POLICY AND STRATEGY

Rehabilitation: a framework for continuity and recovery 2020 to 2021

A framework to help organisations plan rehabilitation services following the coronavirus pandemic.

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• This Framework will assist service planning for the anticipated demand for rehabilitation and recovery of both COVID-19 and non-COVID-19 populations in adults and children.

• There is growing evidence of the impact of the pandemic for four discrete population groups. It is also recognised that there may be impact for wider society in terms of economic impact; loss of usual societal participation and loss of family and friends, alongside the impact for frontline health and care workers. This will increase the requirement for rehabilitation over the coming months if not years.

• Rehabilitation is an investment, with cost benefits for both the individuals and society. It can help to avoid costly hospitalization, reduce hospital length of stay, and prevent re-admissions. (https://www.who.int/health-topics/rehabilitation#tab=tab_1). There is also reduced reliance on long term services. Rehabilitation enables people to live more independently and provides wider societal benefits. For example, enabling people to return to work or education.

• Planning should focus on the individual’s need and demand and capacity rather than location. Priority should be given to providing rehabilitation in the environment that will secure the best outcomes for the individual at, or as close to, home as possible.

• Rehabilitation will need to become “everyone’s business” in order to meet the expected increased demand. A workforce-wide culture of empowering people to be equal partners in maximising their own recovery and independence will be essential. In line with A Healthier Wales, promoting self-management and co-production of care will enable people to take more responsibility for their own health and wellbeing.

• Advances in technology and smarter ways of working must be embedded to support the increased demand and improve access, outcomes and experience.

• The ‘Discharge to Recover then Assess (D2RA) model’ forms the basis of the hospital discharge service requirements: COVID-19. Health and social care services must maximise the active therapeutic input during the early recovery phase and people on these pathways should have an agreed plan, with access to rehabilitation that is appropriate to their need in order to...
ensure that short term services do not become a long term provision unnecessarily.

- Effective rehabilitation is holistic. It includes action to reduce physical, psychological, emotional, social and economic impacts of the pandemic.
- Good data on demand and capacity, workforce modelling and outcomes together with data on the costs and benefits of investment in prudent and value based rehabilitation are essential to improve the quality of planning and delivery.

**Purpose and context**

Wales’ health and care services are moving to a new phase of planning for continuity and recovery as the COVID-19 pandemic continues. This framework seeks to provide assistance to service planning for the anticipated increased demand for rehabilitation of population groups, including both adults and children, affected both directly and indirectly by COVID-19. This includes considering how or whether to use the field hospital capacity as step-in, step-down and intermediate care provision. It is important to note that for the context of this paper the term ‘recovery’ refers to the recovery of the individual and not the recovery phase of the COVID-19 pandemic. In-line with *A Healthier Wales, the plan for Health and Social Care (2018)*, planning should reflect a whole system approach, prioritising services at or close to home, re-establishing wider services and maximising the flow through the system, enabling citizens throughout Wales to live as independently as possible for as long as possible.

The Primary Care Model for Wales is the nationally agreed approach to achieve the ambition of A Healthier Wales and rebalance the health and care system, changing the focus of care from hospital centred services to place based care; with core principles of planning care locally, improving quality, equitable access, a skilled local workforce and strong leadership. This also underpins the rehabilitation response for the current COVID-19 pandemic. Rehabilitation pathways should meet the needs of our populations and should interconnect to match the changing needs of the person. As a result, rehabilitation delivery should be targeted to the environment that optimises the best outcomes for the individual and not be confined to a physical location.
Health, social care, voluntary sector partners and service users will be central to the planning, design and delivery of rehabilitation services to overcome the impacts of the pandemic and the long-term sustainability of the health and social care system. This includes placing rehabilitation in the wider population context, including education, leisure and housing and enabling holistic and targeted approaches to rehabilitation. All of these partners will have unique leadership responsibilities to take forward the rehabilitation agenda.

**Increased population need**

We anticipate an increase in the need for rehabilitation in four main population groups:

1. People post-COVID-19: those recovering from extended time in critical care and hospital and those with prolonged symptoms of COVID19 recovering in the community;
2. People awaiting paused urgent and routine interventions and who have further deterioration in their function;
3. People who avoided accessing services during the pandemic who are now at greater risk of disability and ill-health;
4. Socially isolated/shielded groups where the lockdown has led to decreased levels of activity and social connectivity, altered consumption of food; substance misuse, the loss of physical and mental wellbeing and thus increased health risk.

Alongside these groups, there is growing evidence that COVID-19 has impacted on the well-being of the wider community. This will also need to be addressed if we are to collectively support people and populations to recover and flourish.

As demand on existing rehabilitation services increases, rehabilitation and enabling independence will become “everyone’s business”. Training and up-skilling the wider multidisciplinary and multiagency teams, promoting self-management and co-production of care will need to be promoted alongside access to a range of rehabilitation specialists. This together with advancements in technology and smarter ways of working will support the economies of scale required for the increased demand. Empowering the population to self-care and
self-manage their health will require a shift in traditional rehabilitation approaches and clear messaging around this change.

What is rehabilitation?

- Rehabilitation addresses the impact of a health condition on a person’s everyday life, by optimizing their functioning and reducing the experience of disability. Rehabilitation expands the focus of health beyond preventative and curative care, to ensure people with a health condition can remain as independent as possible and participate in education, work and meaningful life roles. [https://www.who.int/health-topics/rehabilitation#tab=tab_1](https://www.who.int/health-topics/rehabilitation#tab=tab_1)

- Rehabilitation is an investment, with cost benefits for both the individuals and society. It can help to avoid costly hospitalization, reduce hospital length of stay, and prevent re-admissions. Rehabilitation also enables individuals to participate in education and gainful employment, remain independent at home, and minimize the need for financial or caregiver support. [https://www.who.int/news-room/fact-sheets/detail/rehabilitation](https://www.who.int/news-room/fact-sheets/detail/rehabilitation)

Effective rehabilitation will require the health and social care system to:

- Adopt a whole-population and whole systems approach as stated in A Healthier Wales (2018), to identify population groups who may be at risk of avoidable harm.
- Use new ways of working and technology to achieve greater reach and to minimise avoidable deterioration.
- Work in partnership with individuals to make shared decisions on what matters to them, embracing opportunities to support self-management.
- Adopt holistic interdisciplinary approaches to rehabilitation recognising the physical, psychological, emotional, social and economic impact of the pandemic.
- Proactively and creatively support colleagues and students, volunteers and community assets, family and friends to achieve an enabling inclusive culture to maximise the delivery of rehabilitation.
- Commit to retaining the new ways of working we have developed, which have benefits for outcomes, experience, productivity and environmental
impact. The development and use of technology must be a legacy of this pandemic that is taken forward whilst ensuring that those who continue to require face-to-face rehabilitation retain that option for access.

- Where Allied Health Professionals (AHPs) have been re-deployed during the pandemic we seek to urgently return them to roles that utilise their unique professional skills to enable independent living. As well as utilising newly gained skills and ways of working to maximise the recovery and rehabilitation of our population.

**Population group 1: rehabilitation needs of people recovering from COVID-19**

There is growing evidence that those who are recovering from extended critical care or hospital stays experience high levels of psychological and physical trauma, cognitive impacts, delirium, deconditioning, and gastroenterological problems. There is evidence of direct effects of neurological damage caused by COVID-19 in addition to the effects of critical illness and specialist rehabilitation units may be needed to support those who have been affected the most. Their rehabilitation needs will include:

- Ongoing respiratory rehabilitation
- Fatigue management
- Dietetic intervention to support recovery from nutritional depletion and regain strength
- Interventions to improve swallowing and communication
- Physical rehabilitation to recover pre-morbid fitness levels and to return to daily activities, including work, family, education and social roles
- Psychological interventions to overcome the experience of critical care interventions and the reduced quality of life as a result of the above difficulties

Early COVID-19 rehabilitation learning and guidelines can be found at the end of this paper. It is important to recognise the continued learning about incidence, survival rates and the long-term impact of this virus will continue to evolve and planning must be balanced against the continued needs of the wider population.
Population group 2: rehabilitation needs for people awaiting paused planned care

People who have not received usual interventions or whose planned care has been paused may have experienced further deterioration in their function. Rehabilitation will be required to mitigate any impacts of the pause in accessing services or as a result of their reduced activity and participation. Access to a range of rehabilitation interventions will be required to support people to recover to previous levels of health and well-being and to prepare them for any planned interventions using enhanced recovery and rehabilitation. Co-produced rehabilitation, self-management and social prescribing programmes will be essential.

Population group 3: people who avoided accessing services during the pandemic who are now at greater risk of disability and ill health.

Public perception has altered behaviour, fewer people are accessing available health and social care services. It seems possible that some people may have delayed contact with health and care services to their detriment. As social distancing restrictions reduce, people will come forward to seek interventions and rehabilitation to enable them to recover. Provision will need to include emotional, psychological and physical recovery. This includes provision for people with dementia and cardio-vascular disease, those who require children’s and adolescent services and people with learning, physical and sensory disabilities.

The resumption of services should be staggered and prioritised. Experienced rehabilitation professionals need to be central to the planning and the graded return of services. Rehabilitation complements medical and surgical interventions, helps achieve the best outcome possible, can help prevent admission, contribute to a reduced length of hospital stay and is a key strategy for achieving care and sustainability of services. The interdependence of rehabilitation within the essential service pathways is therefore a critical
Component of quality and high value care. Rehabilitation teams are pivotal in assessing the urgency of demand and the related long-term risks to individuals.

Alongside this, many of our colleagues who have experienced the challenges of supporting people with COVID-19, or others who faced the end of life with no family around, or have lost their own family members may not have taken the time to access support services but will now do so.

**Population group 4: people who were socially isolated or shielded**

The shielded and vulnerable populations already faced considerable challenges. Additionally, they have undergone reduced interaction with people, less participation in activities and their normal relationships. For some, impacts of the pandemic lockdown will include loss of employment, family or friends, altered consumption of food, substance misuse, isolation, loneliness and the loss of physical and mental wellbeing. Poverty and reduced opportunities to learn and develop will have long-term consequences without intervention from a range of services including health, social care, education and third sector partners.

Rehabilitation interventions will need to focus on recovering lost abilities and skills and enabling participation in education, work and social activities. This includes physical fitness and stamina, confidence, interpersonal skills and interaction with others, improved nutrition and communication as well as psychological interventions. For some, rehabilitation will need to compensate for loss of skills or increased frailty.

For children and young people, development of skills may have been delayed and rehabilitation will be needed to maximise skill attainment. This includes communication and language development in readiness for school alongside social interaction opportunities missed out during isolation.

**Impact on wider society**

The impacts on wider society are not yet known, but there is growing recognition...
there may be psychological implications. This is not in the scope of this framework, but as our understanding of the needs of the wider population develops this may create further demand for support and care and may require national guidance and action.

Children being away from school, peers and formal education may lead to some negative impacts. As they return, managing their anxieties and uncertainties will be important and AHP support for schools is key. Despite the fact that there are likely to be many positives from families spending more time together, parents may feel isolated from their usual support networks, challenged to provide schooling and relationships may become strained.

For many people loneliness and isolation may lead to increased depression and anxiety. Impacts of loneliness, low mood, anxieties, traumatic experiences and bereavement may require psychological support. However, it is also of note that people can be incredibly resourceful and many will have found ways to adapt to any adversity during this time. Sadly, many people will have lost loved ones and will struggle with having to grieve without being able to visit, say goodbye or have a funeral.

There will need to be a continued focus on the health and wellbeing of fellow colleagues in the aftermath of exhaustion and critically demanding work. For those health and social care workers going to work there are wellbeing risks such as post-traumatic stress disorder, burnout and the need to also access bereavement services. Other key workers have also continued to work tirelessly during this time and it is important they are also supported.

What will this mean for rehabilitation services?

Rehabilitation provision needs to meet the differing needs of all of these population groups and people of all ages. This framework offers a general person centred checklist as an aid to planning at Appendix 1 (*Maximising surge capacity for Rehabilitation - Service information and benchmarking tool*). To supplement this overarching framework, there are frameworks for each of the 4 population groups.
These population specific frameworks help model the capacity and demand for these population groups and the variation for unique individuals within them. Approaches which empower people to manage their own active rehabilitation are highly effective. Health and care staff will need to adopt these approaches to increase quality of outcomes and experience for individuals and to maximise access to resources and reduce variation across services. Services will need to assess and plan to prioritise those in most urgent need and to consider meeting potential increased demand. Ensuring that rehabilitation is “everyone’s business” will support the use of self-management and wider community resources to increase independence and recovery.

It will be critical that the planning focusses on the individual and demand and capacity rather than location. The ‘Discharge to Recover then Assess (D2RA) model’ forms the basis of the hospital discharge service requirements: COVID-19. This requires health and social care in Wales to maximise the opportunity for active therapeutic input during the early recovery phase and people on these pathways should have a clear recovery plan, with access to rehabilitation that is appropriate to their needs. It also requires empowering the wider social, health and voluntary care sectors to embed recovery focussed interventions.

As demand for rehabilitation grows and is embedded as “everyone's business”, a greater proportion of the workforce may require skill development. This includes embedding person centred and self-management approaches to maximise rehabilitation outcomes. Bespoke training packages will support the workforce to develop these skills. Health Education and Improvement Wales is currently working to ensure this.

The transformation and new ways of working which have added value and support our long term direction for the health and social care system in Wales need to be a legacy from the response to COVID-19. It is important to capitalise on online interactions, virtual group interventions, email and telephone communications, the use of remote consultations including ‘attend anywhere’ technologies and these approaches need to be retained as services are re-started in order to manage the demand that will be faced. There is an opportunity to work collectively to help the public recognise the benefits of remote consultations as one of the many ways to access services.
Securing outcomes

In order to maximise outcomes, rehabilitation resource will be required throughout all parts of the system. Strong inter-professional and partnership working throughout health, social care, housing, third and independent sectors will maximise the resource available to support optimal recovery.

There is much variation in timely access to quality rehabilitation across Wales. Adopting an evidence-based person reported outcome measure such as WHODAS enables a Prudent Healthcare approach and will ensure that care is prioritised for those who need it most. This has the added benefit of identifying health inequalities in access to timely, effective rehabilitation. It will also afford health and care planners the opportunity to deliver equity in rehabilitation responsiveness across Wales.

Next steps:

In order for Wales to meet the rehabilitation needs of the population groups described above, action is needed now at regional and local level.

A national rehabilitation task and finish group has been established to provide leadership and oversight and is undertaking national work to support regional and local planning including:

• Leadership for the rehabilitation component within the suite of guidance on how to maintain essential services.
• Developing population specific frameworks for understanding the new and existing demand of rehabilitation services for the population groups described above. This maybe through audit, applying emerging research and lessons learned from this pandemic and population modelling. This can then be utilised locally by health boards and their partners to stratify risk and address gaps in the current capacity of rehabilitation services as well as supporting the development of newer solution focused ways of working.
• Developing guidance on modelling demand and capacity for each population group.
• Developing national outcome measures.
• Leadership within national programmes designed for developing the use of
digital technology and smarter working systems such as video consultation
and the roll out of Attend Anywhere. This will also drive efficiency in services
and help to address gaps in capacity as well as minimising the spread of
infection during the COVID pandemic.
• Developing national training programmes to ensure rehabilitation is
“everyone’s business”, promoting an empowering, person-centred approach
is adopted by all.

Contact us
Email: HSS-HealthSciences&AHPs@gov.wales
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