

National Clinical Guideline for Stroke

Process manual

Responsible officer	Stroke programme manager
First published	2014
Current version	2015/2016 (Version 1.1)
Review date	2017

Contents

Introduction	4
Process overview	4
Project planning	5
Who is involved?	6
Intercollegiate Stroke Working Party	6
RCP guideline coordinator	7
Scope	8
Identifying evidence: searches	8
Linking search questions and search strategies	8
Online medical databases	8
Selecting abstracts from the initial search	9
Creating and sending abstract lists	9
Selecting abstracts from the abstract list	9
Transfer of chosen papers for updates	10
Obtaining papers	10
Reviewing evidence: evidence tables	10
Creating an evidence table	11
Follow up of evidence tables circulated	11
Keeping an audit trail	11
Quality of evidence tables	11
Evidence table current filing	13
Reviewing evidence: teleconferences	14
Assessing quality of evidence	14
Process (for coordinator)	14
Developing recommendations	15
Writing a recommendation or set of recommendations	15
Inclusion of NICE recommendations	15
Considering cost-effectiveness	16
Writing the evidence to recommendations	16
Sources	16

Agreeing recommendations.....	17
Consultation: public consultation	18
Process (coordinator).....	18
Finalising and publishing the guideline.....	20
Editing guideline.....	20
Profession specific concise guidelines	20
Patient version	20
Application	21
Out of cycle review of the Guideline	21
Appendix A: Intercollegiate Stroke Working Party Terms of Reference.....	22
Appendix B: Conflict of interest policy and procedure	24
Appendix C: Conflict of Interest form	26

Introduction

The National Clinical Guideline for Stroke (the Guideline) aims to improve the quality of care delivered to everyone who has had a stroke in the country regardless of age, gender, type of stroke, location or any other feature. The Guideline is also used as the basis of the national audit for stroke, currently the Sentinel Stroke National Audit Programme.

The Guideline is updated on a four year cycle with the process governed by the Intercollegiate Stroke Working Party (ICSWP).

The process for updating the guideline will consider the following key stages:

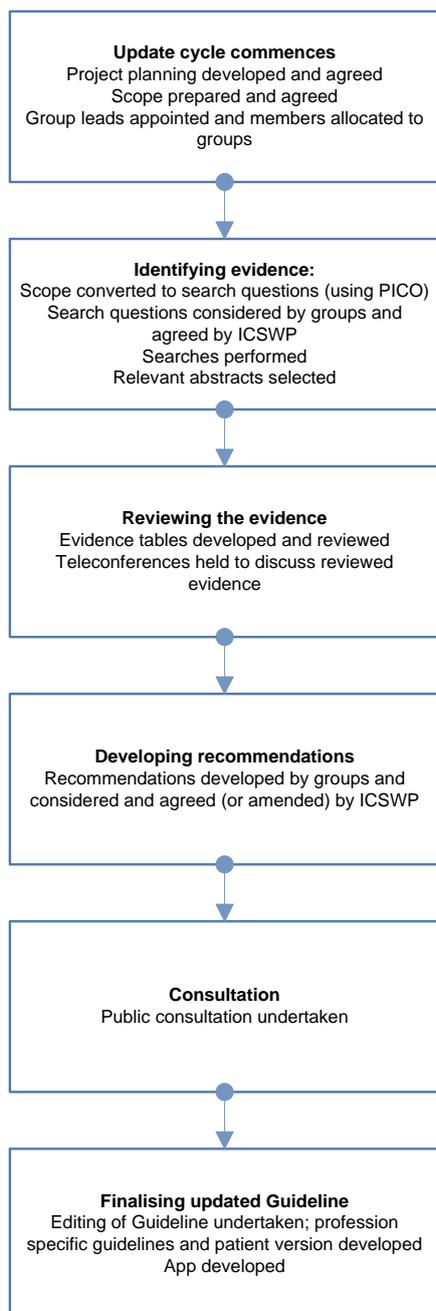
- Development of scope
- Searching the scientific literature
- Selection of studies for inclusion
- Assessing the quality of research
- Development of evidence to recommendation
- Grading of recommendations
- Health economic evaluation
- External peer review
- Funding and conflicts of interest

The key stages from the process will also be clearly outlined for the end user within the published edition of the guideline.

This Process Manual: provides an overview of the process to update the Guideline; an explanation of stakeholders involved in development, and in depth guidance for a number of important aspects of the update.

Process overview

A general overview of the workflow process is pictured below:



Project planning

The development time updating the Guideline is typically 21 months, comprising:

- scope and searching: approximately six months;
- reviewing to ready for public consultation: approximately one year, three months.

Detailed project planning should be undertaken at the start of a cycle; and updated periodically.

Project planning documentation to be used as a base and updated is located:

Research(N:)/Projects/Stroke/Guidelines.

Who is involved?

Intercollegiate Stroke Working Party

The Intercollegiate Stroke Working Party (ICSWP) has overall responsibility for the production of the Guideline. The role of the ICSWP includes, *inter alia*, agreeing the scope of the update, appointing group leads for each section of the update; agreeing allocation of members to groups; reviewing evidence and developing and agreement recommendations.

The ICSWP is composed of: the Chair (currently Professor Anthony Rudd CBE); members from the healthcare professions involved in the stroke care pathway; patient and carer representative organisations; and patient members. The terms of reference for the ICSWP are included at Appendix A to this manual.

During a Guideline update process, ICSWP meetings are held four times per year.

Conflicts of interest

The policy covering conflicts of interest is set out at Appendix B and is based on the NICE policy and procedure. In summary:

- All members of the ICSWP must sign a conflicts of interest form, a blank copy of which is filed in the following location: N:\Projects\Stroke\ICSWP\COIs.doc
- Conflicts of interest must be a constant agenda item of ICSWP meetings, with hard copies of forms filed to be used as a record later. During decision points, if a member has a conflict of interest it is verbally declared and either the member does not join the discussion or leaves the room.

Guidelines editors

The role of the guidelines editors are to oversee the review, drafting and editing process of the guidelines. Each editor will be assigned several subgroups/subtopics to oversee. The role involves:

- Overseeing all activities associated with assigned subgroups (see activities described under “Group leads”).
- Liaising with the guidelines coordinator regularly between meetings to ensure project deadlines are met
- Collating and editing all drafts and responses from assigned subgroup

Group leads

The role of the group lead is to organise the specific topic area they have been allocated by the ICSWP. This involves:

- updating the ICSWP on any large trials or Cochrane reviews that they are a part of, or that are imminent, relevant to the Guideline
- signing off search questions
- acting as the representative for their organisation and relaying feedback on the decisions taken on recommendations to their organisation as required

- identifying external reviewers for papers, organising allocation and distribution of papers to those reviewers
- selecting papers to be reviewed from abstract lists circulated
- organising/ chairing meetings to discuss progress/ papers reviewed/changes to recommendations, and/or participating in any meetings that arranged by the RCP guideline coordinator for their group
- updating the ICSWP on progress at meetings, including:
 - any studies or guidelines soon to be published that might affect the guideline
 - teleconferences planned and the agreed outcome of any teleconferences that have taken place
 - alerting the ICSWP to any controversial recommendations, or recommendations awaiting evidence
- presenting recommendations and ‘evidence to recommendations’ back to ICSWP and contributing to all decisions made.

RCP guideline coordinator

The RCP guideline coordinator (the coordinator) coordinates activities for the production of the Guideline. This includes:

- liaising with the Chair of the ICSWP, guidelines leads and the group leads between meetings
- keeping an audit trail of the guideline update process
- performing searches
- circulating abstract lists to the guidelines leads and group leads and working out any discrepancies between choices
- producing evidence tables and populating with basic information, using mail merge, for reviewers to fill in
- organising meetings, including papers, minutes and following up action points for groups as required
- collating work for discussion and decision at ICSWP meetings
- amending drafts of the Guideline as required following changes made at ICSWP meetings
- organising the public consultation and dissemination of feedback
- adding references into the Guideline, proof reading and preparing the document for publications
- organising the update of the patient version of the Guideline, profession specific guidelines and key recommendations.

Scope

The scope of an update of the Guideline is considered (including referencing the scope of previous editions) and agreed prior to the commencement of the update process by the ICSWP. This generally takes two months to finalise. Once agreed, the scope is converted to a list of questions that can be used to structure systematic searches on medical databases. Questions are developed by group leads, in consultation with groups and relevant professional bodies and are generally structured using the 'Population, Intervention, Control, Outcome' (PICO) format. However, in the case that questions do not appropriately fit the PICO search format, or the relevant literature for a question is not well defined, other frameworks can be used.

When the relevant literature for a question is less well defined or indexed, a multi-stranded approach to searching may be more efficient. This involves developing several shorter search strategies (strands) with an emphasis on precision. Each strand should reflect one way in which the relevant literature may be described. The strands are then combined. It should also be noted that there can often be considerable overlap between some review questions. Review questions that overlap can be grouped together should be identified for searching purposes. For example, questions with the same population may involve comparing several interventions. This should make it possible to carry out one search that covers all interventions.

Identifying evidence: searches

Linking search questions and search strategies

Once the scope is converted to a list of questions and those questions agreed by the ICSWP, those questions are linked to search strategies.

The questions are divided by group and strategies are saved by group. An example is illustrated below for a pre hospital care question: *Can emergency health professionals use a clinical assessment tool to accurately identify those patients with suspected stroke and which clinical assessment tool should be used?*

Online medical databases

Searches are run in MEDLINE, EMBASE, AMED (all accessed using OVID), CINHAL, and Cochrane. The results from these searches are to be screened by the coordinator and the relevant papers exported to reference manager. These are then exported from reference manager as an abstract list and sent to the Chair of the ICSWP for further exclusions. For topics newly added since 2012 searches included the time period from 1966 onwards; for the remainder of the topics searches dates are from 2012 until September 2015, although some landmark publications beyond this will also included.

Searching instructions are available at: N:\Projects\Stroke\Guidelines\2012 Guidelines PLAN\Project planning and management\Help notes\Table of search commands All dbs

Selecting abstracts from the initial search

The number of papers retrieved in the initial search should be recorded for each database searched before selection takes place. The numbers of the initial search results are recorded. Papers are then excluded based on the following criteria:

Population: This will be determined by the question. As this is an update from previous editions including NICE guidelines the core population definition of stroke, adult etc. is clearly defined (I think we have this somewhere as we've shared it with people who have done their own searches) In general the population should be stroke (or if applicable TIA) patients. Sometimes the population will be more specific e.g. stroke patients with communication problems for speech and language therapy topics. Broader populations, such as those with any kind of traumatic brain injury or people with depression should be considered if there is a lack of stroke specific evidence.

Intervention: Similarly, this will largely be determined by the question and in some topics may be quite broad. For example 'How should incontinence of urine and faeces be managed after acute stroke?' will relate to multiple interventions when compared with 'Does the use of aperients reduce incontinence?'

Study type: Reviews (review papers, rather than systematic reviews), letters and single case studies can all be disregarded at this time. Systematic reviews and clinical trials (randomised, controlled) are relevant. Observational studies and qualitative studies are relevant for certain sections, and may be useful where there is a lack of trial evidence to help inform discussion, so should not necessarily be ruled out at this point.

Study size: This will depend on the methodology of the study and the expected effect. At this point, studies should not be excluded on the basis of being underpowered, apart from single case studies. If in doubt, include the study as it can be rejected by group lead or Chair in the abstract list stage.

Creating and sending abstract lists

Abstract lists are sent to reviewers or group leads for that topic, as well as the ICSWP Chair; all are asked to highlight either **"yes order"** or **"not required"**. A reviewer must return lists of papers with the reference manager number rather than the item number. It is important that the reviewer is very clear about which papers are to be ordered.

When an abstract list is returned, the coordinator saves the file and records the person who responded.

Selecting abstracts from the abstract list

Population: As above, this will be determined by the question but broadly whether the population studied were stroke (or if applicable TIA) patients. In general the population should be stroke (or if applicable TIA) patients. Sometimes the population will be more specific e.g. stroke patients with communication problems for speech and language therapy topics. More broad populations such as people with any kind of traumatic brain injury or people with depression can be used but it must be justified by a lack of stroke specific evidence.

Intervention: As with selecting abstracts from the search list, this will also be largely determined by the question and in some topics may be quite broad. Again, for example, a question such as 'How

should incontinence of urine and faeces be managed after acute stroke?’ will relate to more interventions than ‘does the use of aperients reduce incontinence?’

Study type: Again as noted in relation to selecting abstracts from search lists, abstracts selected should not include reviews (just review papers), letters, or single case studies. Systematic reviews and clinical trials (randomised, controlled) are most desirable for many topics. Observational studies and qualitative studies are relevant for certain sections, and may be useful where there is a lack of trial evidence (either because a lack of studies or because it is not ethical) to help inform discussion.

Study size: At this stage any trials that are relevant but seem underpowered to either change a recommendation or be cited they should not be reviewed but can be flagged up as important to help inform discussion.

Transfer of chosen papers for updates

The coordinator transfers all of the papers that were highlighted as ‘yes order’ into the main reference manager database.

Obtaining papers

Papers can often be obtained for free from the following sites:

<http://highwire.stanford.edu/lists/freeart.dtl>

<http://freemedicaljournals.com/>

<http://intranet/intranet/e-library/e-journals/index.asp>

In addition, the following site gives access to RCP journals:

https://auth.athensams.net/?ath_returnl=%2Fmy%2F&ath_dspid=ATHENS.MY

Cochrane:

http://www.mrw.interscience.wiley.com/cochrane/cochrane_search_fs.html

Papers that cannot be located elsewhere are to be ordered from the RCP library and requests stored:

N:\PROJECTS\STROKE\Guidelines\YEARRCP guidelines\Database\Library orders

Select: File

Export

Select “RIS” as the style and name your database eg. Library orders – Level 1 – Oct 06

Select “marked references”

Click ok.

Reviewing evidence: evidence tables

Evidence tables are sent out to reviewers to summarise the papers. They should include the abstract of the paper and be pre-populated with information such as the title and the authors to save time for the reviewer. This can be done using a mail merge with data exported from reference manager.

Creating an evidence table

The extract from EndNote can also be used to pre populate key fields in the individual evidence table or checklist so as to cut down work for both the RCP guideline coordinator and the reviewer.

Follow up of evidence tables circulated

Evidence tables should be circulated with a return deadline of between four (4) and six (6) weeks. In some circumstances, a group may decide not to complete an evidence table if the article does not pass the initial screening, for example if the study is underpowered, not relevant, or has an inappropriate design. In such cases the RCP guideline coordinator should confirm with the Chair whether this is acceptable, and note that it was discussed.

Once searching is completed, the coordinator should create an Excel export of the EndNote database. It should be divided by papers sent out for each group (a separate tab for each group) and a copy sent to the group leads so they can also keep track of papers that have been returned and discussed at teleconferences.

Keeping an audit trail

Completed evidence tables are emailed by to the coordinator or sent via the group lead. The following conventions are to be adhered to for filing:

Electronic filing – folders: YEARGuideline\Evidence tables\Group\Sub topic

Naming convention: “ET Ref ID XXXX initials of person who filled it in”.

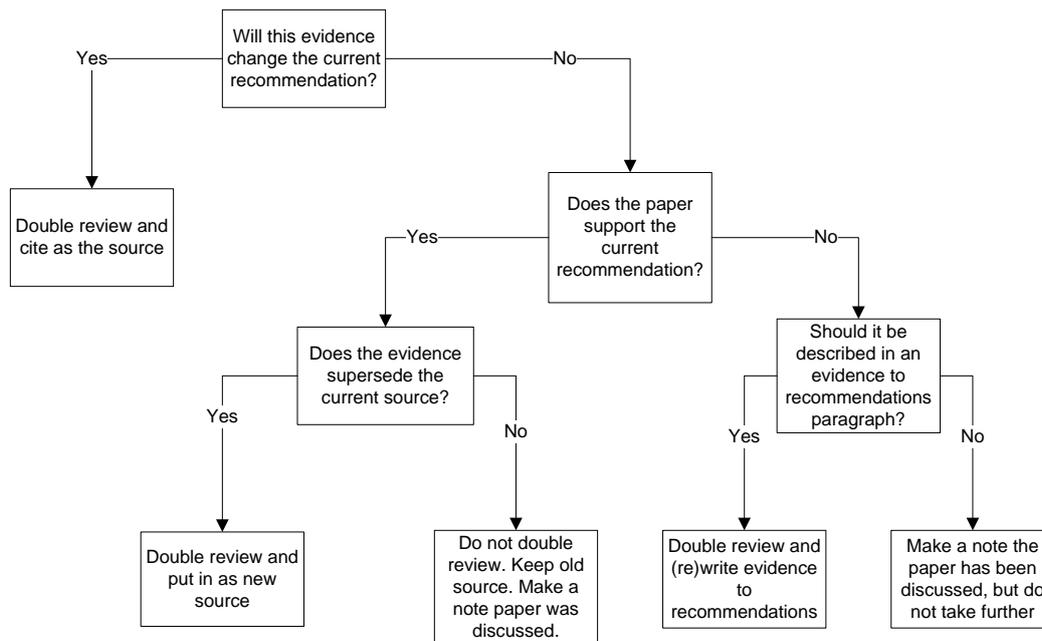
A copy should also be printed out as this will be needed in the teleconferences and because a hard copy is kept filed away. The evidence tables should be uploaded on to the webtool or sharepoint either continuously or at timed intervals, and the ICSWP informed. All of the evidence tables that have been received are to be circulated to ICSWP members prior to an ICSWP meeting.

Quality of evidence tables

The quality of the evidence table should be assessed as they are returned. Indicators of quality include the following:

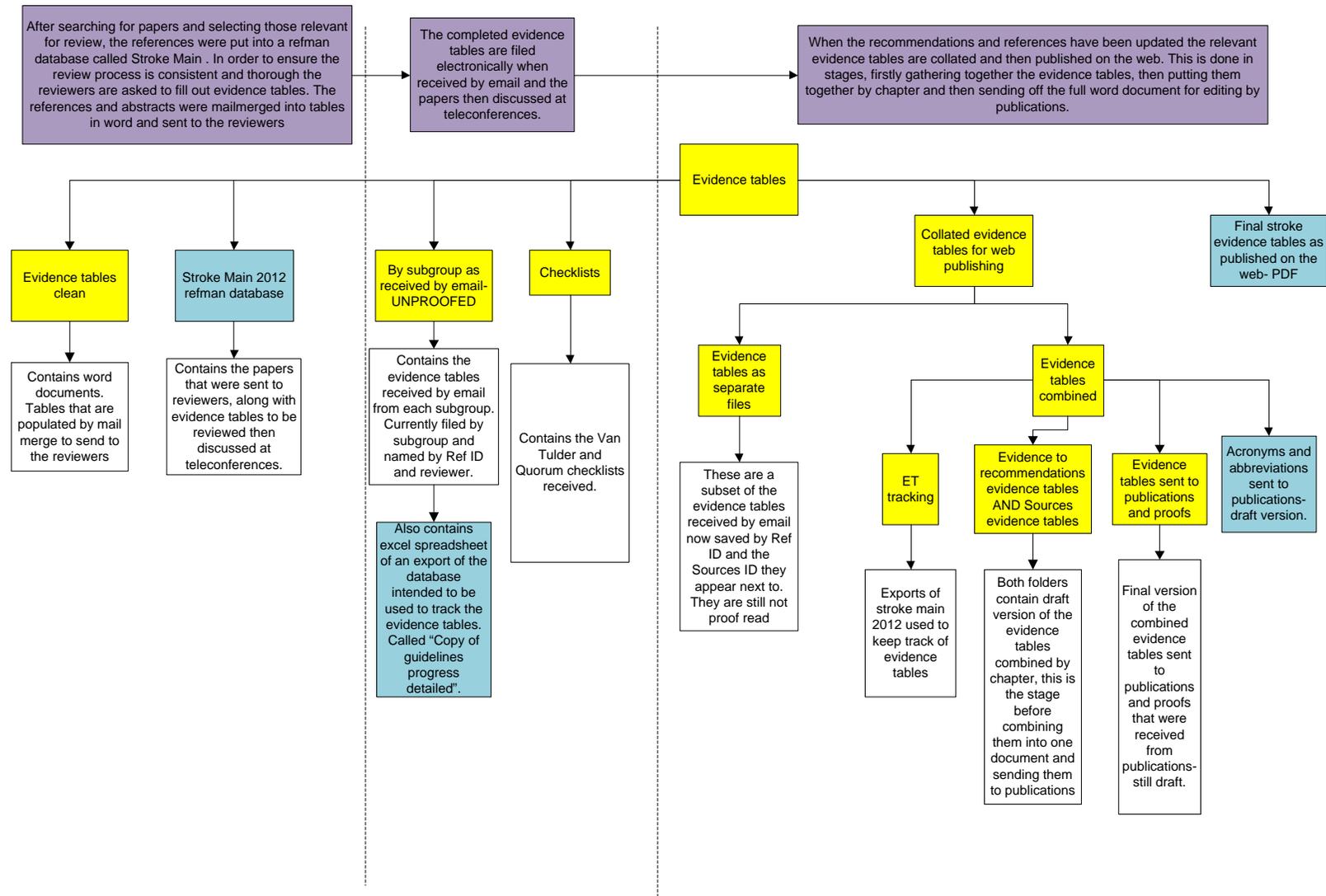
- each column is complete
- there are no spelling mistakes
- there are no obscure acronyms
- there are unbiased quality and comments
- statistics such as numbers needed to treat are filled in.

The coordinator includes the reference IDs of papers that it is agreed will be cited next to the recommendations or evidence to recommendations in a comment in the draft version of the Guideline:



Papers will be double reviewed according to this and a double review is an independent double review (not merely a person reading the evidence table and agreeing with what is written). If there are discrepancies in the views of both reviewers then this should be discussed at a teleconference (this may be a routine teleconference).

Evidence table current filing



Reviewing evidence: teleconferences

Teleconferences are an opportunity for the members of all of the groups to discuss their progress, the evidence that had been reviewed and make initial changes to the draft of the Guideline. The papers that are prepared link the question(s) with the evidence reviewed and the relevant recommendation(s). It is also useful at this time to discuss what the references currently cited are and whether they should be superseded.

In the initial stages of development, discussing the introductions and evidence to recommendations is premature. Evidence to recommendations may be agreed by email, although whether there needs to be one and who should do it can be agreed at the teleconference/ meeting. Introductions are generally altered at the proof reading stage.

Assessing quality of evidence

All studies that were likely to result in the development of a recommendation are to be assessed by a second reviewer to ensure consistency and improve inter-rater reliability.

Useful mechanisms to assess quality are:

- the van Tulder assessment system for the quality of RCTs
- the checklist that was developed for the third edition of the guideline and the widely used PRISMA checklist for systematic reviews and meta-analyses
- the RATS qualitative checklist for qualitative research

Process (for coordinator)

- When organising a teleconference, find out what the Chair's available dates are. Using these dates as a basis, create a doodle poll (www.doodle.com). Generally the date of largest consensus is chosen.
- The Chair should be notified about any planned teleconferences and whether there are any issues with any of the groups. The Chair will then decide whether they need to be present or not.
- Completed evidence tables, named by Ref ID and reviewer, should be circulated by the RCP guideline coordinator prior to the teleconference.
- The group will then go through the papers that have been reviewed and discuss their implications for the current recommendations, ie whether the current recommendation needs to be changed and if not or if so what the recommendation should say.
- Minutes should be taken recording:
 - any changes to recommendations suggested at the teleconference
 - whether papers are to be double reviewed (see flow chart in evidence tables section of these help notes) and who will review them

- whether any evidence to recommendations need to be drafted and who will do them
- which issues will require lengthy debate at the working party meetings.
- Any changes/ lack of changes to the recommendations at this stage are draft and need to be signed off at the next working party meeting, from the basis of an update given by a group lead.

Developing recommendations

Writing a recommendation or set of recommendations

The important characteristics of most recommendations are:

- to define the target population or situation (e.g. patient with a right hemiparesis, all patients within 6 days of stroke, patients who cannot walk at a normal speed)
- **should**
- the action or intervention
 - who
 - what
 - where
 - how
- any qualifier

Furthermore it is important to link related recommendations. For example recommendation (a) might concern assessment, and (b) through (d) might specify the actions.

Exception: Intervention X should not routinely be used unless as part of a research trial.

The NICE guideline manual states that: factors that will be considered before issuing such recommendations include the following:

- The intervention should have a reasonable prospect of providing benefits to patients in a cost-effective way.
- The necessary research can realistically be set up or is already planned, or patients are already being recruited.
- There is a real prospect that the research will inform future guidance.

Inclusion of NICE recommendations

The coordinator must liaise with NICE early on in the update process to determine which parts of the Guideline scope overlap with guidelines NICE are updating or have updated. If a NICE guideline is being developed that significantly overlaps with large part of the Guideline, the Chair of the relevant Guideline Development Group should be invited to ICSWP meetings to provide updates.

Throughout the process relevant NICE draft recommendations should be integrated into draft versions of the Guideline. Any topics of overlap should not be updated in the ICSWP governed process, but NICE recommendations should be included if they overlap with the Guideline's scope.

Considering cost-effectiveness

If the evidence base provides sufficient information about cost-effectiveness to permit a health economic evaluation, this should be undertaken in consultation with the relevant members of the ICSWP. Certain recommendations may have significant resource implications. Any organisational or financial barriers to implementation should be identified within the linked 'Implications' sections so that commissioners and clinical networks can consider the means for local and regional implementation and service re-design.

Writing the evidence to recommendations

An 'evidence to recommendations' section is appropriate for almost all sections but certainly when:

- a recommendation is fully or partially derived by consensus
- the evidence is weak
- the evidence is not stroke specific
- the evidence is conflicting.

The format of an evidence to recommendations paragraph is:

- This should be a short section, usually of no more than 200 words but if the topic is particularly complex then it may need to be longer.
- It should state the question and briefly the relevance.
- Which patients have been included in the research and therefore to whom the recommendation may be most relevant.
- It should include a statement about the strength of the evidence on which the recommendation is made or why no recommendation could be made. This is the opportunity to cite the lower level evidence e.g. small RCTs, case series, single case studies.
- It should cite the key reference(s) that were used to formulate the recommendation.
- It should highlight areas where there is insufficient evidence and where research would be valuable.

Sources

- **Consensus only**
 - good practice point
 - no evidence
 - intervention should only be given in context of a clinical trial (when there is no evidence)

- when there will never be a trial but no one would refute that a treatment should be carried out a certain way.
- **Citation and consensus**
 - evidence used is not stroke specific
 - evidence exists but there is disagreement about its interpretation
 - evidence exists but is not very strong eg lots of underpowered studies
 - part of the recommendation is devised by consensus and another part by a paper eg when there is a set of bullet points (perhaps divide up the sources by bullet point)
 - intervention should only be given in context of a clinical trial (when there is some evidence).
- **Citation only**
 - any study that informed the recommendations
 - trial that informed the recommendations the most.
- **Other clinical guidelines**
 - NICE where relevant (where the recommendation is taken verbatim then just the guideline is cited, where it is used to help form a recommendation the guideline is cited with either the supporting evidence or consensus)
 - JBS, Royal College of Speech and Language Therapists
 - NICE Quality Standards, SSM alone where there is no evidence, with the supporting evidence where there is evidence.
- **Follows on from...:** recommendation derived by logic from other recommendations
- **Evidence reviewed elsewhere in section X.X to ensure there is cross checking/ integration with other sections of the guideline**

Agreeing recommendations

Recommendations are agreed by the ICSWP at its meetings. Any changes discussed at meetings should be included in tracked changes and circulated with ICSWP meeting minutes. If there are no objections they can be approved and accepted with the Chair.

Any contentious recommendations are brought first to the editor assigned to the topic area the recommendation appears in. If the disagreement is unresolved, the editor liaises with his/her co-editors to draft potential resolutions. If there is still contention, the issue is taken to the larger Working Party during a quarterly meeting where it is discussed and voted upon.

Guideline structure

As outlined above, the scope of an update of the Guideline is considered and agreed prior to the commencement of the update process by the ICSWP. This influences the structure of the Guideline; once the order of topics is decided, the following structure is implemented:

- **Introduction:** defining the topic and giving a brief background and clinical context
- **Evidence to recommendations:** outlining in more detail the evidence base behind a particular set of recommendations. This section may include some evidence that the Working Party considered important but not sufficiently strong to justify deriving a recommendation from it. This may not be appropriate for all sections where the evidence base is weak or absent
- **Recommendations:** given as a structured set (listed A, B, C etc.). Each set of recommendations is framed by the clinical process of care, so that a clinician should start with the first and will generally find that the order reflects clinical priorities and practice. Typically, assessment and diagnosis will precede intervention, and common, simple and safe actions will precede complex, expensive and rarely needed actions. The Working Party have expressly avoided recommending that interventions need to be done by specific professional groups, preferring to identify what needs to happen to a patient and leaving clinical services to decide who within the organisation is best equipped to deliver that intervention
- **Sources:** giving a few major references for each recommendation or stating that the recommendation was arrived at by expert consensus of the Working Party
- **Implications:** identifying, where necessary, the broader implications for implementation of the recommendations, including costs, workforce implications and what local teams need to do.

Consultation: public consultation

Public consultation is integral to the Guideline development. The consultation period lasts one month and occurs when the majority of the Guideline has been developed. It is acceptable, for example, to release a draft for consultation with some aspects not yet finalised if those parts are affected by large trials that are reporting after the planned consultation period.

Process (coordinator)

Consultation is undertaken via email. The contacts database is filed:

N:\Projects\Stroke\Guidelines\YEARRCP guidelines\Public consultation\Contacts database\Peer reviewers YEAR.mdb and should of course be updated prior to consultation. To update the database:

- contacts from charities and other organisations can be updated using their websites
- people with relevant specialties can be updated by emailing the relevant group lead
- the members of the ICSWP may suggest additional contacts.

It is extremely important to obtain patient and carer feedback. The Kings College London Patient and Family group provides valuable assistance, Speakeasy as can the patient representatives of the ICSWP and the patient groups are of course represented on the ICSWP including the Stroke Association.

At the beginning of the consultation, the coordinator emails contacts inviting them to respond, with reminders throughout the process at the discretion of the guideline coordinator and certainly one week before the end of the consultation period. It may be helpful to use the following template (amending the chapters as required according to the draft of the Guideline):

Dear colleague,

I am contacting you as part of the public consultation process for the Fifth Edition of the National Clinical Guideline for Stroke.

The Royal College of Physicians Intercollegiate Stroke Working Party have been working on the Fifth Edition of the National Clinical Guideline for Stroke which will be published at the end of September 2016.

The high quality of previous editions of the National Guideline followed invaluable help from peer reviewers. We are inviting you to contribute to the process because of your experience and interest in stroke. Full information is contained in the letter to peer reviewers (please read first before reading the guidelines and providing feedback). The consultation is being conducted electronically and so feel free to forward this to anyone you feel would be interested in taking part. The consultation draft of the document can be downloaded using the links below. Please be aware that the evidence tables will not be available for this consultation and references are not all confirmed, in particular, those in red. This consultation is primarily aimed at obtaining feedback on the recommendations which are also available as a single document. Each recommendation is numbered with an accompanying letter.

The guideline will contain six chapters and you can download each chapter individually, the document as a whole, or the recommendations only using the link provided below. Please also download the feedback form from the website. *This is the only method for taking part in the consultation*

All documents can be accessed via the following link:

<https://www.rcplondon.ac.uk/guidelines-policy/rcp-stroke-guideline-fifth-edition-2016-public-consultation>

If you have any difficulties accessing any of the materials, please email stroke.guidelines@rcplondon.ac.uk.

We can also provide a printed copy of any of these materials upon request.

Comments on the overall structure of the guideline, or on a particular chapter should be titled 'general' but specific marked examples are required.

Each chapter has numbered sections (e.g. 6.2, 5.3.2). Please specify the part you are referring to accurately, by number. Recommendations should be referred to in full (e.g. 5.3.1 rec B). The remaining text as eg 4.2 para 2).

Always please:

- Make your comments or suggestions as specific but as short as possible
- Give any references (and justify anything outrageous!)
- Give your name and email contact details. If we do not have this information, we will be unable to process your feedback.

Please return all forms to Ms Kaili Stanley, Stroke Guideline Co-ordinator before 22 April 2016 at stroke.guidelines@rcplondon.ac.uk. We will be unable to accept any feedback forms after this date. Furthermore, we will not be able to accept comments that have not been put on the correct feedback form.

We will not be able to respond to specific comments individually but everyone who does respond will have their names in the final version of the guideline.

Anticipated publication date: 30 September 2016

Thank you for all your comments and suggestions.

Feedback received should be saved individually, combined and sorted by recommendation number to send to Chair. All persons who respond are to be acknowledged in the published Guideline. The document should be proof read prior to public consultation; it is usual to ask members of the ICSWP to volunteer.

Finalising and publishing the guideline

The 2016 update to the guideline will be published electronically on 26 September 2016.

Editing guideline

Prior to the commencement of the publication process:

- all of the recommendations, evidence to recommendations and references should be finalised – signed off by the group lead/ Chair, subject to changes at editing
- the Guideline should have been proof read by multiple (three or four) people
- the key recommendations and profession specific guidelines should be finalised. These are extracts from the full guideline and include a commissioner specific guide and guides for the nurses, therapists etc. (ie which recommendations to include).
- the appendices should be complete.

Profession specific concise guidelines

These are verbatim extracts of recommendations in the main body of the text selected by groups of professionals, e.g. nurses, as the recommendations most relevant to their profession. The reproduction of these is to be agreed by the ICSWP. .

Patient version

The patient version of the guideline is a lay person summary of the full content of the Guideline, developed in a parallel process and led by a guideline editor and the patient representatives and wide consultation with patient groups and all representatives on the ICSWP. It will be published in

print to be purchased separately from the full Guideline and will also be available electronically for download.

Application

In previous updates a smartphone/tablet application (app) has been developed. In deciding whether to proceed in future updates the following should be considered:

Tender document

A tender process is to be used; the process is available in the Guidelines files.

What is included in the app

The patient version of the app has all of the information in the patient and carers booklet, but the professional version has a subset of information at the front of the app, with the full recommendations accessible as an e-book further back. Accessible within a few clicks on the professional version are the Key recommendations, the profession specific recommendations and approximately 40 topic headings.

Out of cycle review of the Guideline

It is recognised that research evidence changes continuously. As part of its regular annual meetings, the ICSWP will review evidence in response to submissions from members and constituent organisations, with the first scheduled partial review in 2018. It is anticipated that the previous four-yearly cycle of reviews and updating will be amended, taking advantage of the new digital publishing format to permit interim updates to the guideline in response to significant advances in the clinical evidence.

Appendix A: Intercollegiate Stroke Working Party Terms of Reference

Intercollegiate Stroke Working Party

Terms of Reference

April 2013

Aims of Steering Group:

- To develop and enable national and local stroke audit (e.g. sentinel audit, acute audit, profession specific, carotid intervention)
- To represent the views of the constituent organisations that make up the working party
- To complete work as individuals or within sub groups to assist with the delivery of the audit project as per the commissioned time-plan
- To inform the programme of new evidence /developments relevant to the conduct of the audit or its dissemination
- To use the audit process and results to improve stroke care and services
- To identify future potential projects and partnerships to sustain developments in stroke prevention, organisation and process of care.
- To develop and disseminate National Clinical Guidelines for Stroke.
- To develop and oversee the delivery of a peer review system for stroke.
- To provide expert advice to external bodies involved in management of stroke (e.g. National Audit Office, NHS Choices, Healthcare Commission, NICE)

Terms of reference:

- Each steering group meeting will be chaired by the Programme Director or a nominated deputy.
- The steering group will meet a maximum of four times a year
- Meeting dates will be agreed and circulated for the forthcoming year
- A meeting can take place with a quorum consisting of one member from two of the following ABN, RCP, BSRM, BGS and Radiology. And two of the following Nursing, Physiotherapy, Occupational therapy, Speech and Language Therapy, Psychology.
- At least 2 members of the ICSWP will be people using services, their family members or carers, or members of the public and community or voluntary sector with relevant experience (lay members). Lay members should be willing to reflect the experiences of a wide range of people affected by the guideline rather than basing their views solely on personal experience.
- Steering group members should attend a minimum of 2 meetings per year.
- If Steering group members are unable to attend, they are asked to: (i) send comments or speak with the chairperson or programme manager with regard to relevant papers for decision at the meeting
- If a member wishes to leave the steering group they should notify the chairperson
- If a member leaves the steering group, replacements will be sought from that member's professional organisation /peers
- The agenda and papers will be distributed electronically at least 5 working days in advance of meetings
- Steering group members should read meeting papers so that they are informed and have enough information to agree standards, indicators and audit methodology

- Minutes / meeting notes will be distributed within 10 working days following the meeting
- Members should inform the steering group of any developments /changes within their areas of expertise which might influence the audit project
- Steering group members share *a responsibility to promote* dissemination of the audit results, guidelines and peer review and should discuss a mechanism for so doing within their professional organisations
- If there are more than two representatives for an organisation a maximum of two representatives should come to the meeting. It is up to the representatives to decide beforehand who will be coming.

Funding:

- The project budget will cover the costs of organising and hosting the meetings
- Each steering group member will have their expenses covered to attend these meetings as per guidance on travel claims forms.

Appendix B: Conflict of interest policy and procedure

Objective

To ensure that the National Clinical Guideline for Stroke is effective and valued guidance that is not compromised by mismanaged conflicts of interest.

Acknowledgment

This policy and procedure are based on and reflect the NICE *Policy on Conflicts of Interest*: <https://www.nice.org.uk/Media/Default/About/Who-we-are/Policies-and-procedures/code-of-practice-for-declaring-and-managing-conflicts-of-interest.pdf>

Scope

This policy and procedure covers:

- the members of the Intercollegiate Stroke Working Party; and
- members of sub-groups involved in the development and update of the National Clinical Guideline for Stroke
- members of the RCP stroke programme in their capacity supporting the development of the National Clinical Guideline for Stroke

Types of interests

Conflicts of interest may be financial or non-financial, and, as set out by NICE, specific or non-specific. Types of interests and examples are set out on pages 4 to 7 of the NICE Policy on Conflicts of Interest.

Procedure: members of the ICSWP

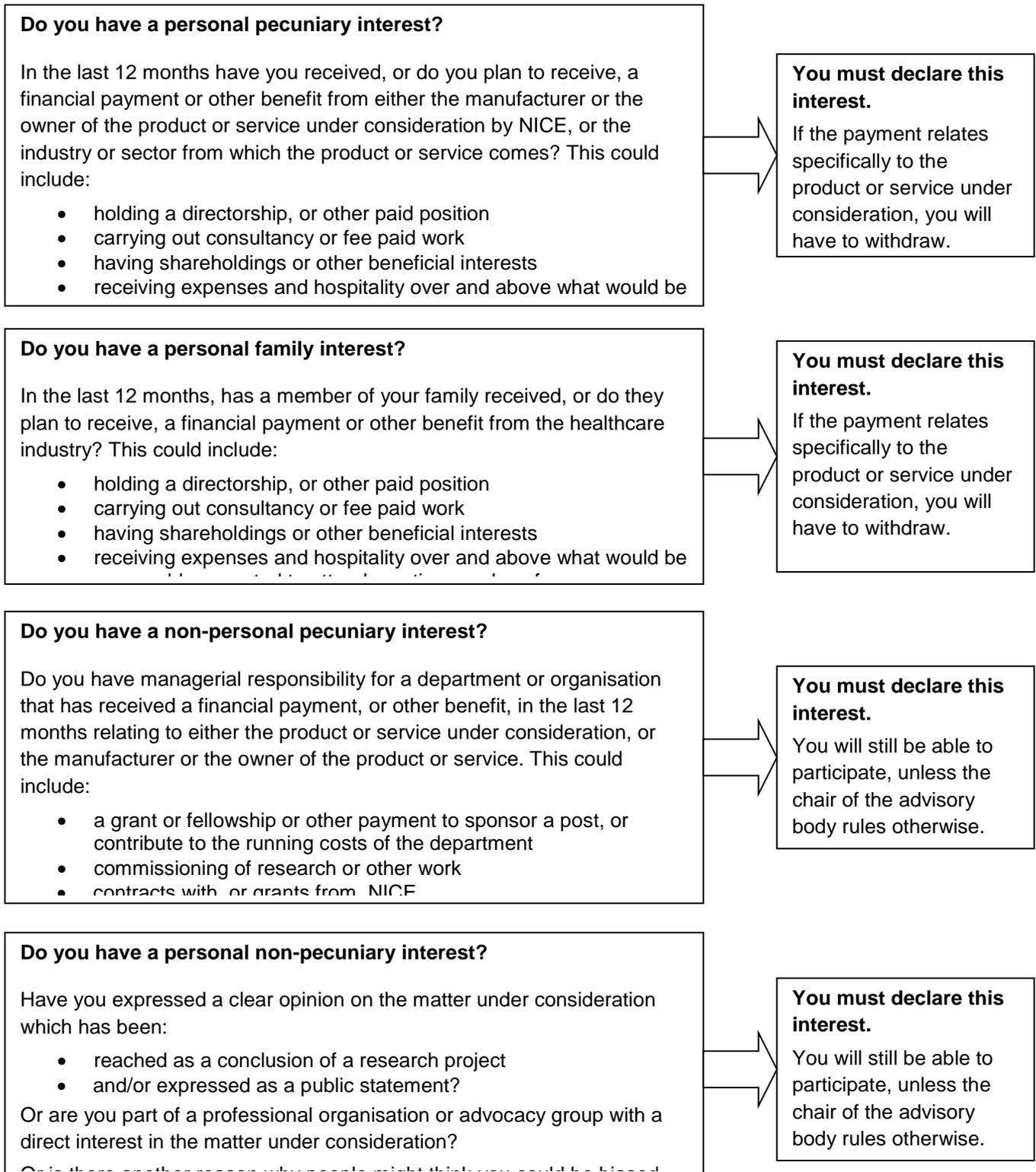
- Upon joining the ICSWP, all members must sign a conflicts of interest form, a blank copy of which is filed in the following location: N:\Projects\Stroke\ICSWP\COIs.doc
 - Information on conflicts and when to declare them, based on the NICE 2014 guidance, is given to members (Appendix C)
- Conflicts of interest are filed in the following location: N:\Projects\Stroke\ICSWP\Conflict of Interests - ICSWP and Subgroups
- Conflicts of interest must be a constant agenda item of ICSWP meetings, with hard copies of forms filed to be used as a record.
- The chair of the ICSWP has no competing interests
- During decision points, if a member has a conflict of interest it is verbally declared and, depending on the level of the interest, the member does not join the discussion or leaves the room.
 - Any potential personal pecuniary and/or personal family interest listed will be considered a conflict if those payments relate directly to the product or service that is being considered (see NICE process in appendix). If a member has declared a non-personal pecuniary or personal non-pecuniary interest, then the chair is required to decide whether or not this interest is significant enough to be considered a conflict, on a case-by-case basis.

Procedure: members of sub-groups/ reviewers

- Upon agreeing to participate in the Guidelines review process, each sub-group member/reviewer must sign a conflicts of interest form, a blank copy of which is filed in the following location: N:\Projects\Stroke\ICSWP\COIs.doc
 - Information on conflicts and when to declare them, based on the NICE 2014 guidance, is given to members (Appendix C)
- Conflicts of interest are filed in the following location: N:\Projects\Stroke\ICSWP\Conflict of Interests - ICSWP and Subgroups
- Conflicts of interest are updated regularly to ensure that they are up to date and cover the entirety of the Guidelines review process. Hard copies of forms filed to be used as a record.
- Either during or before teleconferences, if a reviewer has a conflict of interest it is verbally declared and, depending on the level of the interest, the member does not join the discussion or leaves the teleconference for the time that the topic in question is discussed.
 - Any potential personal pecuniary and/or personal family interest listed will be considered a conflict if those payments relate directly to the product or service that is being considered (see NICE process in appendix). If a sub-group member/reviewer has declared a non-personal pecuniary or personal non-pecuniary interest, then the editor who is leading the discussion is required to decide whether or not this interest is significant enough to be considered a conflict, on a case-by-case basis. If the editor leading the discussion has a potential conflict, an alternative, non-conflicted editor will take over as lead of that discussion.

Appendix C: Conflict of Interest form

The following chart gives an overview of what may constitute a conflict of interest, and what you need to do. It is only intended as a general guide and should be used in conjunction with the full policy, which is available from the NICE website (www.nice.org.uk).



Please note your annual declaration may be made publicly available