26 Swallowing.<br><br>We have ensured references in section 2.15 End-of-life (palliative) care align with section 4.26 Swallowing and are highlighted, including Royal College of Speech and Language Therapists, 2021.<br><br>Section 2.15 also includes<br>The process can be supported by material such as the Clinically-assisted nutrition and hydration guidance from the RCP/BMA (2018) at https://www.bma.org.uk/advice-and-support/ethics/adults-who-lack-capacity/clinically-assisted-nutrition-and-hydration [2023]. |
| 64 | | The Stroke Association | In reference to Recommendation F and line 437, we welcome explicit inclusion of psychologists in the workforce, taking into account the extensive evidence concerning the psychological care needs of stroke survivors and their families. These needs are evidenced in the Stroke Association's Lived Experience of Stroke report, which includes survey data from a large sample of our beneficiaries, showing: 44% of stroke survivors experience anxiety and 44% experience depression after their stroke; 42% experience mood swings; and 16% experience suicidal thoughts.<br><br>However, we would strongly urge that line 437 within Recommendation F take into account the British Psychological Society's recommendations for the clinical neuropsychological component of the community stroke rehabilitation MDT (https://www.bps.org.uk/guideline/recommendations-integrated-community-stroke-services). The BPS outlines the following staffing recommendation: 0.6 | The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline development group.<br><br>The recommendations made for psychologists as part of community-based stroke services is in addition to the recommendations for psychologists as part of the inpatient stroke service workforce. This is in line with provision of psychological care across the stroke care pathway. |

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| | | | (WTE) per 100 referrals to the community stroke MDT, with this figure made up of 0.4 (WTE) qualified psychologists per 100 referrals and 0.2 (WTE) support psychological staff (assistant psychologists etc.) per 100 referrals.<br><br>This contrasts with the clinical neuropsychology/psychology staffing recommendation of 0.2–0.4 WTE per 100 referrals/year in the draft updated guidelines. In addition, the BPS recommends that this figure should be supplemented by a WTE figure of consultant level psychologists, in governance/leadership roles, determined locally. While we recognise the challenges to implementation, the BPS's recommendations reflect the significant role that clinical neuropsychology plays in recovery after stroke.<br><br>In addition, while this recommendation references the support provided by a stroke key worker as being an essential part of the ESD offer, the stroke key worker is not included in the workforce recommendations. We would consider this to be a significant oversight and recommend that the role of the stroke key worker is referenced here, to ensure alignment with the NSSM. To avoid repetition, we have included appropriate evidence for the interventions provided by the stroke key worker within our response to the section 5.27 'Further rehabilitation'.<br><br>In reference to Recommendation J and lines 474-5, we do not believe this wording is sufficient to capture the need for stroke survivors to be connected with and referred to a stroke key worker.<br><br>Suggested edit: As per the NSSM, we would suggest that Recommendation J should instead state that: 'the discharging inpatient stroke team should refer their patient to a stroke key worker to ensure they can access appropriate personalised support.'<br><br>In reference to Recommendation M and lines 486-489, we welcome the inclusion of the need for a named contact and written information, and suggest that the guidance should be explicit that this information be personalised and patient facing. In turn, we suggest that this package of information offered to the stroke survivor should include information on: what support they may need, their stroke and treatment, their recovery, how to stay well, next steps and where to get more help and information. This is what is included in the Personal Stroke | These are clinical guidelines that outline minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>Adding the level of detail suggested in relation to the stroke key worker and personal care record is beyond the scope and protocols followed for this partial guideline update process.<br>We have added the following to support close working with the voluntary sector:<br>G 'collaboration' and 'and the voluntary sector' added<br>J 'e.g. stroke key worker' added<br><br>'personalised' has been added to Recommendation M. |

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| | | | Record, which was developed in response to the unmet need for personalised information and patient involvement in care that stroke survivors reported to us. The Personal Stroke Record, which is referenced in the NSSM, was co-developed with patients, carers and health can professionals.<br><br>Suggested edit: Change Recommendation M to:<br>'Before the transfer of care for a person with stroke from hospital to home (including a care home) they should be provided with:<br>– a named point of contact for information and advice;<br>– personalised patient-facing written information about their diagnosis, medication, and management plan (including information on: what support they may need, their stroke and treatment, their recovery, how to stay well, next steps and where to get more help and information)'<br><br>In reference to the Evidence to recommendations and lines 546-548, we would recommend this review should include a stroke key worker/life after stroke service worker, to ensure collaborative integrated working. We have included appropriate evidence for the interventions provided by the stroke key worker within our response to the section 5.27 'Further rehabilitation'. | |
| 65 | | Northern Ireland Stroke Network | Recommendations are what we should aspire to for future development of Community Stroke Services and overall feeling is that the guidelines are a positive way forward.<br><br>Line 419 – typo remove word be – 'discharge should be provide'<br><br>E: Intensity and duration need to have agreement of service user.<br><br>F: lines 427 – 433 Staffing for community teams.<br><br>The guidelines state that for ESD patients should receive the same level of input as they would in the acute setting – the guidelines are 45 mins 5 days a week of each profession required. (see also line 2254- 2294 re intensity and timescales for delivery)<br><br>Line 219 Acute staffing is (approx.) 1 PT /OT per 5 inpatient beds | Thank you for your comment.<br><br>Thank you – this has been amended.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>These are clinical guidelines that outline minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>We would advise against confusing open caseload with annual |

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| | | | Line 430/431 - community Staffing is 1 PT/OT per 100 referrals a year. So a 20 bed inpatient unit should have 5 PT/OT staff. A community team with 100 open patients on caseload (100 beds if you like) may only have 5 PT/OT as overall referrals in a year are only 500. | referrals in the community and also thinking of these in the same way as 'beds' in a hospital. |
| | | | Clarification could be provided on how community teams can give the same level of therapy to a caseload 5 times as big as the inpatient setting, with the same level of staffing AND travel between patient's homes | WTE recommendations for community services are based on 100 patient referrals per year – if a team has 100 "open patients" on their caseload at any one time, they would have an annual caseload much higher than 100.<br>e.g. if a community team had 500 referrals in 1 year, then the minimum staffing recommendations would be 5 OTs and 5 PTs. |
| | | | Line 440 - Full stop at end of line 440<br>Line 441 – 'Timely access to psychological therapies' … should be new point | Thank you – amended.<br>Thank you – amended. |
| | | | G: A defined list of stroke related needs to be assessed and treated within the community stroke service should be provided. Not all conditions following a stroke are delivered by stroke rehabilitation teams. Would provide clarity in relation to acceptance of initial referral and rereferral back to service | Recommendations for a 20 bed inpatient rehab unit would be 1.13*4 =4.5 OTs and 1.18*4 = 5 PTs. Capacity would depend on annual admissions for this unit. |
| | | | Re "with the option of re-referral after discharge" – the guidance should clarify if this Is this open-ended, can service users be re-referred at any point, by whom and for access to what services. | This level of detail is beyond the scope of the specific questions addressed to update Section 2. Section 4 Rehabilitation and Recovery discusses stroke related needs and Section 5 discusses long term management and these sections include details about these topics. |
| | | | Line 450 – remove comma after support<br>Line 451 – insert 'stroke related' between discharge if 'stroke related' rehabilitation | Thank you – amended.<br>Thank you – amended. |
| | | | K: "Before transfer home of a person with stroke who is dependent in any activities the home environment should be assessed" Home visits are completed based on assessment/need and not necessarily for all service users requiring some assistance. Who will complete these? Will they always be necessary? | |
| | | | L: Re visits/leave at home prior to final transfer of care – Guidance should indication who will provide care needs and if it is family, who is responsible for training family?<br>Evidence: | Throughout the guidelines we focus on the needs of people living with stroke and the clinical interventions required, rather than specify who should provide that intervention. |

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| | | | Line 546: "A regular review… should be an integral process undertaken by community rehabilitation services" – How regular/often? Currently 6-month review completed. Who will complete these reviews? | |
| 66 | | Scottish Intercollegiate Guidelines Network | The RCPE commends the recommendation in relation to a specialist multidisciplinary team structure but would again flag the challenges of ensuring sufficient staffing resources across all disciplines to allow this to function at an optimal level in all instances. | Thank you for these comments.<br><br>We acknowledge the challenges presented by the current workforce issues with regard recruitment and retention of staff, however these are beyond the scope of the current guideline update. |
| 67 | | British and Irish Association of Stroke Physicians (BIASP) | P10 Line 410. 2.8 recommendations. "Hospital inpatients with stroke who have mild to moderate disability should be offered early supported discharge, with treatment at home beginning within 24 hours of discharge." Should access to ESD begin within 24 hours of discharge based on the working week? Is the intention that ESD access should be available 7 days per week or does this refer to the working week? This should be specified.<br><br>P18 Line 788. Recommendation C. "Decisions to withhold or withdraw life-prolonging treatments after stroke including artificial nutrition and hydration should be taken in the best interests of the person and whenever possible should take their prior expressed wishes into account." Could one consider that prior expressed wishes and preferences (where appropriate) be highlighted first and foremost. Best interests are no longer central to the guiding principles of the new Assisted Decision-Making Capacity Act in Ireland but rather a focus on will and preference.<br><br>P10 After 2.8 recommendation E, or just generally within the section, it should be mentioned that effective communication between secondary care rehab teams with both community rehab and primary care is essential, including clear discharge summaries. | Thank you for these comments.<br><br>ESD should be provided by a 7 day service and begin within 24 hours regardless of the day of the week.<br><br>Thank you –amended accordingly.<br><br>Decisions to withhold or withdraw life prolonging treatments after stroke including artificial nutrition and<br>hydration, should whenever possible, take the person's prior expressed wishes into account and be taken in the best interests of that person. When withdrawing artificial nutrition and hydration, a recognised nutrition and<br>hydration decision-making process should be considered. [2023].<br><br>This is addressed in Recommendation J.<br><br>collaboration, close links and protocols for the transfer of care with in-patient stroke services, primary care, community services and the voluntary sector;<br><br>and I<br>Members of the early supported discharge and community stroke rehabilitation services should be involved in hospital discharge planning and decision making by attending stroke unit |

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| | | | | multidisciplinary team meetings. |
| 68 | | The Irish Heart Foundation | Line 504 comments included that although recovery should be tailored for individuals, clinicians should be mindful of asking a newly injured and/or traumatized brain to list goals and make comparisons from their post-stroke life.<br><br>This task could be difficult and therefore emphasizes the need for longer-term rehab post-hospital stay regardless of the physical symptoms presented, and that the emotional and mental effects of a stroke also have implications on the recovery timeframe.<br><br>The focus group was in strong agreeance that lines 507- 508, 'There is strong evidence for the effectiveness of early supported discharge for those who experience mild-to-moderate disability after stroke', is important and should be implemented.<br><br>Many falling into the category of mild-moderate disabilities lacked immediate support when discharged from the hospital and didn't obtain rehabilitation care until 6 months post-stroke, it was agreed among the focus group that consistency between each individual was more necessary. They felt abandoned with a lack of support when discharged home with no knowledge of the community support system, such as the Irish Heart Foundation or other voluntary organisations. Hence Stroke support teams should be more aware (of these services) and should actively refer patients to these services available within the local region.<br><br>Attention was paid to how these community support services could act as a buffer between hospital and rehabilitation care and thereafter if necessary. | Thank you for these comments.<br><br>This is addressed in Recommendation J.<br><br>'collaboration, close links and protocols for the transfer of care with in-patient stroke services, primary care, community services and the voluntary sector;' |
| 69 | | Irish Association of Physical and Rehabilitation Medicine | Again there is no option mentioned to refer the patient with severe disability to a specialist neurorehabilitation centre.<br>Evidence: "Rehabilitation services Medical rehabilitation in 2011 and beyond" Report 2010 - Nov A joint report between the Royal College of Physicians and the British Society of Rehabilitation Medicine | Thank you for these comments.<br><br>Recommendations for the provision of inpatient stroke rehabilitation services are featured in section 2.5. Specific types of stroke rehabilitation unit involved will vary across nations and be dependent on local context.<br>Access to Rehabilitation Medicine has been added to section 2.5 J.<br><br>The references suggested are beyond the scope of the current guideline update. |
| 70 | | British Dietetic | Page 11, line 432: | Thank you for these comments. |

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| | | Association | Are the Speech and Language Therapy staffing levels recommendations to provide communication therapy or including swallowing as well? Consensus from group feeding back was this was low staffing recommendation if for swallow therapy as well.<br><br>Page 11, line 441-444:<br><br>Dietetics appears to be the only speciality recommended in acute staffing levels, but not in ESD and community stroke teams. As dietetic input remains key in supporting rehabilitation (treating malnutrition and enteral tube feeding) and supporting risk reduction in further stroke through secondary prevention dietary advice, it is important to ensure that patients receive timely advice and treatment, and that the guidance recognises the importance of nutrition and hydration by adding dietetics to the minimum MDT core team structure. This is especially important as 'timely access' to dietetics will vary across the country based on how non-stroke services and teams are structured and resourced, especially where patients require domiciliary visits. As the Fisher papers don't mention nutrition, hydration or dietetics in their staffing recommendations (unclear why not considered) I recommend that adding dietetics to the ESD / CST is considered under 'guideline group consensus' and raised with the group.<br><br>Many ESD services do not have Dietetic input and patients may have significant delays to access input if they meet referral criteria.<br><br>Patients requiring oral nutritional supplements may not meet community dietetic team referral criteria – could result in prescription of oral nutritional supplements on discharge from hospital without dietetic review of whether these continue to be indicated long term.<br><br>Does not support the role of the dietitian in providing specialist input to support secondary prevention, health promotion and training for other staff. | The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline development group.<br><br>Timely access to dietetics is listed in section 2.8 F. This reflects the evidence reviewed. |
| 71 | | Brain Injury Matters (NI) | Recommendation J<br>Long-term needs must be identified and discussed prior to discharge from hospital. Accordingly, people can then locate and obtain appropriate support from statutory and voluntary organizations and specialist services. This essential support and rehab discussed needs to be offered in their local communities | Thank you for these comments.<br><br>Section 2.8 line 464 J<br>This 2016 recommendation was reviewed as part of the update for consistency but the topic areas you refer to were out of scope of |

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| | | | across the lifespan.<br>Social Workers in hospital and community teams should be able to initiate assessments of need for people to access 'Self Directed Support' for social and care needs. This will ensure those recovering from stroke have flexibility, choice, and control over the support they receive i.e., to employ a personal assistant / carer, for short breaks and / or to access community opportunities.<br>A significant percentage of those recovering from stroke, their families and carers have reported feeling abandoned following hospital discharge and / or discharge from Community Stroke Rehabilitation Services. Reducing these feelings is essential, and this could be achieved by equipping patients and their families with the knowledge of what funding and support is 1) available and 2) can be accessed and adapted to meet their lifelong needs. | this limited update to the guideline. |
| 72 | | Welsh Association of Stroke Physicians | · 2.8: Unclear definitions of "Early supported Discharge team" and "community stroke team" services. They have the same recommendations.<br><br>· ESD should provide same intensity as in-patient – not possible covering geographical areas/time to travel etc. with staffing levels recommended. | Thank you for these comments.<br><br>These recommendations were informed by consensus papers that define Early Supported Discharge and community stroke rehabilitation and are cited in the guidelines.<br><br>This definition of Early Supported Discharge as an intervention, has been made clearer in the glossary.<br><br>An intervention delivered by a coordinated, stroke specialist, multi-disciplinary team that facilitates the earlier transfer of care from hospital into the community and provides responsive (within 24 hours) and intensive stroke rehabilitation in the patient's place of residence (usually over a time-limited period).<br>This evidence to recommendations section also included the following:<br>Consensus-based recommendations state that people with more severe disability following a stroke, those with rehabilitation needs beyond early supported discharge or those going into residential or nursing homes need access to community stroke rehabilitation. |
| 73 | | Wales Stroke Allied Health Professional Forum | Providing ESD at same intensity as hospital rehab is not possible on current provisions – new guidance states: speech and language therapy (0.4 WTE per 100 referrals/year); How can we provide the same intensity whilst travelling across a broad geographical area to provide therapy in the home? Many stroke pts are not IT literate to enable virtual therapy. | Thank you for these comments.<br><br>These guidelines are based on evidence that defined core components of community stroke services (providing Early Supported Discharge and/or Community stroke rehabilitation) that |

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| | | | On home visits before discharge - this was lost during covid and is very challenging with current bed pressures but is such a valuable step in transitioning to home.<br>Unclear definitions of “Early supported Discharge team” and “community stroke team” services. They have the same recommendations.<br>ESD should provide same intensity as in-patient – not possible covering geographical areas/time to travel etc. with staffing levels recommended. | are relevant for urban and rural settings. The challenges associated with delivering home-based stroke rehabilitation across large rural areas are recognised. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>These recommendations were informed by consensus papers that define Early Supported Discharge and community stroke rehabilitation and are cited in the guidelines.<br><br>This definition of Early Supported Discharge as an intervention, has been made clearer in the glossary.<br>An intervention delivered by a coordinated, stroke specialist, multi-disciplinary team that facilitates the earlier transfer of care from hospital into the community and provides responsive (within 24 hours) and intensive stroke rehabilitation in the patient’s place of residence (usually over a time-limited period).<br><br>This section also included the following:<br>Consensus-based recommendations state that people with more severe disability following a stroke, those with rehabilitation needs beyond early supported discharge or those going into residential or nursing homes need access to community stroke rehabilitation. |
| 74 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 75 | | United Kingdom Clinical Pharmacy Association (UKCPA) | F- include pharmacist to assess swallowing of medication, medication support needs prior to discharge. Pharmacists part of the multidisciplinary team involved in discharge planning. Pharmacists refer to the patient's community pharmacy for enhanced services like Discharge Medicines Service and New Medicines Service, once discharged from hospital. | Timely access to pharmacy is included in section 2.8 F |
| 76 | | The British Association of Prosthetists and Orthotists | We believe expert gait analysis should be added to the list under "Appropriate administration and management (including data management) support with timely access to".<br><br>Timely access to specialist services is essential, in orthotics we tend to receive referrals much too late, when contractures have occurred and gait has | The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group. The list of services cannot be exhaustive but rather indicative of the additional expertise required. Timely access to orthotics is listed in section 2.8 F. |

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| | | | deteriorated. All patients with mobility problems following a stroke should have timely and equitable access to<br>specialist orthotic services. Orthotists should be involved in the planning, provision and review of stroke services. (Use of AFOs following stroke - best practice statement 2009<br>https://strathprints.strath.ac.uk/16846/5641/strathprints016846_1_.pdf) and Golding-Day, Walker, Whitehead. Orthotic intervention following stroke: a survey of physiotherapist, occupational therapist and orthotist practice and views in the UK. Int J Ther Rehabil. 2022;29(6).)<br><br>Throughout the current guideline, the wording is too ambiguous and open to interpretation leading to different provisions depending on which service you access. If orthotists are named members of the team this would become much easier to direct and standardise treatment as it would lead to appropriate commissioning of the often forgotten orthotics service. Not naming the orthotist as a core member of the team leads to a lack of standardised care and a lack of capacity for orthotic treatment which is key to rehabilitation goals and an adjunct to other treatments. | |
| 77 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Community rehabilitation services in general are severely underfunded and understaffed. We urge the working group to consider the option of joining up community services with areas such as neurology.<br>We would also welcome a definition of community stroke rehabilitation fro those with ongoing needs who are not eligible for ESD.<br><br>E: Whilst we welcome the suggestion that the intensity and duration of intervention provided by the stroke community rehabilitation team should be similar, the lack of investment into these services will detract from this. Anecdotal evidence from people disharged from stroke services highlights long waits for community rehabilitation and a lack of sufficient intensity and relatively short duration interventions.<br><br>F: Whilst we welcome the recommended staffing levels, the lack of transparency about how these came to fruition detracts. We would welcome clarity on the recommendation of timely access to MH services/ IAPT/Neuropsychology- current wait times for these services in some areas are months.<br><br>I : We query whether the requirement of ESD and community rehabilitation staff | Thank you for these comments.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline development group.<br><br>These are clinical guidelines that outline minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>To help with this we have added the following sentence in section 2.8 Evidence to recommendations<br>While in some instances it may be appropriate for stroke and neurological rehabilitation to be delivered by the same integrated team, the service must be able to deliver all the relevant recommendations made in this guideline. |

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| | | | to attend MDT/involved in hospital planning has been factored in when suggesting staffing levels. Currently, physiotherapists report that the ESD teams do not have sufficient staffing to attend stroke unit MDT meetings. In areas where different localities are covered, having them attend would involve staff from 3 different community teams due to these different localities covered. We query whether this is an effective use of their time.<br><br>L: We welcome the recommendation of a transition package- however the lack of detail of how this will be provided is lacking. Further resourcing requirements for social care, as well as health, will be needed for this to be successful. We would very much welcome greater clarity on who would be expected to provide this service. Would this be the community team or acute trusts or a combination of both? As identified previously, staffing levels suggested for physiotherapy do not match these recommendations<br><br>In the evidence to recommendations section, specifically lines: 550-551- we would strongly recommend that an indication of which routinely measured ones, outside of the SSNAP data, would be highly beneficial for comparison and continuity of care between acute, rehabilitation and community sectors. | Whilst we acknowledge current challenges relating to waiting times for recommended services, to comment on these is beyond the scope of this current guideline review.<br><br>Evidence based recommendations relating to close working between ESD and community rehabilitation staff, including joint multidisciplinary team meetings, are required to ensure that co-ordinated and timely transfer of patients from hospital to home occurs.<br><br>Recommendation of routinely measured outcome measures was beyond the scope of this current guideline update. |
| 78 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | As noted in response to section 2.5, it would be helpful to include mention of the ability to take part in or support research studies for all staff.<br>(406-408) Many stroke services provide "as per protocol" assessments to those who have had strokes but do not appear to have any therapy goals or needs/ none identified during acute admission. Whilst this can be good in case of hidden deficits or development of problems such as fatigue or high level cognition, vision or mood changes which may have been missed in a quick admission and discharge case, it takes time away from treating those patients who really require it. Can you provide more clarity on "all people…who need it" (e.g. those who work and drive even if no deficits identified; those with previous mood disorders prior to stroke; those with occipital lobe infarcts even if no visual impairments identified on admission) This could avoid any unnecessary "as per protocol" work.<br>(412) provision of ESD being provided within 24 hours. Does the WTE staffing support a 7 day service in order to meet this target of 24 hours?<br>A- mild moderate as defined by what?<br>B- can a timeframe be included here re timely response | Thank you for your comments.<br>We have added 'Encouraging patients to participate in research whenever possible' in section 2.18.<br><br>Whilst these are insightful comments and suggestions, the specific guideline recommendations referred to here were reviewed for consistency with other chapter updates only. They were not included in the evidence review and associated questions included in the guideline update. Hence, it is beyond the scope of section 2.8 to add this detail here.<br>The extensive updates to Chapter 4 Rehabilitation and Recovery cover aspects of rehabilitation raised here.<br><br>A – mild moderate is defined in the source papers that are referenced<br><br>B-agree timing is important but specifying a timeframe for |

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| | | | C- predominantly- how can this be defined- in previous guidance was above 70% of caseload<br>D- typo<br>D- refer to stroke unit section (link)<br>E- include the term needs led here and link to rehab potential section<br>F- can this be presented in a table in the same way as the inpatient recommendations please<br>G- common problems- feels broad- should there be an example?<br>J-just want to be clear that 'care home' is covering residential and nursing home<br>L- can we broaden out the examples to not both be PADL focussed- washing and meal preparation for example. What is a transition package? not a known phrase. Could it say 'could include.....' rather than 'should' as wouldn't be able to do many of these things from an acute unit, certainly not a HASU. Re telephone advice and support- this is very resource heavy- who would do this? Should this be ensuring someone goes home with contact numbers for support as necessary. Why three months? | assessment and treatment for patients accessing community stroke rehabilitation does not have an evidence base to support any particular timescale. English policy documents on the ICSS state assessment should be within 72 hours, but there is no other guidance on which to base a consensus.<br><br>C This aligns with the definition of specialist care in section 2.2<br><br>D Thank you for your comment, it will be amended.<br><br>E based on clinical need is already stated<br><br>D,E,F – thank you for these suggestions however links will complicate this section<br><br>F We have added a table as suggested.<br><br>G adding detail here is beyond the scope of this guideline update<br><br>J – yes, the generic term 'care home' is sufficiently widely used to refer to both.<br>L – these recommendations were reviewed for consistency with other chapter updates but were not updated directly as part of the evidence review and guideline update. |
| 79 | | Irish Heart Foundation, Council on Stroke | Page 10, line 419, typo, remove 'be'<br><br>Physiotherpay<br>Page 10, line 411, There are other considerations for those suitable for ESD, not just severity of stroke, e.g. social circumstances<br>Page 10 line 414, community stroke rehab is not readily available in Ireland<br><br>"Staffing Based on 100 patients per annum the team should consist of:<br>• Co-ordinator or Team Lead<br>• 1.0 WTE Specialist Nurses (SN),<br>• 1.0 WTE Physiotherapists (PT),<br>• 1.0 WTE Occupational Therapists (OT)<br>• 0.4 WTE Speech and Language Therapists (SLT) | Thank you for these comments.<br>We think the 'be' needs to be retained –<br>A Hospital inpatients with stroke who have mild to moderate disability should **be** offered early supported discharge, with treatment at home beginning within 24 hours of discharge.<br><br>Recommendation A and reference to mild to moderate disability, is based on evidence as indicated in the source references.<br><br>Thank for the suggested formatting. We have reformatted section 2.8 F into a table. These outline minimum staffing levels which should be used with an understanding of the local context to inform more detailed service specifications. |

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| | | | • 1.0 WTE Clinical Psychologist/ Neuropsychologist (band 8a for up to 100 patients, band 7 for additional caseload. Need to ensure access to consultant psychology support is available)<br>• Rehabilitation Support Workers or Enablement Workers trained in Stroke Rehabilitation<br>• 0.5 WTE social worker<br>• Administration and Clerical staff<br>The team should also have easy access to podiatrists, orthotists and opthalmologists.<br>https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/07/str-service-spec-esd-062015.pdf<br>In general can the staffing levels be reviewed for the acute stage, ESD and ongoing rehabilitation. | |
| | | | Occupational Therapy<br>Page 10, Section 2.8, Recommendations<br>Consider rewording the recommendations to reflect the strength of evidence underpinning the recommendation e.g. ESD "should", consider using "may" where the evidence base is weaker | Recommendations for offering ESD are retained from the 2016 guideline and are supported by Cochrane systematic review evidence. |
| | | | lines 406-409. Re-phrasing needed, there is a whole cohort of people living with stroke who are not accounted for in this section, ESD and early rehab is important as is ongoing access to rehabilitation for people in long term care and nursing homes – BUT longer term rehabilitation needs of community dwelling people with stroke who are living in their own homes is completely neglected in this section. | We have rephrased a sentence to emphasise this section relates home-based stroke rehabilitation as well as transfer of care from hospital to home, by including the sentence:<br>"Stroke rehabilitation should be provided in the person's own home or place of residence, including residential or nursing homes." |
| | | | Staffing ratios are provided for ESD teams/100 referrals a year, the wording of this is confusing, should specify that per 100 referrals a year means referrals to the ESD service, otherwise it reads as though SLT and MSW have been allocated 0.5 posts /100 referrals to SLT and MSW. Why include staffing ratios for ESD and not Community Stroke teams. Better differentiation required for ESD services and Community Stroke Teams e.g. specify in the recommendations that all mild to moderate strokes should be referred to ESD. These services should be discussed separately in the recommendations to highlight that these are different approaches to stroke rehabilitation. | The staffing levels that are recommended apply to both ESD and community stroke services as specified in F.<br><br>We have updated the formatting for Recommendation F to make this clearer by including a table. |
| | | | K-"Before the transfer home of a person with stroke who is dependent in any activities, the person's home environment should be assessed by a visit with an occupational therapist" cli Consider re-wording this recommendation to reflect | We have chosen to combine recommendations for ESD and community stroke rehabilitation together because many of the recommendations are similar. We have updated the glossary section and evidence to recommendations sections to provide |

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| | | | the agency, clinical reasoning of the occupational therapist and multifactorial decision-making involved in identifying<br>the need for a home assessment such as geographical considerations in rural contexts.<br><br>Dietetics<br>Recommendation F states 'Appropriate administration and management (including data management) support with timely access to: psychological and neuropsychological services (e.g. Improving access to Psychological Therapies {IAPT], community mental health services, psychology or neuropsychology departments), return to work and vocational rehabilitation services, dietetics, pharmacy, orthotics, orthoptics, spasticity services, specialist seating, assistive technology and information, pain management, advice and support for people with stroke and their family /carers. [2023}<br><br>Comment Our fear here is that referring to timely access to dietetics and indeed other disciplines does not reflect the reality in relation to access to services outside of the hospital in the Republic of Ireland. Unless there is a designated route for the stroke ESD to access, then access is significantly delayed (could be months or years). From experience as senior dietitian in acute and rehabilitation stroke care, if there is no clear pathway for quick access of follow up from the acute / rehab dietetics service for these patients their acceptability for ESD is uncertain and putting them at increased risk especially in the malnutrition and dysphagic population. My recommendation is that ESD clients remain under the care of the inpatient acute/rehabilitation dietitian where they originated from who can link with the ESD team, however this in turn would require an increase in staffing beyond 0.71/10 beds as suggested.<br><br>Evidence to recommendations<br>Comment there is no evidence on the need for dietetics in ESD as the research on ESD teams has been largely based in the UK where ESD teams have good access to well-developed community dietetics who can support these clients. This is not the situation in the Republic of Ireland so perhaps this should be worked out locally<br><br>Medical Social work<br>Social work | more information about definitions of ESD and community stroke rehabilitation.<br><br>Also, as described in the section 2.8 Evidence to recommendations section:<br>"These ratios should be viewed as the minimum core team requirements and will require local review and modelling to ensure that services meet patients' needs and deliver the required intensity, recognising that appropriate resource will be required to support people with stroke with more complex disability and needs. To achieve this, existing services including early supported discharge teams and community stroke rehabilitation could be brought together into one integrated seamless service e.g. an Integrated Community Stroke Service"<br><br>We acknowledge this issue. These are clinical guidelines that outline minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>We value the information provided about the Irish context and understand this will influence how the guidelines might be implemented. The guidelines feature evidence based recommendations which can be used flexibly with an |

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| | | | L: Guidelines reference a 'transition package' for people who are dependent in personal activities. This does not make reference to the Irish context of community services. People with a stroke who are dependent in personal activities may require an application to be made to the HSE for home supports. These home support 'packages' do not include training and education or carers specific to their needs and telephone advise and support for three months. These services do not exist in the Irish context and home supports generally refer to carers calling several times per day/week providing physical assistance alone.<br>-We recommend that more reference should be made to the Irish context and community services that are available in Ireland.<br><br>General comment:<br>There is a major difference in the amount and range of social services between the UK and Ireland. Often social workers in UK hospitals are employed by the local authority or there are separate people to refer to regarding post discharge supports.<br>In Ireland Medical Social Workers are employed by the hospital for the stroke units and stroke rehabilitation units/hospitals.<br>There is no comment on services for families in their own right, as opposed to carer training and information. This is particularly relevant for younger stroke cases where there can be young children affected, a non-working spouse, work-related issues, housing issues etc.<br><br>Speech and Language Therapy<br><br>General<br>— IASLT notes that there are only 10 ESD teams in RoI (NoCA, 2021) and in 2021, no hospital in RoI had a fully resourced ESD team.<br>— IASLT welcomes the additional recommendations for acute and community stroke rehabilitation, but SLT recommended staffing levels need to reflect this. The role of SLT has expanded and become more clinically complex since the recommendations on WTE in 2007.<br>— IASLT cautions that the recommendation for community stroke rehabilitation and ESD teams at 0.4 WTE PER 100 referrals / year will not facilitate safe, efficient access to SLT and constitutes a clinical risk.<br>— IASLT would emphasise that the WTEs stated need to reflect a clinical grade as there is a significant difference in scope of practice, competency and | understanding of the local context to inform more detailed service specifications.<br><br>Commenting on services for families in their own right was beyond the scope of the current guideline update.<br><br>The recommended staffing levels and scope of this section was agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>These recommendations outline minimum staffing levels of different disciplines. These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>Staffing level recommendations are based on published and peer-reviewed consensus papers (as listed in the source evidence) and a 2017 Cochrane systematic review. (Langhorne et al 2017).<br><br>Speech and language therapy is included in the core team recommendations.<br><br>The paper cited and suggested additional text/ recommendation are deemed out of scope. Specific questions focused on for the update for Chapter 2 were constrained to resource for in-patient and community stroke care. The update of Chapter 4 included a specific question on intensity, frequency and dose of therapy for language recovery in patients with post-stroke aphasia. Section 4.38. includes specific recommendations about interventions and |

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| | | | funding required for Staff Grade SLT vs Clinical Specialist Grade.<br>— IASLT queries how it is proposed to empower people with aphasia to be involved in meaningful decision-making about their care and needs if SLT staffing is at less than 50% that of OT and PT colleagues.<br>— The national Decision Support Service will launch in Ireland in 2023. This represents imminent and current legally required expansions in the role of SLTs in supporting informed decision making in Ireland (DSS, 2022) for the 2/3 of people who acquire communication impairments post Stroke.<br><br>Specific:<br>— P11, L432 - What evidence is underpinning the recommended minimum SLT ESD staffing of 0.4 WTE per 100 referrals/year?<br>— p11, L444-5 - add "speech and language therapy"<br>— p11, L453 - add after carers; "information, advice, and support should be adapted and delivered in an accessible way for people living with aphasia."<br>— p11, L458 - add "all healthcare professionals working with people with aphasia should have opportunity to access aphasia training and information"<br>— p11, L467 - unclear what is meant by "if they are able". Should complement HSE National Consent Policy 2022.<br><br>— p11, L475 IASLT requests insertion of a new recommendation: "Individuals with aphasia and other communication impairments should not be discharged if they are either unable to communicate their needs and wishes, or there is no documented plan for how and when this will be achieved" (Simmons-Mackie et al, 2017)<br><br>— p12, L489 - insert: “All information should be tailored for people with aphasia (Manning et al, 2019)”<br>— P12 L508: How is "mild to moderate" disability measured? Severity of psychosocial impact is not aligned with severity of communication impairment – i.e., people with ‘mild’ communication impairment may experience significant life upheaval and reduced health-related quality of life – for example, a teacher who acquires dysarthria may have to give up their profession.<br><br>Evidence to recommendations<br><br>From a systematic review of 31 qualitative studies with over 350 people with | care for people with aphasia.<br><br>We have added the term ‘aphasia-friendly’ in Section 2.8 Recommendation G.<br><br>Section 2.8, Recommendation A and reference to mild to moderate disability in the evidence to recommendations section, is based on evidence as indicated in the source references. |

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| | | | post-stroke aphasia, accessible information and collaborative interactions with aphasia-aware healthcare professionals empower individuals to live well with aphasia and to navigate stroke services. Manning, M., MacFarlane, A., Hickey, A., & Franklin, S. (2019). Perspectives of people with aphasia post-stroke towards personal recovery and living successfully: A systematic review and thematic synthesis. PloS One, 14(3), e0214200. https://doi.org/10.1371/journal.pone.0214200<br><br>Simmons-Mackie, N., Worrall, L., Murray, L., Enderby, P., Rose, M., Paek, E. J., & Klippi, A. (2017, 2017/02/01). The top ten: best practice recommendations for aphasia. Aphasiology, 31(2), 131-151. https://doi.org/10.1080/02687038.2016.1180662 | |
| 80 | | Royal College of Physicians of Ireland Clinical Advisory Group | Yes requires full roll out of ESD teams in Ireland – (ESD to provide same intensity rehab as if an inpatient – agree – but aspirational)<br>K Visits /leave to home before discharge – agree but again aspirational<br>Access to supports/therapy in nursing homes – again agree but long way to go too<br>Orthoptics availability is highly desirable but exceptionally limited in the HSE context | Thank you for your comments. |
| 81 | Q12. Section 2.14 Stroke services for younger adults | The Stroke Association | The Stroke Association notes that the structure of this online survey format means that it has not been offered the opportunity to provide comment on the updates to Section 2.13 'Follow-up review and longer term support', and will therefore insert its comments on this section here.<br><br>In reference to lines 722-724, the focus of this narrative is about impairment-based support. We know from talking with stroke survivors that needs at this stage do not necessarily relate to impairment, but rather to participation, mood, confidence, relationships, and other areas. In our Lived Experience of Stroke survey, we found that over half of stroke survivors said that their relationships had been impacted by stroke, but only a third had accessed relationship support. Nearly half (47%) of responding stroke survivors told us they experience a lack of confidence due to their stroke, 44% said that they experience depression, and 42% told us they experience mood swings. We would encourage this section to reflect the need for holistic support for stroke survivors. | Thank you for these comments.<br><br>We have added the following sentences to section 2.13.<br><br>This review should consider physical, psychological and social needs (including relationships and work, where applicable), related to adjusting to life after stroke.<br><br>The provision and timing of appropriate, person-centred follow-up rehabilitation, holistic structured reviews and long-term support after stroke are discussed in more detail in Sections 5.27 Further rehabilitation, and 5.28 Social integration and participation. [2023] |
| 82 | | Different Strokes | I'm pleased to read that there is a specific section for younger adults, recognising the specific needs that these individuals may have. | Thank you for your comment. |

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| 83 | | Royal College of Nursing | Agree with all recommendations | Thank you for your comment. |
| 84 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 85 | | British Psychological Society | There is a very different set of challenges working with younger people. In general, there is greater clinician contact, more rehab reviews, greater intensity prescribed, more coordination and signposting required, and greater potential for social, financial and safeguarding concerns. Although the recommendations state that services should recognise the particular needs of younger people, it would be good to see an explicit acknowledgement of the growing needs within this age group and level of complexity.<br><br>The wider family, particularly siblings or other children may have needs as a consequence of a stroke in the family and it would be helpful to clarify how this support can be accessed and what it might look like. | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline. |
| 86 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Recommendation B: Acute stroke services should have access to a named rehabilitation medicine consultant to facilitate rapid assessment of young patients with complex rehabilitation needs . These patients may need to be transferred to a specialist neurorehabilitation unit.<br>Recommendation C: People who had stroke during childhood and requiring ongoing healthcare into adulthood should have their care transferred to an adult neurorehabilitation team led by a rehabilitation medicine consultant.<br>Early timely referral to specialist neurorehabilitation services to consider such elements as early proactive spasticity management (including prevention of development of abnormal mobility patterns), assessment and rehabilitation of complex cognitive and speech and language disorders and giving younger patients the opportunity for longer periods of rehabilitation focused on social/family and vocational roles. The NICE guideline on trauma recommends MDT assessment, developing rehabilitation plans and setting goals. This is applicable to young people with disabilities after stroke. Reference: NICE guideline. Rehabilitation after traumatic injury.<br>www.nice.org.uk/guidance/ng211 | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline. |
| 87 | | Association of Clinical Psychologists UK (ACP-UK) | Stroke services should not state themselves as being within elderly care medicine. | Not stated as such. No amendment. |

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| 88 | | Scottish Intercollegiate Guidelines Network | The RCPE considers these recommendations are welcome and appropriate. | Thank you for your comment. |
| 89 | | British and Irish Association of Stroke Physicians (BIASP) | In the introduction paragraph, suggest use atypical, rather than unusual cause for their stroke. | The distinction seems marginal. No amendment. |
| 90 | | The Irish Heart Foundation | Many people in this focus group were young stroke survivors (under 65 years), and although glad to be represented within the guidelines they felt that there should be a greater focus and detail within this section.<br><br>It was stated that social support including returning to work, family life, and financial support is ongoing for many more years post-stroke.<br><br>Many comments concentrated on returning to work which will be stated in the appropriate section. There was also a focus on moving between different stages of life post-stroke and the social expectations associated with age- this included starting a family and managing relationships, and social life.<br><br>From these comments, it was concluded that emphasis is required on the need for long-term continuous support and how to access the correct support. | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline.<br><br>The focus on return to work reflected the fact this section was updated in the current guideline process. |
| 91 | | Irish Association of Physical and Rehabilitation Medicine | Again, no mention of the potential benefit of specialist neurorehabilitation services to cater for the specific needs of this population. | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline |
| 92 | | Brain Injury Matters (NI) | Recommendation C<br>People who have had a stroke in childhood and require ongoing healthcare into adulthood<br>should have their care transferred, in a planned manner. This needs to be done in collaboration with appropriate adult services (including statutory health services), social services, and suitable voluntary / third sector organisations. In this way, the obligations and commitments to the UN Convention on the rights of persons with disabilities can be achieved with regards to education (Article 24: “right of persons with disabilities to education” to ”ensure an inclusive education system at all levels and lifelong learning”), Work (Article 27: “the right of persons with disabilities to work, on an equal basis with others”) and to Culture, The Arts, Recreation, Leisure and Sport (Article 30: “opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society” as well “in recreational, leisure and sporting activities”). | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline |

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| 93 | | Association of British Neurologists | It is not clear why PFO is considered a problem in younger adults. Right heart pressures rise as we age, as does the incidence of venous thromboembolism. | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline |
| 94 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 95 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Line 737: We query why the recommendation is limited to return to work, perhaps there should be a wider definition in here to reflect return to further education, providing child care, returning to exercise. It feels like this is not strong enough to meet the needs of this group. (is expanded at 2954 but is should this section be referred to earlier?)<br><br>B: This recommendation should be for ALL stroek services eg: acute, rehab, ESD and not just for acute<br><br>C: It is widely acknowledged that transitionally services from, paediatric care to adult care is lacking with not only a lack of services but a lack of signposting. It is well known that the intensity, frequency and specificity that may have been present in paediatric services are not available in adult services. We would strongly urge more specific guidance around this element rather than the current vague recommendation. | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline.<br><br>The focus on return to work reflected the fact this section was updated in the current guideline process. |
| 96 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Should there be a medical recommendation or link to another section with the relevant recommendations re investigations to determine likely cause of stroke and relevant education to individual and family etc | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline. |
| 97 | | Irish Heart Foundation, Council on Stroke | Section 2.14 p.17 L744 - should include "communication" needs also.<br><br>Occupational Therapy<br>Acute stroke services should: – recognise and manage the particular physical, psychological and social needs of younger people with stroke (e.g. vocational rehabilitation, child care)<br>There is no mention of cognitive needs in the above sentence. Also return to/re-engage in Education would seem relevant for younger people with stroke.<br><br>Also, this recommendation should be reworded to capture the importance of completing a comprehensive assessment with<br>young stroke survivors (YSS) to ensure that any subtle effects of the stroke will be detected e.g. MCI, changes to information processing speed, post stroke | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline. |

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| | | | fatigue.<br>Consider recommending a referral to ESD as many persisting stroke deficits are less apparent in the acute phase e.g. psychological impacts, post stroke fatigue. The emphasis of the role of the HASU and ASU teams with YSS should be about identifying ANY post stroke effects with timely referral to an ESD.<br><br>A recommendation to highlighting early referral to an ESD service will mitigate higher functioning YSS with mild stroke symptoms from being missed, references supporting this include: Teller and Rochette 2009; Finch et al 2017; Mahon et al 2020.<br>Recommendation for the ESD service to make onward referrals to appropriate vocational or community stroke teams where needed is required. The issues facing YSSs are not going to be adequately met in the acute phase and ESD alone.<br><br>Stating that this group need additional input is not adequate – recommendation needs to be stronger as to how this input will be actualised | |
| 98 | | Royal College of Physicians of Ireland Clinical Advisory Group | Agree | Thank you for your comment. |
| 99 | Q13. Section 2.15 End-of-life (palliative) care | Royal College of Nursing | Agree with C. There is scope here to include the consideration of advanced directives (touched on in E) and application of the principles of the Mental Capacity Act<br>Agree with D, but feel there will need to be clear processes and documentation for these decisions to protect nurses from prosecution for supporting choking or assisted death.<br>Agree with E but feel advanced care planning in palliative care should be expanded to more than eating and drinking. There may be scope here to also comment on DNACPR | Thank you for these comments. Rec has been reformulated to prioritise prior wishes and preferences in keeping with the legislation in the various nations.<br>These are overarching principles of good practice, rather than specific to this situation.<br><br>Advanced care planning encompasses all aspects of care at the end of life rather than just eating and drinking, and routinely includes DNA CPR decisions. |
| 100 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 101 | | British Psychological Society | Line 769 should include cognitive problems alongside those other problems listed. Following stroke, cognitive problems may further effect patient needs and clinical approach needs in end of life care post-stroke.<br><br>Recommendation C discusses acting in the person's best interests around | Thank you for these comments.<br><br>In section 2.15 End of life (palliative) care - we have added cognitive problems to this list. |

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| | | | decisions regarding life-prolonging treatments. This assumes that the person does not have capacity to make these decisions themselves, while this may very often be the case, some individuals may have capacity to make these decisions. It would be good to see this reflected in the guidance.<br><br>Although individuals "wishes" are already noted, it would be helpful to also explicitly note that services should endeavour to support individuals' religious or spiritual beliefs where possible. | Stroke may cause a range of problems including pain and distress, depression, cognitive problems, confusion and agitation, and problems with nutrition and hydration.<br><br>We have revised Recommendation C and believe wishes would include an individual's religious or spiritual beliefs.<br><br>Decisions to withhold or withdraw life-prolonging treatments after stroke including artificial nutrition and hydration should whenever possible, take the person's prior expressed wishes into account and be taken in the best interests of that person. When withdrawing artificial nutrition and hydration, a recognised nutrition and hydration decision-making process should be considered. [2023] |
| 102 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | The statement in 2.15 C on decisions being taken 'in the best interests of the person' is liable to misinterpretation. The decision maker must comply with the requirements of the Mental Capacity Act 2005 and take care to elucidate the prior wishes and priorities of the patient and consult with family members and those close to the patient | Thank you for these comments.<br><br>We have revised Recommendation C:<br>'Decisions to withhold or withdraw life-prolonging treatments after stroke including artificial nutrition and hydration should whenever possible, take the person's prior expressed wishes into account and be taken in the best interests of that person. When withdrawing artificial nutrition and hydration, a recognised nutrition and hydration decision-making process should be considered. [2023]' |
| 103 | | Chest Heart & Stroke Scotland | 2.15 (778-779) The link to the BMA takes you out of the document. Can it be changed so the link opens on a separate 'URL page' so this document still stay open on the current page.<br><br>2.15 E (798-800) mentions 'People with stroke with limited life expectancy, and their family where appropriate, should be offered advance care planning, with access to community palliative care services when needed.' Should this say inpatient and/or community palliative care services.' | Thank you for your comment – this has been changed.<br><br>Recommendation E has been revised based on this suggestion:<br>'People with stroke with limited life expectancy, and their family where appropriate, should be offered advance care planning, with access to inpatient and community palliative care services when needed.' |
| 104 | | Royal College of Speech and Language Therapists | General – This is an important addition. However, there is a lack of mention of individualised packages of care.<br><br>Page 18, line 774-779 – Speech and language therapists need to be consulted | Throughout the guidelines we focus on the needs of people living with stroke and the clinical interventions required, rather than specify who should provide that intervention. |

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| | | | with any decisions on eating and drinking with acknowledged risks with capacity assessments and best interest meetings. Adding further need for uplifting staffing as these decisions are time consuming. See RCSLT Eating and drinking with acknowledged risks guidance: https://www.rcslt.org/members/clinical-guidance/eating-and-drinking-with-acknowledged-risks-risk-feeding/#section-2 | |
| 105 | | Association for Palliative Medicine of great Britain and Ireland (APM) | End of Life (palliative) Care needs to have this recommendation repeated as the only mention of specialist palliative care (SPC) input is for dying patients. SPC input is required to support patient advocacy in decision-making, and symptom control, as well as education, etc - so "A stroke rehabilitation unit should have access to specialist palliative care services to offer advice about direction of care, symptom control, emotional support to patients and their families, support care of the dying and rapid discharge to die at home for those who request it and to provide education and support staff in the core stroke MDT, ." Evidence for deaths on stroke units being poorly managed without SPC services; Cowey E, Schichtel M, Cheyne JD, Tweedie L, Lehman R, Melifonwu R, Mead GE. Palliative care after stroke: A review. Int J Stroke. 2021 Aug;16(6):632-639. doi: 10.1177/17474930211016603. Epub 2021 May 17. PMID: 33949268; PMCID: PMC8366189.<br>Our experience of the stroke rehab unit is that the medical team feel they must continue all support for six weeks including artificial nutrition - in some cases even when the patient or their representative are trying to tell them they would rather die than continue it. Support is required from SPC teams to advocate for these patients.<br><br>We couldn't see anything about Treatment Escalation Plans in the document - it would be relevant in acute stroke and rehab phase. We also couldn't see anything about advance care planning discussions for longer term care post hospital discharge. We think these would all be really important additions. | The GDG are supportive to these aspects of good practice at the end of life, although the requirement for access to SPC is clearly stated in Rec 2.15E. The GDG agree that practice in this area could be improved for patients with limited life expectancy, and the review cited reflects that practice remains to be improved since a very similar Recommendation was made in the 2016 edition. To be more specific would require some observational or other comparative evidence (not necessarily from an RCT) that care was improved on stroke units through the implementation of SPC – probably an issue also affecting other clinical areas with high mortality like geriatrics or orthogeriatrics wards. |
| 106 | | Scottish Intercollegiate Guidelines Network | The RCPE considers these recommendations are welcome and appropriate. | Thank you for your comment. |
| 107 | | British and Irish Association of Stroke Physicians (BIASP) | Suggest mention that palliative care referrals should be made early (outside of advanced care planning). | Whilst the GDG is sympathetic to this response, the focus of the update related to this section was: How should eating and drinking be managed towards the end of life after a stroke? so other substantial amendments regarding the timing of SPC involvement were outside scope of the literature review. |
| 108 | | British Dietetic Association | Page 18, line 791-792: | Section 2.15 Evidence to recommendations section includes the following: |

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| | | | Are there any recommendations for "recognised nutrition and hydration decision-making processes"? | The decision-making process to support people to eat and drink with acknowledged risks should be person centred and involve the person and/or family/carers, and other members of the multidisciplinary team, including a swallowing assessment and steps to minimise risk (Royal College of Physicians, 2021; Royal College of Speech and Language Therapists, 2021). The process can be supported by material such as the Clinically-assisted nutrition and hydration guidance from the RCP/BMA (2018) at https://www.bma.org.uk/advice-and-support/ethics/adults-who-lack-capacity/clinically-assisted-nutrition-and-hydration [2023]. |
| 109 | | Association of British Neurologists | Is there any merit in mentioning how some presentations can leave patients looking extremely unwell eg bilateral paramedian thalamic infarcts or cause spuriously high GCS scores eg eyelid apraxia in large right hemisphere lesions bit can have relatively good outcomes. The same cld be said of intracerebral bleeds particularly where there is intraventricular extension. These issues add to the difficulties we face when prognosticating. | Recommendations in this section were reviewed for consistency with other updated sections but the topic areas you refer to were out of scope of this limited update to the guideline. |
| 110 | | Wales Stroke Allied Health Professional Forum | Swallow assessment should be by an appropriately trained SLT | Throughout the guidelines we focus on the needs of people living with stroke and the clinical interventions required, rather than specify who should provide that intervention. |
| 111 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 112 | | United Kingdom Clinical Pharmacy Association (UKCPA) | line 770 -...and swallowing of medication<br>Medication should be reviewed and deprescribed where appropriate in a timely manner. | Recommendations in this section were reviewed for consistency with other updated sections but the topic area you refer to were out of scope of this limited update to the guideline. |
| 113 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | The majority of this section appears appropriate. It is encouraging and beneficial to have the sections on feeding at risk.<br><br>E: We wish to draw attention to the significant issues with patients being identified in a timely manner for palliative or EOL care plans. There is a need to educate family with regards to what this means including the instances that patients may be taken on and off of the care plan, how this is communicated to families and how this is handled. | Thank you for your comment.<br><br>Whilst the GDG is sympathetic to this response, the focus of the update related to this section was: How should eating and drinking be managed towards the end of life after a stroke? so other substantial amendments regarding the timing of SPC involvement were outside scope of the literature review. |
| 114 | | Irish Heart Foundation, Council on Stroke | SLT<br>General<br>— IASLT queries where the additional staffing to support decision making is reflected considering the launch of the new Decision Support Service in Ireland | The recommended staffing levels and scope of Sections 2.5 and 2.8 were agreed through consensus by all relevant professionals simultaneously in the Guideline development group. |

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| | | | (2023) and the Assisted Decision Making and Capacity Act (2015) which is to commence in 2023.<br>— If meaningful SLT supports are recommended re advanced care planning and decision-making, this must be reflected in SLT staffing at Senior Grade and Clinical Specialist level as this requires complex assessment and person-centred, accessible intervention.<br>— For individuals with significant communication disability, a formal capacity assessment requires that the assessment is completed by a suitably qualified person. The IASLT consider that this should be someone who has a knowledge of how to communicate most effectively with the person and is independent of any caring or advocacy roles. Involvement of SLTs in Capacity assessments includes but is not restricted to; assessing communication over a number of sessions, evaluation of abilities, ensuring optimisation of communication skills and that their capacity is maximised at all times, recommending and implementation of facilitative communication strategies to be used by communication partners/capacity assessors during assessment, developing high/low tec assistive technology where appropriate to meet the communicative needs of the individual, being present to provide communication support as required during the assessment process, supporting a person post Stroke to build capacity around choice making and decisions, supporting staff and / or co-decision makers while consulting with people with complex communication needs, education of MDT and family re issues relevant to communication and capacity for decision making (IASLT Position Statement on The Role of SLT in Assessing Capacity and Facilitating Understanding to Support Decision Making for Adults with Communication Disabilities, 2017)<br><br>Specific:<br><br>2.15 Add in Assisted Decision Making and Capacity Act (2015) and IASLT Position Statement on the Role of SLT in Assessing Capacity and Facilitating Understanding to Support Decision Making for Adults with Communication Disabilities (2017). | These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>Recommendations relating to communication disability are covered in Chapter 4. Suggested text is beyond the scope of Chapter 2.<br><br>This is addressed in a specific section devoted to Mental Capacity. |
| 115 | | Royal College of Physicians of Ireland Clinical Advisory Group | Agree<br>L 764 Irish mortality data: in-hospital mortality rate is 10% | Thank you for your comment. |
| 116 | Q14. Section 3.2 | Irish Institute of Clinical | 3.2 A “Patients with acute focal neurological symptoms that resolve completely | Thank you for this comment. The guidelines have been explicit that |

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| | Management transfer to acute stroke services | Neuroscience | within 24 hours i.e. suspected TIA) should be given aspirin 300 mg immediately and assessed urgently within 24 hours by a stroke specialist clinician in a neurovascular clinic or an acute stroke unit."<br><br>Again (as per section 2.3) the IICN reviewers note that this recommendation will lead to TIA evaluations being necessary on a Saturday and Sunday. The majority of true TIAs seen will require carotid imaging, within 24 hours (as per section 3.3 E); and IICN would encourage same day or very soon carotid imaging in TIA assessment as clinicians should not have to take the clinical risk of early avoidable re-occurrence through delayed surgical carotid diagnosis. This can be avoided by evaluating TIA patients with prompt/same day carotid imaging.<br><br>Taking 3.2A and 3.3.E together, we would recommend that the Working Group consider adding a further recommendation:<br>"Patients with TIA or minor stroke should have carotid imaging performed within 24 hours including at weekends"<br>We feel such a recommendation will be important/helpful to strengthen our ability to advocate for resource allocation, and for the clinical safety of TIA opinions delivered over the weekend. | acute stroke care should be available 24 hours a day, 7 days a week [See Evidence to Recommendations 2.3] and this would include access to both brain and carotid imaging.<br><br>Recommendation 3.3 E endorses the need for carotid imaging within 24 hours of assessment and this is deliberately not further qualified so as to indicate that it should be available every day.<br><br>An edited statement has been included within the 3.2 Implication section stating that patients with suspected TIA are assessed, and diagnosed urgently 7 days a week [Line 1103] |
| 117 | | Royal College of Nursing | Agree with all content here | Thank you for your comment. |
| 118 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 119 | | British Psychological Society | no comment | Thank you for your comment. |
| 120 | | Chest Heart & Stroke Scotland | 3.2 A (1045-1048) stipulates that 'Patients with acute focal neurological symptoms that resolve completely within 24 hours (i.e. suspected TIA) should be given aspirin 300 mg immediately and assessed urgently within 24 hours by a stroke specialist clinician in a neurovascular clinic or an acute stroke unit'. Caveat may need to be added here as depending on day of week patient develops symptoms (eg weekend) access to either a neurovascular clinic and/or access to stroke specialist clinician may not be a 7 days a week service in all Health board regions/localities.' | Thank you for this comment. The guidelines have been explicit that acute stroke care should be available 24 hours a day, 7 days a week [See Evidence to Recommendations 2.3] and this would include access to both brain and carotid imaging.<br><br>An edited statement has been included within the 3.2 Implication section stating that patients with suspected TIA are assessed, and diagnosed urgently 7 days a week [Line 1103] |
| 121 | | Royal College of Speech and Language Therapists | N/A | Thank you for your comment. |

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| 122 | | Northern Ireland Stroke Network | A – line 1047 – what is clock start for 24hrs – onset of symptoms? Receipt of referral by acute site?<br><br>B line 1049 – 'ABCD2 should not guide urgency of assessment or subsequent treatment options'. The ESO guidelines clearly state that subsequent treatment should be guided by ABCD2 score in that high risk TIAs should receive DAPT (Dawson et al, European Stroke Journal, 2021) | Thank you for this comment and this has been amended accordingly.<br><br>The evidence suggests that if the ABCD2 score has limited sensitivity to accurately risk stratify patients, then this must be valid whenever or however it is used [Amarenco, 2012] [Line 1079]. The ESO guidelines on the management of TIA [Fonseca et al, European Stroke Journal, 2021] recommends against using prediction tools (e.g. ABCD2 score) alone to identify high risk patients or to make triage and treatment decisions in suspected TIA patients due to limited sensitivity of the scores. The Topic group concluded therefore, if it is used in guiding treatment, it must be considered as being fundamentally inaccurate. Therefore, while it was used in POINT, CHANCE and THALES (note, FASTER suggested high risk clinical features such as weakness, speech disturbance lasting greater than 5 minutes duration), the Topic Group concluded that it should no longer be used to select these patients. Pragmatically, if the clinician thought this was a TIA and they were otherwise suitable for CHANCE, POINT and THALES, they should be treated and managed as such. |
| 123 | | Scottish Intercollegiate Guidelines Network | A – as per 2.4 should be given DAPT or aspirin depending on whether 'high risk' or 'low risk' as per POINT, CHANCE and THALES studies. If giving aspirin only, then specialist review should be within 12 hours to allow DAPT (when needed) within an evidence based time frame ( | Thank you for this comment. This statement has been amended to include the consideration of dual antiplatelet therapy as stated more specifically in Recommendation 3.3 B. Dual antiplatelet therapy should be considered after assessment by stroke specialist within 24 hours after the initial delivery of 300 mg Aspirin. CHANCE, THALES and POINT delivered dual antiplatelet therapy within 12-24hrs and as such the GDG have taken the pragmatic and practical approach to reflect what can be delivered in UK practice and is still reflective of the evidence. |
| 124 | | British and Irish Association of Stroke Physicians (BIASP) | P24 Something should be included about the need to increase TIA service provision to provide 7 day cover in order to see all TIA patients within 24hrs and if appropriate, networks established between neighbouring organisations within an ISDN in order to establish the capacity.<br><br>P24 line 1045 recommendation A. Aspirin 300mg is appropriate for the majority of patients, but may not be appropriate if the patient is on warfarin (with therapeutic INR) or on DOAC. The risk of harm is increased if there is a delay in | Thank you for this comment. This has now been included within the 3.2 Implication section stating that patients with suspected TIA are assessed, and diagnosed urgently 7 days a week [Line 1103]<br><br>Thank you for this comment. The term 'unless contraindicated' has been inserted into the text. [Line 164]. |

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| | | | the patient being seen (which occurs in the NHS) and the patient continues on aspirin inappropriately.<br><br>P24 line 1049 recommendation B We agree ABCD2 score should not be used to triage urgency of referral (all patients should be seen urgently) but we disagree with the recommendation that ABCD2 should not inform subsequent treatment options. The 3 trials supporting DAPT after TIA only included patients with high-risk TIA (ABCD2 score of 4 or more in CHANCE and POINT, 6 or more in THALES) and minor stroke. Risk stratification therefore should inform subsequent management. Given the bleeding risks of DAPT, it would not be appropriate to subject low risk TIA patients to this treatment, without clear evidence of benefit. The recommendation as it stands is not in keeping with ESO recommendation (Dawson et al, Eur Stroke J, 2021). As above, we agree that ABCD scoring systems do not perform adequately for risk stratification to prioritise referrals. However, we disagree that ABCD2 should not be used to inform treatment, as per evidence from CHANCE, POINT and THALES cited above. We agree that patients with possible TIA should not be triaged using risk stratification tools. However, given the reality that referrals to TIA clinics include many patients in whom TIA is very unlikely, some form of triage may be needed. Indeed, this is included in the GIRFT report for stroke, as an example of good practice (Stroke - GIRFT Programme National Specialty Report, NHS, April 2022). We believe that triage of referrals should be considered reasonable, not based on risk scores, but based on likelihood of possible TIA (from information given in the referral).<br><br>P24 line 1049 recommendation B. low risk patients should be considered on an individual basis as there is now movement towards treating all patients' high risk and low risk in a similar fashion. So recommendation ideally -patients should have a discussion with a Stroke Specialist clinician prior to booking brain imaging as CTA and CTP at the initial stage will improve the care of patients and therefore it is advisable that ED doctors liaise with Stroke team prior to requesting initial tests. Triage of a referral by Stroke Team and consultant can be important in terms of running an effective TIA service in view of workforce constraints.<br><br>P25 line 1055 recommendation E. We agree that in in most cases, it is appropriate for decisions about brain imaging to be taken by the stroke specialist. However, there are important exceptions to this, when a CT brain should be performed urgently to exclude a haemorrhage. The indications for | If the evidence suggests that the ABCD2 score has limited sensitivity to accurately risk stratify patients, then this must be valid whenever or however it is used. [Line 1079]. See Amarenco reference [SOS -TIA Study], 2012. The ESO guidelines on the management of TIA [Fonseca et al, European Stroke Journal, 2021] recommends against using prediction tools (e.g. ABCD2 score) alone to identify high risk patients or to make triage and treatment decisions in suspected TIA patients due to limited sensitivity of the score. The Topic group concluded that if the ABCD2 score was deemed to have low calibration in determining future subsequent risk of stroke, if it is used in guiding treatment, it also must be considered as inaccurate. Therefore, while it was used in POINT, CHANCE and THALES (note, FASTER suggested high risk clinical features such as weakness, speech disturbance lasting greater than 5 minutes duration), the Topic Group concluded that it should no longer be used to select these patients. Pragmatically, if the clinician thought this was a TIA and they were otherwise suitable for CHANCE, POINT and THALES, they should be treated and managed as such.<br><br>Thank you for the comment. It is tacit that a triage system would need to be undertaken to coordinate a TIA service particularly in expediting the referral process and this is highlighted in the 3.2 Implication section.<br><br>Thank you for this comment. The indication of brain imaging prior to commencing antiplatelet therapy has been made however the topic group felt that the list did not require to be exhaustive [Line |

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| | | | urgent CT have not been fully described in the draft guidance. These particularly apply to patients who present to ED and are commonly included in ED pathways:<br>1. Patient on anticoagulant or bleeding disorder, to exclude bleed (as stated in draft guidance)<br>2. Current AF and not anticoagulated, to exclude bleed prior to anticoagulation<br>3. Patient with prosthetic heart valves not on warfarin /subtherapeutic INR<br>4. Patient requires DAPT (ie ABCD2 score 4). The ESO guidance states that brain imaging should always be performed prior to initiation of DAPT (Dawson et al, Eur Stroke J, 2021)<br>5. Patient with headache/neck pain (should also include CTA to exclude dissection)<br>We agree that urgent unenhanced CT is the modality of choice to exclude haemorrhage.<br><br>We agree with the comments on imaging, however as above, we believe it is helpful to define the clinical scenarios when urgent CT is indicated to exclude haemorrhage.<br><br>P25 line 1061. Recommendation G. Unless MRIs can be done the same day, which in many centres they cannot. I would consider mentioning other imaging modalities e.g. CT here | 1090].<br><br>Thank you for this comment and this has been highlighted in Recommendation 3.2 E but is not meant to be exhaustive.<br><br>Thank you for this comment. The consensus group for brain imaging considered that MRI should be the principal and preferred choice for delayed presentation TIAs with reference to identifying haemorrhage using blood sensitive MRI sequences. |
| 125 | | RCR Wales | Point F -The recommendation is open to misinterpretation on which patients should be imaged with MRI in TIA.Whilst the 3.2 'evidence to recommendation' comments that only those patient's needing vascular territory confirmation prior to vascular surgery are imaged with MRI, the vagueness of the recommendation in part F may lead all TIA patient's to be referred for MRI, particularly given the comment on detecting the presence of brain ischaemia.<br>Could this be finessed? It is important that suspected TIA patients should be assessed by stroke specialist clinician before decision on brain imaging. Otherwise, there will be more unnecessary scanning. There are constraints in both staff and scanner time availability for every suspected TIA patient to be timely scanned and reported. | Thank you for these comments. The topic group for this recommendation endorsed the use of MRI as the principal modality for detecting presence/distribution of ischaemia however it is acknowledged that in certain circumstances MRI may be contraindicated and therefore it would be a clinician's decision to make a sensible, patient centred and clinical judgement to apply the appropriate clinical imaging. |
| 126 | | Welsh Association of Stroke Physicians | What is the recommendation for assessing whether a TIA is high risk? We note - and welcome - that ABCDetc scores etc are no recommended. | Thank you for this comment. The ABCD2 score has limited sensitivity to distinguish between high and low risk TIA. For |

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| | | | | practical purposes given that 'low risk' patients were de facto identified as 'high risk' subsequently, the Topic Group considered the patients with TIA should be assessed and treated urgently rather than being stratified inappropriately. |
| 127 | | National Imaging Academy Wales | Please see Comments in 16. & 17. in addition.<br>Further agreed guidance for TIA imaging would be helpful - the evidence is scant and the imaging referrals continue to be received and proliferate with little evidence. The lack of the most appropriate referrers is the concern. Addressing this will potentially help when trying to address the shortfall in imaging service capacity for more advanced imaging.<br>One of the team comments:<br>Unfortunately many clinicians are not aware of the TIA guideline and a number of patients with suspected TIAs are not assessed by stroke physicians (as advised by the guideline). This results in referrals for CT heads in patients with suspected TIAs from GPs and non-stroke physicians within the hospital. It would be useful to have more clarity on when a CT-head in patients with suspected TIA is an acceptable first line investigation. Also we have limited resources and struggle to accommodate urgent MRIs in all patients with suspected TIAs. It would also be useful (and would give practical guidance) if there would be guidance on possible alternatives to imaging with MRI (in case there are any). | Thank you for this comment. This has been acknowledged and the GDG hopes that the recommendations made [Recommendation E –Line 1055] will lead to higher quality and appropriate requests for imaging.<br><br>The topic group for this recommendation endorsed the use of MRI as the principal modality for detecting presence/distribution of ischaemia however it is acknowledged that in certain circumstances MRI may be contraindicated and therefore it would be a clinician's decision to make a sensible, patient centred and clinical judgement to apply the appropriate clinical imaging. |
| 128 | | United Kingdom Clinical Pharmacy Association (UKCPA) | Agreed | Thank you for your comment. |
| 129 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations in this section appear appropriate and we have nothing further to add | Thank you for your comment. |
| 130 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Need to include 'Some people after a TIA may have care and support needs beyond prevention: it is the TIA service's responsibility to help them access any care/support/information/advice they require' from the national stroke service model (NHSE).<br><br>Needs recommendation added to 'identify impairments that do not resolve fully (including psychological needs) following TIA or minor stroke and ensure referral to appropriate members of the MDT are required' | Thank you for your comment. The recommendations we have made in Section 3.3 A are not an exhaustive list but it is tacit that clinicians would need to sign post accordingly if further care/support is required for other impairments.<br><br>Thank you for your comments. The GDG would refer to the above response. |
| 131 | | Irish Heart Foundation, Council on Stroke | Section 3.11 Positioning<br>Recommendations B<br>p.46 Line 2048 - for a swallow assessment and any eating / drinking it is | Recommendations for swallowing are covered in Section 4.26. The suggested papers are deemed out of scope of the current guideline update, although the literature review did not pick up the scoping |

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| | | | recommended that the patient sit as upright as possible during the assessment and for minimum 20 minutes afterwards, to reduce the risk of aspiration or choking (IASLT Choking Guidelines, 2021, Chen et al, BMC Scoping Review,2021, Hemsley et al, 2019)<br><br>Evidence to recommendations<br><br>IASLT Choking Guidelines, 2021<br><br>Chen, S., Kent, B. & Cui, Y. Interventions to prevent aspiration in older adults with dysphagia living in nursing homes: a scoping review. BMC Geriatr 21, 429 (2021). https://doi.org/10.1186/s12877-021-02366-9<br>Hemsley, Bronwyn; Steel, Joanne; Sheppard, Justine Joan; Malandraki, Georgia A.; Bryant, Lucy; Balandin, Susan (2019): An integrative review of choking incidents (Hemsley et al., 2019). ASHA journals. Journal contribution. https://doi.org/10.23641/asha.8121131.v1 | reviews cited by the reviewer – possibly because they did not meet the quality threshold. |
| 132 | | Royal College of Physicians of Ireland Clinical Advisory Group | Recommendations A, agree with appropriate staffing and funding and access to diagnostics B, E, F (Agree MRI preferred imaging but implications/funding requirement significant, G<br>L 1059 – access to MRI for all suspected TIAs would prove very difficult, CT would be the usual diagnostic offered in Ireland<br>L 1085-96 – from an Irish perspective, 7/7 access to stroke specialists for TIA, and access to timely MRI is a challenge. Could this be rephrased to reflect that acute CT can be useful to facilitate discharge? | Thank you for this comment. This has been acknowledged and the GDG hopes that the recommendations made will lead to higher quality and appropriate requests for imaging.<br><br>The topic group for this recommendation endorsed the use of MRI as the principal modality for detecting presence/distribution of ischaemia however it is acknowledged that in certain circumstances MRI may be contraindicated and therefore it would be a clinician's decision to make a sensible, patient centred and clinical judgement to apply the appropriate clinical imaging. |
| 133 | Q15. Section 3.3 Management of TIA and minor stroke - treatment and vascular prevention | Irish Institute of Clinical Neuroscience | 3.3A We are concerned about the wording/timing: "Patients with minor ischaemic stroke or TIA should receive treatment for secondary prevention as soon as the diagnosis is confirmed, including ….<br>– blood pressure-lowering therapy with…."<br>c.f. Section 3.10 I. (Don't acutely lower BP unless 185/110). Patients may present as apparent TIA with lacunar osteal/perforator/"capsular warning" syndromes that flicker on and off. Lowering of BP too early might increase the risk of hypoperfusion of the lacunar territory. Seen after the first hemiplegia has resolved as an apparent TIA, it would be suboptimal to acutely lower blood pressure in these individuals as they at high risk for early re-occurrence. We would suggest a five day period before new blood pressure lowering medication | Thank you for this comment. The recommendation stated is not advocating blood pressure lowering for all patients and clinicians would need to make an informed decision of when to commence such therapy and in which patients. |

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| | | | is commenced following TIA or minor stroke.<br><br>3.3E Again (as per section 2.3) the IICN reviewers note that this recommendation will lead to TIA evaluations being necessary on a Saturday and Sunday. The majority of true TIAs seen will require carotid imaging, within 24 hours (as per section 3.3 E); and IICN would encourage same day or very soon carotid imaging in TIA assessment as patients/clinicians should not have to take the clinical risk of early avoidable re-occurrence through delayed surgical carotid diagnosis. This can be avoided by evaluating TIA patients with prompt/same day carotid imaging. Taking 3.2A and 3.3.E together, we would recommend that the Working Group strongly consider adding a further recommendation:<br>"Patients with TIA or minor stroke should have carotid imaging performed within 24 hours including at weekends" We feel such a recommendation will be important/helpful for resource allocation and for the clinical safety of TIA opinions delivered over the weekend. We recommend that such carotid imaging is essential over the weekend, whereas brain imaging is lower priority. | Thank you for this comment. The guidelines have been explicit that acute stroke care should be available 24 hours a day, 7 days a week [See Evidence to Recommendations 2.3] and this would include access to both brain and carotid imaging and a new statement has been included within the 3.2 Implication section stating that patients with suspected TIA are assessed, and diagnosed urgently 7 days a week [Line 1103] |
| 134 | | Royal College of Nursing | Nothing to add to this content | Thank you for your comment. |
| 135 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 136 | | British Psychological Society | Anyone found to have a diagnosis of stroke whilst being seen within TIA clinic can access the services of ESD in the community, which is essential. This needs to be reflected within the recommendations. | Thank for this comment and it goes without saying that referral to ESD services would be enacted according to patients needs wherever they reside (home, community or clinic setting) and this is stated in Chapter 2. |
| 137 | | The Stroke Association | With regards to Recommendation A, we would suggest that there should be a greater emphasis on providing patient information, and on signposting stroke survivors to services that can actually help them act upon this information and make appropriate lifestyle changes. From a survey the Stroke Association conducted as part of Stroke Prevention Day 2022, we know that more than four out of five stroke survivors surveyed say they had not realised that they were at risk of a stroke, and 90% would urge their younger self to make lifestyle changes to prevent their stroke, indicating that access to information is a key barrier to making preventative lifestyle decisions.<br><br>In reference to Recommendation A, we note that people with TIA often do not have a clearly defined pathway following their diagnosis. A common unmet need | Thank you for this comment and Topic Group were satisfied that the current recommendations listed in 3.3 A were adequate to address the secondary prevention issues.<br><br>Thank you for this comment. Although it is acknowledged that cognitive and emotional complications can occur after TIA, this |

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| | | | includes psychological problems, as identified in Dr Eirini Kontou's OPTIMISM study (https://www.nottingham.ac.uk/research/groups/strokerehabilitation/projects/optimism.aspx). We recommend that people should be offered appropriate psychological assessment and therapy following a TIA.<br><br>Suggested edit: Change Recommendation A to:<br>'Patients with minor ischaemic stroke or TIA should receive treatment for secondary prevention as soon as the diagnosis is confirmed, including:<br>– discussion of individual lifestyle factors (smoking, alcohol excess, diet, exercise), provision of information about the risks and benefits associated with these factors, and signposting to services that can help patients make lifestyle changes;<br>– appropriate psychological assessment and therapy<br>– antiplatelet or anticoagulant therapy;<br>– high intensity statin therapy;<br>– blood pressure-lowering therapy with a thiazide-like diuretic, long-acting calcium channel blocker or angiotensin-converting enzyme inhibitor.' | question was beyond the scope of the current guideline. The study highlighted cannot be cited as it is not yet in publication. |
| 138 | | Northern Ireland Stroke Network | B The proposed guidelines are essentially suggesting that all TIAs get DAPT, without clear mention of scan before. However, the 3 RCTs showing benefit of DAPT only recruited high risk TIAs, (based on ABCD) and the European Guidelines explicitly say<br>1. DAPT is for high risk TIAs only<br>2. Brain scan should be done beforehand<br>3. Should be started asap within 24h | Thank you for this comment. It is correct that all 3 RCT's (CHANCE, POINT and THALES) examining the effect of dual antiplatelet therapy used either CT or MRI scanning before randomisation to exclude intracranial bleeding or conditions other than cerebral ischaemia that could account for neurological symptoms and this has now been included in the evidence to recommendation section [3.3], Line 1213. For patients with a TIA, dual antiplatelet therapy should begin as soon as the diagnosis is made, and such patients should have brain imaging performed prior to commencing such therapy [Line 1090].<br><br>If brain imaging is delayed there is an argument that the benefit of starting dual antiplatelet therapy acutely exceeds the risk with intracranial haemorrhage as the benefits with the trials of aspirin/clopidogrel were evident in the first 10 days (risks of major extracranial haemorrhage: 0.2% at 90 days; intracranial haemorrhage 0.1% at 90 days). The evidence suggests that the number patients with suspected TIA who have other conditions such as subdural haematomas, intracerebral haemorrhage is low |

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| | | | | and therefore it may be arguable that withholding antiplatelets acutely and waiting for MRI is not justifiable in specific circumstances, however the Topic Group and Editors supported the use of brain imaging prior to dual antiplatelet therapy in accordance with the trial data.<br><br>The recommendations provided have already endorsed the consideration of dual antiplatelet therapy within 24 hours of symptom onset [Recommendation 3.3 B Line 1121]<br><br>It has been acknowledged in the evidence to recommendations section [3.3] that the evidence applied to patients in the trials were designated as high risk according the ABCD2 nomenclature. The Topic Group have considered this and have concluded that the use of the ABCD2 tool had low sensitivity and poor calibration for determining 'high' and 'low risk TIA' and as such should not be used to make triage or treatment decisions. [Line 1079]. Logically, if ABCD2 score has limited sensitivity to accurately risk stratify patients, then this must be true whenever or however it is used. Due to its limited sensitivity, there would be a concern that patients who were deemed low risk (ABCD2 <4) who were in fact high risk would potentially be excluded from such trials. Pragmatically, the Topic Group/GDG endorsed, if the clinician deemed that the patient had a TIA and they were otherwise suitable for THALES, CHANCE and POINT, they should be treated as such. |
| 139 | | Scottish Intercollegiate Guidelines Network | B – FIRST BULLET POINT - It looks like DAPT is being used by everyone whether high or low risk. This is some distance away from the evidence from DAPT trials. Low risk TIAs were excluded from the trials. If you want to use DAPT in that group you need to show that the benefits are the same and make any risk (which did occur on DAPT) is outweighed by the benefit. If you include all patients you are spinning the results. The trial selected 'high risk' patients to improve the chance of getting a positive result and to limit harm. | Thank you for this comment. It has been acknowledged in the evidence to recommendations section [3.3] that the evidence applied to patients in the trials were designated as high risk according the ABCD2 nomenclature. The Topic Group have considered this and have concluded that the use of the ABCD2 tool had low sensitivity and poor calibration for determining 'high' and 'low risk TIA' and as such should not be used to make triage or treatment decisions. [See Amarenco, 2012]. Logically, if ABCD2 score has limited sensitivity to accurately risk stratify patients, then this must be true whenever or however it is used. Due to its limited sensitivity, there would be a concern that patients who were |

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| | | | | deemed low risk (ABCD2 <4) who were in fact high risk would potentially be excluded from such trials.<br>Pragmatically, the Topic Group/GDG endorsed, if the clinician deemed that the patient had a TIA and they were otherwise suitable for THALES, CHANCE and POINT, they should be treated as such. |
| | | | B – SECOND BULLET POINT - Use of clopidogrel monotherapy here. Has it been shown that clopidogrel monotherapy is as good as aspirin acutely? Why not use aspirin? It's evidence based. As you so eloquently say, some patients will be clopidogrel resistant. Also, there is no PR version of Clopidogrel.<br><br>The recommendation for clopidogrel monotherapy in patients who are not appropriate for dual antiplatelet therapy is an off label use. Ticagrelor is not licensed as anti-platelet therapy for TIA or minor ischaemic stroke. Can this please be noted in the guideline?<br><br>The RCPE supports these recommendations. | Thank you for this comment. The evidence for clopidogrel as monotherapy versus aspirin has been translated from the CAPRIE study, although one acknowledges that the patient population included a variety of atherosclerotic disease including recent ischaemic stroke.<br><br>Thank you for this comment. Recommendations in this guideline about the use of specific drugs (and devices) do not take into account whether the drug is licensed or approved for use by the Medicines and Healthcare products Regulatory Agency (MHRA), European Medicines Agency (EMA), or the Scottish Medicines Consortium (SMC) for that particular use. It is the responsibility of the individual clinician and their healthcare provider to decide whether to permit the unlicensed or unapproved use of drugs in their formulary. |
| 140 | | British and Irish Association of Stroke Physicians (BIASP) | P26 line 1111. Recommendation A. Recommend High intensity 'lipid-lowering' therapy, rather than statin. Also is there enough evidence to truly suggest an anti-hypertensive class? Suggest just say blood pressure lowering medication. Also might be contradictory with section 5.4A-B.? add diabetes? – check HbA1c. Recommend adding BP and lipid targets to this section, when should they be rechecked etc.<br><br>P26 line 1111. Recommendation A. It is not clear whether the recommendation is to give antihypertensive therapy to all patients, or just those with hypertension. It may be helpful to give some guidance on this.<br><br>P26 line 1118. Recommendation B. Perhaps a comment could be made about co-prescribing lansoprazole in all patients over the age of 75, as Peter Rothwell's paper from Oxford showed that over 75, the risk of gastrointestinal haemorrhage | Thank you for this comment. The Topic Group recommended stain therapy as this is considered as first line therapy. The blood pressure therapy classes described are extrapolated from secondary prevention studies (consistent with Recommendation 5.4B).<br><br>It is tacit that antihypertensive therapy should only be given to patients with hypertension and not all patients.<br><br>Thank you for this comment. The article by Li et al (Lancet, 2017) has been noted but this only reflected patients receiving aspirin monotherapy. |

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| | | | increases with aspirin monotherapy. | |
| | | | P26 line 1118. Recommendation B. Some recognition of the choice of PPI to be used with co prescription with clopidogrel should be included. | Thank for you for this comment. The prescription choice of PPI will be left to decision of the individual clinician, noting that omeprazole and esomeprazole may inhibit the efficacy of clopidogrel. |
| | | | P26 line 1118. Recommendation B. The 3 trials supporting DAPT after TIA only included patients with high-risk TIA (ABCD2 score of 4 or more in CHANCE and POINT, 6 or more in THALES) and minor stroke (NIHSS 3 or less in CHANCE and POINT, NIHSS 5 or less in THALES). We suggest the recommendation for DAPT after TIA should only apply to high-risk TIA. In addition, minor stroke should be defined, as per the trials (NIHSS 5 or less for all DAPT regimes would seem reasonable given the findings of THALES). As above, the evidence for DAPT only applies to high-risk TIA and minor stroke. This should be made clear in the summary of the evidence. | Thank you for this comment. The definitions for minor stroke have already been noted in the evidence to recommendations section in 3.3.<br><br>Thank you for this comment. It has been acknowledged in the evidence to recommendations section [3.3] that the evidence applied to patients in the trials were designated as high risk according the ABCD2 nomenclature. The Topic Group have considered this and have concluded that the use of the ABCD2 tool had low sensitivity and poor calibration for determining 'high' and 'low risk TIA' and as such should not be used to make triage or treatment decisions. Logically, if ABCD2 score has limited sensitivity to accurately risk stratify patients, then this must be true whenever or however it is used. Due to its limited sensitivity, there would be a concern that patients who were deemed low risk (ABCD2 <4) who were in fact high risk would potentially be excluded from such trials.<br><br>Pragmatically, the Topic Group/GDG endorsed, if the clinician deemed that the patient had a TIA and they were otherwise suitable for THALES, CHANCE and POINT, they should be treated as such. |
| | | | P26 line 1127. Recommendation B. Should the ticagrelor recommendation be this firm given the not proven generalisability | Thank you for this comment. THALES was the only trial describing the effectiveness of ticagrelor and aspirin versus monotherapy with over 11,000 patients included which is of similar magnitude for the clopidogrel based trials.<br><br>Thank you for this comment. The current evidence available does not specifically inform the clinical usefulness of genetic testing in |

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| | | | P26 line 1136. More firm advice on investigating and managing clopidogrel resistance should be included e.g. checking gene and which antiplatelet to use as alternative. | the UK population with limited availability of such testing and lack of cost effectiveness analyses.<br><br>Thank you for this comment. The mechanism of statin therapy although important, is not relevant to this particular recommendation. |
| | | | P26 line 1138. Recommendation C. A comment could be made about early high intensity statin therapy causing plaque stabilisation and reducing early ischaemic stroke rather than its impact of lowering cholesterol. | Thank you for this comment. This has now been edited with the addition of carotid ultrasound, CT angiography or MR angiography. [Line 1145]. |
| | | | P27 line 1143. Recommendation E. Carotid imaging could include ultrasound, or non-invasive imaging through CT angiography or MR angiography where the degree of stenosis can be calculated. | Thank you for this comment. The choice of imaging modality has now been reframed in Line 1145. |
| | | | P27 line 1143. Recommendation E. The vascular surgery target is 2 weeks from index event to CEA. For most patients, who will not avail of CEA over weekend, carotid imaging next working day may be adequate. We believe CTA (or MRA) may have added value, aside from identifying patients with high grade carotid stenosis who may require CEA. The added value of CTA includes identification of intracranial stenosis, dissection, free-floating thrombus and other abnormalities that may influence medical treatment, as well as useful prognostic information ( eg CATCH study, Stroke 2012:43(4):1013-7). We suggest addition of a recommendation that CTA/MRA should be considered if there is concern about any of the above conditions.<br><br>P27 line 1143. Recommendation E. We think that it should be strongly encouraged for patients to have a CTA or MRA in all stroke patients except those who are likely to go on to have fully supportive or palliative care. | Thank you for this comment. The choice of imaging includes ultrasound as well as CT and MR angiography. |
| 141 | | RCR Wales | Point E- Carotid Doppler should be used as primary diagnostic method. | Thank you for this comment and the editor agrees with this statement that carotid doppler is the principal investigation available in the majority of services. |
| 142 | | Welsh Association of | Reservations about this section were raised based on current evidence | Thank you for this comment. These results have been summarised |

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| | | Stroke Physicians | particularly in relation to the recommendation of a combination of aspirin plus ticagrelor for 30 days after an ischaemic stroke based on the results of the trials listed below.<br><br>Here are the results of the THALES trial:<br><br>"A total of 11,016 patients underwent randomization (5523 in the ticagrelor–aspirin group and 5493 in the aspirin group). A primary-outcome event occurred in 303 patients (5.5%) in the ticagrelor–aspirin group and in 362 patients (6.6%) in the aspirin group (hazard ratio, 0.83; 95% confidence interval [CI], 0.71 to 0.96; P=0.02). Ischemic stroke occurred in 276 patients (5.0%) in the ticagrelor–aspirin group and in 345 patients (6.3%) in the aspirin group (hazard ratio, 0.79; 95% CI, 0.68 to 0.93; P=0.004). The incidence of disability did not differ significantly between the two groups. Severe bleeding occurred in 28 patients (0.5%) in the ticagrelor–aspirin group and in 7 patients (0.1%) in the aspirin group (P=0.001).<br><br>In the POINT trial:<br><br>"Major ischemic events occurred in 121 of 2432 patients (5.0%) receiving clopidogrel plus aspirin and in 160 of 2449 patients (6.5%) receiving aspirin plus placebo (hazard ratio, 0.75; 95% confidence interval [CI], 0.59 to 0.95; P=0.02), with most events occurring during the first week after the initial event. Major haemorrhage occurred in 23 patients (0.9%) receiving clopidogrel plus aspirin and in 10 patients (0.4%) receiving aspirin plus placebo (hazard ratio, 2.32; 95% CI, 1.10 to 4.87; P=0.02)"<br><br>In the CHANCE trial:<br><br>"Stroke occurred in 8.2% of patients in the clopidogrel–aspirin group, as compared with 11.7% of those in the aspirin group (hazard ratio, 0.68; 95% confidence interval, 0.57 to 0.81;  P | in the evidence to recommendations section [3.3] with these results being interpreted to develop the recommendations in 3.3 B. |
| 143 | | National Imaging Academy Wales | See Comments 14. | Thank you for your comment. |
| 144 | | United Kingdom Clinical Pharmacy Association (UKCPA) | 3.3 A- line 1113--include illicit or recreation substance misuse | Thank you for this comment which the GDG felt there was no requirement to produce an exhaustive list. |

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| | | | 1127-- the use of ticagrelor is unlicensed in ischaemic stroke<br><br>1137- pharmacogenomic testing for clopidogrel Cyp 2C19 (see NICE TA on clopidogrel testing under consultation) where available | Thank you for this comment which we have noted.<br><br>Thank you for this comment. At present, the current evidence available does not specifically inform the clinical usefulness of genetic testing in the UK population with limited availability of such testing and lack of cost effectiveness analyses. |
| 145 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We would welcome a consensus on the definition of minor stroke as well as the consideration of further assessment once these individuals are at home in the community.<br>Work by Crow et al indicate a lack of recognition and services available for those who have had a minor stroke | Thank you for this comment and this is noted in the evidence to recommendations section [3.3]. The source is out of scope of our literature searches for this question. |
| 146 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Please add- Where impairments persist past 24 hours following TIA or minor stroke, appropriate intervention (therapy or nursing) should be offered in line with broader stroke guidance.<br>Local referral processes should be in place to ensure timely referral for this group with ongoing unmet needs.<br><br>3.3A- is discussion enough? Should it include some sort of acknowledgment of patient activation and identifying support for those who need intervention to successfully adopt behavioural change.<br><br>Please make link to driving section | Thank you for your comment. The recommendations we have made in Section 3.3 A are not an exhaustive list but it is tacit that clinicians would need to sign post accordingly if further care/support is required for other impairments.<br><br>Thank you for your comments. The GDG would refer to the above response. |
| 147 | | Irish Heart Foundation, Council on Stroke | Dietetics<br>Recommendation A states “Patients with minor ischaemic stroke or TIA should receive treatment for secondary prevention as soon as the diagnosis is confirmed, including:, discussion of individual lifestyle factors (smoking, alcohol excess, diet, exercise)”.<br>COMMENT: This has implications for dietetics services, as patients will need a 1:1 assessment in terms of risk reduction strategies. The implications section for section 3.3 should include the need for specific dietetics staffing to be able to quickly address the needs of this population.<br><br>Medicine<br>Line 1059 For patients with suspected TIA, MRI should be the principal brain imaging - should include unless contra-indications exist. | Thank you for the comments.<br>The recommended staffing levels and scope of Sections 2.5 and 2.8 were agreed through consensus by all relevant professionals simultaneously in the Guideline Development Group.<br><br>These guidelines should be used with an understanding of the local context to inform more detailed service specifications including banding and may include increased staffing if deemed appropriate.<br><br>Thank you for this comment. It is tacit that this is the case and the editors feel there is no requirement for this to be stated. |
| 148 | | Royal College of | Agree | Thank you for your comment. |

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| | | Physicians of Ireland Clinical Advisory Group | | |
| 149 | Q16. Section 3.4 Using imaging to determine diagnosis and treatment of acute stroke | Royal College of Nursing | Nothing to add to this section | Thank you for your comment. |
| 150 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 151 | | British Psychological Society | No comment | Thank you for your comment. |
| 152 | | Scottish Intercollegiate Guidelines Network | The RCPE supports these recommendations but agrees that they will mean in many cases a step-change in provision which will require additional resource. | Thank you for your comment. |
| 153 | | British and Irish Association of Stroke Physicians (BIASP) | NOSIP not mentioned. No recognition of the overlap – individual trusts may struggle with which guideline to follow.<br><br>P29 line 1258 3.4 recommendations. You could consider rewording the recommendation about CT angiography to say: "All patients with an ischaemic stroke should be considered for CT angiography, especially those who are eligible for intravenous thrombolysis or mechanical thrombectomy. The presence of vessel occlusion on a CT angiogram is a strong predictor of neurological disability if left untreated by thrombolysis or mechanical thrombectomy."<br><br>It may also be worth saying something about artificial intelligence here: "Artificial intelligence programmes can detect large vessel occlusion in selected patients and may help identify those that can benefit from mechanical thrombectomy. This should only be used by clinical staff that has had appropriate training."<br><br>P29 line 1269 Recommendation E. The approach to imaging for stroke with delayed presentation is not as simple as either CTP or MRI – ie they are not equivalent (assuming this is referring to standard stroke protocol MRI versus MRI-perfusion).<br>MRI for wake-up stroke may identify a pattern (FLAIR/DWI mismatch) suggestive | Thank you for the comment. The National Optimal Stroke Imaging Pathway has been referenced in the 3.4 Evidence to Recommendation Section [Line 1296], NHS England 2021.<br><br>Thank you for this comment and the GDG felt that routinely considering CT angiography for all patients with ischaemic stroke would not be appropriate or applicable for all patients.<br><br>Thank you for this comment. The terminology of Artificial Intelligence (AI) used in trial settings has already been highlighted in the evidence to recommendations section [3.5], Line 1575.<br><br>Thank you for this comment. The IPA meta-analysis by Campbell [2019] evaluating thrombolysis in patients who were late presenters (4.5-9 hrs) also included 50% who were wake up stroke |

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| | | | of stroke with an onset of less than 4 ½ h ago, thereby allowing thrombolysis to proceed. However FLAIR/DWI mismatch only identifies around 62% of patients who are within the<br>0–4·5 h time window and excludes patients who might have salvageable brain tissue beyond 4 ½ h (Campbell et al, Lancet 2019, 13;394(10193):139-147).<br>CTP (or MR perfusion) is the preferred first-line "additional" imaging modality for late presenters (beyond 4 ½ h) with MCA territory stroke as:<br>1. it is likely to identify more patients eligible for late thrombolysis than MRI using FLAIR/DWI mismatch<br>2. it will also identify patients who present beyond 6h who have salvageable brain and may be eligible for thrombectomy (if LVO present).<br>However, CTP may not identify salvageable penumbra in patients with lacunar stroke, ACA territory stroke and posterior circulation strokes who may be eligible for late thrombolysis; in these scenarios MRI may be more helpful to identify wake-up patients who are suitable for late thrombolysis on basis of FLAIR/DWI mismatch.<br><br>If CT perfusion is being performed, it should be performed at same time as CT and CTA to avoid delays.<br><br>We suggest, all hyperacute centres should have access to both 24/7 CTP and MRI to assess late presenters/ wake-up strokes as appropriate.<br><br>P29 line 1269 Recommendation E. All patients with unspecified time of onset should have advanced imaging either with MRI or CT perfusion depending on local expertise.<br>Ideally all hyperacute patients with Stroke should have CT, CTA, considered for CTP and an MRI acutely if a CTP is not possible. All patients with delay in transfer to the thrombectomy centre or a change in en route should be considered for repeat imaging including CTA or CTP which may guide further management. Also all centres should have availability of a CTP and a robust out of hours service for review with direct liaison re tertiary centres or local report. Every tertiary centre should have a standardised approach to interpretation of CTP to ensure uniformity across Stroke Team.<br><br>P29 line 1272 Recommendation F. Clinical judgement could be applied as to | and employed both CT and MR perfusion. Both these sequences were the principal imaging modalities used.<br><br>The IPA meta-analysis for wake up stroke/unknown time of onset (Thomalla, 2020) used MR in most cases (85%) including MRI DWI-FLAIR mismatch as the principal modality (WAKE UP trial was the largest contributor to the analysis).<br><br>Whilst it is acknowledged that there are some limitations to MRI [DWI-FLAIR mismatch] such as absence of mismatch observed in up to 40% of cases presenting with known stroke duration of < 3 hours, if a service was to employ MR as an available modality for unknown time of onset, it would not be unreasonable for a DWI/MRI sequence to be performed in the first instance.<br><br>The recommendation therefore has been amended to reflect these points advocating CT/MR perfusion as modality for late presenters and wake up and MR DWI FLAIR specifically for wake up [Line 1269]<br><br>Thank you for this comment. This statement has already been endorsed in Line 1296 [section 3.4]<br><br>Thank you for this comment. This has already been highlighted in Line 1251 in Section 3.4<br><br>Thank you for this comment. This has been highlighted in Line 192 under Section 2.4. The NOSIP articulating the multimodality imaging requirements have been referenced [1296]. |

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| | | | when SWI is needed. For example, SWI is very unlikely to add useful information in young patients with likely functional weakness or migraine, for whom MRI is needed to exclude stroke. In contrast, SWI is very helpful in older patients who may have CAA. | Thank you for this comment. The role of MRI SWI sequences are well known for CAA but also for other conditions across all ages (microbleeds for example in vasculitis) |
| 154 | | RCR Wales | Agree to all but again with point E There is growing evidence that CT and CTA in late presentation stroke is non-inferior to CT perfusion. Has the data from the CLEAR study in JAMA neurology and the MR CLEAN - LATE study 2022 been reviewed in making this recommendation. I'm not sure CT perfusion will be needed as a core imaging modality and it is not universally used by interventional neuroradiologists for this reason.<br>Currently there are not enough appropriately trained health care professional to interpret results of acute stroke imaging for decision regarding reperfusion in most HBs to provide 24/7 service. | Thank you for this comment. Data from the CLEAR study was considered, however the GDG and Editors are keenly awaiting the publication of MR CLEAN LATE to include in the guidelines. The results of which have implications of determining the principal imaging modality to be used in the late time window. |
| 155 | | Welsh Association of Stroke Physicians | The emphasis of the recommendations for imaging in patients with symptoms lasting for less than 24 hours is - from the outset - that they have had a TIA and this to some extent leaves begging a number of questions that acute physicians have to confront as a priority including the presence of intracranial pathologies than can present with intermittent symptoms e.g. tumours, sub-durals, small infartcts and bleeds, all of which need to be excluded quickly before other diagnoses are considered. Plain CT imaging of the brain is available, quick and useful in this regard.<br>The investigation of chest pain may inform this discussion. A CXR is valuable in picking up important pathologies associated with chest pain e.g. pneumonia, lung cancer and pneumothorax. At the front door a CT head - the chest x-ray of the brain - is very effective in picking up pathologies that are often labelled as a "TIA". | Thank you for this comment. The recommendations for brain imaging for TIA have been stated in Section 3.2, Recommendation E and F. |
| 156 | | National Imaging Academy Wales | I have received these specific reflections and queries regarding Acute Stroke Imaging<br>- Acquiring a CTH and CTA in acute stroke (arch to vertex) at the same session (= 6<br>§ Patients that present late (from 4.5h up to 24h after onset) or with a wake-up stroke could be considered for thrombectomy if CTP demonstrates certain criteria.<br><br>There is no guidance on what to do if there will be a significant delay between CT/CTA/CTP and the thrombectomy treatment. Common scenarios include:<br>Acute stroke patient presents at 4pm (within 4h of onset of acute stroke), CTH | Thank you for this comment. The importance of developing local pathways and policies at local and regional level to enhance delivery of time critical treatments have been recognised in a number of sections throughout the guidance. |

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| | | | and CTA shows anterior circulation large vessel occlusion confirming eligibility for thrombectomy - it will not be uncommon that the CTH/CTA/CTP acquisition and reporting will take the patient to a time frame of 5.5h-6h after onset; if the patient needs to be transferred to different centre that would delay the thrombectomy further to probably in the region of 7h after onset. Does that mean the patient would have to be re-imaged with CTP to confirm eligibility in the thrombectomy referral centre?<br><br>Implications: These are large, as described as a step-change, with significant increase in required capacity for both imaging provision and interpretation. Concerns are raised that if there is not a contemporaneous step-change in Specialist Stroke Physician/Acute Stroke Unit expertise, there will be an undifferentiated increased demand for advanced imaging which will be difficult for Imaging Departments to manage. | |
| 157 | | United Kingdom Clinical Pharmacy Association (UKCPA) | nil | Thank you for your comment. |
| 158 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations in this section appear appropriate and we have nothing further to add | Thank you for your comment. |
| 159 | | Royal College of Physicians of Ireland Clinical Advisory Group | 24 HOURS TO CAROTID IMAGING | Thank you for the comment. This has already been highlighted in Recommendation 3.3 E. |
| 160 | Q17. Section 3.5 Management of ischaemic stroke | Royal College of Nursing | Grammatical suggestion to intro section, the Allen et al ref may be better at the end of the sentence.<br>No further comment re the recommendations or evidence | Thank you for this comment, noted. |
| 161 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for this comment. |
| 162 | | British Psychological Society | No comment | Thank you for this comment. |
| 163 | | Chest Heart & Stroke Scotland | In the initial paragraph it states '1 in 9 with acute stroke in UK' however data is from SSNAP therefore does this cover Scottish data also? | Thank you for this comment. It only covers nations participating in SSNAP. All three national audits are now cited in the text. |
| 164 | | Royal College of Speech and Language Therapists | N/A | Thank you for this comment, |
| 165 | | The Stroke Association | We welcome the recommendation on starting thrombolysis between 4.5-9 hours | Thank you for this comment. |

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| | | | of known onset, or within 9 hours of the midpoint of sleep when they have woken with symptoms, if they have evidence of salvageable brain on imaging. We also welcome the recommendation on patients receiving thrombectomy 6-24 hours following their stroke, dependent upon the image criteria being met. In addition, we welcome the recommendation on patients with acute ischaemic stroke in the posterior circulation within 12 hours of onset being considered for mechanical thrombectomy. | |
| 166 | | Scottish Intercollegiate Guidelines Network | Tenecteplase is not indicated for use in acute ischaemic stroke so the recommendation is for off label use. Can this be noted in the guideline please? Recommendation B is at odds with the following statement from in the alteplase SPC posology section: Treatment with alteplase must be started as early as possible within 4.5 hours of the onset of symptoms. Beyond 4.5 hours after onset of stroke symptoms there is a negative benefit risk ratio associated with alteplase administration and so it should not be administered.<br><br>The RCPE considers these recommendations are welcome and appropriate. | Thank you for this comment. Recommendations in this guideline about the use of specific drugs (and devices) do not take into account whether the drug is licensed or approved for use by the Medicines and Healthcare products Regulatory Agency (MHRA), European Medicines Agency (EMA), or the Scottish Medicines Consortium (SMC) for that particular use. It is the responsibility of the individual clinician and their healthcare provider to decide whether to permit the unlicensed or unapproved use of drugs in their formulary.<br><br>Thank you for this comment. The evidence stated for alteplase administration > 4.5 hours is valid if there is evidence of salvageable mismatch using either CT/MR perfusion or MRI [DWI-FLAIR mismatch] in wake up stroke. This is the recommendation highlighted in 3.5 B.]<br><br>Thank you for your comment. |
| 167 | | British and Irish Association of Stroke Physicians (BIASP) | P30 line 1315. 3.5 Recommendations. Could we potentially add an extra section about minor stroke: “Patients who present with a minor stroke (NIHSS10 ml (for late thrombolysis based on CTP), it should be noted that the actual patients in the metanalysis who met “automated mismatch criteria” and were shown to benefit from late thrombolysis, had a much more favourable imaging profile than the minimum criteria given in Table 3.5.1. In particular, the alteplase group in metanalysis had median core volume 6.2 ml (IQR 0-22.3 ml) and median perfusion lesion volume of 74 ml (IQR 40.2-117.2 ml). In applying these data to clinical practice, it is important the characteristics of the patients in the trials is borne in mind.<br><br>P30 line 1319 Recommendation B. CT perfusion in MCA territory can miss ACA, lacunar and POCS. We suggest an individualised approach to imaging in late lysis | Thank you for this comment. The editors felt that with the limitations of subgroup analyses that this should not be considered as a priority recommendation.<br><br>Thank you for this comment. The Recommendation B provides the flexibility of either performing CTP or MRI in patients presenting in |

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| | | | or thrombectomy therapy as MRI with DWI/flair mismatch may be more suitable in these patients. | the late time window or in patients with wake up supporting an individualised approach. |
| | | | P30 line 1319 Recommendation B. All patients should be discussed with thrombectomy team with rapid transfer of images and robust clinical governance pathway to ensure decision making is then reviewed at a later date. | Thank you for this comment. The importance of an overarching governance infrastructure has been highlighted in section 2.3 Implications. |
| | | | P31 line 1363 Recommendation I. Agree, but with 4 important additional comments:<br>1. The non-contrast CT (or MRI) criteria for DAWN and DEFUSE-3 should be included as well as perfusion criteria. DAWN excluded patients with 1/3 MCA territory involved (on CT or MRI). DEFUSE-3 excluded patients with ASPECTS score 2), frailty status and comorbidities. | Thank you for this comment. The editors felt that the current recommendations were adequate enough and not to list multiple exclusion criteria. |
| | | | P30 line 1315 3.5 Recommendation. Discussion regarding when to start antiplatelets after thrombectomy. | Thank you for this comment. Aspirin is generally withheld for 24 hours after thrombolysis and the same principal applies with thrombectomy. The editors did not feel the need to state this as a recommendation. |
| | | | P34 line 1447 Consider mentioning recent meta-analysis on basilar artery thrombectomy in evidence section, despite it being weighted by the two mentioned RCTS. | Thank you for this comment. The meta-analysis which has been published in November 2022 [Malik et al] exceeded the time window for inclusion into the guidance. However, it is limited by the non inclusion of fully published data from both recent trials [ATTENTION and BAOCHE] hence it has not been included. |
| | | | P34 line 1452. We agree patients with mild deficits (low NIH scores) benefit from thrombolysis, but only patients with disabling deficits were included in the trials. There remains uncertainty regarding treatment of patients with mild, non-disabling deficits. Hence ongoing trials (eg TEMPO-2). We suggest the word “disabling” is inserted in brackets after the word “mild” in this sentence. | Thank you for this comment. The editors felt that this was not required. Disability perception attained even in mild stroke will vary from patient to patient. |
| | | | P34 Lines 1473-1479. This paragraph is confusing as it initially talks about a radiologically defined penumbra and then describes the WAKE-UP trial. As in previous comments, the WAKE-UP trial used FLAIR/DWI mismatch as a surrogate for time – ie if DWI positive and FLAIR negative, the stroke likely occurred within last 4½ h and is therefore eligible for thrombolysis. FLAIR/DWI does not measure | Thank you for this comment. The line 1473 refers to an opening statement about the merits of advanced imaging in patients with unknown time of onset, > 4.5 hours or wake up and not specifically to the Wake Up trial which you correctly highlighted used the MRI DWI mismatch concept as a temporal indicator of the onset of |

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| | | | penumbra.<br><br>P36 Lines 1565-1577. We suggest that an additional publication from the AURORA metanalysis should be included in this paragraph ie Albers et al. JAMA Neurol. 2021;78(9):1064-1071. This is useful for clinical practice, in that it demonstrated benefit of EVT for patients meeting either the DAWN or DEFUSE-3 criteria across the entire 6-24h window. This supports use of thrombectomy for patients presenting within 6-24h who meet either DAWN or DEFUSE-3 criteria. | ischaemia.<br><br>Thank you for this comment. This has been included in the bibliography. |
| 168 | | RCR Wales | As above.<br>Also for point G /H – should a pre-morbid performance status ie Modified Rankin 0-2 also be included here?<br>Point I – the statement about collaterals on CTA as an imaging criteria has not been included in the table imaging criteria. | Thank you for this comment. This hasn't been included specifically although it is acknowledged that the trials included patients with a pre Rankin score <3.<br><br>Table 3.5.2 includes only the specific criteria for DAWN and DEFUSE-3. |
| 169 | | Welsh Association of Stroke Physicians | Some reservations were expressed about the recommendation of Tenecteplase. The NOR-TEST 2 part A trial found a trend toward an increased rate of symptomatic intracranial haemorrhage with tenecteplase 0.4 mg/kg compared with alteplase 0.9 mg/kg. Furthermore, the tenecteplase group had a significantly lower rate of a favourable outcome and a significantly higher mortality rate. Based on these findings, the trial was stopped early. Although these results are not definitive, it is generally felt that tenecteplase 0.4 mg/kg should not be used for intravenous thrombolysis. Ongoing stroke trials are testing the safety and efficacy of tenecteplase 0.25 mg/kg. One study has shown that tenecteplase may be more effective in lysing large clots in proximal MCA and it could be an option in such patients before endovascular treatment. | Thank you for this comment. It has been acknowledged in the evidence to recommendations section [3.5], Line 1498 of the limitations of the NORTEST-2 study as well as the potential merits of Tenecteplase in patients undergoing subsequent mechanical thrombectomy [EXTEND IA TNK]. The publication of the ACT study which demonstrated non inferiority of Tenecteplase vs Alteplase supports the recommendation on Tenecteplase in 3.5 A. |
| 170 | | National Imaging Academy Wales | As Comments in 16.<br>Thrombectomy in posterior circulation ischaemic infarcts (intra-cranial vertebral and basilar artery occlusion) has been covered for a timeframe for up to 12h (or extended up to 24h) after onset. It states a requirement of NIHSS≥10, favourable PC-ASPECTS score and Pons-Midbrain index. What about patients with a NIHSS ≥6 that present within 4.5h?<br>- In some centres there is emphasis on Modified Rankin Scores of less than 3 to be considered for thrombectomy. This is not included in the guideline (only for decompressive craniectomy). It would be helpful to document clearly if patients should be considered for thrombectomy irrespective of the Modified Rankin scale. | Thank you for this comment. This has been embedded into Recommendation G.<br><br>Thank you for this comment. The prerequisite of patients with a pre-stroke mRS < 3 only be considered for thrombectomy has not been specifically included as it was felt there needed to be a degree of inclusivity based on a individualised approach. |

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| | | | The same with Alberto stroke programme early CT score (ASPECTS score). Some centres would not consider patients for a thrombectomy if the ASPECT score is | Thank you for this comment although the sentence was incomplete. Likewise, the ASPECTS score has not been specifically stated due to the need to adopt an individualised approach although it is acknowledged there is increasing evidence for benefit with scores ≥ 5. |
| 171 | | United Kingdom Clinical Pharmacy Association (UKCPA) | line 1138- tenectaplase is unlicensed in ischaemic stroke currently | Thank you for your comment, which has been acknowledged. |
| 172 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations in this section appear appropriate and we have nothing further to add | Thank you for your comment. |
| 173 | | Irish Heart Foundation, Council on Stroke | Should include Irish National Audit of Stroke 2020 - 10.6% Thrombolysis Rate, 8.6% of all ischemic stroke had thrombectomy | Thank you of this comment. The GDG felt that this statement was not required. |
| 174 | | Royal College of Physicians of Ireland Clinical Advisory Group | L 1305 Please add in Irish data – thrombolysis rate for ischaemic stroke was' 10% in 2021, however both alteplase and tenecteplase was used<br>Have added in some of our 2021 Irish stats to cover mortality, thrombolysis, ICH and therapy input, (also recommended by the Irish Society of Chartered Physiotherapists) can you please cite that as:<br>National Office of Clinical Audit (2023) Irish National Audit of Stroke: A critical review of national stroke data for Ireland from 2013 to 2021.<br>Dublin: National Office of Clinical Audit.<br>ISSN 2737-7245 (Print)<br>ISSN 2737-7253 (Electronic)<br>Electronic copies of this report can be found at:<br>https://www.noca.ie/publications<br>This report was published on 31st January 2023 | Thank you. This statistic has been recorded in Line 1307. |
| 175 | Q18. Section 3.6 Management of intracerebral haemorrhage | Royal College of Nursing | No comment to add | Thank you for your comment. |
| 176 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 177 | | British Psychological Society | No comment | Thank you for your comment. |
| 178 | | Chest Heart & Stroke | 3.6 (1629-1631) 'Patients with ICH can deteriorate quickly and should be | Thank you for this comment. The GDG acknowledged that the |

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| | | Scotland | admitted directly to a hyperacute stroke unit for urgent specialist assessment and monitoring. This edition contains some important changes to recommendations for the immediate management of ICH.' Again the mention of transfer to a Hyperacute stroke centre. Caveat may need to be added (to include acute stroke unit) as hyperacute stroke units are not always going to be available in every region in Scotland. | nomenclature of 'hyperacute stroke unit' was sufficiently recognised to deliver hyperacute care to stroke patients across the five nations. |
| 179 | | Scottish Intercollegiate Guidelines Network | Recommendation B notes that andexanet alfa may be used in the context of a clinical trial and this may reflect the quality of available evidence. However, results of an ongoing study are expected in 2023 and may impact this recommendation. Andexanet alfa reverses the effects of FXa inhibitors (for example, apixaban, rivaroxaban, edoxaban) and it is indicated: for adult patients treated with a direct factor Xa (FXa) inhibitor (apixaban or rivaroxaban) when reversal of anticoagulation is needed due to life-threatening or uncontrolled bleeding. On 7 September 2020, SMC issued interim acceptance advice, however it noted that the company must submit the results of study 18-513, a global randomised controlled clinical study to investigate the use of andexanet alfa versus standard of care in patients with ICH taking apixaban, rivaroxaban, or edoxaban. Results are due June 2023.<br><br>Recommendation C - (comment from Care of the Elderly Consultant) - I have major concerns re this recommendation. This is an intervention without evidence of benefit in terms of functional recovery. It may be safe in a very controlled research setting but may not be outwith that (in a standard NHS setting). So a recommendation to consider doing something that isn't beneficial and may not be safe? Absolutely not what guidelines should be about. This feels like an individual's/ group of individuals personal preference rather than being in any way evidence based. A recent prehospital trial of BP lowering was discontinued because of a signal for harm in the ICH group. Particularly in some smaller hospitals, blood pressure lowering can only safely be done on a critical care/HDU setting, preventing ICH patients from going to a stroke unit bed. I don't think there should be a recommendation here. Units can decide how to interpret the (absent) evidence depending on their local circumstances. There is a risk here that units could face litigation for not lowering BP as it is 'guideline advice'. | Thank you for this comment. Unfortunately, the expected results of ANNEXA-I would be not within the time frame allotted to the publication of this guideline. The estimated completion date is 2024 and the primary outcome is haemostatic efficacy.<br><br>Thank you for this comment. There are a number of studies evaluating this question which are complex and interpretation of the results are important to triangulate recommendations that are evidence based, meaningful, relevant and are deliverable to the relevant patient population.<br><br>The RIGHT -2 trial (pre-hospital GTN transdermal intervention) which has been alluded to recruited 145 patients with ICH and demonstrated that GTN was associated with a worse shift on mRS (borderline significance: P=0.058) but no difference in death in the short term or long term but the numbers in the study are small.<br><br>The individual participant data pooled analysis (observational) including data from INTERACT 2 and ATACH2 [3829 patients) demonstrated that blood pressure lowering (an improvement of 10 mmHg reduction in BP between 1 and 24 hours) was significantly associated with a 10% increase of the odds of improved functional status at 90 days with caution being applied to avoid rapid BP |

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| | | | | lowering in excess of 60 mmHg in the first hour causing a lower odds of good outcome. A smooth control of blood pressure reduction (thereby reflective of blood pressure variability) was supported from the evidence.<br><br>The systematic review and meta-analysis of individual patient data from 16 RCT demonstrated that various strategies to lower BP within 7 days of acute ICH delivered a modest treatment effect on haematoma expansion but did not translate to an improved functional status at 90 days, however BP lowering intervention directed to an intensive target was more effective.<br><br>Although the absolute statistical benefits were not observed from INTERACT 2 and the meta-analysis in terms of functional status (acknowledging the results from the individual patient data analysis and the significant secondary outcomes of the ordinal shift analysis from INTERACT-2), the Topic Group and GDG considered the evidence as meaningful, relatively safe for the interventions and believed that this would result in the improved intensive monitoring of patients with ICH on hyper-acute units which would have the facilities to provide the degree of intensive monitoring required. This has been explained in the implication section [3.6].<br><br>Thank you for your comment. |
| | | | The RCPE welcomes these recommendations and understands that there are some major changes to immediate management of ICH that will require the development of new or amended protocols. | |
| 180 | | British and Irish Association of Stroke Physicians (BIASP) | P37 line 1632 3.6 Recommendations. MRI/MRA at 3 months should include susceptibility weighted imaging (SWI) to assess for an underlying vascular malformation as well as the presence of microbleeds, which, depending on their location may signify hypertension or cerebral amyloid angiopathy as the most likely aetiology. | Thank you for this comment. This has been edited into Line 1669. |
| | | | P37 line 1632. 3.6 Recommendations. Suggest discussion around chemical VTE prophylaxis if this hasn't been covered elsewhere. | Thank you for this comment. VTE prophylaxis (either chemical or non chemical) was beyond the scope of this updated guideline. |

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| | | | P37 line 1642. Recommendation C I would add the following:<br>Patients presenting with very high blood pressure after ICH (200mmHg) should have their blood pressure lowered cautiously. Clinicians should be aware that over rapid BP lowering may lead to cerebral hypoperfusion and worsen clinical outcomes. | Thank you for this comment. The cautious approach of lowering BP in patients with systolic BP > 200mmHg has been highlighted in Line 1717 in the Evidence to Recommendation 3.6 section. |
| | | | P38 line 1651 Recommendation D. The recommendation for immediate referral for repeat brain imaging if deterioration occurs requires some qualification. Repeat imaging should definitely be considered but may not always be necessary or appropriate, for example in patients with a very large haematoma in whom death is expected. | Thank you for this comment. The requirement of repeat brain imaging if patient deterioration occurs will need to be based on a case by case clinical basis. |
| | | | P38 line 1656 Recommendation F. Is it possible to give more guidance here as to what should trigger consideration of CTV/MRV? For example - All patients with large parenchymal or atypical intracerebral bleed should be considered for an early CTV. | Thank you for this comment. The recommendation has not been edited further. The use of such modalities will be guided by local pathways and policies. For example, CTV is more sensitive, easier to interpret and readily available, although involves contrast and is particularly useful in diagnosing dural sinus thrombosis. MRV technology is perhaps particularly useful when used in conjunction with MRI sequences rather than in isolation. |
| | | | P38 line 1664 Recommendation H. Recommend more discussion around when to consider DSA. Ideally patients should have CTA and MRA on assessment and an early consideration for CTV. This may require early repeating of MRA or CTA within 7 days depending on clinical condition and early mass affect. Early MRI including susceptibility rated imaging should be considered. All patients should be discussed at local Neuroradiology Intervention meeting to consider early DSA which may then warrant further repeating after a period of time such as 2-3 months. | Thank you for this comment. The editors are satisfied with the algorithm described in Recommendations G and H. The term 'multidisciplinary' has now been added into Line 1789 in the Implication section [3.6]. The implementation of DSA will depend on locally agreed policy and pathways after multidisciplinary evaluation. |
| 181 | | RCR Wales | H – it's helpful comment that the hypertensive haemorrhages are treated separately here. This allows prudent use of healthcare resources rather than blanket imaging haemorrhages that are not secondary to a vascular malformation. | Thank you for your comment. |
| 182 | | National Imaging Academy Wales | Nil to add beyond Comments from 15 & 16. | Thank you for your comment. |
| 183 | | United Kingdom Clinical Pharmacy Association (UKCPA) | line 1639- DOAC rivaroxaban and apixaban only licensed for reveral with andexanet | Thank you for this comment. The ANNEXA-I study includes patients prescribed rivaroxaban, apixaban and edoxaban. |

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| | | | line 1645- not to drop the systolic BP by 60mmHG within 1 hour as per NICE haemorragic BP guidelines 2022 | Secondary analyses of INTERACT2 and ATACHII data have been performed to address this question, but as noted on line 1711, the randomisation is then lost and these analyses are essentially reporting on observational data. A recent such analysis (Wang X, Di Tanna GL, Moullaali TJ, et al. International Journal of Stroke. 2022;17(10):1129-1136) suggested an association between reduction in SBP > 72 mmHg in the first hour of treatment and a higher adjusted odds of an unfavourable outcome at 90 days, compared to patients with no reduction in SBP. It should be noted that we have not made a recommendation to treat patients with an SBP > 220 mmHg. As such, the maximum initial reduction we are recommending is from 220 mmHg to 140 mmHg, a reduction of 80 mmHg. As this is similar to the 72 mmHg suggested in the analyses of Wang et al and because such analyses are based on observational data, the topic group chose not to make a specific recommendation with regard to a maximum drop in SBP over the first hour. |
| 184 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations in this section appear appropriate<br>We would like to request whether the blood pressure guidance can be extended to include recommended limits for patient mobilisation which would tie in with rehabilitation recommendations in Chapter 4 | Thank you for this comment. This is question is beyond the scope of these guidelines but needs to be based on a case by case basis based on individual factors. |
| 185 | | Royal College of Physicians of Ireland Clinical Advisory Group | L 1627 – Irish data for ICH was 13% in 2021 | Thank you of this comment. The GDG felt that this statement was not required. |
| 186 | Q19. Section 3.8 Cervical artery dissection | Irish Institute of Clinical Neuroscience | There is no mention of whether patients with acute ischaemic stroke secondary to arterial dissection should, or should not, be considered for endovascular intervention in the hyperacute phase. Alteplase if referred to. Should this be phrased “alteplase and/or intra-arterial intervention in the hyperacute phase where deemed clinically appropriate” ? We know this has not been well studied so would be expert group opinion led. | Thank you for this comment. This particular question was not considered explicitly; as you have stated it would have to be considered as consensus opinion on a case by case basis. |
| 187 | | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 188 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 189 | | British Psychological Society | No comment | Thank you for your comment. |

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| 190 | | Scottish Intercollegiate Guidelines Network | The RCPE supports these recommendations. | Thank you for your comment. |
| 191 | | British and Irish Association of Stroke Physicians (BIASP) | P42 line 1864 3.8 Recommendations. A comment about repeat imaging could be made: e.g. Patients started on an anticoagulant should have a repeat CT angiogram at 3 months and if vessel wall healing has occurred, consider switching to an antiplatelet drug such as aspirin or clopidogrel.<br><br>P42 line 1872 Recommendation D and E. While there is no evidence base to recommend longer term anti-thrombotic therapy, practice varies in this area and there may be rationale for some form of antithrombotic therapy beyond 3 months, perhaps guided by repeat imaging. Features such as persisting irregular lumen or development of pseudoaneurysm are often perceived as being associated with increased thrombotic risk (albeit with little evidence) and many clinicians will choose to continue, at least single antiplatelet therapy beyond 3 months in this situation. Other patients may have co-existing evidence of large vessel atheromatous disease on CTA offering some rationale for continuation of therapy. While it is impossible to offer evidence-based guidance here, a sentence mentioning paucity of evidence for treatment beyond 3 months and acknowledgement of variation in practice would be helpful. As it stands, the document gives the impression that treatment is routinely stopped at 3 months, which is probably not the case in clinical practice.<br><br>P42 line 1872 Recommendation D and E. Ideally there should be a recommendation regards timing for repeat imaging and advice with regards to pregnancy advice in woman with cervical artery dissection. | The topic group and GDG did not form the opinion that such a policy was supported by the existing (limited) evidence.<br><br>There is insufficient evidence in this area to support any definitive recommendation about patient selection or treatment beyond 3 months.<br><br>There is insufficient evidence in this area to support any definitive recommendation about patient selection or treatment beyond 3 months, including in pregnant women. |
| 192 | | Association of British Neurologists | Is it worth mentioning that the role of trauma in arterial dissection may have been over emphasised in the past? In the CADISS trial only 25% of patients had a history of trauma. | The existing phrase 'and may have experienced preceding neck trauma' reflects the minority for whom this is the responsible cause. In CADISS, investigators may have had less equipoise for traumatic dissections, so the stated proportion could not be regarded as the definitive word on the incidence. |
| 193 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 194 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We would like to highlight that there is no mention or recommendations for precautions to exercise including head positioning, exercise intensity and weight training in this section | Thank you for your comment. This was not within scope of the partial rewrite and was not mentioned in the evidence reviewed related to this section. |
| 195 | Q20. Section 3.11 Positioning | Royal College of Nursing | Agree with content | Thank you for your comment. |

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| 196 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 197 | | British Psychological Society | No comment | Thank you for your comment. |
| 198 | | Royal College of Speech and Language Therapists | Page 46, line 2048 – For a swallow screen or for a speech and language therapy dysphagia assessment the patient needs to be in an upright position. | Thank you for your comment. This relates to positioning in an inpatient setting, and swallowing which is covered in chapter 4 – This was not within scope of the questions related to this section of the guideline. |
| 199 | | British Dietetic Association | Page 46, line 2049:<br><br>If patient's are lying flat, NG feed should not be running as it's recommended that the head of the bed is at least 30-45 degrees when enteral feed is running. Could this be acknowledged as a factor for consideration within positioning recommendations? | |
| 200 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 201 | | United Kingdom Clinical Pharmacy Association (UKCPA) | line 1190--swallowing of oral medication<br>line 2006-- referred to pharmacist to assess medication appropriateness for oral intake/ alternative formulation | Thank you for your comment. This has been included in the swallowing section (4.26). |
| 202 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations in this section appear appropriate with the caveat that Recommendation D is still considered, i.e. need to be sufficiently upright for eating and drinking or if NG fed. | hank you for your comment. This relates to positioning in an inpatient setting, and swallowing which is covered in chapter 4 – This was not within scope of the questions related to this section of the guideline. |
| 203 | Q21. Section 4.1 Rehabilitation potential | Different Strokes | I am pleased to see that this section recognises various issues regarding rehabilitation, such as:<br>- 4.1A - people can benefit from rehabilitation at any point after their stroke<br>- 4.1C - where 'standard' rehabilitation might not be appropriate... a multi-disciplinary team will work with the stroke survivor towards realistic and meaningful goals<br>- 4.1D - rehabilitation should be needs-led and not time-limited<br>We are supportive of all the recommendations in this area | Thank you for your comments. |
| 204 | | Royal College of Nursing | Agree with all recommendations and welcome the recommendation to avoid the term "no rehabilitation potential. The call for further research in this area is welcomed also. | Thank you for your comments. |
| 205 | | British Cardiovascular | BCS/BCIS have no comment here | Thank you for your comments. |

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| | | Society (including British Cardiovascular Intervention Society) | | |
| 206 | | British Psychological Society | We welcome the collaborative and systemic approach to the recommendations in this section. (Please note a typo in D, "timed-limited").<br><br>G is particularly crucial, emphasising that predictive models make broad assumptions about populations and must be used tentatively and within the appropriate groups to be meaningful.<br><br>Whilst the change in language around rehabilitation potential is welcomed, however, it is not clear at what point re-referral for rehabilitation no longer benefits the patient and is detrimental to the service. Life after stroke requires adjustment in addition to rehabilitation and it feels important for services and patients to be able to make that distinction. Practically, patient-initiated follow-up will affect service resource, if large numbers of patients re-refer whilst staffing remains static this will negatively impact service delivery and quality. | Thank you for your comments.<br><br>Your comments have been considered and it is felt the recommendations adequately cover this, with reference to stroke related needs and/or goals and reference to life after stroke services. It is expected that teams would be staffed according to their caseload, as per the WTE recommendations, including expansion of teams if caseloads permanently increase, to maintain quality and standards. |
| 207 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Specific consideration of referral to specialist neurological rehabilitation services and Rehabilitation Medicine should happen for patients with complex rehabilitation needs after stroke, and this referral should happen as soon as possible after medical stability. At later stages, even with "fixed neurological deficit", and beyond the 6 month timescale stated, referral to specialist services for appropriate patients can lead to completion of personal goals in the domains of functional independence, return to work and social activities, management of mood disorder and complex cognitive and speech and language difficulties. Recommendations: I and J. Those with continuing rehabilitation needs should be directed to appropriate rehabilitation resources, which aren't necessarily within stroke services. People with stroke involving spinal cord should be referred to specialist spinal injuries units for rehabilitation. | Thank you for your comments. Your suggestion was discussed at length and it was felt that Rehabilitation Medicine should be part of the medical complement referenced in the workforce, with local services deciding the compliment of medical sub specialties. Reference to spinal strokes has been made as part of the amended recommendations. |
| 208 | | Association of Clinical Psychologists UK (ACP-UK) | It should be acknowledged that people recovering from stroke continue to make gains beyond 6 months. | Thank you for comments. This point is made in the narrative supporting the recommendations and in the recommendations themselves. |
| 209 | | Royal College of Speech and Language Therapists | General – The RCSLT is concerned that there is a lack of mention of the speech and language therapist in relation to swallowing. Speech and language therapists must be involved in the assessment of swallowing difficulties. Swallow assessment, diagnosis and management should only be undertaken by a qualified speech and language therapist (in some specific circumstances this can be done | Thank you for your comments. Speech therapy have been specifically mentioned in the mental capacity section in response to your feedback, as well as in cognitive screening section. The guideline generally avoids naming specific professions, preferring to recommend tasks are completed by those with the appropriate |

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| | | | by an appropriately trained healthcare professional). Some other clinicians may also have training as needed but there is clinical consensus from across the MDT (including within stroke) that SLTs are the skilled lead profession working with dysphagia. We strongly recommend that it is acknowledged in the guidance that SLTs are the lead profession for dysphagia.<br><br>Capacity assessment should consider speech, language and communication needs in line with the MCA legislation and code of practice. This includes specialist assessment or support from a speech and language therapist.<br><br>General – The tone of the guidance is quite medical-model. It may be helpful to consider including some statements around a person-centred holistic model as well as an asset-based approach with supported self-management.<br><br>General – Pre-morbid levels of engagement must be considered when assessing on-going therapy needs to ensure a higher likelihood of engagement and positive outcome.<br>Weekly goal setting is a welcome recommendation but will need to be adequately resourced.<br><br>Page 49, line 2172 – The RCSLT agrees with avoiding the term 'rehabilitation potential'. We recommend that there needs to be some guidance around patients who are not meeting goals set and managing expectations for those who are not referred on for further rehab.<br><br>Page 49, line 2181 – A person should not be excluded from rehabilitation due to a diagnosis of dementia; research demonstrates people with dementia can make gains/maintain independence with an appropriately tailored rehab programme.<br><br>See:<br>• Carthery-Goulart, M. T., Silveira, A. D. C. D., Machado, T. H., Mansur, L. L., Parente, M. A. D. M. P., Senaha, M. L. H., ... & Nitrini, R. (2013). Nonpharmacological interventions for cognitive impairments following primary progressive aphasia: A systematic review of the literature. Dementia & Neuropsychologia, 7, 122-131.<br>• Cadório, I., Lousada, M., Martins, P., & Figueiredo, D. (2017). Generalization and maintenance of treatment gains in primary progressive aphasia (PPA): a | knowledge and skills, which in many sections, including dysphagia this is highly likely to be speech and language therapists. Your core contribution to the MDT is recognised in the WTE recommendations.<br><br>Reference to these approaches have been strengthened.<br><br>Thank you for your comment.<br><br>Discharge from services for those who are no longer requiring or benefitting from stroke specialist rehabilitation is covered within the recommendations.<br><br>Thank you for your comments, this has been included in the amended chapter. |

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| | | | systematic review. International journal of language & communication disorders, 52(5), 543-560.<br>• Volkmer, A., Spector, A., Meitanis, V., Warren, J. D., & Beeke, S. (2020). Effects of functional communication interventions for people with primary progressive aphasia and their caregivers: a systematic review. Aging & mental health, 24(9), 1381-1393<br><br>Page 50, line 2228-2233 – There is a lack of research on this issue which is important and a difficult area to advise upon. More community-based research is needed – it remains the case that NIHR portfolio studies on stroke continue to have an acute focus much of the time. | |
| 210 | | The Stroke Association | The Stroke Association welcomes the move away from the concept of 'rehabilitation potential' and appreciates the use of the stroke survivor perspective in making this adjustment to rehabilitation guidance. We welcome the emphasis, seen throughout these rehabilitation recommendations on a needs-based, individualised, and collaborative rehabilitation pathway.<br><br>However, we note that the differentiation between post-stroke rehabilitation and life after stroke services is unclear throughout this guidance, leading to a lack of clarity around the involvement of the voluntary sector in providing long term non-clinical support for stroke survivors, as well as a lack of clarity around the role of the stroke key worker in providing this support. This lack of differentiation is reflected in the fact that Recommendation C makes clear the role of life after stroke as working with the rehabilitation MDT, while Recommendation F of section 2.8 does not detail specific recommendations on the life after stroke workforce. To avoid repetition, we have included appropriate evidence for the interventions provided by the stroke key worker within our response to the section 5.27 'Further rehabilitation'. | Thank you for your comment.<br><br>A statement regarding the transition between rehabilitation and life after stroke services has been included in the amended chapter. Many thanks for your comment. We have not specifically mentioned the stroke key worker role, in line with the overall approach in the guideline where we refer to knowledge and skills required rather than particular professional groups. |
| 211 | | Northern Ireland Stroke Network | Lines 2170-2198 - Recommendations are what we should aspire to for future development of Community Stroke Services and overall feeling is that the guidelines are a positive way forward.<br><br>Some concern about the wording in Section 4.1, lines 2172 - 2174 that "Rehabilitation Potential" is "Inappropriately used as a justification for rationing access to services". Is there evidence that this happens? Such a statement could be perceived as inflammatory or accusatory in a guidance document. | Thank you for your comment<br><br>Thank you for your comment. Feedback from clinical teams supports this statement. |

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| | | | The definition of Rehabilitation is “A set of interventions designed to optimise function and reduce disability in individual’s with health conditions”. It is a word that indicates functional improvement. Other domains such as psychological wellbeing, education regarding stroke, social participation etc are very important but the wording should be carefully considered. These latter domains should be considered under Chapter 5 around Long Term Support | Thank you for your comment. Clarification regarding the evidence base for rehabilitation potential and various aspects of rehabilitation has been added in response to your feedback. |
| | | | long term rehabilitation there should be the emphasis on the importance of including communication with and 'shared-caring' of patients with both primary care and the community and voluntary sector helping to address many of the specific issues such as return to work and mood problems etc<br>c: lines 2211-2212 Suggest the last phrase of section could read instead " should be in conjunction with primary care services and community and voluntary organisations where appropriate" | Many thanks. This has been altered accordingly. |
| | | | 2195: “access back into services at any time” Could this open floodgate to referrals which may not be within the scope of stroke community service provision (see comment on need to define services under 2.8 G). Guidance should stipulate who can refer and what services should stroke survivors be able to access. Many have uni discliplinary rather than MDT needs. Has this additional activity been factored into suggested staffing compliment? | Yes, with the community staffing recommendations being per 100 patients, It is expected that teams would be staffed according to their caseload, including expansion of teams if caseloads permanently increase, to maintain quality and standards. The recommendations are purposely broad in line with integrated community stroke services to capture any stroke related needs, at any time, identified by anyone (patient or professional). People being referred with uni disciplinary needs should still be considered by the stroke community team. Integrated community stroke services may negate the need for uni disciplinary services to be maintained as well, as it is recognised staffing resources are limited. |
| | | | 4.1; J “People with stroke should be reviewed annually” Who will complete these reviews? | Someone with the appropriate holistic, knowledge and skills. |
| | | | Evidence:<br>Whilst the benefits of increased therapy are recognised, the evidence base does not robustly support the recommendation of 3 hours daily therapist delivered therapy for every patient or up to a further 6 hours activity outside of therapist delivered sessions. | Your comments have been considered and it is the view of the GDG the evidence reviewed is of sufficient strength to make this recommendation in line with other guidelines internationally. It is also evident from the range of interventions recommended in the guidelines, and the dosage required to effect clinical outcomes, |

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| | | | | that those with motor relearning goals need to increase their therapy intensity. |
| 212 | | Scottish Intercollegiate Guidelines Network | The RCPE generally welcomes all the recommendations in relation to rehabilitation but recognises they may require an expansion in therapeutic staffing complement. | Thank you for your comment. |
| 213 | | The Irish Heart Foundation | The focus group agreed with the negative connotation when using 'rehabilitation potential' in line 2172, as it caps individuals at a certain point in their recovery with no consideration of their pre-stroke physical abilities.<br><br>They also strongly agreed with the holistic view of recovery including both physical and psychological well-being.<br><br>Emphasis was put on collaboratively making a list of goals, where the stroke patient and healthcare professional could make a realistic and appropriate list for the individual based on a 1-1 discussion rather than devised by comparison of the national average for the stroke survivors' age group. | Thank you for your comment.<br><br>Thank you for your comment.<br><br>Goal setting was not within scope of the partial re-write. |
| 214 | | NIMAST | Recommendation G : Could more clarity and direction be given re use of which predictive tool at what stage of recovery . | This was not within the scope of the partial re-write. Tools have been mentioned that came up in the searches that were conducted around broader topics in scope, but no specific searches were conducted to determine which tools should be used at which timepoints. |
| 215 | | Irish Association of Physical and Rehabilitation Medicine | A,F,I,J - There is a failure to address ethical dimensions especially resource justice – it cannot be left unsaid – there cannot currently be a situation where the approach is that rehabilitation continues with all the resource needed until goals are all addressed. This will mean people are years attending services.<br>D- There is marked blinkering in terms of rehabilitation. Stroke people in a stroke world. There is failure to account for the fact that most rehabilitation services caring for people with brain insults will care appropriately for people with stroke. In fact I would go so far as to say stroke rehabilitation is more straightforward on the average relative to TBI or Brain Tumours etc.<br><br>Pragmatically it is a deeply flawed resource argument to expect stroke specific community teams. Does this mean that there should be community TBI, Spine, MS etc teams. A completely different approach should be taken – that being development of community rehabilitation teams that have the expertise to help people with a range of neurological conditions or more generally what the economic and clinical and demographic demands are – this should shape the | Thank you for your comment. The role of the guideline is to recommend what rehabilitation is required. Resourcing in order to meet the evidence based standards is an issue to be addressed by local systems and HEI capacity planning. It would be inappropriate to recommend less than evidence suggests is needed, but is recognised that workforce continues to be a significant issue.<br><br>Thank you for your comments. It is recognised that many stroke teams may be stroke and neuro combined teams. This approach is supported. However as this is a stroke guideline, is the stroke patients needs and the skills required to meet these that is the focus. Local configuration of services is expected, but teams must meet the standards for stroke within the team structure, skillset and provision. |

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| | | | commissioning. | |
| 216 | | Brain Injury Matters (NI) | The introduction to this section states that it "discusses the core principles of rehabilitation" [2167], yet does not define the term. Indeed, the use of the phrase "discharge from rehabilitation" [2193] indicates 1) a model of rehabilitation which is dependent on a team or professional which one can be 'discharged from', and 2) is very much limited by the rehabilitation services (and so related goals) currently or traditionally delivered by statutory rehabilitation professions such as Physiotherapy, Occupational Therapy and Speech and Language Therapy.<br><br>We strongly advocate that this guideline adopts the WHO (World Health Organisation) and UNCRPD (United Nations Convention on the Rights of Persons with Disabilities) definition of rehabilitation as in the UNCRPD Article 26:<br>"States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life".<br>The WHO / UNCRPD definition of rehabilitation (Article 26) makes clear that the purpose of rehabilitation is to attain and maintain maximum independence, ability and full inclusion and participation in all aspects of life.<br>Therefore, core principles of rehabilitation should also consider how services help people with stroke achieve features of the UNCRPD related to Living in the community (Article 19), Personal Mobility (Article 20), Education (Article 24), Work (Article 27) Cultural life, [The Arts], recreation, leisure and sport (Article 30). This requires a 'Societal Model of Rehabilitation' where all departments of state, not just health and social care, must deliver effective rehabilitation. For example Culture, Media, Sport, Education, Housing, Work, Environment, and Transport.<br><br>Recommendation A<br>This should not be limited to the narrow view of what rehabilitation is, as currently or traditionally delivered, but should be based on a WHO / UNCRPD human rights based approach.<br><br>Recommendation B<br>…with health and social care professionals in agreement… [2203] as delivering a UNCRPD definition of 'rehabilitation' may be achieved by social workers | Thank you for your comments. A definition of rehabilitation has been included in the revised chapter. |

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| | | | identifying rehabilitation opportunities relating to Living in the community (Article 19), Personal Mobility (Article 20), Education (Article 24), Work (Article 27) Cultural life, [The Arts], recreation, leisure and sport (Article 30).<br><br>Recommendation C<br>The Multidisciplinary teams should initiate assessments of need for people recovering from Stroke to access 1) 'Self Directed Support' and 2) community opportunities for long-term support and rehabilitation into education, work, cultural life, the arts, recreation, leisure and sport. These are unlikely to be delivered within healthcare?, but rather may be delivered through voluntary / third sector organizations.<br><br>Recommendation D<br>"Their needs… are best met by the skills of the stroke team [2220] – This will be limited by the professionals, staffing, skills and model of service delivery of the stroke team, which may not align with the needs of the person with stroke. E.g., if the person has a need with regards to "psychological wellbeing" and Tier 2 or 3 counselling would best meet that need. If the Stroke Team does not employ an appropriately trained counsellor, then the 'need' of the person with stroke, outstrips the ability of the 'stroke team' to provide it. | |
| 217 | | Welsh Association of Stroke Physicians | Excellent comments about the need to identify goals in all patients.<br><br>ESD is clearly key to a successful and efficient stroke service but it is not clear whether it is practical for ESD teams to be going in to residential and nursing home. The boundaries between what can be defined as therapy and what is care can be blurred e.g. does the development of self-care skills and toileting skills need to be overseen by ESD or is that something carers should be doing? | Thank you for your comment.<br><br>People with stroke, wherever they reside should have access to teams with the appropriate skills, knowledge and resource. Teams will often joint work with care staff, including training and providing set up for rehabilitation activities to continue outside of therapy sessions. The content of rehabilitation would be goal directed, this may include goals around personal care or toileting for some people following stroke. |
| 218 | | Wales Stroke Allied Health Professional Forum | AGREE with points on rehab potential | Thank you for your comment. |
| 219 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 220 | | The British Association of Prosthetists and | Gate keeping as an access to orthotics is an issue. Orthotics is a key treatment but it is a poorly understood service. Ensuring orthotics is a core part of the MDT | Thank you for your comment. This was considered by the GDG. It was felt at this time, there was not sufficient evidence of the role |

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| | | Orthotists | would ensure better integration and access for patients. | of orthotics in stroke to specify they are part of the core team but are referenced as a service which stroke teams require timely and easy access to. Recommendations regarding referral to orthotics have been made throughout chapter four, however orthotics was not in scope of the partial rewrite, so inclusion is limited. |
| 221 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We welcome the recommendations in this section and wish to highlight the following:<br>C: We would welcome a consensus on the definition of standard rehabilitation services in this context. Does it mean the standard stroke rehab services that most patients would have or standard non-stroke rehabilitation services?<br><br>D : This recommendation sets units up for failure as it does not tie in with recommended staffing levels or the intensity of input clearly identified in the relevant research literature. If input is needs led, how can we deliver therapy for a longer length of time within current resources and specifically if in the staffing recommendations, non-contact time such as CPD is included in the WTE and physiotherapy assistance WTE is included in Physiotherapy WTE?<br>Additionally, we applaud the recommendation that access back into services at any time can be done, however, we are not sure about current staffing levels and with the previously suggested staffing levels in Table 2.5 above, how this will be achieved. We would also like to query how this decision to re-access services would be made and by whom? This is further emphasised in response to recommendations I&J below.<br><br>F : We welcome this recommendation and highlight the need to explicitly add that patients and their families should be informed about what would constitute a need for re-access to the service.<br><br>I & J: I=6 monthly review should be to identify and redirect those with ongoing needs and/or goals back into stroke services &<br>J =People with stroke should be reviewed annually. Those for whom new or ongoing stroke rehabilitation goals can be identified and agreed upon should be referred to stroke services for further rehabilitation.<br>These recommendations should be captured and reported on the SSNAP data. These recommendations require all services to be doing a 6-month review and an annual review, however, the 2022 Jan-March SSNAP data suggests otherwise. The data around applicability for follow-up needs to be further unpicked to assist | Thank you for your comment.<br><br>This has been clarified in the revised chapter.<br><br>Many thanks for your comment. Staffing recommendations have been revised and this recommendation clarified to include different methods of delivery.<br><br>Thanks for your comment. This has not been explicitly included in this instance as was felt to be an unnecessary level of detail, but would routinely be part of standard discharge processes and documentation.<br><br>Thank you for your comment. Measurement of compliance with these recommendations is not an issue addressed by the clinical guidelines, but will be taken up by SSNAP in due course. The guidelines recommend standard provision of 6 month reviews in a |

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| | | | with this recommendation; For example, the 2022 Jan-March SSNAP data suggests that only 75% of those who have had a stroke, are eligible for 6month FU and that 71.1% are conducted telephonically for their 6-month follow-up assessments. We are unclear as to the current quality or standardised questioning and whether this does elicit the identification of further needs and whether subsequent referrals are then made on the basis of these. Worryingly the second highest 6-month follow-up provider is listed as "other" in the 2022 Jan-March SSNAP data. We would strongly recommend that it would be helpful if an indication was given as to who should do the review. If not, it leaves the person at risk of it being done by someone less familiar with stroke.<br><br>Evidence Recommendations for this section :<br>Wade, D 2020:<br>https://journals.sagepub.com/doi/full/10.1177/0269215520905112 | later section and continue to be an important area for improvement. In line with the rest of the guideline, a specific profession have not been suggested. However we have stipulated the person conducting the reviews requires adequate holistic, stroke knowledge and skills.<br><br>This paper is not within thew scope of the literature searches fore the guideline. |
| 222 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Please add 'vocational rehabilitation' to this list<br>Love it!<br>2189 and 2211- should we stop using the word 'realistic'<br>A needed culture shift<br><br>Predictive tools- take out the word 'good'. Should this come out as they're still in their infancy and not used- and may be mis-used. 2190- If it stays in, should it read more clearly that this is to understand trends at a population level, rather than on an individual patient basis?<br><br>Good that we've moved towards needs being met, rather than limited to goals being met<br><br>D- typo<br><br>G- feel uncomfortable about this- reads like an individual patient level<br>J- a holistic annual review (this is important as opens the gates to who should be undertaking this- shouldn't be all medically focussed). ? State who/ or what skillset should be required to undertake these | Many thanks for your comment. This has been added.<br><br>Many thanks for your comment. This has been revised.<br><br>Thank you for your comment.<br><br>This has been revised.<br><br>In line with the rest of the guideline, a specific profession have not been suggested. However we have stipulated the person conducting the reviews requires adequate holistic, stroke knowledge and skills. |
| 223 | | Irish Heart Foundation, Council on Stroke | Physiotherapy<br>P.49 4.1 – In Irish setting, Rehab for person with stroke (PWS) who has potential is not available. The same for 4.1 D services are not available.<br>4.1 F I Transition plan for discharge will vary depending on where the PWS is | Thank you for your comment. The evidence base underpins the strong recommendations that services such as these are required for PSW. It is therefore down to local, regional and national systems to discuss commissioning of these. |

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| | | | being treated and the services after discharge will vary also.<br>4.1 I and J 6 month and annual review are not available in Irish setting.<br><br>Occupational Therapy<br><br>Right care, Right Place, Right Time approach' – would indicate that services should expand beyond inpatient rehabilitation and ESD long tern rehab needs of people with stroke in community<br>The removal of the term "no rehabilitation potential" is welcomed however recommendations are needed on HOW the long term needs will be met, and by who?Again, highlights the need to include recommended staffing levels in Community Stroke Teams, how are six-month and yearly stroke reviews to be operationalised, there is NO PLAN or recommendation as to HOW these care needs should be addressed | Thank you for comments. The recommendations suggest a needs led approach, rather than time limited.<br><br>Stroke needs requiring specialist rehabilitation input should be managed by community stroke teams, whenever they arise. WTE staffing recommendations take this into account, with PWS whatever the time point, being part of the caseload upon which WTE is based. PWS should continue to be supported by life after stroke services outside of rehabilitation episodes.<br>Operationalisation of reviews is a local system issue related to local needs and workforce. |
| | | | The multidisciplinary team should consider all available rehabilitation options and recommend the service that is most likely to enable the person with stroke to meet their goals and needs" Consider adding, in addition to providing the person with stroke and their family with the information on rehab options to enable them to make informed decisions as well as ensuring shared decision making with the person with stroke and their family.<br><br>MSW<br>: While annual reviews are what we should be aspiring to for the benefit of the patient, this is not feasible with current staffing levels in the Irish System, and would not be feasible given the recommended staffing levels noted in these guidelines.<br><br>Psychology<br>Well-written overview of rehabilitation. The comment on lack of utility of 'rehab potential' is well made. It is helpful to have restructured this chapter into modes, dosages and timings of therapy, and then broader domains of functioning, as this | Thank you for your comment. Education has been included as well as the importance of shared decision making regarding rehabilitation options.<br><br>Thank you for your comment. The evidence base underpins the strong recommendations for reviews for PSW. It is therefore down to local, regional and national systems to discuss commissioning of these.<br><br>Thank you for your comments. |

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| | | | is more consistent with the goal-setting approaches used in rehabilitation.<br><br>Speech and Language Therapy<br>p.49 L2170, Update section 4.1 name (e.g., Appropriateness of rehabilitation" or similar).<br>P.50 2217 add "communication"<br>P.50 2217 add something along the lines of: “not requiring or not demonstrating appropriateness for rehabilitation in some domains e.g. physical function should not preclude access to rehabilitation for other domains e.g. communication or cognition. Need for stroke-specific rehabilitation in one domain should be sufficient to warrant referral to rehabilitation services” | Thank you for your comments |
| 224 | | Royal College of Physicians of Ireland Clinical Advisory Group | Line 2193: “Decisions regarding discharge from rehabilitation should be made with the involvement of the person with stroke (shared decision-making) when ”realistically achievable” – consider inserting this phrase please | Thank you for your comment. It was considered but not included, in order to be consistent with the rest of the guideline. |
| 225 | Q22. Section 4.2 Rehabilitation approach – intensity of therapy | Royal College of Nursing | Agree with the recommendations, but given the statement on line 2279 that the amount of activity is more important than direct time with a therapist should A read "therapist prescribed" rather than "therapist delivered"? Perhaps encouraging a continuous therapy culture would be useful where the patient is in ongoing recovery mode and any opportunity throughout the day is an opportunity for further therapy and it does not need to be limited to fixed slots with therapists or specific sessions | Thank you for your comment, this was considered but ‘therapist-delivered’ (encompassing both registered and non-registered staff) was felt to be the most accurate term. The Guideline Development Group agrees about the desirability of an overall therapy culture. |
| 226 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 227 | | British Psychological Society | Section 4.2 would best be titled “Rehab approach – intensity of Physical Therapy”. Otherwise, the section made should be re-worded to include references to neuropsychological and wider psychological and mental health contributions (therapy) needed to support post stroke recovery. References made to physical therapy where referenced as ‘therapy’ should be referenced as ‘physical therapy’ for clarity. | Thank you for your comment. This has not been included as per your suggestion, however the narrative and recommendations have been altered to make it clear, which aspects of evidence base has underpinned this section, with more clear reference to motor recovery and functional practice. |
| 228 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Recommendation A –of the physical and cognitive fatigue could impact on ability to benefit from rehabilitation sessions, which will vary depending on the session content and stage of recovery The sessions therefore need to be balanced with rest and not all patients with complex rehabilitation needs will necessarily benefit from 3 hours of daily therapy every day | Thank you for your comment, this has been included in the amended chapter. |

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| | | | Recommendation B – BSPRM support the aspiration for patients to remain active for 6 hours after stroke each day, but comments regarding fatigue above apply<br>Rec D- BSPRM support this rec and suggest such functional activities should be individual to each patients goals and interests | |
| 229 | | Association of Clinical Psychologists UK (ACP-UK) | 4.2 Recommendations page 51, line 2291 – There does not appear to be an acknowledgement of post-stroke fatigue and the need to adapt rehabilitation accordingly, in these recommendations. Advocating 6 hours of activity a day for many people after a stroke with significant fatigue is not going to be possible. Similarly, there will be people who can tolerate more hours. Stipulating this figure could lead to inappropriate expectations on patients and services. Rehabilitation should be focused on the individual's needs. Instead it could stipulate that the minimum access to rehabilitation should be 6 hours a day. | Thank you for your comment, this has been included in the amended chapter. |
| 230 | | Chest Heart & Stroke Scotland | 4.2 (2315) The link to the Avert trial is not opening but if it is to be clicked on to open an it be that the link opens on a separate 'URL page' so this document still stay open on the current page. | Thank you for your comment. This will be implemented. |
| 231 | | Royal College of Speech and Language Therapists | General – The RCSLT is concerned that there is a lack of mention of the speech and language therapist in relation to swallowing. Speech and language therapists must be involved in the assessment of swallowing difficulties. Swallow assessment, diagnosis and management should only be undertaken by a qualified speech and language therapist (in some specific circumstances this can be done by an appropriately trained healthcare professional). Some other clinicians may also have training as needed but there is clinical consensus from across the MDT (including within stroke) that SLTs are the skilled lead profession working with dysphagia. We strongly recommend that it is acknowledged in the guidance that SLTs are the lead profession for dysphagia.<br><br>Page 51, line 2286 – SSNAP data shows that many stroke services are not meeting guideline recommended staffing levels for speech and language therapy. The revised target of three hours a day will be unachievable within current staffing constraints. As the workforce is being stretched to meet a 7-day target, this has the potential to spread and reduce the provision of therapy over the week. This new target was a surprise to us as a professional body.<br><br>The RCSLT has done much work with our members over the past five years to support them to transform their stroke services to meet the 5 day a week, 45 minutes a day, national targets. This new ambitious target will require | The recommendations give a minimum staffing recommendation in order to meet therapy intensity across disciplines, across 7 days. It is recognised workforce challenges exist, which are required to be taken up by local, regional and national systems and HEI capacity planning, as well as skill mix and use of assistants. It is anticipated that all disciplines will take time to progress towards these recommendations. |

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| | | | professional body buy-in and support to ensure it is conveyed to allied health professionals and that they are supported to understand how they can meet this.<br><br>Intensity, rather than duration of input, will depend on the needs of the individual (see https://www.ahajournals.org/doi/10.1161/STROKEAHA.121.035216). Having patient centred input will support outcomes.<br><br>These reasons should not be a barrier to recommendations in place; however, unless there is an increase in funding and resource for more therapists it may be difficult to manage expectations of patients and families as well as the teams in relation to guidance. | Thank you for your comment. Adequate resource (staffing and funding) has been detailed in the implementation chapter (chapter 6) and is essential to meet these recommendations. |
| 232 | | The Stroke Association | With regards to Recommendation A, we would suggest that more detail and clarification is needed to help guide clinicians on the issues of therapeutic rehabilitation dose and intensity. While we welcome the ostensible increase from the previously recommended 45 minutes of each therapeutic intervention per day to the updated target of 3 hours of therapy per day, it is unclear what the composite components of this 3 hours of therapy should be. We recognise that this is deliberately designed as a mechanism for allowing greater flexibility in the provision of the individual components of post-stroke rehabilitation; however, we would suggest that this creates unnecessary ambiguity for clinicians and service providers.<br><br>While potentially allowing for increased flexibility of the provision of rehabilitation, we also express concern that this change will have significant implications for monitoring and oversight of the status of rehabilitation provision across the UK. The 45-minute target for each therapeutic area of post-stroke rehabilitation, while rarely met by any service, facilitated national-level data collection on the provision of each of the three primary therapeutic areas. Moving towards a composite 3-hour target means we will lose this insight into which specific areas of rehabilitation are falling behind. | Thank you for your comments. More detail has been added as to what constitutes the 3 and 6 hours of activity, in the amended chapter.<br><br>Thank you for your comment. Measurement of compliance with these recommendations is not an issue addressed by the clinical guidelines, but will be taken up by SSNAP in due course. |
| 233 | | Northern Ireland Stroke Network | Lines 2279-2281 The level of activity patients are able to undertake during rehabilitation is more important than how much time patients spend in face to face therapy with qualified therapist. Clinicians must drive improvements in the culture and processes of rehabilitation. It is important to acknowledge and to consider that therapy can be delivered in a number of ways including self-directed/self-managed. Promotion of this, where appropriate, would be an | Thank you for your comment, this has been included in the amended chapter. |

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| | | | effective way of managing resources.<br><br>A – line 2286 – 'at least 3 hours of therapist delivered therapy a day' – Is this the recommended level for a service use receiving multidisciplinary input rather than uni disciplinary? Therapy should be delivered in relation to assessed need. Patients may not require therapy from all disciplines, be capable of participating or consent to 3 hours of therapy per day. Experience reported is that service users are frequently reluctant to have more than x1 hour of therapy per day.<br><br>B – Patients remain active up to a further 6 hours outside of therapist delivered sessions – in total that would require patients to be active for 9 hours per day and potentially much more than pre-stroke levels of activity. We suggest activity levels should be tailored to patient needs and preferences. | Thank you for your comment, this has been clarified in the amended chapter.<br><br>Thank you for your comment. This is not what was intended by the recommendation. Activity would be 6 hours in total, of which 3 hours should be therapist delivered. |
| 234 | | British and Irish Association of Stroke Physicians (BIASP) | P51 line 2286 recommendation A. 3 hrs may be too much for some patients. Recommend individualised approach. One size may not fit all. | Thank you for your comment, this has been clarified in the amended wording. |
| 235 | | NIMAST | Recommendation A : Does the 3 hours of therapy a day refer to what the patient receives or what is delivered by therapists. E.G If patient is seen jointly by OT and physio for one hour , this is one hour received by the patient but 2 hours in total delivered by therapists. Clarification would be appreciated . | Thank you for your comment, this has been clarified in the amended wording. |
| 236 | | Irish Association of Physical and Rehabilitation Medicine | A does this refer to a 7 day week or a 5 day week? | Thank you for your comment, this has been clarified in the amended wording. |
| 237 | | Welsh Association of Stroke Physicians | Section 4.2 Rehab intensity<br><br>· Completely agree with the concepts of frequency & intensity. But resources outlined in 2.19 don't support this. The 6 hours a day of activity will still require supervised tasks due to falls risks etc. which requires staffing resources for in-patients. Also the 3 hours of direct therapy contact per day doesn't correlate with staffing levels despite efficient working practices. As previous point. | Thank you for your comment. This has been addressed by revision of the recommended minimum WTE for inpatient teams. |
| 238 | | Wales Stroke Allied Health Professional Forum | We'd need to think how, within disciplines we 'live' monitor that this and how this collective 3hr target daily is met… Also this is MORE than previous expectation of say x3 45mins from each (OT/PT/SLT) disciple – so now 180mins a day ideally. If this is JUST OT delivering this daily or just OT/PT this is a huge goal… : SLT as a sole discipline on current UK staffing could never deliver 3hrs daily to one individual pt. | Thank you for your comment. Measurement of compliance with these recommendations is not an issue addressed by the clinical guidelines, but will be taken up by SSNAP in due course. |

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| | | | Completely agree with the concepts of frequency & intensity. But resources outlined in 2.19 don't support this. The 6 hours a day of activity will still require supervised tasks due to falls risks etc. which requires staffing resources for in-patients. Also the 3 hours of direct therapy contact per day doesn't correlate with staffing levels despite efficient working practices. | Thank you for your comment. This has been addressed by revision of the recommended minimum WTE for inpatient teams. |
| 239 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 240 | | The British Association of Prosthetists and Orthotists | Orthotics enables greater independence by providing properly tailored orthoses. Devices such as lower limb bracing and splints can increase functionality/stability; orthotists as a key member of the MDT can ensure that people have equitable access to this service and receive expert orthotic treatment. | Thank you for your comment. This was considered by the GDG. It was felt at this time, there was not sufficient evidence of the role of orthotics in stroke to specify they are part of the core team but are referenced as a service which stroke teams require timely and easy access to. Recommendations regarding referral to orthotics have been made throughout chapter four, however orthotics was not in scope of the partial rewrite, so inclusion is limited. |
| 241 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Overall : Rehabilitation approach - we welcome the clarity in the new guideline with regards to the use of task-specific training over and above other approaches, including Bobath. It is a significant and positive step for this to be included in the guideline, and it will no doubt support rehabilitation services to understand core evidence base principles of rehabilitation (and have the confidence to de-implement ineffective methods) - impacting on workforce development and rehabilitation delivery. This clarity has been long overdue - and is an important step for neurorehabilitation, ensuring that people with stroke receive rehabilitation that will enable them to meet their potential.<br><br>Line 2254- we suggest removing the word even, on line 2255- 1st word in the line- as this makes it sound like this is an extraordinary occurrence, whereas we know as per 4.1 line 2201 that people have the potential to benefit from rehabilitation at any point after their stroke.<br><br>A : This is a welcome change, and we think it is positive that the intensity recommendation hasn't been made profession specific. We had a query from our regional group with regards to it being "therapist delivered" - we assume this to include therapy assistants, and rehabilitation in a group setting etc. We welcome the recommendation that a minimum of 3 hours of therapy/day should be delivered and the specificity that it should be therapist delivered. However, we wish to highlight that given that most teams were struggling to meet the 45mins therapy/day, and that the staffing levels in table 2.5 do not match this | Thank you for your comments.<br><br>This has been addressed in the revised wording.<br><br>Thank you for your comment, this has been clarified in the amended wording. |

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| | | | requirement, how are teams expected to meet 3 hours therapy/day?<br>A: Further clarification would be welcomed specifically around the fact that the recommendation isn't necessarily for 3 hours of 1:1 therapy? As the staffing levels in Tabel 2.5 would not be adequate for this.<br><br>A: Whilst we welcome the indication that these 3 hours of therapy/day whilst undergoing rehabilitation after stroke is irrespective of setting, we want to highlight that without the appropriate funding to support this requirement, sectors of the patient pathway such as the community stroke teams will be set up to fail. What additional resource is being put into local councils/voluntary sectors to enable patients to access gyms/exercise groups that will help this need? The decades long bleak economic landscape has resulted in the closure of many of these gyms. Where is all this additional funding and resource going to come from?<br><br>We also wondered whether the guideline need to specify that it is 3 hours a day, 7 days a week? (not 5).<br><br>B: The resources and set-up required to deliver recommendation B is lacking - we would welcome a review of how this could be actualised. We are acutely aware of the fact that unless this type of data is required for audit purposes, this recommendation would be hard to implement. Are there any considerations for SSNAP to look at overall activity outside of therapy sessions?<br>We would recommend that the wording is altered from ...." to encourage and support" to something a little more directed and clearer so that services should be expected to do more to enable patients to remain active – instead that there is a need to continually work actively to enable all patients where this is possible to achieve this and to understand the reasons for those whom this is not possible at that point in time and come up with alternative solutions. | Thank you for your comment. Adequate resource (staffing and funding) has been detailed in the implementation chapter (chapter 6) and is essential to meet these recommendations.<br><br>Thank you for your comment, this has been clarified in the amended wording.<br><br>Thank you for your comment. Measurement of compliance with these recommendations is not an issue addressed by the clinical guidelines, but will be taken up by SSNAP in due course. |
| 242 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | 2270/2333- Netherlands, not Holland<br>A- receive a minimum of (at least sounds colloquial).<br>Does this add up with the establishment/WTE.<br>Is this achievable for ESD?<br>Need to add Therapist/therapy assistant delivered.<br>Who is this appropriate for? Do you need to define that it is for people who have motor relearning goals.<br>Do we need to add ' as tolerated'? | Thank you for your comment, these points have been addressed in the amended wording. |

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| | | | Do we need to make it clear this is across disciplines? | |
| 243 | | Irish Heart Foundation, Council on Stroke | Physiotherapy<br>Physio - Page 51, line 2286, 3 hours/day rehab, this may be a guideline but is not achievable on the whole<br>Physio - Page 56 line 2497, typo remove 'that'<br>4.2 A In Irish setting, max available even in rehab. would be 1 hour per day. Three hours would not be possible.<br>4.2 B There is no rehab service (unless ESD) that supports PWS to be active for 6 hours per day - to get into gyms etc... | Thank you for your comment. The evidence base underpins the strong recommendations that services such as these are required for PSW. It is therefore down to local, regional and national systems to discuss commissioning of these. |
| | | | Occupational therapy<br><br>How are the recommended intensity of therapy planned to be delivered over a 7 day period based on the recommended staffing levels in Table 2.5? (how is effective dose defined?) | Delivery and planning of rehabilitation would need to agreed locally to fit the sitting and patient group. Suggestions of different methods of delivering rehabilitation have been included in the revised chapter. |
| | | | Distinction is needed to highlight what stage of stroke service does this refer to - ? 3 hours of therapy in hyper-acute stroke unit?? , or 3 hours of therapy in Rehabilitation Unit?<br>Who will deliver 3 hours of therapy in Stroke Community Rehabilitation Teams?<br>What about post stroke fatigue? Patient preference? Will this impact on intensity of therapy?<br>Page 51 – should the guideline refer to using a Social Prescribing Approach – this appears to be what is being hinted at in recommendation B? | This has been included in the revised wording of the chapter. |
| | | | The final recommendation for increase in therapy post stroke is welcomed – but these guidelines do not address the service provision issues – WHO is going to deliver this intervention? – greater emphasis needs to be placed on a comprehensive recommendation for service delivery and particular emphasis need to be placed throughout this guideline document on developing and expanding longer term rehabilitation services for people living with stroke. | The guideline lays out the core team and minimum whole time equivalents for these, as well as discussing the use of assistants, self practice and group work. The guideline states a person with the correct knowledge and skills for the various interventions, which opens opportunities for others to be part of the delivery team. |
| | | | Dietetics<br>• "The recommendation for people with stroke to receive 45 minutes of each therapy per day in previous editions of this guideline was set pragmatically as a minimum through consensus by the Working Party at that time. The | Thank you for your comment. |

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| | | | Guideline Development Group has debated this further and have increased the recommended amount of therapy in this edition to stimulate much-needed transformation of rehabilitation to improve clinical outcomes."<br><br>COMMENT<br>To achieve the recommended intensity of therapy recommended, the staffing ratio would need to be revised as outlined in Section 2.5 comments. | Thank you for your comment. The whole time equivalent recommendations in chapter 2 have been revised |
| | | | SLT<br>General:<br>IASLT agrees with RCSLT especially re SECTION 4.9 Nutrition and Hydration - there is no reference to SLT.<br>IASLT hold the position that SLTs play a PRIMARY role in the evaluation and treatment of infants, children and adults with eating, drinking and swallowing (EDS) disorders. The incidence and prevalence of such disorders is high and the consequences are potentially very severe therefore appropriate diagnosis and management is critical (IASLT Standards of Practice for SLTs on the Management of Feeding, Eating, Drinking and Swallowing Disorders, 2015).<br><br>Treatment of EDS disorders post Stroke is defined as "any intervention that involves changing the variables of the environment or changing behaviours of service user / others relative to the service user's eating, drinking / swallowing (EDS)". This may be intermittent, include establishment of maintenance programmes, will include education for service users and caregivers (as appropriate) and may involve ongoing activities by other MDT members - supervised and led by the SLT - this work requires an SLT to devise, develop and update the management plan (IASLT Standards of Practice for SLTs on the Management of Dysphagia, 2015). | Thank you for your comments. Speech therapy have been specifically mentioned in the mental capacity section in response to your feedback, as well as in cognitive screening section. The guideline generally avoids naming specific professions, preferring to recommend tasks are completed by those with the appropriate knowledge and skills, which in many sections, including dysphagia this is highly likely to be speech and language therapists. Your core contribution to the MDT is recognised in the WTE recommendations. |
| | | | Agree with RCSLT re the need to acknowledge that HSCPs are ethically bound by CORU and IASLT Codes of Conduct to deliver person-centred care (Speech and Language Therapists Registration Board Code of Professional Conduct and Ethics, 2019, IASLT Code of Professional Conduct and Ethics, 2022). | This is a requirement of all registered staff. It is an assumption that professional standards are maintained by all disciplines mentioned in the stroke team. |
| | | | IASLT agree that people with a Dementia diagnosis and Stroke together should not be excluded from a rehabilitation approach and agree that the research evidence base supports intervention and potential for gains with rehabilitation in | This has been included in the revised wording of the chapter. |

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| | | | this population.<br><br>The section appears to overly focus on motor / physical learning. Cross-reference with updated content from section 4.43 Aphasia.<br>p.50 L2274-2278 - needs to be made explicit that this is essentially in relation to motor learning. | This has been addressed in the revised wording of this section. |
| 244 | | Royal College of Physicians of Ireland Clinical Advisory Group | Recommendations A Line 2286: Please consider starting the sentence with "Where patients are deemed suitable, willing and able people undergoing…… , B<br><br>L2269 Irish Stroke data - In 2021, physiotherapists reported that 51% of patients with a stroke received sufficient therapy. Occupational therapists reported that 38% of patients with a stroke received sufficient therapy and speech and language therapists reported that 46% of patients with a stroke received sufficient therapy. | Thank you for your comments. They have been considered but not included, as is assumed for all recommendations included in the guideline.<br><br>Thank you for this information. This is not information that came up within our search of high quality evidence and needs to be viewed with what patients may report. |
| 245 | Q23. Section 4.5 Remotely delivered therapy and telerehabilitation | Different Strokes | It is positive that this is being considered. But it is essential that the wishes of the stroke survivor are central to any decisions about remotely delivered therapy.<br>The 2022 Neuro Survey showed that:<br>- 38% of respondents agreed, but 29% disagreed with whether they found remote appointments helpful<br>29% of respondents agreed, but 30% disagreed, that remote appointments are ineffective<br>Clearly there is a very mixed picture here, so it's essential that each individuals needs and preferences are taken into account | Thank you for your comment. This has been addressed in the revised wording. |
| 246 | | Royal College of Nursing | The benefits of remote interventions are clearly described in the recommendations and the evidence. Perhaps there could be consideration to the limitations also and suggestions to negate these, for example providing a remote consultation you may not pick up on everything in the environment and may not have as rich a quality interaction with the patient. It may be beneficial to recommend remote interventions are provided based upon a face to face consultation and that if remote intervention is ongoing it would benefit from being supplemented with regular face to face reviews/ | Thank you for your comment. This has been addressed in the revised wording. |
| 247 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 248 | | British Psychological Society | We welcome this set of recommendations; in particular, it is good that information governance issues are noted. | Thank you for your comment. |

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| | | | It would be helpful to make explicit that this is not workable for many patients, due to cognitive, communication or psychological needs, and that those patients will need to be able to access an equitable service in person.<br><br>Experience from NeuroRehabilitation OnLine is that lack of access to hardware (i.e., smartphones / tablets) is often not the primary barrier, and access to wifi / reliable data connection is a bigger barrier, which is not something stroke services can change. Highlighting the role of digital inequalities and digital literacy would be important, as people from lower Socio Economic Status (SES) are already less likely to access therapy and increasing reliance on remote therapy could emphasise this divide.<br><br>In recommendation E it would be helpful to clarify what is meant by a "coaching style relationship". We would be happy to offer some advice from our Division of Coaching Psychology if that would be helpful. | Thank you for your comment. This has been addressed in the revised wording.<br><br>Thank you for your comment. This has been addressed in the revised wording.<br><br>Thank you. This was considered but felt not to be required as is common language with good understanding. |
| 249 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Neurological disabilities do affect the ability to use augmented communication and assistive technology. Assessment of ability to access augmented communications and assistive technology should be carried out via specialist multi disciplinary neurorehabilitation services including a rehabilitation medicine physician | Thank you for your comment. Assessment of ability to access technology has been included in the revised wording.<br><br>Rehabilitation medicine is not specifically named in the team, but is part of the medical staffing recommended within teams. |
| 250 | | Association of Clinical Psychologists UK (ACP-UK) | 4.5 page 55, line 2466 – Whilst the inclusion of telerehabilitation and remote therapy provides another modality for people to receive therapy it is also important to recognise the many barriers that people with stroke may have, which mean this is not an appropriate method to receive therapy. People following stroke will often experience mental fatigue, cognitive difficulties and language difficulties which may make using remote therapies difficult or not possible. The guidance should reflect that it is about recognising patient preference and needs and not just that services should be offering it.] | Thank you for your comment. This has been clarified in the revised wording of this section. |
| 251 | | Chest Heart & Stroke Scotland | Is it possible to suggest where possible linking individuals with stroke to the 3rd sector that may offer remote classes and support. | Thank you for your comment. This has been included in the revised wording. |
| 252 | | Royal College of Speech and Language Therapists | Page 55, line 2455-2458 – Programmes such as Attend Anywhere (https://www.attendanywhere.com/) can be useful in some situations. Programmes such as REACT (https://www.quiddis.com/en/react-ehealth/) can also be useful to keep patients working even if speech and language therapists cannot be present. | Thank you for your comment. In order to future proof the recommendation and not introduce bias, no specific programmes have been suggested. |

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| | | | Page 55, line 2466-2468 – It would be beneficial to add in other specific barriers to teletherapy – cognitive load and communication impairments such as reduced comprehension can make teletherapy hard to implement.<br><br>Page 55, line 2476-2479 – Greater liaison needs to take place within health and social care to facilitate telerehabilitation. For example, there can be issues where technology is funded through councils – it can be difficult to deal with issues arising when the technology has not been provided by healthcare workers themselves. Further guidance would be appreciated on how the integration between services can be optimised in such scenarios.<br><br>Page 55, line 2470-2475 – This only works if qualified staff are available to assess, develop therapy programme, analyse progress and review regularly. Technology should be available (funding allowing). | Thank you for your comment. This has been included in the revised wording.<br><br>Thank you for your comment. This is touched upon in the implementation chapter, but is an issue for local/regional systems to agree.<br><br>Thank you. This point is covered by the recommendations. |
| 253 | | The Stroke Association | We welcome these recommendations. They align with the perspectives of stroke survivors, as expressed in our Stroke Recoveries at Risk survey from 2020, which indicated a high level of satisfaction with telehealth methods of delivering post-stroke support. | Thank you for your comment. |
| 254 | | NIMAST | Addition of information reflecting the following would be useful; The high levels of adherence to tele rehabilitation interventions observed were comparable to in-person rehabilitation, and no safety concerns related to the delivery of tele rehabilitation interventions were reported. (Stephenson et al. 2022, Factors influencing the delivery of tele rehabilitation for stroke: A systematic review; https://doi.org/10.1371/journal.pone.0265828 | Thank you for your comment. This has been included in the revised wording. |
| 255 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 256 | | The British Association of Prosthetists and Orthotists | Telehealth has the potential to decrease the burden of treatment for patients with long-term and multiple conditions. It also has the ability to induce inequities (Eddison, Leone, Healy, Royse, Chockalingam, Eddison N. Healy A. Leone E. Royse C and Chockalingam N. The potential impact of allied health professional telehealth consultations on health inequities and the burden of treatment. Int J Equity Health. 2022;(91):1-12.). It is essential that clinicians delivering telehealth have appropriate training (Leone, Eddison, Healy, Royse, Chockalingam. Do UK Allied Health Professionals (AHPs) have sufficient guidelines and training to provide telehealth patient consultations? Hum Resour Heal 2022 201. 2022;20(1):1-12.) | Thank you for your comment. It is felt this is covered by the wording in the revised section. |
| 257 | | Association of Chartered | Whilst we welcome the recommendation of remote delivery of therapy- this | Thank you for your comment. This has been addressed in the |

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| | | Physiotherapists in Neurology(ACPIN) | section fails to explicitly address the digital inequity across underserved communities that exist. We should not underestimate the time and resources required to ensure good connectivity, the regular failure of devices that may not meet digital requirements for secure IT sources. Ensuring that this data is kept is helpful in understanding resource implications ( eg: Prof Louise Connell's data collection of time spent engaging with online consultation/rehabilitation)<br>This section also fails to address the risk assessment that needs to be conducted in order to ensure effective remotely delivered therapy.<br>Importantly, who benefits most and in what manner would be important aspects to capture as this would be useful in identifying which participants benefit.It would be helpful if it could be emphasised that remote therapy should be used when it is considered the most beneficial option to promote recovery and not because it is the easiest option to put in place. It should not be the default option to cope with limited staffing, time, space, and resources.<br><br>Evidence to recommendations:<br>Buckingham S, Anil K, Demain S, Gunn H, Jones RB, Kent B, Logan A, Marsden J, Playford ED & Freeman J (2022) 'Telerehabilitation for people with physical disabilities and movement impairment: development and evaluation of an online toolkit for practitioners and patients' Disability and Rehabilitation 1-8 | revised wording for this section. |
| 258 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | B- adequate rather than reasonable<br>This should include the review of technologies for appropriateness, safety and information governance (storage of personal data) supposed to be on the end of recommendation D not B<br><br>Add apps in 2461 list of examples | Thank you for your comments. This was reviewed, and considered best as part of Recommendation E. |
| 259 | | Irish Heart Foundation, Council on Stroke | Physio<br>Include line on training for staff who deliver telerehab<br>4.5 Limited Telerehabilitation in Ireland some pilot work during COVID-19.<br><br>SLT<br>P55 Add to 2468 "communication impairment" as a barrier<br>— Add to recommendation A "should be personalised to the individual's goals, preferences and communication status"<br>— P56 Add to L2505 "consideration needs to be given to the person with stroke being cognitively and communicatively able to manage..." | Thank you for your comments. These have been addressed in the revised section. |

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| | | | Occupational Therapy<br>There is need for some explicit caution in this recommendation, and we suggest removal of "should" from wording of recommendation to reflect the weak evidence base.it is stated that the studies were "small, pilot and non-randomised, and did not account for attrition" – this needs to be better reflected in the recommendations. For example, is there any evidence that people with aphasia and communication disorders can engage and benefit from remotely delivered therapy, similarly cognitive problems etc. There is a need for caution as this recommendation could be interpreted and seen as a 'cost-cutting' approach and a poor substitution for in-person delivered therapy and rehabilitation, particularly for rural dwellers.<br>Should this be a universally applied recommendation given the lacking evidence base and<br>remote interventions do not allow for any physical close supervision, hand over hand guidance/tone management/handling that can promote adaptive neuroplastic processes.<br><br>Psychology<br>Helpful to have this included. The role of carers/support people in facilitating this should also be acknowledged. | Thank you for your comment. Clarifications to the revised section make it clearer that telerehabilitation should be used where it is the best fit for the individual taking into account their strengths, difficulties, goals and preferences. Considering it as an option for all is appropriate, but only a proportion of PWS will use telerehab for the reasons stated. |
| 260 | Q24. Section 4.6 Self directed therapy | Royal College of Nursing | Agree with these recommendations. Having acquired disabilities through a stroke may cause mental health needs, such as depression, that may impair motivation to undertake self directed therapies. It may be worth considering supporting mental health needs to promote motivation for self directed interventions. | Thank you for your comment. This was considered but not specifically included as per your suggestion, as it was felt this point was covered by considering the appropriateness for each individual |
| 261 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 262 | | British Psychological Society | No comment | Thank you for your comment. |
| 263 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Recommendation B, C – monitor the psychological effect of "competition" either with self or other in self directed rehabilitation tasks and be aware of low mood depending on the person's individual personality and responses | Thank you for your comment. This was not within the scope of the searched literature or mentioned in the papers reviewed regarding telerehabilitation. Adverse effects would be monitored as part of usual practice with all interventions, which should include psychological effects |
| 264 | | Royal College of Speech and Language Therapists | Page 56, line 2510-2515 – With appropriate candidates, understanding and capturing outcomes of increased dose would benefit all AHPs working in the way. | Thank you for your comment. This is not an issue to be addressed by the guideline. |

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| | | | It may be useful to consider the development of a national database.<br><br>Page 57, line 2519-2522 – It is unclear why upper limb rehab is cited specifically. There is also good evidence for speech and language therapy rehab to be supported by self-directed management too, see BIG CACTUS study (Palmer et al https://www.sheffield.ac.uk/scharr/research/centres/ctru/big-cactus).<br><br>General - Bearing in mind principle of 'errorless learning', collaboration between a speech and language therapist and a patient prior to self-directed therapy is needed. Specifically for goals / content material for aphasia patients.<br><br>General – This section should sit next to section 4.2. It is good to include guidance stating that therapy does not only happen with a therapist present but specifically calling this “self-directed therapy” over just “therapy” only supports the divide. | Thank you for your comment. Upper limb was suggested as an example, as the bulk of the literature reviewed related to upper limb rehabilitation. BIG CACTUS is now referred to in this chapter in the revised section.<br><br>This was considered but not included, as is expected to the case with all interventions where communication may affect access.<br><br>Thank you for your comment. This was not included, as the questions were two distinct questions in the scope of the guideline and will need to be monitored separately |
| 265 | | Welsh Association of Stroke Physicians | Section 4.6 self-directed therapy<br><br>· Absolutely essential. Does this count towards therapy minutes on ssnap? Perhaps a question for ssnap not RCP guidelines | Thank you for your comment. Measurement of these recommendations is not an issue addressed by the clinical guidelines, but will be taken up by SSNAP in due course. |
| 266 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 267 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Overall: This section is a very welcome addition. People living with stroke need to be empowered and educated to know they need to be active outside of their formal therapy sessions.<br><br>B & C: The wording in this section is non-specific especially as we are wanting to increase therapy-relevant time. This makes the word "consider" less helpful in ensuring that self-directed therapy is an important component of rehabilitation. It invites individuals to not see it as a necessity, leaving it too open not to help an individual achieve the skills and knowledge needed to practise successfully. Where self-directed exercises are already used with those able to engage, we also need to ensure we pay attention to and understand the needs of those for whom this does not necessarily work.This includes that that are deemed"motivated" or not. Motivated is a complex term – who determines this and what would be the signs of sufficient motivation to consider self-practice? What happens in the instances someone is deemed not motivated- again, who determines this, and we query whether we take suficient time to understand this | Thank you for your comment<br><br>Thank you for your comment. ‘Consider’ is part of the guideline methodology linked to the strength of the evidence. It reinforces that it is not a one size fits all and whilst it should be considered for all PWS, it may not be an appropriate approach to be used by all.<br><br>Thank you for your comment. Measurement of these recommendations is not an issue addressed by the clinical guidelines, but will be taken up by SSNAP in due course. |

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| | | | and adjust accordingly. This all impacts on the quality and quantity of the rehabilitation that people post-stroke receive. The monitoring aspect of self-directed therapy is essential in ensuring that this is done to increase repetition, working in a task-specific manner. Recommendations around the measuring and monitoring of this, using digital technologies would be very much welcomed. | |
| 268 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | B- is there an additional recommendation required re the therapists role in education of patients to understand importance of self directed therapy in terms of outcome and to identify and address factors which may impact on motivation | Thank you for your comment. We would anticipate education being a key part of introducing any therapeutic technique. |
| 269 | | Irish Heart Foundation, Council on Stroke | Evidence appears to be primarily for Upper Limb exercise and training, does this recommendation fit better under the upper limb sections? Consider rewording the recommendation that self directed therapy may act as an adjunct to other therapist recommended evidence-based upper limb interventions.<br><br>This term 'self directed therapy' and how it is presented appears to basically be addressing self completion of home exercise programmes?<br><br>The term 'self directed therapy' doesn't encompass the broader approach of 'self-management' that would include approaches to manage all daily living issues and is more reflective of broader self management of participation issues (as per ICF definition of participation). Self management is included in section 4.4 (not for review), the term self directed therapy may be too similar and possible misinterpreted as self management? | Thank you for your comment. Whilst the strongest evidence was related to the upper limb, other areas of rehabilitation were included with good outcomes. It is a distinct question in it's own right within the scope of the partial rewrite, therefore is presented as such.<br><br>Self management was not within scope of the partial rewrite and is a different concept with it's own evidence base. |
| 270 | Q25. Section 4.8 Independence in daily living | Royal College of Nursing | Agree with recommendation | Thank you for your comment. |
| 271 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 272 | | British Psychological Society | No comment | Thank you for your comment. |
| 273 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Recommendation B – Assessment should include consideration of impact of hidden deficits affecting function including neglect, frontal lobe dysfunction and visual difficulties | Thank you for your comment. This was considered and wording of the recommendation revised. |

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| 274 | | Scottish Intercollegiate Guidelines Network | The RCPE generally welcomes the recommendations contained in this chapter. | Thank you for your comment. |
| 275 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 276 | | United Kingdom Clinical Pharmacy Association (UKCPA) | line 2569-- medication management support for self management or family/carer management by pharmacist | Thank you for your comment. |
| 277 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | B: It would be helpful to identify how soon the person should be referred to Occupational therapy for assessment. | Thank you for your comment. This was considered and wording of the recommendation revised. |
| 278 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Please remove toileting and add 'work' to list of examples.<br><br>Take out personal ADLs and keep as ADL in generally and remove Legg.<br><br>Should wording be changed to be stroke specialist to be consistent | Thank you for your comment. This section has not been revised as part of the 2023 update, other than an amendment to Recommendation B regarding the timing of OT assessment. The sources are therefore left unchanged. |
| 279 | | Irish Heart Foundation, Council on Stroke | Physio<br>Page 57, line 2564 what setting does this refer to? Assessment within 24 hours seems unrealistic in the home setting.<br><br>OT<br>Recommendation B intervention should be emphasised, not just the assessment, the timing of the OT assessment should be based on time since admission, not referral and take into account medical stability of the person with stroke. Again, as previously mentioned in the OT feedback, the OT should have agency in prioritising and determining what the OT needs of the person are in the hyperacute stage (and indeed the whole continuum of stroke care).<br><br>This whole section 4.7 is titled Activity and Participation – but none of the text (previous and current addition) actually address 'participation' (participation as per the ICF definition of participation).<br><br>While section 4.7 is not for review – it does specifically mention work and driving – but there is no recommendation re driving in this section. Reference should be made to the DVLA guidelines (UK) and the NDLS guidelines (RoI) – specific recommendation on return to driving after stroke and TIA | This recommendation is regarding admission to hospital.<br><br>Work has been added to Recommendation B, thank you for your comment<br><br>Work is now mentioned.<br><br>Thank you, this is outside of scope for this section |
| 280 | Q26. Section 4.9 Hydration and | Royal College of Nursing | Agree with the recommendations and evidence here. The use of hand mittens is a restrictive practice and therefore should be considered in line with Restraint | Thank you for your comment. This was considered and wording of the recommendations revised. |

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| | nutrition | | Reduction Network standards. There would need to be consideration as to why the patient is not tolerating the NG tube and if anything can be done to address this. | |
| 281 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 282 | | British Psychological Society | No comment | Thank you for your comment. |
| 283 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcomes and agrees with these recommendations | Thank you for your comment. |
| 284 | | Chest Heart & Stroke Scotland | 4.9 J (2653-2655) where it says 'People with stroke discharged from specialist care services with continuing problems meeting their nutritional needs should have their dietary intake and nutritional status monitored regularly.' Regularly is ambiguous I think it should stipulate a time frame (e.g. weekly/ fortnightly/monthly).<br>I also think that a separate recommendation (bullet point) should be added to highlight 'Where people with stroke discharged from specialist care services develop difficulties in trying to meet their nutritional needs they should be referred back to specialist to have their dietary intake and nutritional status reassessed.<br>A – should 'normal hydration' be defined? | Thank you for your comment. This was considered and wording of the recommendations revised.<br><br>Thank you for your comment. This was considered and wording of the recommendations revised.<br><br>Thank you for your comment. This was considered and wording of the recommendations revised. |
| 285 | | British and Irish Association of Stroke Physicians (BIASP) | Perhaps include a comment on earlier PEG training for relatives/carers. | Thank you for your comment. This was considered and a new recommendation added. |
| 286 | | British Dietetic Association | Page 58, line 2617-2619:<br><br>Mentions 'multiple methods' to assess hydration within 4 hours. Are these methods detailed?<br><br>Page 59, line 2622:<br><br>Should it be a validated tool instead of structured?<br><br>Page 59, line 2623: | Thank you for your comment. This was considered and wording of the recommendations revised. Altered wording to be in keeping with the rest of the guideline and advocate local standardisation. This leaves room for national standardisation if appropriate.<br><br>Thank you for your comment. This was considered and wording of the recommendations revised. |

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| | | | Is “adequately nourished” based on malnutrition screening tool?<br><br>Page 59, line 2627:<br><br>Lower nutrient density of Texture Modified Diet is not mentioned/acknowledged. Acknowledging this in the guidelines could support with appropriate Dietetic referrals being placed to support patients requiring dietary modification, in particular those not admitted directly to the stroke unit.<br><br>Page 59, line 2633-2640:<br><br>Recommend changing from: ‘be considered for nasogastric tube feeding within 24 hours of admission’ to ‘assessed for nasogastric tube feeding within 24 hours of admission’. This would align the recommendation with the wording of the two similar recommendations on lines 2637 and 2639. Assessed is less subjective and woolly than consider.<br><br>Is there a timeframe for assessment for gastrostomy if patient is unable to tolerate an NGT with bridle?<br><br>Page 59, line 4646:<br><br>‘People with stroke should be considered for gastrostomy feeding if they: – need but are unable to tolerate nasogastric tube feeding’. Could link to the recommendation on 2637 by changing line 2646 to something like ‘People with stroke should be considered for gastrostomy feeding if they: – need but are unable to tolerate nasogastric tube feeding, including attempts with a nasal bridle where appropriate’. May help reduce early PEG where bridle has not been tried yet.<br><br>Page 59, line 2647-2648<br><br>Should it be worded “...Unable to swallow adequate food and fluids orally by four weeks from the onset of stroke and this is likely to continue longer term?”<br><br>Feedback was some stroke rehab settings would not be considering PEG feeding | Thank you for your comment. This was considered and wording of the recommendations revised.<br><br>This was not within scope of the partial re-write<br><br>Referral to a dietician is covered in Recommendation G.<br><br>Thank you for your comment. This was considered and wording of the recommendations revised.<br><br>Thank you for your comment. This was considered and wording of the recommendations revised.<br><br>Thank you for your comment. This was considered and wording of the recommendations revised.<br><br>Thank you for your comment. This was considered and wording of the recommendations revised. |

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| | | | so soon while swallow therapy is ongoing, especially in haemorrhagic strokes to allow for blood to be reabsorbed and potential improvements seen in alertness.<br><br>Page 59, line 2653-2655:<br><br>Who should be monitoring dietary intake and nutritional status post-discharge? As discussed above (section 2.8), currently no recommendation for Dietetic staffing in ESD and community stroke teams. | |
| 287 | | Association of British Neurologists | Is there any merit in using the term "oral feeding" rather than swallowing? This would ensure that pulmonary function, cough, posture, concurrent medical and surgical problems and the availability of food of a suitable consistency and carers with sufficient time are factored in to decision making. | Questions in scope for this section were specific to feeding, including non oral feeding |
| 288 | | Wales Stroke Allied Health Professional Forum | Need more mention of SLT in section around gastrostomy decision making | Thank you for your comment. This point was covered in a revised recommendation regarding MDT decision making. |
| 289 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 290 | | United Kingdom Clinical Pharmacy Association (UKCPA) | Line 2645--People with stroke who require modification of oral medication formulation should:<br>be referred to a pharmacist for medication formulation assessment, advice and monitoring<br>–After SLT have recommended texture of modified food or fluids prescribed using nationally agreed descriptors, Pharmacists should modify the oral formulation for the safe swallowing/administration of medication<br><br>line 2647-- include medication | Thank you, this has been included in the revised wording. |
| 291 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | A: We welcome this recommendation and would be further encouraged if the time period for "regular reviews" were defined, especially in light of the time period post arrival at the hospital is stipulated and in B there is a stipulation for weekly screening of risk of malnutrition.<br><br>F: There is no specification in this section of when the person should be referred to a dietician however the second point refers to consideration for NG feed within 24 hours of admission. Could this first point be tightened in terms of time period? | Reviews would be personalised to the individual.<br><br>Referral to dietician is indicated at point needs are identified by screening |

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| | | | The same applies to G in terms of referral time period<br><br>H: We welcome the guidance re: gastrostomy for patients who do not tolerate an NG are considered not to be appropriate for a PEG as it is presumed they will not tolerate that either. We specifically welcome the clarity around the timeframe for considering the above | Thank you for your comment.<br><br>Thank you for your comment. |
| 292 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | I- needs to have more re environmental considerations/ posture also | Thank you for your comment. These have been included in the revised recommendations. |
| 293 | | Irish Heart Foundation, Council on Stroke | Dietetics<br>COMMENT Recommendation B "Patients with acute stroke should be screened for the risk of malnutrition on admission and at least weekly thereafter. Screening should be conducted by trained staff using a (insert: validated) structured tool. [2023]"<br>COMMENT Recommendation F "Patients with stroke who are unable to maintain adequate nutrition and fluids orally should be:<br>– referred to a dietitian for specialist nutritional assessment, advice and monitoring;<br>– be considered for nasogastric tube feeding within 24 hours of admission;<br>– assessed for a nasal bridle if the nasogastric tube needs frequent replacement, using locally agreed protocols;<br>– assessed for gastrostomy if they are unable to tolerate a nasogastric tube with nasal bridle.<br>I think there should a reference in this section to the need for an out of hours enteral feeding regimen that should be available for use 24/7 to aid compliance with commencing enteral feeding within 24hours of admission if it is indicated as per the Irish National Stroke Programmes 2019 Recommendations for the Management of Nutrition and Hydration in Patients with Stroke – A Guidance Document<br><br>COMMENT: Consider Including in recommendations as per the Irish National Stroke Programmes 2019 Recommendations for the Management of Nutrition and Hydration in Patients with Stroke – A Guidance Document<br>" Referral to dietetics should be considered for those with:<br>- nutrition related co morbidities (i.e. diabetes, components of the metabolic syndrome, constipation, pressure ulcers, falls, renal failure) | This has been included in the revised wording<br><br>This has been included in the revised wording.<br><br>Thank you for your comment. This did not feature in the evidence reviewed for this section.<br><br>This was outside of scope for the partial re-write |

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| | | | 12,23,31,32.<br>- all patients with modifiable risk factors (hypertension, overweight/obesity, suboptimal diabetes control, new diabetes diagnosis and hyperlipidaemia) should be offered specialist dietetics counselling on risk reduction strategies. “<br><br>Evidence to recommendations<br>References for above additional referral criteria as outlined above<br>Royal College of Physicians (2016) National clinical guideline for stroke. Retrieved from https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx on 21/7/17.<br><br>National Stroke Foundation (2010). Clinical Guidelines for Stroke Management. Melbourne, Australia.<br><br>The European Stroke Organisation (2008) Guidelines for management of ischaemic stroke and transient ischaemic attack. Available at http://www.congrexswitzerland.com/fileadmin/files/2013/esostroke/pdf/ESO08_Guidelines_English.pdf.<br><br>Stroke Foundation of New Zealand and New Zealand Guidelines Group. (2010). Clinical Guidelines for Stroke Management 2010. Wellington: Stroke Foundation of New Zealand.<br><br>Casaubon. L.K., Boulanger, J.,Glasser, E., Blacquiere, D., Boucher, S., Brown, K., Goddard, T., Gordon, J., Horton, M., Lalonde, J., LaRivie`re, C., Lavoie, P., Leslie, P., McNeill, J., K Menon, B., Moses, B., Penn, M., Perry, J., Snieder, E., Tymianski, D., Foley, N., Smith, E. E., Gubitz, G., Hill, M.D. & Lindsay, P. on behalf of the Heart and Stroke Foundation of Canada Canadian Stroke Best Practices Advisory Committee. (2015) Canadian Stroke Best Practice Recommendations: Acute Inpatient Stroke Care Guidelines, International Journal of Stroke, 11 (2), 239 – 252.<br><br>American Heart Association. (2016) Guidelines for Adult Stroke Rehabilitation and Recovery. A guideline for healthcare professionals from the American Heart Association/American. Stroke, 47: e98-e169. | |

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| 294 | | Royal College of Physicians of Ireland Clinical Advisory Group | This recommendation is vague; should we suggest using eg tachycardia, hypotension, dry mucous membranes, dry skin, renal profile?<br>E consider inserting in line 2629 "Where appropriate patients with acute stroke who are at risk of malnutrition… | Thank you for your comment.<br><br>No further qualification of appropriate patients was considered necessary. |
| 295 | Q27. Section 4.10 Mouth care | RD-UK | Fully support the recommendations A, B, C, D and E<br>4.10 D and 4.10 E both recommend receipt of training in mouth care, but do not yet stipulate where that training can be obtained from.<br>The eLfH e-Learning for Healthcare site has resources specifically designed for this and it would be useful to those using the Guidelines to be reminded of this.<br>https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0_50050&programmeId=50050 | Thank you for your comment. This was considered and the wording of Recommendation E revised. We are unable to suggest particular training modules as they can quickly become out of date. |
| 296 | | Royal College of Nursing | Agree with all content here. | Thank you for your comment. |
| 297 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 298 | | British Psychological Society | No comment | Thank you for your comment. |
| 299 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcomes and agrees with these recommendations. | Thank you for your comment. |
| 300 | | Chest Heart & Stroke Scotland | 4.10 B Might want to add in a bullet point here to highlight recommendation to use non foaming toothpaste (no Sodium lauryl sulphate SLS) for patients with swallowing issues. | Thank you for your comment. This was considered and wording of the recommendations revised. |
| 301 | | Royal College of Speech and Language Therapists | Page 60, 2711-2713 – Could, 'a clean mouth requires the removal of traces of food and debris and dental plaque. This is not only pleasant for the person with stroke'.... be reworded to 'a clean mouth is pleasant'? Otherwise, it sounds like the process of cleaning is pleasant and it generally isn't.<br><br>Page 61, line 2728-2733 – No mention of low-foaming toothpastes for people with dysphagia e.g. sulphate free (Mouth Care Matters, 2019).<br><br>General – The RCSLT welcomes the addition of this section to the guidance. An issue frequently found in community settings is poor dentition and a lack of access to any dental care. Mouth care for those with dysphagia living in their own home in the community seems to be more of an issue than those in the acute | Thank you for your comment. This was considered and wording of the recommendations revised.<br><br>Thank you for your comment. This was considered and wording of the recommendations revised. |

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| | | | setting because they are not receiving regular mouth care by trained staff. | |
| 302 | | British Society of Gerodontology | Line 2710 - Please change the wording to oral care ( remove health)<br>2714 - please add dental caries and periodontal (gum) disease<br>2716 - remove sepsis<br>Recommendation A - please add regular dry mouth care. There is little evidence, but society wanted there to be a reference to the clinical guidance https://www.gerodontology.com/content/uploads/2014/10/stroke_guidelines.pdf. This guidance is based on evidence and still represents the consensus views of the society.<br>Recommendation C - please add dentures should be kept in a labelled denture container when not in the mouth to prevent dentures loss<br>Recommendations B and C - please add dentures, and toothbrushing should happen after meals in individuals with poor oral clearance.<br>Recommendation D - can add links to NICE oral health https://www.nice.org.uk/guidance/qs151 also add provision and recording of mouth care, please also add undertaking mouth care risk assessments<br>Add to D - the importance of regular dental reviews for stroke patients after discharge from hospital | Thank you for your comment. This was considered and wording of the recommendations revised.<br><br>This was not included, as we have not specified wet or dry mouth care and was not covered in the evidence reviewed.<br><br>This was not included as is not an issue for a clinical guideline, more so important for local implementation.<br><br>This is covered in Recommendation A.<br><br>This was not specifically included as assessment process should include assessment of any risk involved.<br><br>Thank you for your comment, this has been included as a new recommendation. |
| 303 | | Association of British Neurologists | Excellent. | Thank you for your comment. |
| 304 | | Welsh Association of Stroke Physicians | Excellent. | Thank you for your comment. |
| 305 | | Wales Stroke Allied Health Professional Forum | Wonderful to see this section added!<br>Should we be recommending access to hospital based hygienists? | Thank you for your comment. We have not recommended specifically for access to hygienists as we have no evidence of them being routinely available in the hospital setting. |
| 306 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 307 | | United Kingdom Clinical Pharmacy Association (UKCPA) | C--loose dentures - using a fixative e.g Flixodent/Polygrip to secure loose dentures to allow for eating and communication | Thank you for your comment. This was considered and wording of the recommendations revised. |
| 308 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | The recommendations in this section is welcomed in terms of the specificity that it entails.<br>Would this area be something that can be measured on SSNAP? | Measurement of teams compliance with the recommendations is not an issue for the clinical guideline to address, but will be considered by SSNAP in due course. |
| 309 | | Royal College of Occupational Therapists - Specialist Section | C- ??soap and water | Thank you for your comment. |

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| | | Neurological Practice | | |
| 310 | | Irish Heart Foundation, Council on Stroke | Speech and Language Therapy<br>Recommend that this section is called "Oral health care"<br><br>Recommend addition new initial recommendation (p61, L2723):<br>“Per RCP (2016) 'Recommendations for the Care of People with Stroke and Transient Ischaemic Attack", people with stroke, on admission, should be screened for obvious signs of dental disease, receive oral healthcare assessment and ensure that oral healthcare tools are available.” | Thank you for your comment. We have retained the title mouth care, but have added, also known as oral care.<br><br>The current recommendations appear to cover the necessary options, in the absence of definitive evidence. |
| 311 | Q28. Section 4.15 Return to work | Royal College of Nursing | Agree with all contents here. Perhaps there is scope to consider driving also. Many work roles involve driving, or driving too work. A stroke may affect someones safety to drive. | Thank you for your comment. Reference to driving has been added into this section |
| 312 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment |
| 313 | | British Psychological Society | Recommendation B – This recommendation needs explicit reference to neuropsychological assessment relating to neurocognitive functioning, psychological regulation and personal/identity adjustments in view of fitness to work in an altered or new capacity. Key factors for successful return to work include having a clear understanding of the consequences of the stroke including neuropsychological functioning (cognitive, psychological, behavioural, psychosocial). Although an understanding of the consequences is stated, if they have not had access to a neuropsychological assessment and support to understand the findings, people will find this difficult.<br><br>Recommendation D should include cultural barriers in addition to health related barriers to acknowledge the equality and diversity of stroke patients. | Thank you for comment. The recommendations are phrased around the needs of the person, rather than making specific recommendations about which discipline should be delivering the various elements of vocational rehabilitation. This was the decision of the topic group, endorsed by the Guideline Development Group.<br><br>Thank you. This is covered in the first bullet point of Recommendation D under the term ‘barriers’. These are not listed (to avoid an ‘including but not limited to…’ type of statement). Culture is also referred to in Section 1.2. |
| 314 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Medical staff are required to offer patients in employment a FIT note, and should liaise with therapy colleagues in making recommendations on return to work People considering return to work after stroke should be referred to Rehabilitation Medicine physicians with expertise in working with the specialist vocational rehabilitation multidisciplinary teams to provide medical assessment and support in relation to return to work processes | Thank you for comment. A recommendation has been added regarding fit notes, provided by all authorised staff.<br><br>This hasn’t specifically been included, on the assumption that rehab medicine consultants may make up a proportion of the |

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| | | | | medical workforce in the stroke pathway including VR services. |
| 315 | | Association of Clinical Psychologists UK (ACP-UK) | People attempting to return to work following a stroke should routinely be offered a neuropsychological assessment. This can identify higher level cognitive difficulties not seen on routine cognitive screening. By identifying this in advance the appropriate cognitive rehabilitation strategies can be implemented and advice given in terms of reasonable adjustments. Identifying possible difficulties through thorough assessment of cognition will enable the person to make an informed decision around their return to work. Having appropriate assessment and rehabilitation means people are more likely to successfully return to work. | Thank you for comment. The recommendations are phrased around the needs of the person, rather than making specific recommendations about which discipline should be delivering the various elements of vocational rehabilitation. This was the decision of the topic group, endorsed by the Guideline Development Group. |
| 316 | | Chest Heart & Stroke Scotland | 4.15 (2914-2915) The link to assessing fitness to driving takes you out of the document. Can it be changed so the link opens on a separate 'URL page' so this document still stay open on the current page. | Thank you for your comment. This will be implemented. |
| 317 | | Royal College of Speech and Language Therapists | Page 66, line 2972-2978 – There is a need for regional Vocational Rehabilitation specialist centres.<br><br>General – The RCSLT welcomes the inclusion of this section, especially the information relating to prognosis for return to work. | Thank you for your comment. This is included in chapter 6. |
| 318 | | The Stroke Association | We welcome these recommendations for improved support for stroke survivors to return to work. This has been a significant area of need for working age stroke survivors, as highlighted in our Lived Experience of Stroke report.<br><br>We recommend that the guidelines explicitly state that the stroke key worker role can already provide the services outlined in Recommendation B and lines 2997-3000, as the stroke key worker can provide level 3 vocational rehabilitation.<br><br>We would also suggest that lines 3022-3024 should explicitly state that the stroke key worker is included in the phrase 'health professionals'. We would further ask that the guidelines include a clear definition of the term 'health professional'.<br><br>With regards to the suggestion that there is a 'paucity of evidence to inform recommendations on returning to work after a stroke' (line 3032), we would encourage the guideline development group to expand their definition of evidence to include the lived experience of stroke survivors, who are the people most suitably placed to inform best practice.<br><br>We would therefore urge the group to consider the Stroke Association's research | Thank you for your comment<br><br>We have not specifically mentioned the stroke key worker role, in line with the overall approach in the guideline where we refer to knowledge and skills required rather than particular professional groups.<br><br>Thank you for your comment. The guideline is committed to the published methodology re types of evidence included in literature searches. |

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| | | | into this area, which is extensive. In particular, our Lived Experience of Stroke survey found that:<br>· A quarter of all strokes happen to people of working age (i.e. under the age of 65).<br>· Around a third of stroke survivors in this age group have to give up their job following their stroke, while a further 15% have to reduce their working hours.<br>· 15% of working age survivors told us that they had experienced discrimination at work or missed out on a promotion.<br>· One in ten told us that their employer was not supportive following their stroke.<br>· 37% of working age stroke survivors experience a loss of income, likely due to giving up their job or reducing their working hours.<br>· 16% of all stroke survivors face increased costs as a result of their stroke.<br><br>We would also encourage the group to signpost the help that the third sector can provide in return to work services. The Stroke Association also provides wide-ranging resources to assist stroke survivors, including:<br>· 'What we think about: Work after stroke': summarises our position on this area, namely that 'stroke survivors should have the support and opportunity to return to work if they wish and are able to do so' (https://www.stroke.org.uk/sites/default/files/jn_1920.276a_-_pps_-_work_after_stroke.pdf)<br>· 'A complete guide to work and stroke': a guide for stroke survivors returning to work, with suggestions for coping with the emotional changes related to stroke and accessing the relevant financial assistance (https://www.stroke.org.uk/sites/default/files/user_profile/complete_guide_work_and_stroke.pdf)<br>· 'A complete guide to stroke for employers': offers practical advice to employers, such as not rushing stroke survivors back to work, listening carefully to the needs of employees affected by stroke, and creating a return-to-work plan for their relevant employees (https://www.stroke.org.uk/resources/complete-guide-stroke-employers)<br>· Our Stroke Helpline: all our Helpline Officers receive training in how to signpost to additional resources and services available for people hoping to return to work following their stroke.<br>· Our Stroke Support Groups and Here for You service - again there is the chance through our peer support offer, to connect with other stroke survivors in similar situation and learn from others experiences. | |

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| 319 | | British and Irish Association of Stroke Physicians (BIASP) | No comment | Thank you for your comment. |
| 320 | | The Irish Heart Foundation | Those within the focus group who hope to return to work strongly agreed with line 2989, where patients should only return to work after the support they need is provided. There was an emphasis on the need for more education for employers on the specific needs of a stroke patient on returning to work , mainly focusing on fatigue.<br><br>Many expressed that they have yet to return to work due to employers rushing them into returning full-time, which is inappropriate (line 3008).<br><br>Employers require more specific work models to facilitate stroke patients rather than being grouped with extended sick leave and maternity leave cases. These guidelines refer to 'the return to work.'<br><br>Still, the focus group felt that there should be further guidelines to cover the 'continuation of working post-stroke, as the needs of stroke survivors may change throughout employment. One participant discussed that their employer appropriately supported their return to work. Still, they felt abandoned and lacked ongoing support as their post-stroke and employment needs evolved. | Thank you for your comment. |
| 321 | | Irish Association of Physical and Rehabilitation Medicine | A Irish equivalents should aloso be included e.g. Intreo instead of Jobcentre Plus. HSE or Public funded prganisations instead of NHS etc.<br>C - Irish equivalent is Equal Status Acts 2000 to 2015 | Thank you for your comment. This has been included. |
| 322 | | Brain Injury Matters (NI) | Section 2.12 Vocational Rehabilitation<br>Vocational rehabilitation (Return to work) is of relevance to a distinct group of people who have suffered a stroke, particularly younger adults who may have a stroke before retirement, and those with less severe impairments. This guideline should recognize that there is more to life than work. Indeed, the UN Convention on the Rights of Persons with Disabilities discusses the importance of work and education and recreation in equal measure. Specifically, Article 27 identifies "the right of persons with disabilities to work, on an equal basis with others", Article 24 identifies the "right of persons with disabilities to education" [to] ensure an inclusive education system at all levels and lifelong learning" and finally, Article 30 highlights the need for, "cultural life, recreation, leisure and sport" and for disabled people to have the "opportunity to develop and utilize their creative, | Many thanks for your comment. The partial rewrites is wedded to the 59 questions included in the scope. The question here was related specifically to vocational rehabilitation as a specific service/intervention. Hobbies and leisure unfortunately were not within scope of this process. |

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| | | | artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society" in the arts as well as "in recreational, leisure and sporting activities".<br><br>Section 4.15 'Return to Work' should be a sub-category of a section entitled 'Return to education, work, cultural life, the arts, recreation, leisure and sport'.<br><br>The current guideline [2959] highlights the negative consequences of not being in work, yet does not highlight that there is, however, more to life than work. Alongside work, meaningful engagement in education, cultural life, The Arts, recreation, leisure and sport, can restore and develop a strong sense of self-esteem, self-image, self-worth and self-efficacy, never mind pride and dignity.<br><br>A section on 'Return to cultural life, the arts, recreation, leisure and sport' could read, much as for 'Return to work' in the current guideline, as below:<br><br>Section 4.xx Return to cultural life, the arts, recreation, leisure, and sport<br>Social Justice demands going beyond Medical, Biopsychosocial or Social Models of rehabilitation to a 'Societal Model' where all departments of state relating to cultural life, the arts, recreation, leisure, and sport should feel the impact of the UNCRPD. Fundamentally there should be a recognition that inclusion is but the tool for eradicating exclusion from our society.<br>For the purposed of this guideline the term 'The Arts and Sport' will be taken to refer to all aspects of cultural life, the arts, recreation, leisure and sport as described in Article 30 of the UNCRPD.<br><br>Returning to or identifying new interests and opportunities in the arts and sport is an important goal for many people after stroke. As such, at the earliest opportunity, people must be asked about their current engagement in the arts and sport. In this way, they and those supporting them, can (re)discover their value and role within society.<br><br>Engaging with the arts allows people with stroke to develop and utilize their creative and artistic potential for their own benefit and for the enrichment of society.<br>Recreational, leisure and sporting activities may include participation in mainstream activities, as well as being part of disability-specific or mainstream | |

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| | | | activities.<br>Cultural life may include television, visiting cinema, theatre, museums, libraries, tourism services, and accessing monuments and sites of national cultural importance.<br><br>Not getting the opportunity to meaningfully engage in the arts or sport is associated with health risks, reduced quality of life and poorer psychosocial outcomes. Similarly, benefits of returning to the arts and sport include improvements in quality of life, better perceived general health, reduced pain and depression, and higher perceived levels of participation and autonomy.<br><br>Unquestionably, returning to the arts or sport is often complex, and depends on a range of interacting factors and the engagement of different stakeholders. Barriers can include difficulties in relation to transport (personal mobility), toilets (changing places), access and societal attitudes and awareness. Given this complexity, many people require coordinated action, involving trained staff (with the required competencies and knowledge of the relevant legislation), and all stakeholders.<br>Returning to the arts or sport is a neglected area within previous editions of this guideline, amongst NHS staff?, rehabilitation professionals, and wider society, so, remains a largely unmet need.<br><br>Section 4.xx Recommendations<br>Recommendation A<br>People with stroke should be asked about their pre-stroke involvement with the arts and sport at the earliest opportunity, irrespective of whether they plan to return. This could enable staff to have a better understanding of their role in society, and offer the person with stroke an opportunity to discuss their thoughts and feelings.<br>Recommendation B<br>People who need or wish to return to any area of the arts and sport should:<br>– be supported to understand the consequences of their stroke in relation to the arts and sport;<br>– be supported by an appropriate professional (with an understanding of the person's engagement in the arts and sport) to discuss with their organization / club about returning at an appropriate time. Caution should be observed that the person does not return too early after their stroke without the support they | |

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| | | | need;<br>– be supported to identify any requirements / access needs with their organization / club, with input from disability champions (where available);<br>– be referred to a disabled arts organization or para-sports club appropriate to their needs, most of which will be within the voluntary sector<br>– signposted, if required, to seek advice from their organization / club governing body and / or seek specific legal advice regarding their return.<br>Recommendation C<br>Services supporting people with stroke to return to the arts and sport should ensure that:<br>– there is a coordinator (or coordinating team / joint cross agency working) responsible for liaison and support with planning and negotiating return with all those involved who ensures all involved are aware of their roles, responsibilities, and relevant legislation;<br>Recommendation D<br>Rehabilitation programmes for people returning to the arts and sport after stroke should include:<br>– assessment of potential barriers and facilitators;<br>– an action plan for how barriers may be overcome;<br>– supports / interventions tailored to the individual. This may include tuition, coaching, adaptation of the environment, strategies to compensate for functional limitations (e.g., cognition, mobility and arm function), and fatigue management;<br>– collaboration between the person with stroke, their organization / club and healthcare professional in planning, facilitating and monitoring their return (this should also be reviewed on a regular basis).<br>Recommendation E<br>Health professionals who work with people who have had a stroke across all sectors of society should undertake training on facilitating return to the arts and sports (appropriate for the nature and level of service they provide). | |
| 323 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 324 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We welcome this recommendation especially the recommendation that return to work needs to be discussed at the outset irrespective of whether the individual returns to work or not as we know that this may change depending on their rehabilitation outcomes. | Thank you for your comment. Timing of these discussions has been reflected in the revised wording. |

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| | | | We welcome recommendation B: We would urge consideration of better timeline clarification around when employers are approached, depending on the person with stroke's requirements. This would indicate that specificity around the length of involvement of a VR service is also recommended.<br><br>We look forward to the outcome of the RETAKE trial which will have implications for these recommendations | Thank you for your comment. Timing of these discussions has been reflected in the revised wording.<br><br>Thank you for your comment |
| 325 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Return to Work – you evidence there is a need for VR trained staff due to significant health benefits reported in guidelines as well as complexities (2965-2970) but that VR remains a predominantly unmet need in the NHS (2974). Occupational therapists are ideally suited to provide VR in CNRS and specialist VR services (2998-3002), but the availability of this type of support depends on locality funding and commissioning. There is a large discrepancy in the provision of specialist VR and support services across the country. In areas where there are no specialist VR services, needs fall only to OTs within CNRS teams. We would recommend additional OT staffing provision in localities without specialist VR provision, as these treatment interventions are complex, time consuming but entirely appropriate for CNRS staff. In practice it is likely that some "unmet need" results from a lack of OT provision/staffing and pressure on services to meet 24 hr targets for new patients despite the known health benefits for returning to work.<br><br>Need to include fit notes<br>B- and HR where appropriate?<br>?? Recommendation needed re community stroke service needs to be able to deliver VR level 1 and 2. Inclusion of the triangle would be beneficial<br>D- include communication<br>E- Remove 'across all sections of society'. Should have appropriate levels of skills and knowledge | Thank you for your comment.<br><br>Thank you, this has been added.<br>Thank you, this has been added.<br><br>Thank you, this has been added.<br><br>Thank you, this has been revised. |
| 326 | | Irish Heart Foundation, Council on Stroke | Physio<br>4.15 A Agree about occupation.<br>4.15 C Service to return to work only in one Irish setting (Vocational Rehab service).<br>4.15 Overall not available in Ireland but should be.<br><br>OT<br>Evidence for recommendation | Thank you for your comments<br><br>Thank you for your comment |

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| | | | This is a very welcome addition and does address an ICF 'participation' domain.<br><br>line 2974 VR is a neglected area within the NHS - should also include and the HSE.<br><br>Line 2997-3000 Consider including Headway and Acquired Brain Injury ( ABI) Ireland for the Irish context as specific agencies are mentioned for England.<br><br>Consider placing emphasis on timing of return to work interventions within stroke rehab context and specify how VocRehab services differ and how this is more likely to be addressed in sub-acute stroke rehab services. ESD will commence this work with YSSs and refer on for people with ongoing needs.<br><br>There is nothing in these recommendations to suggest that the person should receive a detailed assessment by an occupational therapist to identify if/how any stroke impairments are impacting on roles and responsibilities required to return to work. This is not commensurate with other specific mentions for OTs within the guideline to be involved in assessing disruption to pADL, home assessments etc<br>Also requires a recommendation for having any post stroke impairments managed to mimimise the impact on resuming the worker role. Need for work hardening interventions also justified in this section.<br><br>This document needs to put stronger emphasis on the need for coordinated and dedicated stroke rehabilitation across the trajectory of stroke care – access to longer term rehabilitation needs to be addressed and emphasised in this document in order to begin to address these life-participation issues faced by people recovering from stroke.<br><br>(Kate Radford et al, Nottingham, are currently running a trial on return to work after stroke – findings not published yet as trial is ongoing).<br><br>Psychology<br><br>Excellent overview. More detail might be helpful about where this service should be located. Patients in intensive rehab are often not ready to fully explore this and inpatient services may not be set up for staff to actively engage with | Thank you for your comment. Wording has been altered to read statutory health services to cover all nations<br><br>Thank you for your comment. Services have been given as an example. We have not referenced non stroke specific agencies, but recognise they have a role and add value<br><br>Thank you for your comment. This has been reflected in the revised wording.<br><br>Thank you for your comment. To remain in keeping with the rest of the guideline we have recommended these are carried out by professionals with the correct knowledge and skills. This is most likely to be an occupational therapist, but may be carried out by others with the appropriate training as part of the broader MDT.<br><br>Thank you for your comments. This has been reflected in the revised wording.<br><br>Many thanks. These issues have been addressed in chapter 5.<br><br>Noted. This is mentioned in the evidence to recommendations paragraphs.<br><br>Thank you for your comments. Service configuration is an issue for local/regional agreement, but must meet the recommendations contained within the guideline. |

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| | | | employers on an ongoing basis, but the community services are significantly lacking in Ireland, and where they exist they lack the full MDT expertise to address the specific aspects of stroke (e.g. aphasia) that might pose a barrier to return.<br><br>SLT<br>General<br>4.15 General comment: It should be noted that an ability to communicate effectively (through any means) is a crucial component to fulfilling almost all occupational roles, which presents a disadvantage to people with post-stroke communication difficulties and highlights<br>presents a disadvantage to people with post-stroke communication difficulties and highlights the need for access to SLT assessment and interventions to support return to work post stroke.<br><br>Specific<br>Request addition after L2959 P66:<br>"There is a lower rate of return to work for stroke survivors aged 18-65 years with aphasia (28%) compared to those with no aphasia (45%) (Ross et al, 2011)"<br><br>Request addition to L3019 P67 after "fatigue management"<br>"...aphasia and other communication disabilities..."<br><br>Request new point after P67 L3021:<br>"Given the particular challenges experienced by people with post-stroke aphasia, specialised vocational rehabilitation should be made available that responds to individual communication needs and contexts (Duong et al, 2019)"<br><br>Evidence to recommendations<br>Ross Graham , Shelialah Pereira & Robert Teasell (2011) Aphasia and return to work in younger stroke survivors, Aphasiology, 25:8, 952-960, DOI: 10.1080/02687038.2011.563861<br><br>Duong P., Sauvé-Schenk K., Egan M. Y., Meyer M. J., Morrison T. (2019). Operational definitions and estimates of return to work poststroke: A systematic review and meta-analysis. Archives of Physical Medicine and Rehabilitation, 100(6), 1140–1152. doi:10.1016/j.apmr.2018.09.121 | Thank you for your comments. This is reflected in the revised wording of Recommendations C and D, which now specifically mention communication disability.<br><br>This background observational data was outside of scope for search timeframes.<br><br>This has been included in the revised wording of Recommendation 4.15 C.<br><br>The Recommendations in this section are relevant to all impairments, rather than just communication, cognition, motor, vision etc. This is intentional as treatment at this stage in recovery is disability-focussed rather than impairment-focussed. The available evidence for return to work interventions (albeit limited) is not impairment-focussed but holistic and multi-disciplinary. |

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| 327 | Q29. Section 4.17 Motor impairment | Royal College of Nursing | Agree with all content | Thank you for your comment. |
| 328 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 329 | | British Psychological Society | No comment | Thank you for your comment. |
| 330 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcome the recommendations in connection with encouragement to exercise for stroke patients with lower limb weakness, however spasticity which very often co-exists is not mentioned and can severely limit ability to exercise-. A referral to rehabilitation medicine specialist for assessment and management of spasticity should be made | Thank you for your comment. This will be implemented. |
| 331 | | Chest Heart & Stroke Scotland | 4.17 (3102) The link to Kurl et al is not opening but if it is changed to open then can the link open on a separate 'URL page' so this document will stay open on the current page. | Thank you for your comment. Training described is high intensity exercise appropriate to the individual, not the commercial HIIT programme available in leisure centres or online health apps. |
| 332 | | The Irish Heart Foundation | The focus group voiced a reluctance to the use of HITT (line 3243) as a recovery for a stroke due to the intensity associated with this type of training and the increased number of people having a stroke as a result of HITT training. (Maybe this is a case of terminology rather than the type of exercise described.)<br><br>Stroke survivors agreed that recovery was best when supervised by a specialist trainer. Further comments were made about the lack of detail for those patients with impaired walking and mobility (line 3258). | Thank you for your comment. Training described is high intensity exercise appropriate to the individual, not the commercial HIIT programme available in leisure centres or online health apps. |
| 333 | | Brain Injury Matters (NI) | Recommendation D<br>Repetitive task exercise may be achieved by at an early stage by developing engagement with arts organizations, sports / para-sports clubs or leisure establishments where there is a high degree of physical activity such as dance, cycling, swimming, yoga, Pilates, gym work or walking.<br><br>Recommendation G<br>People who are unable to exercise against gravity should be able to engage in physical activity where gravity is reduced such as swimming, recumbent trikes or gym equipment. Engagement in such exercise is unlikely to need continued input from a Physiotherapist or Occupational Therapist but may be delivered by a swimming coach, cycling instructor, personal trainer or fitness instructor with appropriate training and adjustments having been made with reference to | Many thanks for you comment. The wording of this section reflects the evidence reviewed as part of the search process. |

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| | | | Equality legislation and Article 30 of the UNCRPD.<br><br>Recommendation H:<br>People with stroke should be supported with strategies to maximise exercise adherence such as:<br>Physical activity social networking apps (such as Strava) and virtual online physical activity platforms (such as Zwift) can allow people to participate as well as receive encouragement and support from family, friends and peers engaging on an equal basis as others as envisioned in Article 30 of the UNCRPD.<br>Activities where the family members and friends of people with stroke can also engage in physical activities and sports, where they can participate on an equal basis, as envisioned in Article 30 of the UNCRPD.<br>There is a clear underrepresentation of persons with a disability (including stroke) as staff, as swimming coaches, cycling instructors, personal trainers or fitness instructors, within leisure centres, swimming pools, sports clubs or gyms. All such organizations and clubs should strive to have services which are led and delivered by persons with disability and people with stroke should be encouraged and supported to create and take up such roles. | |
| 334 | | Wales Stroke Allied Health Professional Forum | Have any studies on music therapy and its place in stroke rehabilitation been included in this review of the guidelines? | This was not within scope of the partial re-write. |
| 335 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 336 | | The British Association of Prosthetists and Orthotists | A - "People with stroke should be assessed for weakness using a standardised approach, and have the impairment explained to them, their family/carers and the multidisciplinary team. Assessment and outcome measures should encompass the range of effects of exercise including weakness, cardiovascular fitness and activities". We believe that having an orthotist as a core member of the MDT is essential to this recommendation.<br><br>B - "People with weakness after stroke sufficient to limit their activities should be assessed by a physiotherapist with knowledge and skills in neurological rehabilitation". We believe that this recommendation should include "and an orthotist, where appropriate".<br><br>H- should include: "access to orthotic devices and an opportunity for review of these devices by an orthotist" | Thank you for your comment. This recommendation has been altered to not specifically name physiotherapists.<br><br>Thank you for your comment. This was not in scope of the review and did not feature in the literature reviewed for this question. |

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| 337 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | For this section, we would strongly encourage the recommendation that there needs a comprehensive programme of education for the patient and their family/carers based on their understanding of recovery.<br><br>The section 4 lacks any recognition of cognitive patients, drowsy, low-level patients who are unable to complete repetitive exercise, or move out of bed. We need to be mindful that we address the above patient groups in the recommendation section, as we are aware that the patient being admitted post-stroke has significantly changed over time. We need to be careful not to come across as biased towards the more able patient.<br><br>It would be beneficial to include the use of facilitated exercise for muscle weakness which would address our comment above. Importantly, this would not mean resorting to practices without a strong evidence base. Could lower limb mirror therapy also be recommended for consideration as there is some evidence for this. It is important to recognise that most stroke research does not include patients with more severe weakness so this population often appears to be underrepresented. This lack of research into these areas allows the use of poor evidence-based practices to continue.<br><br>The sections of rehabilitation have limited scope – as lying to sitting, sitting is not included.<br>A: Here it would be helpful if the first line stated 'People with stroke should be assessed for weakness and cardiovascular fitness using a standardised approach.<br><br>C: Whilst we embrace and welcome this recommendation, the reality is far different. In the era where we have been talking about treadmill training for more than 10 years, there is very little concerete evidence clinically that units have this equipment. Therefore, we ask where will these screening/exercise resources come from? How will these be funded? With the lack of rehabilitation space as emphasised recently by the Chartered Society of Physiotherapy, where will this equipment be placed?<br><br>D: We welcome the emphasis on evidence-based practice in preference for those areas of practice that have a less than robust evidence base<br><br>E : We welcome the recommendations about cardiorespiratory fitness after | Thank you for your comment. This has been considered in the revised wording and is referred to elsewhere in the chapter.<br><br>Thank you for your comment. Following review, no amendment was considered necessary.<br><br>This was outside the scope of this partial update and was not covered in any of the literature reviewed for repetitive task practice or other questions related to this section.<br><br>Thank you for your comment. This has been considered in the revised wording.<br><br>Thank you for your comment. The guideline is unable to recommend on how local systems procure/ensure access to equipment beyond the recommendation in Chapter 6. Evidence was strong in order to be clinically recommended. Reference to equipment availability is made in Recommendation E and in Chapter 6. The GDG acknowledges the challenges with implementation that will arise from this guideline.<br><br>Thank you for your comment.<br><br>Thank you for your comment. The stroke guideline is unable to |

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| | | | stroke. Specific doseage recommendations would be useful if and when evidence supports it. Really good idea to link in with other exercise based teams such as pulmonary rehab.Large reliance on NHS services to provide the intensity of training – 3-5x/week for 10-20 weeks. These types of exercise classes are not currently offered in the voluntary sector. Where is all the resource going to come from? Is stroke going to be an inclusion criterion for cardiac rehab programs? This would help services in being able to meet this target<br>We would very much welcome more guidance on cardio-respiratory exercise for those with more severe impairments post-stroke who would be unable to complete a 6-minute walk or shuttle test. | make changes to the criteria to cardiac rehabilitation, but would need to be a decision for local systems. |
| | | | F: can there be a more specific definition of 'respiratory impairment'? Often in practice, people are only identified as having respiratory impairment if they have retained secretions, but it is likely that the intervention would also benefit those with reduced peak flow rate.<br>We would value the recommendation that measures need to be taken as standard to ensure comparisons where these are useful. | Thank you for your comment. Revised wording in the evidence to recommendations paragraph identifies more clearly the limitations of the existing systematic reviews, which limit the strength of the recommendation. |
| | | | G: It is very useful to have the addition about using electrical stimulation for weakness as previous guidelines said this should only be used in the context of a clinical trial. We would also like to highlight the ACPIN FES guidelines to improve mobility in adults with lower limb impairment due to an upper motor neuron lesion | Thank you for your comment. The recommendation as it stands already accommodates this reviewer comment. |
| | | | H: It would be helpful here to indicate, specifically at the second point, that the exercises make sense to the individual based on their understanding of recovery. | Thank you for your comment. This has been considered in the revised wording. Individualisation of priorities and goals is specifically mentioned elsewhere in the guideline. |
| | | | I: There is no mention of how soon after stroke moderate and intense exercise can take place. There is also no differentiation between haemorrhagic vs ischaemic stroke - are recommendations the same or different? No mention of precautions with aneurysms and/or artery dissections as referenced elsewhere. | Thank you for comment. Evidence reviewed did not differentiate between stroke subtypes and adjustments could only result from a clinical assessment of risk in the individual. Precautions for specific causes of stroke are again not specified in the literature. |
| | | | Evidence to recommendations<br>Evidence-based clinical practice guidelines to improve mobility in adults with lower limb impairment due to an upper motor neuron lesion<br>https://www.acpin.net/pdfs/2210%20QMU%20Report.pdf | Thank you for these citations, which support the Guideline Development Group's recommendations regarding Bobath therapy. Johnston et al is already cited. The Dorsch review |

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| | | | Johnston TE, Keller S, Denzer-Weiler C, Brown L. A Clinical Practice Guideline for the Use of Ankle-Foot Orthoses and Functional Electrical Stimulation Post-Stroke. J Neurol Phys Ther. 2021 Apr 1;45(2):112-196. doi: 10.1097/NPT.0000000000000347. PMID: 33675603. https://journals.lww.com/jnpt/Fulltext/2021/04000/A_Clinical_Practice_Guideline_for_the_Use_of.6.aspx<br><br>There are two systematic reviews suggesting that task-specific training is more effective than Bobath therapy on improving upper limb activity, upper limb strength, lower limb activity, and lower limb strength:<br>Scrivener K, Dorsch S, McCluskey A et al. Bobath therapy is inferior to task-specific training and not superior to other interventions in improving lower limb activities after stroke: a systematic review. J Physiother. 2020 Oct;66(4):225-235 https://reader.elsevier.com/reader/sd/pii/S183695532030103X?token=C1791F3E078541ABCB9B7D4CF0A5014A284DBEB9AE118F0CC1C061483BCC0D97C0FBA9314989049BE276F6420B48431D&originRegion=eu-west-1&originCreation=20230108165139<br><br>Dorsch S, Carling C, Cao Z et al. Bobath therapy is inferior to task-specific training and not superior to other interventions in improving arm activity and arm strength outcomes after stroke: a systematic review. J Physiother. 2022 Dec 16:S1836-9553(22)00115-1 https://reader.elsevier.com/reader/sd/pii/S1836955322001151?token=5E6082DBDE557B67CBDC3ED692C1CFB2D4CF506564B27FEFD8782C69DAC6DCD06448C0559BCE27D95B0C2A9AB5939CC3&originRegion=eu-west-1&originCreation=20230108165413 | appeared too late to be included, although recommendations regarding Bobath therapy are already sufficiently supported by Scrivener et al. |
| 338 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | B- People with weakness after stroke sufficient to limit their activities should be assessed by a therapist with knowledge and skills in neurological rehabilitation. [2023]<br><br>I- avoiding all protocols doesn't make sense because of the other recommendation (C) Doesn't read write. Need to say 'excepted where screening is contraindicated' | Thank you, this has been amended accordingly. |
| 339 | | Irish Heart Foundation, Council on Stroke | Physio - Page 71, line 3912, add recommendation about training for staff | Thank you, this has been amended accordingly.<br>. |
| 340 | Q30. section 4.18 | RD-UK | No comment | Thank you, this has been amended accordingly |

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| | Arm function | | | |
| 341 | | Royal College of Nursing | Very detailed. Agree with all content | Thank you for your comment. |
| 342 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 343 | | British Psychological Society | No comment | Thank you for your comment. |
| 344 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Recommendations in connection with encouragement to exercise for stroke patients with upper limb weakness, however spasticity which very often co-exists is not mentioned and can severely limit ability to exercise. A referral to rehabilitation medicine specialist assessment for spasticity management should be made | Thank you for comment. This has been commented upon in the revised section |
| 345 | | Chest Heart & Stroke Scotland | 4.18 E Sources (3405) The links to the various references are not opening but if it is changed to open them then can the link open on a separate 'URL page' so this document still stay open on the current page. | Thank you for your comment. |
| 346 | | Royal College of Speech and Language Therapists | N/A | Thank you for your comment. |
| 347 | | British and Irish Association of Stroke Physicians (BIASP) | No comment | Thank you for your comment. |
| 348 | | Irish Heart Foundation | The focus group was impressed by the number of therapies mentioned in this section; however, the accessibility to these therapies is not described. Therefore, guidelines for health services to refer or signpost these therapies to stroke patients are necessary so that those interested can gain the relevant information.<br><br>GRASP therapy was praised as a successful intervention used by stroke patients, which was more accessible within Ireland but was not included within these guidelines. | Thank you for your comment. Whole time equivalent recommends have been made in chapter 2. Deployment of these staff are to be determined locally.<br><br>Grasp is an example of repetitive task practice, so is covered by this section as a set of exercises and functional tasks, rather than an intervention in it's own right. |
| 349 | | NIMAST | Recommendation A: Why is Bobath singled out as "the other approach "with no reference to other approaches? Have other types of input / models been reviewed to exclude them in addition to Bobath? | The evidence reviewed as a result of the search strategy identified systematic reviews specifically comparing these two approaches |
| 350 | | National Imaging | Nil to add. | Thank you for your comment. |

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| | | Academy Wales | | |
| 351 | | The British Association of Prosthetists and Orthotists | No comment | Thank you for your comment. |
| 352 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We welcome the updated evidence-based interventions for arm function<br><br>Throughout these guideline recommendations, we note that the word "considered" is used in many of the recommendations. Whilst we do not want to be overly prescriptive, we do question if this allows the MDT too much leeway not to adopt what the available evidence suggests is best practice. We note that this is not necessarily the same when it comes to the acute medical management of people who have suffered a stroke whereas in Chapter 2 there is very definitive guidance. This could simply be a lack of robust evidence to support however, we do feel that it is important to identify.<br><br>Lines 3282-3284: We wondered whether the guidelines could go one step further about the tools to predict arm recovery in clinical practice: e.g. the SAFE and PREP2 tools (Alt-Murphy 2022; Stinear et al., 2017b, 3285 Nijland et al., 2010). We think it would be very helpful to clinicians to describe what it is that predicts arm recovery according to this research ie the presence of finger extension/shoulder abduction – in particular, finger extension – see also Fritz SL et al Stroke 2005<br><br>Lines 3298-3302 : We recommend the inclusion of: "learned non-use", as often therapists' neurological assessment forms have not moved with the evidence eg they include spasticity, sensation, balance etc but do not include elements/ headings such as learned non-use ( ie the person has potential to use the arm, but has learned not to use it..) and presence of finger extension, which would direct therapists to interventions such as CIMT – this is an opportunity to include learned non-use as an 'element' (that not enough therapists consider and recognise, hence the potential underuse of CIMT in clinical practice.)<br><br>Line :3301-3302: While we agree with this statement, as this comment appears under the section arm function it should be noted that within some treatment programmes eg CIMT encourages use of the affected arm while eating and drinking / at mealtimes where possible using adapted cutlery / choosing finger food options is considered an important component of the programme - an | Thank you for your comment<br><br>Please refer to the guideline methodology overview in the guideline appendices. Often a 'should be considered' recommendation reflects the selected nature of patients included in trials of interventions that are not appropriate for every patient. Choice of wording is dictated by Guideline Development Group consensus on the quality and applicability of the evidence base upon which the topic group has made the recommendation.<br><br>A literature review of prediction tools for arm recovery was not within the scope of the guideline update.<br><br>The editors considered that this is already sufficiently covered by the eligibility criteria in Recommendations B and D.<br><br>This has been addressed in the revised wording. |

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| | | | opportunity to practice arm function in everyday activity in order to reverse learned non-use of the affected arm. It may therefore be that line 3302 should be qualified in some way to highlight this.<br><br>Line 3327-3335: CIMT: We would suggest a slight change in the manner in which CIMT protocol is explained here. If line 3330 includes shaping to define the intensive graded practice, then "task practice" should also be included with shaping to read (shaping and task practice), as these 2 components make up the intensive graded practice (or repetitive task-orientated training) element of the programme. See Morris DM 2006 CIMT Characterising the intervention protocol.<br><br>Highlighting the original 6 hour protocol ( line 3329) only at this point may not be helpful to clinicians – this is a protocol that is effectively obsolete in clinical practice. The Taub University of Alabama at Birmingham group ( from which the paper Wolf et al 2006 emerged) no longer uses 6 hours of training in their own clinical work or when they teach on CIMT, but 3.5 hours. In fact the reference Taub 2013 ( line 3332) is used in the guideline but the paper uses 3.5 hours of training in its protocol. It would be more helpful to highlight how many different protocols have been used in research / could be used in clinical practice to suit the setting/service/ client with good effect as noted by Kwakkel 2015 and also in the meta-analysis of 16 CIMT RCTs in acute/ subacute stroke by Xi-hua, Liu et al 2017.<br><br>Line 3335: CIMT: We recommend that this sentence is reconstructed to show the benefits of CIMT as highlighted below and in the section above. This would facilitate the translation into clinical practice, in light of the intensity requirements that have been recommended within this guideline. In actual clinical practice, the training elements of CIMT are often delivered through a combination of qualified therapist intervention/ therapy assistant input and self-training (or with a partner/supporter). See the paper 'Automated CIMT extension (AutoCITE) for movement deficits after stroke' 2004 by PS Lum et al, from the Taub group, where 3 hours of daily training was delivered with good results without the need for 1:1 clinical supervision, as an example of how in research the impracticality of delivering one to one intensive training has been addressed.<br><br>A: We welcome this recommendation. A clear definition of "priming techniques" would be most welcome to aid agreement of understanding. | This has been included in the revised wording of the evidence to recommendations paragraphs.<br><br>This has been reflected in the revised wording of the evidence to recommendations paragraphs. There are inevitable limitations on length in these accompanying paragraphs which limit the extent to which these modifications can be described in detail..<br><br>This is valuable practical advice on implementation, but it is outside the scope of an inevitably short evidence to recommendations paragraph.<br><br>Thank you for your comment. It was agreed by the topic group that priming is sufficiently understood and would be an |

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| | | | | unnecessary level of detail. |
| | | | B: We welcome the specificity of this recommendation which is in line with research recommendations. However we feel it would benefit from further clarity as suggested above and below. For clinicians, the entry criteria above is sometimes hard to visualise and assess and do not relate to arm function ability. The wash-rag (flannel) test (Taub E, Morris DM 2001) reflects the minimum motor criteria to be able to take part in a CIMT programme ie to able to 'lift a wash rag off the table top using any type of prehension they could manage and then release the rag' and arguably is more helpful to clinicians. The wash rag test could potentially be useful to add in after line 3372. | Thank you for your comment. The eligibility criteria were carried forward from the 2016 review of the evidence, which of course included the Taub paper. |
| | | | Line 3501.: This is an unnecessary line and suggests that CIMT could be unacceptable to people with stroke which may be the perception of the guideline group / could be perceived as negative by clinicians reading the guidelines, particularly as there is no evidence to suggest that CIMT is unacceptable to people following stroke. If other treatment interventions in the guidelines have not been examined in terms of acceptability then it would appear that there is no need to put this view forward for CIMT – likewise with the statement 3501 re the appropriate support required for its use – this statement is unclear in what it is referring to and not helpful. | Thank you for your comment. It was important given the poor uptake of CIMT, despite the quality of the evidence, for this to be explained. |
| | | | Recommendation B for CIMT has again used the word 'considered' – indeed this word is used in many of the recommendations. Throughout I question if this allows the MDT too much leeway not to adopt what the evidence suggests is best practice. I haven't had time to look but it would be interesting to look at recommendations for things such as scanning and other aspects of medical management to see if the word is used there too. Although I recognise that guidelines are just that, guidelines, and shouldn't be applied without clinical reasoning/judgement, it is important that they do not allow too much leeway for the MDT not to adopt best practice when it should.<br><br>Evidence to recommendations<br>Tools to predict arm recovery:<br>Stinear et al., 2017b,<br>Nijland et al., 2010<br>Fritz SL et al Stroke 2005 | Please refer to the guideline methodology overview in the guideline appendices. Choice of wording correlates with the quality of the evidence base upon which we have made the recommendation. It does mean that all patients should be considered for the intervention, but not all will meet the criteria, or agree to take part. This was the evidentiary standard that the topic group considered was met – sufficient for a 'should be considered' recommendation. |

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| | | | Alt Murphy, M., Al-Shallawi, A., Sunnerhagen, K.S. et al. Early prediction of upper limb functioning after stroke using clinical bedside assessments: a prospective longitudinal study. Sci Rep 12, 22053 (2022). https://doi.org/10.1038/s41598-022-26585-1<br>https://www.nature.com/articles/s41598-022-26585-1<br><br>Line: 3485 Constraint induced movement therapy (CIMT), also referred to as 'forced use' and 'restraint' in the 3486 literature<br>Forced use or restraint are not the same intervention as CIMT and it is confusing to mention them here – The 'also referred to..' line could be removed altogether.<br>Line 3491 the time for which the non-paretic arm are constrained for is reduced and the training hours spread over a longer time period<br>The above statement in bold could be added in here. | Thank you for your comment. The evidence to recommendations has been amended accordingly. |
| 353 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | 1. Using the original CIMT protocol to explain the 3 main CIMT components may not be helpful for clinicians as:<br>• this protocol has not been widely replicated in clinical practice since its inception.<br>• as the description goes on to highlight, the 'time resource needed for CIMT makes it a challenging approach to adopt in practice'<br><br>This introduces CIMT from the beginning in a negative light and focuses on unnecessary information about the original protocol which most therapists will not be able to adopt, nor consider for clinical practice (and we know there are other protocols out there which have been shown to be clinically effective requiring less therapist time). CIMT can be described as per the 3 main components discussed but it may be more useful for clinicians to know from the beginning that there are different protocols to choose from which vary in duration, amount of intensive graded practice and whether 1:1 or group.<br><br>2. The drafted guidelines highlight the variations and modifications of the CIMT protocol in a less than favourable light compared to other upper limb interventions mentioned e.g. mirror therapy. The modifications to the original CIMT protocol are framed as being negative rather than presenting this more neutrally e.g. the counter argument is that the number of different protocols (deemed effective in the research as per Kwakkel et al., 2015 / Corbetta et al. review) described can offer clinicians a certain amount of choice of which to use. | Thank you for comment. It is important we describe the components to encourage use in light of the poor uptake to date and to reinforce the needs for transfer into function.<br><br>Thank you for your comment. Following review, the editors have decided to leave the text unchanged.<br><br>Thank you for your comment. Following review, the editors have decided to leave the text unchanged. |

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| | | | Especially given each service is different. This includes the diversity of services therapists work in i.e. it is not possible for there to be one CIMT protocol to fit all services.<br><br>In addition to this, please also see the meta analysis by Xi-hua Liu (2017) looking at acute and sub acute stroke. This demonstrates the wide range of protocols being used successfully. (Xi-hua, Liu, et. al. (2017). Constraint-induced movement therapy in treatment of acute and sub-acute stroke: a meta-analysis of 16 randomized controlled trials. Neural Regeneration Research 12(9):1443-1450. Retrieved 12 July 2018 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5649464/.)<br><br>Taub (2005) (Autocite Trial) demonstrates that AutoCITE training with greatly reduced supervision from a therapist is as effective as standard one-on-one CI therapy. https://pubmed.ncbi.nlm.nih.gov/15879335/<br><br>3. Stating the summarised findings of the 2 key systematic reviews would help frame CIMT in a more neutral light.<br>Whilst it's mandatory and important to highlight the challenges to CIMT and that further more research is warranted, these guidelines don't highlight the current findings of 2 key systematic reviews of CIMT:<br>• (Kwakkel et al., 2015) 51 RCTs: review shows strong clinical outcomes demonstrated when people received CIMT post stroke. The review shows CIMT to be an effective intervention for UL recovery. It reports improvements in motor recovery of the arm, improved amount of arm / hand use in daily life, improved quality of arm / hand movement in daily life and improved function in activities of daily living.<br>• Corbetta et al., 2015 (42 RCTs): CIMT positive effect in arm motor function, arm motor impairment and dexterity. CIMT recommended intervention for UL impairment in stroke and brain impairment.<br><br>4. Constraint induced therapy is not the same as forced use therapy. The guidelines state:<br><br>"Constraint induced movement therapy 3485 Constraint induced movement therapy (CIMT), also referred to as 'forced use' and 'restraint' in the literature, includes an extended daily period of constraint of the non-paretic arm, repetitive | Thank you. This paper was reviewed and the Cochrane Review by Corbetta was considered to have reached a higher evidentiary standard.<br><br>The paper suggested is outside of the search period for this guideline update and was superseded by the Corbetta Cochrane Review.<br><br>These systematic reviews were reviewed by the topic group and cited. Evidence tables are available in the guideline appendices.<br><br>Thank you for your comment. The sentence has been deleted. |

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| | | | task training for the paretic arm (shaping) and a 'transfer package' to support implementation into everyday life." (p78)<br><br>If you state that CIMT is also known as forced use therapy, therapists are in danger of creating CIMT programmes focusing on constraint more than or to the detriment of the other 2 main components (intensive graded repetitive practice and the transfer package).<br><br>• Forced use therapy was investigated in the Kwakkel et al, 2015 systematic review. 6 RCTs showed no benefit in self-reported amount of arm / hand movement and quality of arm / hand movement in daily life, suggesting the effectiveness of CIMT is not a consequence of placing a mitt restraint on someone's hand (forced use therapy). There needs to be a distinction between CIMT mitt wear and forced -use therapy which has not found to be effective. I.e. all 3 of the main CIMT components need to be in place for CIMT to be effective.<br><br>5. 'Repetitive task training' is not just 'shaping'. The guidelines state:<br><br>"3485 Constraint induced movement therapy (CIMT), also referred to as 'forced use' and 'restraint' in the 3486 literature, includes an extended daily period of constraint of the non-paretic arm, repetitive task training 3487 for the paretic arm (shaping) and a 'transfer package' to support implementation into everyday life."<br><br>'Repetitive task training' is not just 'shaping' but also refers to whole-task practice (continuous whole task practice). I think the word shaping can be taken out of the drafted description here (see below). Or, whole task practice also should be included (or the corrected decided vocabulary for this component of the programme).<br><br>6. "3489 Challenges in clinical delivery and 3490 adherence to original CIMT protocols have resulted in modified CIMT (mCIMT) being adopted, where 3491 the time for which the non-paretic arm are constrained for is reduced."<br><br>Is there a definition of mCIMT? If so what is it and does it need to be used to describe the different programme protocols out there? Does the current definition for mCIMT say the main change in the original programme protocol is | Thank you for your comment. The wording has been amended.<br><br>Thank you for your comment. Modified CIMT has been described in the revised wording for this section. |

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| | | | the amount of 'time the non-paretic arm is constrained for, is reduced?' There are so many variables of change to the original programme protocol, including clinic based / home based / group / 1:1 / programme duration / face to face therapist time etc. Focusing on this one issue does not accurately highlight what mCIMT is. Not sure that mCIMT needs to be defined as it adds to the confusion of what CIMT is (the 3 core components, regardless of programme design).<br><br>7. Eligibility criteria – including a more functional approach to screening / assessment.<br>• It may be helpful for therapists to know they can easily screen potential patients for the movement criteria to join a programme using the 'wash cloth test' / 'flannel test' (also created by Edward Taub and his team. See Taube, E., & Morris, D.M. (2001). Constraint-induced movement therapy to enhance recovery after stroke. Current Atherosclerosis Reports, 3(4), 279-286. ). This is a quick easy screen which can be carried out at any point in the stroke care pathway (rather than state an exact amount of movement required for participants to join, which is often off-putting to therapists).<br><br>8. The importance of therapists understanding that patients need to be screened for learned non-use of the affected UL post-stroke – a major factor of poor UL use post stroke. CIMT intervention is the only UL intervention to address the phenomenon of learned non use. This again can be framed as an important part of screening / assessment just as per other impairments which are recommended e.g. visual impairment, balance etc.<br><br>9. The importance of the transfer package<br>The guidelines can highlight even further the importance of all 3 CIMT components being used together by highlighting the importance of the transfer package. One study carried out by Taub et al., (2013) suggests the use of the t/f package as a crucial component for any CIMT programme, to support generalisation of skills learned in therapy to daily life. Participants in this study made gains up to 2.4 times larger than participants on programmes where no transfer package was used. This points towards the transfer package being particularly key for effective CIMT provision, and can increase the effectiveness of a CIMT programme by 2.4 times (Taub et al., 2013) which is a huge difference. To note - this study was small scale and further research is needed. | Eligibility criteria has been informed by the evidence reviewed following a search conducted in line with the guideline methodology. The eligibility criteria are unchanged from the 2016 review of the evidence, which of course includes Taub.<br><br>The editors considered that this is already sufficiently covered by the eligibility criteria in Recommendations B and D.<br><br>This has been clarified in the revised wording. |
| 354 | Q31. Section 4.19 | Royal College of Nursing | Agree with content | Thank you for your comment. |

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| | Ataxia | | | |
| 355 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 356 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Patients with ataxia in the context of posterior circulation stroke should be considered for assessment by a rehabilitation physician | Thank you for your comment. |
| 357 | | Royal College of Speech and Language Therapists | Page 78, line 3547-3552 – The RCSLT is concerned that there is no mention of the impact of ataxia on speech and swallowing. | Thank you for your comment. Ataxia was not a question within the scope of the partial re-write. No new evidence was reviewed, the section was highlighted as had been split from previous section of balance and ataxia. |
| 358 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 359 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We welcome the updated evidence-based interventions for arm function<br><br>Throughout these guideline recommendations, we note that the word "considered" is used in many of the recommendations. Whilst we do not want to be overly prescriptive, we do question if this allows the MDT too much leeway not to adopt what the available evidence suggests is best practice. We note that this is not necessarily the same when it comes to the acute medical management of people who have suffered a stroke whereas in Chapter 2 there is very definitive guidance. This could simply be a lack of robust evidence to support however, we do feel that it is important to identify.<br><br>Lines 3282-3284: We wondered whether the guidelines could go one step further about the tools to predict arm recovery in clinical practice: e.g. the SAFE and PREP2 tools (Alt-Murphy 2022; Stinear et al., 2017b, 3285 Nijland et al., 2010). We think it would be very helpful to clinicians to describe what it is that predicts arm recovery according to this research ie the presence of finger extension/shoulder abduction – in particular, finger extension – see also Fritz SL et al Stroke 2005<br><br>Lines 3298-3302 : We recommend the inclusion of: "learned non-use", as often therapists' neurological assessment forms have not moved with the evidence eg they include spasticity, sensation, balance etc but do not include elements/ | Duplicate submission – see responses to comment 352 above. |

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| | | | headings such as learned non-use ( ie the person has potential to use the arm, but has learned not to use it..) and presence of finger extension, which would direct therapists to interventions such as CIMT – this is an opportunity to include learned non-use as an 'element' (that not enough therapists consider and recognise, hence the potential underuse of CIMT in clinical practice.)<br><br>Line :3301-3302: While we agree with this statement, as this comment appears under the section arm function it should be noted that within some treatment programmes eg CIMT encourages use of the affected arm while eating and drinking / at mealtimes where possible using adapted cutlery / choosing finger food options is considered an important component of the programme - an opportunity to practice arm function in everyday activity in order to reverse learned non-use of the affected arm. It may therefore be that line 3302 should be qualified in some way to highlight this.<br><br>Line 3327-3335: CIMT: We would suggest a slight change in the manner in which CIMT protocol is explained here. If line 3330 includes shaping to define the intensive graded practice, then "task practice" should also be included with shaping to read (shaping and task practice), as these 2 components make up the intensive graded practice (or repetitive task-orientated training) element of the programme. See Morris DM 2006 CIMT Characterising the intervention protocol. Highlighting the original 6 hour protocol ( line 3329) only at this point may not be helpful to clinicians – this is a protocol that is effectively obsolete in clinical practice. The Taub University of Alabama at Birmingham group ( from which the paper Wolf et al 2006 emerged) no longer uses 6 hours of training in their own clinical work or when they teach on CIMT, but 3.5 hours. In fact the reference Taub 2013 ( line 3332) is used in the guideline but the paper uses 3.5 hours of training in its protocol. It would be more helpful to highlight how many different protocols have been used in research / could be used in clinical practice to suit the setting/service/ client with good effect as noted by Kwakkel 2015 and also in the meta-analysis of 16 CIMT RCTs in acute/ subacute stroke by Xi-hua, Liu et al 2017.<br><br>Line 3335: CIMT: We recommend that this sentence is reconstructed to show the benefits of CIMT as highlighted below and in the section above. This would facilitate the translation into clinical practice, in light of the intensity requirements that have been recommended within this guideline. In actual | |

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| | | | clinical practice, the training elements of CIMT are often delivered through a combination of qualified therapist intervention/ therapy assistant input and self-training (or with a partner/supporter). See the paper 'Automated CIMT extension (AutoCITE) for movement deficits after stroke' 2004 by PS Lum et al, from the Taub group, where 3 hours of daily training was delivered with good results without the need for 1:1 clinical supervision, as an example of how in research the impracticality of delivering one to one intensive training has been addressed.<br><br>A: We welcome this recommendation. A clear definition of "priming techniques" would be most welcome to aid agreement of understanding.<br><br>B: We welcome the specificity of this recommendation which is in line with research recommendations. However we feel it would benefit from further clarity as suggested above and below. For clinicians, the entry criteria above is sometimes hard to visualise and assess and do not relate to arm function ability. The wash-rag (flannel) test (Taub E, Morris DM 2001) reflects the minimum motor criteria to be able to take part in a CIMT programme ie to able to 'lift a wash rag off the table top using any type of prehension they could manage and then release the rag' and arguably is more helpful to clinicians. The wash rag test could potentially be useful to add in after line 3372.<br><br>Line 3501.: This is an unnecessary line and suggests that CIMT could be unacceptable to people with stroke which may be the perception of the guideline group / could be perceived as negative by clinicians reading the guidelines, particularly as there is no evidence to suggest that CIMT is unacceptable to people following stroke. If other treatment interventions in the guidelines have not been examined in terms of acceptability then it would appear that there is no need to put this view forward for CIMT – likewise with the statement 3501 re the appropriate support required for its use – this statement is unclear in what it is referring to and not helpful.<br><br>Recommendation B for CIMT has again used the word 'considered' – indeed this word is used in many of the recommendations. Throughout I question if this allows the MDT too much leeway not to adopt what the evidence suggests is best practice. I haven't had time to look but it would be interesting to look at recommendations for things such as scanning and other aspects of medical management to see if the word is used there too. Although I recognise that | |

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| | | | guidelines are just that, guidelines, and shouldn't be applied without clinical reasoning/judgement, it is important that they do not allow too much leeway for the MDT not to adopt best practice when it should.<br><br>Evidence to recommendations<br>Tools to predict arm recovery:<br>Stinear et al., 2017b,<br>Nijland et al., 2010<br>Fritz SL et al Stroke 2005<br><br>Alt Murphy, M., Al-Shallawi, A., Sunnerhagen, K.S. et al. Early prediction of upper limb functioning after stroke using clinical bedside assessments: a prospective longitudinal study. Sci Rep 12, 22053 (2022). https://doi.org/10.1038/s41598-022-26585-1<br>https://www.nature.com/articles/s41598-022-26585-1<br><br>Line: 3485 Constraint induced movement therapy (CIMT), also referred to as 'forced use' and 'restraint' in the 3486 literature<br>Forced use or restraint are not the same intervention as CIMT and it is confusing to mention them here – The 'also referred to..' line could be removed altogether.<br>Line 3491 the time for which the non-paretic arm are constrained for is reduced and the training hours spread over a longer time period<br>The above statement in bold could be added in here. | |
| 360 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Line 3547: We suggest rephrasing to: Ataxia occurs in around 3% of people with ischaemic stroke.<br><br>A: Please provide clarity on what a standardised approach is/should be<br><br>Evidence recommendations:<br>Stanley Winser, Ho Kwan Chan, Wing Ki Chen, Chung Yau Hau, Siu Hang Leung, Yee Hang Leung & Umar Muhammad Bello (2022) Effects of therapeutic exercise on disease severity, balance, and functional Independence among individuals with cerebellar ataxia: A systematic review with meta-analysis, Physiotherapy Theory and Practice, DOI: 10.1080/09593985.2022.2037115<br>https://bura.brunel.ac.uk/bitstream/2438/13766/3/Fulltext.pdf<br><br>Management of ataxias towards best clinical practice | Thank you for your comment, this revision has been made.<br><br>The Scale for Assessment and Rating of Ataxia (SARA) is a standardised measures of ataxia which has been validated for stroke-related ataxia (Kim et al, 2011b; Choi et al, 2018).<br>Ataxia was not a question within scope, but shows as available for comment as it was separated from previous section titled balance and ataxia. This 2022 evidence was therefore not reviewed.<br><br>Thank you, this has been included in the revised wording |

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| | | | https://www.ataxia.org.uk/wpcontent/uploads/2020/11/Ataxia_UK_Medical_Guidelines._Third_Edition._v3m_Dec_2016_-_updated_Sep_2019.pdf | |
| 361 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | B- ataxia is not solely a physio issue- can the recommendation be worded to say 'therapist' not physiotherapist<br>D- please add recommendation such as' people with ataxia following stroke should be considered for compensatory techniques to aid function and safety, such as proximal stabilisation'.<br>Also should link to the ataxia UK guidelines | Thank you for your comment, this has been included in the revised wording<br>Thank you for your comment, this has been included in the revised wording<br>Thank you for your comment, this has been included in the revised wording |
| 362 | Q32. Section 4.20 Balance | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 363 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 364 | | British Psychological Society | No comment | Thank you for your comment. |
| 365 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Patients with balance issues in the context of posterior circulation stroke should be considered for assessment by an Rehabilitation Medicine physician and referral for specialist neurorehabilitation.<br><br>Patients should be informed of the effect of dual tasking on balance and should, for instance, stop walking before engaging in conversation or dextrous tasks<br>Assessment of peripheral vestibular system including identification and treatment of BPPV should be carried out in addition to therapy approaches for central causes of balance disturbance | Thank you for your comment. In this instance rehabilitation medicine has not been specifically named as is considered part of the medical workforce<br><br>Thank you for your comment. Additional recommendations have been added to incorporate this feedback |
| 366 | | British and Irish Orthoptic Society | This section refers only to motor impairment and does not consider possible visual causes of imbalance that could be considered when assessing and managing patients with balance issues. Although later recommendation for all stroke survivors to have vision assessed within 72 hours by an orthoptist would perhaps catch anyone with these symptoms. As balance can be affected by visual causes, it would be useful to have a reference to the vision section (4.48) in the introduction as is done for the walking. | Thank you for your comment, this has been included in the revised wording. |
| 367 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 368 | | The British Association of Prosthetists and Orthotists | C - "People with limitations of dorsiflexion and/or ankle instability causing balance limitations after stroke should be considered for ankle-foot orthoses and/or functional electrical stimulation. The person with stroke, their | Thank you for your comment. Orthotics was not within scope for the partial re-write. This recommendation was included as a result of orthotics being featured alongside FES- FES for foot drop was |

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| | | | family/carers and clinicians should be trained in the safe use and application of orthoses and electrical stimulation devices in all settings".<br><br>The above recommendation should not only stipulate the ankle, this shows a lack of understanding of orthotic treatment. This recommendation must also include the more proximal joints (the knee and the hip) when discussing orthotic treatment of the lower limb following stroke. | the question within scope |
| 369 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Lines 3580-3583: In the introduction, mention is made about possible causes of balance impairment e.g. altered sensation or reduced midline awareness. We would value if the recommendations included an assessment of the cause(s) of balance impairment for that individual to ensure the treatment is sufficiently targeted.<br><br>We welcome the strong evidence recommendation in Lines 3629-3634 | Thank you for your comment. Assessment of the causes of poor balance has been included as an additional recommendation.<br><br>Thank you for your comment. |
| 370 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | D please add- and/or equipment and adaptation to increase independence, confidence and safety in ADLs<br>Add further recommendation: People with difficulties with sitting balance following stroke should receive an assessment of postural and seating needs. Equipment should be available and provided for patients with identified seating and postural needs regardless of setting | Thank you for your comment. This has been included in the revised wording<br><br>Thank you for your comment, an additional recommendation has been included regarding postural needs |
| 371 | | Irish Heart Foundation, Council on Stroke | Physio - Page 79, line 3580, insert 'to' this is primarily due 'to' lower limb weakness. 4.20 Balance training for PWS is not available "at any time after stroke" | Thank you for your comment. This has been rectified. |
| 372 | Q33. Section 4.21 Falls and fear of falling | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 373 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 374 | | British Psychological Society | Fear of falling requires neuropsychological investigations to establish the cause of the fear. This may be related to impaired neuropsychological integration of sensory input leading to impaired perception and experience of mobility and movement. Fear of falling could also be related to types of stroke directly affecting emotion regulation systems and pathways.<br><br>The Fear of Falling recommendations also fails to mention the option of CBT for | Thank you for your comment. Fear of falling is covered in section 4.21<br><br>This was outside of scope for the partial rewrite |

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| | | | Fear of Falling, despite meta-analytic evidence that this is effective in reducing fear of falling and improving balance in older people (Liu et al. 2018).<br><br>Liu, T. W., Ng, G. Y., Chung, R. C., & Ng, S. S. (2018). Cognitive behavioural therapy for fear of falling and balance among older people: a systematic review and meta-analysis. Age and ageing, 47(4), 520-527. | |
| 375 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | People using orthoses should be fully educated about the risk of pressure damage from their orthoses, especially if sensory loss is present in addition to weakness. Services should provide timely access for orthotic repairs and adaptations | Thank you for your comment. This has been added to Walking (4.23). |
| 376 | | Association of Clinical Psychologists UK (ACP-UK) | There should be acknowledgement of the distress associated with a fear of falling and that psychological support should be offered as part of a falls programme. | Thank you for your comment. Fear of falling is covered in section (4.21). |
| 377 | | British and Irish Orthoptic Society | Whilst this section is largely not been subject to the 2023 update, we wanted to note that vision problems can be a source of imbalance which can lead to falls or a fear of falling. There is a growing evidence base with regard to this area. As with the balance section it may be useful to have a reference to the vision section (4.48) in the introduction as is done for the walking section. The 2022 NICE guideline recommend a vision assessment is part of successful multifactorial intervention programmes for those at increased risk of falling. | Thank you for your comment, vision has been included in the revised wording. |
| 378 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 379 | | United Kingdom Clinical Pharmacy Association (UKCPA) | medication should be reviewed for increased risk of falling e.g sleeping tablets, anticholinergics, assessment for postural hypotension | Thank you for your comment. This has been included in the revised wording. |
| 380 | | The British Association of Prosthetists and Orthotists | F - "People with limitations of dorsiflexion and/or ankle instability causing balance limitations and risk or fear of falling after stroke should be considered for ankle-foot orthoses and/or functional electrical stimulation. The person with stroke, their family/carers and clinicians in all settings should be trained in the safe use and application of orthoses and electrical stimulation devices".<br><br>The above recommendation appears to be too prescriptive, the patient should be assessed for orthotic intervention which may be an AFO, or other orthotic or AFO/ FES combination. Again more proximal joints are not mentioned and must be included. | Thank you for your comment. Orthotics was not within scope for the partial re-write. This recommendation was included as a result of orthotics being featured alongside FES- FES for foot drop was the question within scope with a clinical outcome of improved balance.<br><br>Other orthotics were not within scope of the partial re-write. AFOs were particularly featured as they were compared to FES in the literature reviewed as a result of the FES for footdrop question. |
| 381 | | Association of Chartered Physiotherapists in | Recommendations in this section appear appropriate | Thank you for your comment. |

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| | | Neurology(ACPIN) | Evidence to recommendations:<br>Evidence-based clinical practice guidelines to improve mobility in adults with lower limb impairment due to an upper motor neuron lesion https://www.acpin.net/pdfs/2210%20QMU%20Report.pdf<br><br>Johnston TE, Keller S, Denzer-Weiler C, Brown L. A Clinical Practice Guideline for the Use of Ankle-Foot Orthoses and Functional Electrical Stimulation Post-Stroke. J Neurol Phys Ther. 2021 Apr 1;45(2):112-196. doi: 10.1097/NPT.0000000000000347. PMID: 33675603. https://journals.lww.com/jnpt/Fulltext/2021/04000/A_Clinical_Practice_Guideline_for_the_Use_of.6.aspx | This did not come up in our searches which follow a specific methodology- see manual<br><br>Many thanks, this has been cited in the walking section. |
| 382 | Q34. Section 4.22 Walking | Different Strokes | I would like to see added...'stroke services should consider building links with voluntary sector or other organisations which provide online exercise or other activities for stroke survivors'.<br><br>We have been running free online exercise, delivered by experienced instructors, for almost three years now and we have had very positive feedback on this | Thank you for your comment. This has been included in recommendation. |
| 383 | | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 384 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 385 | | British Psychological Society | No Comment | Thank you for your comment. |
| 386 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Patients with gait problems should be referred to rehabilitation medicine specialist for evaluation for interventions like botulinum toxin injections and orthosis. A full clinical gait analysis should be considered. In appropriate patients, surgical interventions for improving should be considered. | Thank you for comment. Botulinum toxin was not within scope of the partial rewrite and was not featured in any of the literature identified and reviewed as part of the search process for the 59 questions included in scope |
| 387 | | Brain Injury Matters (NI) | Recommendation H<br>Stroke Services should build links with sport and para-sport clubs and their governing bodies as well as recreational fitness facilities to explore how people with stroke can engage in physical activity, on an equal basis as others as envisioned in the UNCRPD Article 30. This should include but is not limited to having access to treadmills, swimming pools, static cycles, recumbent trikes or other relevant gym or fitness equipment.<br>There is a clear underrepresentation of persons with a disability (including stroke) as staff, coaches, trainers or instructors. All such organizations and clubs | Thank you for your comment. It was thought these were adequately covered by the existing recommendations and didn't warrant further examples.<br><br>This was within the scope of the partial rewrite. |

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| | | | should strive to have services led and delivered by persons with disability and people with stroke should be encouraged and supported to create and take up such roles. | |
| 388 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 389 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | A general comment it could be clearer which sections relate to impairment e.g. muscle weakness and which sections relate to activity<br><br>The following recent review in Stroke could be cited within the background section https://www.ahajournals.org/eprint/C6HUIGGXRXCJ7EIQQTV2/full?redirectUri=%2Fdoi%2F10.1161%2FSTROKEAHA.122.038956<br><br>The section is well written but there is very little about 'real world' walking which is a key priority for stroke survivors and how to maintain long-term positive walking / physical activity behaviour. Increasing the volume of walking across the day (e.g. steps per day, bout length) is an important outcome for health and well-being. This is more likely to be achieved post-stroke when behaviour change interventions are included. https://pubmed.ncbi.nlm.nih.gov/27056251/ or this article could be referenced https://jamanetwork.com/journals/jamaneurology/article-abstract/2790532<br><br>The "we walk" study by Jacqui Morris has just been accepted for publication and provides important insights into walking behaviour.<br><br>There also appears to be little about cueing of cadence (auditory rhythmical cueing), biofeedback and virtual reality all of which are cited in other guidelines with supporting literature albeit with weak supporting evidence.<br><br>E: We welcome this recommendation and feel it would be beneficial where this does not exist for funding to be made available for departments to purchase this | Thank you for your comment.<br><br>This paper didn't not meet the criteria for review- as was a review paper, rather than the source trials, systematic review or meta analysis<br><br>Thank you for your comment. An additional recommendation has been added regarding real life ambulation<br><br>Behaviour change strategies were not within scope of the partial rewrite. This has however been added as a comment in the evidence to recommendations section for information.<br><br>This has now been cited<br><br>Thank you for your comment, this was not in scope of the partial rewrite and was not featured in any of the literature reviewed for the questions in scope related to this section<br><br>Thank you for your comment. |
| 390 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Walking narrative doesn't include much about purpose- sounds very mechanical. Could 3705 have an addition of 'and enables increased independence in functional tasks and participation'<br><br>Can an additional recommendation be added to 'assess and facilitate community ambulation according to patients goals- such as walking on rough terrain, over | Thank you for your comment. This has been included in the revised wording.<br><br>Thank you for your comment. An additional recommendation has been added. |

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| | | | distances, walking dogs and reviewing community safety (such as road crossing)'<br><br>3802- typo- ankle | Thank you for your comment. This has been amended. |
| 391 | | Irish Heart Foundation, Council on Stroke | Physio - Page 81, line 3709 typo 'training'. | Thank you for your comment. This has been amended. |
| 392 | Q35. Section 4.23.3 Subluxation and shoulder pain | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 393 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. This has been amended. |
| 394 | | British Psychological Society | As mentioned above, there are currently no recommendations about when to refer on to a pain management team or MDT pain management programme, including psychological approaches to living with pain. We would suggest that this is incorporated to ensure a good quality of life for those living with pain post stroke. | Thank you for your comment. This was outside of the scope of the partial rewrite. Recommendation F includes specialist referral which will include pain service. |
| 395 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcomes and agrees with these recommendations. The treating teams should consider referral to a rehabilitation medicine physician for early use of interventions like orthotic interventions, botulinum toxin injections and suprascapular nerve block help to treat post stroke shoulder pain | Thank you for your comment. These were outside of scope of the partial rewrite. These have been broadly mentioned in an additional recommendation (F). |
| 396 | | Northern Ireland Stroke Network | Whilst not within the scope of this review, 4.23.1 A Line 3834 onwards re pain management still references pregabalin which has been removed from NI formulary due to addiction reasons – I appreciate that this is a national guideline but it may need an amendment for NI | Thank you for your comment. This issue has been addressed in Section 1.8 regarding geographical access to various medicines. |
| 397 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 398 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations in this section appear appropriate<br><br>We wondered whether the group had considered the evidence for the use of lycra sleeves in managing shoulder subluxation and shoulder pain | Thank you for your comment.<br><br>This was outside of scope for the partial re-write |
| 399 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | a- first bullet point- including wheelchair arm rests<br><br>Add something into the narrative or a recommendation that addressing subluxation is a priority in order to optimise upper limb motor recovery and to manage spasticity | Thank you for your comment. This has been reflected in the revised wording. |

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| 400 | | Irish Heart Foundation, Council on Stroke | Physio - Page 85, line 3801, need recommendation for using slings during walking and standing transfers. | Thank you for your comment, unfortunately this was outside of scope for the partial re-write. |
| 401 | Q36. Section 4.24 Spasticity and contractures | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 402 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 403 | | British Psychological Society | No Comment | Thank you for your comment. |
| 404 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | People with spasticity and contractures should be referred to rehabilitation medicine specialist for specialist spasticity service to access assessment under anaesthesia for contractures, for possible targeted botulinum toxin injections, neurolysis, intrathecal baclofen pump and surgery for contractures. | Thank you for your comment. This has been included in Recommendation F. |
| 405 | | The Stroke Association | In addition to the sources already referenced, we would suggest that the guideline development group consider the following two papers on this subject:<br>• https://journals.sagepub.com/doi/full/10.1177/0269215520963855<br>• https://journals.sagepub.com/doi/full/10.1177/02692155221133522 | The evidence for interventions to reduce spasticity has not been reviewed on this occasion. The modifications to the text have been limited to additional Recommendations relating to the role of electrical stimulation, which was within scope. |
| 406 | | Northern Ireland Stroke Network | Spasticity will need a multi-specialty approach to its strategic management. New guidelines should acknowledge that inter/multi- specialty working will sometimes be required. While stroke specific spasticity services are needed, it is also important to treat patients holistically and recognise that stroke patients may have other conditions that contribute to their treatment needs (e.g. frailty, other neurological problems).<br><br>Line 3957 - references use of ashworth scale to measure spasticity – my understanding was that this had fallen out of favour due to its poor reliability | Thank you for your comments. This has been reflected in the revised wording.<br><br>Measurement of spasticity was not within scope of the partial rewrite. Evidence was not reviewed. |
| 407 | | Association of British Neurologists | Is maintenance standing highlighted sufficiently as an important part of the long term management of lower limb spasticity? | This was not within scope of the partial review and therefore has not been referenced |
| 408 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 409 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations in this section appear appropriate.<br><br>Are there any recommendations that can be included for the prevention or treatment of contracture? E.g. consider referring for surgery in certain cases. | Thank you for your comment. |
| 410 | | Royal College of | j- makes this clear this is post injection only (not chronic) | Thank you, this has been revised. |

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| | | Occupational Therapists - Specialist Section Neurological Practice | Add recommendation to ensure monitoring of high risk group (for example those with significant weakness in care homes) to identify worsening spasticity, contracture and intervene to prevent skin breakdown, significant difficulties with hygiene or dressing, pain or positioning.<br><br>Add recommendation re consideration of orthopeadic referral for severe contracture which is causing significant secondary complications including pressure areas or infection | Thank you, a new 'best practice' consensus recommendation has been added.<br><br>Thank you for your comment. The modifications to the text have been limited to additional Recommendations relating to the role of electrical stimulation, which was within scope. A wider review of the literature on spasticity management has not been undertaken on this occasion. |
| 411 | | Irish Heart Foundation, Council on Stroke | OT<br>Consider including the Tardieu Scale as this differentiates the neural from non-neural components of spasticity that the Modified Ashworth Scale doesn't. | Measurement of spasticity was not within scope of the partial rewrite. Evidence was not reviewed regarding Ashworth or Tardieu. |
| 412 | Q37. Section 4.25 Fatigue | Different Strokes | Fatigue is an issue for the majority of stroke survivors - the Different Strokes 2022 beneficiary survey showed that 81% of respondents suffered from fatigue. Recommendation D mentions peer support, but there needs to be more detail on this, and where healthcare professionals can refer individuals to, to ensure that they receive such peer support (ie Different Strokes, Stroke Association etc). Our 2022 survey also showed that, thanks to the support we provide - which is predominantly peer support, 73% of respondents felt they had a better understanding of invisible aspects of stroke, such as fatigue, and 52% felt part of a community. So it cannot be underestimated how important peer support is | Many thanks for your comment. Significance of fatigue has been emphasized in the revised wording. Survey data is not picked up within the search methodology. |
| 413 | | Royal College of Nursing | Suspected typo - line 4034 says see section 4.25 but should probably say 4.40.<br>Agree with content.<br>Post stroke fatigue should also probably be a consideration in the self directed therapy section. | Thank you for your comment. |
| 414 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Many thanks for your comment. |
| 415 | | British Psychological Society | The potential relevance of post stroke cognitive fatigue should be referenced and woven into this section, to support optimal clinical needs-assessment and rehabilitation planning. Post-stroke fatigue is related with neurological necrotic processes leading to inflammatory processes. These affect the neurophysiological activity and induce health behaviours (e.g. fatigue, reduced motivation, mental slowness) to optimise energy preservation and healing. | Thank you for your comment. The description used in this section was directly from the literature reviewed. |

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| | | | Recommendation B does not currently have enough depth. It could be better worded as: Healthcare professionals should apply a comprehensive understanding of all factors contributing to post-stroke fatigue including neuro-physiological, neuropsychological, personality style, context demands and coping styles (e.g. endurance-driven perfectionistic versus reduced engagement/needy/help-seeking).<br><br>Recommendations D and F: Evidence of the usefulness of fatigue management programmes for other conditions should be incorporated in recommendations for post-stroke fatigue (e.g. fatigue after acquired brain injury, chronic fatigue service recommendations, fatigue after multiple sclerosis) including paced activity programmes. (e.d. Asano & Finlayson, 2014)<br><br>Recommendation I clarifies that fatigue can mean that therapy may need to be adapted – It would be helpful if this was referenced in the earlier sections that recommend 3 hours / day active therapy and up to 6 hours / day general activity.<br><br>Asano, M., & Finlayson, M. L. (2014). Meta-analysis of three different types of fatigue management interventions for people with multiple sclerosis: exercise, education, and medication. Multiple sclerosis international, 2014. | Thank you for your comment. This has been reflected in the revised wording.<br><br>Many thanks for your comment. Searches were limited to stroke participants<br><br>Thank you for your comment. This has been referenced in the intensity of therapy section.<br><br>The source is outside the scope of the literature searches. |
| 416 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | There is evidence in other neurological diseases like Multiple sclerosis on the effectiveness of Cognitive Behavioural Therapy in managing fatigue. This option could be considered in manging post stroke fatigue | Many thanks for your comment. CBT for fatigue was outside of the scope for this partial rewrite. Searches were limited to stroke participants. |
| 417 | | Association of Clinical Psychologists UK (ACP-UK) | There is no inclusion of the fact that people recovering from stroke experience both mental and physical fatigue. It is important to acknowledge mental fatigue as often activities (such as watching television, being on computer, talking to people in a group) which can be considered to be relaxing activities are taxing to a recovering brain. There is no mention of sleep hygiene or the need to ensure regular and adequate hydration and nutrition as part of fatigue management.<br><br>Page 90, line 4101 – 'Accept' is an emotionally loaded word and therefore recommending that "learning to accept post-stroke fatigue and recognising the need to manage it" can sound invalidating to people with strokes experience. This should be changed to "learning to manage and live well with post-stroke fatigue". | Thank you for your comment.<br><br>This recommendation has been reworded in a more neutral fashion. |
| 418 | | Chest Heart & Stroke | All – should return to work be mentioned here and the negative impact fatigue | Fatigue has been added to the return to work section. |

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| | | Scotland | can have on a person's ability to engage in work. | |
| 419 | | The Stroke Association | Through this set of recommendations, there is reference to a number of forms of healthcare professional support for stroke survivors experiencing fatigue. With reference to Recommendation D, this includes the provision of 'information, reassurance and support.' We would suggest that the guidelines explicitly state that these services can also be provided by the stroke key worker, as is the case. | Thank you for your comment. We have not referenced specific professionals in line with the rest of the guideline. Stroke key workers would be appropriate to provide information and reassurance, alongside other professional groups. |
| 420 | | The Irish Heart Foundation | Widespread praise for this section as it covers one of the most common symptoms post-stroke, and many found the recommendations valuable. The focus group strongly agreed that a holistic view to describe struggling with post-stroke fatigue was appropriate as it can impact all aspects of their lives (line 4053). Furthermore, they also agreed that fatigue is misunderstood and more education should be done to make the difficulties attached to fatigue more publicly known (line 4073). Attention was paid to recommendation C, where it was pointed out that 'reviewed annually after that' is a critical time frame. However, no one in the focus groups had received fatigue follow-up in how they felt was appropriate or ongoing. Therefore, the emphasis on bringing in a follow-up system was agreed upon. Recommendations G & H are similar, especially regarding patient involvement; thus, education and patient participation could be separated into separate points. | Thank you for your comment. |
| 421 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 422 | | The British Association of Prosthetists and Orthotists | F - should include gait analysis and orthotic devices to improve gait efficiency which in turn will reduce fatigue. | Thank you for your comment. This was not within scope of the partial rewrite and was not featured in the evidence reviewed. |
| 423 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | We welcome this very beneficial addition to the guidelines<br><br>B: Which validated measures would the guidelines recommend under this recommendation especially seeing as the recommendation identifies in Line 4073-4074 and in recommendation G that people with post-stroke identify that their fatigue is not understood by healthcare professionals<br><br>C: The vagueness of the statement around periodic reviewing of post-stroke fatigue which can severely hamper rehabilitation, is not helpful<br><br>A huge body of evidence is missing in the sources and evidence section, specifically those by Dr Anna Kuppuswamy and individuals in her lab and Prof | Thank you for your comment.<br><br>Thank you for comment. In order to futureproof the guidelines, specific measures are not recommended, so as not to become irrelevant if recommended measures are superseded.<br><br>Thank you for your comment. Timing of regular reviews would be individualised according to patient need and presentation.<br><br>Thank you for your comment. Mead's work has been reviewed and cited as part of other studies where she is not lead author, |

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| | | | Gillian Mead. A clear bias towards certain individuals' work is noted.<br><br>Additional sources to consider<br>https://n.neurology.org/content/neurology/95/24/e3321.full.pdf<br>https://bmjopen.bmj.com/content/9/7/e028958.abstract | other studies have been reviewed to inform the section. Literature searching was conducted independently without bias.<br><br>This was excluded on the basis of being short term exploratory study |
| 424 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Adjust recommendation D- to include education to all patients after stroke re fatigue being a common post stroke symptom (to cover those who do not yet identify as having fatigue).<br><br>F dont like wording of learning to accept- change to 'support building acceptance and adjustment of'<br><br>under F- expand pacing and prioritising to include establishing a baseline to avoid 'boom or bust'<br><br>G- can this be worded more simply- seems lengthy and over complicated.<br><br>Doesn't flow well- lengthy and over complicated- can anything be done re this?<br><br>I- why is this is in this section and not anywhere else? | Many thanks, this has been adjusted accordingly<br><br>Thank you for your comment, this has been altered in the revised wording.<br><br>Thank you for your comment. This has not been included as was felt to be an unnecessary level of additional detail which would be implicit in the planning and pacing intervention.<br><br>Thank you for your comment. Following review, it was decided to leave the text unchanged.<br><br>Thank you for your comment. The importance of personalised treatment plans is stated elsewhere in the chapter in relation to other disabilities. |
| 425 | | Irish Heart Foundation, Council on Stroke | Physio -<br>Page 88, line 4034, typo apathy is in section 4.4<br>Page 88, line 4039 typo, remove 'to'<br>Page 89,line 4091, typo, remove 'by'<br>Page 90 line 4095 typo, remove 'by' | Thank you for your comment. These have been rectified. |
| 426 | Q38. Section 4.26 Swallowing | Royal College of Nursing | Agree with content. Not stroke related, but may be relevant the Unsafe Swallow Project https://www.st-annes.org.uk/casestudies/case-study-nursing-care-unsafe-swallow-project/ | Thank you for your comment. These have not been included as are not stroke specific. |
| 427 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |

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| 428 | | British Psychological Society | No Comment | Thank you for your comment. |
| 429 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcomes and agrees with these recommendations | Thank you for your comment. These have not been included as are not stroke specific. |
| 430 | | Royal College of Speech and Language Therapists | General – Speech and language therapists are not named here as healthcare professionals with a core role within this area, but in other sections key professionals are named e.g. 4.30, cognitive assessment, "specialist such as OT or clinical psychologist" and physiotherapist in section 4.17. While it is understood that specialist dysphagia management may involve a few professional groups, the RCSLT recommends adding "a specialist in dysphagia management such as a Speech and Language Therapist". This would place this section on par with other sections which do highlight the key professionals involved in the delivery of care.<br><br>General – The RCSLT is concerned that there is a lack of mention of the speech and language therapist in relation to swallowing. Speech and language therapists must be involved in the assessment of swallowing difficulties. Swallow assessment, diagnosis and management should only be undertaken by a qualified speech and language therapist (in some specific circumstances this can be done by an appropriately trained healthcare professional). Some other clinicians may also have training as needed but there is clinical consensus from across the MDT (including within stroke) that SLTs are the skilled lead profession working with dysphagia. We strongly recommend that it is acknowledged in the guidance that SLTs are the lead profession for dysphagia. For example, we recommend adding/amending the following:<br><br>- Line 4213 – add reference to RCSLT Eating and drinking with acknowledged risks guidance: MDT guidance (2021) - https://www.rcslt.org/members/clinical-guidance/eating-and-drinking-with-acknowledged-risks-risk-feeding/#section-2<br>- Line 4221 – swallow assessments must be carried out by an SLT (in some specific circumstances this can be done by an appropriately trained healthcare professional)<br>- Line 4236 (F) – change “in conjunction with a specialist in dysphagia management”’ to “by an appropriately qualified speech and language therapist (in some specific circumstances this can be done by an appropriately trained healthcare professional)” | Thank you for your comment. ‘Such as a speech and language therapist’ has been included sparingly. This is to remain consistent with other areas of the guideline, with the guideline generally avoiding recommending specific professions and referring instead of competencies or skill sets. The recommendations are written from the standpoint of the person with stroke and their needs and how these might be met.<br><br>This RCSLT guidance has been cited.<br><br>Following editorial review, it was decided to retain the shorter form of wording. |

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| | | | - Line 4237 (F) – change wording to read "to investigate the nature and causes of the swallowing difficulties" (instead of "aspiration")<br>- Line 4242-3 (G) – Amend sentence to read "This should be based on a thorough assessment of dysphagia by a qualified speech and language therapist and may include:"<br>- Line 4250 (H) – change "by a specialist in dysphagia management"' to "by a qualified speech and language therapist (in some specific circumstances this can be done by an appropriately trained healthcare professional)"<br>- Line 4256 (I) change "can be delivered by a trained healthcare professional." to "by an appropriately qualified speech and language therapist (in some specific circumstances this can be done by an appropriately trained healthcare professional)."<br>- Line 4257 (J) change "can be delivered by a trained healthcare professional." to "by an appropriately qualified speech and language therapist (in some specific circumstances this can be done by an appropriately trained healthcare professional)." | This wording has been changed accordingly.<br><br>'Such as a speech and language therapist' has been included sparingly. This is to remain consistent with other areas of the guideline, with the guideline generally avoiding recommending specific professions and referring instead to competencies or skill sets, or describing impairments from the patients point of view rather than treatments delivered by a specific discipline. |
| | | | - Line 4265 (N) add reference to RCSLT Eating and drinking with acknowledged risks guidance: MDT guidance (2021) - https://www.rcslt.org/members/clinical-guidance/eating-and-drinking-with-acknowledged-risks-risk-feeding/#section-2 | This has been cited. |
| | | | - Line 4277 (O) amend sentence to read "…and be regularly reassessed "by a qualified speech and language therapist (in some specific circumstances this can be done by an appropriately trained healthcare professional)".<br><br>Another reason for the importance of mentioning speech and language therapists is due to eating, drinking and swallowing (EDS) competencies being established at under-graduate level. | See response above |
| | | | Page 92, lines 4230-4232 – Regarding point E, patients with stroke with more complex swallow impairment or who require tube feeding or dietary modification should be considered for instrumental assessment (videofluoroscopic swallow study or fiberoptic endoscopic evaluation of swallowing) which is carried out by skilled professionals, usually an SLT with other members of the MDT. | Thank you for your comment. Following editorial review, it was decided to leave the text unchanged. |
| | | | Page 93, line 4238 – Where it specifies that an instrumental assessment should only be used to direct an active treatment/rehab programme, the RCSLT believes that instrumental exams are also used to assist shared decision making. i.e. the | Thank you for your comment. The suggested approach remains consistent with Recommendation E. |

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| | | | outcome of deciding on an active treatment/rehab programme would not be known until after the exam.<br><br>Page 93, lines 4254- 4259 – Regarding points I and J, the information here could do with being checked to ensure it aligns with NICE work & emerging evidence.<br><br>Page 93, lines 4270-427 – Regarding point M, the RCSLT agrees with the recommendations but notes that long term benefits and premorbid level of function/diseases (advanced dementia) should be taken into account, as well as considering ongoing assessment, rehabilitation and longer-term review of enteral feeding plan. This decision requires input from skilled and trained staff to support the patient and family/carer. | The up to date evidence reviewed for Recommendations I and J was Bath et al, 2018; Dziewas et al, 2021; Wang et al, 2021a; Li et al, 2021; Zhao et al, 2022; Hsiao et al, 2022; He et al, 2022<br><br>Thank your for your comment. The key involvement of the multidisciplinary team is mentioned in the recommendations. |
| 431 | | British Dietetic Association | Page 92, line 4223:<br><br>Consider wording as “ongoing monitoring” rather than “monitoring” to make it clear that these patients will likely require ongoing dietetic input as inpatient and/or outpatient.<br><br>Page 93, line 4242:<br><br>Reducing risk of aspiration, choking, improving swallowing efficiency and optimising nutrition and hydration.<br><br>Page 93, line 4263 :<br><br>The term “written guidance” is quite vague. Who is this guidance provided by and what information does it provide? For example, is this over-bed signage?<br><br>Page 93, line 4274:<br><br>Include hydration as well as nutrition. E.g. “are at high long-term risk of malnutrition and / or dehydration”<br><br>Page 94, line 4314-5: | Thank you for your comment. This has been revised.<br><br>Thank you for your comment. This has been included in Recommendation G.<br><br>Thank you for your comment. This was felt to be sufficient without additional examples.<br><br>Thank you for your comment. This has been included in the revised wording. |

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| | | | Improve swallowing with potential to optimise nutrition… | |
| 432 | | Association of British Neurologists | As above, swallowing is but one component of oral feeding. This issue becomes of particular relevance when assessing the evidence for interventions: eg stimulating the pharynx electrically may affect swallowing but will have no effect on the majority of the determinants of successful oral feeding. | Questions covered in the section were particularly related to searches re dysphagia, not feeding. This is covered in a later section. |
| 433 | | Welsh Association of Stroke Physicians | Effective swallowing is a necessity but not a sufficiency for safe oral feeding. By using the term oral feeding useful attention may be drawn to the other determinants of successful oral feeding, some of which - arguably - could be considered as important as swallowing e.g. cough, pulmonary function, posture, conscious level, concurrent medial and surgical problems etc. | Questions covered in the section were particularly related to searches re dysphagia, not feeding. This is covered in a later section. |
| 434 | | Wales Stroke Allied Health Professional Forum | Very Worrying there is NO specific reference to SLT here as a profession! Assessment should be by an appropriately trained SLT. Instrumental assessments including FEES needs qualified SLT personnel. Dysphagia rehab should be delivered by SLT. Text says "by a specialist in dysphagia management" - are we trying to write SLT out of this equation??<br><br>Much of the dysphagia section refers to interventions being performed by a "specialist in dysphagia management" is this assumed to be SLTs, if so is this reflected in the WTE calculations?<br>- The authors themselves state that there is not yet enough high quality evidence to suggest that these findings should be translated to clinical practice yet. It seems premature to me for these to be included in national guidelines even with the tentative phrasing. Gives the impression the findings are more robust than they are and hasn't been rigorously studied to exclude risk of harm.<br>- And as for the PES RCT it was funded by phagenesis! Tiny sample size, huge risk of bias. Much more data need to draw any conclusions before including.<br><br>- I fear families will be pushing for this when so specifically cited in new guidance<br><br>REALLY concerned that SLT are not specifically cited for dysphagia/trache/rehab management- these are complex interventions! | Thank you for your comment. The general principle of the guideline is to avoid specifically naming professionals as far as possible, advocating those with the correct knowledge and skills should undertake tasks. It is recognised many of these recommendations will be led by Speech and Language Therapy and their importance is reflected in the core MDT membership and WTE recommendations.<br><br>The 'may be considered' status of the Recommendation reflects the uncertainty in the evidence, particularly if it refers only to a selected minority of patients. |
| 435 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 436 | | United Kingdom Clinical Pharmacy Association | lines 4191-- include oral medication | Thank you for your comment. This has been included. |

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| | | (UKCPA) | 4223- refer to pharmacist for medication formulation review<br><br>4229-- oral medication formulation modification can be administered with modified food and fluid as per pharmacist recommendation (https://www.sps.nhs.uk/home/guidance/swallowing-difficulties/)<br><br>Line 4264--People with swallowing difficulty after stroke should be provided with written guidance for all staff/carers on how to safely swallow oral medication<br><br>line 4272- include oral medication<br><br>lines 4275- include safe swallowing of oral medication | This has been included in the revised wording<br><br>Thank you for your comment. We haven't added this level of detail, as specific medication modification were outside of the scope of the partial rewrite. |
| 437 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations in this section appear appropriate and we have nothing further to add | Thank you for your comment. |
| 438 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | line 4315 (but general comment across guideline) some E2R are giving details of number of studies and participants and others aren't- would be good to be consistent.<br><br>No comment re those with advanced decisions or best interest processes etc. | Thank you for your comment. This is partially due to slightly different approach between guideline editions. There is a section on capacity which is relevant to all sections of the guideline. |
| 439 | | Irish Heart Foundation, Council on Stroke | Evidence to recommendations<br>— Irish references need to be added as stated above e.g., CORU's Code of Professional Conduct and Ethics SLTs in Ireland (2019) states that SLTs must Maximise health, welfare, protection, and safety of service users with regard to feeding, eating, drinking and swallowing – i.e., SLTs must:<br>o seek to optimise service users' feeding, eating, drinking and swallowing in all environments;<br>o aim to improve quality of life through facilitation of feeding, eating, drinking and swallowing;<br>o undertake appropriate assessment, diagnosis and management of feeding, eating, drinking and swallowing in line with evidence informed practice;<br>o advocate for service users with feeding, eating, drinking and swallowing disorders;<br>o support service users with feeding, eating drinking and swallowing disorders to advocate for themselves. | Thank you for your comment. For consistency throughout the guideline professions have not been specified, referring to those with appropriate knowledge and skills. It is appreciated that Speech and Language therapists are the key professional within the multidisciplinary team involved in dysphagia management. |

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| | | | — Also NB to reference IASLT Standards of Practice for SLTs on the Management of Dysphagia (2015) and IASLT Choking Guideline (2021) and the principles within which supports the core role of SLTs in the assessment and management of oropharyngeal dysphagia. The lack of consistent mention of SLT as the lead clinical professional in this area is a concern for IASLT. SLTs are skilled, specialist and lead professionals in clinical assessment and intervention re dysphagia including the delivery and interpretation of specialist SLT clinical and instrumental assessments such as FEES and Videofluroscopy. | |
| 440 | Q39. Section 4.28 Cognitive impairment – general | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 441 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 442 | | British Psychological Society | Line 4355: The Terminology here needs adjusting slightly for clarity, we suggest: 'Neuropsychological sequelae' …. and include a range of cognitive, psychological, behavioural and psychosocial symptoms and disorders, ….<br>Line 4375: Change 'cognitive impairment to neuropsychological impairment – general (this is important, because the term 'cognitive' is limited and does not included the range of processes, pathways, systems affected after a stroke, whereas the term neuropsychological includes this). This change should be made throughout the section.<br>Line 4383: It was our understanding that the guidelines moved beyond the 'stepped care' approach and now focus on needs-based and matched care. Therefore any reference to 'stepped care' should be removed to avoid confusion. There is no reason why cognitive/neuropsychological management should be different from psychological/mood management.<br><br>Recommendation A – Specialist assessments should not be completed by those who are not trained and authorised to do so. This is not clear in the current wording. It could be better clarified with:<br>Healthcare professions should receive guidance from clinical/neuropsychologists regarding the development of assessment pathways for neuropsychological and psychological conditions. This includes guidance on the selection of assessment | This has been included in the revised wording.<br><br>Thank you for your comment. This change has not been made as the group agreed cognition is common language which is most accessible to wider MDT and non professionals accessing the guidelines. This section is not covering all aspects of neuropsychological impairment, so cognition was felt to be more reflective of its content, in line with the scope of the partial re-write.<br><br>Models of psychological care were not within scope of the partial re-write. Both have therefore been mentioned to remain consistent with chapter 2.<br><br>This has not been altered as these points are covered within the recommendations. |

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| | | | and screening methods, the timeline and context of administration<br>Line 4402 - ….driving is not an impairment. This should not be listed here as it refers to an ability to carry out a specific activity (Driving is dealt within the section above)<br>Line 4403 – should read - applied consistently along the clinical stroke pathway (no need to use the word 'local' as this is a National Guideline)<br>Recommendation B – The recommendation regarding training in supporting people with psychological problems following stroke does not indicate who should provide this training. It should be clarified that Clinical Neuropsychologists or Stroke-Specialist Practitioner Psychologists should provide this training and ongoing supervision and or consultation following training, as the stroke professionals most highly trained and experienced in psychological aspects of stroke.<br>Recommendation D – This could be clarified, we suggest:<br>stroke specialist practitioner psychology/neuropsychology needs to be available along the clinical pathway guiding stroke MDT in supporting baseline neuropsychological care up to the level of complex neuropsychological presentations , including specific issues affecting important decisions such as Mental Capacity, Safeguarding, risks or decisions related to differential management (e.g. in cases of dementia of psychiatric disorders).<br><br>Line 4428 - There is extensive research about outcomes of cognitive rehabilitation (see Zheng et al, 2016; Maggion et al. 2019; Loetscher et al. 2019; Faria et al., 2020 for examples)<br><br>Again, the use of Clinical Psychologist throughout this section should be amended to Practitioner psychologist or similar to be more inclusive. The addition of competency requirement can ensure an expectation of skill. (e.g. stroke specialist Practitioner Psychologist or HCPC registered psychologist with expertise in stroke)<br><br>Zheng, G., Zhou, W., Xia, R., Tao, J., & Chen, L. (2016). Aerobic exercises for cognition rehabilitation following stroke: a systematic review. Journal of Stroke and Cerebrovascular Diseases, 25(11), 2780-2789.<br>Maggio, M. G., Latella, D., Maresca, G., Sciarrone, F., Manuli, A., Naro, A., ... & Calabrò, R. S. (2019). Virtual reality and cognitive rehabilitation in people with | This has been removed.<br><br>This remains unaltered to make clear this is down to a local system level to agree.<br><br>We anticipate training to be delivered by those with adequate skills and knowledge. Recommendation C suggests this should be provided by Neuropsychology.<br><br>Thank you for your comment. This recommendation was aimed at clarifying reasons for involvement rather than grade of professional involved.<br><br>Thank you for your comment. There was little evidence that met the standard for review as per the search strategy set out in the guideline methodology manual.<br><br>Titles have remained unaltered, following involvement from psychologists in the topic groups and GDG. It was also felt to be the most understandable term for the wider reader and is consistent with the sections that have been reviewed since the 2016 edition. |

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| | | | stroke: an overview. Journal of Neuroscience Nursing, 51(2), 101-105.<br>Loetscher, T., Potter, K. J., Wong, D., & das Nair, R. (2019). Cognitive rehabilitation for attention deficits following stroke. Cochrane Database of Systematic Reviews, (11).<br>Faria, A. L., Pinho, M. S., & Bermúdez i Badia, S. (2020). A comparison of two personalization and adaptive cognitive rehabilitation approaches: a randomized controlled trial with chronic stroke patients. Journal of neuroengineering and rehabilitation, 17(1), 1-15. | |
| 443 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | •BSPRM welcomes and agrees with these recommendations | Thank you for your comment. |
| 444 | | Association of Clinical Psychologists UK (ACP-UK) | Page 95, line 4355 – Cognitive difficulties are not a psychological sequel of stroke and should not be described as such. Cognitive difficulties (changes in thinking skills as a direct effect of brain injury) are different from changes in mood or emotion which could be a direct effect of brain injury but also as psycho social consequences of adjusting to stroke.<br><br>Cognition should have its own heading under which examples of cognitive difficulties should be listed.<br><br>Page 96, line 4401 – it is unclear what is meant by 'global cognition': this is not a term that is used clinically.<br><br>Page 96, line 4402 – Driving should not be included at the end of a list of cognitive domains as it is not a cognitive domain. It is a highly skilled task that incorporates multiple cognitive domains. It needs to be covered in a section in its own right.<br><br>Page 96, line 4395 - Recommendation A: In addition to a measure validated for use in people with stroke, the measure also needs to be validated (normed) for that person's population (i.e., normed for people of that age – thinking specifically of how the ACE-III has not been normed for people under the age of 65).<br><br>Moreover, there is no reference in this recommendation or section (or indeed | Thank you for your comment. This was not the view of other respondents or the psychologists in the topic groups.<br><br>Thank you for your comment.<br><br>Thank you for your comment. This was a term that the Guideline Development Group, topic group and editors felt was commonly understood<br><br>This has been removed, thank you<br><br>Thank you for your comment. It was felt this was an unnecessary level of detail and is implicit in validated.<br><br>Thank you. Using the individual's first language and use of an |

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| | | | across the guideline) of ensuring tests are culturally appropriate, or take account of cultural differences of patients. Moreover, there are no recommendations of how this could be approached or managed: for example, appropriate training of the administering clinician, recognising when formal assessment may not be appropriate, the use of tests via an interpreter, using more culturally sensitive batteries or alternative language forms | interpreter have been included. Cultural relevance is considered part of personalised care, including consideration of the person's goals, beliefs and preferences. Personalised care (including that which is culturally appropriate) is covered by overarching statements in Section 1.2. Elsewhere the generic term 'personalised' has been used, without further qualification in the interests of brevity. |
| 445 | | Royal College of Speech and Language Therapists | General – It is important that someone is not excluded from rehabilitation due to a diagnosis of dementia; research demonstrates people with dementia can make gains/maintain independence with an appropriately tailored rehab programme.<br><br>See:<br>• Carthery-Goulart, M. T., Silveira, A. D. C. D., Machado, T. H., Mansur, L. L., Parente, M. A. D. M. P., Senaha, M. L. H., ... & Nitrini, R. (2013). Nonpharmacological interventions for cognitive impairments following primary progressive aphasia: A systematic review of the literature. Dementia & Neuropsychologia, 7, 122-131.<br>• Cadório, I., Lousada, M., Martins, P., & Figueiredo, D. (2017). Generalization and maintenance of treatment gains in primary progressive aphasia (PPA): a systematic review. International journal of language & communication disorders, 52(5), 543-560.<br>• Volkmer, A., Spector, A., Meitanis, V., Warren, J. D., & Beeke, S. (2020). Effects of functional communication interventions for people with primary progressive aphasia and their caregivers: a systematic review. Aging & mental health, 24(9), 1381-1393<br><br>All recommendations – More neuropsychology funding is essential for therapy and not just screening.<br><br>Page 96, lines 4383- 4393 – The RCSLT believes there needs to be specific mention of the consideration required when assessing cognition when someone is presenting with aphasia. There is mention of access to an OT and psychology but really SLTs need to be involved when the person also has language impairment due to the linguistic content of screening and assessment tools. | Thank you for your comment. This has been included in the revised wording.<br><br>Thank you for your comment.<br><br>Thank you for your comment. This has been included in the revised wording |
| 446 | | Scottish Intercollegiate Guidelines Network | The RCPE welcomes the attention paid to the psychological aspects of stroke which have not always been adequately recognised in previous times. | Thank you for your comment. |
| 447 | | Irish Association of | Psychology should not be used the wat it has been used eg as a heading under | Thank you for your comment. This was not the view of the expert |

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| | | Physical and Rehabilitation Medicine | which cognitive sits. Cognition sits under other domains eg communication. I would advise having domain headings based on the patient eg mental health, cognition, communication rather than a professional discipline. | group which heavily included psychologists |
| 448 | | Brain Injury Matters (NI) | Recommendation A<br>Healthcare professionals should select screening tools and assessments for psychological<br>problems appropriate to the person with stroke's needs, with clear rationale provided<br>regarding which tools are to be used in which circumstances. These tools and assessments should:<br>– cover the full range of potential impairments including global cognition, attention, visual perception, memory, executive functioning, driving as well as any activities in the arts or sports where a cognitive assessment may aid and inform their safe and effective participation.<br><br>Recommendation F<br>People with cognitive impairment after stroke should be considered for engagement in sport and other forms of physical activity including with arts organizations, sports / para-sports clubs or leisure establishments where there is a high degree of physical activity such as dance, cycling, swimming, yoga, Pilates, gym work or walking. | Thank you for your comment.<br><br>Thank you for your comment. This was outside of scope of the rewrite. |
| 449 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 450 | | United Kingdom Clinical Pharmacy Association (UKCPA) | pharmacists should assess patients with cognitive impairment if they able to self manage medication or require assistance/support with medication | Thank you for your comment. Ability to safely manage medications is included within Recommendation 4.28 B regarding activities of daily living. |
| 451 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | A: It would be useful for this recommendation to be clear in identifying the appropriate screening tools with the recommended psychometric properties<br><br>C and D: The wording of this recommendation "should be available" is quite vague and does not link in with the evidence base around clinical psychology/neuropsychology- we would welcome a firmer stance on this especially as working clinicians the value of having clinical psychology/neuropsychology as an active team member cannot be over estimated | House style dictates specific measures/tools are not recommended, so as to future proof the guideline. Instead information regarding selection of appropriate tools is included<br><br>Thank you for your comment. This was considered by editors, topic group and GDG and felt 'should be available' was clear and is reflected in their inclusion in the core MDT and WTE levels. |

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| 452 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Is this Psychological general rather than cognition general? and then possible need to re-word to ensure rec's are inclusive of both<br><br>State in narrative- state clearly that this is both mood and cognition.<br><br>4379- reword- something like ' cognitive domains should not be considered of isolation of each other, as .....'<br><br>4385- could be reformatted into bullet points to read more easily<br><br>F would be random if moves to broad general psychological section<br><br>line 4433 Alvarez-Sabin et al (2013) evaluated citicoline (a complex nucleotide composed of ribose, 4433 pyrophosphate, cytosine and choline)- do we need the ingredients??<br><br>A- driving doesn't sit correctly as an impairment- add an extra bullet re this (possibly as part of a wider functional tasks comment) | Thank you for this suggestion. The section has been renamed. Many of the recommendations are relevant to mood as well as cognition.<br>Thank you for your comment. This has been addressed in the revised wording.<br><br>Thank you for your comment. This has been addressed in the revised wording.<br><br>Thank you for your comment, this has been revised.<br><br>Following editorial review, the decision was made to leave the text unchanged.<br><br>Following editorial review, the decision was made to leave the text unchanged.<br><br>This has been revised. |
| 453 | Q40. Section 4.29 Cognitive screening | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 454 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 455 | | British Psychological Society | Introduction –Cognitive screening can be useful, however, it should be made clear that there are limitations and should be highlighted that screening alone should not be used to fully inform any rehabilitation outcomes (especially long-term). Additionally, the importance of screening being taken in the context of pre-morbid ability and function and age, rather than on single cut-off points, should be made clear.<br><br>It is also important to highlight basic issues around the appropriate environment for conducting cognitive screening, i.e., minimised distractions, individual as comfortable as possible with no immediate needs, ensuring assessments are provided in the appropriate language… | Thank you for your comment, this has been reflected in the final wording.<br><br>Thank you for your comment. This has been included within the recommendations |

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| | | | In our members' experience screening may not be carried out because some clinicians consider the patients presenting mood to be "too low" or that they are "too fatigued". However patients presenting with low mood in doing cognitive screens can be engaged when choosing the best times to see patients in order to manage fatigue aspects. Similarly, clinicians will say a screen doesn't need to be done because " they didn't report any problems and seemed fine" – making it clear that screens need to be completed for all patients would be good regardless of whether there are/are not reported problems.<br><br>Recommendation C, would be better without a time expectation at the end. We suggest:<br>People with stroke should be screened for neuropsychological problems as soon as they are able to participate in this.<br><br>Recommendation D and E – given the nature of these recommendations it should be clarified that Clinical Neuropsychologists or Stroke Specialist Practitioner Psychologists should support the team by developing a system of cognitive screening and providing training and ongoing supervision and oversight of its use. This is to ensure that these methods are applied validly and reliably by trained healthcare professionals. Interpretation of neuropsychological and cognitive outcomes need to be undertaken in consultation with the clinical or neuropsychologist. | Thank you for your comment. This is reflected in the recommendations<br><br>Thank you for your comment. This was considered and felt by editors and GDG it was helpful to remain.<br><br>Thank you for your comment. This is out of scope of this section, however training for the MDT is included in section 4.28. |
| 456 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcomes and agrees with these recommendations | Thank you for your comment. |
| 457 | | Association of Clinical Psychologists UK (ACP-UK) | There is no reference in this recommendation or section (or indeed across the guideline) of ensuring tests are culturally appropriate, or take account of cultural differences of patients. Moreover, there are no recommendations of how this could be approached or managed; for example, appropriate training of the administering clinician (not passing a cognitive screen does not always mean there is cognitive impairment, for example there could be sensory impairments), recognising when formal assessment may not be appropriate, the use of tests via an interpreter, using more culturally sensitive batteries or alternative language forms. | Thank you for your comment. Cultural appropriateness is relevant to all sections of the guideline and is reflecting in the opening chapters regarding context (Section 1.2), and clarified in the introduction to this section.<br>Training for those undertaking screens and assessments is covered in 4.28 |

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| | | | Page 98, line 4498, Recommendation E – It is important to recognise that screening tools are limited in what they can show clinically. There will be people with stroke who 'pass' screening tools who have experienced a change in their cognition following stroke. There are some areas of cognition that are not adequately assessed on screening tools, for example executive functioning. Therefore, cognitive assessment should be considered for any person reporting or demonstrating a change in their cognition, irrespective of their screening score. However, all people with stroke who demonstrate clinical concern on screening should be considered for further assessment. | Thank you for your comment, this is reflected in the narrative section. |
| 458 | | Royal College of Speech and Language Therapists | General: The RCSLT suggests that Butt Non-Verbal Reasoning Test (https://www.routledge.com/BNVR-The-Butt-Non-Verbal-Reasoning-Test-The-Butt-Non-Verbal-Reasoning/Butt-Bucks/p/book/9780863884726) can be useful for establishing whether patients have situational understanding at a low level. Cognitive Linguistic Quick Tests (https://www.pearsonclinical.co.uk/store/ukassessments/en/Store/Professional-Assessments/Cognition-%26-Neuro/Memory/Cognitive-Linguistic-Quick-Test-Plus/p/P100009059.html) used by SLTs can be helpful especially to tease out cognitive vs linguistic issues and inform decision making by SLTs with regards to the possibility of rehabilitation. | Thank you for your comment. Specific screens and assessments have not been named, in order to future proof the guideline. Guidance has been given re test selection and recommended local pathways to ensure standardisation across the stroke pathway. |
| 459 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 460 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | These recommendations appear to be appropriate with nothing further to add. | Thank you for your comment. |
| 461 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Recommendations make a clear distinction between purpose and completion of cognitive screening vs cognitive assessment. Whilst it is clear only specialist qualified staff should complete relevant cognitive assessments (4515-4518; 4531-4534) the recommendation is not quite so clear about who would be permitted to complete cognitive screening.<br><br>"All members of the MDT should support those with mild cognitive impairment" (4386-4387) which could be interpreted as including unregistered staff with competency in administering a specific screening tool e.g. MOCA. This might also be supported by lines 4454-4455 that screening is not diagnostic, helps provide preliminary information and establish presence or absence of a deficit. This is at odds with lines 4480-4482, stating screens should only be administered and interpreted by staff trained in use of the tool and lines 4493-3397; "health care | Thank you for your comment. Recommendation D states registered staff should undertake screening.<br><br>Thank you for your comment, this has been resolved in the revised wording. |

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| | | | professionals undertaking cognitive screening should have knowledge and skills to select took… administer… and interpret taking account of… relevant factors"<br><br>4454- could early be changed to initial<br><br>Add something in the narrative- re delirium being more common in the first 24-72 hours but should be considered throughout their stay | <br><br><br><br>Thank you for your comment, this has been altered<br><br>Thank you for your comment. |
| 462 | | Irish Heart Foundation, Council on Stroke | OT<br>This section should also include recommendation when cognitive screening is considered inappropriate e.g. in the presence of delirium, or when a person with stroke has a moderate to severe receptive language impairment even a screen like the OCS is going to be confounded by the receptive aphasia. For these individuals, a recommendation for an occupational therapist to complete a function-based assessment of cognitive functioning via observation of the individual completing a relevant ADL in a contextually appropriate environment at a contextually appropriate time of day is advised. This applies to 4.30 also.<br><br>Psychology<br>Much improved section compared to previous guidelines.<br>480. Well made point re. familiarity with limitations of screening. Need to add that other common stroke impairments including hemiplegia, aphasia and perceptual impairments may affect the choice of screening tool and may require adaptations to the administration of familiar tools – this is one of the main challenges of cognitive/neuropsychological assessment in stroke. | Thank you for your comment. These issues have been included in the recommendations, with appropriate tool selection and recommending functional assessment for those where formalised assessment is not appropriate.<br><br>Thank you for your comment.<br>We have included examples of difficulties which need to be considered, but feel this is implicit in reading the guideline as a whole. We would not advocate adaptation of standardised tools, however are aware that on occasion this may be required but then become unvalidated and unable to be reported in the same way. |
| 463 | Q41. Section 4.30 Cognitive assessment | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 464 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 465 | | British Psychological Society | Again, we suggest you change cognitive impairment to neuropsychological impairment –this is important, because the term 'cognitive' is limited and does not included the range of processes, pathways, systems affected after a stroke, whereas the term neuropsychological includes this). This change should be made | Thank you for your comment. This was discussed by editors, topic group leads and GDG and felt cognition is widely understood language to the whole MDT and public. |

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| | | | throughout the section. | |
| | | | These recommendations need to specify when the specific expertise and training of Clinical Neuropsychologists is required. This is likely to include providing supervision and consultation of other professionals carrying out and interpreting cognitive assessment. | Thank you for your comment. This is addressed in section 4.28 and is therefore not repeated in each subsection. This is also covered in other chapters of the guideline |
| | | | The recommendations need to cover how cognitive assessment results are interpreted and shared with stroke survivors (e.g. via development of a shared neuropsychological formulation). | Thank you for your comment. Formulation is mentioned in 4.28. |
| | | | It may also be helpful to note the ethical consideration around test burden on the individual, i.e., considering whether any given assessment is necessary and meaningful, and only conducting assessments that are likely to be proportionate and to provide valued information. | Thank you for your comment. It was felt this was implicit in all decision making related to stroke care, not specific to cognitive assessment |
| | | | Line 4507: Care should be taken when using the the term 'diagnostic', it refers to a medical approach and neuropsychologists or therapists administering neuropsychological/cognitive measures are not providing a diagnosis. There could also be a legal conflict if this term was used. It may be better to describe the aims, for example "assessment means undertaking a detailed or focused investigation and evaluation that may be to understand both what is wrong and what that means for the person." | Thank you for your comment. This was discussed by editors, topic group leads and GDG and felt this term is widely understood language to the whole MDT and public. |
| | | | Neuropsychological assessments include all measures to ascertain details about neuropsychological functioning in relation to the neurological lesions sustained following stroke whilst also considering pre-morbid predispostions. This may affect a range of cognitive domains and neuropsychological processes. Neuropsychological assessments comprise of a multimodal and multidisciplinary approach incorporating standardised neuropsychological assessments, systematic functional and cognitive language assessments. Additionally, they include subjective variables as expressed by the patients about their experience of neuropsychological difficulties. Detailed assessments provide outcomes about the neuropsychological profile and subtle changes about regression of functions or improvements with rehabilitation. | Thank you for your comment. The question in scope of the guideline was 'cognitive screening', therefore detailed description of neuropsychological assessment has not been included. |
| | | | Line 4515 – 4516 should be changed to: Neuropsychological assessments should | Thank you for your comment. This was reviewed by editors and |

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| | | | be overseen and supervised by a stroke specialist practitioner psychologist/neuropsychologist in conjunction with other stroke specialists such as occupational and speech-and language therapists. This will ensure adequate knowledge and skill to administer and evaluate assessment outcomes in line with type of stroke, premorbid/ psychological/personal variables and performance in other areas of stroke rehabilitation.<br><br>Recommendation B should also include contribution to important decision making as in cases of MCA, safeguarding, placements, and other risks to patients ability to participate in rehabilitation.<br><br>Recommendation C should be clarified to: Neuropsychological assessments should only be carried out by specialists trained in administering these (e.g. clinical and neuropsychologist, speech and language therapists, occupational therapists) who receive appropriate supervision and guidance. This includes updates about the scientific underpinnings and changes to test developments.<br><br>4.37 Neglect<br><br>4760: the given definition is incomplete. This needs to be revised.<br>A better definition might be:<br><br>Neglect refers to a neuropsychological condition common after stroke whereby a person has reduced and impaired ability to process spatial information. This has consequences for further neuropsychological processing including reasoning, memory encoding and retrieval as well as the frequently observed impaired interaction with the environment whereby people overlook or appear to be unaware of items or their contextual field.<br><br>Line 4769 – it is not best practice to use examples of specific test batteries. This is because neglect is not primarily a disorder of attention, but of perceptional processing<br><br>Line 4775 needs clarification because neglect is not primarily an attention disorder. Patients can have good attention. Neglect is a disorder of perception processing and impaired access to internally stored images, hence leading to additional disorders of memory processing, reasoning and communication as well | topic group lead and was not felt necessary to alter wording as these aspects are adequately covered by existing recommendations across section 4.28, 4.29, 4.30, organisation of care and chapter 6. In general, recommendations have specified skills and competences required to deliver an assessment, as opposed to the specific discipline.<br><br>Thank you for your comment, this has been included in the revised wording<br><br>Thank you for your comment. The wording has not been altered in this instance. It is implicit in all areas of care that those undertaking tasks remain updated with knowledge and changes.<br><br>Thank you for your comment. Elements of this suggestion have been included in the revised wording.<br><br>Thank you for your comment. This has not been altered on this occasion as was felt to be a helpful addition.<br><br>Thank you for your comment. There are different views on this. |

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| | | | as the commonly observed behavioural disorders.<br><br>Line 4779 - similar to the above, the definition here could be optimised: Sensory neglect is a disorder or sensory integration resulting from stroke-related interruption of sensory processing pathways. | Thank you for your comment. It was felt the wording used was more accessible to a wider range of people accessing the guideline and helps explain basic presentation rather than neuroanatomical rationale. |
| 466 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcomes and agrees with these recommendations | Thank you for your comment. |
| 467 | | Association of Clinical Psychologists UK (ACP-UK) | Page 99, line 4520 – Advocating the limiting of the cognitive assessment to the "aspect/s of cognition under investigation" is clinically inappropriate and should be removed from the guidance. All areas of cognition should be assessed. People will often report difficulties with Memory because that is how they describe difficulties in cognition but actually they could be experiencing difficulties in Attention or Executive Functioning. The cognitive rehabilitation recommendations for different cognitive domains is different and therefore it is important that cognitive difficulties are appropriately assessed and identified to inform the correct treatment and management approach.<br><br>Page 102, line 4686 – The person would need to have difficulty in function and then there needs to be demonstration of impairment in their mind or brain.<br><br>There is no mention of the frontal lobe paradox – This should be included and made reference to when considering capacity for people with stroke. George, M & Gilbert, S. (2018) Mental Capacity Act (2005) assessments: why everyone needs to know about the frontal lobe paradox. The Neuropsychologist, 5, 59-66] | Thank you for your comment. 4.28 states "Each cognitive domain (e.g. perception, attention, memory, executive functioning) should not be considered in isolation because most everyday activities draw on a range of abilities."<br><br>Thank you for your comment, the mental capacity act guidance is cited for reference<br><br>This was not within the scope of the literature reviewed. |
| 468 | | Royal College of Speech and Language Therapists | The RCSLT agrees with this section and believes it would be beneficial. | Thank you for your comment. |
| 469 | | Association for Palliative Medicine of great Britain and Ireland (APM) | Mental Capacity: We would like to see something about the principle of best interest decision making; that it is the decision that person would have made had they had capacity. I think this remains poorly understood and poorly implemented. | Thank you for your comment. Best interest process has been included in the revised wording. |
| 470 | | The Irish Heart Foundation | This section is titled Cognitive assessment – however, the time frame for assessment post-stroke is not discussed within the recommendations, more detail describing the time frame was thought to be useful by the focus group. | Thank you for your comment. This would be individualised to the person, the reason for undertaking the assessment and risks and implications. |

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| | | | It was agreed that the type of assessment should be limited to the aspect of cognition under assessment rather than an overview (line 4520).<br>Furthermore, there was discussion surrounding the availability of community-based stroke teams with specialization in cognitive assessment in Ireland, the group felt this is a necessary requirement to provide further guidance of support services available at the point of assessment and thereafter. | Thank you for your comment. |
| 471 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 472 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | These recommendations appear to be appropriate.<br><br>We questioned whether there needed to be a recommendation for those who are unable to participate in standardised cognitive assessments, e.g. assess in function? | Thank you for your comment.<br><br>Thank you this has been added as a new recommendation. |
| 473 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | :-) for functional performance<br><br>4.35- mental capacity- do we need to change the DOLs to Liberty Protection Safeguard. and ? does this cover NI and Scotland.<br><br>Line 4694- specifically include SALT for those with communication deficits.<br><br>4.37- problem of attention. 4769- Catherine Bergago.<br>And often co-exists with hemianopia.<br><br>Remove (extinction)<br><br>4774- link to driving recommendations re negelct | Thank you for your comment.<br><br>Thank you for your comment, these have been included in the revised wording<br><br>Thank you for your comment, this has been included in the narrative to this section.<br><br>Thank you, this has been actioned.<br><br>Thank you, this has been actioned.<br><br>Thank you, this has been actioned. |
| 474 | | Irish Heart Foundation, Council on Stroke | OT<br>4.37 Neglect- Recommend removing mention of Rivermead Behavioural Inattention Test to Catherine Bergego Scale. BIT has limited clinical utility, no ecological validity. CBS comparatively has excellent psychometrics, is an occupation-based assessment that provides important clinical information on how neglect is affecting activities, it goes beyond the impairment level.<br><br>SLT<br>Clinical consensus within SLT and OT professional interest groups emphasises that informal non standardised tools may be required to be used where there is | Thank you, this has been actioned<br><br>Thank you, this is reflected in the wording and advocates formalised testing wherever possible, selecting tools appropriate |

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| | | | co-occurrence of aphasia and need for in depth cognitive assessment. Individuals with aphasia are often excluded from studies exploring post Stroke cognition or excluded from "formal" cognitive testing as many standard cognitive assessments rely on language ability (Wall et al, 2017).<br><br>Evidence to recommendations<br>Wall, K. J., Cumming, T. B., & Copland, D. A. (2017). Determining the Association between Language and Cognitive Tests in Poststroke Aphasia. Frontiers in Neurology, 8. Retrieved from https://www.frontiersin.org/articles/10.3389/fneur.2017.00149<br><br>Psychology<br>As above (4.29)<br>4518: influencing variables - suggest including mood and adjustment here.<br><br>Section 4.35 Mental Capacity<br>-While a very welcome and important section for the guidelines, there should be reference to the Irish Context.<br>The Assisted Decision Making (Capacity) Act 2015 has been enacted and while the Decision Support Service is not in operation yet – due in 2023, all professionals must be working within the guiding principles of the act. This legislation has and will continue to shape how all medical and HSCP care is delivered to the person and therefore should be included. | for the individual.<br><br>Thank you for your comment. This has been included in the revised wording |
| 475 | Q42. Section 4.39 Anxiety, depression and psychological distress | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 476 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 477 | | British Psychological Society | It is positive to see the recognition of the psychological impact of stroke and we welcome this section.<br><br>It is unusual to discuss prevention of depression as a standalone concept and we wondered whether recommendation O should become recommendation A. This would highlight the important role of social and wellbeing support as part of | Thank you for your comment.<br><br>Thank you for your comment. The recommendations have been re-ordered accordingly. Prevention of depression was a specific question in scope of the partial re-write which was mandatory to |

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| | | | maintaining psychological wellbeing and preventing disturbance, rather than focusing on psychological therapy as a preventative strategy. | search and provide recommendations. |
| | | | Useful prevalence findings are given for depression and anxiety. The prevalence of PTSD following stroke needs to be added however, as this requires specific intervention and will otherwise disrupt rehabilitation and reduce quality of life. A meta-analysis found that 1 in 4 people develop significant PTSD symptoms due to stroke or TIA (Edmondson et al. 2013). | PTSD was not within scope of the partial re-write and did not feature in any of the evidence reviewed for questions related to this section of the chapter. As a result this is not included. |
| | | | Whilst we acknowledge that there are times when both pharmacological and psychological approaches to treating anxiety and depression are appropriate, we wondered if the guidance should take a clearer stance regarding the appropriateness of medication as a first-line intervention. The guidance seems to be suggesting that psychological approaches should be the primary approach for prevention of depression (whilst undervaluing social and wellbeing support), and only partially relevant for treatment of depression. This is at odds with a stepped / matched care approach, which would highlight the role of specialist stroke psychology with more complex presentations. It also goes against guidance on the treatment of depression in the general population. | Thank you for your comment. Recommendations I and J are not recommending SSRIs as first line treatment. Recommendation R reflects the important role of neuropsychology in these cases. |
| | | | Crucially, a stroke is a significant life event and in this context some emotional distress is normal and part of adjustment to a substantial change in circumstances. The guidance should acknowledge this, and ensure that patients and staff are also aware of this. | Thank you for your comment, this is included in the revised wording introducing section 4.39. |
| | | | Recommendation A could be better expressed as People with stroke should be routinely assessed for psychological problems rather than limiting assessment to only 2 conditions which would not be usual practice. ….<br><br>Recommendation B would not then be necessary is the amendment to recommendation A is made | Thank you for your comment. The recommendation is using anxiety and depression as examples only, not limiting the statement to those two conditions. |
| | | | Recommendation C – again, we suggest not using the word ‘diagnosis’. Diagnosis is made by medical professionals. Stroke specialists apart from medical doctors do not commonly use medical diagnostic guidelines. | Thank you for your comment. Use of the word diagnosis is felt to remain appropriate in this recommendation. |
| | | | Recommendation D is dependent on the availability of mental health services | Thank you for your comment. Wording has been revised |

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| | | | locally, and the speed with which they can be accessed. Services are unlikely to have independent access to Psychology. Recommendation D, line 4866/7 would be better reworded to "….should be referred to a psychiatric team for assessment and risk management" as advising 'referral to a psychiatrist' will be likely to be un-deliverable in a practical way<br><br>Recommendation E should be amended similarly to recommendation A suggestion above -<br>People with psychological disorders ……should be re-assessed at appropriate intervals. They should be considered for appropriate non-pharmacological interventions in combination with medical treatments.<br><br>Recommendation F would benefit from further review and amendment as the reference made to 'MI or problem solving therapy' is unclear in its meaning; the statement could be better worded<br>"Psychological therapies (such as cognitive behavioural therapies), enhanced by motivational interviewing approaches where required, should be offered for those with adequate cognitive and language skills to engage and where a significant risk of anxiety or depression can be identified"<br><br>Recommendation G is problematic in its current form. It is unclear who would assess the "significant risk" nor what the definition of this risk is. Equally it is unclear who would determine a person's ability to engage in therapy. Further, any therapy interventions used should be augmented for stroke and have specific evidence of efficacy in. We recommend not naming specific therapies as there is no specific research evidence of the benefit of one type of psychological intervention over the other (Allida et al., 2020). However, tailored neuropsychological interventions have a high level of clinical effectiveness. The applied approach includes consultancy to the MDTs, training of and collaborating with non-psychology stroke specialists (Clarke & Forster, 2015).<br><br>Recommendation I – As stated above, this guidance should advocate a non – pharmacological approach first in line with other guidance, such as the NICE depression guidance. Also, again, it needs to be specified that any therapy intervention needs to be augmented for use with stroke.<br><br>Recommendation K - As with recommendation G above, we suggest not | Many thanks for your comment. These alterations were not deemed necessary<br><br>Thank you for your comment. The interventions listed in the recommendation relate directly to the interventions studied in the evidence reviewed.<br><br>Thank you for your comment, these recommendations have been informed closely by the evidence base reviewed for prevention of depression and prevention of anxiety. These were questions specified by the scope of the partial re-write.<br><br>Thank you for your comment. Recommendations I and J are not recommending SSRIs as first line treatment, but are a significant aspect of treatment and the evidence base warranting a separate recommendation. |

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| | | | specifying a psychological intervention. We propose<br>People with psychological problems and aphasia, communication, cognitive or other disturbances should be offered a tailored specialist psychological intervention tailored to their symptoms<br><br>Recommendation J – is concerning and we query the evidence of this and it is a concerning recommendation clinically. This intervention would not be something that we would recommend.<br><br>Recommendation L – As previously stated, these guidelines should advocate non-pharmacological interventions for all psychological problems.<br><br>Recommendation R should ensure the assurance that interpretations of outcomes of psychological assessments should be overseen and supervised by specialist stroke clinical psychologist/neuropsychologists<br><br>Edmondson, D., Richardson, S., Fausett, J. K., Falzon, L., Howard, V. J., & Kronish, I. M. (2013). Prevalence of PTSD in survivors of stroke and transient ischemic attack: a meta-analytic review. PloS one, 8(6), e66435.<br><br>Allida, S., Cox, K. L., Hsieh, C. F., House, A., & Hackett, M. L. (2020). Pharmacological, psychological and non-invasive brain stimulation interventions for preventing depression after stroke. Cochrane Database of Systematic Reviews, (5).<br><br>Clarke DJ, & Forster A. (2015) Improving post-stroke recovery: the role of the multidisciplinary health care team. J Multidiscip Healthc. 22;8:433-42. doi: 10.2147/JMDH.S68764. PMID: 26445548; PMCID: PMC4590569. | The approaches listed are those specified in the trials cited for that patient group<br><br>Thank you for your comment. The evidence base supported this recommendation, at the level of considered and within the scope of a clinical trial.<br><br>Thank you for your comment<br><br>Thank you for your comment. This is reflected in Recommendation S. |
| 478 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcomes and agrees with these recommendations | Thank you for your comment. |
| 479 | | Association of Clinical Psychologists UK (ACP-UK) | ['Non-invasive brain stimulation' is a collective term for a range of disparate techniques and distinct interventions. It should not be recommended as a named intervention. The Allida et al (2020) Cochrane review on which this recommendation was based included the following interventions under this banner: transcranial magnetic stimulation, transcranial direct current | Thank you for your comment. Further research is warranted in this area and therefore has been included for people to be considered as part of a clinical trial. |

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| | | | stimulation, cranial electrotherapy stimulation, magnetic seizure therapy.<br><br>These have vastly different purported mechanisms, adverse effect profiles, and clinical implications in terms of delivery and access. Even when conducted as part of a trial, it is not clear that any should be specifically recommended. This is additionally underlined by the 'high risk of bias' rating for the studies included under this banner in the Allida et al review.<br><br>It is unlikely that there is sufficient evidence for any one of these interventions to be recommended and so it is probably best that this recommendation is removed in its entirely. | |
| | | | Insert section between "4.39 Anxiety, depression and psychological distress" and "4.40 Apathy" suggested name "4.xx Hallucinations, delusions and psychosis" or amend section "Section 4.39 Anxiety, depression and psychological distress"<br><br>Delusions, hallucinations and psychosis can affect up to 1-in-20 stroke survivors. People with a pre-existing psychotic disorder, such as schizophrenia, have a greatly increased risk of stroke. Delusions, hallucinations and psychosis are less common than depression or anxiety after stroke but may greatly complicate stroke care and self-care, as the affected person may begin to make decisions based on unsound beliefs about reality. Episodes of psychosis can be transient or chronic, but unlike disorders of awareness such as neglect and acute unawareness of disability, they tend to extend into the post-acute period. Antipsychotic medication, typically the first-line treatment for psychosis, is associated with an increased risk of mortality and further stroke morbidity in those with stroke and psychosis.<br><br>Recommendations<br><br>• The balance of risk and benefit from antipsychotic medication should be carefully considered.<br>• Unlike difficulties with orientation and confusion after stroke, delusional beliefs do not benefit from re-orientating the affected person to correct information and may cause distress, and so staff should be aware of how to discuss delusional concerns with the patient | Thank you for your suggestion. These were out of scope for the partial rewrite and therefore have not been included in evidence review process or the guideline. |

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| | | | • In complex cases, involving risk from psychosis-related behaviour, high-levels of psychiatric morbidity, or clear neuropsychiatric syndromes, there should be access to liaison psychiatry and a referral to specialist neuropsychiatric services should be considered<br><br>Evidence to recommendations<br><br>A meta-analysis of clinical outcome studies has suggested an estimated prevalence of delusions in stroke survivors of 4.67% and an estimated prevalence of hallucinations of 5.05%[1]. The same systematic review found poststroke psychosis was associated with poor functional outcome. A meta-analysis of cohort studies indicate that people with schizophrenia and are at higher risk of stroke [2] and a nationwide cohort study indicated a high risk of recurrent stroke.[3] Meta-analytic evidence shows that antipsychotic medications are generally associated with an increased risk of stroke.[4] A nationwide cohort study reported that in stroke survivors, antipsychotic medication is associated with increase mortality.[5] Contradiction of delusional beliefs is, by definition, unlikely to be helpful as delusion are defined as beliefs that are not swayed by contradiction even when in conflict with external reality. Collaborative therapeutic approaches use non-confrontational Socratic approaches to delusions.[6]<br><br>References<br><br>1. Stangeland H, Orgeta V, Bell V. Poststroke psychosis: a systematic review. J Neurol Neurosurg Psychiatry. 2018 Aug 1;89(8):879–85.<br>2. Li M, Fan YL, Tang ZY, Cheng XS. Schizophrenia and risk of stroke: A meta-analysis of cohort studies. Int J Cardiol. 2014 May 15;173(3):588–90.<br>3. Fleetwood K, Wild SH, Smith DJ, Mercer SW, Licence K, Sudlow CLM, et al. Association of severe mental illness with stroke outcomes and process-of-care quality indicators: nationwide cohort study. Br J Psychiatry. 2021 Aug 19;1–8.<br>4. Zivkovic S, Koh CH, Kaza N, Jackson CA. Antipsychotic drug use and risk of stroke and myocardial infarction: a systematic review and meta-analysis. BMC Psychiatry. 2019 Jun 20;19(1):189.<br>5. Su CC, Yang YHK, Lai ECC, Hsieh CY, Cheng CL, Chen CH, et al. Comparative safety of antipsychotic medications in elderly stroke survivors: A nationwide claim data and stroke registry linkage cohort study. J Psychiatr Res. 2021 Jul | |

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| | | | 1;139:159–66.<br>6. Alford BA, Beck AT. Cognitive therapy of delusional beliefs. Behav Res Ther. 1994 Mar 1;32(3):369–80.<br><br>Page 106, line 4872, F – It is unclear why only motivational interviewing or problem-solving therapy has been recommended. CBT, BT and ACT can all be adapted to be used with people with aphasia or cognitive impairment.<br><br>Page 107, line 4880 – the recommendation of using SSRIs as a preventative approach is inappropriate. This medication was not designed to be preventative. People often feel strongly about being prescribed antidepressant medication. The recommendation reads as if it is clinically acceptable to prescribe to people with language or cognitive difficulties routinely. This is without considering their wishes, access to SLT and psychology, polypharmacy, side effects and that there is often no follow up of these medications resulting in some people taking medication inappropriately for years. SSRIs should be prescribed if there is evidence of clinical need and with the appropriate treatment plan and follow up in place.<br><br>Page 107, line 4885 – Acceptance and Commitment therapy should be included on this list.<br><br>Page 107, line 4893 – The wording of this sentence needs changing to make it clear that treatment for anxiety should be to initially try psychological therapies first with medication treatment considered afterwards if still required. | Thank you for your comment. These interventions have been specified as a result of the evidence reviews<br><br>This recommendation has been made following an evidence review process and is supported by the cited literature<br><br>Thank you for your comment<br><br>Thank you for your comment. The recommendations are advocating individualised treatment appropriate to the circumstances and individuals wishes and preferences. |
| 480 | | Royal College of Speech and Language Therapists | The RCSLT agrees with the recommendations and finds this section useful. | Thank you for your comments. |
| 481 | | The Stroke Association | We welcome the much-needed introduction of these recommendations for post-stroke psychological and emotional support. Psychological support has been consistently highlighted to us as an area of extensive unmet need by stroke survivors. This is evidenced by the results of our Lived Experience of Stroke report, which we note with appreciation have been utilised in these guidelines. We would urge the guideline development group to also consider the following resources:<br>· 'Stroke recoveries at risk': outlines the impact of the pandemic on stroke rehabilitative services. | Thank you for your comment. The literature suggested was not captured within our search, which prioritise systematic reviews, meta analyses and RCTs. |

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| | | | · 'A complete guide to emotional changes after stroke': aimed at stroke survivors, this explains common post-stroke psychological challenges and professional treatments.<br><br>With reference to Recommendation O, we welcome the holistic approach to post-stroke psychological and emotional support and the implementation of research into practice in relation to lower-level psychological interventions. However, this recommendation is explicitly restricted to the clinical stroke workforce, while level 1 psychological support can also be provided by a stroke key worker. We would strongly recommend that the guidance reflects this fact. To avoid repetition, we have included appropriate evidence for the interventions provided by the stroke key worker within our response to the section 5.27 'Further rehabilitation'.<br><br>Suggested edit: Change Recommendation O to:<br>'Stroke clinicians and other members of the wider stroke multidisciplinary team should be aware of the psychological needs of people with stroke and their family/carers, and routinely provide education, advice, and emotional support for them. Multidisciplinary teams should embed approaches that promote physical and mental well-being within the wider rehabilitation package, and collaborate with other statutory and voluntary services to deliver them, such as:<br>– increased social interaction;<br>– meaningful activities to support rebuilding of self-confidence and self-esteem;<br>– increased exercise;<br>– mind-body interventions such as relaxation, mindfulness, Tai Chi and yoga;<br>– other psychosocial interventions such as psychological education groups.' | Thank you for your comment. We would consider stroke keyworker to be part of the clinical team and as such have not been specifically mentioned in line with not mentioning other specific professions in this recommendation. |
| 482 | | The Irish Heart Foundation | It was discussed in detail the importance of not diagnosing anxiety or depression too early after a stroke.<br><br>As a person has experienced a traumatic health event that may be profoundly life-changing, they may need to process it. A person may need time to mourn the future they cannot have and adjust to the idea of a different future.<br><br>Mindfulness, relaxation, and breathing exercises may be more beneficial than SSRIs due to short-term depressive and grieving episodes. The focus group also emphasizes the need for support groups within the community for peer support. | Many thanks for your comment. Timing is not an issue that was indicated in the reviewed literature and for some early indication is important.<br><br>Thank you, this has been reflected in the revised wording<br><br>Many thanks for your comment, these are reflected in recommendation A. |

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| | | | Furthermore, stroke patients described the lack of clinical mental health support. It explained this is often left to the acute or rehabilitation service Social Worker; therefore, the execution of these recommendations would be much more valid and comprehensive than before.<br>The Irish Heart Foundation would welcome the recommendations in Section O- (lines 4907-4916)" and would highlight the important role that voluntary organizations can provide in collaborating with MDTs in the provision of meaningful activities, social interactions, increased exercise, mind-body interventions, and psychoeducation sessions to increase psychological well-being and QOL. | Thank you, this has been reflected in Recommendation A. |
| 483 | | Brain Injury Matters (NI) | Recommendation F<br>Counselling for patients and family members of those with stroke: This should include individual and systemic (family) counselling as indicated. | Thank you for your comment. Counselling was not in scope of the partial rewrite and was not featured in the evidence reviewed for other questions relevant to this section. Therefore is unable to be included. |
| 484 | | National Imaging Academy Wales | Nil to add. | Thank you for your comments. |
| 485 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | A: We refer to our previous comments on the lack of signposting to psychometrically robust tools to use in standardisation of assessment. This lack of signposting is a missed opportunity to ensure that there is the opportunity to compare across teams and sectors. Indeed the missing references to a core outcome set for routine data collection would be a must for stroke care going forward<br><br>F: We welcome this recommendation and wish to highlight that the training funding for this needs to be part of any additional stroke funding.<br>We wish to further highlight that practically, it may be difficult to ensure continuity from acute to rehab to community as what is available in each setting and postcode is so varied.<br><br>The remaining recommendations in this section are welcomed, however there needs to be clarity on where the additional funds for this is coming from. | Thank you for your comment. This is discussed in section 4.28, Recommendation A. Specific tools are not recommended, to ensure the guideline doesn't become out of date, as new tools are developed.<br><br>Thank you, this is an issue for local systems.<br><br>Thank you, this is not an issue for the guideline to comment upon. |
| 486 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | 4825- use term emotionalism (emotional lability)<br><br>Difficult to notice the different sections pertaining to prevention and treatment- can read as contradictory if not clear. | Many thanks. This has been corrected<br><br>Thank you for your comment |

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| | | | Very long section- can get a bit lost- does it need headings?<br><br>N- what is high intensity? Needs to be clearer to understand when you'd trigger the action in the recommendation<br><br>R can go/be moved to the general psychological principles bit | Thank you, this was not possible in the design of the guideline<br><br>Thank you for your comment, this is described within the psychological interventions themselves.<br><br>Many thanks. This section was not moved as the section title did not change |
| 487 | | Irish Heart Foundation, Council on Stroke | Section 4.39 Anxiety, depression and psychological distress<br>Please comment on the following<br>Recommendations A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R<br>SLT<br>p.105 L482 "The incidence of post-stroke depression is higher for people with aphasia (62%-70%) versus those with no aphasia (Lincoln et al, 2011)"<br><br>Evidence to recommendations<br>Lincoln NB, Kneebone II, Macniven JAB, Morris RC. Psychological Management of Stroke. 2011. Wiley Online Library 9781119961307<br><br>Psychology<br>Hugely improved compared to previous guideline: promotes a more person-centred and holistic view of mood and well-being post stroke.<br>4891 – reference to people with aphasia is welcome, although people with aphasia can engage in treatments other than behaviour therapy, including counselling/psychotherapy adapted by a skilled practitioner, depending on the severity of their condition. Worth highlighting that all psychologists or mental health practitioners in stroke develop skills in adapting effective therapies to people with aphasia (and work jointly with SLTs where possible).<br><br>Advocacy<br>for some patients this is not the time to receive education and advice. Emotional support is a much longer-term requirement that might best be delivered as per at the lowest level of complexity. Recommendations elsewhere in the document that emotional support is needed for people undertaking vocational programme to return to work and for carers are welcome. But once the importance of the emotional support is recognised it should also be acknowledged that much more is needed for stroke survivors | Thank you for your comment. The reference is out of scope for inclusion<br><br>Many thanks for your comment<br><br>Many thanks. Recommendations for those with aphasia specifically mentioned the interventions reviewed as a result of the search. We are unable to recommend interventions for which we have not reviewed the evidence.<br><br>Many thanks for your comment. The current state is reflected in the narrative section for 4.39, quoting high levels of unmet need. |
| 488 | Q43. Section 4.40 | Royal College of Nursing | Agree with content | Thank you for your comment. |

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| | Apathy | | | |
| 489 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 490 | | British Psychological Society | Recommendation A does not explain how apathy will be identified. There are short, validated screening measures of the different subtypes of apathy that should be used for this (e.g. the Dimensional Apathy Scale, validated in community stroke survivors by Myhre et al. 2022).<br><br>The need for a neuropsychological review to be provided by suitably qualified psychologist for patients where apathy is queried and for this review to then inform the treatment approach should be more strongly woven in here.<br><br>Recommendation C – again we query the use of the stepped care model throughout this section. The previous iteration of the guideline recommended matched care and not stepped care so the reference to stepped care needs to be removed or evidence that supports this change in guidance should be provided.<br><br>We propose: following a comprehensive clinical and/or neuropsychological assessment of apathy, patient should receive a comprehensive MDT programme aimed at optimising their ability to participate in stroke rehabilitation.<br><br>Recommendation E – The recommendation that MDT members receive training in psychological care including apathy does not specify who would be qualified to provide such training. Clinical neuropsychologists or Stroke Specialist Practitioner Psychologists have the training, experience and expertise needed to provide this training and ongoing supervision and or consultation following training. | Thank you for your comment. Assessment of apathy was not within scope and therefore the evidence not reviewed. We are therefore not able to recommend specific assessment tools.<br><br>Thank you, this is referenced in rRcommendation C<br><br>Thank you for your comment, this is to remain consistent with organisation of care chapter. Evidence of matched care/stepped care was not within scope for review<br><br>Many thanks. The recommendation has not been altered as is about the MDT receiving training rather than the individual providing it. It is an expectation that training is provided by people with the correct levels of knowledge and skills. |
| 491 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Patients with post stroke apathy impacting on rehabilitation, should be referred to a specialist in rehabilitation medicine for assessment of rehabilitation potential and management. | Thank you for your comment. Editors and topic group did not feel this was required. |
| 492 | | Royal College of Speech and Language Therapists | The RCSLT agrees with the recommendations and finds this section useful however it would be interesting to know how stroke survivors felt about the use of the term 'apathy'. | Thank you for your comment. Stroke association has provided feed back on behalf of service users. |

| # | Section | Organisation | Comments received | GDG responses |
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| 493 | | The Irish Heart Foundation | The shock of changes to one's abilities post-stroke was commented on within the focus group. An essential part of recovery is to accept the changes that have occurred and the want to recover/ move forward with life. Therefore, a lack of drive to make and meet personal goals can slow this process.<br><br>An idea agreed upon to help deal with apathy was a peer support/ 'buddy' system within community/rehabilitation care. This would allow stroke patients to relate to one another and observe other stroke survivors' lifestyles to empower them to progress. | Thank you for your feedback. This was not featured in any literature pertaining to apathy, but generally peer support is advocated in the guideline. |
| 494 | | Association of British Neurologists | Of particular relevance when interpreting trials of treatment in depression after stroke; some of the patients recruited may have had apathy, or apathy and depression, rather than just depression. | Thank you for your comment. |
| 495 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 496 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | These recommendations appear to be appropriate.<br>The lack of training on how to identify apathy over other cognitive or mood issues is not clearly signposted here. | Thank you for your comment. We would expect the training provided for psychological care to cover this aspect. |
| 497 | | Irish Heart Foundation, Council on Stroke | Psychology<br>Noting here that the issue of insight, including aspects of agnosia and the spectrum of acceptance/denial, is a commonly presenting aspect of psychological response to stroke and an issue that psychology is often required to address (more so than apathy specifically). It would be beneficial to include a specific section on approaches to improving insight and engagement. | Thank you for your comment. This was not within scope for this section, or within the partial re-write. |
| 498 | Q44. Section 4.43 Aphasia | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 499 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 500 | | British Psychological Society | These recommendations do not mention the need for modified screening for depression and suicidality in people with aphasia, despite the increased risk of both (Chun et al., 2022).<br><br>Recommendation A – line 4997 – this would be better worded as 'neuropsychological disorders' rather than 'cognitive disorders' for clinical accuracy. | Thank you for your comment. This is covered in recommendations for all screening to be appropriate for the individual. Scope for this section was treatment for aphasia. Suicidality was not specifically within scope for the partial re-write |

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| | | | Chun, H. Y. Y., Ford, A., Kutlubaev, M. A., Almeida, O. P., & Mead, G. E. (2022). Depression, anxiety, and suicide after stroke: a narrative review of the best available evidence. Stroke, 53(4), 1402-1410. | |
| 501 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | BSPRM welcomes and agrees with these recommendations<br>Aphasia friendly versions of all information leaflets on stroke should be made available to people with aphasia . | Thank you for your comment. This is a point of general guidance covered elsewhere in the guideline |
| 502 | | Royal College of Speech and Language Therapists | General – The RCSLT feels that the majority of the section is helpful with regards to the acute as well as chronic phase, intensity, no cut-off etc. However, the RCSLT is concerned this section suggests a strong impairment-based approach and we suggest a change in the emphasis. The breadth of the rehabilitation needs to sit across impairment, life participation, environment, and psychosocial adjustment. It would be supportive to mention an accessible communication environment across stroke services, such as staff trained in communication support principles, conversation partner training for families/ friends e.g. https://www.ucl.ac.uk/short-courses/search-courses/better-conversations-aphasia-e-learning-resource. | Thank you for your comment. A broader view of rehabilitation has been included in the revised wording. |
| | | | With regards to capacity assessment, speech, language and communication needs should be considered in line with the MCA legislation and code of practice. This includes specialist assessment or support from a speech and language therapist. | This has been included in the revised wording |
| | | | Overall, functional access to quality of life outcomes through therapy improves outcomes e.g. accessing social groups, return to work, improving relationships through conversation partner training. | These aspects have been included in revised wording |
| | | | Page 111, lines 5082-508 – Digital therapies need to be directed by an SLT especially if we don't know when intensity becomes a factor, so this shouldn't be defined in months. | Thank you, further recommendations have been added with regards to this |
| | | | Page 111, lines 5085-5086 – The RCSLT welcomes the recommendation about communication aids. It is important to note that there should be appropriate assessment of suitability and acceptability on an individual basis. We also suggest that there is an explanation of the range of both high-tech and low-tech options. | Thank you for your comment. This has been included in the revised wording. |
| 503 | | The Irish Heart Foundation | The focus group discussed the need for more emphasis on the involvement of carers and family support for people with aphasia -they agreed that carer input | Thank you for your comment. This has been included in an additional recommendation (I). |

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| | | | was very beneficial and kept the person motivated for change while attending SLTs.<br>It was further discussed that the ability to speak should not dictate whether SLT is necessary, an assessment (including cognitive) should be carried out regardless of the level of disability.<br><br>The levels of therapy hours stated will make a good target for Irish Community Rehabilitation Services to follow- many of the focus group participants were discharged from rehabilitation care without sufficient services and links within the community for support for living with aphasia . | Thank you for your comment. |
| 504 | | Wales Stroke Allied Health Professional Forum | Interestingly SLT is cited here but seems we are not considered as the essential professional in dysphagia management??<br>Why are we specifying comprehensive aphasia programmes considered after 3 months? 3 months shows the best compliance and efficacy data but think statement should encourage 'earlier the better if able to tolerate? '<br>Offering ongoing therapy for communication for as long as patients continue to make meaningful gains is challenging as general SLT OP services are not funded specifically by stroke to enable this unlimited access to prolonged aphasia therapy. Time is in ESD is limited to 6 weeks | Thank you for your comment.<br><br>Thank you for your comment. The topic group felt this recommendation best reflected the evidence reviewed.<br><br>Thank you for your comment. |
| 505 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 506 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | A: This recommendation would benefit from having a timeline that would aid assessment and intervention<br><br>B: The vagueness around frequency and length of input is not helpful- we would recommend clarity around this.<br><br>E: Whilst we welcome this recommendation as it should be standard- we would welcome further signposting to the use of appropriate services to facilitate this<br><br>Line 5111 is missing the reference to the meta-analysis<br><br>Considering how vital SLT is it would be good to see a 7 day service. The lack of SLT on weekends and bank holidays continues to hinder stroke care. | Thank you for your comment. The Guideline Development Group considered that the most appropriate descriptor was 'early' given the greater variability in when patients are ready for communication assessment and rehab. In this way it differs from recommendations about motor assessments (within 24 hours).<br><br>Thank you for your comment. This recommendation was welcomed by the RCSLT and is purposely needs led.<br><br>Thank you for your comment.<br><br>Thank you for your comment. This is reflected in chapter 2 |

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| 507 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | B- or other health care professionals | Thank you for your comment, but the Guideline Development Group felt that communication rehab should be under the overall supervision of a speech and language therapist. |
| 508 | | Irish Heart Foundation, Council on Stroke | Speech and Language Therapy<br>General<br>— IASLT agrees with RCSLT comments around the need for a change in emphasis.<br>— The proposed staffing for SLT will present a barrier to delivering these recommendations.<br><br>— 4.43 Where a person has a known or suspected communication disorder and requires a cognitive assessment and / or evaluation of capacity - SLTs have the necessary clinical skills to support people with communication disabilities in maximising their decision making ability, building their capacity and supporting cognitive and capacity assessments (as part of the MDT). All professionals involved in capacity assessments and assessments of cognition for people with acquired communication impairment (approx 2/3 post Stroke) should receive mandatory training from a SLT to ensure that they are aware of how best to support communication access in their interactions (IASLT Position Statement on the Role of the SLT in Assessing Capacity and Facilitating Understanding to Support Decision Making for Adults with Communication Disabilities, 2017).<br><br>Specific:<br>— p.110 L5056, add: "Communication impairments post-stroke, including aphasia and dysarthria, are common affecting about 64% (Mitchell et al, 2020)"<br><br>— Then Add: "p.105 L482 "The incidence of post-stroke depression is higher for people with aphasia versus those with no aphasia" (Lincoln et al, 2011) | Thank you for your comment:<br><br>This has been addressed in the final wording.<br><br>The GDG agree, but do not consider that such an observation should preclude making an evidence-based recommendation. This is addressed in the revised WTE recommendations and chapter 2, supported by innovative ways of delivering therapy<br><br>Thank you for your comment. This is covered in earlier section regarding mental capacity. The questions within scope for this section were regarding intensive therapy for aphasia specifically.<br><br>Content reviewed in preparation for final Guideline Development Group approval of the text, and not recommended for substantial amendments. In general, evidence from RCTs synthesised in the RELEASE collaboration took precedence over other, less methodologically robust studies and analyses in dictating the content of the aphasia section approved by the topic group.<br><br>This is referred to in the introductory paragraph. |

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| | | | — p.110 L5056, add to Reading " reading (separately called dyslexia or alexia) and writing (dysgraphia or agraphia)" | Amended text included. |
| | | | — p111 L5090-92 + P112 L5110-39- Evidence around intensity of aphasia therapy might meaningfully be added to +/or summarised in Section 4.2 - Intensity of therapy p.51 - as observed above, Section 4.2 is overly focused on motor & physical learning principles. | |
| | | | — p.111 L5075, recommendation A, suggest that this is broadened to: "All people with stroke should receive prompt screening for communication impairment using a valid, reliable tool, and if indicated, assessed by a Speech & Language Therapist determine the nature, severity and personal consequences. | Not accepted for amendments. |
| | | | — A second recommendation is required in L5078 (p111):<br><br>"Once identified, aphasia status should be formally documented in acute settings and communicated to all relevant healthcare workers; patients with aphasia should be assigned a named team member to provide advocacy and communication support, and to ensure prompt referral to SLT regardless of dysphagia status". | Not accepted. |
| | | | — P111, L5093, recommendation G - suggest separating into 2 recommendations.<br>FIRST:<br>“All healthcare workers involved in stroke care and others working with PWA are provided with enough aphasia information and training appropriate to each profession / setting, to facilitate delivery of safe and quality healthcare”<br><br>SECOND:<br>“The carers and family members should receive aphasia information and training in strategies to support communication from a Speech and Language Therapist to enable them to optimise engagement in rehabilitation and promote autonomy and social participation” | This intent is already covered by the existing wording. No amendment. |
| | | | — P111 L5099 Suggest new recommendation:<br><br>“People living with aphasia should have access to information about aphasia and | |

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| | | | treatment options at all stages of recovery."<br><br>Evidence to recommendations<br>About 50% of hospital inpatients with stroke have reduced ability to communicate their healthcare needs. Inpatients with communication impairment (including aphasia) have a six-fold increased risk of experiencing a preventable adverse event in acute settings. It is crucial that patients with communication impairment, like aphasia, are recognised as being potentially vulnerable in healthcare settings. Aphasia also makes it harder to gain information, self-advocate and report substandard care. To ensure safe, quality stroke care, it is crucial that PWA are recognised as potentially vulnerable in healthcare settings. This would firstly involve early (documented) identification of aphasia-status with standardised communication of aphasia-status to all relevant healthcare workers at ward level and beyond to rehabilitation and primary care. The Australian stroke guidelines and CCRE best practice statements call for prompt communication screening and assessment of functional communication abilities for all people with stroke using a valid, reliable tool, to ensure quality, safe, appropriate acute stroke care. Early acute screening for dysphagia but not aphasia / functional communication poses a risk of under-referral and identification of people with aphasia and no dysphagia. For aphasia in acute settings, we need to formalise early recognition of aphasia and assignment of a named team member to provide oversight of care and onward referrals, advocacy, and communication support.<br><br>A lack of aphasia knowledge amongst healthcare workers involved in stroke and aphasia care has been documented in Ireland and internationally. It is essential that all healthcare workers involved in stroke care and others working with PWA are provided with enough aphasia information and training appropriate to each profession / setting, to facilitate delivery of safe and quality healthcare. Training healthcare professionals in the use of communication strategies may increase access to information and shared decision making for PWA. Conversation Partner Training approaches (delivered by Speech and Language Therapists) have been demonstrated to increase aphasia knowledge, communication strategies and/or confidence.<br><br>Inconsistent access to support and information for families runs counter to best practice and can exacerbate negative relationships and "third-party disability". A | The replacement of whole sections of the guideline already written by topic groups is not invited or encouraged. Peer review serves primarily to identify significant evidence that has been overlooked which might modify recommendations. |

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| | | | pathway of care for post-stroke aphasia must be person and family centred, responsive to the informational, emotional and support needs of spouses and children of PWA at all stages of recovery.<br><br>A lack of information about aphasia and relevant support is disempowering and further reduces access to person-centred, collaborative healthcare and social and community participation. A lack of aphasia information additionally exacerbates negative relationship changes, including with spouses, children and friends, common with post-stroke aphasia. There is a need for comprehensive, aphasia-friendly information about aphasia, its consequences and treatment options, that is available in a range of formats, and signposted by healthcare workers involved in stroke and aphasia care. Due to their communication disability, some PWA may also benefit from repeated opportunities to discuss and refine their understanding of aphasia.<br><br>REFERENCES<br>— Simmons-Mackie, N., Worrall, L., Murray, L., Enderby, P., Rose, M., Paek, E. J., & Klippi, A. (2017, 2017/02/01). The top ten: best practice recommendations for aphasia. Aphasiology, 31(2), 131-151. https://doi.org/10.1080/02687038.2016.1180662<br><br>— Mitchell C, Gittins M, Tyson S, Vail A, Conroy P, Paley L, et al. Prevalence of aphasia and dysarthria among inpatient stroke survivors: describing the population, therapy provision and outcomes on discharge. Aphasiology. 2020:1-11. doi: 10.1080/02687038.2020.1759772.<br><br>— National Stroke Foundation. Clinical guidelines for stroke management. Melbourne, Australia: National Stroke Foundation; 2010.<br><br>— Lincoln NB, Kneebone II, Macniven JAB, Morris RC. Psychological Management of Stroke. 2011. Wiley Online Library 9781119961307.<br><br>— O'Halloran R, Lee YS, Rose M, Liamputtong P. Creating communicatively accessible healthcare environments: perceptions of speech-language pathologists. Int J Speech Lang Pathol. 2014;16(6):603-14. doi: 10.3109/17549507.2014.894125. PubMed PMID: 24665913. | |

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| | | | — Carragher M, Steel G, O'Halloran R, Torabi T, Johnson H, Taylor NF, et al. Aphasia disrupts usual care: the stroke team's perceptions of delivering healthcare to patients with aphasia. Disabil Rehabil. 2020:1-12. doi: 10.1080/09638288.2020.1722264.<br><br>— Manning M, MacFarlane A, Hickey A, Franklin S. Perspectives of people with aphasia post-stroke towards personal recovery and living successfully: A systematic review and thematic synthesis. PLoS One. 2019;14(3):e0214200. doi: 10.1371/journal.pone.0214200.<br><br>— Horton S, Lane K, Shiggins C. Supporting communication for people with aphasia in stroke rehabilitation: transfer of training in a multidisciplinary stroke team. Aphasiology. 2015;30(5):629-56. doi: 10.1080/02687038.2014.1000819.<br><br>— Forster A, Brown L, Smith J, House A, Knapp P, Wright J, et al. Information provision for stroke patients and their caregivers. Cochrane Db Syst Rev. 2012;11. doi: 10.1002/14651858.CD001919.pub3.<br><br>— Manning M, MacFarlane A, Hickey A, Franklin S. Perspectives of people with aphasia post-stroke towards personal recovery and living successfully: A systematic review and thematic synthesis. PLoS One. 2019;14(3):e0214200. doi: 10.1371/journal.pone.0214200.<br><br>— Manning M, MacFarlane A, Hickey A, Galvin R, Franklin S. Policy brief: Optimising stroke care for living well with aphasia in Ireland. University of Limerick: SPHeRE / HRB; 2020.<br><br>— CCRE in Aphasia Rehabilitation. Aphasia Rehabilitation Best Practice Statements 2014. Comprehensive supplement to the Australian Aphasia Rehabilitation Pathway. Brisbane, Queensland.2014.<br><br>— Grawburg M, Howe T, Worrall L, Scarinci N. Third-party disability in family members of people with aphasia: a systematic review. Disabil Rehabil. 2013;35(16):1324-41. doi: 10.3109/09638288.2012.735341. PubMed PMID: 23826903. | |

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| | | | — Aphasia United. Best practice recommendations: Aphasia United,; 2018 [30.10.2020]. Available from: http://www.aphasiaunited.org/best-practice-recommendations/.<br><br>— Hemsley B, Werninck M, Worrall L. "That really shouldn't have happened": People with aphasia and their spouses narrate adverse events in hospital. Aphasiology. 2013;27(6):706-22. doi: 10.1080/02687038.2012.748181.<br><br>— Bartlett G, Blais R, Tamblyn R, Clermont R, MacGibbon B. Impact of patient communication problems on the risk of preventable adverse events in acute care settings. Can Med Assoc J. 2008;178:1555-62. | |
| 509 | Q45. Section 4.48 Vision | Royal College of Nursing | Agree with all content, but considering there may also be difficulties with aphasia, alexia, and cognitive decline, it may be worth adding the consideration of adapted visual tests, such as the Cardiff Acuity Cards | Thank you for your comment. This has not been included as we have not recommended specific assessments. |
| 510 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 511 | | British Psychological Society | Visual disturbance post-stroke (e.g. Charles Bonnet syndrome) can be very distressing for patients, who are often reluctant to report symptoms. Ensuring stroke-specialist staff have an awareness of these conditions and are able to offer education around them would be helpful for patients. It would be good to see this reflected in the guidelines. | Thank you for your comment. This was outside of scope of the partial re-write. |
| 512 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Patients need to know about the impact of visual field defect on driving after stroke, particularly the need to inform the DVLA about this. | Thank you for your comment. Link to the driving section has been included in the revised wording |
| 513 | | British and Irish Orthoptic Society | The additional information adds significant value to orthoptic practice in the field. The evidence around timing in which visual assessment should be performed after stroke, staffing levels, and guidance around the treatment options available, is of great support to orthoptic stroke service planning. | Thank you for your comment. |
| 514 | | Royal College of Speech and Language Therapists | The RCSLT believes this is useful and agrees with recommendations. | Thank you for your comment. |
| 515 | | Welsh Association of Stroke Physicians | If early assessment by an orthoptist is required for all patients the workload will be considerable and potentially of little value as so many patients will improve considerably over the first few weeks.<br>If an assessment by orthoptics was reserved for those patients with a persistent | Thank you for your comment. Screening is to be completed by any appropriately trained professional.<br><br>WTE suggestions are made within this section. |

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| | | | or disabling visual problem it may be a better use of resources. | |
| 516 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 517 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Is there a consensus recommendation on use of rehabilitation techniques to help address issues such as gaze stabilisation and diplopia?<br>Should orthoptists not be considered an essential profession in the stroke MDT? It seems very varied between trusts and anecdotal evidence highlights the importance of the orthoptist in assessing and intervening where needed, | Thank you for your comment. This was not within scope for the partial re-write.<br><br>This has been considered by editors and GDG and felt prompt access to orthoptists is appropriate. |
| 518 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Very orthoptist-ish- doesn't feel as balanced as other topics where being broader across professions and those with skills.<br>Need to add to the blurb- visual disturbance has a significant impact on safety, confidence and independence and therefore should remain a focus for all members of the MDT to support with adjustment and adaptation.<br>Physiotherapists and Occupational Therapists will be particularly involved in guiding rehabilitation plans for those with visual disturbance affecting mobility and function.<br><br>5272 - doesn't have to be orthoptists to undertake screening- should be those with appropriate skills and knowledge (such as Occupational Therapists).<br><br>Need to add a recommendation in regarding impact of visual changes in functional tasks and interventions implemented to improve safety, confidence and independence in ADLs. | Thank you for your comment. The wording has been revised to reflect the MDT involvement and impact of visual changes.<br><br>Thank you, this has been addressed in the revised wording<br><br>This has been added in Recommendation D |
| 519 | | Irish Heart Foundation, Council on Stroke | Orthoptist and ophthalmologist are specifically mentioned. Consider adding a recommendation that the person be assessed by an occupational therapist to determine how the VFD impacts ADL including reading, navigating environment, shopping and that people with a VFD should be offered eye movement based strategies to address hemianopic alexia. | Thank you, this has been included in the revised wording. |
| 520 | Q46. Section 5.4 Blood pressure | Irish Institute of Clinical Neuroscience | As with IICN comment in section 3.3 and in line with this guideline elsewhere, we recommend clarifying here that BP is not lowered until 5 days following acute stroke/TIA onset. | The issue of the timing of BP intervention after stroke is covered in Evidence to Recommendations. |
| 521 | | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 522 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |

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| 523 | | British Psychological Society | No Comment | Thank you for your comment. |
| 524 | | Chest Heart & Stroke Scotland | All – should it be recommended how often BP should be monitored after stroke? Appreciate it is difficult to give information that fits all, but guidance would be useful.<br><br>High risk of patient anxiety when home monitoring BP, should be considered and discussed also? | Clinical judgement is required here, considering other issues such as co-morbidities, other medication and frailty. Flexibility reflected in Recommendation 5.4E<br>Addressed in Recommendation 5.4G |
| 525 | | The Stroke Association | Recommendation A states that 'people with stroke or TIA should have their blood pressure checked'. This does not make reference to NICE guidance NG136 which indicates that the pulse should be palpated at the same time as checking for blood pressure, to check for any pulse irregularity. It is important that all CVD risk factors are checked at the same time, treating the patient holistically and securing better impact and value for money.<br><br>Suggested edit: Change Recommendation A to:<br>'People with stroke or TIA should have their blood pressure checked, and treatment should be initiated and/or increased as tolerated to consistently achieve a clinic systolic blood pressure below 130 mmHg, equivalent to a home systolic blood pressure below 125 mmHg, except for people with severe bilateral carotid artery stenosis, for whom a systolic blood pressure target of 140–150 mmHg is appropriate. Concern about potential adverse effects should not impede the initiation of treatment that prevents stroke, major cardiovascular events or mortality. People with stroke or TIA should also have their pulse palpated at the same time as this blood pressure check, to check for any pulse irregularity.'<br><br>In reference to Recommendation G, it's important that this is done alongside enhanced collaboration with healthcare professionals and patients to ensure that people can raise concerns, questions and high readings in a timely manner. We suggest that Recommendation G also recommends that guidance is given on stroke survivors manually checking their pulse as well whilst using home blood monitoring.<br><br>Suggested edit: Change Recommendation G to:<br>'People with stroke using home BP monitoring should use a validated device with an appropriate measurement cuff and a standardised method. They (or where | Agree. Addressed by addition to Evidence to Recommendations section and new citation of NICE CG136, 2022. |

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| | | | appropriate, their family/carer) should receive education on lifestyle, how to use the device, the implications of readings for management, and be provided with ongoing support, particularly for people with anxiety or cognitive and physical disability after stroke. People with stroke should also receive guidance and information on manually checking their pulse to check for pulse irregularity.' | |
| 526 | | Northern Ireland Stroke Network | The guidelines focus entirely on secondary prevention for both medication and BP control. Whilst the remit of this section is secondary prevention, we suggest that primary prevention around BP management, should be referenced somewhere in the stroke guidelines.<br>The role of General practice in ongoing blood pressure management should be highlighted. | The scope of the guideline is confined to secondary prevention. Other guidance (e.g. NICE CG136) addresses primary prevention. The GDG agree regarding the principal role of primary care, and this is stated in Rec. 5.4E. |
| 527 | | Scottish Intercollegiate Guidelines Network | The RCPE generally supports the recommendations in this chapter and considers that long term management and secondary prevention are of critical importance. | Thank you for your comment. |
| 528 | | British and Irish Association of Stroke Physicians (BIASP) | P121 line 5530 Recommendation A. Suggest greater consideration of BP targets in the elderly and frail in the context of stroke secondary prevention, rather than a 'one-size fits all'.<br><br>P121 line 5548 Recommendation E. We suggest BP should be checked more often than annually. At 3 month FU and then every 6 months in the community. | Agree, although this is an issue wider than just BP. General guidance on the significance of targets (and other evidence) for individualised care that applies across the entire guideline is given in Section 1.2.<br><br>No evidence to guide Recommendation. The existing recommendation represents the consensus of the GDG, but there will be other views. |
| 529 | | The Irish Heart Foundation | The IHF focus group agreed with the recommendations however in both the recommendations and evidence to recommendations there were no details regarding the age-related differences in high blood pressure for older patients. | The GDG is not recommending a different approach to BP management dependent on age. Co-morbidity and frailty are considered to modify targets and other evidence, and general guidance for individualising recommendations that applies across the entire guideline is given in Section 1.2. |
| 530 | | Association of British Neurologists | For all interventions is there merit in tables which include the NNT and costs? | The GDG is sympathetic to attempts to guide clinicians on the relative merits and costs of different interventions, although a detailed comparative and cost-effectiveness analysis is beyond the scope and resources of the guideline project. |
| 531 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 532 | | United Kingdom Clinical Pharmacy Association (UKCPA) | line 5367-- not Docette box but Medicines Compliance Aid / Pill Box | Outside the scope of the consultation (unamended 2016 Section). |
| 533 | | Association of Chartered Physiotherapists in | E: Would this not be better reviewed at the 6-month and annual reviews? G.P. services are overwhelmed and slow to respond, leading to variations across the | No evidence to guide Recommendation. The existing recommendation represents the consensus of the GDG, but there |

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| | | Neurology(ACPIN) | UK.<br><br>G: Whilst this recommendation is supported and encouraged, consideration needs to be given to those who are unable to afford these devices. These are the same people who suffer from health inequalities and are underserved.<br><br>Signposting to the British Heart foundation here would be very useful as they provide a wealth of information including signposting to which blood pressure monitors are suitable for home use: https://www.bhf.org.uk/informationsupport/risk-factors/high-blood-pressure | will be other views.<br><br>Recommendation 5.4F states that home BP monitoring should be *considered.* Device costs may well be a consideration for individual patients, although many general practices have loan machines to address such inequalities.<br><br>The GDG has generally avoided signposting to specific websites/pages as this contributes to built-in obsolescence. The use of a *validated* device in included in Rec. 5.4G and the BHF is one source of information on this (as is the BIHS). |
| 534 | | Irish Heart Foundation, Council on Stroke | Physio<br>5.4 pg 123 line 5617 typographic error et al.,<br>5.5 A pg 124 line 5644 5.5 A : comment advice alone is insufficient to achieve behaviour change in lifestyle related risk factors -could this be advice and behavioural change counselling<br>5.4 pg 122 line 5548 reword People with stroke or TIA should have their blood pressure-lowering treatment monitored frequently and increased to achieve target blood pressure as quickly as tolerated and is safe in primary care<br>OT<br>COMMENT: Insert " Blood pressure is a modifiable risk factor with significant diet and lifestyle contributors for which patients should receive individualised dietetic counselling to address personalised contributors" This is in line with evidence as per section 4.9, with implications for access to dietetics and staffing requirements. | Thanks – corrected.<br>Agree – Recommendation 5.5 A has been modified to reflect this.<br><br>This would insert a statement rather than a Recommendation – not accepted. |
| 535 | | Royal College of Physicians of Ireland Clinical Advisory Group | Recommendation F. There is no mention of ambulatory BP monitoring. This is widely used in the Irish Health Service.It seems to be at odds with NICE, where ABPM advised for those with HTN 140-180/90-120; HBPM is for those who don't tolerate ABPM. The ESC guidance is for out of office BP measurement ABMP and/or HBPM as an alternative to office for diagnosis, and in specific situations. | Agree – Recommendation 5.4 F has been modified to reflect this option. |
| 536 | Q47. Section 5.5 Lipid modification | Royal College of Physicians | Recommendation B--please review: treatment should begin with high-dose atorvastatin. Earlier sections of guideline recommends atorvastatin 20-80 mg daily. | Recommendation 5.5B includes the recommendation to use a lower dose of high-intensity statin in certain circumstances. |
| 537 | | Royal College of Nursing | Agree with content | Thank you for your comment. |

| # | Section | Organisation | Comments received | GDG responses |
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| 538 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 539 | | British Psychological Society | No Comment | Thank you for your comment. |
| 540 | | The Stroke Association | In reference to Recommendation A, we suggest that this advice should be tailored to the individual to improve adherence to the recommendations of how they should modify their lifestyle post stroke. We suggest that stroke survivors should not just be given advice but referred to support groups and services that they can join to help them with that ongoing support.<br><br>Suggested edit: Change Recommendation A to:<br>'People with ischaemic stroke or TIA should be offered personalised advice on lifestyle factors to reduce cardiovascular risk, including diet, physical activity, weight reduction, alcohol moderation and smoking cessation. If appropriate, people with ischaemic stroke or TIA should be referred to support groups and other services to assist them to make these lifestyle changes.' | Agree. The recommendation has been amended to reflect the need to offer not just advice but also support with these lifestyle modifications. |
| 541 | | Scottish Intercollegiate Guidelines Network | The Scottish Medicines Consortium has issued advice on lipid medicines, some of which includes restrictions on use. Can the guideline please signpost to the SMC website for further information regarding what is accepted for use in NHSScotland? www.scottishmedicines org.uk<br>SIGN can supply further information or links to specific advice if needed. | Agree, although this is a wider issue than purely for lipid medicines. Signposting to the SMC and other information regarding the licencing and approval for use of drugs is included in Section 1.8, encompassing the entire guideline. |
| 542 | | British and Irish Association of Stroke Physicians (BIASP) | Is the 4-6 week target for lipid lowering evidence based? Is it achievable, or would it be better to quote a % reduction in non-HDL-C (40%) as per NICE.<br><br>Importantly there is no consideration of frailty. One in four people presenting | The principal new evidence considered for the 2023 edition is the Treat Stroke to Target trial of more intensive cholesterol-lowering target, which titrated lipid-lowering therapy at an interval of 15 days (see protocol at PMC6960693). 4-6 weeks represented the consensus of the GDG bearing this in mind with other practical considerations, but seeking to avoid treatment inertia. The TST trial demonstrated that intensification of lipid-lowering treatment was achievable for the majority, often through the addition of ezetimibe to high-intensity statin, guided by LDL-C. This and difficulties with the measurement and interpretation of non-HDL-C reductions from baseline is one reason why the principal lipid targets in Rec. 5.5C are given in LDL-C.<br><br>The GDG agrees that frailty and co-morbidities are important |

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| | | | with stroke is living with frailty and we know that advanced frailty has a prognosis worse than many solid organ cancers.<br>Could we have a best practice point to consider frailty when planning secondary prevention and follow-up. | considerations in secondary prevention, and would not encourage an absolutist approach to this and other guideline recommendations. General guidance on the significance of targets (and other evidence) for individualised care that applies across the entire guideline is given in Section 1.2. |
| 543 | | British Dietetic Association | Page 124, line 5645:<br><br>Advice on lifestyle factors to reduce cardiovascular risk including weight management and diet:<br><br>Who provides this advice/recommendations? Responding group felt this should be provided by a staff member with correct education/training?<br><br>At what point? e.g. during or after inpatient stay | Advice on lifestyle factors to reduce cardiovascular risk will vary from general advice on a low-salt, weight-reducing diet such as that available from the BHF and other websites, to specific diets for example, for renal and other patients. Specifying routes and criteria for referral is beyond the scope of this general guideline. |
| 544 | | Welsh Association of Stroke Physicians | Could there be a table including NNT etc for all the treatments in this section? | The GDG is sympathetic to attempts to guide clinicians on the relative merits and costs of different interventions, although a detailed comparative and cost-effectiveness analysis is beyond the scope and resources of the guideline project. |
| 545 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 546 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations appear to be appropriate for this section and we have nothing further to add. | Thank you for your comment. |
| 547 | | Irish Heart Foundation, Council on Stroke | Dietetics<br>Recommendation C amend “optimise dietary and lifestyle measures;” to read “optimise dietary and lifestyle measures with supported structured individualised dietetic counselling”. This is in line with evidence as per section 4.9, with implications for access to dietetics and staffing requirements. | Agree – Recommendation has been partly modified to reflect this. |
| 548 | | Royal College of Physicians of Ireland Clinical Advisory Group | B: Atorvastatin is specifically mentioned. I can’t recall any other specific drug being mentioned e.g. in the hypertension section. Should this be reconsidered and left as a potent statin?<br>We don’t have inclisiran or bempedoic acid available in Ireland; Should we add, ‘if available’ to the text.<br>5664 – consider the use of additional agents such as injectables (inclisiran or monoclonal antibodies to PCSK9) or bempedoic acid (for statin-intolerant people taking ezetimibe monotherapy); | The general principle of recommending a drug with the lowest acquisition cost and the greatest clinical experience is being observed here.<br>This circumstance (the drug not being available) is covered by the use of the word ‘consider’ – the prescriber would consider and exclude that option. Similar issues of availability of these and other drugs affecting local formularies in the UK are also covered by ‘consider’. |
| 549 | Q48. Section 5.6 | Royal College of Nursing | Agree with content | Thank you for your comment. |

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| | Antiplatelet treatment | | | |
| 550 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 551 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 552 | | United Kingdom Clinical Pharmacy Association (UKCPA) | pharmacogenetic testing for clopidogrel -Cyp 2C19 if poor metaboliser, consider alternative antiplatelet | The GDG considered the issue of detection and management of loss-of-function mutations to still be a matter for research, particularly in Western populations. The issue of considering potential clopidogrel resistance is addressed in Rec. 5.6A. |
| 553 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations appear to be appropriate for this section and we have nothing further to add. | Thank you for your comment. |
| 554 | Q49. Section 5.7 Anticoagulation | Royal College of Nursing | Agree with content | Thank you for your comment. |
| 555 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 556 | | Scottish Intercollegiate Guidelines Network | Line 5948.<br>Worth emphasing that the simple HAS-BLED score has been validated in patients taking DOACs and offers better calibration than other risk scores (eg ORBIT) at least in general AF populations.<br>See references:<br>PMID: 36318457<br>PMID: 34555148<br>PMID: 34783372<br>Biomarker (imaging, blood or urine) based scores always improve on simple clinical risk scores, and if imaging data are available, the MICRON-ICH offers improvement, although untested in a broad range of real world cohorts<br><br>Line 6005<br>Should also cite the INVICTUS trial, in AF with rheumatic valve disease (mostly mitral stenosis), where warfarin was superior to rivaroxaban (a DOAC)<br>PMID: 36036525 | This evidence was not considered by the GDG as it was either published after the re-run searches in Sept-Oct 2022, or not in an appropriate population. However, the essential meaning of this comment is consistent with the existing text, recommending the use of a validated tool such as HAS-BLED or MICON-ICH.<br><br>Agree. The addition of the INVICTUS Trial strengthens the recommendation. Amended. |

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| 557 | | British and Irish Association of Stroke Physicians (BIASP) | P128 line 5855 "should not be commenced in people with severe hypertension, which should be treated first" WE feel this is a bit it of a blanket statement that could be misinterpreted. Surely it should depend on CHADSVASC and ORBIT.<br><br>P128 line 5855 'severe hypertension' should be defined | The GDG accepts that there will require the exercise of clinical judgement in balancing the relative risks and benefits from anticoagulation and the management of severe hypertension. Defining this is not guided by any definitive evidence and will remain a matter of clinical judgement guided by the guideline.<br><br>The GDG has adopted the somewhat arbitrary definition of severe hypertension from NICE NG136 of a clinic BP of 180/120 or higher. |
| 558 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 559 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations appear to be appropriate for this section and we have nothing further to add. | Thank you for your comment. |
| 560 | | Irish Heart Foundation, Council on Stroke | line 6018 close collaboration between stroke physicians / neurologists / cardiologists...<br>suggest include Geriatricians with an interest in stroke medicine - alot of stroke care and especially out of hours thrombolysis is provided by Geriatricians in the Republic of Ireland.<br>Again this is also applicable to 6118-6119 - add in Geriatricians with an interest in stroke | The GDG seeks to avoid long 'including but not limited to…' lists of specialties which might also include Rehabilitation Medicine, Acute (Internal) Medicine etc, all of whom contribute to stroke care in various places. In avoiding this, the term 'stroke physician' represents the best compromise between brevity and inclusivity, and is widely recognised. For Rec 5.10B this has be simplified through the use of the simple term 'patient's physician'. |
| 561 | | Royal College of Physicians of Ireland Clinical Advisory Group | As noted in the review there is some minimal evidence for cerebral venous sinus thrombosis treated with DOAC. It is unlikely large randomised trials will be done considering how rare it is. Below I note a meta-analysis, and retrospective study1,2 . We have taken a pragmatic decision that DOACS work effectively for DVT and PE as proven in clinical trials and it is reasonable to conclude that as the same mechanism is involved in venous thrombosis elsewhere DOACS are effective and this has been our experience in practice. Dabigatran with its very effective reversing agent is a reasonable first choice considering the risk of bleeding.<br>1 ACTION –CVT S. Yaghi et al. Stroke 2022;53,728-738<br>2 DOAC in treatments of cerebral venous thrombosis; a systematic review. G.Bose et al . Neurology. BMJ open-2020-040212 | Although the GDG understand the pragmatic approach taken by the reviewer, the retrospective non-randomised study of Yaghi et al cannot provide the evidence on safety that would be required for a change in recommended management of CVST, and the authors themselves stress the importance of a large randomised trial to change practice and guidelines. No change to recommendations. |
| 562 | Q50. Section 5.9 (Paroxysmal) Atrial fibrillation | Royal College of Nursing | Nothing to add | Thank you for your comment. |
| 563 | | British Cardiovascular Society (including British | BCS/BCIS have concerns about the recommendation to use more telemetry in stroke patients. Telemetry does not pick up atrial fibrillation automatically, and | Recommendation 5.9A is not specifying telemetry, simply 'cardiac monitoring' – either by telemetry or Holter. |

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| | | Cardiovascular Intervention Society) | so it would be necessary for the telemetry to be monitored closel by people able to easily differentiate among differing heart rhythms. That would either require additional training of stroke ward nurses, or increased workload on cardiology nurses elsewhere in the hospital. This has workforce (and cost) implications. Given these limitations in the use of telemetry, it may be that Holter monitoring is a more reliable way of detecting occult AF.<br><br>However, increased use of Holter monitoring also has some workforce implications, as there is a national shortage of physiologists. The impact of this recommendation will depend on how widely the practice of Holter monitoring is already post stroke. We note that it is only recommended in patients suspected of cardioembolic stroke and appropriate for DOAC<br><br>An issue needing consideration if using Holter monitoring more widely would be the incidental findings, other than AF. Stroke physicians are not generally familiar with interpreting this test and so are likely to involve cardiology. Such findings could be considered as part of the workload of a stroke/cardiology MDT, although such MDTs are not widely available and initiating them would have job planning implications as they require dedicated consultant time to run.<br><br>Similar concerns relate to other, more extended monitoring or the use of loop recorders. They require physiologist time, carry opportunity cost and will need cardiologists interpreting incidental findings.<br><br>6091 “Close collaboration between stroke physicians/neurologists and cardiologists can facilitate expert decision-making in challenging cases”<br><br>We feel that this could be offered through a cardiology stroke MDT, supported by radiology colleagues. This would need job planned cardiologist time and that should be modelled. Unless cardiology workforce expands, this could mean difficult decisions on prioritising cardiologist time to allow increased input to MDTs. | This is issue is covered in the Implications section.<br><br>Agreed. This has been added to the section. |
| 564 | | Northern Ireland Stroke Network | Whilst the remit of this section is secondary prevention, we suggest that primary prevention around AF management, should be referenced somewhere in the stroke guidelines.<br>The role of General Practice in AF detection and management (before and after stroke) should be mentioned. | The scope of the guideline is confined to secondary prevention. Other guidance (e.g. NICE NG196) addresses primary prevention including the role of primary care. |

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| 565 | | British and Irish Association of Stroke Physicians (BIASP) | The recommendation for 24 hours of cardiac monitoring to look for PAF could be more ambitious.<br>Services will often only deliver the minimum monitoring recommended, and if we limit to 24 hours of monitoring this would be a step back for many services.<br><br>Consider a formal recommendation to set up a stroke-cardiology MDT – it has been transformational for some services. | The assessment of the current evidence by the GDG did not support recommending an initial longer period of monitoring beyond 24 hours (Rec 5.9A), and that sequential or continuous monitoring is appropriate for selected patients (Rec 5.9B). If services are altered to be consistent with this recommendation, that should free up resources.<br>The closer collaboration between stroke/neurologists and cardiologists through an MDT has been added to the implications section. |
| 566 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 567 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations appear to be appropriate for this section and we have nothing further to add. | Thank you for your comment. |
| 568 | Q51. Section 5.10 Patent foramen ovale | Irish Institute of Clinical Neuroscience | This section recommends possible PFO closure in selected individuals below 60 years old with otherwise unexplained TIA or ischaemic stroke and gives a timeframe - within six months.<br>We empirically observe high variability of access to investigations for PFO among different services and regions, and wonder if there are barriers to access for the stroke in younger persons cohort.<br>We would value the inclusion of the optimal timing and modality of investigation for PFO as a guideline recommendation e.g.<br>“Selected people under 60 years old with otherwise unexplained ischaemic stroke should be offered (trans-oesophageal) echocardiography with bubble within (?8 weeks) of stroke onset”. | The GDG considered that setting an overall recommendation for the process of PFO closure was the most helpful to make, and that to make additional recommendations about steps within that process would not help to reduce variability in access any further. This was based on consensus within the GDG in the absence of definitive high-quality evidence. |
| 569 | | Different Strokes | In recommendation B, I would add that individuals who are being considered for a PFO closure should be given details of organisations that can provide info on other people who have had the closure and who detail their experiences of this. We have a dedicated section on our website of peoples' experience of PFO closure (as well as doing newsletter articles on this subject), and often, what will most put people at ease is not so much reassurance from medical professionals (important as this is) but that of people who have had the operation. | This is a general observation about the benefits to patients (well recognised by the GDG) from contact with peers and other patients with the same condition – rather than being specific to PFO closure only. No specific amendments to this section. |
| 570 | | Royal College of Nursing | Nothing to add | Thank you for your comment. |
| 571 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | The paper discusses PFO being common in people and may be cause of stroke in those under 60. It implies they all should get an echo and then be considered for closure “Selected people below the age of 60 with ischaemic stroke or TIA of otherwise undetermined aetiology in association with a PFO and a right-to-left | Rec 5.10B relates to ‘selected people below the age of 60 with ischaemic stroke or TIA of otherwise undetermined aetiology…should be considered…’, including through discussion by the cardiology-stroke MDT. The GDG believes this represents an |

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| | | | shunt or an atrial septal aneurysm should be considered for PFO device closure within six months"<br><br>This could mean everyone under 60 with a stroke will need an echo. The additional demand on echo services should be modelled and how many additional physiologists will be required to provide those scans. BCS/BCIS feel that only stroke patients below 60 with a cardioembolic stroke and no other cause should be offered echocardiography and suggest that these patients/scans should be discussed by a cardiology stroke MDT assuming this is available.<br><br>Incidental findings may be an issue for cardiology if there is large scale echo imaging of the heart. Whilst some of these will be clinically significant in their own right, such as significant LVSD, other abnormalities will be detected of less clear cut significance (minor LV diastolic dilation, Left atrial dilation, minor valvular abnormalities.). These incidental findings will create resource demands on cardiology services and will be associated with some patient anxiety.<br><br>6158 "stroke services should establish regular multidisciplinary meetings cardiology to appropriately select patients for consideration of endovascular device closure" Such MDMs are not widely available as yet. Establishing them widely would have job planning/workforce impications. BCS/BCIS consider that establishing such MDMs widely would need regional collaboration as most stroke services will not be in hospitals that offer PFO closure and other more specialist cardiology procedure. There may need to be a model where local MDTs can refer to a regional one if more specialist advice is needed. | appropriate degree of investigation of young patients with cryptogenic stroke or TIA, irrespective of the resource implications but accepting that the participants in the RCTs will themselves have undergone a degree of selection, and indicates the need for clinical judgement to be used in selecting appropriate patients.<br><br>The GDG agrees that the appropriate use of resources such as PFO closure devices requires MDT collaboration, supported by appropriate resources as outlined in the Implications section. |
| 572 | | Welsh Association of Stroke Physicians | I think it is dangerous to suggest closure for patients who have had a TIA. Ideally closure would be reserved - as it was in the trials - for those with large artery infarcts involving cortex in whom all other causes have been excluded. | The GDG took the view that the inclusion of patients with both TIA and stroke of otherwise undetermined aetiology (i.e. all other causes have been excluded) was an appropriate interpretation of the available evidence. This is consistent with NICE in its interventional procedures guidance IPG472. |
| 573 | | National Imaging Academy Wales | Nil to add. | Thank for your comment. |
| 574 | | United Kingdom Clinical Pharmacy Association (UKCPA) | 5.1.4.2 HRT---- topical HRT reduced risk vs oral HRT<br>'Transdermal administration of estradiol is unlikely to increase the risk of venous thrombosis or stroke above that in non-users and is associated with a lower risk compared with oral administration of estradiol. The transdermal route should therefore be considered as the first choice route of estradiol administration in | Thank you for your comment. This section is outside the scope of the guideline update. |

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| | | | women with risk factors.' https://thebms.org.uk/publications/consensus-statements/bms-whcs-2020-recommendations-on-hormone-replacement-therapy-in-menopausal-women/ | |
| 575 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations appear to be appropriate for this section and we have nothing further to add. | Thank you for your comment. |
| 576 | Q52. Section 5.19 Cerebral amyloid angiopathy | Royal College of Nursing | Nothing to add | Thank you for your comment. |
| 577 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 578 | | British and Irish Association of Stroke Physicians (BIASP) | Should there be a distinction acknowledged within CAA of (microbleeds vs siderosis) as the risk of ICH is significantly different.<br><br>It is great that research gets a mention for many of the unresolved questions, a recommendation to only do something '….in the context of a trial', could be supported by details of how people can get their patients into that trial.<br>If there were an appendix with a list of contact details for those trials relevant to guideline recommendations that could really help trial recruitment. However we recognise the limitations in keeping this up to date.<br><br>We also noted that other sections of the guideline didn't refer to ongoing trials as often – suggesting some inconsistency. | These observed differences in natural history have not resulted in recommendations for a different therapeutic approach in clinical practice.<br><br>The GDG has decided to avoid specifying particular trials to avoid built-in obsolescence. Other prospectively-maintained international registries of RCTs are of course available.<br><br>The GDG considered at each point where a recommendation for trial participation was appropriate, but to an extent that depended on whether there was a realistic expectation that trial participation was a practical proposition for the patient. |
| 579 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 580 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations appear to be appropriate for this section and we have nothing further to add. | Thank you for your comment. |
| 581 | Q53. Section 5.20 CADASIL | Irish Institute of Clinical Neuroscience | Expert opinion is that triptans and alteplase are contra-indicated in CADASIL. | There is a range of opinion and expert consensus on the appropriate translation of treatments from other areas into CADASIL, and this is reflected in Rec 5.20B which itself is largely derived from European expert consensus (Mancuso et al, 2020). |

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| 582 | | Royal College of Nursing | Nothing to add | Thank you for your comment. |
| 583 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 584 | | British Psychological Society | CADISIL risks progressive cognitive decline and vascular dementia development and thus comes with specific psychological and neuropsychological support needs, post diagnosis and over the course of the disease (Chabirat et al., 2009); this should be woven into guidance. Disease diagnosis having the risk of a profound psychological impact that can disable the individual if adequate psychological support from an experienced psychologist (with relevant expertise) isn't made available<br><br>Bersano, A., Bedini, G., Oskam, J., Mariotti, C., Taroni, F., Baratta, S., & Parati, E. A. (2017). CADASIL: treatment and management options. Current Treatment Options in Neurology, 19(9), 1-15. | Recommendations in section 5.20 are limited to medical interventions for secondary stroke prevention. The wider issue of the long term management of CADASIL and its attendant disabilities is beyond the scope of this guideline, but is addressed by expert consensus elsewhere e.g. the EAN guidelines (Mancuso et al, 2020). Chabirat 2009 is outside the literature searching scope for this update. |
| 585 | | Royal College of Speech and Language Therapists | Overall, the RCSLT feels this is interesting. | Thank you for your comment. |
| 586 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 587 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations appear to be appropriate for this section and we have nothing further to add. | Thank you for your comment. |
| 588 | Q54. Section 5.21 Cerebral microbleeds | Royal College of Nursing | Nothing to add | Thank you for your comment. |
| 589 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 590 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 591 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Recommendations appear to be appropriate for this section and we have nothing further to add. | Thank you for your comment. |
| 592 | Q55. Section 5.23 Physical activity | Royal College of Nursing | Nothing to add | Thank you for your comment. |

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| 593 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 594 | | British Psychological Society | No comment | Thank you for your comment. |
| 595 | | The Irish Heart Foundation | The focus group emphasized the need for stroke exercise interventions to collaborate with other established rehabilitation services for cardiac conditions to increase accessibility across Ireland for stroke patients.<br>One participant stated 'I am envious that these gyms/exercise times were available to those who had heart attacks and wish there was an equivalent for stroke'.<br><br>They strongly agreed with the need for strong links between community groups as this is where they benefited most over longer periods of time with regards to ongoing participation in exercise programmes ( for example The Irish Heart Foundation community support services post-stroke exercise classes ).<br><br>Older participants of the focus group(over 65) felt that there should be other forms of exercise suggested for those who have a restriction with walking ( i.e. they find that cycling is a good alternative). | The GDG agree – reflected in Recs 5.23G and H.<br><br>Reflected in Recommendation E. Walking is recommended (See Evidence to Recommendations). |
| 596 | | NIMAST | A clearer definition of physical activity should be included, emphesising 'day to day' activity rather than solely focusing on the subset 'exercise'.<br>A second point to raise is that we currently don't know how to best promote physical activity in the non ambulant population.<br><br>Lastly, measurement of physical activity (using physical activity outcomes) should be embedded in physical activity programmes. (Claire McFeeters, Katy Pedlow, Niamh Kennedy, Heather Colquhoun & Suzanne McDonough (2022) A summary of the body of knowledge on physical activity for people following stroke: a scoping review, Physical Therapy Reviews, 27:5, 346-375, DOI: 10.1080/10833196.2022.2102748)<br><br>In terms of recommendations, it would be helpful to add that those regions without specific exercise referral schemes for stroke, should develop these. | Reflected in Recommendations 5.23A and B.<br><br>The measurement of physical activity is required to fully implement Recommendation 5.23C. Scoping reviews are excluded.<br><br>The recommendations in this section (and indeed the guideline as a whole) apply uniformly to all UK nations and regions and to Ireland, irrespective of the current level of resourcing. |
| 597 | | Brain Injury Matters (NI) | Recommendation C<br>The recommended 20 weeks program should only be viewed as an introduction | Agreed. Supporting the transition to ongoing activity is reflected in Rec 5.23G. |

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| | | | to physical activity, not as an end in itself, with a hope that people will continue to engage on a lifelong basis. There must be a clear route at the outset of such programmes for support and lifelong sustainable engagement in the community. There should be established links with arts organizations, sports / para-sports clubs or leisure establishments where there is a high degree of physical activity such as dance, cycling, swimming, yoga, Pilates, gym work or walking.<br><br>Recommendation G<br>Stroke rehabilitation services should have links with community-based exercise organisations, clubs and facilities (such as support groups, arts organizations, sports / para-sports clubs, gyms, leisure establishments or exercise referral schemes where there is a high degree of physical activity such as dance, cycling, swimming, yoga, Pilates, gym work or walking) such links should be designed to support people with stroke to transition into ongoing physical activity as part of, and during, any exercise programme. If people engage in a 20 week programme, following which they are then expected to 'transition' into something they will continue in the years to come, this is much less likely to happen.<br>The evidence is clear that a key to long-term engagement in physical activity, is social support and socialization which can be found in arts organisations / groups, sports, para-sports clubs. | |
| 598 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 599 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | There is a lot in this section about 'structured exercise' but very little about daily physical activity which is important for health and well-being post-stroke. The importance of selecting physical activity outcomes, goals and activities that are meaningful to enhance long-term behaviour change could be incorporated<br>It might be helpful to include this review about long-term physical activity<br>https://pubmed.ncbi.nlm.nih.gov/30333027/<br>or this older review<br>https://pubmed.ncbi.nlm.nih.gov/24389402/<br>and this work could be included as part of a consensus statement about how to support long-term PA:<br>https://pubmed.ncbi.nlm.nih.gov/36057723/<br><br>C& H : We query whether stroke will be an inclusion criterion for access to cardiac rehab programs.<br>We also query how are these facilities with specialist equipment going to funded, | Agreed. This is reflected in Recs 5.23A, B and C regarding individualised goals and preferences for people with stroke and TIA.<br><br>Stroke would not itself be a sole qualifier for cardiac rehab. Rather, Recommendation 5.23H states that such programmes should work together to improve access. |

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| | | | resourced, staffed and whether the staff will have the appropriate training for those patients who have had a stroke?<br><br>F : Whilst we welcome the inclusion of fitness instructors and "other appropriately trained people", we strongly recomment that the wording be changed from : "interagency working where possible" to something that recommends interagency working as a must-do.<br>We also would appreciate an understanding who will monitor the competency and quality of the professionals delivering physical fitness training outside the NHS.<br><br>For these recommendations, it would be useful to know how soon post-stroke can these recommendations be implemented. What should be monitored and how regularly should this occur? Is this an area that can be picked up in the 6-month and 12-month reviews and reported via SSNAP? | The consensus of the GDG was that, in the absence of definitive evidence, interagency working was desirable but could not be regarded as an evidence-based 'must do'.<br>Regulation of fitness practitioners inside and outside formal healthcare in the UK and Ireland is outside the scope of the guideline.<br><br>The GDG observes that the evidence does not allow a proscriptive recommendation regarding timing, other than to recommend that fitness training should be available regardless of time since stroke (Rec 5.23C). |
| 600 | | Royal College of Occupational Therapists - Specialist Section Neurological Practice | Note to ensure 'care home' being used as a catch up term across the guideline that we mean nursing and residential care home<br><br>A offered a holistic structured review<br><br>Add recommendation somewhere- community stroke services should make links to formally ensure adequate training and care provision regarding complex needs including positioning, seating, spasticity, dysphagia for people following stroke in care homes.<br><br>C- provided with information rather than guidance about | Noted.<br><br>The existing recommendations identify the need for treatments to be individualised (Recs 5.23A and E) |
| 601 | | Irish Heart Foundation, Council on Stroke | Physio<br>Ensure consistency in use of terms, aerobic / cardioresp etc<br>5.23 pg 146 line 6621 5.23 Physical activity: Comment: this section deals exclusively with exercise-based interventions and does not address lifestyle counselling and supports to improve physical activity participation during daily life including reducing sedentary behaviour and increasing overall activity. Exercise (planned, structured, repetitive, and purposefully focused on improvement or maintenance of one or more components of physical fitness) - as described -is only a subcategory of physical activity. Physical activity is any bodily movement produced by skeletal muscles that require energy expenditure. | Although not part of the 2023 update, Rec 5.23B covers the issue of general activity and reductions in time spent without moving. The changes to Rec 5.23C result directly from a review of the evidence specifically around fitness training. |

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| | | | Advocacy<br>line 6660 - The role of support groups and the importance of referring to them is mentioned a number of times in the document as listed above. There is no recognition, however, that the vast majority of stroke survivors in the Republic of Ireland don't have access to such services due mainly to the lack of availability of statutory funding for stroke support in the community.<br><br>All<br>Line 6655 - suggest change line to When delivered outside NHS or HSE services ..... to add in HSE. | This refers to a resource issue impeding implementation (something also covered in Chapter 6) rather than a Recommendation. No change to recommendations.<br><br>Acknowledged by the change of text to 'statutory health services' to encompass both the UK and Ireland. |
| 602 | | Royal College of Physicians of Ireland Clinical Advisory Group | L 6655 'when delivered outside the NHS…or HSE...' | Acknowledged by the change of text to 'statutory health services' to encompass both the UK and Ireland. |
| 603 | Q56. Section 5.27 Further rehabilitation | Different Strokes | As stated in lines 6862-6871, it is good to see recognition of support from community/voluntary organisations. Early referral is key though, so that individuals can start to receive support from such organisation as soon as possible. I don't agree with how recommendation C is phrased - this makes it sound that only at the point that further needs have been identified, or when it is decided that health or social care input is not required... should details of community/voluntary organisations be provided. Such organisations should be here to complement statutory services, not to act as a replacement for them. It is much more preferable for stroke survivors to be receiving support from stroke specific charities while they are still receiving statutory support... this way, when the statutory support ends they will already have the support of other organisations, and the end of the statutory support will feeling less like 'falling off a cliff' which is how many people describe this. Perhaps this recommendation could be rephrased to reflect this | The Recommendations in Section 5.27 do not confine assessment for further needs and support (from statutory or voluntary organisations) to 6 months and annually thereafter – Rec 5.27A recommends that it may be requested earlier. |
| 604 | | Royal College of Nursing | Nothing to add | Thank you for your comment. |
| 605 | | British Cardiovascular Society (including British Cardiovascular Intervention Society) | BCS/BCIS have no comment here | Thank you for your comment. |
| 606 | | British Psychological Society | This section would benefit from wording to reflect that a person's psychological support and rehabilitation needs can be expected to increase over time, in many cases, where psychological adjustment difficulties can be expected to develop and increase over time, as practical day to day difficulties, post-stroke, become | The GDG agrees that a simple linear trajectory of recovery cannot be assumed and is not the experience of many people with stroke. This edition is the first to explicitly recognise the need to intervene for new or existing health and social care needs (including access |

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| | | | more recognised. This understanding must inform rehab pathway design and access; including access to psychological support (and neuropsychological review where needed) | to psychological as well as physical/practical support) if there is a risk of subsequent deterioration (Rec 5.27B). |
| 607 | | British Society of Physical and Rehabilitation Medicine (BSPRM) | Patients with ongoing complex rehabilitation needs after six months should be referred to rehabilitation medicine consultants for assessment for further specialist neurorehabilitation to meet ongoing goals. | The GDG agrees that the often-complex and varying needs of people with stroke at 6 months or beyond are best met by a variety of statutory and voluntary services, including rehabilitation medicine. |
| 608 | | Royal College of Speech and Language Therapists | Page 150, line 6887 – The RCSLT agrees that a 6 monthly review is essential to ensure on-going progress is monitored and maximised or needs not missed.<br><br>Overall, the RCSLT believes this is helpful and needs to be planned for. | Agreed, no amendment necessary. |
| 609 | | The Stroke Association | Move to above 5.27 except for last two paragraphs<br>As we have not been provided with an opportunity to comment on the updates to Section 5.26 'Life after Stroke', we shall do so here. We are disappointed to note that lines 6812-6827 highlight the need for longer term life after stroke support, yet provide no recommendations for what this support should be, beyond a 6-month review, which is then repeated in section 5.27 'Further rehabilitation'. We would strongly suggest that there should be a more robust 'Life after stroke' section, with services and interventions that provide support in this space named in the recommendations.<br><br>A dedicated 'Life after stroke' section would facilitate clear guidance on these evidence-based services and interventions, many of which can be provided by the stroke key worker. As outlined in the upcoming Integrated Life After Stroke Service (ILASS) model, these services and interventions include those listed below, with the evidence base and/or quality indicator also provided:<br><br>• Personalised care and support planning.<br>o NHS England (2019) Delivering Universal Personalised Care https://www.england.nhs.uk/personalisedcare/upc/.<br>o National Clinical Guidelines for Stroke 2023, section 5.1 'A comprehensive and personalised approach', Recommendation A.<br>• Emotional support.<br>o All Stroke Key Workers/Coordinators are trained to provide level 1 psychological and emotional support.<br>o The Stroke Association's Lived Experience of Stroke report highlights the substantial and life-changing psychological and emotional impacts of stroke, and | The scope of the guideline update was established through a consultation exercise, through which the topic of further rehabilitation was supported by developments in the evidence since the 2016 edition, but it was not proposed or supported at the time to revise or expand the structure of these sections in the manner suggested. The GDG would reassure this reviewer that the recommendations that they refer to from Chapter 6 about the commissioning (or provision) of long term services (Section 6.5) are retained, although Chapter 6 is not open for peer review. Section 6.5 still includes much of what this reviewer seeks to see stated somewhere within the guideline.<br><br>The GDG does not agree with moving section 5.27 to another part of the guideline. Although there is no perfect location for this or any section relating to the management of a non-linear and complex condition, Chapter 5 remains the best place for it.<br><br>The Stroke Association's work in highlighting unmet need in the long term after stroke is invaluable, although the evidence base for effective interventions in the later stages of living with stroke is much less substantial – a thorough treatment of the evidence is already included in Section 5.27 Evidence to Recommendations, and recommendations regarding provision for people with stroke are made in Section 6.5. |

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| | | | underlines the currently unmet need for improved psychological and emotional support services.<br>• Personalised information provision.<br>o Forster et al (2012) Information provision for stroke patients and their caregivers https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001919.pub3/full<br>o The NICE Clinical Guidelines for Stroke Rehabilitation in Adults indicate that professionals should "working with the person with stroke and their family or carer, identify their information needs and how to deliver them, taking into account specific impairments such as aphasia and cognitive impairments".<br>• Carer support.<br>o National Clinical Guidelines for Stroke 2016, Recommendation 6.51.<br>o National Clinical Guidelines for Stroke 2016, Recommendation 2.16.1.<br>• Six month reviews.<br>o For over 20 years, since publication of the National Service Framework for Older People, it has been recommended that all stroke survivors are offered regular reviews of their support needs. This recommendation is based on clinical consensus, acknowledging that stroke survivors continue to have ongoing and changing support needs in the longer-term.<br>• Communication support.<br>o National Clinical Guidelines for Stroke 2016, Recommendation 4.4.1.1.<br>• Practical support, including advice on housing and employment.<br>o National Clinical Guidelines for Stroke 2016, Recommendation 6.5.1.<br>• Support to access suitable social and leisure activities outside their homes.<br>o National Clinical Guidelines for Stroke 2016, Recommendation 6.5.1.<br>• Support to receive the maintenance interventions (e.g. provision of exercise programmes and peer support) to enhance and maintain health and well-being.<br>o National Clinical Guidelines for Stroke 2016, Recommendation 6.5.1.<br>o A literature review published by NESTA and National Voices in 2015 found that "peer support can help people feel more knowledgeable, confident and happy, and less isolated and alone" (NESTA and National Voices (2015) Peer support: What is it and does it work? https://www.nationalvoices.org.uk/sites/default/files/public/publications/peer_support_-_what_is_it_and_does_it_work.pdf). A further literature review found that "peer support leads to significant improvements for people with long-term physical and mental health conditions across a range of health and wellbeing | |

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| | | | outcomes" (NESTA (2016) The Power of Peer Support https://media.nesta.org.uk/documents/cfsaif_power_of_peer_support.pdf).<br>• Secondary prevention.<br>o National Clinical Guidelines for Stroke 2016, Recommendation 5.1.1.<br>• Health and wellbeing support, including physical activity.<br>o National Clinical Guideline for Stroke 2016, Recommendation 5.8.1.1.<br><br>We note that the services and interventions listed above can often be provided by the third sector. Clear reference should be made to the potential for clinicians to utilise the third sector for post-acute stroke support, to avoid unnecessary duplication of service provision.<br><br>A dedicated 'Life after stroke' section would also ensure alignment between these guidelines and the following:<br>· The National Stroke Service Model (NSSM) in England, which has a 'Life after stroke' section and an impending Integrated Life after Stroke Service (ILASS) model.<br>· Northern Ireland Department of Health's Stroke Action Plan, which follows a 'Rehabilitation and long term support' format and 'has also developed a Long Term Service Specification.'<br>· The Welsh Government's Quality Statement on Stroke, which references the need for 'self-management, peer support and group consultations to life after stroke services' and will soon develop nationally agreed, optimised clinical pathway service specifications.<br>· The Scottish Government's Progressive Stroke Pathway, which details '11.2 Supported Self-Management and Longer-term support' as its own section.<br><br>Suggested edit: Develop a more robust and comprehensive 'Life after stroke' section, detailing the evidenced interventions that make up non-clinical life after stroke support from the acute stage onwards, as outlined above, in line with the NSSM and in recognition of the significant need for personalised support post-stroke. Reference the role of the third sector in providing these services. This should be based on the upcoming ILASS model, and the Stroke Association would be happy to support its development.<br><br>With regards to Section 5.27 'Further rehabilitation', we strongly suggest this section is moved to the 'Principles of rehabilitation' section for better continuity | |

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| | | | and ease of implementation. We again note with concern that these recommendations reference the long-term needs of people affected by stroke, yet limit recommendations to a 6-month review, contrary to the guidance within the NSSM and contrary to the services and interventions outlined in the upcoming ILASS model.<br><br>Suggested edit: Move Section 5.27 'Further rehabilitation' into 'Principles of rehabilitation' section, recognising the needs-based nature of rehabilitation and aligning with the Recommendation 4.1 A (2201-2) that 'people with stroke should be considered to have potential to benefit from rehabilitation at any point after their stroke.' | |
| 610 | | Scottish Intercollegiate Guidelines Network | I think it is worth emphasising how (very) high risk post ischaemic stroke patients are for cardiovascular outcomes, the so-called stroke heart syndrome. Hence the need to more stroke-cardiology MDT discussions on such patients to mitigate CV risks<br>PMID: 35354300<br><br>Also, the ESC has called for a structured integrated care approach to management of stroke and heart disease, which should be discussed<br>Integrated care for optimizing the management of stroke and associated heart disease: a position paper of the European Society of Cardiology Council on Stroke.<br>Lip GYH, Lane DA, Lenarczyk R, Boriani G, Doehner W, Benjamin LA, Fisher M, Lowe D, Sacco RL, Schnabel R, Watkins C, Ntaios G, Potpara T.Eur Heart J. 2022 Jul 7;43(26):2442-2460. doi: 10.1093/eurheartj/ehac245. PMID: 35552401 | The GDG agree and this is part of their rationale for setting a lower treatment target, for example, than the BP target recommendations contained in NICE NG136 and a lower target for lipid management – both supported by RCT evidence specific to stroke. However, these are generally-applied targets for secondary vascular prevention rather than requiring stroke-cardiology MDT discussions for every patient – these remain appropriate for selected patients. The treatment objectives outlined in the article to which the reviewer refers (although the article itself is outside the scope of the guideline search strategy) are already reflected in the various sections on antiplatelet treatment and risk factor management, and longer term rehabilitation – including co-ordination between cardiac and stroke rehabilitation (section 5.23).<br><br>Paper is out of scope of the research questions that were searched |
| 611 | | British and Irish Association of Stroke Physicians (BIASP) | No comment | |
| 612 | | The Irish Heart Foundation | From the focus group, many stroke survivors agreed that upon discharge they were left unequipped with the appropriate support as stated in lines 6829. It was noted that many patients were discharged straight home from the hospital and did not enter a rehabilitation facility and that this scenario should also be mentioned here to maintain inclusivity.<br><br>When support groups are mentioned, only organisations from the UK are | Agree – this is already stated in the introduction.<br><br>The role of statutory and voluntary services in the provision of |

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| | | | referenced. The Irish Heart Foundation is supporting about 15% of all stroke patients being discharged in Ireland and its name should be included. The Focus group commented that this would allow healthcare professionals to know what Community Services are available to refer their patients to upon returning home.<br><br>At several points, the document says that stroke services should liaise with community support groups. There is no mention of the need for the statutory health service to ensure that stroke support, including face-to-face, online and phone support is available as of right to all stroke survivors.<br>All stroke survivors should be informed of the community supports available to them e.g. The Irish Heart Foundations Stroke Connect Service and ongoing supports as part of their discharge planning so they can choose to avail of this support when they are discharged home from the hospital or rehabilitation setting. | support after stroke is covered in Chapter 6 (not open for review). |
| | | | Currently, the vast majority do not have access to community support services that can help them live as well as possible for as long as possible in their homes. The reason for this is that statutory funding is only provided to deliver community support to a few hundred people in Ireland – which by any estimate of the number of survivors is less than 1% of our stroke population.<br><br>The focus group agreed and complimented the recommendations suggested in this section and commented they were surprised these were only being added now as they heavily agreed that continuous support was necessary post-discharge. | The importance of the appropriate funding of the voluntary sector provision in life after stroke is covered in Chapter 6. |
| | | | An interesting comment from a survivor mentioned that upon discharge (6 weeks post-stroke) they were too overwhelmed and hadn't yet processed the severity of their stroke and the extent of shortcomings they had. It was only once they began to recover from the serious side effects that other less obvious but more frustrating symptoms became apparent.<br>It was at this stage they now required support and ongoing help to overcome them. This comment emphasizes the need for ongoing community support at an appropriate timescale to the individual. (Recommendation A-G) | Agree – a common experience that serves to emphasize the need for flexibility in post-stroke services that can adapt to when the person is ready to receive them. Already reflected in the Recommendations, including the ongoing role for a stroke co-ordinator (aka key worker) in Rec 5.27E. |
| | | | Furthermore, the guidelines do not emphasize enough the need for carers ( ie Next of kin, family, and friends) to receive guidance and support. The necessary | Agree - the needs of carers are specifically addressed in Section 2.16. |

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| | | | information required by carers for stroke survivors is lacking, no matter what level this role may have (i.e. physical care to emotional support). | |
| 613 | | Irish Association of Physical and Rehabilitation Medicine | There is a failure to address ethical dimensions especially resource justice – it cannot be left unsaid – there cannot currently be a situation where the approach is that rehabilitation continues with all the resource needed until goals are all addressed. This will mean people are years attending services | An alternative view would suggest that the predominant way in which people with stroke are affected by resource (in)justice at present is through missing out on the care and support that many people need for life lived with severe disability. Much of the needs of people with stroke, particularly over the longer term, are unmet and invisible to wider society. Although its impact is inevitably limited, this guideline seeks to redress resource (in)justice by clearly identifying a wide range of evidence-based interventions that should be available to all people with stroke – recommendations that are made without seeking to argue that people with stroke are any more deserving of limited resources than any other group. |
| 614 | | Welsh Association of Stroke Physicians | The need for patients to be considered for interventions months and years after the first event is welcomed but it is not clear whether this should be done in primary care or by longer term follow up in stroke services. | This is a familiar conundrum in relation to provision of longer-term follow-up, and one that evades the easy presumption that any one professional group has the capability to address all identified needs. The formula for this is for the GDG to describe the competency required (as in Rec 5.27A and D, and the Implications section), for local adaptation and implementation. |
| 615 | | National Imaging Academy Wales | Nil to add. | Thank you for your comment. |
| 616 | | United Kingdom Clinical Pharmacy Association (UKCPA) | stroke and frailty - polypharmacy review and deprescribing using person centre care | The importance of personalised/individualised care, including consideration of co-morbidities, in addressed in Section 1.2. |
| 617 | | Association of Chartered Physiotherapists in Neurology(ACPIN) | Whilst we welcome these recommendations, it should be noted that:<br>A: The 2022 Jan- March SSNAP data identify that for the majority of those eligible for 6-month reviews, 23.5% are done by "Other"; 20.7% by a Voluntary services employee. We are not sure what the content of those reviews are and would recommend as we have elsewhere in this document that many of these recommendations could be reviewed at these time points. Standardisation of the review contents would be welcomed.<br><br>Major limitations in current waiting lists and limited availability of services depending on area of the country. Considerations of how this could be achieved without adequate services and staffing would be welcomed. | Although complete standardisation of review contents is beyond the scope of this guideline, the GDG did identify appropriate domains that should be included (Recs 5.27A and B). |
| 618 | | Royal College of | We recommend adding text to state that patients should be able to re-refer | Agreed. Flexibility with the timing of review is reflected in Rec |

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| | | Occupational Therapists - Specialist Section Neurological Practice | themselves to the community rehabilitation team if their needs change at any time, and this should not be restricted to a 6 or 12-month review. | 5.27A. Self-referral to long-term support services is included in Section 6.5, Rec A. |
| 619 | | Irish Heart Foundation, Council on Stroke | Dietetics<br>COMMENT: Patients discharged with recognised long-term needs incl. dysphagia and enteral nutrition support need to have a clear pathway for transfer of care and regular review outlined prior to discharged. This is of particular relevance to the Irish setting where access to SLT and dietetics in the community is difficult. Consider inserting recommendation as per Irish National Stroke Programmes 2019 Recommendations for the Management of Nutrition and Hydration in Patients with Stroke – A Guidance Document<br><br>" - All patients' with stroke on enteral feeding should be able to access dietetic services independent of the location of their care (acute inpatient, inpatient rehabilitation or community based services).<br>-Referral pathways should be in-situ across all services to ensure seamless transferral of nutritional care from those on enteral tube feeding across services (acute, rehabilitation, community and care homes). "<br><br>SLT<br>— p.149 L6832 "unmet needs" should explicitly include 'communication' - this is clearly specified in the previous section 5.26 as being a higher risk factor for a greater number of unmet needs.<br><br>— p.150 L6877 - add "communication" and "information" to list of needs.<br><br>— p.152 L6975 remove "whilst limited" - same as in section 2.13 L722. [insert comment]<br><br>All<br>line 6865 e.g. Chest Heart and Stroke Scotland,,,,,, should this also include the Irish Heart Foundation and the British Heart Foundation Northern Ireland ?<br><br>Advocacy<br>The draft guidelines also don't take account of the broader spectrum of practical, social and emotional support services that are now available to, and are valued by, stroke survivors. Once the importance of the emotional support is recognised | These remarks are more suited to the 'Stroke Services' Chapter 6 which itemises the components of comprehensive long-term services for people with disabilities after stroke. Amendments made there instead.<br><br>The GDG felt that the present list of the three principal domains of physical and psychosocial health is sufficient for the purposes of these general recommendations, with the advantage of not being expanded to a very long list of potential impairments. Common unmet needs from the literature are cited in lines 6838-6843.<br><br>Agree – added (although it is examples rather than a comprehensive list of available organisations)<br><br>Agree, although these consensus recommendations represent a significant step in the right direction. Many of these life after stroke services are referenced in Chapter 6. |

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| | | | it should also be acknowledged that much more is needed for stroke survivors<br>It should also be understood that life after stroke support programmes have developed far beyond the traditional model of weekly or monthly face to face groups. Services now exist in partnership with stroke units to help manage the transition home, as well as supporting ESD teams and therapists providing rehabilitation in the community. The delivery of these services is in sharp contrast to the piecemeal approach to life after stroke support in these guidelines which will not be sufficient to address the sense of abandonment that many stroke survivors experience post discharge.<br>Admittedly, the evidence base for this new brand of services is low, due primarily to the lack of research carried out into the impact of life after stroke programmes. But service evaluation by the Irish Heart Foundation which is currently supporting about 15% of stroke patients in the Republic of Ireland on discharge from hospital demonstrates that a pathway extending throughout life after stroke is crucial to the physical and psychological wellbeing of many survivors.<br>This includes support to make the transition home; short programmes covering a wide range of areas such as cognitive skills, communication support, counselling and psychological support; peer to peer support; befriending services; physical activity programmes; online support; face to face groups; and ongoing information and access to nurse led support lines.<br>Inclusion of a coherent life after stroke services pathway in guidelines would significantly increase the prospect of the relatively small amounts of funding required for such services to be unlocked. The prima facie case for these services is strong based on satisfaction surveys and patients own estimation of impact. Robust independent evaluation should now be prioritised and a greater focus placed in subsequent guideline reviews on life after stroke services in order to capitalise fully on the extraordinary improvements that have been achieved in acute services over the last decade | |
| 620 | | Royal College of Physicians of Ireland Clinical Advisory Group | Line 6854: recommended by several key organisations… add The National Stroke Strategy (NSS) (Ireland). I think NSS section on stroke rehab and recovery, and the stroke key worker section fits - important to have it represented.<br>Line 6865 The Irish Heart Foundation The stroke connect service is a good example and again important to be represented.<br>Please add a link to Irish driving guidelines, the driving section was greyed out but this is the link ndls-sla-inte-tioma-int-2022.pdf (rsa.ie)<br>Section 4.35 holds no description of the Irish Mental capacity's current status. I | Thanks – now added.<br><br>Thanks – now added.<br><br>Thanks – now added. |

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| | | | have included this link gov.ie - Assisted Decision-Making (Capacity) Act 2015 (www.gov.ie) | Thanks – now added. |