

2	2	<p>The Remit: The BSRM recognises the importance of TEAM working between Consultant Physicians in Rehabilitation Medicine, Geriatricians, General Practitioners, the Stroke survivor, their next of kin or carers, nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians, social workers and psychologists in the long term rehabilitation of the stroke survivor across the hospital-community divide. We believe that Stroke rehabilitation is a patient-centred process during which the members of the multidisciplinary team assist the patient achieve their stated goals. There is evidence in the Rehabilitation literature of the impact of goal setting in multidisciplinary rehabilitation. We believe that effective communication between the members of the MDT named above is crucial to the success of the rehabilitation process and must be underpinned by formal weekly (at least) meetings to identify problems, set or review goals, monitor progress and plan discharge.</p>
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3	<p>3.1.(a)</p> <p>3.1.(b)</p> <p>3.1.(c)</p> <p>3.2.(a)</p> <p>3.2.(b)</p> <p>3.2.(C)</p>	<p>Stroke is an enormous and serious Public Health and economic problem for England. It contributes to the gap in life expectancy between the most deprived areas and the population as a whole. The fact that 25% of strokes occur in people below the age of 65 years means that a significant number of people in their working life are affected as shown by the £1.8 billion loss in productivity shown in the National Stroke Strategy (December 2007). Rehabilitation is therefore crucial to get people back to work and minimise the annual expenditure of £2.4 Billion spent on informal care.</p> <p>Being the single largest cause of disability in England the aim should be to offer rehabilitation to Stroke survivors to maximise their abilities and render them as independent as possible.</p> <p>It is timely that at long last we are going to address the survivors of the third largest cause of death in England and Wales through effective rehabilitation. Its position in the National statistics should have flagged it up earlier for attention along with ischaemic heart disease and all types of cancer.</p> <p>Immobility is a consequence of most types of Stroke. Early mobilisation will ensure that patients gain centrality of position when sitting early to help progress towards good sitting balance. The righting reflexes can be attenuated if rehabilitation is delayed. Current evidence shows that early mobilisation is beneficial and needs to be continued. There are no randomised controlled trials directly comparing various methods of improving mobility in Stroke though several physiotherapy interventions are employed with varying degrees of success.</p> <p>Also see section 2 above</p> <p>Outcome measures are vital in the assessment Activities of Daily Living (ADL) and identification of disabilities. They assist in monitoring progress of rehabilitation, leading to review of the Rehabilitation programme at suitable points in the clinical care of the stroke survivor. Several scales abound and many Units choose scales which differ from those chosen by sister Units. We would suggest that all Units adopt a minimum basket of scales to measure ADLs (The Barthel scale. Though this has a ceiling effect it has been extensively used in Rehabilitation Research and scoring has been shown to be consistent across different Units), Cognition (The FIM/FAM includes a component on the measurement of cognition and is therefore recommended. Several Units use it in the UK), Handicap (There is no validated measure per se which measures handicap, but other scales do so indirectly. Without evidence this is not recommended), Quality of Life (may be used in the community but little critical evaluation of the Quality of well-being scale has been carried. It would be premature to make a firm recommendation in the Stroke Rehabilitation Guideline), Depression (there are several scales for assessing depression in a Rehabilitation context, but none has been subjected to the rigour of randomised controlled trial. We would not recommend any in particular on the basis of clinical evidence) and Care giver Strain Index (This would be useful in the community Rehabilitation of Stroke survivor. Its validity was well tested in the original study, but has not been subjected to randomised controlled trials. It has not been widely used (Measurement in Neurological Rehabilitation, Derek Wade, Oxford publications 2003). We recommend it for community Rehabilitation.</p>
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4	<p>4.1.1(a)</p> <p>4.1.1(b)</p> <p>4.1.2 (a)</p> <p>4.1.2(b)</p> <p>4.2.(a)</p> <p>4.3..1(a)</p>	<p>See section 1.1 above</p> <p>It is recognised that Stroke in African Caribbean people in this country is twice as likely as it is in people of Anglo-Saxon or European extraction for reasons which are not clear. Stroke occurs at a younger age in this ethnic group and hence does have implications for work and education. A high proportion of African Caribbean people have risk factors for Stroke such as hypertension which many are unaware of. Studies have also shown that African Caribbean women are overweight compared with European women of the same age. A large abdominal girth (>88cm for women and >102cm for men) is a risk factor for Strokes. What is not clear is whether these figures are equally applicable to African Caribbeans. In areas of high density of African Caribbeans special attention needs to be paid to addressing risk factors for Stroke during rehabilitation by promoting regular blood pressure measurements, exercise, a healthy diet of fruit, vegetables, reasonable amounts of alcohol consumption according to National guidelines. There are specific interventions which have been shown to work best in this ethnic group.</p> <p>We recognise the importance of integrating Vocational Rehabilitation and continuation in main stream school into the rehabilitation process for stroke survivors in this age group. We recommend vocational rehabilitation as an integral part of the Rehabilitation for this patient population.</p> <p>People who suffer transient ischaemic attacks (TIAs) usually suffer a stroke within a week to a fortnight of an index TIA unless preventive measures are undertaken such as treatment with anti platelets eg Aspirin, Dipyridamole retard (singly or in combination) in combination with a statin. In suitable people carotid endarterectomy within two weeks of a critical TIA may avert the occurrence of a major Stroke. The symptoms typically last about 10 to 30 minutes but last up to 12 hours. Often the disability is not sufficiently significant to warrant admission into a Stroke Rehabilitation facility. The TIA clinics which are now prevalent in most Trusts will treat this group of patients.</p> <p>The National Stroke Strategy Quality Marker 1 (QM1) promotes public awareness in the recognition of signs and symptoms of Stroke in the community. In Hospital the chosen setting for treatment and rehabilitation is the Stroke Unit which >95% of Trusts on the land now have. Early supported discharge from the Stroke Unit and provision of Community Rehabilitation by a dedicated Neuro-rehabilitation Team (employing similar principles such as goal setting and regular Team meetings as in the Stroke Unit Team) is the way forward. This will speed up discharge from hospital and enable stroke patients to continue rehabilitation in their own social surroundings. Community provision of Stroke rehabilitation will ensure that Stroke Unit gains are not lost. There are randomised controlled trials comparing Rehabilitation in hospital and in the community but there is no statistically significant difference between the two. Hence Community rehabilitation is recommended provided a Community Multidisciplinary Team is in Place to offer ongoing Rehabilitation.</p> <p>A myriad of impairments lead to disability and, hence impede recovery from Stroke. Hemiplegia, upper limb weakness which lags</p>
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4.3.1(a)		<p>(1). A systematic review of randomised controlled trials of exercise therapy for upper limb function has not shown that a particular approach to arm function is more efficacious than others. Hence specific training should be used to improve arm function for specific selected tasks until new evidence suggests otherwise. We recommend current practice until better evidence to the contrary emerges.</p> <p>(2). Whilst treadmill training is not commonly employed as a rehabilitation intervention some stroke patients may benefit from it. It may be useful in a selected group of patients but lack of evidence precludes the use of this Rehabilitation intervention on the basis of cost-benefit ratio.</p> <p>(3). Ankle foot Orthoses are useful in correcting foot drops resulting from Stroke but careful joint assessment by a physiotherapist and an orthotist is recommended.</p> <p>(4). Muscles affected with spasticity may need correcting with botulinum toxin before the application of orthoses. Studies have shown the benefit of botulinum toxin injection to relieve muscle spasticity, but these have been small, but show benefit. We recommend the use of botulinum toxin injection in relieving muscle spasticity.</p> <p>(5). A small number of patients may benefit from Functional Electrical stimulation (FES), but few studies have been carried out to establish its place in the rehabilitation of Stroke patients. Multicentre studies need to be carried in several Rehabilitation Units to define its place in Stroke Rehabilitation. It is recommended in a selected group of patients.</p> <p>(6). Dedicated Speech and Language Therapist to address language and speech disturbances in Stroke is vital. Under nutrition impacts negatively on Stroke rehabilitation. The Malnutrition Universal Screening Tool should be applied in the detection of under-nutrition. It is estimated that 70% of older persons in the community are under nourished. Stroke will exacerbate this state. Patients with dysphagia who cannot tolerate nasogastric tube feeding or who have had an NG tube for three weeks, should be considered for insertion of gastrostomy feeding tubes. The timing of PEG feeding is not clear and should be clearly defined in the Guideline.</p>
4.3.2		No comments
4.4		Main outcome measures. Please refer to comments on 3.2.(b)
4.5		BSRM would like to see the use of evidence based interventions rather just cost effective interventions. Interventions that are evidence based and cost effective would be a preferable choice.
4.6.1		The BSRM has been privileged to have taken part in this consultation as the Society believes the principles of rehabilitation such as TEAM working, Patient centred goal setting are applicable to Stroke rehabilitation and will benefit many stroke survivors.
4.6.2		The BSRM looks forward to having representation on the Guideline Development Group in April 2010.
5.1.1		We take note of the cited NICE guidance which is to be incorporated in the Guideline.

6		<p>The BSRM would like to draw the attention of the Guideline Development Group to the following relevant references which were consulted in the preparation of this response:</p> <ul style="list-style-type: none"> • Stroke Units: an evidence based approach Eds Peter Langhorne and Martin Dennis, BMJ publications 1998 • Stroke Treatment and prevention-an evidence based approach by Graeme Hankey, Cambridge University Press 2005 • Stroke Unit Trialists collaboration. Organised inpatient (Stroke Unit) Care for Stroke (Cochrane review). The Cochrane Library, issue 1, 2001.Oxford • Scottish Intercollegiate Guidelines Network(SIGN).Management of Patients with stroke part iv: rehabilitation, prevention and management of complications, and discharge planning. Edinburgh SIGN;2002 (Sign publication no 64) • Organisatie en Financiering van Musculoskeletale Neurologische Revalidatie in België 2007
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Closing date: 5pm on 24th February 2010

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