NATIONAL CLINICAL GUIDELINE FOR STROKE

for the United Kingdom and Ireland

THERAPY INTENSITY RECOMMENDATIONS

FACT SHEET

WHY IS 3 HOURS OF THERAPY RECOMMENDED IN THE CURRENT GUIDELINE?

We now have sufficient evidence to recommend increased levels of therapy related to motor function. This is across a range of interventions for walking, balance, and upper limb, with each intervention regime requiring sufficient dose and intensity to be effective. The intention of the recommendation is to ensure that more than one intervention is used where this may be of benefit and to ensure that a range of treatments, across multiple disciplines can be delivered at evidence informed doses to achieve clinical effectiveness. This evidence was also independently reviewed by NICE stroke rehabilitation guideline (2023), also recommending an increase in therapy.

IS 3 HOURS APPROPRIATE/EXPECTED FOR ALL PATIENTS?

No. The guideline states that therapy must be provided in line with a person's preferences, needs and goals. Those who are unable to tolerate 3 hours of therapy a day should be facilitated to be as active as possible. Therapy can be accumulated throughout the day and includes functional practice with motor goals and semi supervised practice, provided across therapy disciplines. It is not possible to say from the evidence who are the appropriate cohort for 3 hours of therapy per day, but we hope that over the next 5 years of SSNAP data collection and research, we'll be able to better describe this group. The case remains that evidence supports that 'more is better' for motor recovery for all people following stroke. An overall increase in therapy intensity should remain a goal for all stroke services, using repetitive task practice as its main approach, providing 3 hours of therapy per day for those who can tolerate it.

DID RECOMMENDATIONS FOR THERAPY STAFFING LEVELS CHANGE TO REFLECT THE INCREASE IN THERAPY REQUIRED?

Recommendations for registered therapy staffing levels for inpatient stroke care were increased to reflect 7 day working, augmented by support workers and rehabilitation assistants. Different ways of working are also recommended, including use of groups, open gyms, and rehabilitation companions. A detailed review of inpatient staffing levels was not within scope for the partial update of the guidelines and so the increase was based on the previous methodology and published WTEs from the 2016 guideline. Support worker and rehabilitation assistant staffing levels were not included in this original methodology and there is no robust research to underpin a recommendation. Community staffing levels were based on published evidence and the National service model for an integrated community stroke service and are the minimum levels required. Intensity of therapy delivery can be increased through use of rehabilitation assistants, groups, open gyms and telerehabilitation.

IF 3 HOURS IS FOR MOTOR RECOVERY, WHAT ABOUT EVERYTHING ELSE?

The 3-hour recommendation is regarding motor therapy only (including functional practice). Therefore people with stroke will continue to require therapy pertaining to other impacts of stroke, outside of this time, such as therapy for cognition or communication. Delivery of Speech therapy continues to be recommended for 45 minutes of therapy, 5 days out of 7 (unchanged from previous guidance). Therapy priorities and timetabling will need to be negotiated with the person with stroke and within the multidisciplinary team, to account for fatigue and patient choice. In the community, SSNAP will capture provision across new important aspects of integrated, personalised rehabilitation, such as healthy living and lifestyle management; vocational rehabilitation; social care and care delivery.

HOW DO WE DELIVER 3 HOURS OF THERAPY?

There is no doubt that increasing therapy delivery is a challenge, with current levels of delivery continuing to be below the previously recommended 45 minutes of each discipline 5 days a week. The evidence however requires us to move towards this over time. This will require different ways of working such as introducing more group work, semi supervised practice, use of rehabilitation companions and telerehabilitation. Patient choice and circumstances (including activation) must guide content, timing and mode of therapy. SSNAP will collect data on methods of therapy delivery including groups and telerehabilitation.

WHY IS SSNAP MOVING AWAY FROM MEASURING DISCIPLINE SPECIFIC PROVISION?

The National Clinical Guideline for Stroke (NCG23) recommends person centred care and interdisciplinary working. Measurement is therefore moving away from which disciplines provide therapy, to measuring what interventions people with stroke receive. This includes removal of double counting when more than one professional has been involved in a session. This move also allows monitoring of provision of two important areas of rehabilitation with recommended intensity levels- motor therapy and intensive comprehensive aphasia programmes (ICAPS) and broader aspects of integrated needs led rehabilitation in the community.

IF SSNAP IS MOVING AWAY FROM DISCIPLINE SPECIFIC REPORTING, HOW WILL WE BUILD CASES FOR CHANGE SUCH AS NEEDING INCREASED WORKFORCE?

SSNAP are in the process of reviewing the organisational audit (previously completed biannually for acute and community stroke services). These organisational audits will continue to capture workforce information in relation to nationally recommended staffing levels, as well as waiting times and activity data. These data will be able to updated on an ongoing basis by teams. Discipline specific assessment targets have been retained in the clinical dataset such as assessment by each discipline within 24 hours (previously 72 hours). These data can be combined, with overall therapy intensity and outcomes (via new outcome measure collection) to build business cases and understand the contributions of the MDT.