



Llywodraeth Cymru  
Welsh Government

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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# Contents

## Key points

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### Purpose and context

---

### Increased population need

---

### What is rehabilitation?

---

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

---

### Population group 2: rehabilitation needs for people awaiting paused planned care

---

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

---

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

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### Impact on wider society

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### What will this mean for rehabilitation services?

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### Securing outcomes

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## Key points

- this Framework will assist service planning for the anticipated demand for

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rehabilitation and recovery for people affected by COVID-19, including those presenting with Long COVID (which includes both ongoing symptomatic COVID-19 and post-COVID-19 syndrome) and non-COVID-19 populations in adults and children

- there is growing evidence of the impact of the pandemic for four discrete population groups. As the pandemic has progressed, the longer-term rehabilitation needs of people with Long COVID have been recognised. 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 social care workers. This is likely to increase the demand for rehabilitation over the coming months and more probably for many years
- rehabilitation is an investment, with cost benefits for both the individuals and society. It can help to avoid costly hospitalisation, reduce hospital length of stay, and **prevent re-admissions**. Rehabilitation also reduces reliance on long-term health and social care services. Rehabilitation enables people to live more independently and provides wider societal benefits. For example, enabling people to return to work or education
- service planning, coordination and provision should focus on the individual's need, using learning from peoples' experiences to drive improvement and demand and capacity, rather than location. Priority should be given to providing rehabilitation in the environment, and by the service that will secure the best outcomes for the individual at, or as close to home as possible
- the most appropriate way to meet the rehabilitation needs of people with acute COVID-19 and Long COVID is by integrating access via existing local primary and community care professionals. Due to the widely variable impact people experience because of the pandemic across the 4 main populations groups, and the range of symptoms people with Long COVID may experience
- onward referral to other specialist services or secondary care as needed enables a person-centred approach, directing people to the expertise most suited to their own symptoms. Review of existing service inclusion/ exclusion criteria will ensure good access for people with long COVID. This approach will maximise the use of expert resources, as well as identify where there are gaps in rehabilitation service provision and additional resource to provide

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care and treatment in a timely way is required

- exciting new opportunities for partnership working with exercise, cardiac, respiratory and neuro-physiologists should be explored
- 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. This includes partnership working with rehabilitation engineers in the assessment and provision of assistive technology to optimise peoples’ independence in the community
- 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. 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. Where necessary people identified as having long COVID should also have an agreed plan, with access to rehabilitation appropriate to their needs
- 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 we emerge from the COVID-19 pandemic. This

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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 may include considering how to access capacity for therapy-led, step-up, step-down and/or 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, integrating the needs of people with COVID-19 related rehabilitation needs into the re-establishment of wider health, care and community services; 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 who have had COVID-19: those recovering from acute COVID-19 symptoms, including people who experienced extended time in critical care and hospital, or those whose acute care was managed in the community and those with prolonged symptoms of COVID-19 (Long COVID) 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, as described by the World Health Organisation (WHO), optimises a person's functioning and reduces the experience of disability by addressing the impact of a health condition on their everyday life. 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 (Krug, 2017).

This guidance uses the WHO International Classification of Functioning, Disability and Health (ICF) to describe rehabilitation interventions at an impairment, activity and participation level. See appendix one for definitions.

Dietz (2011) describes 4 elements of rehabilitation: preventive, restorative, supportive, palliative:

- preventative rehabilitation occurs shortly after a new diagnosis or onset of new impairments. The aim is to provide education, advice and interventions to prevent or slow onset of further impairments and maintain a person's level of ability. This is a common form of rehabilitation in long-term conditions, such as cancer, Chronic Obstructive Pulmonary Disease (COPD) and many neurological conditions. It also underpins supported self-management and can include interventions aimed at maintaining ability for as long as possible
- restorative rehabilitation focusses on interventions that improve impairments such as muscle strength or respiratory function and cognitive impairment to get maximal recovery of function. This is a common form of rehabilitation after surgery, illness or acute events such as a major trauma or a stroke
- supportive rehabilitation increases a person's self-care ability and mobility using methods such as providing self-help devices and teaching people compensatory strategies or alternative ways of doing things. This may include the provision of assistive equipment or environmental modifications. This is sometimes referred to as adaptive rehabilitation (Dietz, 1980)
- palliative rehabilitation enables people with life limiting conditions to lead a high quality of life physically, psychologically and socially, while respecting their wishes. It often focusses on relieving symptoms, such as pain, dyspnoea and oedema, preventing contractures, breathing assistance,

psychological wellbeing, relaxation or the use of assistive device, in order to maximise functional independence and support comfort, dignity and quality of life.

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
- develop new approaches to multi professional working and communication within community and primary care to enable earlier decision making around anticipatory interventions and early rehabilitation pathway initiation
- opportunities for data collection within primary care systems to capture the services involved in providing anticipatory care and rehabilitation, and associated outcomes and impact need to be explored
- 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

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

This population includes people recovering from extended time in critical care and hospital, those whose acute care was managed in the community and those with prolonged symptoms of COVID-19 recovering in the community. There is evidence that people recovering from acute and extended critical care or hospital stays experience high levels of psychological and physical trauma, cognitive impacts, delirium, deconditioning, and gastroenterological problems. There is increasing evidence of the need for rehabilitation to support the recovery of people regardless of the severity of their original infection. 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

COVID-19 rehabilitation guidelines can be found at the end of this paper. The early guidance published in May 2020 has been updated in response to learning from the changing nature of the impact of COVID-19 and the [NICE guidance](#). 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. This includes provision for people awaiting cancer, orthopaedic and other planned care. Improved access to a range of health, social care and community rehabilitation interventions will be required to support these people to maintain or recover 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 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

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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 initial pandemic lockdown and subsequent social restrictions 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, community and third sector partners.

As social restrictions become part of daily life, 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.

Digital resources to support the safe and effective return of this population to social engagement can complement physical interventions. This may be particularly beneficial for groups affected by dementia, cognitive impairment and mood disorders. Resources to support these vulnerable populations can be

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found in the [Primary and Community care Guidance for vulnerable groups identified as having a higher risk of the impacts of COVID-19](#).

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 long-lasting 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.

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## 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 Inpatient 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 both early and longer-lasting recovery phases and people on these pathways should have a clear recovery

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plan, with timely, local access to rehabilitation that is appropriate to their needs. It also requires empowering the wider social, health, community and voluntary care sectors to embed recovery focussed interventions into routine care.

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** has developed a digital resource to support 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 resources will be required throughout all parts of the system. Strong inter-professional and partnership working throughout health, social care, housing, community, 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

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responsiveness across Wales.

A formal plan to support the National reset and recovery work to reflect the refreshed A Healthier Wales actions will be considered in due course.

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