COMMUNITY HOSPITALS ASSOCIATION

Led by The Health Foundation

Supported by NHS England and Improvement

Case Study

Rehabilitation services during Covid

Community hospitals are key providers of rehabilitation and intermediate care services. During the pandemic there were changes to the way that rehabilitation was planned and delivered, and in many cases an increase in the frequency of rehabilitation offered. There were also examples of creative ways of supporting patients to improve their independence, given the restrictions of Covid-19.

Duygu Sezgin et. al. (April 2020) described intermediate care as "time-limited services which ensure continuity and quality of care, promote recovery, restore independence and confidence at the interface between home and acute services, with transitional care representing a subset of intermediate care." Their study also concluded that models of intermediate and transitional care "are best delivered by an interdisciplinary team within an integrated health and social care system where a single contact point optimises service access, communication and coordination."

Context

It was therefore unsurprising that thirteen out of twenty organisations providing Community Hospital services who were interviewed as part of our Q Exchange project, described the changes in their in-patient rehabilitation or intermediate care services during the Covid-19 pandemic.

There is so much to share across these organisations, that the Project Team have pulled the learning together into this single case study.

What Community Hospitals did and the impact

REHABILITATION CARE PATHWAY

We heard that there was more focus upon the rehabilitation pathway, in some areas specific teams were set up to enable the pathway. The Home First principles were viewed as paramount. If required, assessment, care planning (recovery/rehabilitation or short-term intensive support) could take place in a 24-hour bed-based settings including Community Hospitals, with planned prompt discharge. This acknowledged that during the pandemic the safest place was for people was to be at home.

Some staff reported positively on the increased flow of patients through Community Hospital beds during this time and becoming dynamic rehabilitation units with clearer discharge procedures and reduced average length of stay. This approach was also positive for the patients, with a reduced risk of hospital acquired infections and motivating for them and their families when planning a quick discharge back to their own homes. This was enabled by dynamic multi-disciplinary team working across teams, acknowledging that a risk-based approach where safety risks can be taken as community teams were actively picking up these risks on transfer of a patient to their home environment.

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The increased pressure on hospital beds in the health and care systems enabled Community Hospitals to respond differently and change the way they worked. As therapists were not able to hold outpatient clinics they were deployed to work on the wards and therefore they could intensify the rehabilitation offering to up to 7 days a week.

In Oxfordshire, they implemented a 7-day rehabilitation service to improve patient flow, which helped promote recovery, and the average length of stay for patients reduced in some of their hospitals from 28 days to 23 days. Positive patient feedback was recorded in the patient feedback system called "I Want Great Care" February 2022.

Read more about this in the Oxford Health and Care Foundation Trust Case Study: Leadership and autonomy enable a 7-day therapy service

Although in some areas, concerns were raised that due the pressure on Community Hospital beds and the acuity of patient's needs that some patients were not helped to reach their rehab potential before discharge.

WORKING DIFFERENTLY

It was noted that the rehabilitation of Covid positive patients was difficult due to Covid infection prevention and control restrictions, for example patients were less free to mobilise, not all equipment such as stairs were accessible and additional cleaning of equipment had to be factored in to treatment time. Out of these challenges came innovation with therapists working creatively. They mobilised people in bays using mobile stairs and grab rails instead of using the equipment in the therapy rooms.

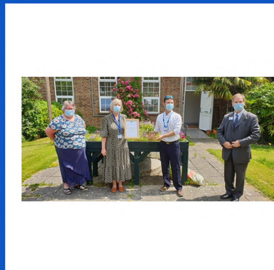
Occupational Therapists worked with relatives to assess and manage the provision of equipment on discharge without visiting the patient's home using virtual digital technology, with a relative a taking measurements, photographs or videos of the home environment.

Read more about this in the Sussex Community NHS Foundation Trust: Virtual Home Assessments

In Sussex Community NHS Foundation Trust, at the start of the pandemic they implemented multi-professional staff training at pace, to deliver a competent and confident redeployed workforce for their community hospitals.

Over a period of 4 weeks, they developed and ran a multi-professional training programme, utilising the skills of physiotherapy, occupational therapy and nursing staff alongside developing a suite of supportive resources, which enabled 100+ clinicians who had been identified as potentially being available for redeployment to increase their knowledge and skills ready for working on our community wards. In addition, it enabled current ward staff to update in clinical areas such as respiratory care if they wished. The feedback on this initiative from staff was very positive.

Read more about this in the Sussex Community NHS Foundation Trust: Training multi-professional staff at pace during the pandemic



2020 Winner
Innovation and Best Practice
related to Covid-19

Training multi-professional staff at pace during a pandemic

Sandra Speller
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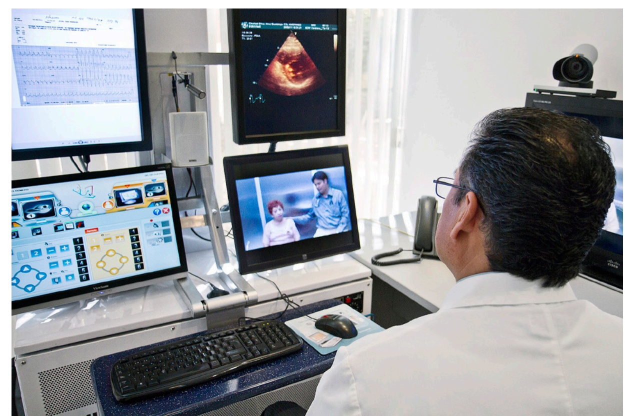

During the project interviews, we heard about therapists and in particular Speech and Language Therapists using telehealth consultations for inpatient therapy and outpatient appointments. This enabled triage of referrals and the sharing of caseloads across clinicians and consultations with in-patients and ward staff, as well as attendance at multi-disciplinary team meetings.

The staff we spoke to, did recognises the impact of their virtual working on ward staff, as they needed to set up the telehealth consultations and some patients needed significant support to use the technology. Virtual meetings were hard for difficult conversations. Despite the challenges, the outcomes were reported as positive as the patients were getting the therapeutic input that they needed.

Case Study

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Staff also shared their concerns about the impact of no visitors on their patients, and the further isolation on the ward due to the Covid restrictions. As a result, staff who were already working under pressure implemented a significant range of wellbeing activities, some examples are outlined below which have case studies on our website.

Cornwall Partnership Trust

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COMMUNITY SUPPORT

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DISCHARGE AND DISCHARGE PLANNING

The discharge processes changed during the pandemic as it was important to ensure a safe transfer of patients from Community Hospitals while complying with the timescales for Covid testing, managing patients clinically, and noting that each discharge required a huge amount of coordination. Supporting and providing key information to carers and families was an essential element of the transition from hospital to home.

Discharge planning and multi-disciplinary meetings were held in person prior to Covid, however the pandemic changed this. Many hospitals set up virtual discharge planning meetings and some hospitals using the 'Attend Any Where' platform. Staff reported that it was difficult for families when they attended to see their family member on screen as they could not visit in person. This required important preparation to support the families prior to meetings which was undertaken by ward staff, a Discharge Co-ordinator or in some circumstances redeployed staff took on this role.

Virtual meetings enabled all members of the multi-disciplinary team to attend, so attendance was reported as improved resulting in decisions being made promptly too, again improving patient flow through the in-patient beds.

In other areas, redeployment of staff enabled greater therapy input into care at the end of life care. For example, the redeployment of Occupational Therapists (OTs) to enable people at the end of their life to be able to get home quicker with the appropriate equipment and support to be with their families.

Also, there was more interagency working which was positively reported, with the Council, housing providers, health, social care and voluntary agencies working together to enable prompt discharge planning. Some areas set up specific interagency databases so agencies could easily monitor a patient's discharge plan and outcome.

Learning

Rehabilitation and intermediate care services in community hospitals responded positively and flexibly to the Covid-19 pandemic with individual innovation, quality improvements and enhanced integrated working

Despite the increased pressure in health and social care systems, staff frequently described a strengthening in relationships and integrated working including multidisciplinary working and integration between the community hospital, other acute and community health services and social care. Many of the changes in practice and innovation were common across a number of Community Hospitals but it was noticeable how many solutions were unique and tailored to the population served and the individual situation.

Contact

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