Community Rehabilitation Alliance (CRA)

Community Rehab Alliance core asks 2023-24

The CRA political engagement group agreed to develop a list of key CRA messages for partners to use in their own political engagement ahead of the UK General Election.

Our shared aim is for commitment from political parties to high-quality rehabilitation provision in policies of the next government and the opposition.

The purpose of this document is to set out our shared priorities that CRA partners can incorporate within their own political engagement in the coming months.

The CRA is calling on political parties to include in their manifestos and post-election:

1. **Make a commitment to rehabilitation as an equal pillar of health care to medicines and surgery and reflect this in an updated NHS Constitution.**
2. **Mandate ICBs to improve access to high quality community rehabilitation services for their populations with a single accountable lead in each ICB for rehabilitation.**
3. **Commit to expansion of the rehabilitation workforce in the community making use of the full workforce available, including AHPs, mental health experts, nurses, support workers, exercise professionals and the voluntary sector.**

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Rehabilitation should have parity with medicines and surgery in the NHS

Advances in healthcare mean many more people now survive illness and injury that would previously have killed them. The challenge for the government and NHS now is to ensure people live well for longer – and rehabilitation is the key to this.

Rehabilitation is as essential to good health outcomes as medicines and surgery. It optimises outcomes from surgery and medicines and enables people to manage their long-term mental and physical conditions successfully.

The NHS Constitution and handbook includes rights to surgery and drug treatments but not rehabilitation. Rectifying this in the next Parliament will show what's needed to ensure the NHS is meeting modern population needs.

Yet despite its obvious value, access to rehabilitation is poor:

- **Rehabilitation can reduce the risk of a further stroke by 35% and enable people to regain function and independence[1] but only 32% get what is recommended.[2-3]**
- **Falls are a large cause of emergency hospital admission, with 23% of calls to 999 due to falls. Fracture Liaison Services (FLS) are a cost-effective model that delivers a return on investmentof £3.26 for every £1 invested by reducing admissions and bed days.**

- **Chronic Obstructive Pulmonary Disease (COPD) exacerbations are the 2nd largest cause of emergency hospital admissions. Rehabilitation reduces admissions by 14% and hospital bed days by 50% but less than 40% of eligible people are offered it.**
- **Cardiovascular disease accounts for 1 million hospital admissions per year, 100 000 of these are due to heart attacks. Rehabilitation prevents the progression of cardiovascular disease (CVD) and heart attacks. Yet only 50% of eligible patients receive it. There would be 50 000 fewer hospital admissions if access was 85%.**

Lack of access to rehabilitation fuels health inequalities and reduces healthy life expectancy. By 2035 2/3 of adults will be living with multiple long-term conditions.[4] People in the poorest communities have a 60% higher chance of being diagnosed with a long-term condition than those in the richest, with a 30% higher chance their condition will be more severe.[5,6]

Treatment and care for people with long-term conditions costs £7 in every £10 of the total spent on health and social care, accounting for 50% of all GP appointments and 70% of hospital bed days. 5 People of working age with a long term condition are twice as likely not to work.[7,8] Those most confident in managing their condition have 38% fewer emergency admissions and 32% fewer attendances at A&E than the least confident.[2-3] Equitable access to high quality rehabilitation would reduce the financial burden on health and social care, and increase economic activity, particularly in areas of high deprivation.

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ICBs need to provide strategic accountability for rehabilitation services.

Transforming our health care system to be rehabilitative requires leadership at a system level.

Rehabilitation must be more integrated across NHS and social care sectors and personalised to meet the needs of people with multiple long-term conditions. This includes co-locating services closer to home in local leisure facilities and community venues.[5]

Services outside of hospital must be modernised so that falls, injuries and diagnosis are followed swiftly by patient advice, preparation for treatment, supported self-management and rehabilitation. Musculoskeletal (MSK) First Contact Practitioner roles in primary care are a good example of improving access to early diagnosis and expert advice and the MSK Health Hubs are a good example of supported self-management, using existing leisure facilities.

The CRA's Rehabilitation Best Practice Standards show what good rehabilitation looks like in all sectors. These multi-condition, multi-professional standards aim to improve individual and population-based health and well-being and decrease variation. The standards drive cost-savings through early supported discharge, care delivery within the community wherever possible and preventing avoidable re-admission. The CRA's Making Community Rehab Data Count provides recommendations for ICBs, and others, to address the large gaps in community rehab data, vital to achieving improvements.

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The rehabilitation workforce in the community must be expanded as a priority

Workforce plans must include an expansion of staffing in community-based rehabilitation including AHPs, nurses, non-registered support workers, geriatricians, exercise professionals, local authority and social care workers, mental health specialists, social prescribers and health and wellbeing coaches. Trusts must accurately monitor and record the size, skill mix and capacity of their existing rehab workforce to support workforce planning.

Integrated Care Boards (ICBs) must prioritise the community rehabilitation workforce in their people plans and apprenticeship strategies. Where surgical hubs are being set up to manage the backlog, the rehab workforce must keep pace, to ensure people are in optimal condition for surgery and to recover as well as possible.

Advanced Clinical Practitioners for long-term conditions should play a critical role in leading service redesign, working across primary care and community services to improve integration and referrals and reduce demands on doctors.

Much of the hands-on rehabilitation provision can be delivered safely and effectively by support workers and exercise professionals. We need to upskill and grow the support worker workforce, with apprenticeships for Rehabilitation Assistant Practitioners.

More psychology roles would reduce the detrimental impact of co-morbid mental health problems that can exacerbate physical illness by improving access to psychological expertise and upskilling non-mental health staff to provide psychological support within their service.[9] The voluntary sector also has an essential role in supporting ongoing self-management of long-term conditions and reducing social isolation and have developed new roles including social prescribers and health and wellbeing coaches.

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The CRA is an alliance of 50+ health charities and professional bodies all committed to improving the provision of accessible, high-quality and person-centred community-based rehabilitation and recovery services and promoting the #RightToRehab campaign.

For further information please contact the CRA at:

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References

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