Kingston Hospital Charity

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Falls Prevention Community Exercise Volunteers

1. Introduction

Falls and fractures are a common and serious health issue faced by older adults in England. People aged 65 and older have the highest risk of falling; around a third of people aged 65 and over, and around half of people aged 80 and over, fall at least once a year.
Falling is a cause of distress, pain, injury, loss of confidence, loss of independence and mortality. Approx 14% (25,000 people) of Kingston Borough population are aged 65 and over.

The Community Exercise Volunteers project has been set up during the COVID19 pandemic to provide a programme of exercise and emotional support to people at risk of falls. It is focussed on bridging the gap between hospital, home and community rehabilitation services. Currently the waiting list for Kingston Community Falls is five months in which time a patient's health and wellbeing can severely deteriorate if their functional movement is not supported. Volunteers will provide information about local activities that will meet people's needs such as the Get Active exercise on referral programme, better bones or community exercise classes supporting patients to reduce barriers to get active.

The aim is to support patients at risk of falls within the community to remain in their homes and assist them with a physiotherapy prescribed exercise programme to help restore their health, wellbeing and independence. Patients will have enhanced physical and emotional wellbeing during a time where waiting lists for community rehabilitation services and other local community exercise classes are increasing and many older adults are feeling anxious and isolated.

2. Research national policy- national initiatives

2.1 National context: Right to Rehabilitation - Chartered Society of Physiotherapists, Feb 2020

"While medical breakthroughs now help many more people survive illnesses and injuries that would previously have killed them, modernisation and investment in community rehabilitation has not kept up.....too many people with long term conditions cannot access it at present....

Too often people receive intensive rehabilitation in hospital but then have long waits when they get home, if it's available at all...While patients wait their recovery is halted and can reverse - causing lasting disability, distress and deterioration of health."

2.2 The NHS Long Term Plan is committed to enhance access to community rehabilitation across England.

2.3 "Falls are the 6th largest cause of disability in the UK today....it is anticipated that 1/4 of all falls could be avoided, saving £59 million in emergency admissions and a similar amount in social care costs.

Vos T, Barber RM, Bell B et al. Global, regional and national incidence for the Global Burden of Disease study 2013, The Lancet 2015; 386 (9995) 743-800

3. **Local Context: The Kingston Health & Care Plan 2019 - 2021 has identified three priorities for 'Aging Well':**

One of which is to maximise people's independence and resilience to enable them to live well at home where it is their choice.

Its impact will be that "more people will still be home 91 days after being discharged from hospital into re-enablement."

However in the current climate:

"The proportion of older people who received re-enablement or rehabilitation services after discharge from hospital [in Kingston Upon Thames] has been significantly lower than in England and London."

The Kingston Health & Care Plan, 2019 - 2021

4. **Gap analysis**

Commencing in January 2021, **Digital Gentle Movement Volunteers** support patients on the ward via a touch away app and guide patients through exercises in their chair or in their bed. It has already proven successful in improving the mood, reducing stress levels and improving perceptions of pain in patients supported by the intervention.

We also have an established **Remote Discharge Support Service** which supports patients once they have been discharged from hospital via the telephone. During a six week period our volunteers provide practical and emotional support to patients so that they have a better experience between hospital, home and the community, regularly referring patients

to local community services such as, falls prevention, community physiotherapy, adult social services and befriending services, etc.

However, neither of these projects have specifically aimed to bridge the gap between the intensive rehabilitation support that patients receive whilst in hospital which is complemented by the Gentle Movement Programme, and sustaining the mental, physical and systemic health benefits of functional exercise once home from hospital.

5. Aims of the Project/Objectives

i) Bridging the evidenced gap between hospital and community rehabilitation services.

ii) Patients identified at risk of falling by hospital physiotherapists to be discharged with a home exercise programme and the support of a volunteer to rebuild their strength, balance and confidence. Reducing the risk of falls at home and in the community.

iii) Prevent hospital readmissions associated with deconditioning and falls

iv) Provide emotional support and community connectivity to reduce isolation and loneliness by providing empathy, active listening and supporting them to access additional support outside of the sessions.

6. Inclusion criteria

- Patients 65 and over that live within Kingston borough
- Patients that are housebound or due to Covid-19 not able to access exercise groups.
- To be identified by physiotherapist:
    - At risk of falling
    - Had a fall in the last 12 months
    - Fear of falling (0-10 scale)
- Physical Outcomes to be measured by Volunteer:
    - Timed Up And Go (TUAG) in under 40 secs, independently or with walking aid
    - 180 Turn – must be 10 step or less
    - Sit To Stand (STS) in 60 secs- no minimum criteria for this test

Exclusion criteria:

- Patients with serious pathologies or who are not medically stable
- Patients who need manual assistance walking
- Patients who have significant cognitive impairment and are unable to engage in assessment or follow instructions.

7. Outcomes

Measured by physical assessment (TUAG/ 180 turn/ 5 second STS test), EQ5D-5L (a self-assessed health related, quality of life questionnaire) and Trust Business Intelligence data.

Patient: Improved balance, strength, mobility and coordination.
Patient: Improved confidence and reduced fear of falling
Patient: Improved self-care (e.g. washing and dressing)
Patient: Improvement in usual activities (e.g. housework and leisure, etc)
Patient: Decrease in pain perception
Patient: increased positive mood, decreased feeling of anxiety and depression, reduced feeling of loneliness /social isolation
System: Reduction in deconditioning whilst awaiting the start of a community rehabilitation service and other local community exercise classes

System: Increased take-up by patients of services and support for rehabilitation in their local community as a direct result of the 8 week intervention, e.g. exit strategy leads directly to a patient taking up a local bone health service.

Organisation: Reduced attendances and admission related to falls or deconditioning

8. Delivery option

8.1 Delivery model

Patients are identified from the Three Care of the Elderly wards – Blyth, Kennet and Derwent

Every morning during the ward meeting, the physio team will identify patients eligible for the community exercise service. These patients will automatically receive a home exercise booklet and prescribed exercises within the booklet which focus on improving mobility, balance and strength.

There will be a dedicated exercise volunteer to assist with the physical outcomes and administrative tasks (referrals) on the wards twice a week to support the physio team and promote the service.

This dedicated exercise volunteer will complete initial physical outcomes and run through the physio prescribed exercises with patients. The exercise volunteer will report back to the physio team that this has been completed and confirm whether referral onwards is suitable. If suitable, the referral will be emailed to the community exercise service to be processed and each patient will be allocated to a community exercise volunteer via the project manager.

The community exercise volunteers will have a master copy of the exercise booklet to support home visits.

8.2 Breakdown of Session Schedule once Patient has been discharged home

Month 1 - Two sessions per week

x1 face to face home visit)- 1st session to measure physical outcomes and Pre- EQ5D-5L

x1 via zoom or telephone (reminder to do exercise, provide information about local activities that will meet people's needs such as the Get Active exercise on referral programme, better bones or community exercise activities or healthy walks)

Month 2- One session per week

X 1 face to face visit- 8th session (last session- measure physical outcomes and Post- EQ5D-5L)

Therefore a maximum number of sessions a participant should receive is **12.**

COVID19 Screening Questions- to be asked 24hrs before each home visit:
Q1. Do you or anyone in your household have a high temperature?
Q2. Do you or anyone in your household have a new, continuous cough?
Q3. Have you or anyone in your household lost their sense of smell and (or) taste?
Q4. Are there any other reasons why you think you should not take part in an activity session?
Q5. Have there been any changes to your medication?

9. Recruitment plan

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Whilst it is not compulsory, we want to aim this role at physiotherapy students, occupational therapy students and anyone with a previous exercise background

14th June 2021- Role description to be finalised and ready for advert
w/c 28th June 2021- Volunteering Adverts Open
w/c 12th July 2021- Interview assessments
w/c 2nd August 2021- Training for the volunteers
w/c 30th August 2021- Volunteers start date

10. Clinical Plan

- Provide initial training to ward physiotherapists and tech's about the service and how to refer
- Provide Exercise Training to Volunteers and support on the ward
- Clinical supervision for volunteers at monthly meetings
- Daily supervision will be covered by the escalation process document
  Input into how a patient is handed over to volunteer

11. Exit strategy

After eight weeks participants will be referred to relevant community exercise services such as falls service, better bones service, and community exercise classes (e.g Get Active by the local council). Participants will also be advised to sustain and self manage their prescribed exercise programme.

12. Training Plan

The Trust's existing Indemnity Insurance covers the activities of volunteers in the community

August (date tbc) – Role Specific Training (approx. 3-4hours) to be delivered by lead Physiotherapist for Elderly Care (Exercise- progression/adaptations). Project manager and volunteer service manager will deliver training related to the role, boundaries, safety, screening questions, documentation and reporting, identifying hazards and escalating. Awareness training will also be provided for signs and symptoms of hyper/hypotension.

August (date tbc) - Basic Life Support training (1hr) to be delivered in a group by lead Resuscitation Officer

August (date tbc) – Lone Worker Training (1hr) to be delivered in a group by Head of Facilities/LSMS

13. Evaluation

The Trust will utilise the Helpforce Insight & Impact service to support effective evaluation of the community exercise volunteers project. The Insight and Impact service consists of an online tool and dedicated team of advisors to progress the Trust through a four-stage evaluation process:

1. **Define** – clarifying and fine tuning the overall objectives of the community exercise volunteer projects and the goals for all beneficiaries.
2. **Design** – developing an 'outcome model' to illustrate what activities will happen to achieve intended outcomes. A 'data model' will also be developed to describe and plan what data needs collecting, how it will be collected, when and by who to enable the impact to be measured.
3. **Collect** – gathering the data set out in the 'data model' plan. This can be done through the Trusts own tools (e.g. Better Impact) or using the Helpforce Impact Reporting system if required, or a mix of the two.
4. **Evaluate** – analysing the data collected and reporting evidence of outcomes.

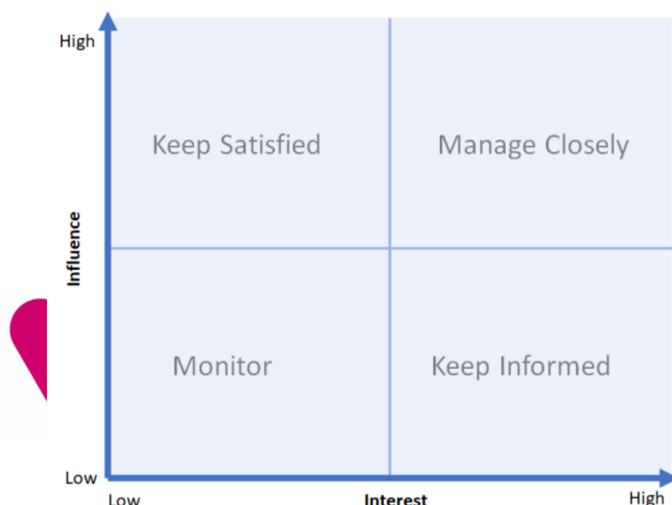
Between May and Mid August 2021 the following activities will need completing as part of evaluation:

- Define stage
- Design stage
- Development of any surveys, forms or other mechanisms of collecting data
- Collation of any baseline data

Post launch of the project in September 2021 there will be ongoing collection of data as set out in the data model until the project end date on 31st March 2022.

Assuming Helpforce has permission to process the data collected throughout the project, analysis and a report on the evidence of outcomes will be finalised by 31st April 2022.

14. Stakeholder Map and Management



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Stakeholder	Their Interest	Approach	Responsible

15. Governance

Project Sponsors are individuals with overall accountability for the project. The Project Sponsor is primarily concerned with ensuring that the project delivers its objectives. Sponsors for this project are:

- Maeve Hully, Director of Volunteering, Helpforce
- [Name] Deputy Director of Nursing, Kingston Hospital Trust

Steering Group – The firsts steering group meeting is on 20th May 2021, and aims to bring together expertise, experience and rigor around the needs and quality of the community exercise volunteers project. Terms of reference can be found in appendix A.

The members of the steering group are:

Role	Organisation
Community & Outreach Manager	Kingston Hospital
Head of physiotherapy	Kingston Hospital
Matron - Elderly care	Kingston Hospital
Physiotherapy Team Lead - Elderly care	Kingston Hospital
Head of volunteering	Kingston Hospital
Deputy Director of Nursing	Kingston Hospital
OT inpatient lead	Kingston Hospital

Joint and Bone Health Physiotherapist	Kingston Hospital
Service Improvement Lead Dementia and Delirium	Kingston Hospital
Social Work Practitioner	Kingston Hospital
Falls Prevention Service Lead	Your Healthcare CIC
Community physio lead	Your Healthcare CIC
Frailty Nurse Consultant- A&E	Kingston Hospital
Gentle Movement Volunteer	Kingston Hospital
Director of volunteering	Helpforce
Programme Manager	Helpforce

16. Risks

The table identifies key risks, what impact (High, medium or low) they may have on the project and the likelihood (High, Medium or Low) of it happening. Mitigation options will be considered and agreed by the project manager and steering group throughout the project.

Risk/ Challenges	Likelihood (H/M/L)	Impact (H/M/L)	Impact	Mitigation Option?
Inclusion criteria does not target the most appropriate patient cohort	M	M	Service does not meet planned objectives	
Inclusion criteria is not agreed with enough time to test and scope cohort size	L	M	Capacity (number of volunteers) is not aligned with service need	
There are none to few applications for the volunteer role	L	H	Service cannot launch as planned in September	
Dedicated project lead is not secured from September	L	M	Monitoring, continuous improvement and evaluation of the service is hindered and delayed	

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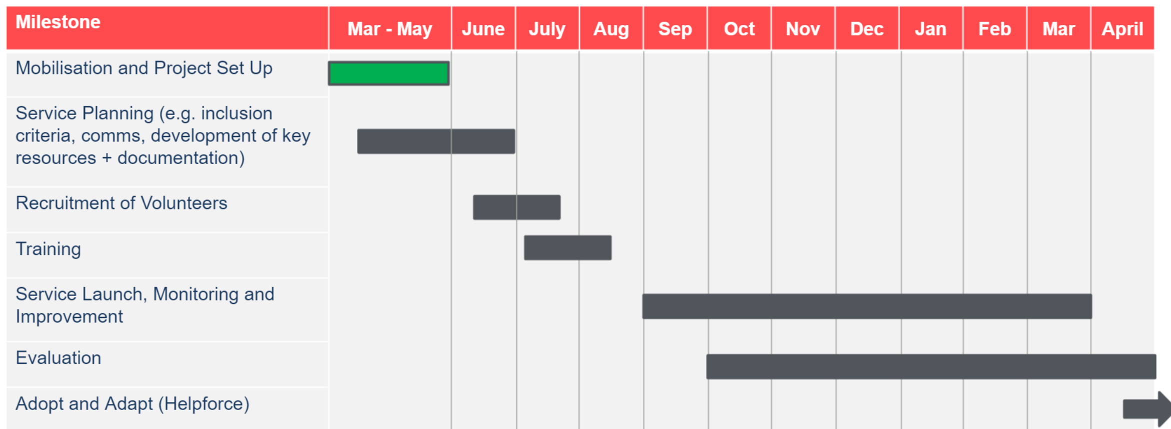
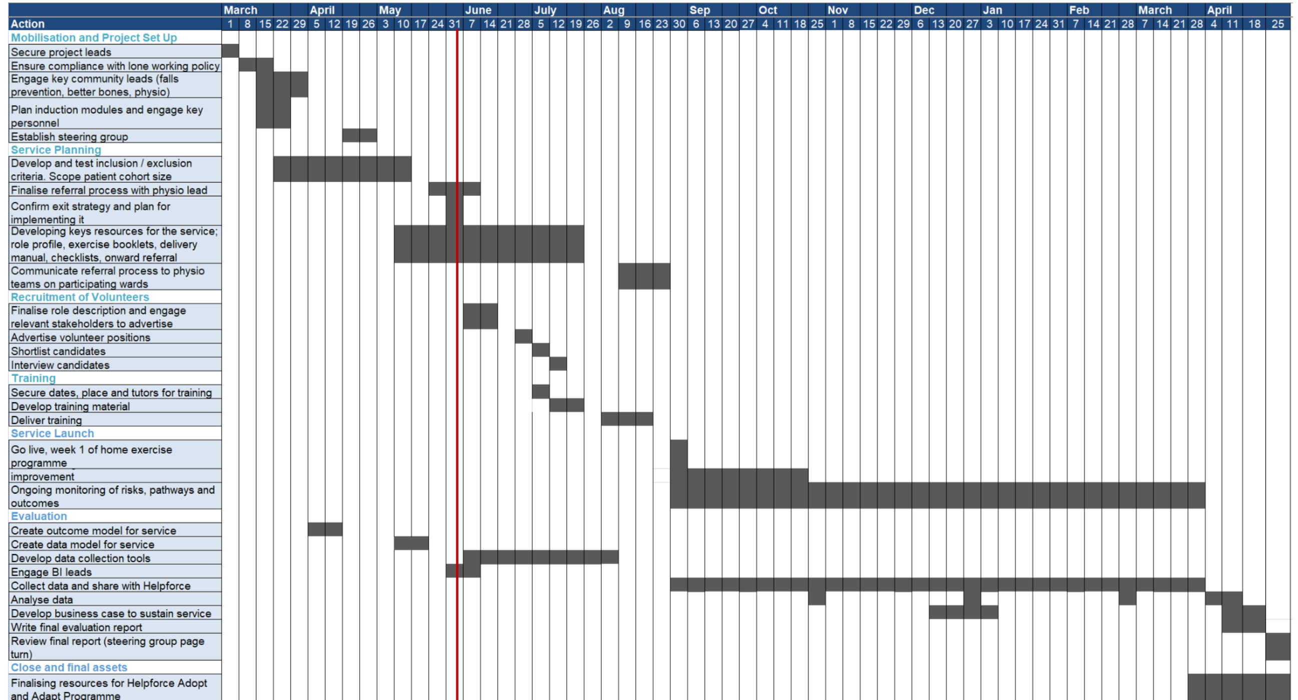
17. Timeline

High level timeline



Detailed timeline (excel version available)



Volunteering
Kingston Hospital NHS Foundation Trust

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Appendix A

Steering Group Terms of Reference

1 AIM / PURPOSE

To ensure the effective delivery of the Kingston Hospital Volunteering Service "Community Exercise" Project and to support the ongoing development and improvement of the Project.

2 DUTIES / OBJECTIVES

- To attend a steering group meeting every 6 weeks
- To advise on the scope of the Project
- To assess progress against project milestones and collectively decide mitigating actions where required
- To coordinate the allocation of resources and implementation of mitigating plans as required
- To provide subject matter expert feedback on the progress of the Project
- To promote engagement with the Project across identified wards, departments and services at the Trust
- To facilitate communication around internal and external developments which may impact the project
- to ensure adherence with Trust and community best practice
- To provide sign off, approvals and authorisation around safeguarding, and Trust and community policies.
- To ensure the project is delivering on agreed objectives and review the annual report before submission to Kingston Hospital Charity & Helpforce, joint funders.

3 COMMUNICATION

The Group will receive minutes of the meetings and reports, including project reports from the Project Manager.

- Requests for Agenda items should be sent to the Project Manager a minimum of two weeks in advance. The Chair will decide when and if items can be added, depending on previous commitments and time restraints.

- An approved agenda and papers will be circulated by email to all members at least five working days in advance of meetings taking place.

- Minutes from the previous meeting will be circulated to all members no later than 14 working days after the meeting.

- From time to time it may be necessary for the Chair to make an urgent decision at short notice. Members will be advised of this at the next available meeting, or by other means, such as email.

4 PERMANENCY

Duration of the project (to March 2022)