British Geriatrics Society
Improving healthcare for older people

Reablement, Rehabilitation, Recovery: Everyone's business

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Foreword

In spring 2023 we published our Blueprint, *Joining the Dots*, outlining why investing in high-quality, joined-up care for older people improves outcomes for individuals and their carers, reduces demand for services, increases the resilience of health and social care systems, and delivers economic and societal benefits.[1] The Blueprint presents 12 recommendations that will support systems to design effective models of care which deliver value. One of the 12 recommendations is to protect and preserve the right to rehabilitation for all older people who need it, in line with the principles and best practice outlined by the Community Rehabilitation Alliance.[2]

Our new report takes a deeper dive into this recommendation and presents evidence and examples of rehabilitative approaches designed to optimise recovery and improve the functional ability, health and wellbeing and social participation of older people at home and in different care settings.

In developing this report, the BGS has been pleased to work with a multidisciplinary group of members from across the UK and with our partners from professional bodies and third sector advocacy organisations. The BGS has a wide range of resources to support the development of rehabilitation services for older people. Our 5,000 members represent a range of disciplines and work in roles within acute, primary and community care settings across the four nations of the UK. Members share the same goal – to improve healthcare for older people. We urge anyone involved in the commissioning of rehabilitation services for older people to engage with the expertise of the BGS and its members to help deliver the right to rehabilitation, at the right time and in the right setting, for all older people who need it.

People are living for longer with more complex conditions in older age and often require specialist care from a range of professionals across the multidisciplinary team. Older people access NHS and social care services more than any other age group and demand for such services will continue to grow. But across the UK, health and social care services are currently failing older people. Changes are needed across the system to address the problems of sub-optimal care for older people. One key element of this is the provision of timely, high-quality rehabilitation which is essential to improving outcomes on both an individual and system level.

Professor Anne Hendry
Lead author

Professor Adam Gordon
BGS President

Executive summary

The case for investing in services to prevent and manage frailty is set out in the British Geriatrics Society's Blueprint.[1] Frailty is not an inevitable part of ageing, and putting in place measures to prevent or delay its onset or progression should be a priority for every health system across the UK.

Those measures include investment in well-designed rehabilitation services that enable people to live independently for longer and achieve what matters to them, and helping to reduce demand for emergency care and long-term support. The aims of rehabilitation will vary depending on the individual. However, generally rehabilitation refers to supporting somebody to recover after a period of ill health. For some older people this will be a full return to the level of health they had before becoming ill (referred to as 'return to baseline') while others will not make a full return to their previous health state.

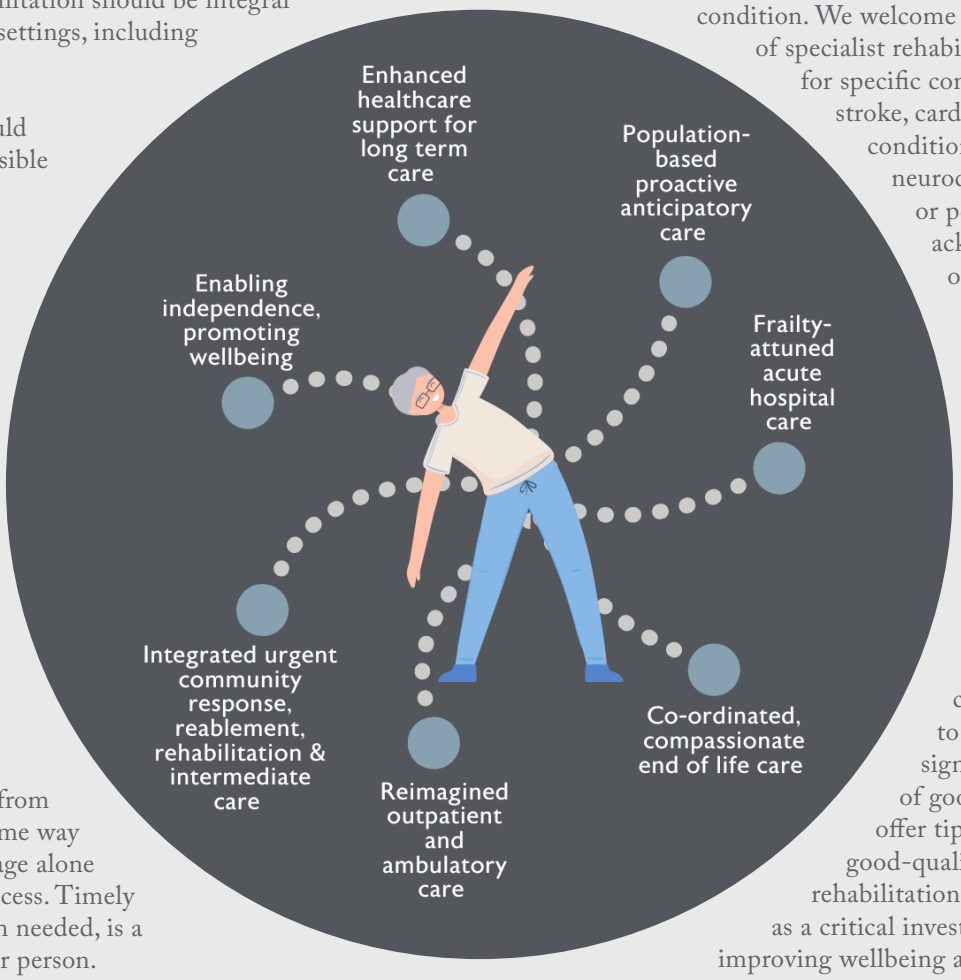
Many older people are currently excluded from rehabilitation services because of restrictive access criteria, limited capacity or postcode lottery of provision.[3] Systems must act now to address this inequity.

As an essential component of virtually all healthcare for older people, rehabilitation should be integral to care plans in all settings, including long term care.

Rehabilitation should start as soon as possible after the onset of illness and has a role in preventing further decline. Rehabilitation improves lives. Older people themselves report that they value the independence and autonomy that rehabilitation provides and the feeling of being stronger and preventing future injury. Every older person can benefit from rehabilitation in some way and chronological age alone should never bar access. Timely rehabilitation, when needed, is a right for every older person.

Rehabilitation for older people should involve healthcare professionals from across the multidisciplinary team and across acute, primary, community and social care. There is no 'one size fits all' model for rehabilitation. It must be integral to the holistic care that supports older people to live well at home, and be personalised to their situation and priorities. Rehabilitation should be viewed as a continuum of reablement, restorative and recovery approaches, not a separate service. These approaches must be a key component at every stage of health and care for older people at each of the touchpoints outlined in the Blueprint (see illustration below):

- Enabling independence, promoting wellbeing through physical activity and participation
- Proactive care and early intervention using population health approaches
- Integrated urgent community response, reablement, rehabilitation and intermediate care
- Frailty-attuned acute hospital care that promotes recovery and prevents deconditioning
- Reimagined outpatient and ambulatory care in community hubs and multidisciplinary clinics
- Enhanced healthcare support for long term care at home and in care homes
- Co-ordinated, compassionate end of life care integrating principles of palliative, geriatric, and rehabilitative medicine.



The main focus of this report is rehabilitation for older people experiencing frailty or loss of function because of acute illness or exacerbation of a chronic health condition. We welcome the wide range of specialist rehabilitation services for specific conditions such as stroke, cardiorespiratory conditions, brain injury, neurodegenerative disease or polytrauma. We also acknowledge the role of rehabilitation to support people adapt at the end of their life.[4] However, we do not focus on these types of rehabilitation in this report.

Throughout this document, we highlight evidence, call out myths to be challenged, signpost examples of good practice and offer tips for designing good-quality age-attuned rehabilitation for older people as a critical investment in both improving wellbeing and reducing future dependency.

The report will be of interest to our members and to senior decision makers who are planning and commissioning hospital or community services which respond to acute illness or injury and support recovery for older people.

Key messages

Throughout this resource, we identify 12 key messages for health and care systems to deliver effective and integrated rehabilitation as a right for all older people, wherever and whenever they need it.

The case for rehabilitation

1. Systems should invest in rehabilitation as a priority for more sustainable care. Rehabilitation for older people improves lives, delays escalation of dependency, reduces demand and costs for readmission to hospital and avoids premature long-term care.

2. Rehabilitation is an essential component of virtually all healthcare for older people and should be integral to care plans in all settings: at home, in hospital, ambulatory care, care homes and hospice.

3. Every older person can benefit from rehabilitation in some way: age alone should not bar access. The approach, intensity and pace of rehabilitation should be flexible and may need to be adapted for people with delirium, dementia, depression, sensory or communication impairments.

4. The business case for rehabilitation in older people is compelling. Future research should address the evidence gaps around older people who have been excluded from studies due to cognitive impairment or socio-economic or cultural inequalities.

Practical provision of rehabilitation

5. Most rehabilitation is delivered in the community. Rehabilitation at home allows a clearer focus on practical, real-life goals. These goals should be based on 'what matters to me' conversations and include the ability to take part in activities that the individual enjoys.

6. Older people with acute illness decondition rapidly so need rehabilitation to start as soon as possible – healthcare professionals should not wait for a crisis to pass before providing rehabilitation at home, hospital or care home. All staff in all care settings, including acute and virtual wards, should prevent older people deconditioning by encouraging mobility and offering early active rehabilitation.

7. Relational and informational continuity and coordination of care are the essence of person-centred integrated care. Older people should have a personalised care plan that addresses their rehabilitation needs and is contextualised to their health trajectory, social circumstances and cultural norms. This plan should be iterative, following the patient across transfers of care, and promote continuous enablement as their needs change.

Building capacity and capability

8. Rehabilitation is a multi-agency endeavour involving many health and social care disciplines, voluntary sector, volunteers, unpaid carers, housing and community leisure services. Systems should work with all partners to offer rehabilitation for older people as a key component of health and social care within age-friendly communities.

9. Rehabilitation is everyone's business – older people themselves, carers and all health, social care, housing and voluntary sector workforce need to understand how to motivate and support enablement in later life. Systems should work with education providers to support everyone involved to work together and at the top of their licence to increase collective capacity for reablement and rehabilitation for older people.

10. Rehabilitation needs the appropriate space, equipment, facilities and IT infrastructures, including access to care records that can be shared across providers in all care settings. Systems should commission a menu of options from a range of partners in environments that are fit for purpose. Services should be of sufficient duration to enable older people to achieve their social goals as well as undertake activities of daily living at home.

11. The quality of rehabilitation services should be monitored, tracking changes in health and functional outcomes, patient and carer experience, and considering coverage and cost-effectiveness. This intelligence should be used to continually improve services. Quality indicators should acknowledge personalised goals and outcomes, and that delay of further functional decline may be a more realistic outcome than recovery of independence for people who have progressive life-limiting illness or are at the end of life.

Leadership

12. Senior leadership is critical for a strategic and sustainable approach to planning and delivering rehabilitation for older people. Systems should identify a senior officer or non-executive Board member with a specific role in assuring equitable access to rehabilitation attuned to the needs of older people and continually improving the quality of services delivered.

Chapter two:
Purpose and context

Introduction

The importance of rehabilitation was highlighted in recommendation 7 of the BGS Blueprint: "*Protect and preserve the right to rehabilitation for all older people who need it, in line with the principles outlined by the Community Rehabilitation Alliance*."[1]

Rehabilitation (or recovery) is a set of interventions designed to optimise functional ability, social participation, improve health and wellbeing and reduce disability in individuals with health conditions in interaction with their environment.[5] Due to resource constraints within the NHS, rehabilitation packages are typically time-limited. Interventions include:

- Holistic assessment considering the social determinants of health and acknowledging multimorbidity
- A personalised rehabilitation treatment plan based on shared decision-making and goal- oriented personalised interventions
- Information, advice and education to build confidence and support self-management and participation
- Medication reviews and advice to ensure medicines are used to optimise rehabilitation
- Structured exercise (one-to- one, in groups, in person or online)
- Support with diet
- Psychological support
- Support with communication, adaptations, assistive technology and digital skills.

A European consensus statement defined geriatric rehabilitation as a multidimensional diagnostic and therapeutic approach which aims to optimise functional capacity, promote activity, preserve functional reserve and social participation in older people with disabling impairments.[6] A systematic review of 42 European studies of integrated care for older people called for a more (integrated) holistic response, blending a chronic care approach with education, enablement and rehabilitation to optimise function, particularly at times of a sudden deterioration in health, or when transitioning between home, hospital or care home.[7]

Comprehensive Geriatric Assessment (CGA), a highly evidence-based approach that combines assessment and multidimensional interventions, tailored to modifiable physical, psychological, cognitive and social factors, improves outcomes for older people and is the cornerstone of an integrated approach to preventing and managing frailty.[8,9] Rehabilitation should be considered a core element of CGA – not an optional add-on.

Key message 1

Systems should invest in rehabilitation as a priority for more sustainable care. Rehabilitation for older people improves lives, delays escalation of dependency, reduces demand and costs for readmission to hospital and avoids premature long-term care.

Rehabilitation is also a key component of proactive care as set out in NHS England's new framework for proactive care for older people living at home with moderate or severe frailty.[10] Average annual costs of primary and secondary care service are three to four times higher for individuals who have moderate to severe frailty, but overall system costs are highest for people with mild frailty as the largest population cohort.[11] Many providers and health and care systems aspire to scale up proactive care for people with all levels of frailty to prevent escalation of health and care needs, delay onset of disability, and reduce demand for emergency department attendance or admission to hospital or care home.[12] Rehabilitation capacity is critical for successful proactive care (sometimes known as pre-habilitation, as detailed in chapter three) and for scaling up intermediate care community alternatives to acute hospital care.[13] For an individual with deteriorating health and wellbeing, rehabilitation goal-setting may overlap with future care planning or end-of-life care planning. It will be important to recognise trigger points where the goals of care may change, through shared decision-making with the individual supported by those who are important to them.

Key message 2

Rehabilitation is an essential component of virtually all healthcare for older people and should be integral to care plans in all settings: at home, in hospital, ambulatory care, care homes and hospice.

Why rehabilitation is needed now more than ever

Across the globe, the consequences of COVID-19 and deconditioning as a result of lockdown are driving new approaches to rehabilitation.[14] This is in part to compensate for the loss of focus on rehabilitation during the pandemic due to the redeployment of staff and loss of physical space for rehabilitation, and to address the new challenge of long COVID where people are living with disabling symptoms such as breathlessness, communication and cognitive challenges, and fatigue, all of which are amenable to rehabilitation.[15] The

rise in deconditioning and dependency experienced by older people and their carers during the pandemic is increasing pressure on a social care sector already in crisis. Delays in access to rehabilitation further increase dependency and generate even more demand for an overburdened system.

Rehabilitation is central to the ambitions of the UN Decade of Action on Healthy Ageing.[16] The purpose of rehabilitation is to optimise functional ability in essential everyday activities and enable participation in education, work, life roles and the things that bring meaning, purpose and happiness to the individual. It supports people to overcome difficulties with thinking, seeing, hearing, communicating, eating and moving around, and helps them to regain the specific skills and confidence required to resume or maintain participation in their work, hobbies or interests and social network. This is sometimes described as a recovery-based approach, supporting people to regain control of their lives and work on things that enable them to lead good lives.

A rights-based approach is particularly important for older people and people with disabilities who are at risk of being marginalised in access to healthcare. Access to rehabilitation is enshrined in the Convention on the Rights of Persons with Disabilities[17] and high-level actions to improve access and equity of rehabilitation provision are set out in the World Health Organization's 'Rehabilitation 2030' work programme.[18] Rehabilitation must be flexible and cater to the specific needs of the individual. For older people in particular, this may mean adapting aspects of the rehabilitation offer to meet the needs of individuals experiencing delirium, dementia, depression, sensory or communication impairments.

Key message 3

Every older person can benefit from rehabilitation in some way: age alone should not bar access. The approach, intensity and pace of rehabilitation should be flexible and may need to be adapted for people with delirium, dementia, depression, sensory or communication impairments.

State of rehabilitation: Reflection on policy, capacity and access in each of the four nations

BGS members across the UK report differences in access to rehabilitation for older people in their area. Variations range from different provision for reablement and community rehabilitation at home to whether or not older people can access rehabilitation in hospitals or in care homes.

England

There is considerable variation in the quality of and access to rehabilitation services across England. There are some key guidance documents targeted at commissioners and providers, which aim to reduce this unwarranted variation. Importantly rehabilitation services need to be given the same level of priority, resource and funding as other aspects of the healthcare system such as urgent and emergency care. Until this happens, Integrated Care Systems will find it challenging to provide consistent high-quality rehabilitation services for their local population, particularly given the multidisciplinary workforce and budgetary restraints many currently face.

NHS England's Intermediate Care Framework[13] focuses on intermediate care services delivering rehabilitation following hospital discharge and identifies four key priority areas. Firstly, improving demand and capacity planning with better utilisation of data metrics. Secondly, improving workforce utilisation through new ways of working such as blended roles. Thirdly, implementation of effective multidisciplinary team care transfer hubs. Finally, improving data quality and overcoming the information governance barriers, which often impede this.

NHS England have also published a community rehabilitation and reablement model[19] and NHS RightCare have published a community rehabilitation toolkit.[20] Both documents focus on recommendations pertaining to community rehabilitation more generally. Several key aspects of the patient journey are covered including maintaining independence, preventing deterioration, the need for integrated care, the community-hospital interface, adequate workforce, and improving data quality, all of which should incorporate experience of care, timely access to services, and ensuring person-centred care is at the heart of rehabilitation. This should all be underpinned by strong leadership at all levels of the health and social care system to drive the necessary changes in behaviour and culture required for high-quality rehabilitation for all.

The Community Rehabilitation Best Practice Standards developed by the Chartered Society of Physiotherapists (on behalf of the Community Rehabilitation Alliance) is another useful reference guide in how to run high-quality rehabilitation services.[2] It neatly describes what the expectations of different stakeholders should be and what is needed to deliver on the key recommendations. These include the patient, clinician, rehabilitation lead, network, commissioner and social care provider.

In his annual report in 2023, the Chief Medical Officer for England, Professor Sir Chris Whitty, highlights the provision of rehabilitation as a key component of a coordinated treatment plan for older people which should be developed as a result of comprehensive geriatric assessment: *'CGA is based on the premise that a full evaluation of an older adult living with frailty by a team of healthcare professionals from multiple disciplines may identify a variety of treatable health problems, resulting in a co-ordinated plan and delivery of health care, social care and rehabilitation care leading to better health and wellbeing outcomes.*[21]

Scotland

The Scottish Government's Once for Scotland Person-Centred Approach to Rehabilitation[22] builds on their earlier Rehabilitation Framework published during the pandemic.[23] The 2022 document sets out six principles that should underpin all rehabilitation services: Easy to access for every individual; Provided at the right time; Realistic and meaningful to the individual; Integrated; Innovative and ambitious; Delivered by a flexible and skilled workforce. While these principles are laudable, there is no clear roadmap for delivery. Healthcare professionals report that rehabilitation services are struggling across Scotland, due to lack of workforce capacity and a backlog of maintenance issues within healthcare facilities. Specialist medical supervision for rehabilitation services for older people has traditionally been provided by geriatricians who are now being redeployed into services such as Hospital at Home, Frailty Units and Perioperative services, along with advanced practitioners

from allied health professions and nursing. While these services provide good outcomes for patients who can access them, without a significant increase in staffing, these good outcomes for some patients will be at the expense of adverse outcomes for the increasing number of older people needing rehabilitation. Community rehabilitation services are understaffed and repeated realignments of these services have eroded the previously strong links between primary care and community services. Rehabilitation for older people with frailty is often provided in community hospitals which are impacted by the primary care and community workforce crisis. The ongoing crisis in social care compounds these challenges as older people experience a delay in being discharged from hospital and in starting their community rehabilitation.

Wales

In 2022, the Welsh Government published the All Wales Rehabilitation Framework: Principles to achieve a person-centred value-based approach.[24] This document sets out principles of rehabilitation, using the anagram of WALES:

- **W**ellbeing – investment in the workforce to provide a holistic, person-centred, needs-based approach.
- **A**ccessible – co-produced services that are equitable and inclusive to all.
- **L**iving happier, healthier, longer – healthy living, prevention, supported self-management and optimisation.
- **E**veryone's business – a collaborative whole workforce and stakeholder ethos.
- **S**ustainable – long term service planning, embracing digital innovation for societal benefit and greener ways of working and living.

This framework is supported by Health Education and Improvement Wales's community rehabilitation standards, published in late 2023.[25] This document provides seven best practice standards designed to improve the quality and experience of rehabilitation:

1. Co-produced community rehabilitation must be built around the needs of patients and their support network, delivering personalised rehabilitation to ensure people have choice and control over the way their rehabilitation is planned and delivered.
2. Effective rehabilitation adopts a biopsychosocial approach due to the diversity of needs of the person.
3. Effective partnerships and good communication are central to providing seamless rehabilitation in the right place for everyone.
4. Good data is essential to drive improvement in the quality and value of community rehabilitation services.
5. A core part of community rehabilitation is supporting people to stay well, take control of their lives, maintain independence, and support self-management as part of a sustainable health solution for Wales.
6. Rehabilitation services need to be accessible to people when and where they need so that longer term issues can be minimised, resulting in better health and wellbeing for the individual and a reduced burden on society.
7. Rehabilitation requires a motivated, engaged and valued health and social care workforce, with the capacity, competence and confidence to meet the needs of the people of Wales.

BGS members in Wales report that additional resources are needed to realise this vision including a focus on ensuring care is provided in the right setting with rehabilitation starting as early as possible to prevent deconditioning. Strong leadership and an understanding of rehabilitation are needed to ensure that rehabilitation services are coordinated and effective. Without this we risk extending length of stay in hospital, protracting the rehabilitation journey in the community and adding to the care pressure on social services and on friends and families who provide so much of the care at home.

The Right to Rehab campaign[26] in Wales is led by the Chartered Society of Physiotherapy with input from other organisations in Wales interested in rehabilitation. The campaign considers the publication of the above standards as a campaign win, along with investment in the allied health professional workforce for reablement and a ministerial commitment that rehabilitation space lost during the COVID-19 pandemic should be reclaimed or a suitable alternative provided. The campaign is currently calling for consistent delivery of the rehabilitation standards across every health board in Wales, the appointment of a rehabilitation lead in every hospital and the appointment of rehabilitation voices in every Regional Partnership Board to promote integration of services in the community.

Northern Ireland

There is currently no national framework guiding rehabilitation services for older people in Northern Ireland. It is therefore up to individual Trusts to determine how rehabilitation is provided. BGS members in Northern Ireland report that all Trusts offer a number of rehabilitation pathways to facilitate discharge for older people. However, chronic staff shortages and competing priorities between acute and community care result in ongoing challenges for Trusts providing rehabilitation for older people with frailty. The lack of gold standard and key performance indicators for general rehabilitation has an impact on budget and resource allocation. All Trusts promote the ethos of 'home first', which includes discharge to the individual's own home including residential homes, with follow-up from an acute assessment team or community rehabilitation team. While this approach is advisable, there is concern that this pathway cannot always meet the needs of patients, particularly those with complex needs or requiring intensive rehabilitation. Community rehabilitation teams often hold waiting lists of two to three weeks to response. Therapy staff are supported by care staff or rehabilitation assistants. However, input can be as infrequent as once a week.

Many acute wards, with the general exceptions of orthopaedics and stroke, struggle to provide responsive rehabilitation and deconditioning is an ongoing concern despite widespread knowledge and local endeavours. Further education and a focus on creating a culture which promotes rehabilitation as everyone's business is required to prevent the consequences of higher dependency, higher frailty levels and increased rehabilitation resources to support patients to regain function.

Due to inherent pressures within all Trusts, the need to maintain flow continues to influence decision-making for discharge planning and rehabilitation pathways. Unfortunately there is disparity in access to comprehensive geriatric assessment for older people across Trusts. This has been further impacted by decisions to redirect geriatrician input, hence removing geriatricians from a number of rehabilitation inpatient and intermediate care facilities across Trusts.

There is widespread concern regarding the lack of integrated delirium pathways, and access to suitable rehabilitation environments for patients with delirium and dementia. These patients often have complex needs and take time to rehabilitate. However, decisions to withdraw rehabilitation can be made too early, having a significant impact on quality of life and use of Trust resources. Intermediate rehabilitation facilities are often unsuitable for these patients and as a result, patients can be subject to lengthy waits to access inpatient rehabilitation. They often remain in acute wards and are at high risk of deconditioning and decompensation. Alternatively they may be discharged to interim nursing care facilities which vary in culture regarding rehabilitation and may provide only limited rehabilitation services due to pressures within community rehabilitation services.

What matters to older people receiving rehabilitation and those who provide it

There is limited peer-reviewed evidence about what matters to older people receiving rehabilitation but many presentations at BGS conferences have highlighted experiential evidence and some charities have published qualitative research and case studies. Future research should address gaps in the evidence and ensure that people who have traditionally been excluded from research, such as those with cognitive impairments, are included. Common themes highlighted are:

Autonomy and independence

Older people value autonomy and independence above all else when receiving rehabilitation. Autonomy and independence look different for each individual and apply whether they live in their own home or in a care home. Everyone has something to gain from rehabilitation so goals must be personalised to what matters to the individual with the overall aim of promoting dignity, choice and control, improving their sense of wellbeing, and enabling them to live the life they would like, including taking part in activities and hobbies that they enjoy. Physical functional ability has a huge influence on an older person's ability to do the things they love, and its decline can have negative impacts on their mental health.

"It is so uplifting, there is tremendous psychology involved in improving one's aged body. If somebody tells you, you can do it, you'll do it, you'll try." **- Dance programme participant**[27]

Wellbeing, confidence and choice

Rehabilitation, particularly group programmes, helps to reduce loneliness and isolation as many participants appreciate the opportunity to socialise with people in similar circumstances. Case studies illustrate the importance of offering a choice of meaningful activities and nurturing a sense of pride and achievement to counter levels of anxiety and low confidence that often prevail. For example, participants in rehabilitation programmes to prevent falls frequently speak of psychological benefits from reducing their fear of falling and restoring energy and confidence to get out and about.

"I hadn't got proper balance, so they asked me to go to physiotherapy and when they explained what they wanted me to do I was completely honest and said, "I won't do them". And then they said, "would I like to join a dance class?" which has been absolutely brilliant. I have loved it and I really look forward to coming every week and I haven't looked forward like that to anything." **- Dance programme participant**[27]

Prevention of further ill health/injury

Many patients value the role of rehabilitation in preventing further pain, ill health or injury, reducing their need for surgery, for home care support, or admission to hospital or care home. This is also the most obvious system benefit – providing good quality rehabilitation prevents ill health, injury and more intensive use of health and care services, thus avoiding system costs. At a time when statutory services are under extreme pressure, investment in high-quality rehabilitation is a clear 'invest to save' action.

"I'm feeling much more confident now. I feel I am able to do things for myself. I can say to the staff 'stop, I can do that for myself. I don't need your help.' I really wasn't sure about trying that at first because my knees used to be really stiff but now they feel great. I feel like I can't stop moving my legs."
-Participant in care home rehabilitation[28]

What matters to carers

Resource limitations and time restrictions are key considerations for care workers and unpaid carers supporting the rehabilitation goals of older adults they care for. Their critical role in promoting participation and carry-over of rehabilitation interventions requires support from education and training and digital tools that enable their participation as a full partner in the rehabilitation programme.

"The carers noticed a massive difference with how much they were doing for themselves, how much confidence they had because it was given back to them. I think the family had seen a big difference as well." **-Care Home Activity Coordinator**[28]

What matters to rehabilitation professionals

Healthcare professionals often speak about 'rehabilitation potential' – the perceived likelihood of a patient responding to rehabilitation. We challenge the term 'no rehabilitation potential', all too often applied to older patients, limiting their access to rehabilitation services. Cowley's research[29,30] identified three questions for healthcare professionals to consider when assessing rehabilitation potential: 'will it work?', 'is it wanted?' and 'is it available?' It is important to ensure rehabilitation goals are tailored to the individual, so that they are meaningful, achievable and more likely to meet the desired outcome even if that is seemingly small gains in independence and quality of life. Critical to this is understanding the motivation of people taking part in rehabilitation programmes, and how this can be supported, particularly in the presence of cognitive impairments. It is also important to ensure finite resources are used wisely. Clinicians need to carefully balance the principle that all older persons can achieve some tangible benefits from rehabilitation with the reality of targeting limited resources to make the greatest population impact. Realising the value of rehabilitation requires a personalised approach to engage and motivate older people to participate and a tiered, multi-agency model with a mix of skills to optimise collective workforce capacity and capability, as described in NHS England's good practice guidance on community rehabilitation and reablement.[19]

"We found this improved mental wellbeing. Patients were smiling, they were more engaged with the therapy afterwards and they were more engaged with ward staff…"
- Occupational Therapist[31]

"One of the key challenges for older people in hospitals is loneliness and also inactivity. Some of the key benefits I see when patients engage in hospital activities are greater positivity and improvement in mood, eating more, and being more concordant and engaging with the treatment plan that they are having and also subtle other improvements such as improved sleep and more engaged in the discussions when it comes to planning their discharge." **- Consultant Geriatrician**[31]

"As a physio, I know that movement matters and it matters so much in hospital when you spend so much time being sedentary or in bed. I know how quickly people can lose their independence through lack of activity…" **- Clinical Specialist Physiotherapist**[31]

Key message 4
The business case for rehabilitation in older people is compelling. Future research should address the evidence gaps around older people who have been excluded from studies due to cognitive impairment or socio-economic or cultural inequalities.

Chapter three: Evidence and examples at different system touchpoints

BGS Blueprint

In March 2023, BGS published *Joining the Dots: A blueprint for preventing and managing frailty in older people*. This document sets out what good quality, age-attuned, integrated care looks like for older people with frailty. The Blueprint uses seven touchpoints that an older person may come into contact with throughout their later years. These touchpoints are not intended to be read as a pathway of care but rather elements of care that should surround the individual as and when they require them, as demonstrated on page 4 of this report. The Blueprint document highlights examples of innovative practice across the UK and is intended to support commissioners and providers to plan services for older people.

Our rehabilitation report focuses on the touchpoint described in the Blueprint as 'integrated urgent community response, reablement, rehabilitation and intermediate care'. But rehabilitation is key to all of the Blueprint touchpoints, as detailed in the Executive Summary. It is relevant across all stages of older people's healthcare and in all care settings.

Good Boost is a social enterprise delivering digital musculoskeletal supported-self management services in partnership with 140 leisure centres, swimming pools, community venues and charities. They offer 'plug and play' technology-enabled solutions to convert existing spaces and venues into opportunities for rehabilitation to promote wellbeing and manage health. Find out more at **www.goodboost.ai**

"It's helped me so much with my balance. It's stopped making me feel isolated. I look forward to coming here on a Friday [because] I get to see people and chat to [them], to know there's other people out there like me, that's got the same sort of problems as me, and it's great and we can compare notes and things like that."
- Participant

Watch the case study video at:
www.bgs.org.uk/resources/rehabilitation-case-studies-bgs-autumn-meeting-2023#anchor-nav-good-boost

Staff at Guy's Hospital, London offer an innovative dance programme as an alternative to exercise classes for older adults prescribed strength & balance physiotherapy. Co-designed with patients, physiotherapists and dance artists, the ten-week **Breathe Dance for Strength & Balance** programme is proving popular and showing promising results. Find out more at **https://breatheahr.org**

"I can walk much better; I can sit up and down on a chair without holding the ends. In fact, I have decided not to have an evening carer anymore because I can do the jobs that she did on my own and that really is a wonderful experience."
- Participant

Watch the case study video at **www.bgs.org.uk/resources/rehabilitation-case-studies-bgs-autumn-meeting-2023#anchor-nav-breathe-dance-for-strength-and-balance-programme-gstt**

Enabling independence, promoting wellbeing through physical activity and participation

There is strong evidence that regular exercise, particularly strength and balance training, reduces falls and partially reverses or slows progression of frailty.[32-34] A systematic review of ten studies with one or more physical activity components found improved physical performance and some evidence to suggest deterioration was ameliorated for up to 12 months.[35] Home-based exercises are a simple, safe and widely applicable intervention that may improve disability in older people with moderate, but not severe, frailty,[36,37] and improve physical performance, reduce falls, and preserve health-related quality of life.[38] After hospitalisation, they are effective at improving activities of daily living, mobility and quality of life.[39]

Mild-intensity mixed or singular exercises such as walking or tai-chi are moderately effective and easy to implement.[40] Combining muscle strength training and protein supplementation was the most effective and easiest intervention to implement in primary care. Interventions combining resistance and balance training were most successful in treating physical symptoms associated with frailty, reducing falls, and maintaining health benefits. Combining different types of physical exercise may maximise impact on mobility, balance, body mass and levels of activity.[41] Programmes should incorporate behaviour change to help older adults to include physical activity as part of lifestyle changes.

Tailored approaches and support are needed to fully involve people with communication, cognitive, sensory or physical impairments in these activities. More evidence from broader, well-developed interventions addressing a wider range of clinically relevant outcomes is needed.[42]

Age NI **Move More Live More** programme, funded by Innovate UK, aims to improve activity levels, strength, balance and overall health and wellbeing and reduce falls so that older adults in Northern Ireland can get the most out of later life. It builds on their previous work with former Olympian, Lady Mary Peters, to promote the importance of maintaining strength and balance. The Age NI Move with Mary initiative is a series of five exercise videos catering for every ability.

Watch the Move with Mary videos at **www.ageuk.org.uk/northern-ireland/information-advice/looking-after-yourself/movewithmary**

Later Life Training is a not-for-profit organisation that provides specialist, evidence-based, effective exercise training for health and exercise professionals working with older people. The website has links to peer-reviewed scientific publications on the effects of prolonged sedentary behaviour and the benefits of exercise interventions. Find out more at **https://laterlifetraining.co.uk**

Proactive care and early intervention

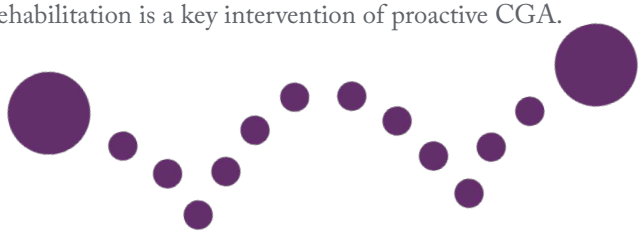
Pre-habilitation aims to lower health risks or prevent rapid deterioration for people waiting to undergo planned surgery or cancer treatments. They are assessed while awaiting their planned treatments and supported to be more physically active, to improve their nutrition, and may be offered emotional and psychological support.A systematic review has shown that pre-habilitation prior to elective surgery improves recovery and is cost-effective.[43]

"[Before pre-habilitation] I was to have some work done on my back, surgery, like metal work, a big operation… so that was like a big tick." **- Pre-habilitation participant**[44]

The Cancer Older People's Service at the Beatson, West of Scotland Cancer Centre, and Maggie's Centre set up a **Living Well with Cancer in Older Age Class**, led by an exercise expert and supported by a frailty nurse specialist. Older adults can self-refer at any point in their cancer journey and staff can refer to support pre-habilitation or rehabilitation goals. Early outcomes were improved fitness, nutrition and stress and people more able to live well with their cancer.

Watch the case study video at **www.bgs.org.uk/resources/rehabilitation-case-studies-bgs-autumn-meeting-2023#anchor-nav-living-well-with-cancer-in-older-age-class-maggie-s-the-beatson**

International studies report promising results from combining proactive CGA for older people in primary care with rehabilitative interventions. Studies from Sweden and Catalonia reported a reduction in hospital stay and in overall healthcare costs in the intervention groups. Rehabilitation is a key intervention of proactive CGA.



The **Jean Bishop Integrated Care Centre** provides proactive care in Hull and East Riding and offers a virtual model for those living in rural and remote locations. Reported benefits include good Patient Reported Outcome Measures (PROMs), reduced unscheduled activity in primary and secondary care and high levels of staff satisfaction and successful recruitment. Learn more about the service at **www.hullccg.nhs.uk/integrated-care-centre-2**

Reablement, community rehabilitation and intermediate care

Reablement is an approach to home-care services for older adults at risk of functional decline. It is used as a rehabilitation intervention for people who use social care services. Unlike traditional home-care services, reablement is frequently time-limited (usually six to 12 weeks) and is an intensive assets-based, person-centred and goal-directed approach that promotes and maximises independence and wellbeing.[47] It aims to ensure positive change using user-defined goals and is designed to enable people to gain, or regain, their confidence, capacities and the necessary skills to live as independently as possible, especially after an illness, deterioration in health or injury.

A multi-centre controlled trial involving 47 municipalities in Norway found significant treatment effects from a four to ten week reablement programme compared to traditional home-based services with some persisting benefit up to 12 months.[48] Although previous published studies report mixed results, economic modelling by NICE considers home care reablement has a high probability of being cost saving and recommends it is offered as a first option to people being considered for home care and as part of the review or reassessment process of people already receiving home care.[49] A more recent report by the Nuffield Trust analysed NHS Digital Adult Social Care Outcomes Framework data on the proportion of older people at home at 91 days after discharge from hospital into reablement and rehabilitation services at home or in an intermediate care facility.[50] Between 2011/12 and 2019/20 this measure of success was consistently around 82%, dropping to 79% in 2020/2021. Success rates are comparable by gender and only fall slightly with increasing age to 77% in the over 85s. Despite these positive outcomes and NICE recommendations, in 2020/2021 only 3% of over 65s received reablement on discharge from hospital. Reablement offers a critical opportunity for integrated systems to invest to save.

Community rehabilitation is provided by healthcare professionals at home, in day hospitals or ambulatory care settings, or in community hospitals or care homes. It may include individual, group and outdoor mobility components, overseen by a multidisciplinary team. The evidence review by NICE, mainly of community stroke or cardiac rehabilitation, reported high levels of patient acceptability, fewer GP presentations

The **Social Care Institute for Excellence** has published useful guidance document on the role and principles of reablement. It is designed for those working in or commissioning reablement but may also be useful to carers and those receiving reablement.

Read the briefing at **www.scie.org.uk/integrated-care/intermediate-care-reablement/role-and-principles-of-reablement**

The **Active Recovery Pilot** in Leeds sees physiotherapists and occupational therapists working with social care staff to visit people in their own homes on their first day out of hospital. The cross-organisational working between social care workers and allied health professionals has improved patient outcomes, improved the efficiency of hospital discharges, and helped patients regain their independence more quickly.

Read more at **www.csp.org.uk/news/2024-03-25-video-case-study-joined-working-rehab-centre**

and admissions to hospital at six months and reduced length of hospital stay.[51] There was also potential benefit in terms of patient satisfaction but no effect on carer quality of life. A cost-consequence analysis of an Australian randomised controlled trial of early supported discharge community rehabilitation for older people with frailty found that community-based rehabilitation was less costly (cost saving: £3238 per patient) and had better outcomes (less delirium, better quality of life, lower length of stay in hospital and in treatment, higher patient satisfaction, higher carer satisfaction and higher GP satisfaction) compared with inpatient rehabilitation.[52] Overall, NICE recommends community rehabilitation as a viable alternative to hospital inpatient rehabilitation for patients who have had medical emergencies, maximising and maintaining independence and reducing the overall burden on the health and care system.

Key message 5

Most rehabilitation is delivered in the community. Rehabilitation at home allows a clearer focus on practical, real-life goals than is possible with hospital in-patient rehabilitation. These goals should be based on 'what matters to me' conversations and include the ability to take part in activities that the individual enjoys.

Reablement and community rehabilitation are both key components of **Intermediate Care** - a range of integrated services that: promote recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living.[53] These services are usually delivered for no longer than six weeks and often for as little as one to two weeks.

North East London Foundation Trust has an intensive multidisciplinary **Community Rehabilitation Service** across three London boroughs. The service operates seven days a week and manages people with complex and intensive rehabilitation needs. They support people to achieve personalised goals at home and identify other resources to help them continue their recovery once discharged from the team.

Watch the case study video at **www.bgs.org.uk/resources/rehabilitation-case-studies-bgs-autumn-meeting-2023#anchor-nav-intensive-rehabilitation-services-nelft-team**

The **Integrated Rehabilitation and Enablement Program (iREAP)** in SE Sydney provides a day hospital-based interdisciplinary programme for older people at risk of frailty, falls, or who have Parkinson's Disease and other neurodegenerative conditions. The group format leverages the benefits of social and peer support and applies health coaching principles to support self-management and enablement. Evidence showed the model improved functional and quality of life outcomes in participants whilst they built enduring networks and supportive relationships.

Read more about the programme at **https://aci.health.nsw.gov.au/ie/projects/the-integrated-rehabilitation-and-enablement-program-ireap**

Torbay and South Devon Intermediate care service was 'enhanced' by employing GPs and pharmacists as well as involving the voluntary sector to be part of a daily interdisciplinary team meetings, working alongside social workers and community staff (the traditional model). Enhancing intermediate care through greater acute, primary care and voluntary sector integration can lead to more complex older patients being managed in the community, with modest impacts on service efficiency, system activity, and notional costs off-set by perceived benefits.[54]

Read more about the service at **https://ijic.org/articles/10.5334/ijic.s3584**

The Older People's Short Term Assessment Team in the **South Eastern Health & Social Care Trust, Northern Ireland** provides Intermediate Care Services to older adults through a single point of access and a multidisciplinary team that includes social workers, occupational therapists, physiotherapists and intermediate care support workers. The team aims to unlock potential and improve quality of life while building capacity to live well at home, for as long as possible.

Read more about the team at **https://setrust.hscni.net/service/older-peoples-short-term-assessment-team**

Most intermediate care is provided at home, but some people receive 'step up' or 'step down' intermediate care in dedicated beds in community hospitals or care homes. Rehabilitation for older people is a core function of the contemporary community hospital which offers a slower-paced and more homely setting than the acute hospital.[55] For example, older individuals with frailty in the Sub-Acute care for Frail Elderly (SAFE) transitional care unit in Ontario, Canada experienced shorter hospital stays, were less likely to be discharged to settings other than home and had similar 30-day acute care outcomes as control patients post-discharge.[56] A mixed methods study of bed-based intermediate care in an Acute Geriatric Community Hospital (AGCH) in Amsterdam reported that older patients admitted to the AGCH valued the quiet 'home-like' environment and found it conducive to recovery and reconnecting with family.[57]

The UK Community Hospital Association has published highlights on innovations in rehabilitation services developed during the pandemic. This ranged from digital innovation to reduce the need for home visits to rapid training, utilising the skills of physiotherapy, occupational therapy and nursing staff alongside a suite of supportive resources, which enabled clinicians to become available for redeployment to community wards.

Find out more www.communityhospitals.org.uk/pdf/case-studies/Rehabilitation_v2%20Full%20CS.pdf

Urgent community response services may provide both intensive short-term hospital-level care at home through virtual wards[58] and Hospital at Home,[59] and goal-oriented home-based and bed-based reablement and intermediate care services that optimise recovery through rehabilitation.[60] Successful services have a multi-professional team led by clinicians who can provide CGA, first line diagnostics and create both acute and rehabilitation care plans. The extent to which rehabilitation is included in the large-scale deployment of Hospital at Home and virtual wards services varies across the UK. This is a cause for concern.[61] Meeting the acute and post-acute rehabilitation needs of older people needs to be explicitly included in the design of these services, and well-integrated with transitional and intermediate care services to fully impact on individuals who experience cyclical decline and are at high risk of readmission.

More information about community rehabilitation services is in our *Right Time, Right Place* report[62] and in a series of videos at **www.bgs.org.uk/resources/community-geriatrics-video-case-presentations.**

Rehabilitation interventions which incorporated an outdoor mobility component following acute illness or injury led to sustained improvements in physical activity, outdoor mobility and endurance among older adults, with a dose-response relationship for a walking programme.[63] There was a possible interaction between the walking programme and social intervention components adding weight to potential benefit from integrated approaches that build connections and wellbeing through local resources and social networks. Rehabilitation must be flexible as patients' needs evolve over time and as they transition between care settings. It is important to review and reduce rehabilitation intensity over time to avoid over-reliance on services.

These issues are well set out in the Community Rehabilitation Alliance Best Practice Standards:[2]

- Referral processes are explicit, easy, efficient and equitable
- Rehabilitation interventions are timely, co-ordinated and prevent avoidable disability
- Rehabilitation interventions meet patients' needs and are delivered in appropriate formats
- Rehabilitation pathways should meet needs and be delivered locally with access to specialist services
- Rehabilitation programmes should enable optimisation, self-management and review
- Rehabilitation services are well led, adequately resourced and linked to other services
- Rehabilitation services involve families.

Rehabilitation in acute hospital care

Deconditioning

Older patients are at risk of deconditioning in hospital from long periods of immobility resulting in loss of muscle mass, functional decline and increased risk of death or long term care. Effective care requires early mobilisation, rapid establishment of rehabilitation goals, and continued rehabilitation input until their condition has stabilised. Comprehensive guidance is set out in the Silver Book II.[64] Active Hospitals[65] aim to change the physical activity culture within hospitals to encourage patients to move more. The 'Sit up, get dressed, keep moving' campaign encourages older people in hospital to be active and supports healthcare professionals to help their patients remain active to support recovery and reduce readmissions. This work complements the #endPJparalysis international campaign.[66]

Key message 6

Older people with acute illness decondition rapidly so need rehabilitation to start as soon as possible – healthcare professionals should not wait for a crisis to pass before providing rehabilitation at home, hospital or care home. All staff in all care settings, including acute and virtual wards, should prevent older people deconditioning by encouraging mobility and offering early active rehabilitation.

Group activities in acute wards at Liverpool University Hospitals NHS Trust help patients maintain independence, wellbeing, and positive mental health while in a restricted hospital environment. Bed disco at Broadgreen Hospital is an inclusive, fun way of preventing deconditioning or promoting reconditioning and benefits both patients and staff.

"You can partake if you are in bed, if you're only able to sit up [or], if you're standing and walking. We can tailor it to get you to exercise and move at your pace but also to do something that is going to be clinically effective. Bed discos involve cardiovascular exercise. They can involve coordination, range of movement, we can put strength training in there, we can put balance activities as well. But they are about fun, they are about motivation and it's about getting a person to want to be active, want to exercise. The mood lifts that we have seen as well as the physical benefits are fantastic." - Clinical Specialist Physiotherapist, Liverpool

Watch the case study video at www.bgs.org.uk/resources/rehabilitation-case-studies-bgs-autumn-meeting-2023#anchor-nav-bed-disco-at-broadgreen-hospital-liverpool

NHS Highland and the team behind 'The Broons' legendary comic characters have joined forces to launch an educational 'deconditioning' comic strip for Scotland's ageing population. The information features The Broons' characters and is likely to be identifiable to all ages, but particularly older people and their families.

Read more about the initiative at www.nhshighland.scot.nhs.uk/news/2024/02/nhs-highland-and-the-broons-embark-on-a-braw-initiative-to-tackle-deconditioning

At Nottingham University Hospitals NHS Trust, a programme was developed to train and support Physical Activity Champions on acute hospital wards as part of the Active Hospitals project. Healthcare assistants reported an increased confidence in promoting physical activity for older people in the hospital setting and supporting exercises using 'Keep Moving' resources.

"Patients do ask about how to be more active, so it's always brilliant to let them know that we have volunteers that come and help. All the volunteers are another bright smiley face and a positive interaction for the patients who might otherwise have been having a bad day." **- Healthcare Assistant[67]**

Read more about Active Hospitals at www.nuh.nhs.uk/active-hospitals.

General rehabilitation

Effective components of inpatient rehabilitation for older adults include endurance exercise, early intervention and shaping knowledge on post-discharge walking endurance. A review of studies showed that early intervention, repeated practice, goal planning, enhanced medical care and/or discharge planning increased the probability of discharge to home.[68] There is much debate about how to assess patients' potential to benefit from rehabilitation, particularly faced with the dynamic pattern and complexities of frailty in acute illness. A structured Rehabilitation Potential Assessment Tool (RePAT) was found to support clinicians in decision-making and encourage them to be more aware of biases.[69]

Rehabilitation following surgery

Increasing numbers of older people undergo emergency or elective surgery.[70] Clinician-reported, patient-reported and process-related outcomes are poorer in older surgical patients compared to younger people.[71] Older surgical patients who receive CGA-based perioperative care and rehabilitation have better outcomes and experience in both emergency and elective surgical settings.[72] However, implementation of such services is still patchy.[73]

A joint guideline from the Centre for Perioperative Care and the BGS covers all aspects of perioperative care relevant to adults with frailty undergoing elective and emergency surgery.[74]

The case for early mobilisation and rehabilitation after hip fracture is robust.[75,76] Functional recovery and survival are better for patients, both with or without dementia, who are mobilised earlier after surgery.[77] People with dementia who receive enhanced care and rehabilitation in hospital are less likely to develop delirium. Orthogeriatric-led care reduces the length of hospital stay by three to four days.[78]

Older patients with critical illness may have or may develop common geriatric syndromes. NICE guidance recommends comprehensive assessment at an early stage, careful reassessment at each transition in their care and at two to three months after hospital discharge as needs change. It notes these multi-dimensional needs often require an MDT and geriatric expertise.[79]

Rehabilitation and enablement within care homes

The BGS report, *Ambitions for Change*,[80] makes 11 recommendations to improve healthcare delivered in care homes. Recommendation 6 calls for equitable access to rehabilitation: "*Regardless of where they live, care home residents should be able to access NHS-funded rehabilitation, equipment and other services according to their needs, in the same way that an individual living in their own home would.*"

Access to rehabilitation in a care home varies across areas. Some residents in some care homes may have access to a therapist to assess their needs but equipment or exercise support are unlikely to be funded by the NHS in the way they would be for an individual at home, with an expectation that they will be funded by the care home or by the resident's family. This inequity must be addressed. A fundamental requirement is prevention of falls as all care home residents should be considered at high risk of falls and can benefit from a multifactorial fall risk assessment and tailored interventions, repeated at least once annually or when a resident's condition changes.[81] Promotion of physical activity may conflict with a traditional care and protect ethos in care homes. Where possible, an exercise specialist (physiotherapist or exercise physiologist) should be consulted to provide specialist advice on feasible and safe exercise and physical activity, tailored for residents.

The Care Inspectorate's Care about Physical Activity (CAPA) programme in Scotland, helps care providers build physical activity and more movement into the lives of older individuals they support.

"Residents that were quite hesitant for socialising, never mind exercising, we've seen a big difference… We had a few residents that were really struggling, and their physical and mental wellbeing has gone through the roof which has been amazing to see… [For some residents] life existed in a wheelchair for them, and all of a sudden, all of the staff have the confidence to ensure that they are walking, that they are attending classes, they are keen to go on and start their day." **- Care Home Activity Coordinator.**

Watch the case study video: www.bgs.org.uk/resources/rehabilitation-case-studies-bgs-autumn-meeting-2023#anchor-nav-rehabilitation-in-the-community-the-capa-care-about-physical-activity-team

As well as providing long-term care, some care homes provide 'step up' and 'step down' intermediate care for older people who need time to regain confidence and mobility to be able to return home. A short stay can create a safe environment where people can re-engage socially and regain their ability and confidence to return home. This may be useful for people whose home environment is not suitable or who lack a family carer to provide overnight support. A retrospective comparison

of two older adult hospital inpatient cohorts found the introduction of a discharge pathway to intermediate care in a care home corresponded with reduced length of hospital stay but there was no change in the number or characteristics of patients discharged to a care home long-term and similar 6-month outcomes. Costs were not considered.[82] More published peer-reviewed studies of this model of care are required to provide further evidence of its effectiveness.

Regardless of where rehabilitation takes place, it should be addressed to meet the needs of the individual and set out in a personalised care plan which should be adjusted as the person's situation changes.

Guidance from the National Care Forum and Care Provider Alliance has useful tips and case studies for planning and delivering effective intermediate care in care homes.[83] The good practice report highlights the required staffing and need for a dedicated area with appropriate furniture, dining space, accessible toilets and kitchen appliances for making a drink and snack.

Key message 7

Relational and informational continuity and coordination of care are the essence of person-centred integrated care. Older people should have a personalised care plan that addresses their rehabilitation needs and is contextualised to their health trajectory, social circumstances and cultural norms. This plan should be iterative, following the patient across transfers of care, and promote continuous enablement as their needs change.

Chapter four: Building our capacity and capability

Proactive and integrated workforce model

Many staff from different healthcare disciplines, social care and housing providers, community and third sector partners work alongside unpaid carers to support older people to achieve their rehabilitation goals. Family carers provide valuable support for recovery and need to be supported as equal partners in care, albeit recognising their capacity may be limited due to their own health or other constraints. Which practitioners should be involved in rehabilitation should be based on holistic assessment of need and individualised goals. Multidisciplinary teams are varied in composition and the leadership of the team should not be based on an idea of 'seniority' but on which team member has expertise in the priority concern of the individual.

Integrated workforce planning is required to meet the growing demand for rehabilitation in an ageing population. NHS England suggests education and training places for allied health professions will need to grow by as much as 25% by 2030-31 to meet demand.[84]

Workforce models that optimise skill mix and enable people to work at the top of their licence can increase system capacity and extend the reach to older people who are currently excluded from access to rehabilitation. A strategic and integrated approach can be facilitated by appointing a rehabilitation director operating at executive level within the system and establishing a local network of providers who consider existing services and collaborate to improve access, ensure equity of provision, reduce fragmentation and make best use of collective workforce capacity. Capacity planning involves assessing needs of individuals and aggregating at a neighbourhood level. There are models to help in planning required capacity.[85] Population segmentation and risk stratification have been applied over recent decades to better understand levels of need within a neighbourhood and plan capacity of teams accordingly.

Many rehabilitation programmes are for specific conditions (eg stroke, heart failure, respiratory disease) but often have common elements and shared resources that are useful for people with multimorbidity or frailty. Flexible delivery may enhance interdisciplinary learning and service efficiency as illustrated by the generic Healthy and Active Rehabilitation Programme developed in Ayrshire in Scotland, working with leisure service partners.[86]

The Collaborate Don't Compete project[87] describes how different exercise professionals can work together to promote stronger rehabilitation outcomes, including for older people.

Key message 8

Rehabilitation is a multi-agency endeavour involving many health and social care disciplines, voluntary sector, volunteers, unpaid carers, housing and community leisure services. Systems should work with all partners to offer rehabilitation for older people as a key component of health and social care within age-friendly communities.

The NHS Fife Intermediate Care Service provides rehabilitation to people within their own homes. This community rehabilitation initiative aims to ensure patients have the best chance of achieving their personal goals, improving independence, general health and wellbeing, whilst in their home or homely setting.

Working together to improve outcomes for Pat in St Andrews, Fife: Following initial inpatient rehabilitation after a stroke, Pat was referred to the local intermediate care team for Early Supported Discharge rehabilitation at home with a personal goal to be able to walk outside again with a stick. Rehabilitation support workers visited Pat daily, encouraging her to regain independence with personal care, and developed a personalised exercise programme to promote balance, mobility, self-management, independence and wellbeing. Pat progressed to walk with a stick indoors then outside with support workers. She started an out-patient rehabilitation class at the local community hospital and was motivated by exercising with others. She then moved on to Active Options, a community exercise group. A local area co-ordinator helped Pat identify a social group that could support her to get out and about, be active and socialise.

Read more about community rehabilitation in NHS Fife at www.nhsfife.org/services/all-services/icass-integrated-community-assessment-and-support-services/intermediate-care-service/community-rehabilitation

Education and training support

Professionals engaged in rehabilitation need core competencies in communication, shared decision-making, goal-setting and collaborative practice. They also need skills in assets-based approaches, supporting self-management, identifying and escalating potential medication-related problems, and identifying and signposting carers to support for wellbeing. Education should include raising awareness of human rights duties such as challenging ageism and ageist stereotypes; confidence in tolerating risk in encouraging mobility; understanding how to create a safe and enabling physical environment; and support for motivational coaching and behaviour change to sustain the gains. Student placements, simulations and rotational posts that offer experience in different settings are valuable. Non-registered members of staff are critical in delivering programmes of rehabilitation and need training to equip them to have the right skills.

The BGS offers an online educational module on frailty[88] that can support practitioners contributing to rehabilitation to develop these important competencies. NHS England also offers a frailty e-learning module for the public and for generalist professionals that includes a sub-section on rehabilitation.[89] Additional required rehabilitation competences include skills such as case management and care coordination as reflected in a new capability framework for virtual wards and hospital at home services in England.[90]

Key message 9

Rehabilitation is everyone's business – older people themselves, carers and all health, social care, housing and voluntary sector workforce need to understand how to motivate and support enablement in later life. Systems should work with education providers to support everyone involved to work together and at the top of their licence to increase collective capacity for reablement and rehabilitation for older people.

A Bevan Exemplar project in a community hospital in Wales upskilled healthcare support workers as Rehab Champions to reduce delays between purposeful therapy contacts and to help the MDT adopt a 24-hour approach to implementing rehabilitation plans for patients. Patients were discharged with lower dependency, smaller packages of care than anticipated, reduced manual handling equipment needs and had a shorter length of stay than the previous average.

Read the case study at https://bevancommission.org/wp-content/uploads/2023/08/Rebecca-McConell-BCUHB-.pdf

Occupational therapists and physiotherapists in integrated community services at Guy's and St. Thomas' NHS Foundation Trust complete an enhanced Level 1 Medicines Reconciliation as part of the patient's initial assessment. This facilitates timely identification of issues relating to medicines, and prompts consideration of the impact of medicines on rehabilitation goals (e.g. on pain management). Where required, therapists refer to a team of pharmacists and pharmacy technicians to support the optimisation of medicines.

"The occupational therapist checked the medication that I had been given by the Hospital and noticed missing medication and contacted my GP to arrange for it to be re-prescribed. They also supported me in contacting my GP, as I wanted a lower dose of pain killers (that I was not allergic to). My GP, encouraged by their email, acted quickly but I still did not have my newly prescribed medication, and the pharmacy were not answering when I tried several times to enquire by phone. The occupational therapist telephoned directly and got through and by that evening the newly prescribed medication had been delivered to my home."
- Patient at Guy's and St Thomas' NHS Foundation Trust

Physical environment

The optimal environment for rehabilitation is generally the individual's home but this may not be feasible for some people due to lack of space, lack of equipment, or challenging circumstances, particularly for older people who live alone and need support to engage in rehabilitation.

Provision of simple equipment can be crucial in ensuring that an individual is able to rehabilitate in their own home. In all settings, the physical environment should be able to support older people who require specific support for sensory, functional or cognitive impairments or to help them engage with the rehabilitation process.

Physical space for rehabilitation in hospitals has diminished in recent years, exacerbated by the pandemic and by a spiralling

maintenance backlog resulting in closure of some areas for extended periods of time. In some hospitals, the function of former rehabilitation spaces has changed to accommodate patients with acute medical needs. In a survey by CSP at the end of 2022, physiotherapists reported a loss of rehabilitation space in more than 100 areas across the UK. In a follow-up survey in May 2023, 96% of respondents said the situation had stayed the same or worsened. Rehabilitation needs the appropriate space, facilities and IT infrastructure.

"On the Occupational Therapist's first visit to my home, she noticed that my raised toilet seat was not fitted correctly as my toilet seat underneath was broken. It had caused a few scary moments when it kept slipping when using it. She immediately securely fitted the raised toilet seat, and it was wonderful to have a safe toilet to use. When she saw I was struggling to move my meals from the kitchen to my table, she arranged a trolley, which has been a real life saver as there were many things I could not carry due to being on two crutches. The trolley has helped improve my daily living considerably. She was excellent in helping me with Adult Social Services to get installed bathroom aids, a bed rail and grab rails at my front door. All have helped in my daily living needs and will continue to be of help, as I have a permanent issue with my right knee." – Patient at Guy's and St Thomas' NHS Foundation Trust

Key message 10

Rehabilitation needs the appropriate space, equipment, facilities and IT infrastructures, including access to care records that can be shared across providers in all care settings. Systems should commission a menu of options from a range of partners in environments that are fit for purpose. Services should be of sufficient duration to enable older people to achieve their social goals as well as undertake activities of daily living at home.

Digital solutions

How patients receive their rehabilitation is important. In a study by the British Heart Foundation, while a majority of people expressed a preference for face-to-face support, others commented that they felt that they were able to get the same experience from a telephone or video call.[91] In a recent interview study within a trial of remote physiotherapy for early stage Parkinson's disease, participants found remote consultation with a physiotherapist acceptable and liked the convenience of not having to travel to the clinic.[92] However technical difficulties included positioning of the camera and limitations of internet connectivity. If these challenges can be overcome, telerehabilitation has potential to make rehabilitation more accessible. Other considerations are lack of equipment, limited digital infrastructure, difficulty in establishing a therapeutic relationship online, a need for more training and support and simpler technologies that can be personalised.[93]

An overview of technologies used to facilitate remote rehabilitation in adults with deconditioning, musculoskeletal conditions, stroke, or traumatic brain injury, was unable to draw firm conclusions.[94] Targeted digital solutions for physical activity are more promising. A review of digitally enabled physical activity and exercise interventions for older residents in long-term care facilities reported increased function and activity.[95] A recent qualitative study which explored remote delivery of a programme of physical activity and exercise for people with early dementia or mild cognitive impairment during COVID-19 found that remote delivery could be challenging for carers, people with dementia and therapists.[96] However, creative approaches to address these issues were identified.

Digital solutions are also required to enable continuity of information between providers and at transitions between settings or services. These are a key aspect of an integrated approach to rehabilitation. For example, a care plan should be able to be shared across interoperable systems and accessed and added to by key staff involved in rehabilitation and support.

National IT solutions, such as the Summary Care Record application, may be useful but most areas have much work to do in information governance and interoperability of systems to improve access to data for the range of providers of rehabilitation and intermediate care.

The National Institute for Health and Care Research has produced guidelines for the use of virtual home assessment tools.[97]

Measuring what matters

As health and care systems implement new models of rehabilitation, there is a need to understand and communicate the benefits for patients, carers, professionals, organisations and systems. Multi-dimensional interventions for older people often prove challenging to evaluate. Analysis of rehabilitation service data is critical for planning, commissioning and monitoring their performance. Good quality data is a prerequisite for continuous quality improvement and benchmarking of rehabilitation services. However, we lack standard national datasets and there is often limited interoperability between the local datasets that exist in different care settings. A recent report by the Community Rehabilitation Alliance offers recommendations for addressing these issues.[98]

Thoughtful consideration of different professional values, cultures and approaches is required when introducing tools to measure quality and outcomes of multidisciplinary rehabilitation interventions.[99]

Monitoring and evaluation of complex rehabilitation interventions will require a range of mixed methods approaches, depending on the maturity of the service. Ideally there should be a continuous quality improvement approach using small-scale local data to drive improved practice and outcomes at point of care. Periodic reviews of activity, case-mix and patient and carer feedback will support assessment of reach, inclusion and experience. More detailed evaluations should consider interdependencies through contribution analysis and assess both cost-effectiveness and social value.

Considering wider outcomes beyond health, longevity and Quality Adjusted Life Years (QALY) will enable commissioners to have a broader understanding of effectiveness and value from investment in new ways of working.[100,101]

Examples of monitoring and evaluation tools:

- The Measure Yourself Concerns and Wellbeing Tool from Meaningful Measures has been adopted by the Gloucestershire complex care at home service.[102]
- The International Consortium on Healthcare Outcomes has developed numerous tools for patient-centred outcome measure.[103]
- The Welsh Government have published a rehabilitation evaluation framework to assist Health Boards, local authorities and third sector partners to understand the demand for and to evaluate the impact of rehabilitation.[104]
- Akpan and colleagues published a standard set of health outcome measures for older persons.[105]
- A reablement team in Dumfries and Galloway, Scotland used the community IoRN2 tool (Indicator of Relative Need) to measure impact and as a catalyst for outcomes focused conversations and collaborative practice.[106]
- The Patient-Reported Outcomes Measurement Information System (PROMIS) is a short form designed to measure physical function in geriatric rehabilitation patients.[107]
- The BEPOP (Benchmarking Exercise Programme for Older People) national benchmarking first wave seeks to determine and promote exercises associated with positive outcomes for older people living with, or at risk of, sarcopenia or physical frailty.[108]

Key message 11

The quality of rehabilitation services should be monitored, tracking changes in health and functional outcomes, patient and carer experience, and considering coverage and cost-effectiveness. This intelligence should be used to continually improve services. Quality indicators should acknowledge personalised goals and outcomes, and that delay of further functional decline may be a more realistic outcome than recovery of independence for people who have progressive life-limiting illness or are at the end of life.

Chapter five: Conclusions

With population ageing and older people living for longer periods with frailty and multimorbidity and the resultant impacts on cognition, mobility and continence, the need for greater investment in rehabilitation is urgent and growing. Rehabilitation for older adults is an important 'invest to save' approach for health and care systems as it reduces the impact of acute or chronic conditions, illnesses or injuries by preventing or delaying long term disability and dependency and reducing carer burden. Optimal rehabilitation helps prevent avoidable hospital admissions or readmissions, reduces hospital length of stay, reduces the need for long-term social care at home and reduces rates of admission to long-term care facilities. It should be embedded as a core component of care at all levels of an integrated health and social care approach, and be readily accessible at home, in hospitals, in care homes, in primary care services, ambulatory care settings and in other community facilities such as leisure centres.

However, there are continuing workforce challenges and no new national funding to ramp up rehabilitation capacity. To transform care and support, systems must view rehabilitation as critical 'invest to save' expenditure and rapidly work with partner organisations to build capability across the collective workforce. Rehabilitation involves healthcare professionals across the multidisciplinary team and across all care settings. Ensuring no older person is left behind requires integrated workforce planning for population health and strong collaborative leadership within integrated systems. To ensure that this issue is given adequate prominence by systems, a designated senior officer or Board member should be responsible for ensuring access to high-quality rehabilitation for older people.

Key message 12

Senior leadership is critical for a strategic and sustainable approach to planning and delivering rehabilitation for older people. Systems should identify a senior officer or non-executive Board member with a specific role in assuring equitable access to rehabilitation attuned to the needs of older people and continually improving the quality of service delivered.

The BGS has a wide range of resources to support the development of rehabilitation services for older people

Our 5,000 members work in a range of multidisciplinary roles across acute, primary and community care settings across the four nations of the UK and share the same goal – to improve healthcare for older people.

We urge anyone involved in planning or commissioning rehabilitation services for older people to engage with the expertise of the BGS and its members. We stand ready to help systems deliver the right to rehabilitation, at the right time and in the right setting for all older people who need it.

Visit www.bgs.org.uk for more information about our work.

Contributors

- **Professor Anne Hendry,** Senior Associate, International Foundation for Integrated Care (IFIC); Honorary Professor, University of the West of Scotland; Honorary Physician, NHS Lanarkshire Research and Development Department
- **Lucy Aldridge,** Policy Co-ordinator, BGS
- **Dr Michael Azad,** Co-chair, BGS Frailty and Urgent Care Special Interest Group; Consultant Geriatrician, Nottingham University Hospitals NHS Trust
- **Dr Neil Chadborn,** Senior Research Fellow, University of Nottingham
- **Dr Alison Cowley,** Associate Chief Allied Health Professional Research & Innovation, Nottingham University Hospitals NHS Trust; Honorary Associate Professor, University of Nottingham, School of Medicine
- **Dr Amanda Crawford,** Consultant Geriatrician, South Eastern Health and Social Care Trust
- **Lyndsey Dunn,** Vice-Chair, BGS Nurse and AHP Council; Clinical Service Manager, Fife Health and Social Care Partnership
- **Sally Greenbrook,** Policy Manager, BGS
- **Cliff Kilgore,** Chair, BGS Wessex Council; Consultant Practitioner Integrated Care/Older People, Bournemouth and Christchurch medical team
- **Professor Finbarr Martin,** Emeritus Consultant Geriatrician and Professor of Medical Gerontology, King's College London
- **Dr Vimal Sriram,** Director of Allied Health Professionals, University Hospitals Bristol and Weston NHS Foundation Trust
- **Dr Jennifer Stevenson,** Lead Pharmacist for Older Adults, Guy's and St. Thomas' NHS Foundation Trust; Honorary Senior Lecturer, King's College London

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British Geriatrics Society
Improving healthcare
for older people

Marjory Warren House
31 St John's Square, London EC1M 4DN

Telephone 0207 608 1369
Email enquiries@bgs.org.uk
Website www.bgs.org.uk
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