

Healthy Ageing

Top tips for best practice guide

Rehabilitation for older adults during and post COVID-19:

September 2020

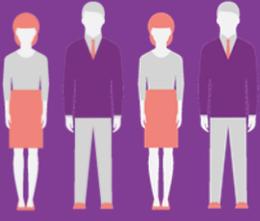
This top tips for best practice guide, has been developed for health and social care professionals and those commissioning rehabilitation services for older adults living in Wessex. The guide offers a 'one stop shop' approach derived from national literature searches and supplemented with real-world case examples from clinicians in Wessex and further afield. You will find links to resources, case examples and networks that have emerged during the first six months of the COVID-19 pandemic.

Wessex Academic Health Science Network Limited (WAHSN) has undertaken the horizon scanning activity in goodwill for the purpose of improving healthcare services and has no commercial interest in any of the information presented. Wessex AHSN's research activity is not intended to include an exhaustive list of resources and Wessex AHSN are not responsible should there be a relevant resource or link produced that has not been identified and reported in this document.

We intend this document to be updated as new best practice examples emerge. For further information or to share your best practice examples with us, please contact our Healthy Ageing team healthyageing@wessexahsn.net.

Top tips for best practice	Examples including toolkits, resources, case studies	Description of resource	Further information
<p>1. Review nationally and locally available NHS toolkits and resources</p> 	Resource list, links, and articles	A table of key emerging resources and links for quick reference, combining national and local resources and highlighting some of the articles of interest that have been written during the first six months of the COVID-19 pandemic (March 2020 – August 2020), compiled by Wessex AHSN.	Emerging resources and links list
	Webinar	NHS Acute Frailty Network: Reducing the impact of deconditioning during the COVID-19 pandemic , evidence based top tips from a webinar run by the acute frailty network.	Reducing the impact of deconditioning
	Download Toolkit	The NHS Right Care Community Rehabilitation Toolkit published March 2020. Toolkit providing system improvement priorities, guidance, and a community rehabilitation self-assessment tool to assess and benchmark current systems, helping find opportunities for improvement.	https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf

<p>2. Post COVID-19 rehabilitation will be complex and require multidisciplinary multiagency working</p> 	<p>Case example</p>	<p>NHS Seacole Centre, Headley Court Surrey (an inpatient 300 bed rehabilitation unit launched for COVID-19 rehabilitation May 2020)</p> <p>Health and social care organisations worked together to transform Headley Court, a disused military hospital, into an inpatient 300 bed rehabilitation facility. Local GP practices, CSH Surrey, Surrey County Council and the hospital worked together to provide joined up care for survivors of COVID-19.</p>	<p>https://www.surreyheartlands.uk/nhs-seacole-centre-headley-court-surrey-ready-for-COVID-19-rehabilitation/</p>
<p>3. Join local and national networks, (many now run virtual forums), exploring the needs of older adults, where best practice is shared</p> 	<p>Examples of national and local networks</p>	<ul style="list-style-type: none"> ▪ Depending on your professional qualification, contact your national college. Many have specialist groups working with older people, e.g. Specialist section older people Royal College of Occupational Therapists to share best practice ▪ NHS England and NHS Improvement Ageing Well – sign up via Future NHS collaborative platform ▪ Wessex AHSN Healthy Ageing – sign up to our newsletter ▪ ReSTORE network (Rehabilitation, Sharing Thoughts for Optimising Recovery) for anyone with an interest in rehabilitation and recovery in the South West region (Dorset, South Wiltshire, Somerset) ▪ British Geriatrics Society hold annual informative conferences sharing best practice 	<p>https://www.rcot.co.uk/about-us/specialist-sections/about-specialist-sections</p> <p>NHS collaborative platform</p> <p>Email to request newsletter sign-up: healthyageing@wessexahsn.net</p> <p>Joining Instructions</p> <p>https://www.bgs.org.uk/events</p>
<p>4. Work with local charitable, voluntary, and social entrepreneurial organisations working together to meet the needs created</p>	<p>Case example</p>	<p>Communicare Southampton</p> <p>A local charity that enriches the quality of life for lonely, isolated people of all ages in Southampton. A committed group of around 300 volunteers, many of whom themselves have been shielding during the COVID-19 pandemic, aim to make life more than just existence predominantly for older people. The ethos of the organisation is to tailor the service around need. During COVID-19 the service quickly adapted and wrapped itself around the concerns of older people and its volunteers offering:</p> <ul style="list-style-type: none"> ▪ A friendly chat on the phone ▪ Daily social welfare checks ("Hello Southampton") 	<p>Annie Clewlow Communicare Manager manager@communicareinsouthampton.org.uk</p>

		<ul style="list-style-type: none"> ▪ Finding a pen pal ▪ Shopping and errands for the house bound ▪ Support attending a medical appointment (with clear COVID-19 risk assessment and guidance for volunteers and service users) ▪ Themed postal initiatives reaching up to 1,000 people, creating belonging, meaning and a way to disseminate important information enabling the service to connect with service users (including those not able to access email and digital means of communication). Examples included a VE day card, sunflower and cress growing, face covering offer. 	
<p>5. Staff working in new ways to deliver new innovative rehabilitation approaches</p> 	<p>Case example</p>	<p>Tele-rehab service Hampshire (virtual rehab for care home residents)</p> <p>Working alongside the accelerated launch of the telemedicine care home service (launched April 2020 across North and Mid Hampshire) a Tele-rehab pilot in two care homes in Hampshire is planned to start in October 2020.</p> <p>Southern Health NHS Foundation Trust staff are working in partnership with Hampshire County Council staff offering virtual rehabilitation support aiming to maximise mobility and independence in care home residents.</p> <p>Key ways of working:</p> <ul style="list-style-type: none"> ▪ Identify functional loss early ▪ Use remote video consultation ▪ Design individually tailored programmes of interventions to meet agreed patient goals ▪ Upskill care home staff to improve and promote independence of residents ▪ Aim to demonstrate impact and scale up and spread if the proof of concept is successful. 	<p>Karen Cubbon Senior Manager Southern Health NHS Foundation Trust Romsey Hospital</p> <p>Karen.cubbon@southernhealth.nhs.uk</p>

	Webinar	<p>Example of information shared on one Webinar from the ReSTORE network (Rehabilitation, Sharing Thoughts for Optimising Recovery), 31st July 2020. Webinars held weekly at the start of the pandemic, now moved to fortnightly for anyone interested in rehabilitation and recovery in the South West region (Dorset, South Wiltshire, Somerset)</p> <p>Bone Health top tips: Clare Cockill shared top bone health tips for older people.</p> <p>Frailty, Sarcopenia, and deconditioning Sue Bridge presented top tips on physical activity.</p>	<p>Webinar link</p> <p>Clare Cockill Specialist Nurse Lead for Osteoporosis, Fracture Liaison & Bone Density Yeovil District Hospital top tips Clare.Cockill@YDH.NHS.UK</p> <p>Sue Bridge Trainee Advanced Clinical Practitioner/Physiotherapist Frailty Assessment Unit Yeovil District Hospital Susan.Bridge@YDH.NHS.UK</p>
	Innovation	<p>Our Dorset Digital App Library (digital app Library for Dorset)</p> <p>The digital health & care app library of clinically assured apps and videos powered by partner organization the Organised Review of Care and Health Apps (ORCHA) allows professionals and clinicians to recommend interventions safely. Each app has an independent and impartial review undertaken by a clinical team of experts. An example search of fitness and senior fitness would give recommendations of apps that have been designed specifically for older adults wanting to promote physical activity. Filters allow you to tailor the app to each individual patient allowing you to support them digitally in a truly personalised way. Link to local site https://ourdorset.nhs.uk/apps. Please note, apps which are relevant to COVID-19 will be clearly identified by a purple badge and have been coordinated and approved with NHSX.</p>	<p>https://ourdorset.orcha.co.uk/about/</p> <p>Webinars and information sessions for PCNs or practices that are interested in understanding how to embed this into their operating procedure. For more information please contact:</p> <p>Carly Ings Dorset Clinical Commissioning Empowered Self-Care and Access Project Support Officer Carly.Ings@Dorsetccg.nhs.uk</p>
	Innovation	<p>New dedicated 10 bed stroke and rehabilitation unit at the Yeatman Hospital, Sherborne</p> <p>Pilot running from August 2020- April 2021.</p> <p>“An important part of the COVID-19 response has seen specialist inpatient rehabilitation beds move out of the acute hospital into a local community</p>	<p>Louise Clark Allied Health Professional lead for stroke services/ Head of Occupational Therapy Dorset</p>

		<p>hospital enabling acute beds to be reserved for those with highest medical needs. Importantly it recognises the need for a specialist inpatient pathway for this patient group, serving as a pathway to offer under Discharge to Assess.</p> <p>Having a small unit, closely linked with the acute site has allowed us to develop a unit with intensive rehabilitation at the core of its design and ethos, proactively managing flow, ‘pulling patients’ as soon as they are medically ready to be managed on a non-acute site, with discharge plans already underway at the point of transfer.</p> <p>Early indications show an increase in efficiency of rehabilitation delivery, increased therapy minutes delivered, increased weekend therapy for rehabilitation patients and a reduced length of stay compared with a comparable cohort from previous years. We hope that if the unit continues following the pilot, this will increase rotational opportunities for staff with acute and community stroke services, helping build skills and attractive for recruitment and retention. The project has enabled the trial a Consultant Therapist post as clinical lead for the unit, releasing consultant stroke physician time to focus on acute care.</p> <p>This pilot recognises the need for a commissioned service for patients outside of the scope of Early Supported Discharge and provides evidence to build a case for change for community stroke rehabilitation moving forward.</p> <p>For more information please contact Louise Clark.”</p>	<p>County Hospital NHS Foundation Trust</p> <p>louise.clark37@nhs.net</p>
	<p>Case example</p>	<p>“During Lockdown Christchurch Day Hospital was closed and some of the staff were redeployed to help on the wards. Other staff worked in the Community teams or supported the Emergency Department (ED) at the Royal Bournemouth Hospital to increase patient flow.</p> <p>As a Vestibular physiotherapist who normally sees patients later in their journey it has been great to work with ED, seeing older patients with acute dizziness (once any underlying health conditions had been excluded). Through stepping out of my work role I was contacted by Dorset CCG to review some videos posted onto "Our Dorset Video Library", helping to ensure clear information on the safety of exercise. See below for the link and the disclaimer:</p>	<p>Clare Shearer Senior Physiotherapist with an interest in Neurology and Vestibular disorders Christchurch day hospital</p> <p>Clare.shearer@rbch.nhs.uk</p>

		<p>https://healthvideos.ourdorset.nhs.uk/vertigo</p> <p>I am now planning on working with ED on improving the dizzy patients "patient pathway" by delivering training on Benign paroxysmal positional vertigo (BPPV). A greater awareness of our service for older persons with dizziness and its referral pathway has been created through new ways of working necessitated by COVID-19.</p>	
<p>7. Cross sector, multiagency working must continue at scale delivering a needs-based, individualised approach, close to home, to enable older people to live well for longer despite COVID-19.</p> 	<p>Case example</p>	<p>Small things have a big impact. Individual listening to individual offering holistic joined up care enabling Right care, Right time, Right place.</p> <p>Within Dorset a 10-week project was initiated by Dorset HealthCare University Foundation Trust, to pilot therapists, paramedics and a consultant nurse in primary care working together with an urgent response service. The team linked with local 111 and 999 services and the integrated urgent care team, utilizing one of their urgent response cars as a mobile unit.</p> <p>As a result of the project, Christchurch PCN has commissioned a service that offers a holistic model of care enabling older people to stay in their own homes (if possible and best for the individual) and reduces the requirement for emergency hospital conveyances. Reducing the need for a hospital conveyance has many benefits for individuals in terms of rehabilitation. Evidence shows that 10 days in a hospital bed leads to 10 years of lost muscle mass in people over 80.</p>	<p>Amy Hassan Clinical Manager/ Occupational Therapist for Christchurch Primary Care Network</p> <p>Amy.Hassan@rbch.nhs.uk</p> <p>https://www.bgs.org.uk/blog/10-days-in-a-hospital-bed-leads-to-10-years%E2%80%99-worth-of-lost-muscle-mass-in-people-over-age-80</p>
<p>Case example</p>	<p>Example of individualised multi-agency working approach adopted by the Yeovil Frailty assessment unit.</p> <p>Through COVID-19 the frailty assessment unit at Yeovil District Hospital, used telephone triage for the pending caseload of patients waiting for frailty assessment. Specialist advice could be offered, particularly around latest activity guidelines for older adults. Where triage highlighted individuals becoming deconditioned physically, psychologically, or emotionally they were linked to community services or given urgent same day appointments by the frailty team or community teams/ resources offered.</p> <p>COVID-19 webinars helped keep the team informed with key messages. Many local services including Somerset Activity Sports Partnership</p>	<p>Sue Bridge Trainee Advanced Clinical Practitioner/Physiotherapist Frailty Assessment Unit, Yeovil District Hospital (article on triaging patients waiting frailty assessment)</p> <p>Susan.Bridge@YDH.NHS.UK</p> <p>Abstract link</p>	

		(SASP) and Wellbeing South Somerset (SPARKS) for social prescribing were utilized to support patients. Weekly virtual MDT meetings were developed with local complex care teams linking practice health coaches, community rehabilitation teams and practitioners to provide ongoing care, treatment, and advice.	
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Further information on healthy ageing projects can be found on our website:

<https://wessexahsn.org.uk/programmes/35/healthy-ageing> or follow us on Twitter **@wessexageing**