Stronger For Life: The Active Sussex Reconditioning Project

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Executive Summary

The Active Sussex Stroke Reconditioning Project was established in response to the urgent need to address hospital-associated deconditioning, a major barrier to recovery for stroke survivors and older adults with complex needs. Stroke continues to be one of the leading causes of long-term disability in England, and prolonged inactivity during hospital stays can significantly impair patients' physical, emotional, and cognitive rehabilitation. Recognising this challenge, East Sussex Healthcare NHS Trust, in collaboration with Active Sussex, Rother District Council (Active Rother), and East Sussex Public Health, developed a six-month pilot to test an integrated, community-based model of reconditioning care for patients at the Irvine Rehabilitation Unit.

At the heart of the project was the introduction of health instructors into the hospital setting, working alongside NHS staff to deliver structured, twice-weekly activity sessions tailored to stroke patients' needs. This was complemented by a system of personalised discharge planning, where each patient had a one-to-one conversation with the 20/20 Health team to assess their post-discharge needs and ensure referrals or signposting to local community groups. The project embodied a 'one workforce model', promoting collaboration across hospital and community partners to provide seamless, consistent care that continued beyond the inpatient setting.

Evaluation of the project revealed significant improvements in patient outcomes, including:

- 35% increase in physical performance (Sit-to-Stand test)
- 25% reduction in rehabilitation complexity, indicating greater independence and reduced care burden
- 21% improvement in mental wellbeing scores (WEMWBS)
- 60% increase in self-reported health confidence among patients
- reduction in fall-related harm, with no falls resulting in fracture during the pilot period.

Qualitative feedback reinforced these findings. Patients reported improved confidence, motivation, and a sense of purpose, alongside reduced social isolation and increased readiness for discharge. Staff observed greater willingness among patients to engage in physical activity and improved culture on the ward, with more proactive encouragement of movement throughout the day. Despite its successes, the pilot also highlighted ongoing barriers to sustained engagement in the community, including health-related anxieties, social isolation, transport limitations, and financial constraints. These insights are critical for shaping future commissioning, system design, and support services.

Recommendations

To ensure long-term impact and scalability, the project team identified the following recommendations:

1. Embed physical activity into inpatient and community stroke care as a standard part of the rehabilitation pathway.
2. Adopt a 'one workforce model' integrating NHS and VCSE professionals to provide consistent and holistic care.
3. Scale up the community integrated model including localised discharge pathways that include timely referrals and ongoing support in the community.
4. Address known barriers to participation, particularly access to transport, finance, and confidence for those with complex needs.
5. Utilise technology for wider scope such as livestreamed or recorded sessions to increase accessibility and reach.
6. Align with national and local strategies including the NHS 10 Year Plan.
7. Prioritise workforce development including training on deconditioning and behaviour change for all inpatient staff.
8. Implement robust evaluation frameworks using validated tools to ensure consistent measurement of functional, emotional, and confidence-based outcomes.
9. Co-design services with patient voices at the centre to improve engagement and relevance.
10. Secure long-term funding to support sustainable delivery and scale across multiple sites.

Introduction

Stroke remains one of the leading causes of long-term disability in England, often resulting in significant physical, cognitive, and emotional challenges for survivors. Among these challenges, a decline in physical function due to inactivity during hospital stays poses a major risk to recovery, independence, and overall wellbeing.

Recognising the urgent need to address hospital associated deconditioning, the Active Sussex Stroke Reconditioning Project was launched as a collaborative initiative between East Sussex Healthcare NHS Trust, Active Sussex, Rother District Council (Active Rother), and East Sussex Public Health. The project aimed to test an innovative, community-integrated model that promotes earlier and more sustained physical activity for stroke patients during and after their inpatient stay at the Irvine Rehabilitation Unit.

Drawing on national clinical guidelines, local priorities, and insights from the Live Longer Better Community of Practice & Learning, the project was designed to enhance stroke rehabilitation by embedding structured exercise into the hospital environment and ensuring continuity of reconditioning support in the community. This pilot represents a proactive shift from managing the effects of inactivity to empowering patients with the tools and support needed to rebuild function, confidence, and independence throughout their recovery.

Background

In recent years there has been significant progress made across the health and social care sector to recognise the issue of deconditioning as a clinical syndrome. We have also seen a growing awareness about deconditioning across professional organisations and medical literature, which has also resonated with NHS staff and the public.

However, there is still a major challenge around hospital-based deconditioning. The Irvine Rehabilitation Unit is keen to proactively address this risk of harm for patients and work with community partners to ensure sustained activity levels once patients leave the hospital setting. Deconditioning syndrome can be defined as the ‘condition of physiological, psychological and functional decline that occurs as a result of complex physical changes’, which happens with prolonged bed rest and the associated loss of muscle strength. Evidence shows:

- Deconditioning contributed to delayed discharge in more than 47% of older patients.

- Many older patients who were walking independently two weeks prior to admission needed help to walk when they left hospital.
- Patients spend up to 83% of their time in bed, and 12% in a chair.
- Hospitalised patients are 61 times more likely to develop disability in activity daily living (ADL) than those not hospitalised.
- Up to 50% of older people become incontinent within 48 hours of admission.
- 50% of patients experience functional decline between admission and discharge.

In England, stroke is a primary cause of long-term disability, with survivors often becoming deconditioned and adopting a sedentary lifestyle. Such a lifestyle can have serious consequences, including difficulty with daily tasks, an increased risk of falls, and a greater likelihood of experiencing another stroke or developing other cardiovascular conditions.

Evidence on the negative effects of inappropriate prolonged bed rest highlights an urgent need to shift focus from merely preventing deconditioning to actively promoting reconditioning through physical activity for all patients. With findings supporting the benefits of exercise for people with long-term health conditions, it's crucial for healthcare professionals to identify and implement effective strategies for behaviour change, share best practices, and scale up initiatives to prevent deconditioning at speed.

***"If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat."* Chief Medical Officer, 2020.**

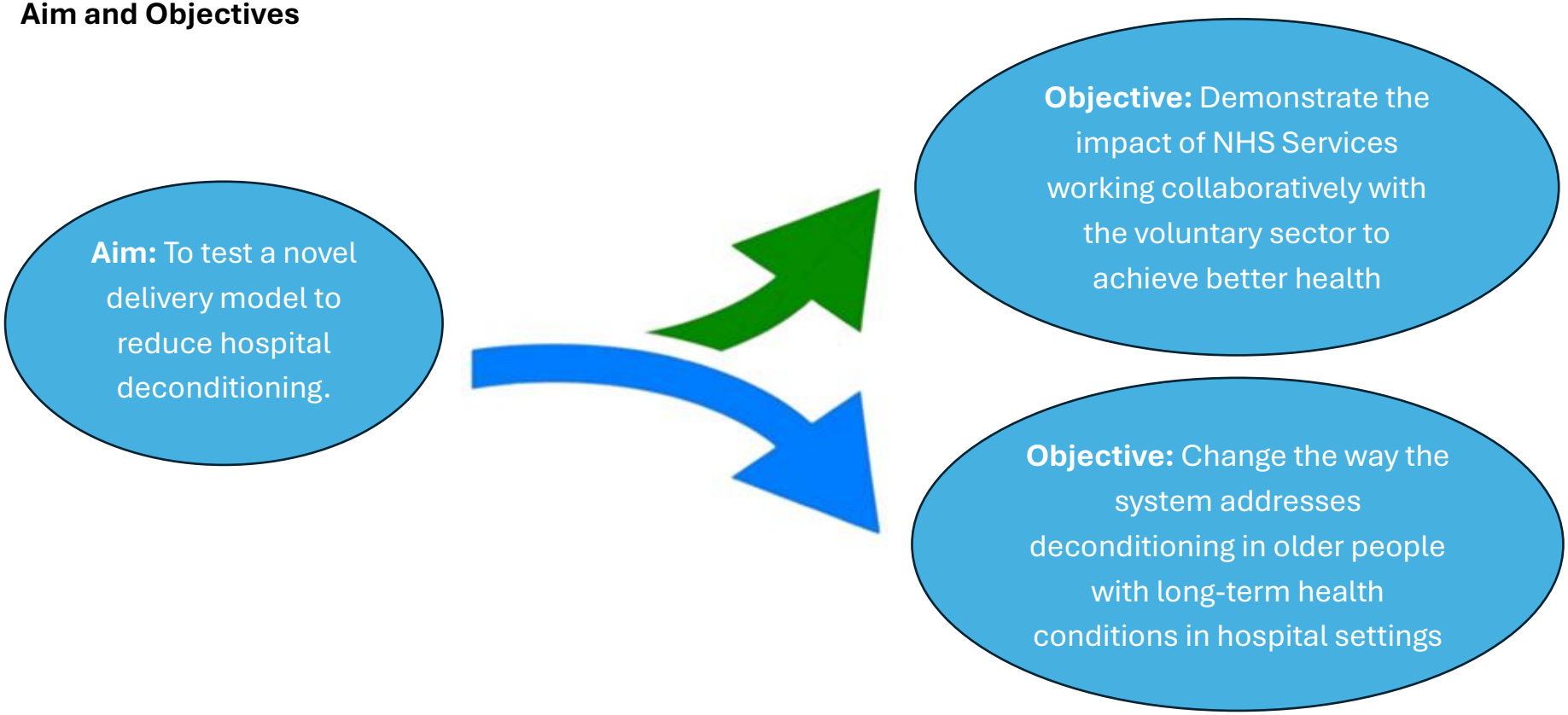
Rationale

The Active Sussex Stroke Reconditioning Project was driven by a combination of national guidelines, local innovation, and collaborative ambition. The 2023 Royal College of Physicians (RCP) Stroke Clinical Guidelines recommend delivering at least six hours of activity per day for inpatients, highlighting the urgent need to improve physical activity levels and reduce hospital-associated deconditioning. There was a shared recognition among hospital teams and community partners of the mutual need to address this issue and minimise the long-term harm caused by inactivity during hospital stays. The project also presented a valuable opportunity to pilot a novel approach to

the rehabilitation workforce, exploring new models of delivery and integration. Learning from the national Live Longer Better Community of Practice and Learning, and connections made through the Active Sussex Conference helped spark a collaborative working group to develop a test and learn approach to addressing deconditioning in a clinical setting.

This innovative approach aligns with national policy (including the NHS 10 Year Plan and community rehabilitation transformation priorities) and local system ambitions to promote personalised, preventative, and recovery-focused care. It also supports a broader Quality Improvement culture within East Sussex services, providing an opportunity to generate learning, test new workforce models, and ultimately enhance the health and independence of stroke survivors across the region.

Aim and Objectives



Methodology

To address the aim and objectives the project was undertaken through a 'quality improvement' lens that enabled partners to test an approach across health, community partnership and public health with potential learning for future commissioning. The project took on a collaborative approach with a strong commitment to co-design from the outset with a commitment to working in a multidisciplinary way to support ongoing access to activity beyond discharge. The Irvine Rehabilitation Unit's quality improvement culture allowed for a clear ambition to increase the intensity of rehabilitation offered. Additionally, the project aligned closely with broader efforts to improve long-term physical activity habits in the community, supported through wider collaboration with community-based partners in different localities across East Sussex.

Stakeholders

- **Active Sussex** – Strategic organisation working collaboratively with partners to addressing inequalities and create the conditions that gives everyone the opportunity to live active and healthier lives in Sussex.
- **East Sussex Healthcare NHS Trust** - the integrated NHS provider delivering both hospital and community care across East Sussex.
- **Rother District Council (Active Rother)** - local partnership covering the Rother district in East Sussex, coordinated by Rother District Council to support more people to be active.
- **East Sussex County Council (Public Health)** - the county's local public health authority, operating under East Sussex County Council, tasked with improving population health and reducing health inequalities.
- **20/20 Health** - Exercise referral specialists working with medical professional to improve patients' quality of life.

Intervention

Active Sussex in partnership with East Sussex Healthcare NHS Trust, Rother District Council (Active Rother) and East Sussex Public Health used £10,332 to deliver a pilot that addressed deconditioning amongst patients recovering from a stroke in the Irvine Rehabilitation Unit. Funding was used for:

- Health Instructors to deliver 26 weeks of activity within the hospital setting to groups of patients recovering from stroke and at risk of deconditioning. Sessions were delivered twice a week alongside therapists already operating within the hospital.
- Patients to be supported into community-based provision where they could continue their rehabilitation and take steps towards living a more active and healthier life with long-term habits formed around moving more.

The project wanted to build on the work already happening at the Irvine Rehabilitation Unit enhancing their activity offer through a range of approaches:

Governance

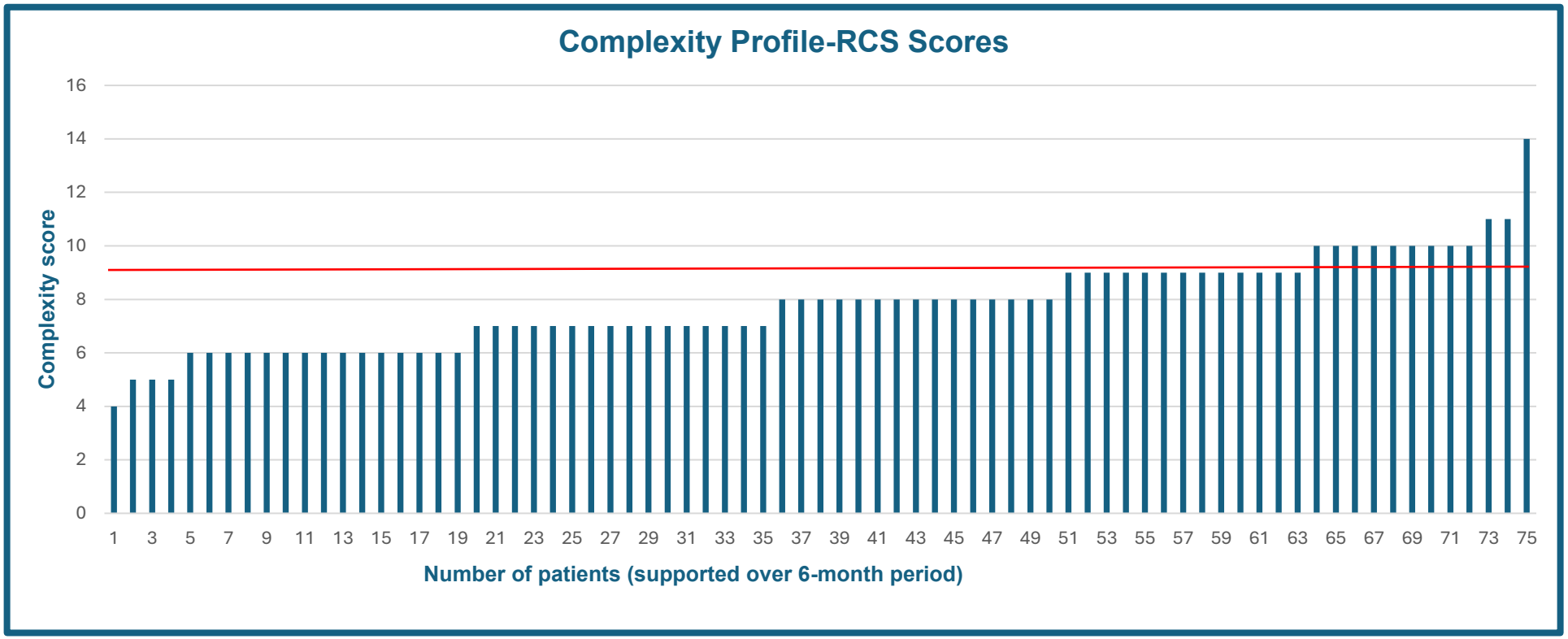
As part of the stroke reconditioning pilot, a comprehensive set of governance challenges had to be navigated to ensure the safe, effective, and sustainable delivery of the programme. Central to this was the establishment and agreement of a Memorandum of Understanding (MOU) between East Sussex Healthcare NHS Trust (ESHT) and Active Sussex which outlined roles, responsibilities, and operational parameters.

To facilitate integrated working, honorary contracts were issued to non-ESHT colleagues including community-based health instructors and support staff ensuring they were formally recognised and permitted to work within NHS settings. All non-ESHT personnel were also required to complete and sign off on mandatory training modules, aligning them with ESHT standards on safeguarding, infection control, and patient handling. Risk management processes were put in place to address potential issues around lone working, patient mobility, and cross-organisational responsibilities, while clinical governance structures were established to support ongoing reporting, quality assurance, and escalation of concerns.

Additionally, data sharing agreements were implemented to ensure patient information could be lawfully and securely exchanged between stakeholders, supporting continuity of care from hospital to community. Long-term engagement was enabled through community funding mechanisms that supported the continuation of health instructor led sessions after discharge. Addressing these governance areas early in the project was critical to its success, ensuring legal compliance, operational clarity, and a safe environment for patient recovery.

Target Cohort

Although the funding was primarily focused on older adults following stroke, as a needs led unit anybody who was identified with significant risk of deconditioning was included such as those with who have suffered a stroke, fall, brain injury, polytrauma, spinal Injury



The Irvine Rehabilitation Unit takes people with high levels of physical and cognitive complexity, and the graph above illustrates the spread where a Rehabilitation Complexity Scale (RCS) of above 9 is usually considered to be a highly specialist rehabilitation cohort. Within the group there was also people with significant frailty. No age-related exclusion criteria were applied. Patients at risk of deconditioning were identified during weekly multidisciplinary team (MDT) meetings at the Irvine Rehabilitation Unit using a dedicated inclusion screening tool. Once identified, patients were invited to participate in tailored exercise classes both within the inpatient setting. To support informed participation, individuals were provided with a project-specific leaflet alongside information from local community providers. The therapy team was responsible for completing outcome measures at both the beginning and end of each patient's inpatient stay, ensuring progress could be monitored and recorded. Upon discharge, the therapy team made formal referrals to community providers, enabling a seamless transition. These community providers then continued to support the patients through regular exercise classes offered closer to home, promoting ongoing engagement and physical recovery beyond hospital discharge.

Data Collection

A diverse range of data sources was collected to assess the impact of the project on individuals at risk of hospital-associated deconditioning. The data collection and evaluation framework were co-designed with stakeholders to ensure relevance and robustness. A combination of functional and activity-based measures was used to capture individual outcomes. In addition to outcome measures, demographic information, risk of harm indicators, and health confidence scores were gathered. The pilot also assessed the knowledge and skills of the healthcare workforce in relation to deconditioning, to understand broader system readiness.

To understand the impact of the sessions quantitative data was gathered on the following:

- **Rehabilitation Complexity Profile** - to understand and describe the complexity of a patient's rehabilitation needs, particularly in inpatient settings. It provides a simple overall measure of resource requirements for rehabilitation across the following domains:
    - Basic care and risk
    - Rehabilitation nursing
    - Therapy (number of disciplines and intensity)
    - Medical acuity
    - Equipment needs

- **Sit to Stand** - physical performance test to assess lower limb strength, balance, and functional mobility, particularly in older adults or people undergoing rehabilitation.
    - The individual sits on a standard chair, without armrests, placed against a wall for stability.
    - Arms are crossed over the chest.
    - The individual stands up fully and sits down as many times as possible within 30 seconds, without using their arms for support.
    - The number of full stands completed is recorded as the score.
- **Berg Balance Scale** - clinical tool assessing balance and fall risk in older adults and individuals undergoing rehabilitation. It is a 14-item list with each item consisting of a five-point ordinal scale ranging from 0 to 4, with 0 indicating the lowest level of function and 4 the highest level of function.
- **Risk of Falls Related Harm** - information collected about patient falls that result in some level of harm or injury as opposed to falls with no adverse outcome.
- **Warwick & Edinburg Mental Wellbeing Scale Short Version (WEMWBS)** - self-report tool designed to measure mental wellbeing in the general population and in various clinical and research settings.

All data was anonymised prior to analysis and shared with project partners in compliance with data protection protocols, supported by the Trust's Information Governance team.

To explore the sustainability of engagement, qualitative data was gathered in the form of:

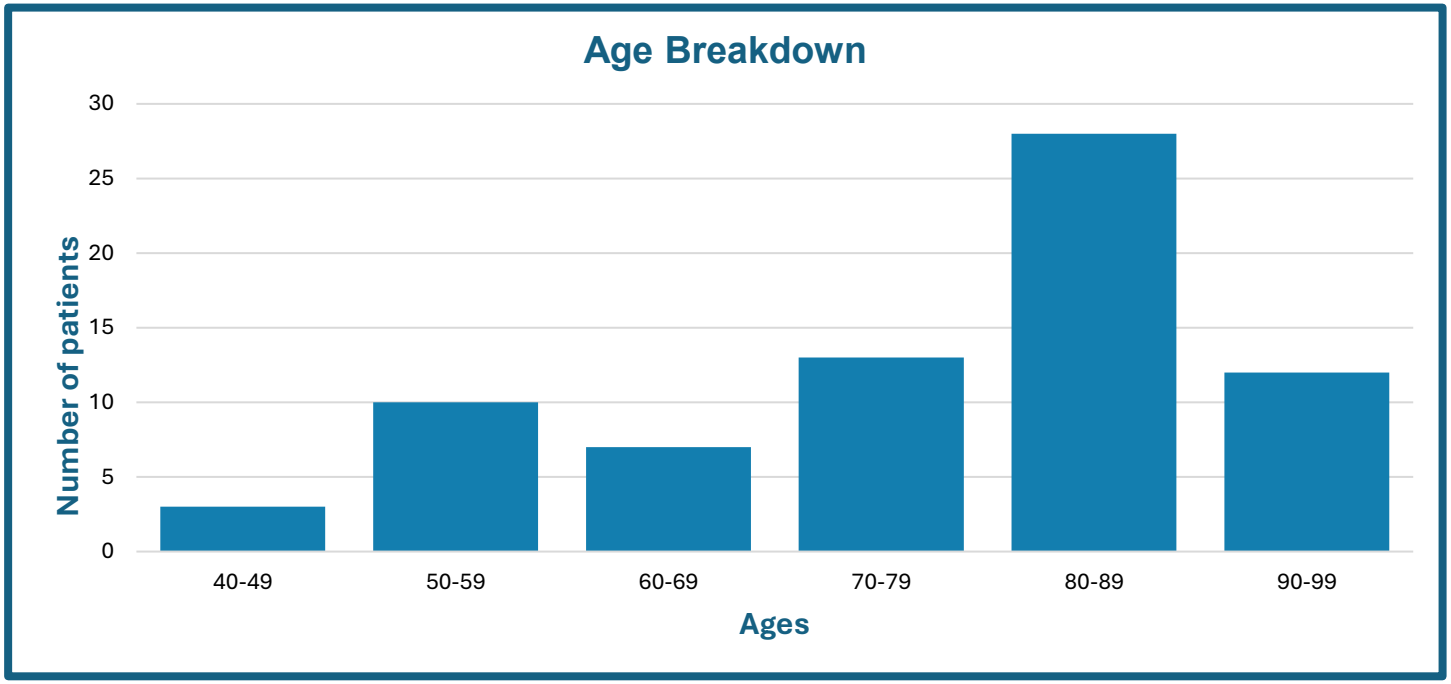
- **Patient Feedback –** At the end of the delivery patients were asked five questions to understand the impact of the sessions and the ongoing challenges to remaining active after discharge.
- **Follow-up Telephone Calls** – post-discharged conversations provided insight into continued participation in community-based activities, levels of confidence in self-management, and identified any ongoing barriers to engagement.
- **A Patient Story** – told through a video case study offering insights into personal experience and the real-world impact of the intervention. The video also involved insight from the workforce involved in the project.
- **Surveys for Nurses** – questions to gather feedback and evaluate knowledge, and confidence in addressing deconditioning, as they play a critical frontline role in promoting mobility, encouraging patient engagement, and sustaining a culture of recovery-focused care throughout the stroke pathway.

Results and Analysis

The following results present a comprehensive analysis of the project's impact on patient outcomes, highlighting improvements in physical function, mental wellbeing, and self-management confidence, as well as the broader effects on rehabilitation efficiency and workforce culture. When considering the results it is important to recognise that this pilot was conducted with the Irvine Rehabilitation Unit serving patients with moderate to high complexity of needs who were engaged in comprehensive multidisciplinary rehabilitation programmes. Accordingly, any improvements observed should be interpreted in the context of this intensive rehabilitative environment.

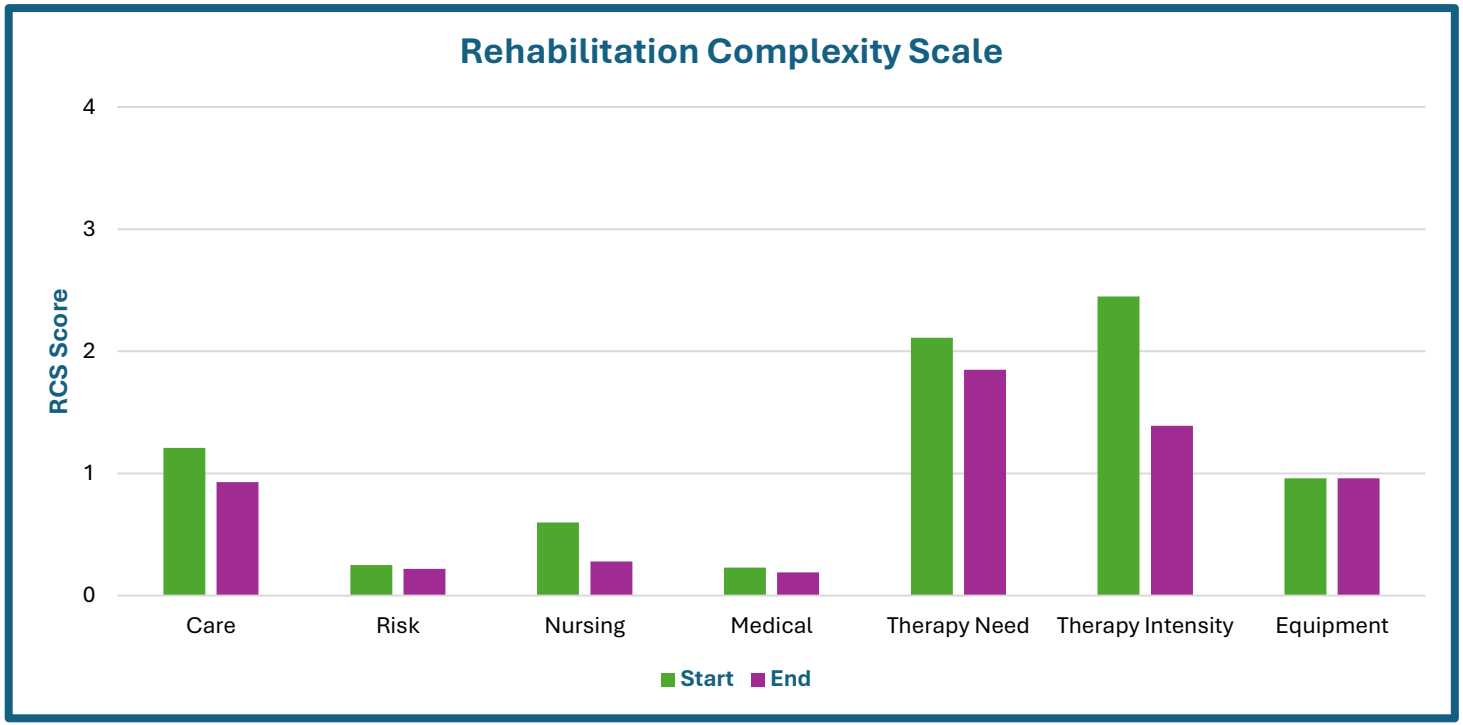
Cohort Profile

The project engaged people aged from 40 up to 97. Most participants were from older groups, with only but 3 being under 50 years of age. The largest cohort were people aged 85-89, which accounted for over a quarter of participants.



Rehabilitation Complexity Profile

The Rehabilitation Complexity Scale (RCS) provides a simple classification of rehabilitation needs of a person and the level of complexity of those needs. The graph below illustrates the domains in which the cohort group had higher scores that represented greater needs. These were care, therapy need (the number of disciplines involved) and intensity of rehabilitation. Higer scores in these domains (on admission) would also reflect those patients which the team identified at greater risk of deconditioning. The RCS was reviewed on discharge from the unit, and the change in score from admission was calculated. Across all domains, a reduction in the level of need was observed.

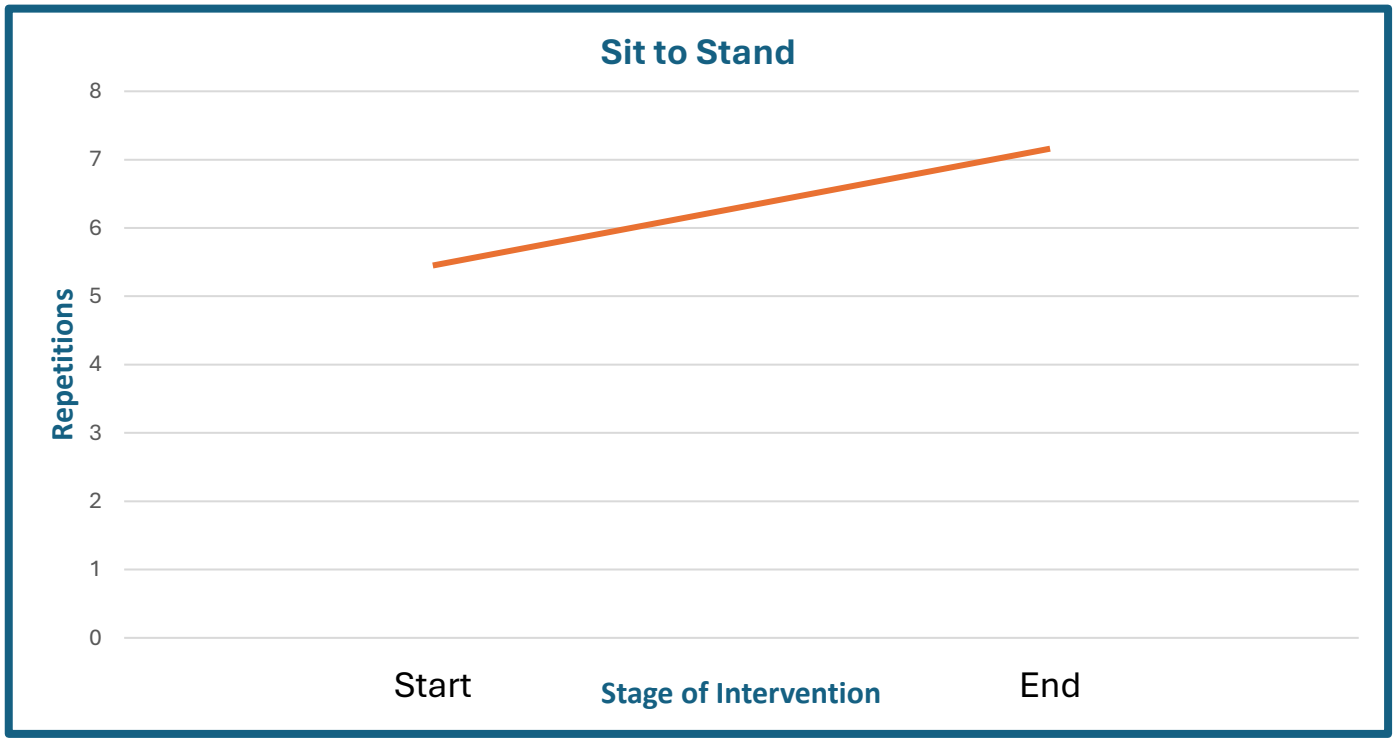


Strength and Balance

Through the pilot there was the aim to understand the changes within the patient cohort in relation to the improved confidence to move and maintain strength and balance which enabled them to feel more able to move independently on the ward. This was complemented by collecting information on the risk of falls related harm.

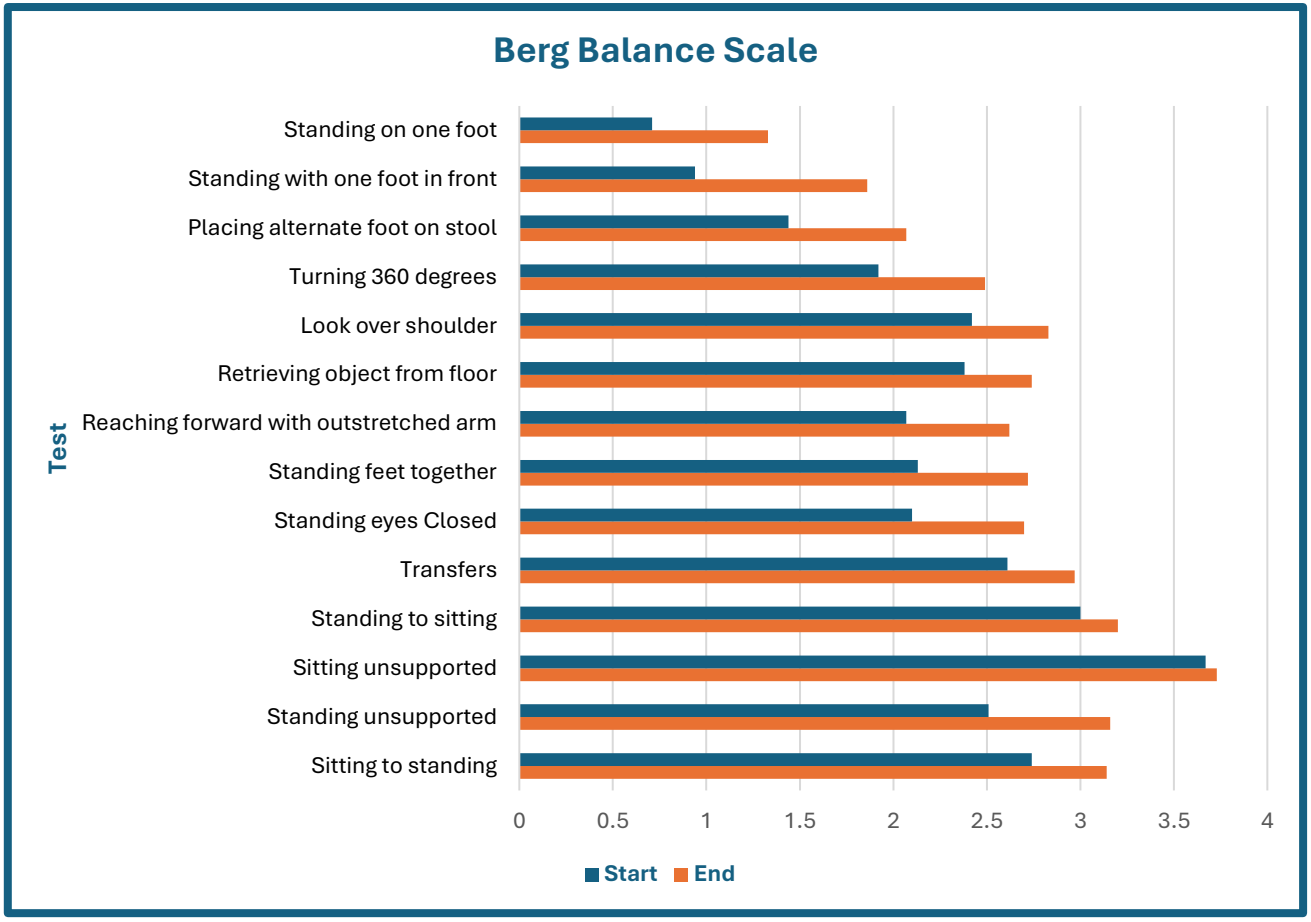
Sit to Stand

Participants were encouraged to complete as many full stands as possible within 30 seconds. The total number of repetitions that were completed was recorded. If a patient needed to use their arms to complete the test, they are scored 0. The data shows the average number of reps that were possible in the time given. The table graph illustrates an 25% improvement in the number of sit to stand repetitions that could be completed within 30 seconds. When considered alongside other activity measures it shows a general trend towards improved strength and balance.



Berg Balance Scale

Tests showed a positive increase at the end of the intervention, with 'standing with one foot in front' seeing the largest increase. 'Sitting unsupported' saw no change but had the highest levels of proficiency from the start. Scores were given between 0-4 based on competency to complete task. The scores in the table are an average for the whole group tested.

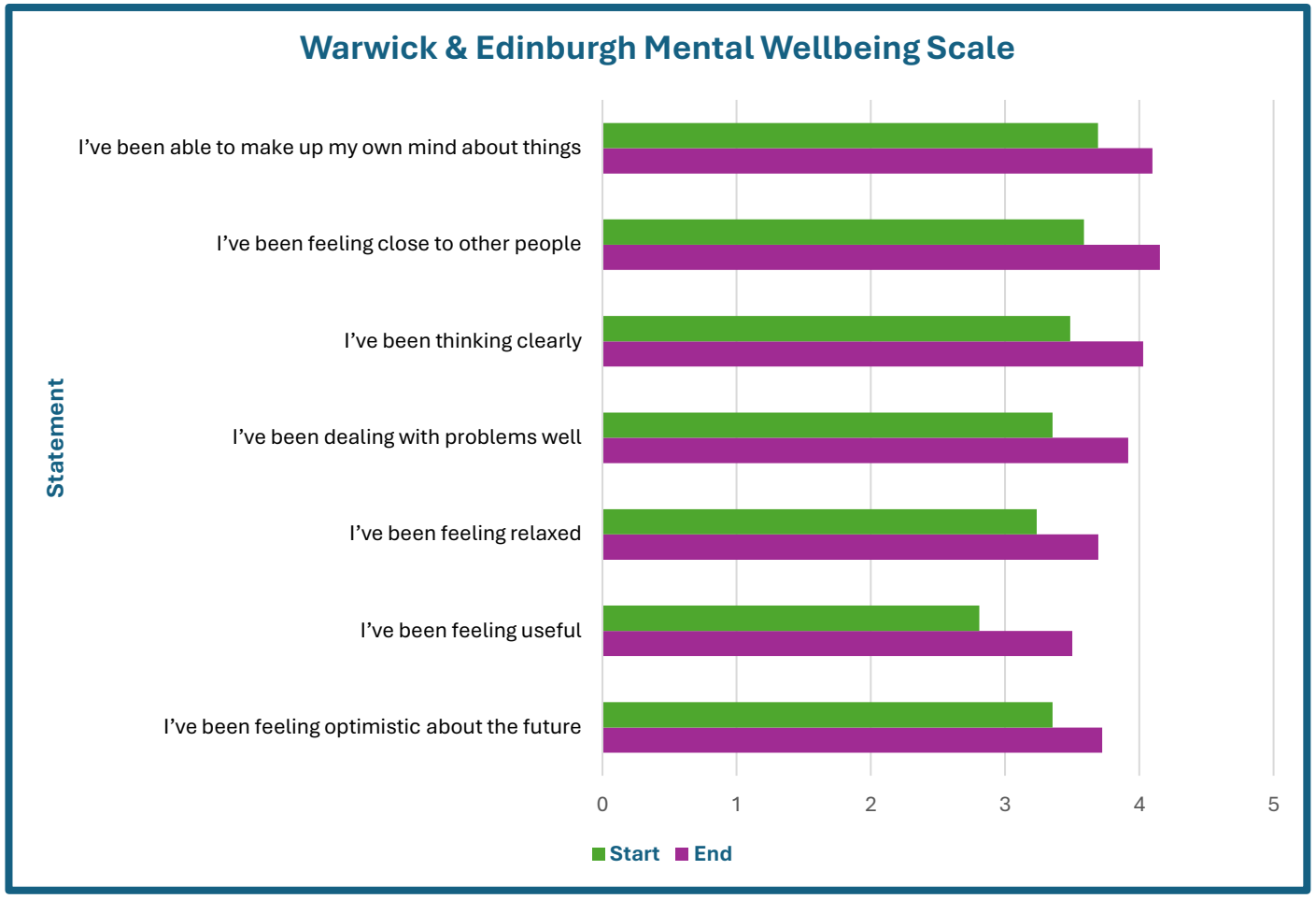


Risk of Falls Related Harm

Throughout the pilot, information was collected relating to the risk of harm caused by deconditioning with the number of falls as an indicator. These findings were correlated with improvements in the Berg Balance Scale, and whilst there was a small increase in falls during the project, it was noted that these were low level falls for these patients, with no falls resulting in harm or injury. In discussion with the clinical teams, it was felt that patients were more confident in their balance and their ability to mobilise and therefore keen to increase their independence on the unit. Furthermore, through patient feedback and follow up calls there were some emerging themes of improved confidence to move, independence to initiate exercise on the unit and at home, and reduced fear to move.

Warwick & Edinburgh Mental Wellbeing Scale (Short Version)

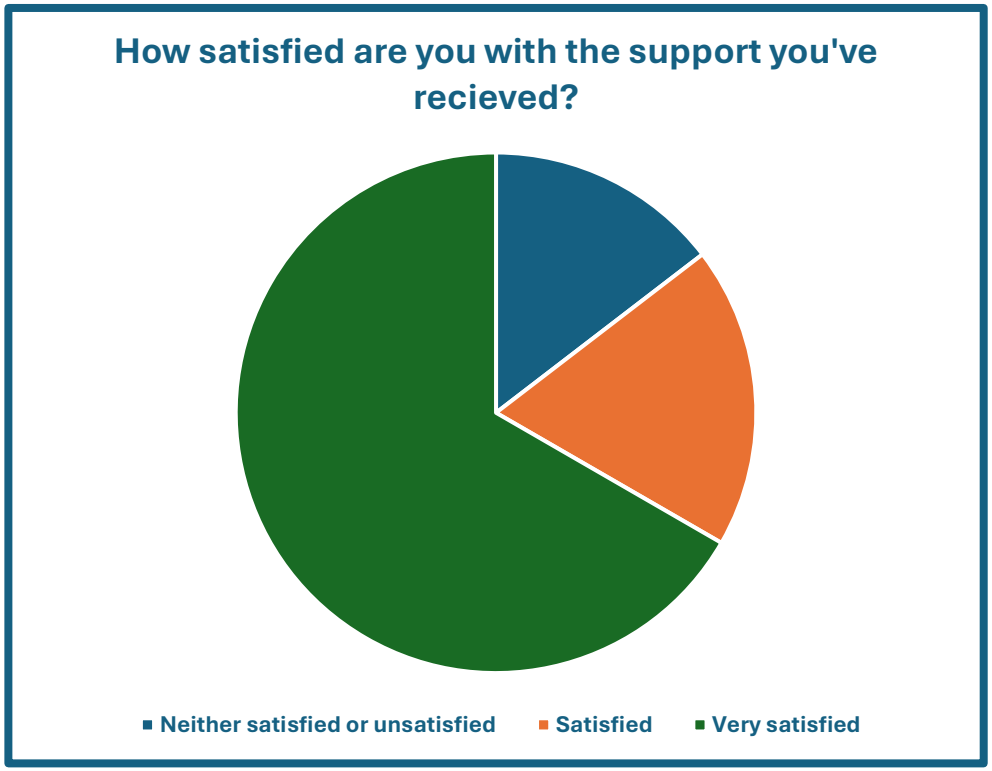
Responses were given using a 5-point scale, summed to provide a single score. All seven questions saw a positive increase at the end of the intervention, with “I’ve been feeling useful” showing the largest increase. This aligned with patient feedback about how the activity group additionally supported a sense of routine and purpose whilst undergoing rehabilitation. The nature of the exercise group was adapted to meet the different levels of capability across the participants. Rehabilitation sessions focused on relearning lost skills or learning how to adapt following physical, cognitive and social impairments which patients may find challenging. Whereas the exercise group took an inclusive strengths-based approach ensuring participation irrespective of the nature of a person’s level of impairment.

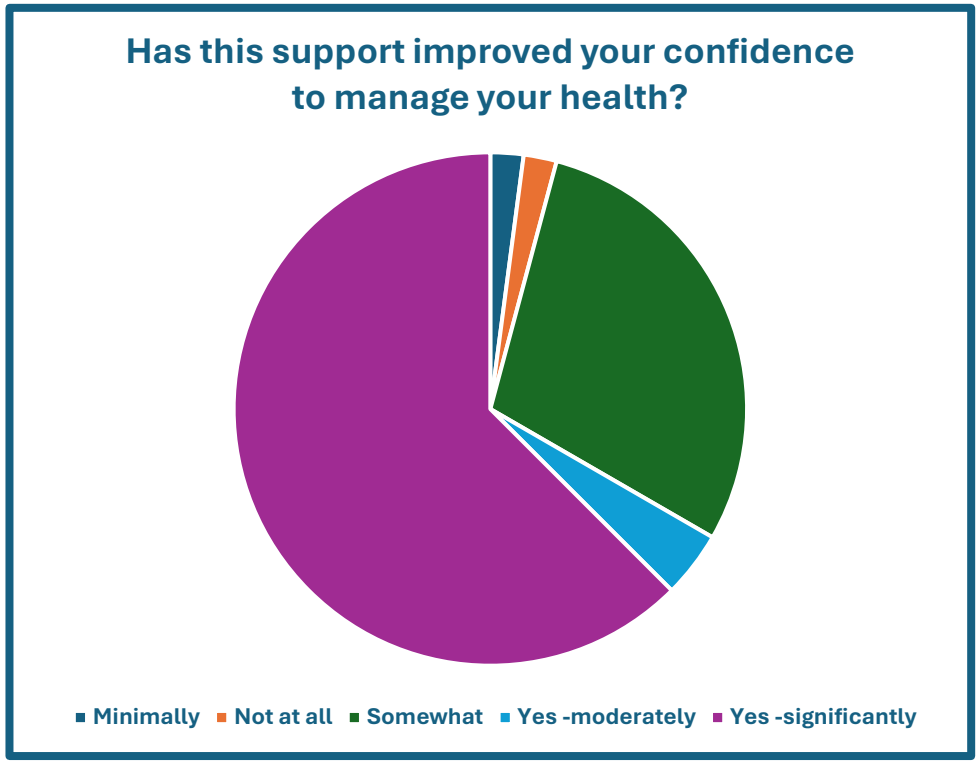


Patient Satisfaction

Patient responses to additional questions, showed a highly positive experience regarding the support they received, reinforcing the value of the intervention in promoting positive patient experiences and confidence in care.

Indications are that patients felt notably empowered and capable of managing their health following the intervention provided on the ward. At the point of discharge, these findings suggest that patients were leaving the ward with the knowledge, skills, and reassurance necessary to take an active role in their ongoing recovery and wellbeing.





Patient Feedback

Patient feedback was gathered using two ‘Likert Scale’ questions. Overall, 67% of patients reported being very satisfied with the support they received, with no reports of dissatisfaction. Additionally, 63% said the support had significantly improved their confidence in managing their health, and none reported that it had not helped.

Further open-ended questions drew the following responses –

"I really enjoy the sessions that the ladies from 20/20 health run. Before coming to the groups, I often found that my gym sessions could be a bit overwhelming as there was a lot to take in and understand. With the groups I was able to exercise in a room full of people in a similar situation to me without judgement of fear of embarrassment. After my fall I was anxious to get moving again, so once I went back to the group, I was greeted with kind words and encouragement".

"Hospitals can often be a lonely place, however the community atmosphere gave me events to look forward to and has formed friendships that has carried over following my discharge."

"My time in hospital was strange as I didn’t feel much of a connection with those in my bay, the groups gave me a chance to have meaningful interactions with patients of a similar age to me, and those with similar values.”

"The groups at the Irvine unit are simply wonderful and were a great joy when I was there. As anyone will tell you I can talk the legs off an iron chair. However so could the others in the group. I felt respected and was grateful for the time I was given to ensure I was comfortable and happy".

"I've always been a sociable person and having the chance to be able to speak to new and friendly people every week was a blessing. The loneliness you can feel whilst in hospital can be overwhelming, but the smallest bit of kindness can make a world of difference, and that's exactly what the groups did for me".

"All the groups at BIU were a laugh. Luka and the ladies from 20/20 Health were a joy to be around and gave me and the other patients a reason to get out of bed and get moving".

Patient Story

A short video[1] presents an overview of the project and the impact on a patient capturing the emotional and practical effects of the intervention from their perspective. It also features reflections from staff members who contributed to the project, offering a broader view of its impact on both care delivery and outcomes.

Follow-up Telephone Calls

Follow up calls were made with 48 patients responding. Those that didn't respond either declined phone calls, were unable to be contacted, or could not provide reliable responses. Conversations provided insight into continued participation in community-based activities, levels of confidence in self-management, and identified any ongoing barriers to engagement. While it should be acknowledged that this can lead to survival bias, overall, there were positive responses. The following themes emerged from the feedback.

What did the sessions do for you ahead of being discharged?

1. Greater confidence
2. Greater level of fitness
3. Greater knowledge and understanding of how to remain conditioned
4. Greater sense of purpose

What were the challenges you faced on returning home?

1. Continuing to exercise in the same way on my own
2. Persisting health issues
3. Isolation and dependence
4. Getting out and about

What are the enablers to being active in the community?

1. Maintaining a support network
2. Access to knowledge and resources
3. Accessible local sessions
4. Regular touch points with activity providers

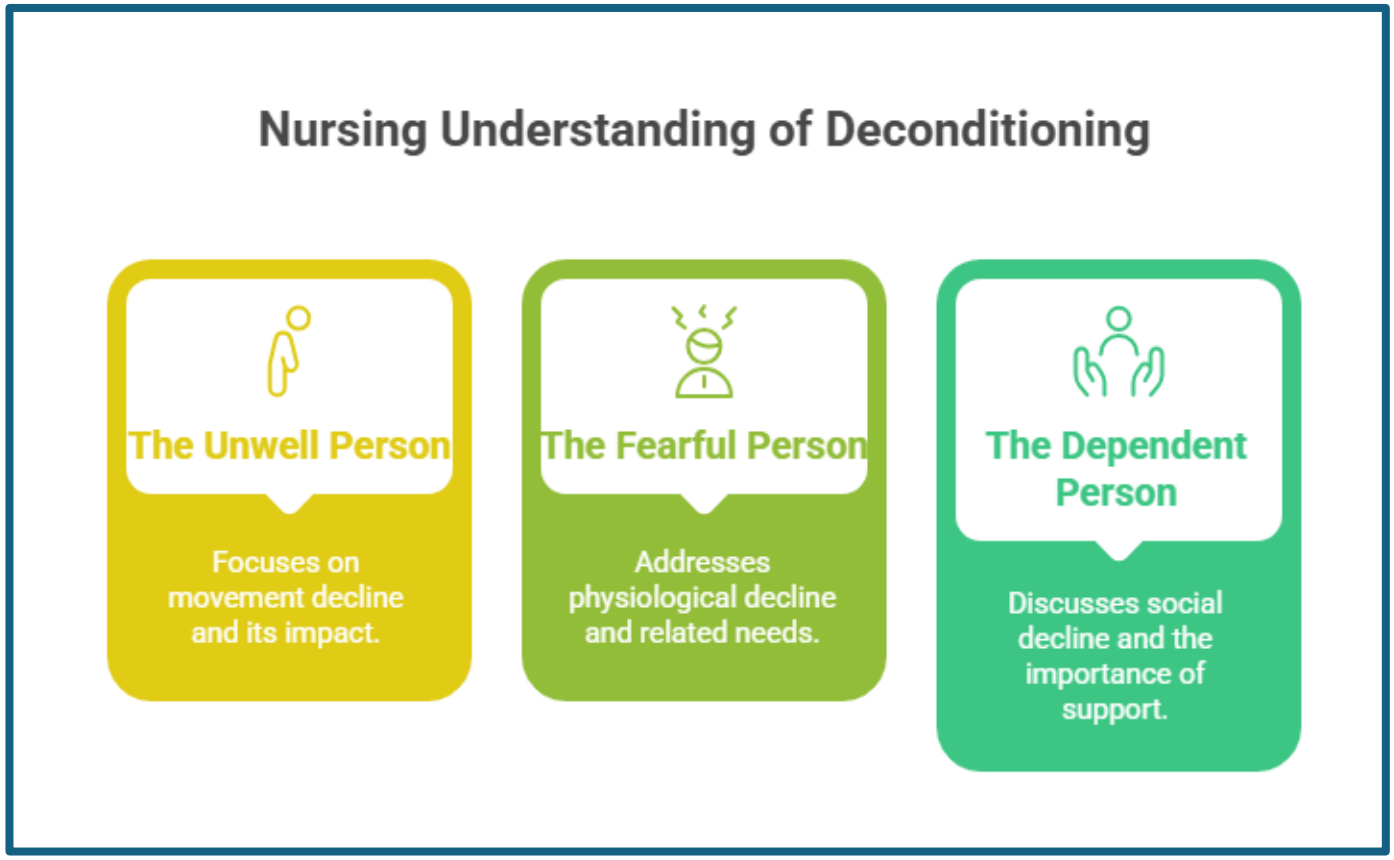
What are the barriers to being active in the community?

1. Finance (cost of other activities in my area and travel to get to sessions)
2. Transport links
3. Fear and anxiety regarding health conditions
4. Accessibility

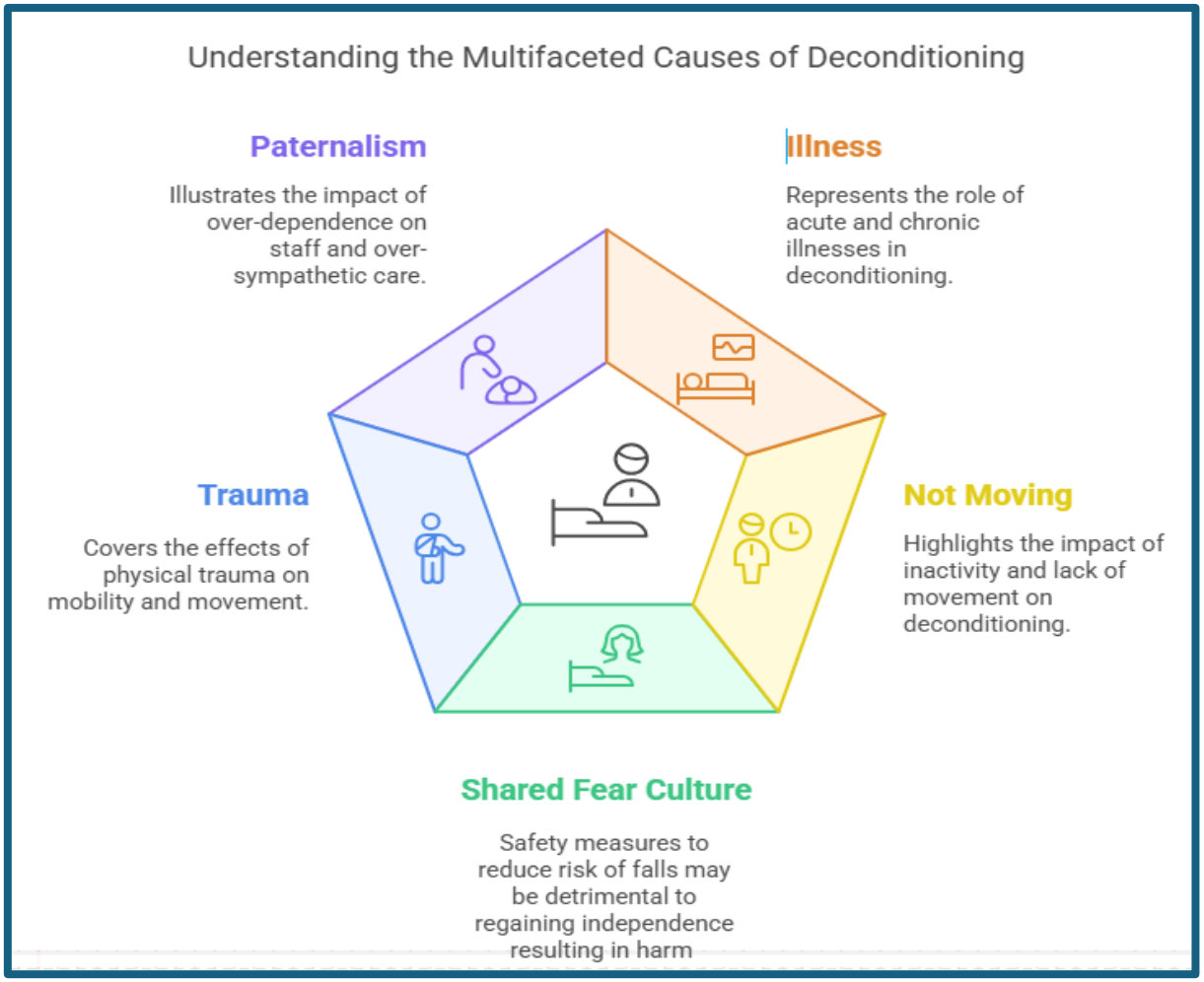
[1] Unlocking Stroke Recovery: The Power of Exercise

Surveys for Nurses

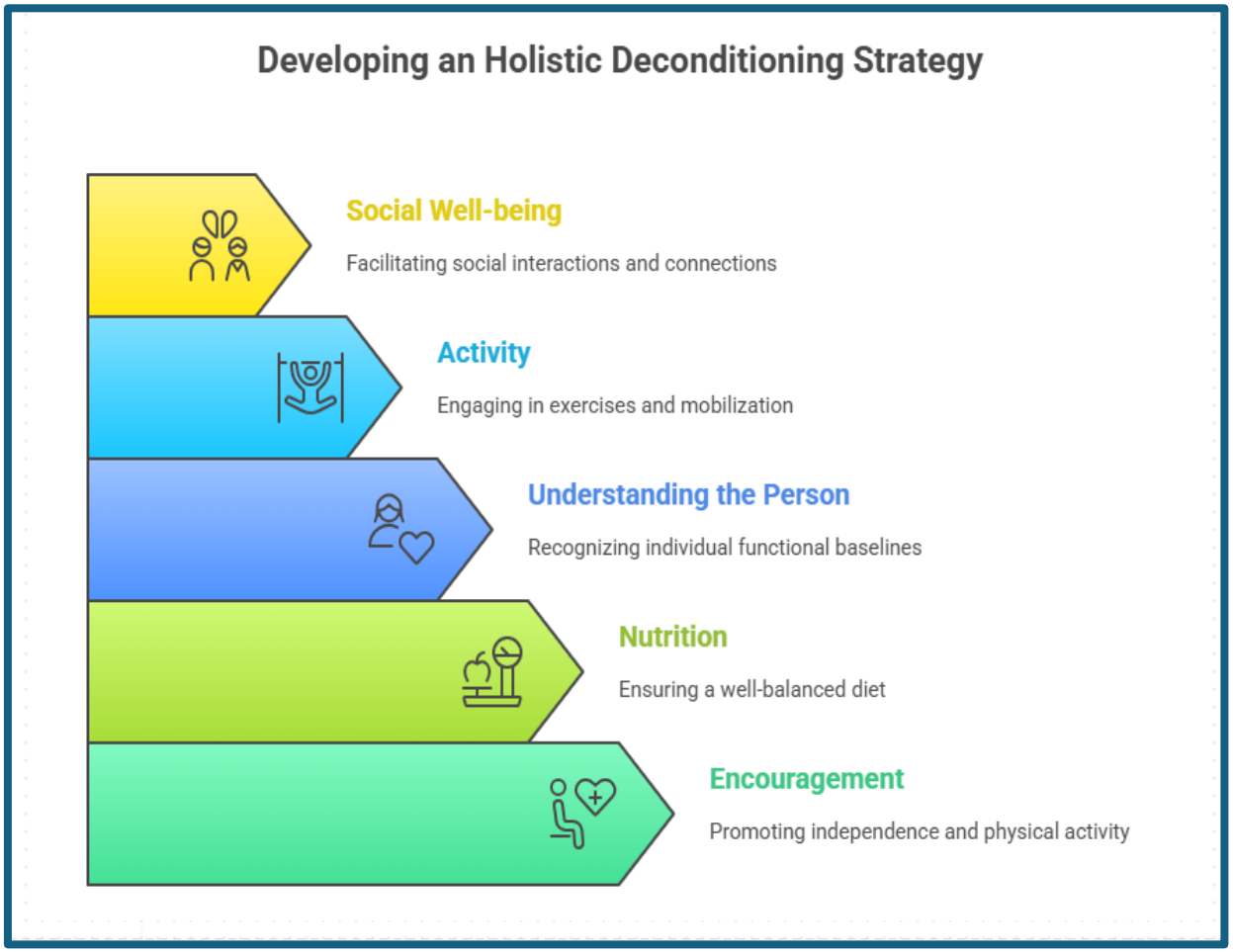
Surveys of 20-night staff (Band 3-6) were completed, and their feedback was explored. Emerging themes were shared back with the team to understand how theses may inform training needs for staff. The nursing teams also gave feedback on important considerations for how the Irvine Rehabilitation Unit should approach the risk of deconditioning in the future. The feedback from nursing colleagues on their understanding of the causes of deconditioning were described in the following way.



They were underpinned by aspects of the persons situation such as illness and trauma, as well as the contribution of longstanding paternalistic healthcare behaviour resulting in a shared fear culture resulting in people not moving.



Below is the future approach to which the staff want to adapt the way they support individuals and the solutions in reducing deconditioning at ward level.



Outcomes and Impact

The project delivered support for 75 patients in a six-month period through an additional 54 exercise sessions, where each person achieved at least 9 hours of additional activity per stay.

There was improvement across the board when it came to the physical tasks in the Berg Balance Scale, with results correlating with the information gathered on the risk of Falls Related Harm which showed low level falls for patients and no falls to fracture occurring during the pilot phase showing a reduction in falls overall.

Additionally, the results from the additional questions were reinforced by recurring themes reported by participants regarding how the pilot supported their confidence, fitness, understanding and sense of purpose. Together these findings reflect the multidimensional benefits of the intervention, particularly in fostering motivation, capability, and ongoing engagement in health-promoting behaviours.

The following outcomes also showed significant impact following the initial intervention:

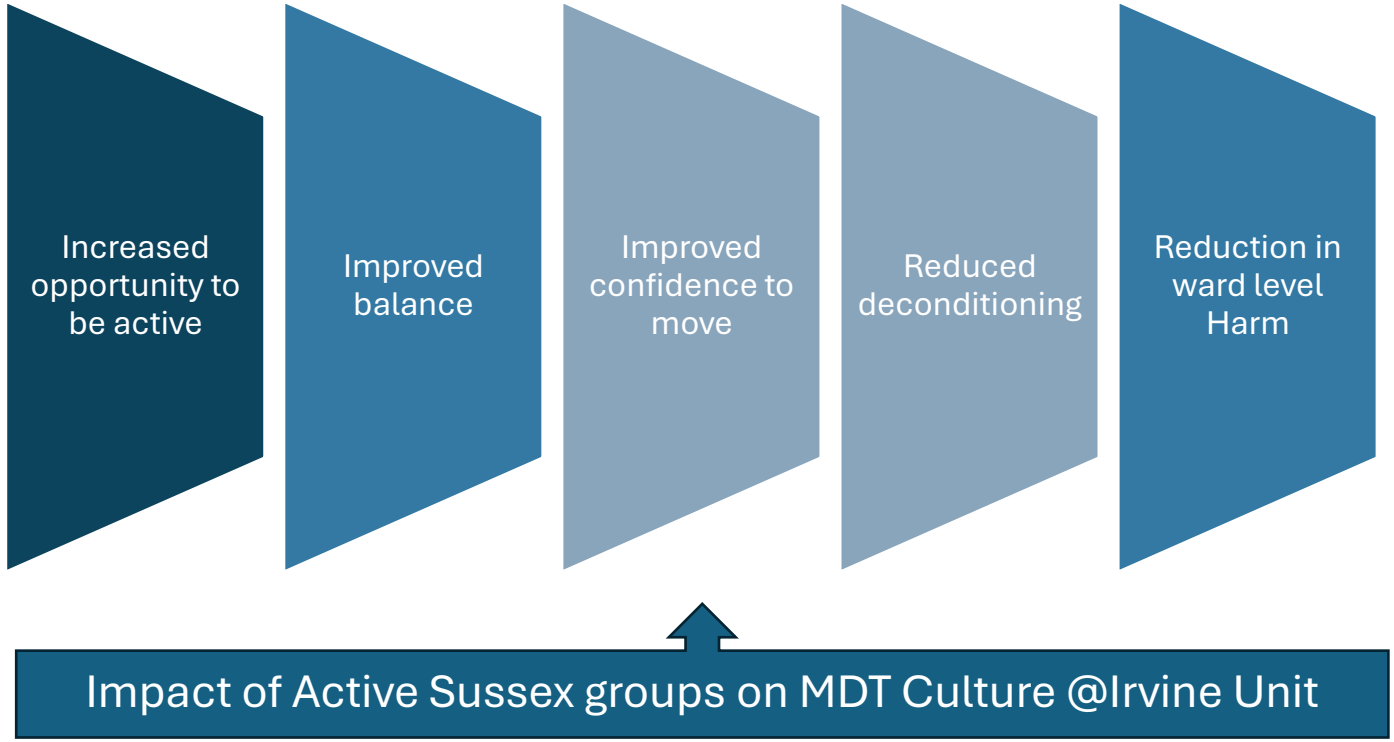
- 35% increase in Sit to Stand
- 25% reduction in Rehabilitation Complexity
- 21% improvement in the Warwick & Edinburg Mental Wellbeing Scale

The pilot showed an increased opportunity for patients to be active, improving their balance and confidence to move on the unit. This also led to a shift in ward culture, with staff more aware of periods of patient inactivity. This understanding was enhanced by nursing teams' shared perspectives on deconditioning, leading to a deconditioning strategy.

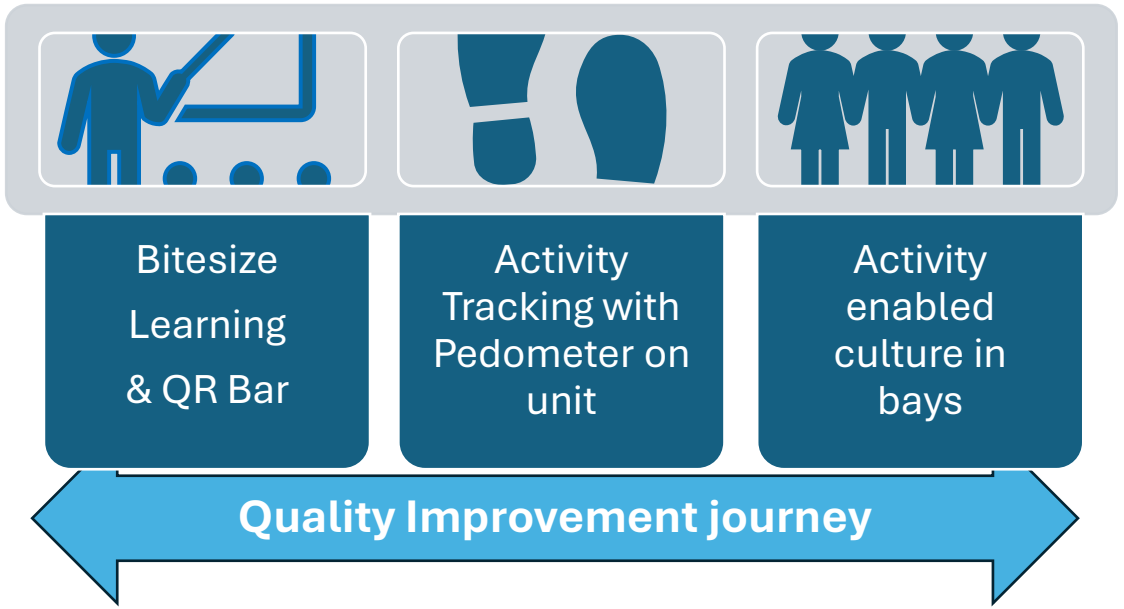
Clinical teams reported that patients were more confident in their balance and ability to move and were more motivated to increase their independence. This aligns with patient feedback, which showed a 60% increase in health confidence. Patients also had less fear of movement and were more independent in exercising both on the unit and at home.

At discharge, all patients had one-on-one conversations with the 20/20 Health team to discuss post-discharge needs. Individuals were referred to local community resources like strength and balance sessions, seated exercise classes, and walking groups. While most patients felt the program increased their confidence to be active at home, improved exercise tolerance, and reduced social isolation,

some faced barriers to continuing with community groups, including ongoing medical conditions, social isolation, transportation, and financial issues.



Since the start of the project the Irvine Rehabilitation Unit has set up bitesize learning training on deconditioning and have access to evidence-based information as part of developing the workforce knowledge and skills. There is also a commitment to undertaking further 'Quality Improvement' projects looking at patterns of activity in patients during the day. The unit has already introduced a programme of activity that happens in the bays including singing, chair seated yoga and creative activity sessions. There are also plans to explore the implementation of an activity tracker pedometer within the unit.



A ‘one workforce model’ has been central to the success of this stroke project, ensuring that hospital staff and community-based health instructors are seen by patients as a united team working collaboratively to support recovery and long-term condition management. By integrating health instructors into the hospital setting, patients experience a seamless transition between clinical care and community-based rehabilitation, which helps build trust, reduce anxiety about discharge, and reinforce consistent health messaging. This unified approach not only enhances patient confidence and motivation but also fosters a more sustainable recovery pathway by embedding community support early in the rehabilitation journey. There is unified agreement from all stakeholders involved that the project has been a fantastic starting point on which to address the challenge of deconditioning within inpatient settings and through that transition back into the community.

“One of the key things we have really enjoyed about this pilot is partners working collaboratively to deliver the project. It’s been a great way to test out all those strengths of the different partners and how they come together to help us deliver something that’s much better for patients. This project will offer our system in Sussex a really great opportunity from which to build on how we work much better with our community partners.” **Karen Poole, AHP Rehabilitation Consultant, ESHT.**

“Having somebody else based in that community setting can give you a better idea of what’s going to happen after they leave. This reinforces our clinical understanding. It’s one thing understanding how many sets of stairs someone can do, but as soon as someone gets home, they are faced with new challenges that we in an inpatient setting don’t see. It’s nice to know more about that continuation and it further develops our practices in the clinical setting.” **Luke House, Associate Practitioner, ESHT**

“It’s been really good to individuals going through their recovery and needing our help less. We are seeing patients now coming into the community and doing some of our exercise session. Just seeing that process that they go through and that progress that they make from coming into the stroke unit to then coming out into the community is fantastic”. **Jas Gray, Exercise Instructor, 20/20 Health**.

"The Active Rother Partnership programme recognises the importance of reducing inactivity amongst residents. We were delighted to be a partner in this exciting approach to reducing the risk of deconditioning amongst stroke patients. This project has recognised how through being more active and working together collaboratively, we can play a significant role in improving health and wellbeing outcomes amongst our local population." **Stuart Ramsbottom, Active and Healthy Communities Specialist, Active Rother.**

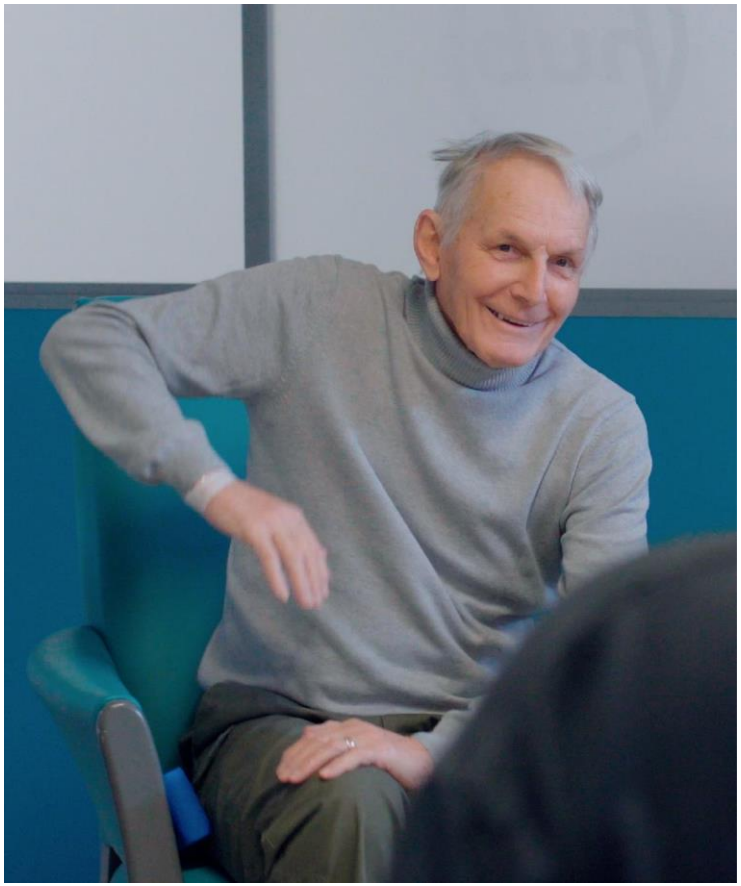
"This project has shown the real power of collaborative working across health and the community voluntary sector. By aligning our expertise and resources, we've been able to offer more holistic and personalised support to patients at risk of deconditioning, both in hospital and at home. Going forward, this kind of integrated partnership working is essential if we want to achieve better health outcomes, reduce inequalities, and build truly preventative, community focused healthcare." **Ross Joannides, Strategic Relationship Manager, Active Sussex.**

Recommendations

Based on the outcomes and learning from the pilot, the following recommendations have been identified to support the future development, scaling, and sustainability of the reconditioning model.

1. **Embed Physical Activity into Stroke Rehabilitation Pathways**
   Physical activity should be treated as a core clinical intervention, not a supplementary activity. Embedding structured movement and exercise into inpatient care is critical to preventing deconditioning and promoting recovery.
2. **Adopt a One Workforce Model**
   Promote integrated team-based working between hospital staff, community health instructors, and VCSE partners. Patients benefit when support is consistent across hospital and community settings, reducing anxiety and improving continuity of care.
3. **Scale the Community-Integrated Model**
   Expand the use of community-led physical activity sessions post-discharge, ensuring timely referrals and warm handovers. This promotes sustainable reconditioning and reduces dependency on inpatient rehabilitation.
4. **Address Known Barriers to Participation**
   Tackle transport, social isolation, and financial constraints by providing local, low-cost or free activity options and improving accessibility to community venues. Work with local authorities to create inclusive environments for recovery.
5. **Utilise Technology for Wider Reach**
   Invest in digital and livestream activity options to reach patients unable to attend in person, particularly those with mobility or transport challenges. Ensure digital literacy support is available where needed.
6. **Align with National and Local Strategies**
   Ensure future project phases are explicitly aligned with the NHS 10 Year Plan, and Integrated Care System (ICS) priorities to strengthen sustainability and attract further funding.

7. **Prioritise Workforce Development**
   Build on the success of staff training and cultural shifts by continuing education around deconditioning, reconditioning, and activity-based care. Expand access to learning tools and quality improvement support.
8. **Implement Robust Evaluation Frameworks**
   Continue using tools like the Rehabilitation Complexity Scale, Berg Balance Scale, Sit-to-Stand Test, and self-management assessments to monitor outcomes. Evaluation should be built into all future phases for impact tracking and scaling decisions.
9. **Co-Design Services with Patients**
   Use patient feedback and lived experience to shape ongoing service development. Involving patients in design leads to more relevant and effective interventions, and strengthens motivation to remain active.
10. **Secure Long-Term Funding**
    To scale and sustain the model, explore blended funding approaches from NHS, public health, adult social care, and VCSE partners. Emphasise the cost savings linked to reduced rehab complexity, improved outcomes, and fewer readmissions.



Stroke Reconditioning Pilot (Phase 2)

Following the successful completion of the initial pilot, plans were made to scale up the intervention looking at resources available across ESHT and other NHS Trusts in Sussex.

Next Steps

The aim is to build on the initial learning by exploring the methodology and enabling conditions required to deliver an activity-based programme in inpatient settings using digital or livestream formats. The second phase of this project will be funded by a £6,000 grant from East Sussex Adult Social Care & Health. The department is eager to collaborate with partners to advance key priorities from their Social Care Strategy, 'What Matters To You' and the East Sussex Adult Social Care Prevention Strategy. They are also keen to align resources and help scale up this project, which they believe will enable individuals to recover function sooner through hospital and community-based physical activity, ultimately reducing long-term care dependency. They are keen to align resources and support the scaling up of this project which they see as enabling individuals to recover function earlier, through a pathway of hospital and community-based physical activity, reducing long-term care dependency. There is also an understanding that embedding physical activity into care pathways in a way that this project does, ensures movement is seen as a core part of sustaining health, not a secondary offer. The objectives of Phase 2 are to:

- Explore opportunities for cross-sector collaboration in delivering livestreamed activity sessions
- Identify the infrastructure, workforce, and operational conditions necessary for success
- Define governance arrangements that enable voluntary, community, and social VCSE partners to be embedded in a 'one workforce' approach through both in-person and virtual models
- Evaluate how livestreamed activity sessions can enhance access to movement opportunities in bedded care environments
- Assess the return on investment (ROI) of this collaborative delivery model across multiple organisations
- Identify proactive, sustainable pathways for embedding physical activity habits into community life post-discharge.

Work will be done to reach out to activity providers in localities where patients are being discharged. This will include local leisure providers, wellbeing teams embedded within tier-two local authorities, and independent providers with the qualifications and expertise to support patients discharged from hospital with multiple long-term health conditions and symptoms. A relationship will be established with a clinical lead in each hospital setting and the activity provider to ensure a safe and appropriate referral that reducers the fear and risk of the patient not engaging once discharged. There will also be an exploration with Integrated Neighbourhood Teams (INTs) to better understand if they can play a role in supporting patient discharge and improving post-discharge care through community-based activity sessions.

Further Rationale for Next Steps

The **Fit for the Future": NHS 10 Year Plan**[2] is a bold, long-term strategy which aims to change the way the system operates and supports patients. Aligning the stroke project with the NHS 10 Year Plan is essential to ensure the service reflects national priorities around prevention, personalised care, and integrated community support. It also strengthens the project's sustainability by embedding it within wider system goals for improving outcomes and reducing health inequalities in rehabilitative care.

1. **Shift from Hospital to Community**

   NHS Strategy Objective: "Move care closer to home through Neighbourhood Health Centres and reduce dependency on hospital beds."

   Project Alignment:

   - The project builds a structured discharge pathway, transitioning patients from inpatient care at the Irvine Rehabilitation Unit into community-led physical activity sessions in East Sussex.

[2] Fit for the Future: 10 Year Health Plan for England, https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

- Health instructors bridge hospital and community care, supporting continuity of rehabilitation outside clinical environments.
- The model directly reduces inpatient rehab burden while maintaining gains freeing up capacity in hospitals and preventing re-admissions.

2. **Analogue to Digital Transformation**

   NHS Strategy Objective: “Deliver digitally integrated care, using the NHS App and real-time data.”

   Project Alignment:

   - Future plans include ‘Phase 2’ digital and livestream expansion, enabling remote rehab support, directly supporting NHS ambitions around digital scaling of preventative and therapeutic services.

3. **Sickness to Prevention**

   NHS Strategy Objective: “Shift from reactive care to prevention and reconditioning; support healthier ageing.”

   Project Alignment:

   - The project targets deconditioning proactively, addressing it as a preventable set of symptoms.
   - Focus on early, low-risk movement interventions reduce the risk of falls, incontinence, and stroke recurrence.
   - It supports functional independence, helping stroke survivors avoid long-term care needs and repeat hospitalisation.

4. **Integrated and Collaborative Workforce**

   NHS Strategy Objective: “Promote new models of team-based working including with VCSE partners and skill-mix innovation.”

   Project Alignment:

   - The partnership between NHS Trusts, Public Health, Active Sussex, VCSE partners, local authorities mirror the model promoted in the NHS plan.
   - Health instructors are new, flexible roles supporting therapy goals without requiring clinical staff time consistent with workforce expansion aims.
   - Staff at the BIU reported a positive cultural shift and greater confidence in promoting independence.

5. **Outcome-Focused Innovation**

   NHS Strategy Objective: “Pay for outcomes, scale what works, and spread innovation through evaluation.”

   Project Alignment:

   - A robust evaluation framework included Rehabilitation Complexity Scale, Berg Balance Scale, Sit-to-Stand, Warwick & Edinburgh Mental Wellbeing Scale, and Self-management Assessment Scale.
   - Outcomes demonstrated reduced rehab complexity, improved mobility, confidence, and mood showing tangible return on investment.
   - The model is scalable, costed, and underpinned by a replicable framework which is ready for wider adoption.

6. **Tackling Inequality and Enhancing Access**

   NHS Strategy Objective: "Reduce inequalities in access to health services and improve experience in underserved communities."

   Project Alignment:

   - The program is delivered in an area with higher deprivation and stroke risk.
   - Engaged patients aged 40 to 97, with a focus on older adults, frailty, and complex needs.
   - Prioritises personalised rehab goals and social inclusion, especially for those at risk of isolation or dependency.

Unlocking the Power of Movement in the NHS

In 2025, NHS England published their 'Four Ways Forward: Unlocking the power of movement in the NHS'[3] with the aim of harnessing the benefits of physical activity in healthcare. Further evidence that the benefits of physical activity for prevention, management and treatment are substantial for conditions currently most associated with economic inactivity, like mental health and musculoskeletal health, but also multi-morbidities. Conversely, physical inactivity, which is associated with inequalities in health outcomes, impacts on the demand on NHS services. The evidence for the positive impact of regular small amounts of exercise in the prevention and treatment of common conditions is overwhelming. The scaling up of the Stroke Reconditioning Project will remain aligned to the 'Four Ways Forward':

1. Empowering health and care professionals
2. Integrating physical activity into clinical pathways
3. Supporting the NHS workforce
4. Supporting innovation and evaluation with partners

[3] Four Ways Forward: Unlocking the power of movement in the NHS, Unlocking the power of movement in the NHS | Sport England

Conclusion

The Active Sussex Stroke Reconditioning Project proved the impact of physical activity and community integration in stroke recovery. By targeting hospital deconditioning, the project improved functional mobility, wellbeing, and confidence. A unique model, introducing health instructors to wards, created a collaborative approach with NHS staff and community partners, offering consistent messaging and support from hospital to home and boosting patient engagement and readiness for discharge. This "one workforce model" bridged the gap between clinical care and long-term support, making reconditioning a shared priority.

Positive outcomes were both quantitative and qualitative. The project led to improved lower limb strength, reduced rehabilitation complexity, and higher wellbeing scores. Patients reported increased confidence, social connection, and a renewed sense of purpose. Staff surveys also showed a shift in attitudes, fostering a more proactive culture where movement was actively encouraged. The project also identified both factors that enable and those that hinder sustained activity post-discharge. While many patients successfully joined community sessions, barriers like health anxiety, transport, and financial issues remain.

This pilot, which aligns with NHS strategy, offers a scalable model for tackling deconditioning in other settings. The evidence strongly supports continued investment and expansion, including digital and livestream innovations proposed for ‘Phase 2’. The approach has not only improved individual patient outcomes but has also begun to shape a new culture of integrated, prevention-focused rehabilitation in Sussex. It positions physical activity as a core clinical intervention rather than an optional add-on in stroke care and beyond and serves as a strong foundation for future system-wide transformation, where movement and reconditioning are at the heart of recovery.