Resource impact summary report

Resource impact
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The guideline covers stroke rehabilitation for adults and young people aged 16 and over who have ongoing rehabilitation needs. It aims to improve stroke rehabilitation by making recommendations on common problems and conditions after stroke, assessing rehabilitation needs, planning and managing rehabilitation during and after hospital, and by specifying how stroke units and multidisciplinary stroke teams should be organised. It also covers self-care, including return to work programmes, and supporting people with long-term rehabilitation needs.

There are around 84,350 strokes a year in England causing about 32,000 deaths per year. The number of hospital admissions per year due to stroke in England is approximately 126,000, this figure will include individuals who have had repeat strokes. Although stroke is one of the biggest causes of death in the UK, most people survive a first stroke, this is due to improvements in organised stroke care and new acute treatments. This has led to an increase in the number of people in the community who need comprehensive post-stroke care and rehabilitation.

Most acute care is delivered within stroke units as part of organised stroke services. Post acute care can be delivered in secondary or primary care including community-based NHS providers, often by teams working across organisational boundaries. Within such services, specialist multidisciplinary teams of appropriately skilled professionals work together to deliver goal-directed rehabilitation with the aim of helping people to relearn any skills they may have lost, improve their quality of life and enable them to live as independently as possible.

Most of the recommendations in the updated guideline reinforce best practice and should not need any additional resources to implement. However, some of the guideline areas and recommendations may represent a change to current local practice. Where a change is required to current practice, this may require additional resources to implement, which may be significant at a local level. Benefits derived from the change in practice may help mitigate any additional costs.

Depending on current local practice, recommendations/areas which may require additional resources and result in additional costs include:

- **Recommendation 1.2.16:** Offer needs-based rehabilitation to people after stroke. This should be for at least 3 hours a day, on at least 5 days of the week, and cover a range of multidisciplinary therapy including physiotherapy, occupational therapy and speech and language therapy.

Evidence showed more intensive physiotherapy improved quality of life and activities of daily living. The recommendations will increase the amount of therapy that is provided for 5 days a week. This could lead to a change in practice which may impact on resources, although this will be balanced out by long-term health benefits and potential care savings.

The committee did emphasise that therapy should be provided for as little or as long as the person requires it and should be based on their needs, to ensure they can get the most out of their rehabilitation.

Based on 84,350 strokes in England and 50% of people being suitable for more intensive treatment after stroke, if 25% of people required an extra 3.75 hours of therapy for 1 week this would equate to an annual requirement of 39,539 additional hours per therapy and an additional 25 whole time equivalents (wte; 39,539/1,560 annual hours per person). Any increase in hours required will be determined by current practice and whether services can be reconfigured to increase hours earlier in the pathway.

The template assumes 1 wte is equivalent to 1,560 hours of therapy per year (net of annual leave/bank holidays/continuing professional development/sickness), this can be amended in the template if required.

Clinicians highlighted that working practices may need to change to accommodate more intensive therapy. This could be done by working more innovatively such as semi-supervised therapy, group work and greater use of technologies.

- **Recommendation 1.11.6:** Offer behavioural exercises (for example, chin tuck against resistance) to people with oropharyngeal dysphagia (OPD) for at least 5 days per week.

Increasing the intensity of behavioural exercise from the previously recommended 3 days a week to 5 days will lead to a change in practice and extra resources, although this will be balanced out by long term health benefits and potential care savings.

Clinical experts assume 50% of stroke patients have OPD. If 25% of the 42,175 people require an additional 1 hour per week for 4 weeks this would equate to an annual requirement of 42,175 hours and an additional 27 wte speech and language therapists (42,175/1,560 annual hours per person). Any increase in hours required will be determined by current practice and whether services can be reconfigured to increase hours earlier in the pathway.

Implementing the guideline may lead to the following benefits:

- Quicker recovery allowing patients to be discharged earlier.
- Better health outcomes and care experience.
- Downstream cost savings from higher intensity therapy include reducing disability, residential or home care requirements and home adaptations.

These benefits may also provide some savings to offset some of the potential costs identified above.

A local resource impact template is available to help organisations estimate the resource impact of these recommendations. The local template allows users to indicate what proportion of people they expect to receive more intensive therapies. This enables users to assess what staffing resource will be required to implement the guidance locally.

The assumptions in the template are for illustrative purposes and can be amended to reflect local practice. Users can input current and future practice for the number of hours and weeks therapy is delivered for, as well as the grade of staff used to deliver the therapy.

Stroke services are commissioned by integrated care boards. Providers are NHS hospital trusts, community providers and primary care providers.