NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Stroke

Date of Quality Standards Advisory Committee post-consultation meeting:
7 January 2016

2 Introduction

The draft quality standard for stroke was made available on the NICE website for a 4-week public consultation period between 7 September and 5 October 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 35 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically

not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement? Are any other areas required to ensure diagnosis and initial management, acute-phase care, rehabilitation and long-term management of stroke are covered? For example a named rehabilitation contact throughout rehabilitation

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft placeholder statement 7: Do you know of any relevant evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance that covers identifying stroke in adults without Face, Arm and Speech Test symptoms have the potential to improve practice? If so, please provide details.

5. For draft quality statement 3: Does this statement adequately address rehabilitation intensity within community settings?

6. For draft quality statement 5 and 6: Do these statements adequately address the ongoing need to review goals?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- General support was received for this quality standard and the good practice it promotes.
- Stakeholders highlighted that not enough focus was given to carers of people with stroke.
- Stakeholders highlighted that coordination of care should be covered within this quality standard, with reference to a named contact for people who receive rehabilitation.
- Stakeholders did raise that 6 quality statements (excluding the placeholder) may not be enough to cover all improvement areas along the stroke pathway.
- A stakeholder suggested that the definition of TIA should be changed to include 'resolve with 24 hours without cerebral infarction'.
- A stakeholder felt that the statements were not robust as they did not make reference to specific tasks and timescales, therefore it could be open to interpretation.
- A stakeholder felt that the quality standard needed to strive to improve quality of life not just function for people who have had a stroke.

Consultation comments on data collection

- Stakeholders felt that most data could be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP).
- Stakeholders highlighted that if data could not be collected via SSNAP it would be an additional workload for those who provide care for people with stroke.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults presenting at an accident and emergency (A&E) department with suspected stroke are admitted to a specialist acute stroke unit within 4 hours of arrival.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- There was support amongst stakeholders for this statement, given that achievement of the linked indicator within the SSNAP is low.
- Stakeholders felt that this statement should reference hyper-acute stroke units (HAPU).
- Stakeholders highlighted that given there will be issues collecting data about people with suspected stroke, the statement should reflect that diagnosis takes place within A&E (with a specialist diagnostic assessment) before admission to a stroke unit.
- Stakeholders suggested that where the Rankin score is used as an outcome measure, it should be a change in the Rankin score, not just an absolute figure given that some people may have disabilities pre-stroke.
- A stakeholder felt that the wording of the statement should reflect the centralisation in Manchester, London and other areas as some people may be transferred to a unit at another provider.
- A stakeholder highlighted that some people may present sometime after having had a stroke (e.g. 48 hours) and the statement should not be applicable to these people.
- A stakeholder highlighted that this statement should cover the provision of thrombolysis.

5.2 Draft statement 2

Adults with acute stroke and indications for immediate brain imaging have a scan performed within 1 hour of arrival.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Stakeholders felt that this statement is widely achieved and therefore not a priority, with 44% of all people with stroke having it performed within 1 hour and 88% of all people with stroke receiving the scan within 12 hours.
- Stakeholders highlighted that this statement should cover the provision of thrombolysis. With this in mind a stakeholder felt that within an hour was not soon enough, suggesting it should be performed within 15 minutes of arrival when thrombolysis is indicated.
- Stakeholders highlighted that without using the wording of SSNAP it will be difficult to measure this statement.
- Stakeholders suggested that where the Rankin score is used as an outcome measure, it should be a change in the Rankin score, not just an absolute figure given that some people may have disabilities pre-stroke.
- A stakeholder felt that this statement may not reflect those people who require brain imaging sooner than 1 hour, therefore 1 hour should be referred to as the maximum.
- A stakeholder felt that the wording of the statement should reflect the centralisation in Manchester, London and other areas as some people may be transferred to a unit at another provider.
- A stakeholder suggested that a timeframe should be included for when the report of the brain imaging is produced, therefore the statement would read "…have a scan performed and reported within 1 hour of arrival".

5.3 Draft statement 3

Adults with stroke having stroke rehabilitation are offered at least 45 minutes of each relevant therapy for a minimum of 5 days per week.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Stakeholders felt that additional specialisms should be referenced within this quality statement, including orthotists, dietitians and amending speech therapists to speech and language therapists.
- Stakeholders highlighted that while it is important that people have the opportunity to access therapy for this time many will not be able to tolerate this, or some may be able to tolerate more. The following suggestion was made “adults undergoing stroke rehabilitation are offered as much appropriate therapy as they are able to tolerate, for most this would be at least 45 minutes, minimum of 5 days a week”
- Stakeholders felt that the statement should be explicit in that this intensity relates to community rehabilitation services as well as those within acute care.
- A stakeholder highlighted that it was not clear how long this intensity should last.
- A stakeholder felt that while this timeframe may be applicable for some specialist rehabilitation, it may not be appropriate for others such as cognitive support which may be more long-term.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5:

- Stakeholders felt that this statement needs to be more explicit in relation to community care such as referring to adults with stroke having stroke rehabilitation within hospital or the community.
- A stakeholder felt that focusing upon a named contact or key worker would help to ensure this level of rehabilitation was received in the community.

5.4 Draft statement 4

Adults with stroke who are able to move from bed to chair (with or without help) are offered early supported discharge.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- There was general support for the statement in that it is important to promote early supported discharge services.
- Stakeholders questioned whether the ability to move from bed to chair was a suitable marker for early supported discharge. Suggestions were made such as using the modified Rankin scale or Barthel index, or the person's ability to call for help.
- A stakeholder felt that the suitability of a person's home environment should be taken into account.
- A stakeholder suggested that some people may be at risk of being discharged too soon based on this statement, such as those with significant psycho-social or cognitive impairments, or those who may experience social isolation.
- A stakeholder added that the statement should be strengthened to ensure that early supported discharge should be at the same intensity as inpatient care.

5.5 Draft statement 5

Adults with stroke have their rehabilitation goals agreed within 5 days of arrival.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Stakeholders felt that there was a need to take into consideration people who are seriously ill at day 5 or unable to input into their rehabilitation goal setting due to impaired cognition. May be a need within this to include family and/or carers via shared decision making.
- Stakeholders highlighted that goals can change significantly overtime. Day 5 may have immediate goal setting such as a person's ability to walk and feed themselves, however these will change to long term goals quite quickly.
- Stakeholders suggested that this statement may not be aspirational as SSNAP data shows that this is being achieved, with others suggesting that experience from SSNAP has shown it is difficult to collect.
- A stakeholder suggested speech and language therapists can assist in identifying goals.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6:

- Some stakeholders felt that setting goals at 5 days and then reviewing goals at 6 months may be adequate although the need to review is not explicitly stated.
- Other stakeholders felt that goals should be reviewed more frequently suggesting at 6 weeks, 3 months, 6 months and annually.

5.6 Draft statement 6

Adults who have had a stroke have their health and social care needs reviewed at 6 months after the stroke and annually thereafter.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Several stakeholders supported the inclusion of this statement, given the current variation in those who receive a 6 month review according to SSNAP.
- Stakeholders queried who in the health and social care system would be responsible for reviewing these people, and in which setting this review would take place.
- Stakeholders highlighted that this statement omits a more regular 6 week review which was also raised in relation to consultation question 6.
- A stakeholder queried how long this rehab will continue.
- A stakeholder highlighted that this review my also include treatment adjustments.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6:

- Some stakeholders felt that setting goals at 5 days and then reviewing goals at 6 months may be adequate although the need to review is not explicitly stated.
- Other stakeholders felt that goals should be reviewed more frequently suggesting at 6 weeks, 3 months, 6 months and annually.

5.7 Draft statement 7 (placeholder)

Identification of stroke in adults without Face, Arm and Speech Test symptoms.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Stakeholders were conflicted in whether this area should be retained as a quality improvement area, with some believing it to be important in order to push the development of guidance in this area, with others believing guidance would not be possible in this area, and suggested that it would effectively be a textbook of neurology.
- A stakeholder suggested that wider accessibility to brain imaging outlined in draft statement 2 would improve the identification of these people.

Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

- Stakeholders were not aware of any relevant evidence-based guidance that could be used to develop this placeholder statement.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Support for self-management
- Secondary stroke prevention (hypertension and anticoagulation)
- Integration and co-ordination of care
- Visual problems
- Rehabilitation community team
- Vocational rehabilitation
- VTE prophylaxis
- TIA clinics
- Provision of therapy 7 days a week

Some suggestions map to original statements in QS2 that were not prioritised for the QS update:

- Treatment for acute ischaemic stroke including intravenous thrombolysis and intra-arterial thrombectomy. Partly covered by QS2 statement 3.
- Identification and treatment for dysphagia and malnutrition. QS2 statement 4.
- Urinary incontinence support. QS2 statement 8.
- Psychological rehabilitation. Partly covered by QS2 statement 9.
- Support for carers. QS2 statement 11.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
001	BOSTON SCIENTIFIC	General	Boston Scientific is a global manufacture of implantable devices used to prevent strokes. As a manufacture of these devices, we work closely with clinicians who are involved in implanting these devices, along with clinicians who are involved in research and trials, in particular ICSS.We have also for the last 10 years been involved in media campaigns around stroke symptom awareness and treatment. F.A.S.T. campaign being one.
002	BOSTON SCIENTIFIC	General	We welcome this quality standard, and would like to reinforce the importance of the following.
003	BOSTON SCIENTIFIC	General	Timely intervention is critical
004	BOSTON SCIENTIFIC	General	The patient pathway and stroke networks are vital.
005	BOSTON SCIENTIFIC	General	We welcome the proposal from MONITOR and NHSE to have a stroke treatment incentive.
006	British Association of Prosthetists and Orthotists (BAPO)	General	BAPO support the stated aims and recommendations of this quality standard.
007	British Society for Antimicrobial Chemotherapy	General	Members of The British Society for Antimicrobial Chemotherapy (BSAC) have no comments for this consultation: Stroke in adults' quality standard
008	BRITISH SOCIETY OF INTERVENTIONAL RADIOLOGY	General	Beyond my area of clinical expertise, I have no general observations
009	College of Occupational Therapists	General	It would be relevant to highlight the range of settings in the introduction- i.e. hyper acute, acute stroke rehabilitation unit, specialist rehabilitation centres, ESD, community rehabilitation. Standards remain acute focussed and there is a lack of detail and emphasis on life after stroke and rehabilitation. A standard reflecting the stage following admission when a person is considered for rehabilitation could encompass the importance of prompt, specialist and broad assessment by all relevant professionals.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
			The standards do not appear to reflect the importance of adults with stroke managing their condition. This may be due to lack of evidence but current thinking and policies, such as: the Five Year Forward View in England, place emphasis on the importance of enabling people to manage their condition.
010	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
011	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network	General	Introduction the definition of TIA is quite outdated - at least add the line 'resolve with 24 hours without cerebral infarction'
012	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network	General	These are target driven rather than standards of care Lack quality and do not reflect patient centred treatment Our overarching comment for all of them, is that they seem to be a lot less robust than the previous statements. For example, reference to timescales and specific tasks in relation to stroke symptoms/side effects are infrequent, which raises our concern around the measurability of the new statements. Our feeling is that the new statements are very much open to interpretation……. We also feel that there is less of a focus on support to carers for stoke patients, which we would have thought would be key due to the direction of travel and the drive for more patients to be supported in the community and the impact that this will have on carers and family. And further more none of the indicators refer to co-ordination of care, which is imperative given that the statements reinforce the requirement for patients to move between units, e.g. hyper acute, acute and community.
013	Health and Social Care Information Centre	General	These look fine to me
014	Medtronic Limited	General	Medtronic welcomes the draft quality statements in supporting uptake of Stroke guidance and improving quality of patient care
015	RNIB	General	About the RNIB: Royal National Institute of Blind People (RNIB) is the UK's leading charity providing information, advice and support to almost two million people with sight loss. We are a membership organization with over 12,000 members throughout the UK and 80 percent of our Trustees and Assembly members are blind or partially sighted. We encourage members to get involved in our work and regularly consult them on matters relating to Government policy and ideas for change. As a campaigning organization we act or speak for the rights of people with sight loss in each of the four nations of the UK. We also disseminate expertise to the public sector and business through consultancy on products,

ID	Stakeholder	Statement number	Comments[1]
			technology, services and improving the accessibility of the built environment. RNIB is pleased to have the opportunity to respond to this consultation
016	RNIB	General	Equalities Act 2010: We believe that all NICE work should reflect the duties of public bodies under the Equalities Act 2010, not just in relation to communication and accessible information, but in relation to non-discriminatory treatment. We would expect NICE to take steps to meet their legal obligations. This not only requires public bodies to have due regard for the need to promote disability equality in everything they do - including the provision of information to the public - but also requires such bodies to make reasonable adjustments for individual disabled people where existing arrangements place them at a substantial disadvantage.
017	Royal College of Nursing	General	This is to inform you that the Royal College of Nursing have no comments to submit to inform on the above quality standards at this time.
018	Royal College of Physicians (RCP)	General	The RCP is grateful for the opportunity to respond to the NICE Quality Standards Consultation – Stroke (update). We would like to make the following comments.
019	Royal College of Physicians Of Edinburgh	General	Thank you for your email. I have forwarded your email onto Council to confirm and they have stated that they have no specific comments to add to the draft quality standard.
020	Royal College of Speech and Language Therapists	General	The RCSLT would consider amending 'detailed analysis' to 'specialist assessment and therapeutic intervention'. People are referred not only for assessment, but also therapy (which is only mentioned at the 6 month review) which includes addressing the impairment and the consequence of the disorder.
021	Royal College of Speech and Language Therapists	General	The RCSLT suggest amending: 'and offer treatment if there is potential for functional improvement' > 'and offer treatment if goals are identified'. Treatment is not just about improving the functional ability of the person with communication difficulty / aphasia; it goes far beyond this e.g. consequence of disorder.
022	Royal College of Speech and Language Therapists	General	Consider altering the statement 'Help and enable people with communication difficulties after stroke to communicate their everyday needs and wishes' to 'Help and enable people with communication difficulties after stroke to communicate their everyday needs, wishes, thoughts, feelings'. More emphasised placed on topics of conversations important to Quality of Life.
023	Royal College of Speech and Language Therapists	General	The RCSLT suggest altering 'offer training in communication skills (such as slowing down, not interrupting, using communication props, gestures, drawing) to the conversation partner' to 'offer training and support in the best techniques to maximise interaction / conversation to the conversation partners. Providing examples of 'ramps' has the potential to limit the skill and scope of supporting someone to communicate. Although there are general techniques, they need individual application supported by an SLT.'
024	Royal College of Speech and Language Therapists	General	The RCSLT request that Nutrition and Dietetics are added to the core members of the Stroke Team. If the patient is not well hydrated and well-nourished there isn't much chance any rehabilitation will be effective. Dietitians are vital as

ID	Stakeholder	Statement number	Comments[1]
			part of the Stroke Team in ensuring their nutrition and hydration are addressed. They are also vital in the decision making process for those patients where long-term alternative feeding is being considered.
025	Royal College of Speech and Language Therapists	General	Does the review capture the importance on improving quality of life not just improving functional deficit for people with communication difficulties?
026	SCM - The Dudley Group NHS Foundation Trust	General	Having reviewed the briefing paper; the draft standard would appear to address the key themes raised by the multiple stakeholders that have contributed. In addition it attempts to address the key domains in the 2015-16 NHS outcome frameworks, the 2015-16 Adult Social care framework as well as the current Public Health three year plan.
027	SCM- The Dudley Group NHS Foundation Trust	General	Evidence sources and Policy contexts are clear
028	SCM - The Dudley Group NHS Foundation Trust	General	How confident are the authors of the widest possible circulation for comments on the document? For example SRR sent this out to members on the afternoon of 30/09/15 for a 05/09/15 response which I would think limited members responses. I have not received it through the CSP or special interest group (ACPIN), have not received it through my academic clinical networks and, working as a full time clinician, have not received it through my Trust either. Our Stroke co-ordinator has also confirmed she has not seen it. I am just interested in the process of genuine stakeholder involvement
029	The East Midlands Stroke Clinical Advisory Group	General	The East Midlands Stroke Clinical Advisory Group feel very strongly that reducing the number of quality statements to six presents a risk to patient care. Stroke is the third largest cause of death in the United Kingdom, and a third of people who have a stroke are left with long term disability, the effects of which can include aphasia, physical disability, loss of cognitive and communication skills, depression and other mental health problems. Recovery can continue for many years after an individual has had a stroke and so quality statements should be set to influence delivery of evidence based specialised care for patients across care settings from acute into community, to support both physical and mental health.
030	The Society and College of Radiographers	General	The outcome: 'carer experience of people who have had a stroke' and the importance of improving people's experience of outpatient care This is clearly relevant to Radiographers and is covered in section 8 of the HCPC SOP's.
031	UK Neurointerventional Group / The Royal College of Radiologists	General	We suggest that reference should be made to existing NICE guidance IPG458
032	Association of British Neurologists (ABN)	Question 1	Yes this draft quality standard accurately reflects the key areas for quality improvement
033	British Medical Association	Question 1	We believe that the draft quality standard identifies areas worthwhile quality improvement.
034	RCGP	Question 1	The key areas covered are clearly important for quality management. The RCP 2012 UK Clinical guideline for Stroke

ID	Stakeholder	Statement number	Comments[1]
			guideline 4th edition contains over 300 specific recommendations covering almost every aspect of stroke management. https://www.rcplondon.ac.uk/sites/default/files/national-clinical-guidelines-for-stroke-fourth-edition.pdf . The group identified 28 key recommendations, I think that these recommendation should be considered to expand the current draft 6 recommendations. These should include 2.2.1.B, 4.13.A, 6.21.1A, 6.24.1.B and 7.4.1.A. [MH]
035	SCM - The Dudley Group NHS Foundation Trust	Question 1	I think the suggestion of a named contact would be a useful proposal as service users regularly express a feeling of 'dropping out' of the system and being 'unable to get back into it again' once this initial contact has been lost. It is; however, problematic to achieve, with staff turnover and frequent episodes of maternity leave etc.
036	Association of British Neurologists (ABN)	Question 2	Yes the systems and structures are available to collect the relevant data
037	Boehringer Ingelheim	Question 2	The metrics of Quality Statement 3 and 7 are unclear, which in turn makes the collection of relevant data problematic. It is not clear for how long the rehabilitation should be provided for in Quality Statement 3. There are no metrics at all in Quality Statement 7. It is not clear what the symptoms of "suspected stroke" are in Quality Statement 1. This could lead to the collection of inconsistent data. Quality Statement 5 does not make it clear what is meant by "arrival"; for example, this could be at A&E or a stroke unit. Again, this lack of clarity could lead to the collection of inconsistent data. It would be helpful if the documentation of data was all coordinated and documented in one place. SSNAP currently captures some of the data within the draft Quality Standard. Going forwards, one location for such data collection would be beneficial.
038	British Medical Association	Question 2	The question is oddly phrased, as if systems and structures were available, the collection of data would be possible by definition. Instead we believe that the questions should ask 'could systems and structures be arranged so as to collect the data?'
039	London Stroke Strategic Clinical Network	Question 2	Quality statement 1 would require an additional local audit to collect relevant data. Given the existing challenge of submitting quality data to the national stroke audit (SSNAP) it is questionable if this is advisable or would result in any clinical benefit. Quality statements 2 – 6 – data could either be directly lifted or derived from SSNAP.
040	SCM - The Dudley Group NHS Foundation Trust	Question 2	Many of the data required is already generated by SSNAP; however, some of the calculations currently completed by SSNAP may be worthy of review to ensure their appropriateness.
041	Association of British	Question 3	No specific examples are identified

ID	Stakeholder	Statement number	Comments[1]
	Neurologists (ABN)		
042	British Medical Association	Question 3	No examples available.
043	Association of British Neurologists (ABN)	Statement 1	I agree with this Statement
044	British Association of Stroke Physicians	Statement 1	BASP commends the Quality Statement 1 of Prompt admission to specialist stroke units within 4 hours of arrival as firstly this emphasizes the pressing priority for all stroke patients (where applicable) to receive the key evidence based processes in such a unit but secondly highlighting the speed of admission within the emergency hospital organization given the competing priorities e.g. A&E 4 hour target. There are problems with the denominator – "suspected stroke". It does not include patients with a delayed diagnosis where stroke was not initially suspected and it potentially includes patients without a final diagnosis of stroke who might be disadvantaged by stroke unit admission. The size of both of these groups reflects the quality of the initial assessment. Patients with stroke should be identified accurately in ED and have a specialist diagnostic assessment. If stroke remains the most likely diagnosis patients should be admitted to a stroke unit within 4 hours. SSNAP only includes patients with a final diagnosis of stroke rather than all patients with suspected stroke at 4 hours so monitoring this standard will require local data collection as well. The statement mentions that some patients may need high dependency care but does not mention hyperacute stroke unit care.
045	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network	Statement 1	Should this specify to a HASU? Impact on DSC? The wording should reflect the centralisation in Manchester, London and other areas - i.e. 'or transfer to a unit where this can be done'. Also that the standard is not applicable when a patient is presenting some time after their stroke (for the purposes of our system that is 48 hours but I believe the research would support 24 hours or even less).
046	Intercollegiate Stroke Working Party	Statement 1	We support retaining this as a QS given that only 56% of patients currently get to a stroke unit within 4 hours and this is the key to most of the rest of the performance standards being achieved. It is also concerning that compliance with this standard has fallen over the last year from 58% suggesting that the pressure hospitals are under from acute medicine are resulting in a decline in the quality of care for stroke
047	London Stroke Strategic Clinical Network	Statement 1	Recent evidence demonstrates that rapid access to evidence based treatment improves outcomes, hence it is helpful to retain a focus on this aspect of stroke management in view of the competing targets in A & E. SSNAP measures time to admission for confirmed strokes. Time to admission for suspected strokes would be more difficult to define and measure without the introduction of an additional local audit and may not reflect the most appropriate pathway for individuals who do not have a diagnosis of stroke. Diagnosis should be confirmed in A & E to enable identification of the most appropriate pathway. Clarity would be improved if the statement emphasised that this relates to admission to a hyper-acute stroke unit.

ID	Stakeholder	Statement number	Comments[1]
048	NHS Wales Delivery Unit	Statement 1	Comment on outcome measure b). Many patients presenting with stroke will have a pre-stroke Rankin score above zero based on their pre-existing disability. Therefore, a more appropriate measure will be the change in score and this is already reported within SSNAP.
049	RCGP	Statement 1	Is this correct that it applies to patients with suspected stroke? For patients who present in A&E with a suspected stroke, but where the diagnosis is excluded in A&E, then they should not be included in the denominator. Surely it should be those in whom stroke is confirmed? [DJ]
050	Royal College of Physicians (RCP)	Statement 1	We support retaining this quality standard. It reflects a number of important components in the stroke pathway which impact on patient outcomes and is routinely recorded.
051	SCM - University of Manchester and Salford Royal Foundation Trust	Statement 1	We support retaining this as a QS given that only 56% of patients currently get to a stroke unit within 4 hours and this is the key to most of the rest of the performance standards being achieved. It is also concerning that compliance with this standard has fallen over the last year from 58% suggesting that the pressure hospitals are under from acute medicine are resulting in a decline in the quality of care for stroke
052	SCM - The Dudley Group NHS Foundation Trust	Statement 1	Does this add anything to the existing standard? Perhaps the only addition is the requirement for written admission protocols
053	St. George's Hospital, London	Statement 1	We support retaining this as a QS. We strongly support direct access to stroke beds for patients.
054	Stroke Association	Statement 1	The Stroke Association supports this statement. SSNAP data has highlighted significant regional variation in the proportion of patients getting to a stroke unit within four hours so including a statement on this should help drive better outcomes including reduced disability and mortality.
055	The East Midlands Stroke Clinical Advisory Group	Statement 1	Agreed
056	Boehringer Ingelheim	Statements 1 and 2	Boehringer Ingelheim welcomes the targets outlined in Quality Statements 1 and 2, however feels that the inclusion of incentives for meeting, and consequences for not meeting the targets would drive efficiency. An example of this could be including the targets within the CQUIN framework. Neither of these two Quality Statements describe a link to improving the ability to offer thrombolysis to eligible patients simply to get a scan or admission to a ward. Boehringer Ingelheim would suggest that there needs to be a more specific recommendation that patients are managed in a stroke service capable of delivering thrombolysis as well as managing acute stroke. Route cause analysis could help identify areas where services could be improved when targets have been missed.
057	Association of British Neurologists (ABN)	Statement 2	I agree with this Statement
058	British Association of	Statement 2	Accurate early diagnosis is essential for all patients so they can access evidence-based treatments. This means

ID	Stakeholder	Statement number	Comments[1]
	Stroke Physicians		stroke unit care (see above), antiplatelets and blood pressure control in intracerebral haemorrhage. All patients therefore will benefit from early imaging. Achieving statement 1 requires all patients to have imaging to establish the diagnosis before admission to a stroke unit at 4 hours. All patients with a suspected acute stroke should have a scan within 1 hour.
059	BRITISH SOCIETY OF INTERVENTIONAL RADIOLOGY	Statement 2	I find this paragraph a little confusing – the indications for immediate brain imaging are very well described in the next section on the same page – I presume the 'may need to take, blood thinning treatment' refers to those who may be suitable for thrombolysis? Why not say 'may benefit from clot-dissolving drugs' as first indication. Also I would say a CT Head (aka brain scan in this context, as MRI is not routinely available in most units in the hyperacute setting) 'helps determine the type of stroke' rather than 'will show the type of stroke' as it's not uncommon to have a normal unenhanced brain CT with acute non-haemorrhagic stroke – CT angiography and CT perfusion studies would be required to provide a more comprehensive assessment of stroke type, and these are not routinely performed in the UK
060	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network	Statement 2	Should this specify to a HASU? Impact on DSC? The wording should reflect the centralisation in Manchester, London and other areas - i.e. 'or transfer to a unit where this can be done'. Also that the standard is not applicable when a patient is presenting some time after their stroke (for the purposes of our system that is 48 hours but I believe the research would support 24 hours or even less).
061	Intercollegiate Stroke Working Party	Statement 2	We believe that this is a wasted standard. 44% of patients are scanned within 1 hour currently and that is probably near the correct number and 88% are scanned within 12 hours. We do not believe that keeping this as a QS will result in significant improvements in the quality of care. Furthermore it is a difficult standard to measure as it requires all the indications for urgent scanning to be accounted for and not all of these are included within SSNAP
062	London Stroke Strategic Clinical Network	Statement 2	If the intended outcome of this quality standard is to improve access to thrombolysis for appropriate patients it would be preferable to state this more obviously (see response to question 1).
063	Medtronic Limited	Statement 2	Medtronic welcomes the quality statement 'Adults with acute stroke and indications for immediate brain imaging have a scan performed within 1 hour of arrival'. This Quality Statement will facilitate patients with acute ischemic stroke and confirmed large-vessel occlusion that will benefit from treatment with Mechanical Clot Retrieval as an adjunct therapy to thrombolysis or as a standalone treatment where thrombolysis is contraindicated or has been unsuccessful. Improved functional 90 day outcomes have been proven in recent studies in this group of patients References; 1. Stent-Retriever Thrombectomy after Intravenous t-PA vs. t-PA Alone in Stroke, Jeffrey L. Saver, Mayank Goyal et al (April 2015), http://www.nejm.org/doi/full/10.1056/NEJMoa1415061. 2. Randomized Trial of Revascularization with Solitaire FR Device versus Best Medical Therapy in the Treatment of Acute Stroke Due to

ID	Stakeholder	Statement number	Comments[1]
			Anterior Circulation Large Vessel Occlusion Presenting within Eight Hours of Symptom Onset (REVASCAT) Drs. Jovin and Davalos et al (April 2015) http://www.nejm.org/doi/full/10.1056/NEJMoa1503780?rss=searchAndBrowse http://www.nejm.org/doi/full/10.1056/NEJMoa1411587 3.
064	NHS Wales Delivery Unit	Statement 2	Time is brain, and the number needed to treat (NNT) with tPA, for a good outcome, increases by a factor of 1 for every 10 minutes that elapses. There is already a considerable delay with the reporting /review of scans once brain imaging has been performed. The BASP standard for the administration of tPA requires patients to be treated within 30 minutes of arrival. These principles/aspects cannot be reconciled with a standard that requires a scan to be performed within 1 hour of arrival. In Wales, some radiology colleagues quote this standard as a justification for delaying immediate brain imaging. Patients who are eligible for thrombolysis must be taken direct to the scanner and immediate brain imaging performed within 15 minutes of arrival, with the scan being reviewed/reported within 30 minutes of arrival to facilitate timely administration of the bolus dose. An achievement target of 50% is inappropriate, this should be, as an absolute minimum, 90 per cent. Outcome measure b) should be revised to reflect the change in Rankin score.
065	Royal College of Physicians (RCP)	Statement 2	We consider that this standard is open to very variable interpretation and they are not data that are recorded routinely.
066	SCM - University of Manchester and Salford Royal Foundation Trust	Statement 2	We believe that this is a wasted standard. 44% of patients are scanned within 1 hour currently and that is probably near the correct number and 88% are scanned within 12 hours. We do not believe that keeping this as a QS will result in significant improvements in the quality of care. Furthermore it is a difficult standard to measure as it requires all the indications for urgent scanning to be accounted for and not all of these are included within SSNAP. It would be better to go with the 12 hour all patients scanned standard
067	SCM - The Dudley Group NHS Foundation Trust	Statement 2	Does this add anything to the existing standard? Perhaps the only addition is the requirement for written protocols
068	St. George's Hospital, London	Statement 2	This standard does support early access to brain imaging for stroke patients. However, the definition of 'indications for urgent brain imaging' are unclear and therefore unauditable via SSNAP. Therefore, consideration should be given to modifying this standard. One option is to set a target of 75% of patients with confirmed stroke to have brain imaging undertaken within an hour of hospital arrival.
069	Stroke Association	Statement 2	This statement will be difficult to measure, as it can't be directly measured from SSNAP. SSNAP does not collect data on indications for immediate brain imaging. We suggest rewording the statement to aim for the SSNAP clinical audit, and Accelerating Stroke Improvement Programme, target of 50% of all stroke patients receive brain imaging within one hour.
070	The East Midlands Stroke Clinical Advisory Group	Statement 2	Agreed

ID	Stakeholder	Statement number	Comments[1]
071	The Society and College of Radiographers	Statement 2	The Society and College of Radiographers have reviewed this draft guidance and have focussed on the requirements of medical imaging. We feel the quality standard would benefit from including a time scale for the report of the brain scan. As a suggestion Adults with acute stroke and indications for immediate brain imaging have a scan performed and reported within 1 hour of arrival. Quality statement currently states: Adults with acute stroke and indications for immediate brain imaging have a scan performed within 1 hour of arrival.
072	UK Neurointerventional Group / The Royal College of Radiologists	Statement 2	There is a risk that as phrased this QS will tend to lead to drift towards accepting lower imaging performance than is appropriate- i.e. within 1h rather than scan as soon as possible We suggest rephrasing to: "….scan performed within a maximum of 1 hour of arrival and that, where indicated, advanced brain imaging is performed expeditiously (e.g. CT Angiography or MRI)." This revised statement is required to ensure that requirements for modern diagnosis & initial management of stroke are capable of being met.
073	Association of British Neurologists (ABN)	Statement 3	I agree with this Statement
074	Boehringer Ingelheim	Statement 3	It is not clear whether there is a ceiling to the length of time a patient may receive this rehabilitation therapy for. It is also unclear about how this therapy would fit in with personal care budgets.
075	Boehringer Ingelheim	Statement 3	Boehringer-Ingelheim considers this statement too broad as rehabilitation is delivered by many different specialty services and may not all be appropriate to be delivered 5 days a week eg cognitive/memory support, emotional support but may be required over a longer period of time post stroke.
076	British Association of Prosthetists and Orthotists (BAPO)	Statement 3	BAPO support statement 3 on access to therapies. However it is our belief that stroke patients will benefit in the short and long term by also having rapid access to an orthotic service. Within stroke rehabilitation, orthotics is sometimes treated as a sub section of physiotherapy, with physiotherapists in some instances supplying pre-fabricated orthotic devices and frequently making onward referrals to an orthotic service. This is not helpful to patients or to orthotic services. Orthotists are the best placed professionals to assess patients who may require orthotic treatment as they are competent to prescribe and if necessary modify CE marked pre-fabricated orthoses/orthotic devices. They can in addition prescribe and design custom orthoses which are frequently necessary for post stroke patients. There is some evidence that early orthotic intervention leads to better outcomes, including balance, than those receiving later orthotic treatment (Nikamp et al., 2013) and this is supported by clinical experience in centres where this is properly implemented. For these reasons we would propose that an additional statement is made: Adults with impaired mobility having stroke rehabilitation are assessed by a specialist orthotics service within 6 weeks of having a stroke.

ID	Stakeholder	Statement number	Comments[1]
			The addition could alternatively be incorporated as part of point 3: Statement 3. Adults with stroke having stroke rehabilitation are offered at least 45 minutes of each relevant therapy for a minimum of 5 days per week and have direct access to associated specialist services such as orthotics where needed. Nikamp C, Buurke J, Nederhand M, et al. Timing of ankle foot orthoses after stroke: First results of a randomized longitudinal study. Presented at International Society of Prosthetics and Orthotics 2013 World Congress, Hyderabad, India, February 2013.
077	British Association of Stroke Physicians	Statement 3	It is implied in statement 4 that this applies equally to patients receiving rehabilitation in the community but this should be made clearer here. Adults receiving stroke rehabilitation in hospital or in the community should be offered 45 minutes of each relevant therapy for a minimum of 5 days per week.
078	College of Occupational Therapists	Statement 3	This does not reflect those who are unable to tolerate 45 minutes or those who can tolerate more. Suggestion for possible wording: 'adults undergoing stroke rehabilitation are offered as much appropriate therapy as they are able to tolerate, for most this would be at least 45 minutes, minimum of 5 days a week.' Consider including.. Delivered by stroke specialist/stroke skilled professionals. Outcomes should also include improvement in function and engagement in occupation rather than just readmission rates. P17. "The outcomes that an adult with stroke should expect to achieve will depend on the type of rehabilitation needed" The outcomes will be dependent on the stroke severity, prognostic indicators rather than the type of rehabilitation needed. Appropriately resourced and skilled rehabilitation options should be available to meet the varying needs of adults recovering from stroke, ranging from those with mild-moderate impairment to those with significant impairment/disability. These rehabilitation options should be available according to need, irrelevant of person's location (ie NH's). Not all areas have dedicated rehabilitation facilities or teams in the community who can deliver ongoing specialist rehabilitation for those outside of the ESD criteria, or those needing a longer period of specialist rehabilitation to reach their potential.
079	Greater Manchester,	Statement 3	How will this apply to Greater Manchester and London centralisation?

ID	Stakeholder	Statement number	Comments[1]
	Lancashire and South Cumbria Strategic Clinical Network		Should this specify to a DSC? Impact on HASU? Exclusion criteria needed- what is the potential negative impact? Where did this original guidance come from and is there any evidence to show why this figure is best/most effective. In my experience, many patients are unable to tolerate this, plus in most organisations it is a very hard target to achieve given staffing levels. Other than NICE guidance and expert opinion, where is the evidence?
080	Intercollegiate Stroke Working Party	Statement 3	Big improvements have been seen in the intensity of therapy provided in hospital since the 45 min standard was introduced but there is still a long way to go so we agree that this is an important standard to retain. However the group felt that the wording for this statement should be consistent with the National Clinical Guideline for Stroke (2012) recommendations which specify that only patients who are able to tolerate a particular therapy are provided this level of intensity.
081	London Stroke Strategic Clinical Network	Statement 3	See response to question 5 above.
082	Nutricia Advanced Medical Nutrition	Statement 3	Correction of 'speech therapists' to 'speech and language therapists' and inclusion of dietitians as specialists who may be involved in rehabilitation therapies.
083	Royal College of Physicians (RCP)	Statement 3	We consider that this is an important standard to retain. Since it was introduced there have been significant improvements in the amount of therapy delivered in many hospitals but performance is variable.
084	Royal College of Speech and Language Therapists	Statement 3	Please see below for comment in quality statement 3 / pg. 17
085	Royal College of Speech and Language Therapists	Statement 3	The RCSLT believe the important thing here is that individuals have the opportunity of receiving the intensity of rehabilitation as appropriate to their condition at the time. Many individuals will not be able to manage 45 minutes of therapy in the early days following stroke, however they may well be good enough to manage this a little later in the course of their recovery - but this is often when they have been discharged and this specification no longer applies. Intensive therapy has been demonstrated to be effective but the timing of this is important. It should be offered at the most optimal time from the patient's point of view - but this is often not possible. Determining why a patient is not receiving 45 minutes of therapy per day would be a useful exercise i.e. if it could be determined whether it was the patient's condition or a shortage of staff. The RCSLT think this is reasonably well covered in the document but must apply to those discharged home early as community rehabilitation does not often offer the interdisciplinary team, or the intensity which is available in the hospital. Patients who have no physical problem but have speech-language or swallowing problems may be particularly disadvantaged.
086	Royal College of Speech and Language Therapists	Statement 3	The RCSLT would like this quality statement to include: "they can help people who have problems with their memory and concentration: understanding, speaking, reading…" If the person does not understand what is said to them their

ID	Stakeholder	Statement number	Comments[1]
			participation in other therapies and in daily life is curtailed.
087	Royal College of Speech and Language Therapists	Statement 3	Please change “speech therapists” to “speech and language therapists”
088	SCM - University of Manchester and Salford Royal Foundation Trust	Statement 3	Big improvements have been seen in the intensity of therapy provided in hospital since the 45 min standard was introduced but there is still a long way to go so we agree that this is an important standard to retain
089	SCM - The Dudley Group NHS Foundation Trust	Statement 3	This presents an important amendment to the current guidelines with the reflection that rehabilitation should be accessible ‘at any stage of the stroke pathway’ and reiterates that rehab should be offered as ‘long as the person is making progress’. I am not sure the quality measure reflects these nuances well. This will also need to be clearly flagged to both CCGs and providers as key indicators as current practice often sees these two details as exceptionally challenging.
090	St. George’s Hospital, London	Statement 3	This standard should be retained. However, it’s often not appropriate for certain patients, eg those medically unwell or too drowsy. Interpretation of this is relevant regarding SSNAP.
091	Stroke Association	Statement 3	The Stroke Association supports this statement due to the importance of rehabilitation to stroke survivors, as set out above. We believe ensuring a key focus on NICE guidelines on the amount of therapy stroke survivors receive in hospital is important to include in the quality standard as the last four SSNAP audits have shown no improvement in the amount of therapy patients receive in hospital. Further guidance is needed on adequate referral of patients to support in community. This is where a named contact or key worker would be very valuable, and would prevent stroke patients being discharged into their community with no contacts and no support. The ongoing effects of a stroke are life-long for many patients. Access to therapy services beyond the acute setting is vital.
092	The East Midlands Stroke Clinical Advisory Group	Statement 3	Agreed
093	Association of British Neurologists (ABN)	Question 5	Yes
094	British Medical Association	Question 5	It is difficult to assess the amount of rehabilitation available in the community setting and whether the statement adequately addresses it, as this depends on the available resources. Although it is more useful to offer more than one stroke rehabilitation therapy each day rather than one session every 24 hours, it is unclear whether there is a capacity to do so.
095	London Stroke Strategic Clinical Network	Question 5	The SCN supports the inclusion of a quality statement related to rehabilitation intensity. The proposed quality statement is appropriate for rehabilitation provided by acute and ESD teams. There is currently no evidence which defines appropriate levels of rehabilitation intensity in community teams.
096	SCM - The Dudley Group	Question 5	I believe draft statement 3 needs to be more robust and directed if it is to address intensity of therapy in the

ID	Stakeholder	Statement number	Comments[1]
	NHS Foundation Trust		community I believe the measure (numerator/denominator) does not measure the proposed standard appropriately as it measures ALL receiving rehab and not those who can 'tolerate' this rehabilitation intensity as stated in the standard. I have been attempting to engage SSNAP in this dialogue too.
097	Association of British Neurologists (ABN)	Statement 4	I agree with this Statement
098	British Association of Stroke Physicians	Statement 4	In modern care settings nearly all patients can be transferred from bed to chair if appropriate equipment and seating is available. Patients who are suitable for early supported discharge are generally but not always able to transfer independently or with the help of one person. The denominator should reflect this rather than being restrictive.
099	College of Occupational Therapists	Statement 4	This does not include the other important criteria (evidence based) for ESD, such as toileting, able to maintain safety overnight and between visits, able to call for help. It would be appropriate to include these. The College feels it is important to specify stroke specialist/skilled ESD (as in previous point) Clinical outcomes measuring functional improvement should be measured alongside length of stay and quality of life.
100	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network	Statement 4	Should other functional systems be used i.e MRS, Bartel not just transfer Structure of the ESD team: Mandatory team members: Nurse?? Statement 4 regarding ESD is lacking, in our view and requires further clarity regarding measures, data collection and the components that would be required to ensure a quality delivery of service.
101	Intercollegiate Stroke Working Party	Statement 4	We agree that a statement in support of stroke specialist ESD should be retained as there are still CCGs who do not commission ESD and even where teams do exist the proportion of patients provided with ESD is too low. However using 'bed-to-chair' as a standard is too vague (patients could be assisted via staff or machinery and/or have other complex needs which mean discharge with ESD is inappropriate) and it is not measurable via the Sentinel Stroke National Audit Programme.
102	London Stroke Strategic Clinical Network	Statement 4	The SCN supports the inclusion of this quality standard. However, evidence indicates that to be eligible for ESD individuals should be able to transfer safely from bed to chair with the help of one person (if an able bodied family member of carer is available) or independently if they live alone.
103	Royal College of Physicians (RCP)	Statement 4	We consider that there is still a need for this standard to promote the continued commissioning of Early Supported Discharge (ESD) services
104	Royal College of Speech and Language Therapists	Statement 4	The RCSLT believe that with reduced length of stay, many patients are being discharged to community rehabilitation at an early stage - the above comment applies here as well, (see qual. Statement 3, pg. 17 comment)
105	Royal College of Speech and Language Therapists	Statement 4	The RCSLT would ask that you expand this statement. It does not take into account those individuals with significant psycho-social, cognitive or communication disorders who would be put at risk if discharged home "early" without these areas being addressed. It also does not take into account those living on their own (which would lead to social

ID	Stakeholder	Statement number	Comments[1]
			isolation) and those living with frail, infirm or otherwise unfit carers. As it stands this quality statement could endanger patients and carers more than keeping the patient in hospital for longer. A patient with severe cognitive, communication and mood issues discharged home alone would pose serious concerns for a stroke team and the risk of readmission is extremely high.
106	Royal College of Speech and Language Therapists	Statement 4	Whilst the RCSLT feel this is important to consider there may be local or family resources that should be taken into account. Furthermore, the use of some technologies has been found to reduce risk.
107	SCM - University of Manchester and Salford Royal Foundation Trust	Statement 4	We agree that this should be retained as there are still CCGs who do not commission ESD and even where teams do exist the proportion of patients provided with ESD is too low. But the way this is worded it is impossible to measure. There are lots of patients who can transfer from bed to chair who are NOT suitable for ESD. The important thing is that each centre has access to ESD
108	SCM - The Dudley Group NHS Foundation Trust	Statement 4	Should the qualifying safety statement 'as long as this can be done safely' be overtly present in the quality statement per se and not just in the later explanatory notes on page 21 and 22.
109	St. George's Hospital, London	Statement 4	We agree that this should be retained. The quality of ESD teams is very variable. This QS is not currently auditable. We suggest setting a target of 20% of stroke patients going home with ESD.
110	Stroke Association	Statement 4	The Stroke Association supports the principle of this statement because despite being recommended in NICE Stroke Rehabilitation Guidance, the National Stroke Strategy and the Cardiovascular Disease Outcomes Strategy Early Supported Discharge (ESD) is still not available to all appropriate patients, and there is significant regional variation in availability (median proportion of patients discharged to ESD team is less than 20% compared to an estimated 40% that would benefit). We would suggest that the detail of checking that someone can move from bed to chair be removed from the statement, as this is not the only criteria for eligibility for ESD. For example any cognitive impairments must be taken into account, as should the safety of their home environment. This simple definition risks oversimplifying assessing eligibility for ESD. Anecdotally, we have heard that in some areas ESD is not being implemented properly. ESD should be of the same intensity as inpatient care and should be stroke specific. Strengthening of this statement to this effect would be useful.
111	The East Midlands Stroke Clinical Advisory Group	Statement 4	Agreed
112	Association of British Neurologists (ABN)	Statement 5	I agree with this Statement
113	Boehringer Ingelheim	Statement 5	The care of patients with stroke should be documented in an individual care plan. Rehabilitation should be part of this individual care plan.

ID	Stakeholder	Statement number	Comments[1]
			It would be helpful for the Quality Standard to include details of alternative methods for agreeing rehabilitation goals for patients who are unable to input into their own goals due to impaired cognition, receptive or expressive dysphasia's or severity of stroke. The inclusion of family and /or carers in rehabilitation decisions would also be beneficial for patients.
114	British Association of Stroke Physicians	Statement 5	Goals should be reviewed weekly however BASP is not convinced that this particular standard is one of the most pressing priorities for stroke care given the other omissions.
115	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network	Statement 5	Exclusion criteria needed- what is the potential negative impact? Other than NICE guidance and expert opinion, where is the evidence?
116	Intercollegiate Stroke Working Party	Statement 5	While no one would argue that goal setting is unimportant again we feel this is not a good choice for a QS. It is not a well defined intervention. Some would suggest it has to be an exercise with patient's carers and staff meeting together to set goals. Others just do as a professional group, while others we suspect would answer in the affirmative if just the physio had seen them. Experience from SSNAP is that the data are probably not well recorded.
117	London Stroke Strategic Clinical Network	Statement 5	Rehabilitation goals are undoubtedly a vital element of delivering individualised and focussed interventions. However, the target of 5 days set in this statement does not appear to be especially aspirational given that SSNAP shows that the national median for 2014-2015 was 1 day, with an upper range of 3 days. The SCN suggests that this may not be a priority for improvement at this time.
118	RCGP	Statement 5	Reason for commenting is that the idea of shared decision making is certainly implied, but not explicitly included. [DJ]
119	Royal College of Physicians (RCP)	Statement 5	We consider that this is a very difficult standard to define and record.
120	Royal College of Speech and Language Therapists	Statement 5	The RCSLT would suggest this requires slightly re-wording. There is a need to take into account those patients who are seriously ill at day 5, post onset. It also needs to consider those with complex and rapidly changing impairments where at day 10 or 15 post stroke – the patient's goals are very different to day 5. The RCSLT suggest: "The process of establishing rehabilitation goals with patients and their carers starts within 5 days of their arrival and is reviewed regularly." The current wording will lead to very rigid goals being set and the inability to modify and alter them depending on the needs of the patient.
121	Royal College of Speech and Language Therapists	Statement 5	Speech and language therapists can assist in identifying whether an individual has capacity to consent to participate in goal setting and can facilitate communication between team members by ensuring that there is a clear understanding of the level of comprehension, any reading difficulties, presence of the separation and most

ID	Stakeholder	Statement number	Comments[1]
			appropriate ways to facilitate expression.
122	SCM - University of Manchester and Salford Royal Foundation Trust	Statement 5	While no one would argue that goal setting is unimportant again we feel this is not a good choice for a QS. It is not a well defined intervention. Some would suggest it has to be an exercise with patient's carers and staff meeting together to set goals. Others just do as a professional group, while others we suspect would answer in the affirmative if just the physio had seen them. Experience from SSNAP is that the data are probably not well recorded.
123	SCM - The Dudley Group NHS Foundation Trust	Statement 5	Definitions section – does goal setting have to 'take place in goal-setting meetings'? What is the evidence that this is the most effective way of achieving goals that are set? Outcome measures – is readmission a measure of the effectiveness of goal setting? (page 24)
124	St. George's Hospital, London	Statement 5	We propose to remove this QS. Interpretation is broad. It has no measureable impact on patient outcomes and is not measureable in SSNAP.
125	The East Midlands Stroke Clinical Advisory Group	Statement 5	Not agreed. It is not felt that there is a significant enough gap in the provision of this element of care to warrant a NICE statement relating to it. Whilst the acute stay is clearly important, from a rehabilitation perspective it is a very short part of the stroke survivors overall recovery. Recovery from stroke can take years and so we feel that a therapy focused statement should take this into account rather than focusing on very early goals during the acute phase of care. There are also other aspects of care where the strength of a NICE statement can act as a lever for change so if the number of statements is to be so significantly reduced we would suggest others are of a greater priority (see below)
126	Alzheimer's Society	Statement 6	In order to ensure long-term management of stroke, health and social care reviews as part of quality measure 6 should include identification and risk reduction of vascular dementia. A person who has had a stroke, or who has diabetes or heart disease, is approximately twice as likely to develop vascular dementia. About 20 per cent of people who have a stroke develop post-stroke dementia within six months. People who have had a stroke should be encouraged to reduce their risk of dementia by managing their condition appropriately, through taking prescribed medicines and following professional advice about their lifestyle.
127	AntiCoagulation Europe	Statement 6	We would suggest that it is in the patient's interest to be reviewed by their GP/managing clinician on any occasion when a health issue may arise which could influence stroke risk and treatment. We would hope that this would be undertaken as good practice, however, if a patient is seen by numerous HCP's, it's important that the stroke and ongoing risk is re-assess appropriately and monitored consistently.
128	Association of British Neurologists (ABN)	Statement 6	I agree with this Statement
129	Boehringer Ingelheim	Statement 6	It is not clear who in the health and social care system will be responsible for reviewing and actioning Quality Statement 6. The draft statement is very prescriptive. Stroke patients should be assessed on an individual case by case basis.

ID	Stakeholder	Statement number	Comments[1]
			There may be need for more frequent reviews if clinically necessary. Given that 25-33% of strokes are recurrent and 3 in 10 stroke survivors go on to have a recurrent stroke, could more be done to reduce this by reviewing health and social care needs earlier than 6 months? Is this timeframe able to impact the burden of recurrent stroke?
130	British Association of Stroke Physicians	Statement 6	BASP concurs with standard of 6-month reviews, which currently is implemented poorly nationally. Further clarification is required what tools should be used, by whom and which location should these assessments be carried out in. It should be highlighted that this is a commissioning priority and is embedded within the CCG Indicators Outcome.
131	College of Occupational Therapists	Statement 6	This section lacks a clear rationale for omitting 6 week reviews. This section lacks reference to our responsibility to the carers. For the main body of the text/descriptor: This should be conducted by someone who is stroke skilled/specialist, with the review being holistic in nature including health (such as medical, therapy, continence, medication management, sexual function, emotional health) and social (such as housing, care needs, carer needs, equipment, benefits, social interaction). This section lacks inclusion of those with aphasia in having their needs and views represented.
132	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network	Statement 6	Who should perform this? What standards are to be included? i.e mood, function, on going care needs Is this patient specific and individual? What about review at 6 weeks? When is the end? 2,3,4 yrs after initial stroke?
133	Intercollegiate Stroke Working Party	Statement 6	Important area for improvement. Still a long way to go both in terms of commissioning and provision of services. So we support this QS
134	London Stroke Strategic Clinical Network	Statement 6	There is evidence that there is wide variation in the delivery of six month reviews. Consequently the SCN supports the inclusion of this quality standard.
135	RCGP	Statement 6	Appropriate that this should focus on QoL. Interesting that assessing it is, for GPs, to be done via QOF. The current QOF indicator addresses secondary prevention and includes nothing about assessment of QoL. I personally think it would be difficult to construct a simple QOF measure that would capture this, with the danger that it would be trivialised into a matter of box-ticking, as so much else is in QOF. I would not welcome a QOF indicator measuring it, but I welcome its addition here. [DJ]
136	Royal College of Physicians (RCP)	Statement 6	We very strongly support this standard as there is a need for better long-term integration of the stroke pathway across care boundaries.
137	Royal College of Speech and Language Therapists	Statement 6	The RCSLT request mention of: “Adults who have had a stroke have their health and social care needs reviewed, and their treatment adjusted as required, at 6 months after the stroke and annually thereafter”.

ID	Stakeholder	Statement number	Comments[1]
138	Royal College of Speech and Language Therapists	Statement 6	RCSLT suggest that the 6 month review also needs to take into account people with ongoing dysphagia in order to review whether modified diet or PEG feeding is still required. Changing circumstances of patients and their families may require consideration of other communication supports/communication
139	SCM - University of Manchester and Salford Royal Foundation Trust	Statement 6	Important area for improvement. Still a long way to go both in terms of commissioning and provision of services. So we support this QS
140	SCM - The Dudley Group NHS Foundation Trust	Statement 6	Should this be more explicit about who completes these reviews? It is not clear that there is an expectation that goal setting is re-visited here (hence the importance of who completes these reviews)
141	St. George's Hospital, London	Statement 6	This is clearly an important standard. We support this standard to encourage commissioning of such services.
142	Stroke Association	Statement 6	The Stroke Association supports this statement. It is clear that ongoing monitoring and support is very important in improving patient experience, identifying patients who need further treatment, ensuring that services provided are meeting patients' needs and checking that secondary prevention is being provided. Recent SSNAP data found that whilst the vast majority of patients after stroke at the time of audit were applicable to receive a 6 month review, this is currently happening in only 17.8% of cases. The previous quality standard mentioned reviews at 72 hours and 6 weeks and we have concerns about losing this focus. As an organisation who support people affected by stroke, we often hear from patients and carers who describe the experience of being discharged into the community as like "falling off a cliff edge". A process of a 6 week review, followed by 6 month and then annual review can help facilitate a pathway back to further specialist review, advice, support and rehabilitation where required.
143	The East Midlands Stroke Clinical Advisory Group	Statement 6	Agreed
144	Association of British Neurologists (ABN)	Question 6	Yes
145	Boehringer Ingelheim	Question 6	Boehringer-Ingelheim considers Statement 5, the requirement to agree goals with a patient within 5 days denies stroke patients who are unable to do this due to effects of their stroke this opportunity by not including relatives/carers in this process. The target of 6 months in Statement 6 may limit the opportunities to address secondary prevention earlier and therefore reduce the risk of recurrent stroke.
146	British Medical Association	Question 6	Given that early work is most valuable, agreeing the rehabilitation goals within 5 days of arrival and then reviewing them again after 6 months, seems to be a considerable time interval. We believe it would be beneficial to consider a review at three months.
147	College of Occupational	Question 6	Please consider if there is a need to clarify where "on arrival" refers to.

ID	Stakeholder	Statement number	Comments[1]
	Therapists		It is important that goals are person centred - set jointly and used to shape treatment planning. In the main body of the documentation include guidance on how this is facilitated, for example: how is this carried out with people with aphasia, how are MDT goals set for those without capacity in best interest. Goals may include improvement in impairments, increased independence in every-day occupations (such as self care), leisure, work, relational goals (i.e. about relationships) or other social goals (such as accessing transport or further education). Is there evidence that goal setting influences readmission rates? Clinical outcomes addressing function and occupation would be a more effective measure of goals. This section lacks sufficient detail regarding the review of goals - the importance of regular review and transferring goals to any new service (progression along the pathway).
148	London Stroke Strategic Clinical Network	Question 6	Please see relevant comments below.
149	Royal College of Speech and Language Therapists	Question 6	For the draft statement 5 & 6, the RCSLT do not believe the statements address the ongoing need to review goals – it is not in the wording of the statement.
150	SCM - The Dudley Group NHS Foundation Trust	Question 6	The need to set goals is clearly stated in draft statement 5. I am doubtful however if draft standard 6 makes the importance of revisiting goals explicitly clear. I also wonder if this is the avenue for reviewing goals – it depends who is completing the 6-month review.
151	Stroke Association	Question 6	The Stroke Association supports the principle of this statement, however as it represents what ought to be basic care, we feel that it is not aspirational enough and will therefore have minimal impact in improving care. The goals of a patient will change significantly over time, so only having goals set at day 5 will mean the goals are set quite low – at this point the patient will probably set basic goals such as wanting to walk, feed themselves, dress themselves. Over time, as their situation improves, and particularly once discharged home, the goals become much more complex, such as wanting to go and do their own shopping and cooking their own meals. Focussing rehab based on a patient's goals after 5 days is not realistic for long-term rehab and risks a situation where it is assumed the rehab the goals have been achieved and the job is complete. One cannot simply tick the box and assume the job is done at this stage. Rehabilitation takes place over a very long period of time for most patients, and as mentioned above, the effects of a stroke can be life-long.

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			We suggest rewording and strengthening the statement to something like: “Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours. Documented multidisciplinary goals to be agreed within 5 days and reviewed at 6 weeks, 6 months and annually thereafter.” This statement could also be an opportunity to promote a named rehabilitation contact. The previous quality standard set out that all carers of stroke patients are given a named point of contact. Having a named point of contact is incredibly important in supporting patients and coordinating care and the removal of this standard is a key gap in this version of the quality standard. There are Dementia Navigators for dementia and Key Workers in cancer to help signpost and support people throughout their journey; stroke patients should receive the equivalent level of care.
152	Association of British Neurologists (ABN)	Statement 7	I agree with this Statement
153	Boehringer Ingelheim	Statement 7	The current evidence base may also help as this identifies the risk factors and presentation of an acute neurological event which are the same for PCA stroke as for other strokes. Education of risk factors alongside FAST signs will improve awareness and suspicion of stroke by emergency services earlier to ensure similar access to appropriate acute care.
154	British Association of Stroke Physicians	Statement 7	Evidence suggests that there is no validated scoring system that identifies stroke in adults without the Face, Arm and Speech Test (FAST) in pre-emergency situations and therefore it is questionable whether this particular standard is a pressing priority that requires development.
155	Intercollegiate Stroke Working Party	Statement 7	A pointless standard. There is no validated tool that has been shown to be effective in differentiating FAST negative stroke patients when delivered by paramedics. Out of all the topics you could have suggested developments this is a bizarre one
156	London Stroke Strategic Clinical Network	Statement 7	Evidence indicates that there is not a validated tool which can reliably identify stroke in patients without Face, Arm and Speech Test (FAST) symptoms. It is doubtful that a focus on this will result in significant clinical benefit. The SCN would suggest that there are currently other more important priorities.
157	London Stroke Strategic Clinical Network	Statement 7	See response to question 4 above.
158	RCGP	Statement 7	I think it would be impossible to write helpful guidelines here. The risk would be that it would rewrite a textbook of neurology, and would finish up being patronising to doctors. The diagnosis of stroke without classical hemiplegic symptoms is difficult and trying to simplify it in order to write a guideline would be likely to result in unforeseen consequences. [DJ]
159	Royal College of Physicians (RCP)	Statement 7	We do not understand how this could be achieved. It is certainly a difficult group of patients to identify but there are no validated clinical tools and even advanced imaging can result in false negatives.
160	SCM - University of	Statement 7	A pointless standard. There is no validated tool that has been shown to be effective in differentiating FAST negative

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	Manchester and Salford Royal Foundation Trust		stroke patients when delivered by paramedics. There is good evidence from recent trials that FAST is the best test we have. So I think this is a complete waste of time.
161	SCM - The Dudley Group NHS Foundation Trust	Statement 7	See earlier comments - I believe this is a priority piece of work.
162	St. George's Hospital, London	Statement 7	This is more of a research question than a QS. There is no good tool to achieve this QS with.
163	Stroke Association	Statement 7	The Stroke Association suggest removing this statement as there is no evidence that there is a better alternative to the FAST test when identifying stroke in an acute setting. http://stroke.ahajournals.org/content/44/11/3007 Stroke can be difficult to identify in those who do not present with "typical" symptoms. The main example is probably patients with cerebral small vessel disease (SVD), who often have a series of smaller or sometimes 'silent' strokes which gradually leads to the onset of vascular dementia. These patients enter directly into a dementia pathway with no recognition of their condition as stroke and no link through stroke services. If the link between stroke, SVD and dementia were more widely acknowledged, these patients could receive support much earlier via stroke services rather than present directly into dementia services once their condition has deteriorated over a long period of time.
164	The East Midlands Stroke Clinical Advisory Group	Statement 7	Not agreed. It was not felt that there are sufficient and evidence based tools available to categorically evidence stroke suitable for adoption at the same level and breadth of coverage as FAST. Trials of ROSIER in the London area are understood to have been inconclusive.
165	UK Neurointerventional Group / The Royal College of Radiologists	Statement 7	Specific mention of advanced brain imaging is also relevant to QS7 – identification of stroke in adults with posterior circulation or other "atypical strokes" that are harder to both diagnose and classify clinically is greatly facilitated by early recourse to advanced brain imaging. Therefore it needs to be widely available for stroke patients. Some centres have the scanners already & we are aware that they are capable of doing this type of imaging
166	Yorkshire Ambulance Service	Statement 7	Yorkshire Ambulance Service recently noticed that some strokes were being missed due to the patient not presenting with the typical FAST positive symptoms and were FAST negative but having a stroke. After identifying this we issued an operational update to all clinicians, call takers in the Emergency Operations Centre and the clinical hub a poster making them aware of the other symptoms that could potentially be a stroke. Although there is no evidence based guidance that covers identifying patients who are FAST negative Yorkshire Ambulance Service is making staff aware that certain strokes can be FAST negative with the hope of improving practice and patient treatment.
167	Association of British Neurologists (ABN)	Question 4	No new evidence is submitted that could be used to develop this placeholder statement.
168	British Medical Association	Question 4	We are not aware of any evidence-based guidance that could be used to develop this placeholder statement.
169	SCM - The Dudley Group NHS Foundation Trust	Question 4	I am unaware of published data on placeholder statement 7. However; I believe this to be a fundamental area for development and for a tool to be generated to support front line clinicians as posterior circulation strokes continue to

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			be missed in routine assessment by many clinicians, specialists and non-specialists alike.
170	Boehringer Ingelheim	Additional statement	Boehringer-Ingelheim considers that more could be included to draw attention to the importance of secondary stroke prevention. 3 in 10 stroke survivors go on to have a recurrent stroke and 25-33% of strokes are recurrent. More effective use of anticoagulation in this setting could reduce the incidence of stroke in the high risk population. Data on anticoagulation is already being captured in SSNAP so modification could help collect this data. Differentiation of type of anticoagulation for ischaemic/haemorrhagic stroke could identify better use of agents that significantly lower the risk of ICH. Boehringer-Ingelheim considers the addition of a standard regarding the management of TIA may also be useful as 15% of ischaemic strokes are preceded by a TIA and improved care, for example more rapid access to anticoagulation in patients found to be in AF could have an impact on stroke rates. As the risk of stroke following TIA is 5% at 48hrs, 8% at 1 week and 12% at 1 month, time to initiation of anticoagulation/access to anticoagulation services in this setting is critical. The Quality Standard could address primary prevention of stroke. Boehringer Ingelheim considers it to be important to cross reference the Quality Standard on Stroke with the Quality Standard on AF in order to ensure that the issue of stroke prevention is addressed. Indeed, prevention features strongly in NHS England's 5 Year Forward View. Addressing the need to prevent stroke is also aligned with the Government's Medicine's Optimisation Programme.
171	BOSTON SCIENTIFIC	Additional statement	Following a TIA it is essential a patient is treated as an emergency, and is assessed and admitted to the correct hospital offering acute stroke care.
172	British Association of Stroke Physicians	Additional statement	BASP commends the initiative of the NICE Quality Standards in order to continue improving the longer-term consequences following stroke. However, there are some important omissions from this document that require further attention. There are also a number of standards that have been described which although are relevant, may not be a pressing priority for stroke services. BASP also believes that the membership of the Quality Standards Committee should have been more inclusive with a wider range of specialist stroke opinions although there were members from the stroke specialty. BASP notes with regret that there is a major omission regarding standards relating to the prevention of venous thrombo-embolism. This is particularly relevant with the recent NICE guidance highlighting the benefits of Intermittent Pneumatic Compression devices. Evidence from SSNAP currently shows a significant shortfall in uptake of these devices nationally and thus adoption of such a standard would significantly lend support in addressing this issue. Another important omission is the absence of standards relating to clinical psychology within the multidisciplinary team. Although there has been some improvement nationally with the uptake of such services, there still remains a significant absence of psychology input. With the significant proportion of levels of mood and cognitive disorders post stroke, this is a potential lost opportunity.

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			Given the emphasis and priority of seven day working, BASP is surprised of the omission of this particular standard relating to provision of therapy across seven days but acknowledging that the overall quality of care should not be compromised over normal working hours.
173	British Heart Foundation	Additional statement	We are concerned that the quality standard does not cover secondary prevention of stroke (although control of hypertension is mentioned in the briefing paper for the standard) or cardiovascular disease more broadly, given the significant risk of a range of cardiovascular diseases associated with stroke. The standard could cross-reference NICE guidance and quality standards on CVD risk reduction.
174	BRITISH SOCIETY OF INTERVENTIONAL RADIOLOGY	Additional statement	Whilst relatively recent, there is strong evidence that intra-arterial clot retrieval in large vessel occlusive stroke significantly improves patient outcomes (see Falk-Delgado et al, J NeuroIntervent Surg 2015, Balami et al, Int J Stroke 2015 for 2 recent meta-analyses). Furthermore guidelines/recommendations are being updated in Europe to reflect this evolving therapeutic option. Large vessel occlusion accounts for about 10% of all embolic stroke, and responds less favourably to thrombolytic therapy, hence the rationale for clot retrieval (akin to emergency percutaneous coronary intervention in acute myocardial infarction). Hence, I would advocate that this area needs urgent consideration from NICE as part of the early management of acute stroke as it has the potential to improve patient clinical outcomes, lessen the burden on rehabilitation services and prove extremely cost effective.
175	British Specialist Nutrition Association	Additional statement	The NICE CG 68 and the National Clinical Guideline for Stroke should be referenced to in the NICE Stroke QS because they recommend screening and managing malnutrition and dehydration following stroke - this is important because early assessment of nutritional risk and appropriate nutritional management may improve survival of stroke patients (Yoo SH et al. 2008. Undernutrition as a predictor of poor clinical outcomes in acute ischemic stroke patients. Arch Neurol. 65:39-43.).
176	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network	Additional statement	Provision to provide Thrombolysis/ Thrombectomy
177	Intercollegiate Stroke Working Party	Additional statement	With only 6 or 7 standards to cover the whole complex stroke pathway which involves often hundreds of professionals there is inevitably going to be a problem with missing critical areas of care. The purpose of the standards should be to encourage development of high quality care in areas where care is currently below standard and they should be aspirational. The impact of the improvements should be to improve patient outcomes through reduced disability and mortality. The overall impression from this document is that it is just a repeat of the 2010 standards but with some of them dropped. Where is the innovation? What is the point of just renewing the same set of standards with no developments? The areas that would greatly benefit from a standard are VTE prophylaxis through the use of intermittent pneumatic compression Provision of post stroke psychological support. We do collect the need for psychology input on SSNAP and whether it has been provided at 6 months

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			7 day working
178	London Stroke Strategic Clinical Network	Additional statement	The London stroke Strategic Clinical Network (SCN) is encouraged that NICE remain focussed on producing standards that aim to drive improvement in services that meet the longer term needs of individuals following stroke. However, the restricted number of quality standards that are being proposed limit the accurate reflection of a pathway of care that continues over a prolonged period of time and is delivered by a multiplicity of professionals in a variety of settings. These standards do not represent progression from the previous set of standards. Since significant improvements in the delivery of stroke care across the pathway still need to be achieved, this could potentially result in a lost opportunity. Most of the standards proposed are relevant, but there are some significant omissions, which may be more pertinent and pressing priorities at this time. Areas that require quality improvement: Swallow screen within 4 hours of admission – this is critical to identifying patients with an unsafe swallow thus reducing the risk of aspiration, which is known to increase morbidity after stroke. Initiation of fluids and nutrition within 24 hours – SSNAP data has indicated that this is an important metric for improved outcomes. Thrombolysis within one hour of clock start – rapid access to this evidence based treatment also implies the need for timely access to scanning for applicable individuals. Stroke/ Neurorehabilitation specific community teams – evidence demonstrates that the delivery of early supported discharge (ESD) for stroke survivors improves outcomes. However, a significant percentage of individuals require less intense rehabilitation for a longer period of time following ESD intervention. It is crucial that such services are made available to capitalise on the gains made with ESD. Access to clinical psychologists/ neuropsychologists – it is well documented that a significant proportion of people who have had a stroke experience some degree of emotional, cognitive and/or behaviour change post stroke, which impacts on their ability to engage in rehabilitation and participate in daily life. The complexity of these symptoms renders IAPT (Improving Access to Psychological Support) services inaccessible to the majority of stroke survivors. However, access to clinicians with the skills to support them and enable them to participate in rehabilitation and daily life is limited. Access to vocational rehabilitation – around one quarter of strokes occur in people of working age. Vocational rehabilitation after brain injury such as stroke is challenging, due to complex physical deficits and the unseen effects of stroke. It requires a skilled multidisciplinary approach. The National Stroke Strategy (DOH 2007) quality marker 16 states that those with stroke should be enabled to participate in paid, supported and voluntary employment. A recent

ID	Stakeholder	Statement number	Comments[1]
			survey in London (2014) indicated that the current provision of vocational advice, support and rehabilitation is patchy. Where it does exist it varies greatly in quality and outcome. The SCN proposes that the most pressing priorities at this time are swallow screening, community teams and clinical psychology.
179	Nutricia Advanced Medical Nutrition	Additional statement	Malnutrition is prevalent in stroke patients. The overall prevalence of malnutrition in stroke patients ranges from 6.1% to 62% (Foley et al. 2009a). A recent study carried out in UK hyper acute stroke units found that the prevalence of patients at high risk of malnutrition is 29% (Gomes et al. 2014). This value agrees with the proportion of stroke patients at risk of malnutrition previously reported by Stratton and colleagues of 30% for those in the acute and community setting (Stratton et al. 2003). A recent review by Gomes et al. systematically reviewed key aspects of the nutritional support of stroke patients at risk of malnutrition with the following findings: Being malnourished on admission is associated with an increased risk of mortality and poor outcome (Dennis, 2003; Martineau et al., 2005). Up to one quarter of patients become more malnourished in the first weeks after a stroke (Davalos et al., 1996; Yoo et al., 2008) Increased malnourishment is associated with increased mortality (Davalos et al., 1996) and complications (Yoo et al., 2008), as well as poorer functional and clinical outcomes (Davalos et al., 1996; Gariballa et al., 1998a). It has been shown that introducing protocols and training into stroke unit care can significantly improve outcomes (Middleton et al., 2011). Dysphagia is common after acute stroke with incidence reported to be around 40% and in some studies as high as 78% (Martino et al 2005). There is good evidence for a link between dysphagia and poor clinical outcomes including a higher incidence of death, disability, chest infection and longer hospital stay (Martino et al 2005). As patients with malnutrition and dysphagia are likely to have poorer outcomes, the need for timely detection of dysphagia for all patients with acute stroke is essential. To address this, The Royal College of Physicians included the following recommendations in their National clinical guideline for stroke (Fourth edition September 2012). We suggest that additional quality statement(s) are developed following Statement 2 in the NICE Quality Standard to highlight that screening and intervention for dysphagia and malnutrition should be completed upon acute admission. 4.13 Initial, early rehabilitation assessment

ID	Stakeholder	Statement number	Comments[1]
			All patients should be assessed within a maximum of 4 hours of admission for their: ability to swallow, using a validated swallow screening test (eg 50 ml water swallow) administered by an appropriately trained person nutritional status and hydration 4.17: Nutrition: feeding, swallowing and hydration Patients with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and they should have an ongoing management plan for the provision of adequate hydration and nutrition. All patients should be screened for malnutrition and the risk of malnutrition at the time of admission and at least weekly thereafter. Screening should be undertaken by trained staff using a structured assessment such as the Malnutrition Universal Screen Tool (MUST). All people with acute stroke should have their hydration assessed on admission, reviewed regularly and managed so that normal hydration is maintained. People with suspected aspiration on specialist assessment or who require tube feeding or dietary modification for 3 days should be: reassessed and be considered for instrumental examination (such as videofluroscopy or fibre-optic endoscopic evaluation of swallowing) referred for specialist nutritional assessment. People with acute stroke who are unable to take adequate nutrition and fluids orally should be: considered for tube feeding with a nasogastric tube within 24 hours of admission considered for a nasal bridle tube or gastrostomy if they are unable to tolerate a nasogastric tube referred to an appropriately trained healthcare professional for detailed nutritional assessment, individualised advice and monitoring. Nutritional support should be initiated for people with stroke who are at risk of malnutrition. This may include oral nutritional supplements, specialist dietary advice and/or tube feeding. People with dysphagia should be given food, fluids and medications in a form that can be swallowed without aspiration following specialist assessment of swallowing. Routine oral nutritional supplements are not recommended for people with acute stroke who are adequately nourished on admission and are able to take a full diet while in hospital. Swallowing problems: assessment and management Until a safe swallowing method has been established, all patients with identified swallowing difficulties should: be considered for alternative fluids with immediate effect

ID	Stakeholder	Statement number	Comments[1]
			have a comprehensive assessment of their swallowing function undertaken by a specialist in dysphagia be considered for nasogastric tube feeding within 24 hours be referred for specialist nutritional assessment, advice and monitoring receive adequate hydration, nutrition and medication by alternative means be considered for the additional use of a nasal bridle if the nasogastric tube needs frequent replacement, using locally agreed protocols. Any stroke patient unable to swallow food safely 1 week after stroke should be considered for an oropharyngeal swallowing rehabilitation programme designed and monitored by a specialist in dysphagia. This should include one or more of: compensatory strategies such as postural changes (eg chin tuck) or different swallowing manoeuvres (eg supraglottic swallow) restorative strategies to improve oropharyngeal motor function (eg Shaker headlifting exercises) sensory modification, such as altering taste and temperature of foods or carbonation of fluids texture modification of solids and/or liquids. Every stroke patient who requires food or fluid of a modified consistency should: be referred for specialist nutritional assessment have texture of modified food or liquids prescribed using nationally agreed descriptors have both fluid balance and nutritional intake monitored. Stroke patients with difficulties self-feeding should be assessed and provided with the appropriate equipment and assistance (including physical help and verbal encouragement) to promote independent and safe feeding as far as possible. All stroke patients with swallowing problems should have written guidance for all staff/carers to use when feeding or providing liquid. Nutrition support should be initiated for people with stroke who are at risk of malnutrition which should incorporate specialist dietary advice and may include oral nutritional supplements, and/or tube feeding. Instrumental direct investigation of oropharyngeal swallowing mechanisms (eg by videofluoroscopy or flexible endoscopic evaluation of swallowing) for stroke patients should only be undertaken: in conjunction with a specialist in dysphagia if needed to direct an active treatment/rehabilitation technique for swallowing difficulties, or to investigate the nature and causes of aspiration. Gastrostomy feeding should be considered for stroke patients who: need but are unable to tolerate nasogastric tube feeding are unable to swallow adequate amounts of food and fluid orally by 4 weeks are at long-term high risk of malnutrition.

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			Any stroke patient discharged from specialist care services with continuing problems with swallowing food or liquid safely should: be trained, or have carers trained, in the identification and management of swallowing difficulties should have regular reassessment of their dysphagia beyond the initial acute assessment to enable accurate diagnosis and management should have their nutritional status and dietary intake monitored regularly by a suitably trained professional. References: Davalos A. et al.(1996) Effect of malnutrition after acute stroke on clinical outcome. Stroke 27(6): 1028-1032. Dennis M. (2003) Poor nutritional status on admission predicts poor outcomes after stroke Observational data from the FOOD trial. Stroke 34: 1450-1455. Foley NC et al.(2009a) Which reported estimate of the prevalence of malnutrition after stroke is valid? Stroke 40: e66-74. Gariballa, S.E. et al. (1998c) Nutritional status of hospitalized acute stroke patients. Br. J. Nutr. 79, 481–487. Gomes F et al. (2014) Risk Of Malnutrition On Admission Predicts Mortality, Length Of Hospital Stay And Hospitalisation Costs At 6 Months Post Stroke. Stroke 45: A63. Martineau J, Bauer JD, Isenring E, Cohen S (2005) Malnutrition determined by the patient-generated subjective global assessment is associated with poor outcomes in acute stroke patients. Clinical Nutrition 24 (6): 1073–7. Martino R, et al (2005) Dysphagia after stroke. Stroke 36 (12): 2756–63. Middleton Set al., on behalf of the QASC Trialists Group (2011) Implementation of evidence-based treatment protocols to manage fever, hyperglycaemia, and swallowing dysfunction in acute stroke (QASC): a cluster randomised controlled trial. Lancet 378 (9804): 1699–706. Intercollegiate Stroke Working Party (2012) National clinical guideline for stroke Royal College of Physicians. Fourth Edition Stratton RJ et al.(2003) Disease-related malnutrition: an evidence-based approach to treatment. Cabi Publishing Yoo SH et al. (2008) Undernutrition as a predictor of poor clinical outcomes in acute ischemic stroke patients. Archives of Neurology 65 (1):39–43.
180	RNIB	Additional statement	Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? Are any other areas required to ensure diagnosis and initial management, acute-phase care, rehabilitation and long-term management of stroke are covered? For example a named rehabilitation contact throughout rehabilitation? We welcome Stroke NICE quality standard and quality statements 1-7. However, we would like to see the following aspects addressed and/or included in this guideline:

ID	Stakeholder	Statement number	Comments[1]
			What a good stroke rehabilitation service looks like Narrative around how health and social care professionals will work together to deliver the package of rehabilitation. There seems to be no emphasis on integration or co-ordination of care. All patients should have a sight test as soon as possible after suffering from a stroke. Visual problems can affect up to two thirds of stroke patients and can impact on their general rehabilitation. For example, sight loss can impede mobility and increase the risk of falls and fractures. Early detection of visual problems will mean that patients can either be treated or learn coping strategies to help them with their everyday living activities i.e. ensuring they use good lighting in their home. It is important to note that patients may have had poor sight before their stroke. Especially as most strokes occur in those over the age of 65 and the risk of sight loss increases with age. Therefore, a sight test will help detect non-stroke related eye problems so that they can be managed appropriately. As with other problems caused by stroke, some people's sight loss may be transient, resolving itself over time. Therefore the guideline should highlight the need for professionals to be mindful of the link between visual problems and stoke throughout rehabilitation; as well as the potential for the problems to be transient in some patients. Registering sight loss with the local council (where appropriate). This would help stoke patients with sight loss get practical support from local social services. Patients need proper assessment and advice as they are often keen to know whether they can return to driving post stroke. Many factors dictate whether a person is fit to drive including ability to concentrate and make decisions. Therefore, we believe advice on fitness to drive should be given to all stroke patients (where appropriate) and not only to those with visual field loss. Further information is available from the Stroke Association at: http://www.stroke.org.uk/document.rm?id=824 Which professionals are best placed to deliver the interventions. This would help show clear lines of responsibility and therefore accountability.
181	Royal College of Speech and Language Therapists	Additional statement	The RCSLT are a little disappointed that there is no mention of continued support for self-management and we believe there is a need to mention the importance of access to 6 month review for patients discharged to a nursing or residential home.
182	SCM - University of Manchester and Salford Royal Foundation Trust	Additional statement	1. With only 6 or 7 standards to cover the whole complex stroke pathway which involves often hundreds of professionals there is inevitably going to be a problem with missing critical areas of care. The purpose of the standards should be to encourage development of high quality care in areas where care is currently below standard and they should be aspirational. The impact of the improvements should be to improve patient outcomes through reduced disability and mortality. The overall impression from this document is that it is just a repeat of the 2010 standards but with some of them dropped. Where is the innovation? What is the point of just renewing the same set of standards with no developments? The two areas that would greatly benefit from a standard are VTE prophylaxis through the use of intermittent pneumatic compression

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			Provision of post stroke psychological support. We do collect the need for psychology input on SSNAP and whether it has been provided at 6 months Suggest a stretch rehab guideline such as every patient who needs orthoptic referral gets it.
183	St. George's Hospital, London	Additional statement	1. These QS are limited in scope. We propose consideration of standards that will advance stroke care and outcomes. Examples include: Adults with TIA should be seen in a dedicated TIA clinic within 24 hours of referral Patients admitted with stroke who are at high risk of VTE should be offered IPC's All patients with large intracranial artery occlusion as the cause of their stroke should be referred for thrombectomy if it can be performed within 6 hours of stroke onset. This would require a change to the SSNAP dataset such that all patients arriving with acute stroke should have a CTA performed. All patients with ischaemic stroke/TIA and atrial fibrillation should be advised on suitability for anticoagulation Adults with ischaemic stroke should have a swallow assessment by a trained member of staff within 4 hours of arrival in hospital
184	Stroke Association	Additional statement	As set out in the Stroke Association's response to the previous consultation on this Quality Standard, stroke is a complex condition. For a condition that has such a complex and multidimensional pathway, the suggested 7 statements are inadequate in reflecting what needs to be done to improve the stroke care pathway. For this reason, the Stroke Association believes that key aspects of acute care, such as thrombolysis, swallow screening and nutrition assessment, urinary incontinence support, and screening for mood disturbance and cognitive impairment, are not covered by this quality standard. It also does not adequately address rehabilitation and long-term management of stroke and we are therefore concerned that commissioners may not consider fully coordinating services across all relevant agencies accompanying the whole stroke care pathway as was initially intended by NICE.
185	Stroke Association	Additional statement	We recommend the following additional statements: Access to clinical psychology in the acute and community settings. We welcome the focus on rehabilitation in this Quality Standard. It was a key area for improvement as set out in the national audit office's report, and not enough has been done to improve stroke rehabilitation. However we are concerned that this Quality Standard seems to be focussed on physical rehabilitation, with no guidance on addressing the emotional, psychological and cognitive effects of stroke. These are very often neglected. We suggest including a statement on clinical psychology. Involvement in the acute stroke multidisciplinary team has significantly improved, with 61% of acute MDTs including a psychologist, according to the latest SSNAP annual acute organisational audit. However this means that 39% of patients still have no access to this vital support. All stroke units should have access to clinical psychology. In the community setting, the first SSNAP post-acute organisational audit results indicate that only 55% of CCGs

ID	Stakeholder	Statement number	Comments[1]
			commission psychology services. The SSNAP post-acute clinical audit will measure whether it has been provided at 6 months. The Stroke Association Daily Life Survey in 2010 found that nearly 40% of people who had a stroke reported their need for help with emotional problems was unmet. IPC for VTE prophylaxis in immobile patients. Consider intermittent pneumatic compression (IPC) for VTE prophylaxis in immobile patients who are admitted within 3 days of acute stroke as per the addendum to NICE Guideline CG92 Venous thromboembolism in adults admitted to hospital: reducing the risk: http://www.nice.org.uk/guidance/cg92/evidence/guideline-addendum-june-20152 The SSNAP acute clinical audit measures the use of IPC, with the latest percentage of patients using IPC being 13.7%. Assessment and support for carers. In the previous Quality Standard, carers are mentioned twice and have a standalone standard dedicated to them, the loss of this focus is in our view one of the key omissions of this draft. Carers need support once patients are discharged back into their communities, their needs may even be greater than the person they are caring for. There is no mention of carers' needs being assessed prior to discharge, neither is there mention of information provision for carers, despite being vital in supporting people who have had a stroke after leaving hospital. For this reason we suggest including detail of carer needs assessments, and information provision, prior to discharge to avoid breakdown of care later on. Consistent 7 day 24 hour care. The SSNAP audit highlights significant variation in care depending on the day of the week and time of day, as well as some concerning figures relating to staff shortages. Ensuring that there are sufficient staff available in acute stroke units and in the community at all times is vital to achieving these quality statements. For this reason the Quality Standard should address the need for adequate specialist staff available 24 hours a day 7 days a week.
186	The East Midlands Stroke Clinical Advisory Group	Additional statement	Community Stroke Rehabilitation – early supported discharge is an evidence based service appropriate for approximately 40% of stroke survivors. It is a time limited intervention and many patients require ongoing rehabilitation. ESD is not suitable for a large number of patients who also require a form of rehabilitation support to maximise their recovery. Community Stroke Rehabilitation (specifically, domiciliary, stroke specialist recovery) should be recommended for all stroke survivors for whom it is appropriate for as long as they have stroke related recovery goals.
187	The East Midlands Stroke Clinical Advisory Group	Additional statement	Psychological and emotional support – given the national drive for Parity of Esteem and the well established evidence of the impact of Stroke on psychological and emotional wellbeing we would like to recommend that a quality statement is included that requires the provision of appropriate services for stroke survivors and their carers.
188	The East Midlands Stroke Clinical Advisory Group	Additional statement	Mechanical Thrombectomy – in view of the evidence base for this treatment it is felt that a quality statement will act as a lever for the required changes required to ensure it is available for all appropriate patients at the earliest

ID	Stakeholder	Statement number	Comments[1]
			opportunity.
189	The East Midlands Stroke Clinical Advisory Group	Additional statement	Time to swallow assessment – SSNAP data evidences that this is an area of care where significant improvement is required. It is felt that a quality statement will act as a lever for the required changes required to ensure it is available for all appropriate patients at the earliest opportunity.
190	UK Neurointerventional Group / The Royal College of Radiologists	Additional statement	We think that omitting any mention of new technologies/treatments is a missed opportunity – Table 4 box 3 (p11) should be renamed "Treatments for people with acute stroke" and intra-arterial thrombectomy should be listed as well. THROMBECTOMY: This is a treatment that, if given within 6h, has a bigger absolute benefit than alteplase within 3h with NNT to reduce disability score by 1+ point on Rankin scale of only 2.5 (ref Saver et al NEJM April 17th 2015). A very recent cost utility analysis published in Stroke by LSE/Imperial groups demonstrate it is also highly cost effective (ref DOI: 10.1161/STROKEAHA.115.009396 September 2015).
191	UK Neurointerventional Group / The Royal College of Radiologists	Additional statement	The comment on acute stroke therapy is also relevant to Table 1 Domain 3 of Draft QS document. The most powerful way we have of improving recovery after stroke is to improve access to the proven acute therapies of IV thrombolysis and IA thrombectomy. An additional quality statement recognising the need for acute intervention therapy (missing entirely from draft QS 1-6) would be highly appropriate e.g. Proposed Quality Statement 3: "Adults with acute ischaemic stroke should, where it is indicated, receive expeditious intravenous &/or intra-arterial therapy as soon as possible after brain imaging" QS 3-7 then in turn become QS 4-8 This additional Quality statement is required to ensure that the initial management/acute-phase care is adequately covered as currently in the draft no mention of stroke treatment as such is made in headline statements. Stroke is now often a TREATABLE CONDITION – we feel this is a powerful message to send to the wider public and health services. The "treatment statement" was indeed QS 3 in the 2010 document – the situation has not improved so much that in our view it can now be removed – still 18% of eligible patients don't get IVT and only 57% get it within 1h of arrival at hospital. Since 2010 IA Thrombectomy has been proven to be a powerful additional acute therapy where indicated.

Registered stakeholders who submitted comments at consultation

- Alzheimer's Society
- AntiCoagulation Europe
- Association of British Neurologists (ABN)
- Boehringer Ingelheim
- Boston Scientific
- British Association of Prosthetists and Orthotists (BAPO)
- British Association of Stroke Physicians
- British Heart Foundation
- British Medical Association
- British Society for Antimicrobial Chemotherapy
- British Society of Interventional Radiology
- British Specialist Nutrition Association
- College of Occupational Therapists
- Department of Health
- Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network
- Health and Social Care Information Centre
- Intercollegiate Stroke Working Party
- London Stroke Strategic Clinical Network

- Medtronic Limited
- NHS Wales Delivery Unit
- Nutricia Advanced Medical Nutrition
- Royal College of GPs (RCGP)
- Royal College of Nursing
- Royal College of Physicians (RCP)
- Royal College of Physicians Of Edinburgh
- Royal College of Speech and Language Therapists
- Royal National Institute of Blind People (RNIB)
- SCM - The Dudley Group NHS Foundation Trust
- SCM - University of Manchester and Salford Royal Foundation Trust
- St. George’s Hospital, London
- Stroke Association
- The East Midlands Stroke Clinical Advisory Group
- The Society and College of Radiographers
- UK Neurointerventional Group / The Royal College of Radiologists
- Yorkshire Ambulance Service