Supplementary Table 1 - Developing statements for the Delphi

Theme One: Reasons related to the Person

Findings from Focus Groups (at a coding level)	Findings from Literature	Proposed Delphi Statement
Medically unwell **Blood pressure unstable** **Heart-rate unstable** **Too drowsy/not alert enough to participate** **If feeding has been established or not** **For palliative care** **Fatigue limits therapy** **Receiving 45 minutes of therapy can be limited by co-morbidities.** **Therapy sessions may be cut short as patient not feeling well**	Clinical instability, concurrent medical illness and post-stroke fatigue could influence provision of therapy for a stroke survivor (Clarke 2018) Fatigue and medical complications can be barriers to rehabilitation. (Taylor 2015) Patient's health status influences physiotherapists' guideline adherence on intensity of practice (Ottermans 2012)	A Stroke survivor may not receive the recommended amount of therapy for medical reasons (such as unstable blood pressure, chest infection, nutritional status etc.)
Impaired attention can limit a stroke survivors' ability to tolerate therapy	Cognitive impairment can be a barrier to therapy intervention (Taylor 2015)	A therapy session may end if the stroke survivor is not able to

A patient's impaired attention can limit their ability to tolerate therapy.		maintain appropriate attention to the therapy input
Not all patients can tolerate 45 minutes of therapy **Difficult to break down 45 minutes into smaller sessions for those who can't tolerate all in one go** **Stroke survivor may not receive 45 minutes of therapy because they are unable to tolerate therapy Patient fatigue demonstrates that they are not tolerating therapy** **The amount of therapy a patient gets depends on what they can tolerate.** **Some patients can't tolerate 45 minutes of therapy in a day, even if its broken into shorter sessions**	Potentially, the reason why people didn't receive the recommended amount of therapy is because they were unable to tolerate therapy (Foley 2012)	A therapy session may end if the stroke survivor is not tolerating the therapy input
Changing the amount of input that is given to someone who is 'not progressing' **Speed at which someone is going to progress influencing decisions** **Objectively demonstrating that someone is not improving using Outcome Measures** **Patients who are making the most progress are prioritized for therapy**	People who are not making progress are considered to be a low priority for therapy after stroke (McGlinchey and Davenport 2015)	If a stroke survivor isn't making progress in therapy, they are unlikely to continue to receive 45 minutes of daily therapy

Patient's level of dependence can indicate their appropriateness for therapy	Functional level post-stroke can be an indicator of how much therapy someone received (Hakkennes 2011)	If a stroke survivor remains very dependent on care, they are unlikely to continue to receive 45 minutes of therapy daily
Patients not receiving 45 minutes on the basis that they can self-manage **Patients not receiving the 45 minutes, because they can direct their own therapy** **Do not receive 45 minutes of therapy if they can self-direct their therapy**	People who are able to perform exercises independently may be a lower priority for Physiotherapy after stroke (McGlinchey and Davenport 2015)	If a stroke survivor can exercise independently, they are unlikely to receive 45 minutes of therapy daily.
Some patients are more motivated for therapy than others **Patient's motivation can limit them receiving 45 minutes of therapy**	People who are motivated are more likely to be considered high priority for Physiotherapy (McGlinchey and Davenport 2015) People who are motivated are considered most appropriate for intensive rehabilitation (Taylor 2015)	A Stroke survivor may not receive the recommended amount of therapy if they are not motivated for therapy
Low mood can be a barrier to delivering the 45 minutes of therapy.	Depressive symptoms effect participation in rehabilitation (Skidmore 2010)	A Stroke survivor may not receive the recommended amount of therapy if they are low in mood.
Might not get it if patient declined. **Sometimes patients don't want daily therapy**	If a person requests to stop physiotherapy then it will be stopped (McGlinchey and Davenport 2015)	A Stroke survivor may not receive the recommended amount of therapy if they do not consent to therapy

Lack of consent can be a barrier to delivering the 45 minutes of therapy. **Patients may decide they don't want therapy** **Patient choice may determine whether or not they receive 45 minutes of therapy** **Patient might not have therapy if they do not consent (provided they have capacity)**		
Might not get it if patient has visitors **Visitors may limit the ability to deliver 45 minutes of therapy** **Having visitors can mean that Stroke Survivors don't want to engage in therapy**	**No related findings in literature**	A Stroke survivor may not receive the recommended amount of therapy if they have visitors
Need consistent participation from patient to continue	**No related findings in literature**	A stroke survivor may not be prioritised for daily therapy if they are not consistently participating in therapy
Not identified in focus groups	Lack of English as a first language may limit rehabilitation input (Taylor 2015)	A stroke survivor may not receive 45 minutes of therapy if they speak little or no English
Not identified in focus groups	Lack of social support may limit rehabilitation input (Taylor 2015)	A Stroke survivor may not receive 45 minutes of therapy due to social

	Presence of social support is associated with selection for rehabilitation (Hakkennes 2011)	issues (such as lack of social support, addiction or social complexity)
If someone was fully dependent before (might not receive the guideline amount of therapy)	Pre-stroke functional level is associated with selection for rehabilitation (Hakkennes 2011)	If a stroke survivor was dependent on care before they had a stroke, they are less likely to continue to receive 45 minutes of therapy daily.
Some people might benefit from therapy, but it is not given to them, as they appear to be at 'baseline' and safe for discharge	Post-stroke functional level is associated with selection for rehabilitation (Hakkennes 2011) Those who are at baseline level of mobility/function are low priority for physiotherapy (McGlinchey and Davenport 2015)	If a stroke survivor has returned to their previous level of function, they are less likely to continue to receive 45 minutes of therapy daily.
Therapy sessions may be cut short as patient has made other plans **Being able to 'get to' patients may influence the amount of therapy they have**	**No related findings in literature**	A Stroke survivor may not receive 45 minutes of therapy if they have other priorities (such as an appointment or a wish to do something else at the time they are offered therapy).
Patients may decide they don't want therapy because they want to be doing something else (stated specifically in relation to ESD). **A patient's own priorities will influence whether they receive 45 minutes of therapy (Stated specifically in relation to ESD).**	**No related findings in literature**	In the community, a Stroke survivor may not receive 45 minutes of therapy if they are prioritising 'getting on with their life'

Theme Two: The individual Therapist

Findings from Focus Groups (at a coding level)	Findings from Literature	Proposed Delphi Statement
Difficult to deliver 45 minutes of therapy when there is a lot of new patients **New admissions can limit the ability to deliver 45 minutes of therapy** **Might not receive 45 minutes of therapy due to competing targets** **New patient assessments limits ability to provide 45 minutes of therapy**	New patient assessments are high priority (more likely to receive therapy) (McGlinchey and Davenport 2015)	A stroke survivor may not receive 45 minutes of therapy due to new patient assessments being prioritised
Stroke rehabilitation sessions are the third priority (after admissions and discharges)	For those with a clear prognosis, therapists' focus was on facilitating discharge (Taylor 2015) Discharge planning takes up a large proportion of therapist time, particularly in socio-economically deprived areas (Taylor 2015) People who need a lot of support with discharge planning get less face-to-face therapy time (Taylor 2015) People who are approaching imminent discharge as high priority (more likely to	A stroke survivor may not receive 45 minutes of therapy due to patient discharges being seen as a priority.

	receive therapy) (McGlinchey and Davenport 2015) Discharge planning was prioritised over face-to-face therapy (Clarke 2018) Focus on discharge planning may detract from rehabilitation (Taylor 2018).	
Size of caseload can determine ability to provide the recommendation	Decisions regarding the frequency of therapy depend on time available (McGlinchey and Davenport 2015)	A stroke survivor may not receive 45 minutes of therapy because of the size of the therapists' caseload.
Not identified in focus groups	Non-clinical commitments (staff meetings, in-service training, ward handovers) reduce f2f therapy time (McGlinchey and Davenport 2015) Units that spend more time in information exchange deliver less rehabilitation to the people on their units. (Clarke 2018) Time spent in other non-patient contact activity (such as planning, documentation, ordering equipment/transport, developing training, staff supervision) effected the amount of therapy provided to people (Clarke 2018)	Non-patient contact activities (such as handover, MDT meetings, planning therapy sessions, ordering equipment and documentation) limit my ability to deliver 45 minutes of therapy to stroke survivors

Not identified in the focus groups	Therapists either are not aware of, or didn't discuss the evidence underpinning the recommendation for a minimum of 45 minutes of therapy, in relation to therapy delivery (Clarke 2018). Therapists rely on their clinical experience when providing therapy, not research evidence (McGlinchey and Davenport 2015).	My knowledge and understanding of stroke recovery effects the decisions I make regarding amount of therapy I provide to stroke survivors.
The need to ensure that resources are used appropriately **Ensuring family understand about decisions made re: amount of therapy.** **Have to consider the best use of resources in the provision of therapy** **Objectively demonstrating that someone is not improving using Outcome Measures** **Prioritizing patients when there is a lack of resources** **Not providing people with more therapy for the sake of it** **Needing to manage (or potentially ration?) a resource**	**No related findings in literature**	It is important that I can justify the decisions I have made about the amount of therapy a stroke survivor receives.
Doing the 'best thing for the patient'	How much therapy delivered depends on the individual characteristics of both the person and the therapist (Taylor 2015)	The therapy a stroke survivor receives should be based on what

The amount of therapy a patient gets is based on what they need. **What the patient needs is more important than a fixed amount.** **Patient need is most important** **Importance of delivering what patients need, not what is outlined in guidance.** **Care needs to be individualized** **Therapy should be patient-focused** **Therapy is tailored, dependent on patient need**		they need, not on a pre-specified amount.
Relatives expect therapy daily. **Public may know about guidelines** **Patients/relatives' awareness of guideline** **Increases accountability to patients** **Potentially only accountable to some patients (those who are 'savvy' and have 'read up')** **Should be able to justify to patients/relatives why they are not receiving the guideline amount of therapy**	Individuals/families that can 'work the system' may influence therapist decision-making (Taylor 2015)	If a relative and/or carer are aware of the guidance, then I am more likely to ensure the stroke survivor receives 45 minutes of therapy

Not identified as a factor related to therapy deliver in either focus groups or research literature, but based on experience of working in stroke care, and following discussion with research team		A stroke survivor may not receive 45 minutes of therapy because I am due to leave work and there isn't time.
Not identified as a factor related to therapy deliver in either focus groups or research literature, but based on experience of working in stroke care, and following discussion with research team		A stroke survivor may not receive 45 minutes of therapy because I don't feel well, either mentally or physically.
Not identified as a factor related to therapy deliver in either focus groups or research literature, but based on experience of working in stroke care, and following discussion with research team		How I am feeling (including my mood and physical comfort) influences the decisions I make regarding amount of therapy I provide to stroke survivors.

Theme Three: The Stroke MDT

Findings from Focus Groups (at a coding level)	Findings from Literature	Proposed Delphi Statement
Investigations can limit the ability to deliver 45 minutes of therapy **Stroke survivor may not receive 45 minutes of therapy if they have to be taken for investigations**	Therapy input may be limited if patients are off the ward (Foley 2012)	A stroke survivor may not receive 45 minutes of therapy if they need to go for a medical investigation.
Competing professionals can limit the ability to deliver 45 minutes of therapy **Amount of therapy input can be dependent on the other therapy that the stroke survivor is also receiving**	Not specifically identified in the literature, although could relate to people 'not being ready' for therapy – as below.	A stroke survivor may not receive 45 minutes of therapy if they are seeing another healthcare professional at the time of their therapy session.
Therapy sessions may not start on time due to people needing their medications. **Limited by sessions not starting on time/patients not being ready for therapy.** **Therapy sessions may not start on time due to people's NG tubes still being attached.**	There can be issues with people not being ready for therapy sessions (Taylor 2015) Patients not being ready for therapy influenced the amount of therapy delivered (McGlinchey and Davenport 2015) Achieving the 45 minute guideline was limited by people not being ready for therapy (Clarke 2018)	A stroke survivor may not receive 45 minutes of therapy if they are receiving other healthcare input, such as medication or artificial feeding.

Therapists are collectively focused on delivering 45minute guideline **Regular, MDT meetings to discuss the guidelines**	Therapists discuss daily which people were and were not appropriate for the guideline 45 minute guideline (Taylor 2018). Teamwork is required to facilitate joined-up working across the MDT (Taylor 2015)	Other members of the MDT (including other therapists of a different profession to me) influence the decisions I make regarding amount of therapy I provide to stroke survivors
Therapists are collectively focused on delivering 45minute guideline	Therapists discuss daily which people were and were not appropriate for the guideline 45 minute guideline (Taylor 2018). Teamwork is required to facilitate joined-up working across the MDT (Taylor 2015)	Therapists of the same profession to me influence the decisions I make regarding amount of therapy I provide to stroke survivors.

Theme Four: The Organisation

Findings from Focus Groups (at a coding level)	Findings from Literature	Proposed Delphi Statement
Lack of flexibility within the working day may be one reason why someone might not receive 45minutes of therapy - if they 'miss their slot' **Fast pace in acute stroke** **Interruptions to therapy sessions occur due to the nature of acute hospital work** **Amount of therapy limited by the nature of service provision**	**Nothing found in the literature**	Stroke survivors may not receive the recommended minimum of 45 minutes of therapy in the acute setting, due to the fast-paced nature of the service.
Resources can impact the provision of 45minutes of therapy **Size of caseload can determine ability to provide the recommendation**	**?Clarke 2018 and Taylor 2018**	Stroke survivors may not receive 45 minutes of therapy in the acute setting, due the caseload being very large at times.
In the community, it is unusual for a patient to have more than 45 minutes of therapy-a-day – even if they have more than one therapy involved **Use of combined OT/PT sessions, even when sometimes might benefit from separate. (in the community)** **Harder to achieve 45 minutes as part of ESD**	**Nothing found in the literature**	Stroke survivors receiving Early Supported Discharge (ESD) input are unlikely to receive more than one session of therapy-a-day when they are at home

People don't want as much therapy at home (ESD). **Patients lack time for therapy at home** **Stroke Survivors may want less therapy in order to "get back to normal life"**	**Nothing found in the literature**	Stroke survivors receiving ESD input don't want more than one session of therapy-a-day when they are at home
Amount of therapy limited by the nature of service provision (ESD service limited to 6 week duration)	**Nothing found in the literature**	Stroke survivors continue to receive therapy for as long as they would benefit from it, within the ESD setting.
Not always the same discipline for 45minutes (in ESD). **People don't want as much therapy at home (ESD).** **Patients lack time for therapy at home** **Stroke Survivors may want less therapy in order to "get back to normal life"** **Harder to achieve 45 minutes as part of ESD** **In the community, it is unusual for a patient to have more than 45 minutes of therapy-a-day – even if they have more than one therapy involved** **Use of combined OT/PT sessions, even when sometimes might benefit from separate. (in the community)**	**Nothing found in the literature**	The guideline for 45 minutes of therapy is not appropriate for stroke survivors receiving ESD.

Resources can impact the provision of 45minutes of therapy **Stroke survivor may not receive 45 minutes of therapy due to staffing levels** **Might not receive 45 minutes of therapy due to issues with staffing.** **Staffing levels influence the amount of therapy that patients receive.** **Highlighting staffing issues.**	Staff are not replaced when they are off sick/in meetings/in training and this impacts the provision of therapy (Foley 2012) Lack of staff availability can make it difficult to deliver therapy (McGlinchey and Davenport 2015) Higher levels of staffing are linked with greater achievement of the 45 minute guideline (Clarke 2018) Sometimes, therapists' make decisions around about a person's suitability for therapy based in resource availability (Taylor 2018)	Lack of therapy staff, can be a reason why a stroke survivor does not receive the 45 minute guideline
Lack of flexibility within the working day may be one reason why someone might not receive 45minutes of therapy - if they 'miss their slot' **Difficult to break down 45 minutes into smaller sessions for those who can't tolerate all in one go** **Difficult to achieve a schedule that is not 45 minutes in a block** **Efforts may be made to go back to fatigued patients, but it depends on the patient**	Therapists rarely returned to stroke survivors later in the same day to increase their 'dose' of therapy (Clarke 2018)	Logistically, it is difficult to return to a stroke survivor for a second time in a day, if they are unable to tolerate 45 minutes of therapy in one session.

Therapy can be broken up over the day to enable stroke survivors to have more therapy. **Difficulty being flexible with patient sessions due to planning** **Book in more sessions-a-day if patient's tolerance is low.** **Some people benefit more from shorter, more 'intensive' sessions**		
Non-achievement of guidelines gains management attention **Not achieving national target perceived as failure.** **Importance of getting a good SSNAP score** **SSNAP increases accountability/scrutiny**	There is a belief that SSNAP scores influence service-commissioning decisions (Taylor 2018) Potentially, the SSNAP audit encourages commissioner-centred care, as opposed to patient-centred care (Taylor 2018). Achievement of the guideline is of great concern to senior therapists and therapy managers due to the real or perceived scrutiny from hospital managers and commissioners (Clarke 2018) Therapists may be concerned regarding how the achievement of the 45 minute guideline effects future commissioning decisions (Taylor 2018)	The achievement of a good SSNAP score for my organisation influences the amount of therapy I provide to stroke survivors.

Judgment from managers/ managers judge what you are doing **Guidelines perceived as a target**	There is a belief that SSNAP scores influence service-commissioning decisions (Taylor 2018) Potentially, the SSNAP audit encourages commissioner-centred care, as opposed to patient-centred care (Taylor 2018). Achievement of the guideline dominates the thinking of those who account for the SSNAP performance ratings (Clarke et al. 2018)	I feel pressure to achieve a minimum of 45 minutes of therapy for all stroke survivors on my caseload.

Theme Five: The Guideline and it's measurement

Findings from Focus Groups (at a coding level)	Findings from Literature	Proposed Delphi Statement
The guideline gives a sense of obligation to provide a certain amount of therapy **The 45 minute guidance has given a target to aim for** **Everyone should have 45 minutes of therapy unless there is a reason not to**	SSNAP (measuring the achievement of the 45 minute guideline) shapes therapy (Clarke 2018)	The presence of the 45 minute guideline influences the amount of therapy I provide to stroke survivors.

Potentially the 45 minute guideline disadvantages some people, who would benefit from more than 45minutes of therapy **The 45 minute guideline supports decision making**		
Pressure to deliver 45 minutes daily, even if the therapist feels it may not be the right thing for the patient.	Therapists feel a conflict between their clinical judgement that the person can't tolerate a longer session and the 45 minute recommendation and the implications this would have for their SSNAP score (Clarke 2018)	I feel pressure to provide all stroke survivors with a minimum of 45 minutes of therapy, even if it is not clinically indicated.
More than 45 minutes of therapy is needed by some patients **People should have more than 45 minutes if it will benefit them, they can tolerate it and they consent to it.** **Therapy sessions are not limited to 45 minutes.** **Generally, patients get the right amount of therapy**	**Nothing found in the literature**	Stroke survivors who would benefit from more than 45 minutes of therapy-per-day, generally receive it.
Uncertainty surrounding how patients will feel about 45 minutes of therapy 7 days-a week **Potentially patients don't want therapy at the weekend.** **Potentially patients don't want therapy on Sundays**	**Nothing found in the literature**	Providing 45 minutes of therapy seven days a week is not appropriate for the majority of stroke survivors.

7-day therapy might not reflect 'real life' **7-day therapy means that patients have no rest** **Therapy encroaching on 'family time' at weekends.** **Not necessarily therapy at the weekend that is an issue, more therapy seven days-a-week.** **Inpatients may be less likely to mind what day-of-the week it is.** **Some patients can' t tolerate therapy 7 days-a-week** **Patients may need a break from therapy.**		
SSNAP recording finishes once 'active' therapy is complete	SSNAP data is no longer recorded when someone is no longer receiving therapy (Taylor 2018)	If a stroke survivor is not appropriate for 45 minutes of therapy-per-day, then they will be discharged from therapy on SSNAP
SSNAP recording finishes once 'active' therapy is complete	Some therapists on some stroke units record 'maintenance' therapy whilst awaiting discharge and some do not (Clarke 2018)	If a stroke survivor is discharged from therapy on SSNAP, then they won't receive 45 minutes of daily therapy
Prioritizing patients when there is a lack of resources **What is the best alternative if unable to meet 45 minutes/day?**	**Nothing found in the literature**	When I am unable to provide a minimum of 45 minutes of daily therapy, the best alternative is to

Choose to provide more people with less therapy, daily, when unable to provide the recommendation		provide daily therapy at a lesser number of minutes.
Prioritizing patients when there is a lack of resources **What is the best alternative if unable to meet 45 minutes/day?** **Better to spend more time with fewer patients (difference of opinion)**	**Nothing found in the literature**	When I am unable to provide a minimum of 45 minutes of daily therapy, the best alternative is to provide 45 minutes of therapy on fewer days.