Stroke and transient ischaemic attack in over 16: diagnosis and management (update)

Consultation on draft scope
Stakeholder comments table

27 September to 25 October 2017

Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association of Chartered Physiotherapists in Neurology	General	General	The current guideline was published in 2008. In the NICE 'CG68 Stroke Review Recommendation April 2012' there was awareness of the ongoing research relating to early mobilisation. NICE 'CG 68 –Stroke, Surveillance review decision, April 2014' identified ongoing trials including 'AVERT3'. Then in NICE 'Surveillance report 2017 – Stroke and transient ischaemic attack in over 16s' further commentary was provided on the AVERT Trial. In the section entitled 'Impact on guideline' it is stated "…Therefore, mobilisation guided by the patient's wishes or clinical condition may be a better strategy than enforcing a strict mobilisation protocol. Further analysis suggested that increased frequency of mobilisation may be beneficial, but increased duration of mobilisation may be harmful. There is no clear evidence that earlier time to first mobilisation is harmful. This finding is consistent with the recommendations in the guideline to help people to sit up and undertake mobilisation when their clinical condition permits." While the findings of the AVERT trial are consistent with the current guidelines "to help people to sit up and undertake mobilisation when their clinical condition permits" the guideline may benefit from revision due to the new knowledge gained from the AVERT trial as per the NICE commentary earlier in 2017. For example, 1) Should first getting out of bed be based 'only' on clinical condition, as per the current guideline?	Thank you. Following stakeholder input, we have decided to add questions on early mobilisation and positioning and review the evidence on this.

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			2) or, as in the NICE Surveillance report 2017, should "mobilisation guided by the patient's wishes" be included in an update? 3) Should strict mobilisation protocols be enforced or avoided? 4) Can guidance as to what suitable 'clinical condition or patient wishes' means, be more fully described, based on the protocols and observations undertaken by the AVERT trial? 5) Further guidance may be required relating to the effects of time to first mobilisation, its frequency and duration, especially when the 2017 surveillance reports that increased duration may be harmful, without being clear as to what this duration or harm is. In summary, it is felt that 1.7 Early mobilisation and optimum positioning of people with acute stroke, should be included in this update. A) Given the learning that can be gained from the AVERT trial in particular, its methods and its findings, questions can be answered, and those that remain unanswered identified. B) That clinicians with a knowledge of the AVERT trail, or other guidelines which refer to it, would rightly question why section 1.7 is not considered in this update. C) Neurological Physiotherapists would welcome clear and detailed guidelines, from the experts in the field, as they	

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			assess, treat and manage their patients delivering interventions to achieve the best clinical benefit for their patients, with the least risk of harm, based on the highest quality and most up-to-date evidence.	
Birmingham Community Healthcare Trust	5	19 (table on p7)	Evidence from AVERT (A Very Early Rehabilitation Trial) trial has been incorporated into RCP Guidelines for Stroke 2016 – NICE will not be in harmony with RCP Guidelines if evidence regarding very early mobilisation is not reviewed. This evidence should be reviewed.	Thank you. Following stakeholder input, we have decided to add a review question on early mobilisation to the scope of this update.
Birmingham Community Healthcare Trust	9	11	Need clarity on recommended pathways for stroke patient that have decompressive hemicraniectomy, as they often end up on neurosurgery pathway – they may need surgical pathway initially but then assurance that they will access stroke rehab or complex neuro and support where appropriate to needs.	Thank you for your comment. We will take that into account when making the recommendations.
Boehringer Ingelheim Limited	2	25	SSNAP latest report (https://www.strokeaudit.org/Documents/AnnualReport/2015-16-SSNAP-Annual-Report.aspx, Nov 2016) and infographic (https://www.strokeaudit.org/Documents/National/AcuteOrg/2016/2016-AOAInfographic.aspx, July 2016) show a cost to the NHS of £1.03 billion per year (in England, Wales, Northern Ireland). This would be more than 5% of a £8.9 billion cost reported in the draft scope.	Thank you for your comment. We have updated the total costs of stroke from NHS and social care perspectives according to the SSNAP data from 2015-2016.

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Boehringer Ingelheim Limited	3	15	Should this be 999 rather than/ in addition to 111	Thank you. We have added 999 to the list to make it clearer although we had considered 999 to be included under pre-hospital emergency care settings.
Boehringer Ingelheim Limited	4	22	Should this be 999 rather than/ in addition to 111	Thank you. We have added 999 to the list to make it clearer although we had considered 999 to be included under pre-hospital emergency care settings.
Boehringer Ingelheim Limited	**5** **6**	6-7 Row 8, Column 2 (over 80s)	Data on use of alteplase in the over-80s was published recently and is available in this citation (Ahmed N et al. Neurology 2017;89:1-8).	Thank you.
Boehringer Ingelheim Limited	**6** **8**	Row 8, Column 2 (thrombolysis and thrombectomy)	Published evidence points to the clinical benefit for patients eligible to receive thrombolysis followed by thrombectomy have better outcomes over thrombectomy alone (Park HK et al. Cerebrovasc Dis 2017;44:51-58). This is also bolstered by current clinical guidelines endorsed by NICE (Royal College of Physicians. National clinical guideline for stroke. 2016; Available from: https://www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines). Thrombolysis is a relatively low cost intervention. The cost of thrombolysis and thrombectomy together to improve patient outcomes is not much higher than the cost of thrombectomy alone for the appropriate patient.	Thank you for your comment. We have noted the evidence you provide and will be performing a systematic review on this topic.

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	9 3-5	11		
Boehringer Ingelheim Limited	**6** **7**	Row 9, Column 1 (Aspirin and anticoagulant treatment) 5	For patients with Atrial Fibrillation (AF), 'Interventions to Prevent Stroke' in CG180 (https://www.nice.org.uk/guidance/cg180) can be sign-posted here.	Thank you we have added this guideline to our list of related guidelines.
British Association of Stroke Physicians	General	General	In general BASP supports the update of the guideline in all of the areas suggested - review of thrombectomy, off label use of TPA in the over 80 yr olds, review of imaging in TIA, BP control in ICH and the role of surgery/hemi-craniectomy	Thank you for your comment.
British Association of Stroke Physicians	General	General	The draft scope does not include a review of the evidence behind early mobilisation in acute stroke and BASP would recommend this.	Thank you. Following stakeholder input and after careful consideration we have decided to add a review question on early mobilisation to the scope and review the evidence on this.
British Association	General	General	BASP feels that a review of the evidence behind early supported discharge is warranted - especially as this could/may occur within the 2 week period following stroke. Is	Thank you. Early supported discharge is covered in the stroke rehab guideline (CG162) and may be considered for update in its next update cycle. NICE pathways connect the

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of Stroke Physicians			there a role for combining the rehabilitation and acute NICE guidelines as clinically there are often blurred margins between the two areas?	guidelines and provide a way of linking recommendations together across the two guidelines.
British Association of Stroke Physicians	General	General	BASP feels that the timing and suitability of anticoagulation for atrial fibrillation post stroke remains an area of considerable uncertainty and a review of this evidence base may be warranted.	Thank you. This is covered within the atrial fibrillation guideline (CG180).
British Association of Stroke Physicians	5	3	BASP would recommend widening the scope of this evidence review to include clopidogrel and not just aspirin as antiplatelet therapy in TIA	Thank you. Clopidogrel is covered in NICE TA 210. The section updated here is on aspirin administration immediately after a TIA is suspected, before diagnosis, and the wording has been updated for clarity (when TIA first suspected). This is because new evidence was identified in the surveillance report which may lead to a change in recommendations.
British Association of Stroke Physicians	5	6	BASP requests NICE to consider the evidence for the role of TPA in patients with minor stroke	Thank you for your comment. The surveillance report noted that new evidence was unlikely to alter recommendations and therefore TPA has not been prioritised for update, although may be looked at in comparison with thrombectomy.
British Association of Stroke Physicians	5	8	Thrombectomy clearly confers benefit but one of the major challenges facing stroke medicine is redesign of services to provide timely and specific management of patients who require complex input. BASP feels that a review of the evidence behind which service design may provide the best outcomes could be considered.	Thank you for your comment. In this update we will focus on the clinical and cost effectiveness of thrombectomy, but we will take account of how recommendations may impact on practice when these are produced.

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British HIV Association (BHIVA)	General	General	BHIVA recommends that an HIV test should be carried out.	Thank you. The committee considered this and felt this was too specific for inclusion in the scope, but may be discussed when considering the evidence and if necessary cross referred to.
British Psychological Society	General		The Society believes that reference should be made to the younger population (16 - 25) as they fall into a watershed area between adult and paediatric services in terms of onward rehabilitation and transition planning is essential.	Thank you. We will consider your point when making recommendations. Rehabilitation is covered in CG162 and is linked with this guideline by NICE pathways.
British Psychological Society			**References** Addo, J., Ayis, S., Leon, J., Rudd, A. G., McKevitt, C., & Wolfe, C. D. (2012). Delay in presentation after an acute stroke in a multi-ethnic population in South London: the South London stroke register. *Journal of the American Heart Association*, ***1*(3)**, e001685. Bray, J. E., O'Connell, B., Gilligan, A., Livingston, P. M., & Bladin, C. (2010). Is FAST stroke smart? Do the content and language used in awareness campaigns describe the experience of stroke symptoms? *International Journal of Stroke*, ***5*(6)**, 440-446. Dombrowski, S. U., Ford, G. A., Morgenstern, L. B., White, M., Sniehotta, F. F., Mackintosh, J. E., Skolarus, L. E. (2015).	Thank you for this information. We will check these studies against the inclusion criteria for the relevant reviews in the update.

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			Differences Between US and UK Adults in Stroke Preparedness. *Stroke*, ***46*(11)**, 3220-3225. Dombrowski, S. U., Mackintosh, J. E., Sniehotta, F. F., Araujo-Soares, V., Rodgers, H., Thomson, R. G., ... & White, M. (2013). The impact of the UK 'Act FAST'stroke awareness campaign: content analysis of patients, witness and primary care clinicians' perceptions. *BMC Public Health*, ***13*(1)**, 915. Dombrowski, S. U., White, M., Mackintosh, J. E., Gellert, P., Araujo-Soares, V., Thomson, R. G., Sniehotta, F. F. (2015). The stroke 'Act FAST' campaign: Remembered but not understood? *International Journal of Stroke*, **10(3)**, 324-330. Flynn, D., Rae, V., Ford, G. A., Rodgers, H., Price, C., & Thomson, R. G. (2011). The Impact Of Phase One Of The Fast National Stroke Awareness Campaign: A Time Series Evaluation. *Cerebrovascular Diseases*, **31**, 77. Lincoln, N.B., Kneebone, I.I., Macniven, J.A.B., Morris, R.C. (2011) *Psychological management of stroke*, John Wiley & Sons, Inc., Milton, Queensland, *638 pp. ISBN 978-0-470-68427-6* Mellon, L., Hickey, A., Doyle, F., Dolan, E., & Williams, D. (2014). Can a media campaign change health service use in a	

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			population with stroke symptoms? Examination of the first Irish stroke awareness campaign. *Emerg Med J*, **31(7)**, 536-540.	
British Psychological Society	2	22	The Society believes that the draft scope would benefit from including evidence that survivors often fear Stroke recurrence, with many reporting anxiety, particularly when going home following discharge from hospital. (Lincoln, 2012).	Thank you. We have added Rehabilitation after critical illness in adults (CG83) to the list of related guidelines. This covers assessment symptoms that have developed during the critical care stay, such as, anxiety and depression. This will also be linked to for the NICE pathway.
British Psychological Society	2	26	The draft scope currently excludes statistics on common psychological difficulties following Stroke. For example, between 30-33% of people will experience depression at some point post-Stroke (BPS, 2010; Ayerbe, 2014). Furthermore, anxiety affects around 25% of people with Stroke & may only become evident after several months (Campbell-Burton et al, 2011). The incidence of post-traumatic stress post-stroke appears to be between 5% and 30% (Bruggimann et al, 2006; Sampson et al, 2003; Sembi et al, 1998). Significantly, nearly 75% of people with emotional difficulties felt their needs had not been fully met (McKevitt et al, 2011).	Thank you. We have added Rehabilitation after critical illness in adults (CG83) to the list of related guidelines. This covers assessment symptoms that have developed during the critical care stay, such as, anxiety and depression. This will also be linked to in the NICE pathway.
British Psychological Society	3	4	The Society believes that the NHS Improvement for Stroke (2011) recommendations that psychological care following stroke should be a whole multi-disciplinary team approach should be included within the scope. Furthermore, the Royal	Thank you. We have added Rehabilitation after critical illness in adults (CG83) to the list of related guidelines. This covers assessment before their discharge from critical care to

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			College of Physicians (2016) guidelines state that services for people with Stroke should offer psychological support to all patients regardless of whether they exhibit specific mental health or cognitive difficulties.	determine their risk of developing physical and non-physical morbidity. This will also be linked to for the NICE pathway. NICE pathways will also link the guideline to Stroke Rehabilitation Guideline (CG162) that details recommendations on emotional and psychological needs after stroke.
British Psychological Society	3	6	The Society has concerns that the draft scope states that it is for "People using services, their families and carers and the public". However, there is little evidence that people are taken into consideration. The current focus is solely on health care professionals in various health care settings. Little content of this draft is relevant to individuals, family members or the general public. The guideline considers Stroke patients as passive recipients of treatment decided by health care professionals and no relevant information for family, friends, carers and the general public is included. The phase of pre-hospital delay, the primary reason for suboptimal treatment rates in Stroke, from the perspectives of individuals and witnesses suspecting Stroke/Transient Ischaemic Attack (TIA) is not covered. This was also not included in the original guideline and The Society believes that this needs to be addressed.	Thank you. Although included areas are clinical, they have the potential to impact significantly on the care of people in the NHS and are therefore relevant to them. We will have lay members on the committee to ensure that the patient and carer perspective is considered and that recommendations are inclusive. NICE words its recommendations in a way that encourages informed decision-making and patient centred care.

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			If pre-hospital delay is not addressed then please ensure that it is clear that this guideline is not relevant for Stroke patients, their family, carers and the public. Moreover, it would be important to ensure that the tone of the guideline stresses the need to involve patients, families and carers in the decision making process as much as possible and medically advised.	
British Psychological Society	4	8	The Society has concerns that draft scope states that one of the relevant settings includes 'pre-hospital emergency care settings'. However, little evidence exists that this will be examined from the perspective of people using services, their families and carers and the public. Raising Stroke awareness of the need to immediately engage with emergency services upon the suspicion of Stroke has been attempted through the Act FAST campaign (http://www.nhs.uk/actfast/Pages/stroke.aspx#ksiPqSZ1rvcuXj72.97), which has been disseminated in several waves since 2009 and has recently been modernised in terms of looks, although little of the content has changed. The campaign is based on Face Arm Speech Test (FAST) which the previous guidelines recommends to screen for stroke/TIA outside the hospital. Based on FAST the Act FAST campaign (Face Arm Speech Time to call 999) has been developed for the general public.	Thank you for your comment. Pre-hospital emergency care has been included as a setting and any relevant evidence will be included as well as discussed by the committee. The section on assessment tools/checklists was not prioritised for update as detailed in the surveillance review as new evidence is unlikely to change the recommendations. Public health campaigns such as raising awareness of stroke symptoms are outside the scope of this guideline.

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			There are at least two reasons for reviewing the evidence around FAST to ensure that the campaign is fit for purpose, including a suboptimal evidence base for the effectiveness of the campaign, and an evolving and changing pre-hospital care context. 1. Evidence on Act FAST effectiveness: Little systematic evaluation of the FAST campaign has been undertaken to date. Despite some positive indication of effectiveness (Flynn et al., 2014) other studies suggest suboptimal effects of the campaign (Addo et al., 2012; Mellon et al., 2014). Moreover, limitations of the use of the FAST acronym for passive use in a general population public health campaign have been noted (Bray et al 2010), including studies examining stroke patients/witnesses experiences (Dombrowski et al., 2013), as well as using experimental methods (Dombrowski et al., 2015). Furthermore, cross cultural evidence has shown that when compared to settings where no national stroke awareness raising campaign such as Act FAST exists, recognition and response to stroke symptoms is worse in UK individuals. (Dombrowski et al., 2015). 2. Changing pre-hospital care context: Given the financial pressures on the NHS health care system, especially in	

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			emergency care, and the introductions of campaigns such as Choose Well and non-emergency numbers such as NHS111, it would be important to examine how emergency campaigns promoting engagement with emergency services are perceived within this context.	
British Psychological Society	9	22-24	The Society believes that neuropsychological disability or psychological reaction to TIA or Stroke need to be included within the scope. Since we know that these domains may be significantly impacted by TIA and Stroke, it would be helpful if the section on degree of disability or dependence to include neuropsychological disability (i.e. cognitive impairment) following stroke and also within Quality of Life, once medical stability has been achieved to consider domains of psychological adjustment as related to both TIA and Stroke.	Thank you for your comment. These are the main outcomes (high priority outcomes, but not necessarily the only outcomes considered) and the committee will determine the most appropriate outcomes, which may include additional measurements, when developing protocols for each review and take this into consideration.
Intercollegiate Stroke Working Party	General	General	The draft scope currently covers updates on five areas of the guideline and excludes updates on many of the areas originally covered in the 2008 update. In 2008, it was agreed between NICE and the ICSWP that the ICSWP would provide recommendations on all areas not included within the CG68 update, and that the ICSWP would, in turn, not consider any questions that NICE was considering. We therefore recommend NICE continue the precedent set in 2008 and signpost users to the 2016 RCP National Clinical Guideline for	Thank you. Areas not prioritised for update were selected based on the NICE surveillance report. This details where evidence is absent or where new evidence is unlikely to change existing recommendations.

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			Stroke, which has been NICE accredited and contains updated, evidence-based recommendations on areas not included or not being updated in the CG68 update.	
Intercollegiate Stroke Working Party	General	General	Since the last update, there has been powerful new evidence related to areas outside of the current draft scope (including early rehabilitation after stroke, dysphagia, and long-term support). We are disappointed that the draft scope does not include plans to include this evidence given the many advancements that have been made in post-stroke support and long term care.	Thank you. Areas prioritised for update were selected based on the NICE surveillance report. This details where evidence is absent or where new evidence is unlikely to change recommendations. After stakeholder input, we have added new review questions on early mobilisation and positioning. Updates to the stroke rehabilitation guideline will be considered during its next review cycle.
Intercollegiate Stroke Working Party	7	Table	Given the implications of the AVERT "A Very Early Rehabilitation Trial after stroke (AVERT): a Phase III, multicentre, randomised controlled trial", along with the recently published HTA report https://www.journalslibrary.nihr.ac.uk/hta/hta21540/#/abstract, we strongly recommend that the evidence about early mobilisation and positioning be reviewed, as this has important implications for acute stroke care.	Thank you. Following stakeholder input, we will add review questions on early mobilisation and positioning to the scope of this update.
Mid Essex Hospital NHS Trust, Chelmsford	5	3	Aspirin is the drug of choice for TIA – clopidogrel use only if Aspirin intolerant	Thank you for your comment. The use of clopidrogel is covered NICE technology appraisals guidance TA 210. We are looking at use of aspirin pre-diagnosis of TIA only.

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Mid Essex Hospital NHS Trust, Chelmsford	5	4	All TIAs should be investigated with MRI same day Carotid Doppler/Echo and heart monitor the same day. Posterior circulatory syndromes and embolic pattern of strokes in Magnetic resonance imaging involving solitary vascular territory should have a Computerised tomography Angiogram or Magnetic Resonance angiogram the same day	Thank you for your comment.
Mid Essex Hospital NHS Trust, Chelmsford	5	6	Intravenous thrombolysis should be continued in people over the age of 80 –off label – adequate experience available now for safety and efficacy	Thank you for your comment. This will be reviewed in this update.
Mid Essex Hospital NHS Trust, Chelmsford	5	2	Risk stratification should no longer be done – all TIAs should be seen in 24 hours and	Thank you for your comment. The update includes a review of risk stratification.
Mid Essex Hospital NHS Trust, Chelmsford	5	8	Mechanical thrombectomy should be offered 24/7 in Neurosciences centres only and should be commissioned/funded urgently. The referral should be simplified by use of Computerised tomography and Computerised Tomographic Angiogram alone. Specifically, use of Computerised Tomographic perfusion should not be encouraged as yet	Thank you for your comment. We will review evidence on thrombectomy in this update.
Mid Essex Hospital NHS Trust, Chelmsford	5	9	Should be offered for thrombi distal to the proximal large vessel when systemic thrombolysis is not feasible	Thank you for your comment. This has not been prioritised for update.

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Mid Essex Hospital NHS Trust, Chelmsford	5	10	Blood pressure should be controlled if patient with Intracerebral hemorrhage presents within 6 hours and BP is to be controlled to 140/90 within 1 hour of arrival for 24 hours	Thank you for your comment. This will be reviewed in this update.
Mid Essex Hospital NHS Trust, Chelmsford	5	11	Age cut off should be relaxed for decompressive hemicraniectomy. For suboccipital craniectomy, there should be no age limit and decision should be individualised and for hemicraniectomy the age cut off should be decided on a case by case basis	Thank you for your comment. This will be reviewed in this update.
National Stroke Nursing Forum	General	General	Surgery for people with acute stroke – criteria on monitoring / management of patients while waiting referral to tertiary centres for surgery in order than adequate services to monitor patients are commissioned. Especially in light of mechanical thrombectomy. Recommendation 1.9.2.2 – to ensure services commissioned appropriately, stipulate level 1 / level 2 nursing	Thank you. Monitoring and management while waiting for surgery is covered in the surgery for acute stroke chapter, but will not be updated (no new evidence was identified in the NICE surveillance report that would affect the recommendations). The committee will review evidence on the use of mechanical thrombectomy and may make recommendations on this topic if it is appropriate to do so.
National Stroke Nursing Forum	General	General	Review of use of GCS indicators in the guidance. GCS is not a sensitive measure for deterioration in acute stroke. Would recommend NIHSS as used for recommendation 1.9.2	Thank you for your comment. GCS wasn't identified as a topic for review in the surveillance report and therefore hasn't been prioritised for update. In terms of using GCS as an outcome measure in the reviews, we will determine the most appropriate outcomes when developing protocols and take this into consideration.

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National Stroke Nursing Forum	Page 6	general	Specialist care in acute stroke- Given there is new evidence on nurse staffing levels, would recommend a review of guidance on nursing staffing levels. It is suggested in parts of the guidance, but it would be useful to clarify this.	Thank you for your comment. We are not reviewing staffing levels but will consider the current levels and the impact on implementation when making our recommendations.
National Stroke Nursing Forum	Page 6	General	Suggest early mobilisation will not be reviewed, however there is new evidence from Headpost and AVERT, RCP 2016 guidelines have included it in their recommendations and it is very important to ensure that NICE is consistent with RCP guidance	Thank you. Following stakeholder comments, early mobilisation and positioning is now included in the scope.
National Stroke Nursing Forum	Page 6	General	Avoidance of aspiration pneumonia – increased guidance on positioning, oral care	Thank you. The surveillance report did not find new evidence that indicated a change might be needed for recommendations in this area. The stroke rehab guideline (CG 162) makes recommendations on oral care to prevent aspiration pneumonia. This will be cross referred to and linked to the NICE pathway. Following stakeholder input we have added a review question on positioning to the scope of this update.
Pfizer	General	n/a	We note that no evidence review is planned for pharmacological treatments. Although we would agree that the available agents do not need review, there is emerging data around the time at which different pharmacological therapies	Thank you. The surveillance report noted that new evidence was unlikely to alter recommendations and therefore the pharmacological management section has not been prioritised for update.

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			may be initiated, specifically with respect to anticoagulation therapy in patients with stroke secondary to cardiac emboli caused by atrial fibrillation. There is a trend to initiate anticoagulation at less than 14 days after the TIA or stroke in patients classified as being low risk of haemorrhagic transformation. We believe this is an important update that warrants a review of the evidence.	
Pfizer	General	n/a	The current guideline scope has no mention of screening patients for atrial fibrillation, one of the most common causes of ischaemic stroke. The identification of the presence or absence of atrial fibrillation is essential to determining the appropriate pharmacological therapy for secondary prevention of further ischaemic events. We believe that this also warrants evidence review within this guideline scope.	Thank you. The atrial fibrillation guideline (CG180) covers assessment and diagnosis in those presenting with stroke or TIA. This will be linked in the NICE pathway.
Royal College of general Practitioners			What should primary care do with sudden onset vertigo which might be the only sign os a posterior territory circulation stroke. The signs to differentiate central from peripheral vertigo (dolls eye movements etc) are not realistically reliable or practices to be of use. There is no 'exclusion' such as unless other conditions make referral inappropriate. As a result, currently people at the end of their lives with end stage cancer and dementia in bed in nursing homes are being sent via 999 to Hospital.	Thank you for your comment. This topic is reviewed in the Suspected Neurological conditions guideline currently in development, due to published in January 2018.

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Royal College of general Practitioners			Inclusion of the new areas iidentified in the Royal College of Physician (RCP)National clinical guideline for stroke Fifth Edition 2016 www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx 1. Mechanical thrombectomy for acute ischaemic stroke (Sec on 3.5) 2. Urgent brain imaging within 1 hour of hospital arrival for suspected acute stroke (Sec on 3.4) 3. Acute blood pressure management in intracerebral haemorrhage (Sec on 3.6) 4. Urgent management of suspected minor stroke and TIA irrespective of risk stratification (Sec on 3.2) 5. Incorporation of clinical psychology/clinical neuropsychology, dietetics and orthoptics expertise into the multi-disciplinary stroke rehabilita on team (Sec on 2.4) 6. Changes in the practice of early mobilisationon after acute stroke (Sec on 3.12) 7. Pragmatic management of swallowing difficulties in end-of-life stroke care (Sec on 2.15)	Thank you for your comment. The surveillance report has guided our decision on what to prioritise for update. Following stakeholder input, we have decided to add review questions on early mobilisation and positioning to the scope of the update. NICE guideline NG31 covers the care of the dying adults in the last days of life and includes recommendations on swallowing problems, oral care and hydration. Areas related to rehabilitation are covered in NICE guideline CG162 and any new evidence will be considered in the update cycle of that guideline.

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			8. Mechanically-assisted methods for gait training in people unable to walk after stroke (Sec on 4.9.4) 9. Lower blood pressure targets for secondary stroke preven on compared with previous NICE guidelines (Sec on 5.4).	
Royal College of general Practitioners			Can the NICE guideline committee nclude a section on prehospital care of strokes and review the evidence in Australian Stroke foundation draft guidelines http://www.opalinstitute.org/uploads/1/5/3/9/15399992/draft_clinical_guidelines_for_stroke_management_2017__summary_of_recommendations_public_consultation__1_.pdf Pre-hospital care Strong Recommendation All stroke patients should be managed as a time critical emergency. The dispatch of ambulances to suspected stroke patients who may be eligible for reperfusion therapies requires the highest level of priority. Furthermore, the highest level of priority should also be provided when transporting suspected stroke patients to hospitals capable of offering reperfusion therapies within appropriate timeframes. (Berglund et al 2012 [5])	Thank you for your comment. We have noted the evidence you have provided. We are planning to cover the pre-hospital setting and will discuss service delivery when making our recommendations.

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			Strong Recommendation a. Ambulance services should preferentially transfer suspected stroke patients to a hospital capable of delivering reperfusion therapies as well as stroke unit care. (O'Brien et al 2012 [13]; De Luca et al 2009 [11]; Quain 2008 [12]) b. Ambulance services should pre-notify the hospital of a suspected stroke case where the patient may be eligible for reperfusion therapies. (O'Brien et al 2012 [13]; De Luca et al 2009 [11]; Quain 2008 [12]) General practitioners are encouraged to educate reception staff in the FAST stroke recognition message and to redirect any calls about suspected acute stroke to 999 (000 in Australia) .	
Royal College of general Practitioners			Can the NICE guideline committee include a section on prehospital care of transient ischaemic attacks and review the evidence in Australian Stroke foundation draft guidelines http://www.opalinstitute.org/uploads/1/5/3/9/15399992/draft_clinical_guidelines_for_stroke_management_2017__summary_of_recommendations_public_consultation__1_.pdf Transient ischaemic attack Strong Recommendation • All patients with suspected transient ischaemic attack (TIA i.e. focal neurological symptoms due to focal ischaemia that have	Thank you for your comment. We have noted the evidence you have provided. We are planning to cover the pre-hospital setting and will discuss service delivery when making our recommendations.

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			fully resolved) should be assessed urgently. (Lavallee et al 2007 [19]; Rothwell et al 2007 [20]) • Patients with symptoms that are present or fluctuating at time of initial assessment should be treated as having stroke and be immediately referred for emergency department and stroke specialist assessment, investigation and reperfusion therapy where appropriate. (Lavallee et al 2007 [19]; Rothwell et al 2007 [20]) • In pre-hospital settings, high risk indicators (e.g. crescendo TIA, current or suspected AF, current use of anticoagulants, carotid stenosis or high ABCD2 score) can be used to identify patients for immediate specialist assessment. (Lavallee et al 2007 [19]; Rothwell et al 2007 [20]) Strong Recommendation When TIA patients present to primary care, the use of TIA electronic decision support, when available, is recommended to improve diagnostic and triage decisions. (Ranta et al 2015 [9]) In TIA patients, use of the ABCD2 risk score in isolation to determine the urgency of investigation may delay recognition of atrial fibrillation and symptomatic carotid stenosis in some patients and should be avoided. (Wardlaw et al 2015 [2]; Sanders et al 2012 [3]; Galvin et al 2011 [4]; Merwick et al 2010 [18])	

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Royal College of Nursing	General	General	The Royal College of Nursing welcomes proposals to update the guideline for the diagnosis and initial management of stroke and transient ischaemic attack in over 16s. The RCN invited members who care for people with stroke and heart conditions to review and comment on the draft scope on its behalf. The comments below reflect the views of our members.	Thank you for your comments.
Royal College of Nursing	General	General	There is new evidence from the Stroke Oxygen Study (SOS) in patients with stroke which would be helpful to be included in the updated guideline.	Thank you. This study was identified in the surveillance report, which stated that "Studies show no clear evidence that routine oxygen supplementation has beneficial effects in acute stroke. This finding supports the recommendation not to use supplemental oxygen routinely in the absence of hypoxia."
Royal College of Nursing	General	General	The evidence regarding the nursing staffing ratios should be considered and included, to enable effective implementation.	Thank you for your comment. NICE no longer makes recommendations around specific nursing staffing ratios in its guidance.
Royal College of Nursing	General	General	Statin treatment and the use of Atorvastatin is now recommended in the RCP stroke guidelines as result of the Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) trial. Suggest this information should be considered for inclusion in the update of the NICE stroke guideline.	Thank you for your comment. NICE guideline CG181 included the SPARCL trial and makes recommendations for use of lipid modification for secondary prevention. We will add a reference and link to that guideline. The wording of recommendations around use of statins in acute stroke will be reviewed.

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Royal College of Nursing	General	General	Reversal of anticoagulation should include new approved reversal for Dabigatran. Suggest this information should be considered for inclusion in the update of the NICE stroke guideline.	Thank you. This is a developing area, with little published evidence. As such it was agree that this should be looked at within the next update cycle of the guideline and not within this update. Your comment will be flagged to NICE's surveillance team.
Royal College of Nursing	2	13	Suggest add other symptoms of a stroke that relate to the posterior circulation of the brain.	Thank you. While your point is valid, this change has not been made as this section is a brief introduction: we will look to include more detail in the appropriate evidence review in this update.
Royal College of Nursing	2	24	Estimated cost of treatment, ongoing social care and loss of productivity is about £1.03 billion per year to the NHS (SSNAP).	Thank you. We have updated the total annual cost to the NHS to £1.03 billion per year, as per the SSNAP data.
Royal College of Nursing	2	14 to 16	Suggest double check the stated figures with latest Sentinel Stroke National Audit Programme (SSNAP) data.	Thank you. This has been checked and amended.
Royal College of Nursing	2	19 and 20	According to the latest SSNAP data, this figure is about 6%.	Thank you. This has been checked and amended to give mortality at 30 days.
Royal College of Nursing	2	25 and 26	Treatment cost also is about 9% of the total cost according to the recent SSNAP data.	Thank you for your comment. We have updated the total costs of stroke from NHS and social care perspectives according to the SSNAP data from 2015-2016.
Royal College of Nursing	3	4	Thrombectomy has been commissioned by NHS England, as a result, it should be no longer be referred to as treatment that is "increasingly being used".	Thank you. This phrase has been deleted.

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Royal College of Nursing	5	3	Suggest add Antiplatelet therapy after suspected TIA	Thank you. Clopidogrel is covered in NICE TA 210. The section updated here is on aspirin administration immediately after a TIA is suspected, before diagnosis, and the wording has been updated for clarity (when TIA first suspected). This is because new evidence was identified in the surveillance report which may lead to a change in recommendations.
Royal College of Nursing	8	23	Royal College of Physicians (RCP) Stroke Guidelines recommend that ABCD2 scores should no longer be used but rather that the clinical history of the patient should be taken into consideration when triaging a referral. However, the provision of a 7 day service for TIA clinic could potentially increase pressure on services due to the inability to perform vascular imaging (carotid Doppler) during the weekend. If this provision is to be appraised, we suggest that the updated guideline needs to look at the cost effectiveness of this service.	Thank you for your comment. We will consider this if conducting health economics modelling in this area.
Royal College of Nursing	8	26	As per RCP stroke guidelines, in patients with suspected TIA, aspirin 300mg should be given by healthcare professionals and on diagnosis start Clopidogrel 75mg immediately	Thank you. This is covered in NICE technology appraisals guidance TA 210. The section updated here is on aspirin administration only and the wording has been updated for clarity this (when TIA first suspected).
Royal College of Nursing	8	28	Our reviewer queried the appropriateness of this question. From a service provision point of view, it would be challenging for centres/hospitals to routinely provide all patients with TIA easy access to MRI slots if required. Not all hospitals will have easy access to MRI slots for patients. The radiology	Thanks you for your comment. We will take into account the availability of equipment when interpreting the evidence and making recommendations.

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			service may only provide the MRI service for inpatients and outpatients which time is booked.	
Royal College of Occupational Therapists		General	**Inconsistency in messages**. The RCP guidelines have included significant new rehabilitation evidence, published after the guideline was written, e.g. the AVERT trial being one of the largest rehab trails completed. If NICE do not change their current guideline, it will be at odds with the RCP guideline and will be highly confusing for clinicians. Other results- such as HEADPOST need attention. Are we going to sit people up or not? So positioning is an issue for Occupational Therapists, Physiotherapists as well as nurses.	Thank you. After stakeholder input, we have decided to add review questions on early mobilisation and positioning.
Royal College of Occupational Therapists		General	**Hyper acute management of stroke patients is not restricted to medical management** and there is evidence regarding early input from stroke skilled nursing and therapy which influence outcomes and assist in giving important direction to the MDT (for instance best way to approach patient and give information according to their cognitive, visual and communication abilities from day one).	Thank you. Following stakeholder input, we have added review questions on early mobilisation and positioning. We also note that the stroke rehab guideline (CG 162) includes sections on MDT and patient information. These guidelines are linked to in the NICE pathway.
Royal College of Occupational Therapists		General	**Questions should be included on acute therapy assessment and intervention** following stroke: • The contribution of MDT working in hyper acute stroke care • Role of stroke specialist nursing in hyper acute stroke care	Thank you. Following stakeholder input, we have added review questions on early mobilisation and positioning. We also note that the stroke rehabilitation guideline (CG 162) includes sections on MDT and patient information. This information is linked in the NICE pathway.

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			• Best ways to support patients, families and give information in hyper acute stroke care.	
Royal College of Paediatrics and Child Health			Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Stroke and transient ischaemic attack consultation. We have not received any responses for this consultation.	Thank you.
Royal College of Pathologists / British Society for Haematology	4	4	The term 'completed stroke' should be clearly defined. There is a short window during which intervention is helpful and delaying intervention while waiting to see if a stroke is 'completed' is not necessary	Thank you. The guideline will have a glossary and definitions section and this will be considered for inclusion.
Royal College of Pathologists / British Society for Haematology	5	General	NICE should consider adding a section on investigations aimed at identifying an underlying cause of the stroke. Some physicians request thrombophilia screens, particularly in young patients, but there is no evidence that the thrombophilic defects tested for in a standard screen are associated with stroke with the exception of antiphospholipid antibodies. Standard thrombophilia screens, even in young patients, are not indicated. There are some situations where testing for a specific abnormality might be useful e.g. a Jewish patient with a positive family history indicative of an X-linked disorder could be screened for Fabry's. However, reducing the requesting of unnecessary thrombophilia screens will lead to cost savings.	Thank you for your comment. We are not covering the cause of stroke as this is not a priority for the update. This guideline is focussed on the acute management of stroke.

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Royal College of Pathologists / British Society for Haematology	5	1	A TIA may arise from different causes eg: carotid plaque or cardioembolism. Because the treatment for these aetiologies is different, the guideline should give greater emphasis to early diagnosis. For example, if a patient has crescendo TIAs and the aetiology is AF, then there may be a case for rapid anticoagulation. But not if it is coming from a plaque.	Thank you for your comment. We are not covering the cause of stroke as this guideline is focussed on the acute management of stroke.
Royal College of Pathologists / British Society for Haematology	5	5	There may be uncertainty about the risk-benefit ratio of heparin (or other immediate anticoagulation) for some stroke patients, that maybe dependant on MRI appearance	Thank you for your comment. The surveillance report noted that new evidence was unlikely to alter recommendations and therefore heparin has not been prioritised for update, although it may be looked at in comparison with thrombectomy.
Royal College of Pathologists / British Society for Haematology	6	Pharmacological treatments	CG68 recommends that: *People with antiphospholipid syndrome who have an acute ischaemic stroke should be managed in the same way as people with acute ischaemic stroke without antiphospholipid syndrome.* It should be made clear that the subgroup of patients with antiphospholipid syndrome are at a particularly high risk of further arterial or venous thrombosis. This is a strong indication for lifelong anticoagulation.	Thank you for your comment. The guideline does not cover the ongoing management of people with antiphospholipid syndrome or other causes of stroke.
Royal College of Speech and			The guideline update consultation relates to diagnosis and immediate treatment for stroke/TIA and does not update issues related to rehabilitation (including dysphasia and dysphagia) or	Thank you. Stroke rehabilitation is covered in a separate NICE guideline (CG162). We have added new review

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Language Therapists			long-term management. The Royal College of Speech and Language Therapists strongly recommend that early intensive rehabilitation and therapy is updated as part of this guideline. The RCP have recently updated all of these areas reflecting the new evidence provided in RCTs and other studies with robust appropriate methodologies. There could be a difference between the RCP Stroke clinical guidelines and the NICE acute stroke guideline, which can cause confusion to clinicians, therapists and commissioners.	questions on early mobilisation and positioning after stakeholder input.
Royal College of Speech and Language Therapists			If these are published by NICE as up-to-date guidelines on stroke then individuals will not realise that there is new evidence in these areas that could influence commissioning of services.	Thank you. The surveillance report highlights new evidence and we will update areas for this partial update, as indicated in the scope, that may change recommendations. Changes to the original guideline will be highlighted when this guideline is published. It is expected that areas identified in the surveillance report that were unlikely to lead to a change in recommendations are also unlikely to change the way that services are commissioned.
Royal College of Speech and Language Therapists			The Royal College of Speech and Language Therapists (RCSLT) is disappointed that a speech and language therapist has not been invited to join the stroke guideline update committee, considering the importance of early screening and assessment for dysphagia, safe swallowing, early hydration and nutrition, and the new evidence of increased mortality associated with aspiration pneumonia with delays in detection of dysphagia.	Thank you. As this is a partial update of stroke (CG68), only those specialties relating to the clinical areas to be updated have been invited. Co-optees may be invited to join the committee should their expertise be required during development.

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			Although there is a radiographer on the committee we would expect to see another AHP with therapy, rehabilitation and long-term management experience present to promote multidisciplinary involvement in delivering good quality stroke care from day one and recognising AHPs important role in preventing delayed discharge of care. NICE invited a speech and language therapist to join the guideline development group on both acute stroke (CG68) and stroke rehabilitation (CG162). The RCSLT would expect this crucial input to be recognised in this guideline too.	After stakeholder input, we have added review questions on early mobilisation and positioning and we seek to appoint a physiotherapist to the committee. We have updated the scope to include mention of the nutrition support guideline as related guidance: a link to this guideline is already included in the NICE pathway on stroke. The guideline on stroke rehabilitation (CG162) is not being updated at this time.
Society and College of Radiographers	2	29	There are still geographical variations regarding how timely the brain scan is due to transfer times to hospital and staff and scanner availability. https://www.swast.nhs.uk/Downloads/Clinical%20Guidelines%20SWASFT%20staff/CG20_Stroke_Transient_Ischaemic_Attacks.pdf https://www.strokeaudit.org/results/Clinical-audit/Regional-Results.aspx The Society and College of Radiographers would welcome recommendations regarding time from scan to clinical evaluation/report.	Thank you for your comment. We will take into account the variation in current practice of transfer time and time from scan to report when making our recommendations.

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Society and College of Radiographers	3	1-4	Again, due to geographical variations and the distance to transfer to hospital, some patients are exceeding the target or optimal time to treat with mechanical thrombectomy. They are therefore missing the opportunity to benefit from significantly reduced chance of disability. Other limitations to this treatment include availability of a bed on an appropriately staffed ward for after care.	Thank you for your comment. We will take into account the variation in current practice when reviewing the evidence and drafting recommendations.
Society and College of Radiographers	4	4	The Society and College of Radiographers would welcome the development of guidelines for stroke in people under 16.	Thank you for your comment. Treatment for under 16s was not covered by the original guideline and so won't be covered in this update.
Society and College of Radiographers	5	4	Following risk stratification review, the urgency of brain imaging after TIA may need further promotion. Following evidence review if the recommendation is for MRI imaging in preference to CT in people with suspected TIA, this will have resource implications in terms of staff and scanner availability 24/7.	Thank you for your comment. We will take feasibility of implementation and variation in current practice into account when making our recommendations.
Society and College of Radiographers	5	8	Mechanical thrombectomy is not available in all hospitals. Patients who initially meet the criteria may face increased transfer times that could then exclude them from treatment due to increased delay. Transfer time to the nearest specialist acute stroke unit offering mechanical thrombectomy may therefore have a significant impact on patient outcome.	Thank you for your comment. We will take feasibility of implementation and variation in current practice including the time from decision to procedure into account when making our recommendations.

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			Any increase in referral for mechanical thrombectomy will have resource implications with regard to staffing interventional radiology suites around the clock. The Society and College of Radiographers welcomes recommendations regarding time from decision to treat to start of procedure. This will help to inform workforce planning where staff may currently be on call from home.	
Society and College of Radiographers	5	11	Surgery may involve further transfer to a neurosurgical centre and The Society and College of Radiographers welcome recommendations with regard to target times for transfer. We would also welcome recommendations regarding the procedure for rapid, around the clock, transfer of images.	Thank you for your comment. We will take feasibility of implementation and variation in current practice including transfer times into account when making our recommendations.
Stroke Association	General	General	The Stroke Association welcomes the update of the clinical guideline on the treatment of stroke and the opportunity to provide comments on the scope. However, Given the significant improvements and developments in the treatment and care of stroke in the last 9 years since this guideline was published, it is hugely disappointing to see that most areas of the guideline are not being updated.	Thank you. This update is a partial update as guided by the surveillance report. The surveillance report noted which areas had new evidence that was likely to lead to a change in recommendations. Future surveillance reviews will again examine the published evidence base which could prompt a subsequent update of this guideline.

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			Despite a near 50% reduction in mortality since 2007, stroke is still the 4th largest cause of death in the UK and the single biggest cause of disability, with huge associated costs to the health services, social care, informal care and the wider economy through lost productivity. Further, the structure and delivery of many elements of stroke services has changed following the implementation of the 2007 National Stroke Strategy, which comes to an end this year. The Stroke Association is currently working with NHS England, The British Association of Stroke Physicians and other key arm's length bodies to develop a new national plan for stroke to prioritise additional improvements to the system over the next three years. It is therefore extremely timely that the full clinical guideline be updated to ensure that they reflect new research developments and emerging and established best practice so that the progress already made in treating this devastating condition over the last decade is not lost.	
Stroke Association			The Intercollegiate Stroke Working Party updated the Royal College of Physicians Guideline last year which is a ready-made source of key evidence and clinical consensus on areas where more research is needed[1]. We strongly recommend the	Thank you.

[1] National clinical guideline for stroke. Intercollegiate Stroke Working Party. Fifth Edition 2016. Available at: https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx

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			Guideline Development Group considers widening the scope of this update and utilising the significant work by the ICSWP in updating the NICE guideline. Crucially, it makes recommendations for commissioners on the ideal structure of stroke services, an area where there is very strong evidence that could be better promoted to commissioners in order to improve patient outcomes.	
Stroke Association	General	General	We were also very disappointed to see an exclusive focus on acute clinical professionals in those you are seeking to recruit for the Guideline Development Group. We strongly recommend that the membership of the group is expanded to include allied health professionals such as physiotherapists, occupational therapists, speech and language therapists and psychologists who are vital to acute and post-acute stroke care.	Thank you. As this is a partial update only those specialties relating to the review questions to be updated have been invited. Following stakeholder comments, we have added the areas of early mobilisation and positioning to the scope and will advertise for a physiotherapist to join the committee. Co-optees may also be invited should their expertise be required during development.
Stroke Association	General	General	The scope of this review should be expanded to include the developments around avoiding deep vein thrombosis and pulmonary embolism which are both common and serious post-stroke complications. Section 3.13 of the RCP 2016 stroke guideline includes an overview of the new evidence in this and NICE clinical guideline 92 should be flagged to ensure that intermittent pneumatic compression is offered to patients with immobility after acute stroke. Despite being recommended in CG92, uptake among stroke patients has been slow, with	Thank you. We have added CG92 (which is currently being updated) to the list of related guidance. In addition, this will be linked to once the NICE pathway is updated.

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			fewer than 20% of patients receiving them and wide variation between hospitals[2]. A specific recommendation on their use in the stroke clinical guideline would help promote their adoption, and would lead to cost savings and improved outcomes.	
Stroke Association	General	General	The importance of stroke rehabilitation needs more attention within this guideline and we recommend the scope being expanded to include the recommendations set out in CG 162 which covers stroke rehabilitation. Given the increasing drive for integration across care settings, it seems sensible to review whether these should remain as two separate guidelines. Further, CG 162 states that it covers stroke survivors who have a continuing impairment 2 weeks post-stroke, which leaves a significant gap between the acute care covered in this guideline and the recommendations around how to ensure stroke survivors receive the rehabilitation and support they need as soon as they need it. There have been significant changes in how rehabilitation services are structured since this guideline was developed. Average length of stay in hospital for stroke patients continues to decline and this trend is set to continue with changes to	Thank you. The stroke rehabilitation guideline (CG162) will remain a separate guideline but will be cross referred to where relevant. The online NICE pathways will help to connect the guidelines. Updates to the stroke rehabilitation guideline will be considered during its next review cycle.

[2] Kavanagh, M. et al, Assessing the uptake of Intermittent Pneumatic Compression in acute stroke following the publication of the CLOTS3 trial, ECOC 2016 Poster Presentation. Available at: https://www.strokeaudit.org/SupportFiles/Documents/Research/IPC-uptake-FINAL.aspx

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			hospital bed provision and further advances in acute treatment. Early Supported Discharge, for example, which has been shown to improve outcomes and save money[3], is only mentioned briefly in the rehabilitation guideline, with no detail on eligibility or what patients should expect to receive. This is a huge gap and a wasted opportunity for the NHS to cement best practice more uniformly across the country. Given that we know post-acute care has not kept pace with the improvements we have seen in acute care and that stroke survivors continue to report feeling abandoned when they leave hospital, combining the guidelines would send a strong message to the clinical community about the importance of post-stroke support, whilst also ensuring seamless patient pathways are adequately set out one robust clinical guideline. Again, the RCP stroke guideline includes recommendations and evidence that would be helpful to review.	
Stroke Association	2	18	The figure of 80,000 admissions per annum is for England only, not for the whole of the UK, as implied due to the incidence rate for the full UK being used in line 17. Suggest adding 'in England' to the end of this sentence for clarity.	Thank you, this has been amended.

[3] Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis. Commissioned by NHS England. Technical Report, 10 August 2016. Available at: https://www.strokeaudit.org/SupportFiles/Documents/Health-Economics/Health-economic-report-March-2017-FINAL-DRAFT-(1).aspx

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Stroke Association	2	24	The figure for the cost of stroke to the UK listed here is from 2009 and therefore out of date. The Stroke Association has commissioned research to update this figure which will be released in time for the new guideline. This will be published in a peer reviewed journal, and as such we recommend the updated figure be used in the guideline.	Thank you for your comment and the information regarding costs. We have updated the figure for the cost of stroke to the NHS.
Stroke Association	2	25	Although it is not a protected category under the Equality Act, people from the most economically deprived areas of the UK are around twice as likely to have a stroke than those from the least deprived areas[4]. A new study of stroke audit data has found that the most deprived patients had an average age of onset 5 years lower than the least deprived patients[5]. They also had greater co-morbidities and were less likely to have been independent before their stroke, suggesting that there is overlap with the equality issues around age and disability. We therefore strongly recommend that the guideline considers socioeconomic depravity to help reduce the health inequalities relating to stroke.	Thank you for the information. We will consider this when making our recommendations. This has been added to the equality impact assessment.
Stroke Association	4	12	We welcome the specific consideration of older patients in the guideline due to the fact that stroke incidence in people over 80 years of age is increasing due to the ageing population.	Thank you. Age has been identified as an equality consideration for the guideline, and is detailed in the equality impact assessment. This will be highlighted both in the

[4] Public Health England: National Cardiovascular Disease (CVD) Profiles. Available at: http://www.sepho.org.uk/NationalCVD/NationalCVDProfiles.aspx
[5] Vestesson, E., et al. Relationship between deprivation and outcome for stroke patients: data from the UK national Stroke Registry. International Forum BMJ (Gothenburgh) 2017. Poster Presentation. Available at: https://www.strokeaudit.org/SupportFiles/Documents/Research/ISC2016_deprivation.aspx

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			However, we know through our Life After Stroke Services – which support over 60,000 stroke survivors each year – that younger stroke survivors, specifically those under 55, often report delays to diagnosis and problems accessing appropriate post-stroke support which we do not see as acutely in stroke survivors closer to the average age of onset. Further, new age of onset data published by the Stroke Audit team this year shows that strokes in men in this age group are growing faster than the trend in overall incidence[6]. Nearly double the number of working age strokes now occur in men than in women. A new study looking at suicide after stroke shows than men are also more likely to die from suicide following a stroke than women[7]. We therefore strongly suggest that younger stroke survivors and particularly younger men are considered as a group requiring specific consideration to address these issues.	evidence and when the committee makes recommendations. We have now specified patients under 55 as a group for special consideration in the scope.
Stroke Association	5	1 – 3	We welcome the review of risk stratification in those with suspected TIA as well as recommendations around aspirin after a TIA to decrease the significant numbers of people who experience a full stroke following their TIA. Given the new	Thank you for your comment

[6] Age and gender breakdown. SSNAP 2017. Available at: https://www.strokeaudit.org/Documents/National/Clinical/Apr2016Mar2017/Apr2016Mar2017-AgeGenderBreakdown.aspx

[7] Vestesson E, et al. How Common is death by suicide after stroke? A national registry study. ECOC 2017 Poster presentation. Available at: https://www.strokeaudit.org/SupportFiles/Documents/Research/Stroke-and-suicide.aspx

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			evidence in this area, specifically around the use of aspirin[8], stronger recommendations offer a significant chance to prevent strokes and save money in both health and social care. The provision of specific information to patients and their families at this stage is also crucial to ensure they take action to reduce their risk and are well supported.	
Stroke Association	5	6	Significant new research on the use of alteplase in acute stroke has been published since this guideline was produced in 2008. The scope mentions the use in those over 80, who have been shown to benefit as much as those in younger age groups if they receive the treatment within three hours. We welcome this update, but urge the Guideline Development Group to review other evidence, including the use of alteplase in mild strokes as well as the use of lower doses to decrease the risk of haemorrhage. A review of the evidence is included in section 3.5 of the Royal College of Physician's 2016 stroke guideline[1].	Thank you. We note that there is NICE technology appraisals guidance on alteplase and any new evidence will be captured during its next update cycle.
Stroke Association	5	8 – 9	We warmly welcome the inclusion mechanical thrombectomy, a game-changing treatment which has been shown to be highly clinically and cost-effective. In 2015, the Stroke Association undertook a short online survey and gathered views from 39 people with either direct experience of	Thank you. The committee will discuss the requirements for this review when agreeing the protocol.

[8] Rothwell, et al. Effects of aspirin on risk and severity of early recurrent stroke after transient ischaemic attack and ischaemic stroke: time course analysis of randomised trials. The Lancet. Volume 388, No. 10042, p365-375, 23 July 2016

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			thrombectomy or experience via a close family member or friend. Most of those who responded described their experience in a positive way, with 24% describing it in a neutral or negative way. When asked about the main benefits, half said the procedure had helped to avoid severe disability, with others saying that it had saved their life. Some people reported negative experiences, including pain or discomfort during the procedure, or mental health problems associated with actually being discharged home so early (as the thrombectomy had been so successful). We would like to see recommendations that encourage clinicians to support patients with these aspects of the procedure which will not come through in published literature that the Guideline Development Group will review.	
Stroke Association	6	Table	Given the evidence mentioned in point 7 above which supports the widening inclusion criteria for the use of alteplase and in point 8 around the introduction of thrombectomy, it seems like a missed opportunity not to review all of the evidence around specialist treatment for acute stroke, and specifically about the standards for urgent brain scanning. The sooner both thrombolysis and thrombectomy are given, the better the outcomes. In order for all eligible patients to receive these acute treatments, services need to be set up to offer urgent assessments, brain scans and potentially hospital transfers. Last year the RCP stroke guideline recommended that all	Thank you for your comments. The surveillance report identified new evidence in the areas listed. However if there is a knock on impact on other recommendations as a result of the new evidence then we will consider amending them.

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			suspected stroke patients receive urgent brain scanning within 1 hour, and we strongly urge the Guideline Development Group to consider widening the scope in this area. Without stronger recommendations around the timeliness of brain scanning for all patients, it is unlikely that all eligible patients will be able to access the acute treatments they need.	
Stroke Association	6	Table	New oral anti-coagulants are now available to reduce stroke risk for patients in atrial fibrillation, which justify a review of the pharmacological treatments section of this guideline. Specifically, new recommendations are needed to address what should be done to start patients on long term anti-coagulation who do not spend a full two weeks in hospital, as length of stay is continuing to decline.	Thank you for your comment. Oral anti-coagulants for atrial fibrillation is covered in NICE guideline CG180.
Stroke Association	6	Table	Stroke survivors are at high risk of dehydration, malnutrition, infection, hypoxia and Hyperglycaemia and new evidence published over the last 9 years has shown that staff training and more proactive dysphagia screenings can significantly improve outcomes. We strongly recommend that the evidence around maintaining homeostasis and around hydration and nutrition is reviewed to provide more clarity on immediate post-stroke care. Preventing post-stroke complications has the potential to save lives and money by improving outcomes and decreasing dependence on informal and formal care. The new evidence in this area is summarised in section 3.10 of the RCP 2016 stroke guideline.	Thank you for your comment. The surveillance report did not find evidence that was likely to change recommendations in these areas. Areas related to rehabilitation are covered in NICE guideline CG162 and nutrition support is additionally covered in NICE guideline CG32.

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Stroke Association	7	Table	We welcome the review of evidence around blood pressure control as new studies have been published in this area.	Thank you for your comment
Stroke Association	7	Table	We strongly recommend that the scope of this guideline update is expanded to include reviewing the evidence around early mobilisation as two new studies have markedly changed clinical practice in this area. The AVERT study in 2015 found that very early mobilisation had a detrimental effect on outcomes and therefore has changed the recommendations around early mobilisation in the RCP 2016 stroke guidelines. The current recommendations around mobilisation in CG68 do not provide sufficient clarity around this and therefore should be updated. Further, a 2016 paper looking at appropriate dosing of mobilisation and rehabilitation in AVERT found that smaller, more frequent bursts of activity has the potential to provide patient benefit and should be reviewed for inclusion[9]. Given the substantial disability burden that stroke causes it's important that all stroke patients have the best possible chance at a good recovery and a failure to update these recommendations could put that at risk.	Thank you. Following stakeholder input, we will add review questions on early mobilisation and positioning to the scope of this update.
Stroke Association	7	Table	New evidence has been published on the avoidance of aspiration pneumonia which should be considered as part of	The surveillance report did not identify any new evidence that would change the current recommendations on the

[9] Bernhardt, J., et al, Prespecified dose-response analysis for A Very Early Rehabilitation Trial, Neurology. Published online. February 17 2016. Available at: http://www.neurology.org/content/early/2016/02/17/WNL.0000000000002459.full.pdf

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			this guideline review, considering that pneumonia is a common and very serious post-stroke complication, and remains one of the most common causes of post-stroke mortality[10]. Reducing the incidence of post-stroke pneumonia would help reduce bed days and limit unnecessary cost to the NHS. The current recommendation in the guideline does not offer specific enough guidance to health professionals and would benefit from being reviewed.	avoidance of aspiration pneumonia; therefore this section will not be updated. However this may be considered in the next update cycle. We note that the stroke rehabilitation guideline (CG 162) makes recommendations on oral care to prevent aspiration pneumonia.
Stroke Association	8	4 – 10	Because stroke can so often have a profound effect on ability to communicate, it can reduce capacity not only to make decisions, but also to convey them. 33% of stroke survivors are affected by communication problems, including receptive aphasia (difficulty understanding what is being said), expressive aphasia (difficulties expressing oneself), or a mix of the two.[11] Our recent survey of stroke survivors found that 27% of them have either severe or moderate communication difficulties (aphasia), and this percentage is sure to be higher for individuals in the immediate aftermath of their stroke, as aphasia tends to be worst in the first days and weeks following	Thank you. This will be considered when reviewing the evidence and making recommendations. NICE guideline CG162 covers stroke rehabilitation and makes some recommendation in this area that will be linked to by the NICE pathway. We have also added some considerations on how patients access information to the equality impact assessment.

[10] Smith, C.J. et al, Can a novel clinical risk score improve pneumonia prediction in acute stroke care? A UK multi-centre cohort study. J Am Heart Assoc. 2015;4:e001307; Bray, B.D. et al, The association between delays in screening for and assessing dysphagia after acute stroke, and the risk of stroke-associated pneumonia, JNNP online, first published June 13, 2016, 10.1136/jnnp.2016.313356

[11] Stroke Association, 'State of the Nation', January 2016, https://www.stroke.org.uk/resources/state-nation-stroke-statistics

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			a stroke. [12] Stroke can also affect short-term memory which can make communication slower and more difficult. Therefore, we recommend some of the specific barriers that stop stroke survivors accessing appropriate information and support are tackled within this guideline, as these are not sufficiently covered by generic guidelines on patient information and experience.	
Stroke Association	8	11 – 18	The SSNAP audit contains a wealth of economic data which will be helpful in developing this part of the guideline.[3]	Thank you, we will consider the SSNAP data in development of the guideline.
Stroke Association	9	24	We welcome the inclusion of quality of life as a key patient outcome. However, a significant barrier to this is poor follow-up with stroke survivors after discharge. As above, it would help if this guideline covered the full stroke pathway, including discharge and rehabilitation, so that a recommendation could be made about the importance of following up with stroke survivors at six weeks, six months and annually, to assess their progress and unmet needs. Only 30% of stroke survivors are currently followed up in this way. Crucially, this data should also be recorded on SSNAP so that we can start to build a more complete picture of the performance of stroke services and where improvements are needed.	Thank you for your comment. These are the main outcomes (high priority outcomes, but not necessarily the only outcomes considered) and the committee will determine the most appropriate outcomes, which may include additional measurements, when developing protocols for each review and take this into consideration. NICE guideline CG162 covers stroke rehabilitation so will we not include aspects related to rehabilitation in this guideline. However the online NICE pathways will seek to make the link between the two guidelines so that they are easy to access.

[12] *A New Era for Stroke,* conducted by The Stroke Association in March 2016. 1,174 stroke survivors in England, Scotland, Wales and Northern Ireland responded to the survey.

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Stroke Association	9	30	An updated Stroke Quality Standard was published by NICE in 2015. This scope document incorrectly lists the out of date document from 2010.	Thank you. This has been updated.
Stroke Association	10	1 – 4	This guideline should refer clinicians to the RCP 2016 stroke guideline which includes recommendations based on expert clinical consensus in areas where there is a paucity of evidence. It also covers the full stroke pathway and contains recommendations on the structure of services, which are outside the scope of this guideline but are still very valuable resources for commissioners and health professionals. They were developed using a NICE accredited guideline development process.	Thank you. This will be taken into consideration when developing the guideline.
Stroke Association	10	1 – 4	The guideline should also refer clinicians to the Royal College of Paediatrics and Child Health 2017 guidelines on the treatment of stroke in children, which covers all stroke patients under 18 years old. These were also developed using a NICE accredited process[13].	Thank you. This will be taken into consideration when developing the guideline.
The Chartered Society of Physiotherapy	General	General	We suggest that the AVERT multi-centre trial needs formally reviewing as part of this process, as the interpretation of the findings by NICE in the preliminary review is different to those of the RCP and these two guidelines are therefore potentially confusing for clinicians. The AVERT trial identified that there could be a risk of a worse outcome with very early mobilisation.	Thank you. Following stakeholder input, we have decided to add questions on early mobilisation and positioning.

[13] Stroke in childhood: clinical guideline for diagnosis, management and rehabilitation. RCPCH May 2017. Available at: https://www.rcpch.ac.uk/stroke-guideline

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			We do not feel this is sufficiently mitigated for in the previous recommendation with the statement “when clinical condition permits”.	
The Dirac Foundation	General	General	I think comment and consideration are definitely needed regarding the differential diagnosis with respect to motor or hemiplegic migraine (FHM), essentially migraine with unilateral motor symptoms (MUMS), and especially hard to distinguish in the case of the silent forms of these migraines (i.e. pain free). Migraine gets only a passing mention in https://www.nice.org.uk/guidance/cg68/chapter/1-Guidance#rapid-recognition-of-symptoms-and-diagnosis. Such migraines as the above are very difficult to distinguish from TIA despite very different etiology, with migraine being typical verifiable as of neurological origin, and importantly there is very different therapeutic strategy. In one study, 38% of patients with MUMS were told they had had a stroke, and 17% believed they had had a stroke despite normal brain imaging [*]. Symptoms overlap on a significant number of points. Those for hemiplegic migraine include weakness or paralysis on one side of the body, numbness on one side of the body, loss of balance and muscle control, visual disturbances, such as double vision or blind spots, sensitivity to light and sound, slurred speech or mixing up of words, fever, dizziness, nausea, and vomiting, and confusion. In addition, symptoms like loss of muscle control and coordination can more rarely become more	Thank you for your comment. The range of differential diagnoses and presentations are beyond the scope of this guidance.

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			permanent, causing further potential confusion with TIA. The large differential diagnostic error rate is in part likely due to significant differences in prevalence. Ischemic strokes are typically considered cardiovascular disorders and 15 to 30% are typically classified as cardioembolic in origin. Hemiplegic migraine of neurological origin is much less prevalent at 0.01%. However, migraine iin general is a very common disorder, occurring in 15–20% of the population, and occasional FHM may be commoner, occurring at least once or twice, in in patients with a history of common migraine.	
The Dirac Foundation	General	General	Genomic biomarkers are likely to provide strong differentiating evidence. With respect to common polygenic migraine in general, genome-wide association studies have so far identified single nucleotide polymorphisms at some 38 loci, typically in ion channels or associated proteins, but I understand that approximately 5 are very common. FHM is distinctly genetic but with genetics that are not too complex, being defined by two or more people in the same family experiencing migraines that include temporary paralysis on one side of the body, and 50% of children born to a parent with FHM have a chance of inheriting the disorder. Three distinct genes have been identified in connection with common forms of FHM, i.e. CACNA1A, ATP1A2, and SCN1A. It is understood that these genes can lead to a breakdown in the	Thank you for this information.

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			communication process for nerve cells believed to be the etiology of the numbness in the body. [*]William B Young, Kaanchan S Gangal, Raoul J Aponte, and Ronald S Kaiser (2006), Migraine with unilateral motor symptoms: a case–control study, J. Neurol . Neurosurg. Psychiatry. 2007 Jun; 78(6): 600–604.	
Thrombosis UK	General	General	We would like to suggest that: a) there is a thrombosis expert on the panel or b) an expert be co-opted in to provide advice on this area	Thank you, this will be taken into consideration when recruiting the guideline committee. If this expertise is not represented by the full members of the committee, an expert may be co-opted.
Thrombosis UK	General	General	Consideration to written information shared with care/patient for on-going care and monitoring post discharge to support prevention and early detection of a secondary stroke'	Thank you. The stroke rehabilitation guideline (CG162) includes a section on Providing support and information. This is linked to by NICE pathways.
University Hospitals Birmingham NHS Foundation Trust	General	General	Comment related to table pg6 to 7, early mobilisation and optimum positioning of people with acute stroke: AVERT trial (A Very Early Rehabilitation Trial) Efficacy and safety of very early mobilisation within 24 h of stroke onset (AVERT): a randomised controlled trial. The AVERT Trial Collaboration group (2015) The Lancet 386, 9988, 1-102 Evidence from this study indicates that early mobilisation in short frequent sessions has a positive effect on functional outcome post stroke. Royal College of Physicians (RCP) Stroke Guidelines 2016 have amended recommendations in line with this evidence. If this is not reviewed, NICE guidance	Thank you. Following stakeholder input and after careful consideration, the scoping group have decided to add a review question on early mobilisation to the scope and review the evidence on this. The surveillance report did not identify any new evidence that would change the current recommendations on the avoidance of aspiration pneumonia; therefore, this section will not be updated. We will highlight this area to NICE for continuing surveillance of the guideline.

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			will be out of sync with RCP which will lead to confusion and lack of clarity in clinical practice. Comment related to table pg 6 tp 7, avoidance of aspiration pneumonia. SIGN Guideline 199 2013 recommends oral hygiene to prevent aspiration pneumonia. CG68 does not mention oral care, could the evidence be reviewed?	We note that the stroke rehabilitation guideline (CG 162) makes recommendations on oral care to prevent aspiration pneumonia. NICE pathways connect the guidelines and provide a way of linking recommendations together on acute management of stroke as well as rehabilitation.
University Hospitals of Leicester NHS Trust	Page 6	Imaging: Urgent CEA	No evidence review is planned for this aspect of care. Would it be possible to consider a Quality Standard for Urgent carotid surgical intervention, with a recommendation for research to ascertain the safety and outcomes following urgent / early carotid surgery	Thank you. We are not covering this as there was no new evidence identified in the surveillance report that would be likely to alter the recommendations. The quality standard in stroke will be reviewed once this update is complete.
University Hospitals of Leicester NHS Trust	Page 6	Pharmacological treatments; Reversal of anticoagulation	No evidence review is planned for this aspect of care. Would it be possible to consider a quality standard for reversal of Anticoagulation treatment, with a Door To Needle Metric (akin to DTN for thrombolysis)	Thank you. We are not covering pharmacological treatment other than thrombolysis as there was no evidence identified in the surveillance report that would be likely to alter recommendations. The quality standard in stroke will be reviewed once this update is complete.
University Hospitals of	Page 7	Nutrition &	The previous guideline suggested an early feeding plan with consideration for nasogastric feeding to be setup within 24 hours. It would be useful to have expert guidance / consensus	Thank you. The surveillance report concludes that new evidence in this area is unlikely to change guideline recommendations.

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Leicester NHS Trust		hydration	statements on when this might be inappropriate (e.g. due to the presence of adverse prognostic features) Can this be added to the scope of consideration?	We have added the nutrition guideline (CG32) to the list of related guidance and this will be linked into the NICE pathway.