A community rehabilitation and reablement model

Good practice guidance for integrated care boards (commissioners and providers)

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Introduction

This document is focused on rehabilitation and reablement[1] provided alongside step-down intermediate care – time-limited, short-term (typically no longer than 6 weeks) health and/or social care provided to adults (aged 18 years or over) who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover.

A major barrier to delivering step-down intermediate care is a lack of timely access to high quality rehabilitation in the community. Work with local systems suggests that this is largely driven by therapy workforce challenges, with the fragmentation of services across health and social care, including independent providers. This has resulted in in practical challenges to delivering improvements. Increasing community rehabilitation capacity will require a shift in how services are organised and delivered to maximise the use of the workforce and increase productivity and efficiency.

This document consists of best practice guidance that systems should consider in connection with their intermediate care and rehabilitation services and implement where appropriate locally and affordable within available budgets.

The community rehabilitation model aims to increase capacity and access to high quality therapy-led rehabilitation assessments[2] and interventions that are timely, safe and person-centred, for people discharged on intermediate care pathways from acute settings and virtual wards. The model will ensure:

- Individuals will be the centre of discussions about their goals and the support needed to achieve those goals based on the ‘what matters to you?’ approach. Conversations will include the individual, and their family, friends or carers where appropriate.
- Any transition points will be managed effectively, ensuring an as seamless as possible experience of step-down intermediate care with consistent communication throughout.

It aims to achieve this through:

- Maximising the use of the registered and unregistered therapy workforce based on the expertise and skills required and the point in the pathway where it is required.
- Supporting delivery by a multi-disciplinary, multi-agency workforce working in integrated ways, pulling in relevant skills, expertise and community assets as required.

[1] Throughout this document, where the term ‘community rehabilitation’ is used, it includes therapy-led reablement interventions to support people to recover and retain function.
[2] A rehabilitation assessment involves a holistic review of a person's needs to identify the interventions needed to support them to recover and retain function. It is not the same as a Care Act assessment which assesses long-term/ongoing social care needs.

- Ensuring rehabilitation assessments and interventions are therapy-led[3], i.e. overseen by a registered therapist[4] who will offer advice, support and guidance as required, with strategic oversight for quality, including safety.
- Utilising digital interventions to supplement and support access to rehabilitation and to clinical expertise.

The model is agnostic of settings and providers, and the core principles apply to both community bedded settings (beds in care homes, community hospitals and other bed-based rehabilitation facilities) and rehabilitation in a person's home (usual place of residence). A framework published in 2021 is available to support the delivery of Care units in care homes for short-term rehabilitation and reablement care.

The model focuses on increasing community rehabilitation (including therapy-led reablement) capacity. It also encourages movement and activity in hospital to ensure people are in the best possible condition on discharge to maximise the benefits of any community rehabilitation they receive. It does not preclude the provision of other services that would be required as part of holistic intermediate care services to support people's recovery.

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[3] Therapy-led refers to professional oversight rather than line management which will be organised at a local level as appropriate.
[4] Delivery by a member of staff who is not a registered professional in the relevant speciality should be overseen by someone with the relevant registration.

Guiding principles

The guiding principles of the new model are:

- People requiring community rehabilitation have access to the appropriate level of expertise, based on their individual needs, including people with particular conditions, needs, protected characteristics, or those living in particular circumstances.
- This includes but is not limited to: people living with frailty, mild cognitive impairment, dementia or delirium, palliative and end of life care needs, mental health conditions, learning disabilities, autism, obesity (including bariatric patients), younger adults, and people living in an unsafe environment, in prison, experiencing homelessness, or at risk of homelessness.
- People have the right to make their own decisions about their community rehabilitation if they have the mental capacity to do so. If there is a reason to believe a person may lack the capacity to make a specific decision, steps must be taken in accordance with the Mental Capacity Act 2005 as outlined in the Mental Capacity Act Code of Practice.
- Support is person-centred and holistic. This will be achieved by making every contact count, reducing handoffs and ensuring continuity of care.
- Community rehabilitation assessments and interventions are therapy-led and delivered by a mixed multi-disciplinary and multi-agency workforce which is able to pull in relevant skills, expertise and community assets as required.
- Staff work flexibly in line with a ‘one workforce’ culture across services, settings and sectors, building relationships and increasing skills.
- New ways of working are embraced, making best use of the full range of skills across the workforce, including the use of assistive and digital technologies when appropriate.
- There is leadership at all levels of the health and social care system which operates across organisational boundaries, with an agreed champion at neighbourhood-level, driving changes in behaviours and culture, and promoting integration and trust.

1. Acute inpatient / virtual ward care

During a person's acute inpatient or virtual ward stay and whilst they meet the criteria to reside in that setting, **planning for discharge** and **movement and activity on the ward** will take place. Once they no longer meet the criteria to reside (i.e. on their Discharge Ready Date), **care transfer (discharge)** will be initiated.

Planning for discharge – good practice:

- Begins as early as possible from the point of admission[5].
- Involves the person, and their family, friends or carers (including any young carers) where appropriate, and community teams and providers who know them well[6] – an independent advocate may be useful if someone finds it difficult to understand their care and support or finds it hard to speak-up.
- Considers the person's holistic needs, including concerns relating to dementia, delirium, memory and confusion.
- Considers the home environment and other relevant factors so that any issues can be identified and planned for at an early stage (e.g. need for carer support, equipment or home adaptations[6], issues relating to homelessness/risk of homelessness, including referral of people who are homeless or at risk of homelessness to a local housing authority[7]).
- Considers safeguarding concerns and act in accordance with legislation[8].
- Involves communication and close working with community teams to gather relevant information about the person (if known to them) and ensure timely deployment of home adaptations.

A variety of assessment tools may be used as appropriate, including for example, the Patient Categorisation Tool or the Rehabilitation Complexity Scale.

The British Geriatrics Society recommend use of the Comprehensive Geriatric Assessment (CGA), particularly for people with moderate or severe frailty, to ensure a multi-dimensional holistic assessment and development of a suitable plan to support people to return home with the appropriate rehabilitation support.

Use of tools such as the Rockwood Frailty Scale at admission to capture how the person was two weeks prior to admission can provide an indication of what a person might hope to achieve with rehabilitation and reablement interventions, and support discharge into intermediate care.

[5] Section 91 of Health and Care Act 2022; Hospital discharge and community support guidance
[6] RCOT Adaptations without delay; Disabled Facilities Grant (DFG) guidance
[7] Section 10 of the Homelessness Reduction Act 2017
[8] Care Act 2014; Safeguarding Adults; a guide for health care staff

Movement and activity on the ward:

- Involves encouraging the person to undertake physical and social activity (including self-care) while on a hospital ward or virtual ward.
- Could be undertaken by ward staff or therapy support workers, with access to registered therapist and specialist input where required, and supported by the person's family, friends or carers where appropriate.
- Could be achieved by appropriate education and training, including building capability and core skills in the ward and therapy workforce to manage and support people with dementia, delirium or confusion to be mobilised.

Movement and activity on the ward reduces the risk of deconditioning (physiological, psychological and functional decline), supports people to go home on discharge, enhances people's recovery, and could reduce the level of step-down intermediate care needed.

Where a registered therapist is required in hospital settings, systems will maintain continuity of care between the ward and home settings. Some systems have achieved this through an in-reach model with community-based therapy teams supporting the person during their hospital stay and continuing their rehabilitation in the community after discharge.

Care transfer (discharge) – good practice:

- Takes place at the point the person no longer meets the criteria to reside.
- Does not generally require an assessment for rehabilitation needs as this will take place in the community once the person has been discharged.
- Involves describing information to the care transfer hub on the person's:
    - current functional, psychological and cognitive state – this might include whether the person can walk, eat, drink, go to the toilet independently, climb the stairs, communicate and any cognitive elements
    - state prior to admission
    - environment they will be returning to.
- Utilises information that has been collected and collated by ward staff or support workers which could be streamlined through an agreed referral form to ensure the required information is summarised once and in a consistent way to facilitate efficient discharge and referral processes.
- Information is used by the care transfer hub to inform triage to determine the most appropriate discharge pathway, and whether the person needs immediate social care support.

Further detail on care transfer hubs is available in the Intermediate care framework.

2. Rehabilitation assessment in the community

Once the person has been discharged, their **community rehabilitation needs** should be assessed and captured in an **individual rehabilitation plan.** The plan should describe what they can expect during their intermediate care journey and ensure that services are streamlined.

Assessment for community rehabilitation needs – good practice:

- Usually[9] takes place in the community, i.e. in the person's home (usual place of residence) or in a short-term community bedded setting, as soon as possible after the person no longer meets the criteria to reside and is discharged, to reduce the risk of deconditioning. Individual personal circumstances will always be considered, and a flexible approach may be needed, for example, for people with dementia or delirium, to ensure that they receive therapy and support when they can most benefit from it.
- Takes a holistic approach including cognitive and psychological screening, a medication review and a review of physical functionality and communication needs.
- Undertaken by staff who have, or have access to, the skills, knowledge and experience required to assess the person's needs including managing complexity.
- Could be delegated to and undertaken by skilled support workers with oversight and supervision from a registered therapist, where clear protocols exist or there is a predictability element to the individual's response or treatment.
- May identify that someone is suitable for transfer to a supported self-management pathway.
- Results in an individual rehabilitation plan designed to support the person throughout their intermediate care journey (regardless of setting), reducing the need for duplicate assessments.

The individual rehabilitation plan – good practice:

- Is established when the person no longer meets the criteria to reside/on discharge (containing a note of any CGA, frailty, or other assessments which have already been completed, and any other relevant information gathered during discharge planning), and developed in full promptly after the community-based assessment.
- Is developed with the person, and their family, friends or carers where appropriate, using the question 'what matters to you?' and involving providers of short-term interventions as appropriate.
- Records the outcome of the therapy-led assessment and include information on what matters to the person, the agreed interventions and any equipment required during the intermediate care phase.

[9] A person who is 'discharge ready' should not be delayed in hospital awaiting an assessment for community rehabilitation needs.

- Outlines interventions delivered in a home-based or short-term community bed-based setting depending on the needs of the person – where possible a person who commences their intermediate care in a community bedded setting will have a plan that builds in discharge to their own home (usual place of residence) to continue their rehabilitation outlining the steps needed.
- With agreement from the person, is recorded in their shared care record and their personalised care and support plan (if they have one) to inform their future care and support needs, reducing the need for duplicate requests for the same information.
- Records planning for the person's transition from intermediate care – this may need to be updated as the plan is reviewed.
- Is reviewed during the rehabilitation process on an ongoing basis and with the person and their family, friends or carers where appropriate, and revised, if necessary, in line with the identified outcomes and goals.

3. Delivery of rehabilitation interventions

Community **rehabilitation interventions** are provided to the person to help them rehabilitate, re-able and recover as much as possible from the event that led to their acute inpatient/virtual ward stay and maximise their independence.

Rehabilitation interventions – good practice:

- Commences with minimal delays following the agreement of the individual rehabilitation plan to reduce the risk of deconditioning (physiological, psychological and functional decline), or requirement for further assessments.
- Is therapy-led and delivered through a multi-disciplinary, multi-agency workforce working in integrated ways, utilising technology to facilitate communication and access to specialist expertise, and where appropriate to support remote rehabilitation or monitor progress.
- Optimises input from registered therapists to provide specialist and bespoke interventions and manage complexity, with protocols in place for delegation, accountability and supervision.
- Maximises the use of skilled support workers and other staff and volunteers with direction, advice and oversight from registered therapists (see Annex A).
- Is delivered in line with the guiding principle: Support is person-centred and holistic, through making every contact count, reducing handoffs and ensuring continuity of care.
- Is delivered at the right level for the needs of the individual, considering reasonable adjustments where required[10] and minimising the use of double-handed care where safe and appropriate to better enable the person to retain or regain their independence and reduce the over-prescription of care.
- May be delivered in a home-based or short-term community bed-based setting depending on the needs of the person – where possible a person who starts their intermediate care in a community bedded setting will be supported at a suitable point to be discharged to their own home (usual place of residence) to continue their rehabilitation provided it is a suitable and safe environment.
- Is delivered in line with the individual rehabilitation plan, with planning for transition from intermediate care considered at each review so a person's experience of leaving intermediate care is seamless with minimum delays.

Staff delivering community rehabilitation interventions should have the knowledge and skills to enable them to recognise and respond to deterioration in a person's physical or mental health or circumstances. Onward referrals will depend on the type and extent of deterioration and could be to a range of services (see Annex A in the intermediate care framework). These include but are not limited to: Urgent Community Response, crisis response,

[10] Equality Act 2010

community-based falls response, mental health crisis response, palliative and end of life care, or virtual wards.

4. Transition from intermediate care

During the person's intermediate care journey, **planning for transition from intermediate care** should take place. Following the period of intermediate care, the person may be able to live independently or self-manage in the community, or they may require **assessment for long-term/ongoing needs**

Planning for transition from intermediate care – good practice:

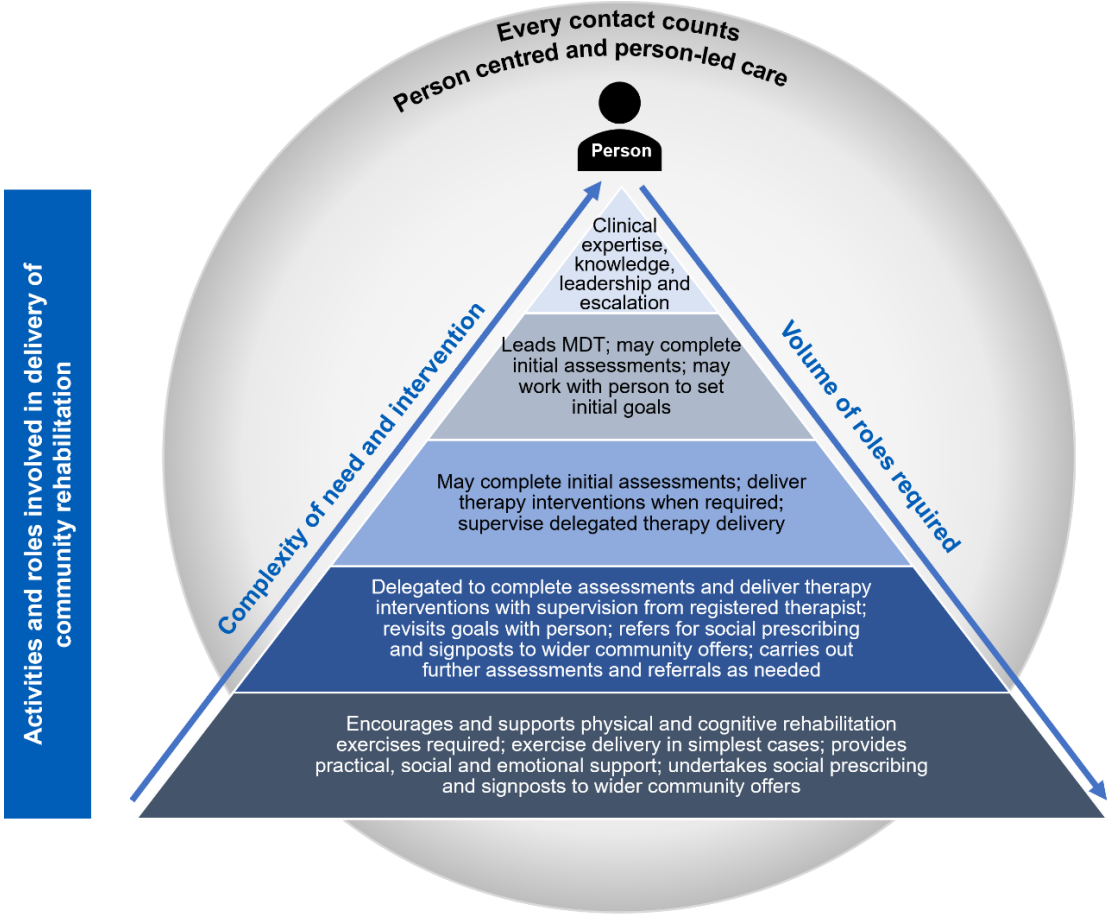
- Starts early in the pathway to enable a seamless and efficient transition – as a minimum planning is discussed during the assessment for rehabilitation needs and when developing the individual rehabilitation plan.
- Involves the person and their family, friends or carers where appropriate, as well as providers of long-term care and support as appropriate.
- Is undertaken by multi-disciplinary, multi-agency staff working together to ensure that any onward plans are coordinated so that people who have longer-term needs are clear on which people or services will be involved.
- Actively considers the broad range of onward options available depending on the needs of the individual, such as:
    - self-management with signposting to other services in the community, for example local strength and balance classes, or the use of Apps and other technology-based support
    - long-term care in a person's own home or care home, which may be self-funded
    - ongoing community rehabilitation
    - additional support through, for example, social prescribers, community or faith groups and other voluntary organisations

Assessment for long-term/ongoing needs:

- Will be anticipated, where required, early in the pathway and fully completed towards the end of the intermediate care period.
- May take many forms depending on the needs of the individual, e.g. in some cases an individual may require a new or updated assessment, such as a Care Act assessment or NHS Continuing Healthcare assessment.

Annex

Annex A: Example community rehabilitation pyramid of expertise and wider resource pool



Examples roles (vary by ICS):

Leadership and higher-level expertise: consultants (e.g. rehabilitation medicine specialists, consultant therapists, geriatricians); advanced practice therapists

Assessment and supervision: therapists; physicians; other qualified health professionals as required for the individual

Rehabilitation delivery: support workers, senior support workers, assistant practitioners, apprentices and students; other non-registered physical, communication, cognitive, social and wellbeing practitioners; exercise therapists; care workers; community nurses with rehabilitation interest

Rehabilitation support: unpaid carers, families and friends; voluntary and community sector workers and volunteers; health and wellbeing coaches; leisure industry workers

Wider care and support, specialist expertise and community assets: community nurses; GPs; community pharmacists; community mental health and dementia teams; palliative and end of life care teams; learning disability and autism teams; social prescribing link workers, care-coordinators and health and wellbeing coaches; care workers; social workers; unpaid carers, families and friends; voluntary and community sector workers and volunteers; local authority housing and homelessness teams; leisure industry workers