Nations Together
FOR FALLS PREVENTION

THURSDAY 23rd MARCH 2-3pm

(3 year anniversary of the COVID-19 pandemic lockdown in the UK)

DECONDITIONING: WHERE ARE WE NOW?

Speakers include:

Dawn Skelton, Professor of Ageing & Health, Glasgow Caledonian University, member of 4 Nations Falls Collaborative

Eleri D'Arcy, Occupational Therapist, Swansea Bay University Health Board. Wales, Swansea Bay University Health board and member of the Welsh Falls Prevention Taskforce

Julia Clayton, AHP Dementia Specialist Physiotherapist, Betsi Cadwaladr University Health Board East, Wales

Hannah Niland, Senior Physiotherapist, Southern Health NHS Foundation Trust, England

Éamonn Doherty, Physiotherapist & Community Falls Coordinator, Belfast Health & Social Care Trust, Northern Ireland

Lianne McInally, AHP Senior Manager, East Ayrshire Health and Social Care Partnership, Scotland

Today's Webinar – 3rd anniversary of UK 'lockdown'

- Cameras off and microphones muted (automatically)
- WEBINAR WILL BE RECORDED
- Feel free to tell us who you and where you are in the Chat
- Put any Questions into the Q&A box or the Chat (eg. Q. Do you have a link to those resources?)
- The link to the recording will be sent out to all registered and available to those who did not register
- Please email dawn.skelton@gcu.ac.uk with any ideas for future speakers on deconditioning and ideas for action
- A huge thanks to Karen McDairmant and to ReaCH for hosting

Research Centre for Health (ReaCH)

Improving health and wellbeing for all

- Research Centre for Health (ReaCH) pursues a wide range of multi-disciplinary applied health research that is economically and socially relevant.
- We aim to make direct and significant contribution to the UN Sustainable Development Goal 3 – ***good health and wellbeing***.
- Our focus is on enhancing the **lives of people with long-term health conditions** and **developing and evaluating public health and lifestyle interventions.**

Website: www.gcu.ac.uk/reach Email: reach@gcu.ac.uk

Twitter: @GCUReach

4 Nations Falls Collaborative

Representatives from **stakeholder bodies from each of the four Nations** including the NHS, Public Health, Allied Health Professionals, Health & Social Care and 3rd sector:

- share knowledge, information, best practice, experience, evidence, materials, educational resources and skills - learn from each other and develop effective working practices
- work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk, provide examples of approaches that provide evidence-based cost reduction to the wider health/care system
- strengthen collaboration, whilst recognising there will be national variations in approach, ambition and practice
- share promotion and use of falls and fractures data and information technology to provide more consistent UK wide information
- link communications teams (eg. UK-wide campaigns, materials, positive stories)

Further resources and webinars here - https://edshare.gcu.ac.uk/7217/

What is deconditioning?

Deconditioning is the syndrome of physical, psychological and functional decline that occurs as a result of prolonged inactivity and associated loss of muscle strength

Deconditioning can occur at any age, but amongst older adults can occur more rapidly (symptoms experienced within one week), be more severe, and be extremely challenging to reverse

Pangioti, M et al. BMJ 2019

Effects of deconditioning

- Psychological effects
  - Low mood
  - Depression
  - Anxiety
  - Loss of control
  - Loss of confidence
  - Fear of falling
  - Lower PA/ higher SB on discharge and beyond
- NHS
  - Increased length of stay
  - Increased risk of falls
  - Increased risk of pressure sores and infections

Figure I. Deconditioning and its potential consequences

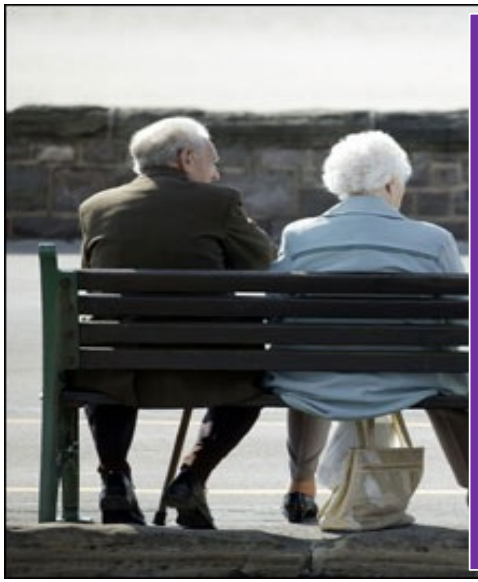
Adapted from British Geriatrics Society (2020) – Reproduced with permission from the British Geriatrics Society

Chen et al. Int J Geriatr Psychiatry 2022; BGS 2020; Fisher et al. arch Int Med 2010; Fisher et al. Arch Phys Med Rehab 2016; Ostir et al. JAGS 2013; Loyd et al. JAMA 2020

Sedentary behaviour health risks

In **older adults** (>60 years old), sedentary behaviour has been found to be significantly associated with:

- Higher plasma glucose
- Higher BMI and waist:hip ratio
- Higher cholesterol
- Reduced muscle strength
- Reduced bone density
- Increased frailty
- Increased falls
- Increased fear of falls and avoidance of activity



Those with highest quartile of sedentary behaviour had a 26% higher risk of falling relative to the lowest quartile

Rosenberg D et al. JAGS 2021; 69;718-725

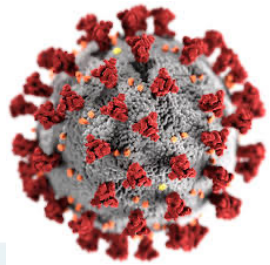
Copeland et al. Brit J Sports Med 2017, Gennuso et al. Med Sci Sports Exerc 2013.; Skelton. Age Ageing 2001; Chastin et al. Bone 2014; Jiang et al. Front Public Health 2022; Amaral Gomes et al. Clin Interv Aging 2021

Physical Activity, Sedentary Behaviour and Falls

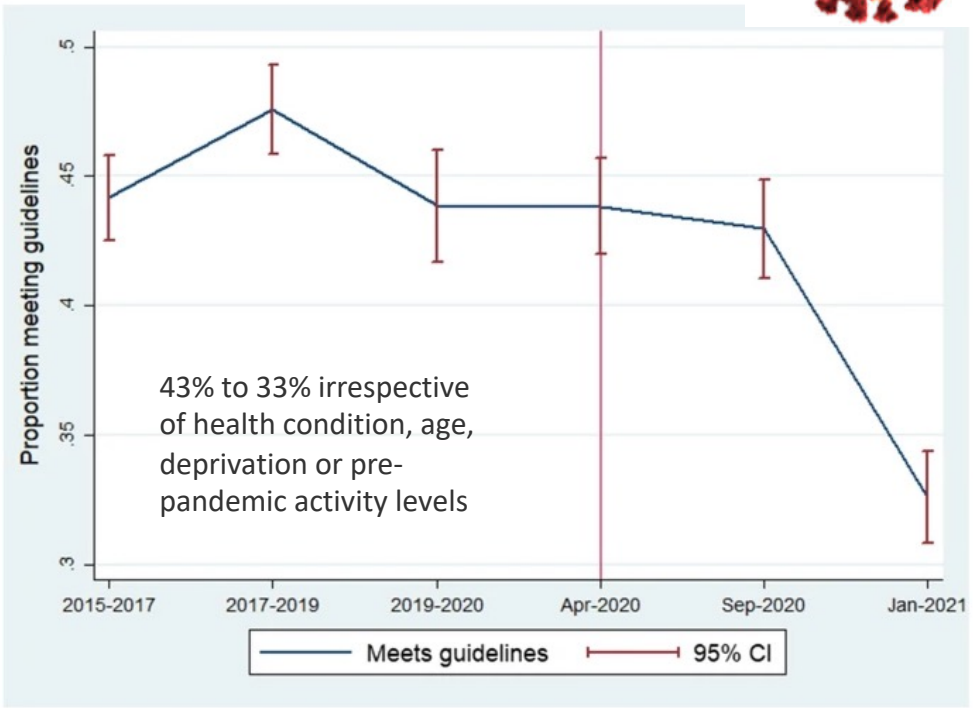
- Reduced PA and SB are associated with reduced muscle mass
- Low step counts (less than 1413 steps per day) lead to reduced muscle mass within 14 days
- Self reported prolonged sitting (greater than 8 hours a day) is independently associated with falls in past 12 months
- Greater periods of physical inactivity are related to higher risk of falls in a dose-dependent manner
- During hospitalisations patients stand and walk less than 10 mins/day, mostly with clinicians

Breen et al. J Clin Endocrin Metabol 2013; Rosenberg et al J Gerontol 2016; Jefferis et al MSSE 2015; Jasper et al. IJERPH 2020

Effect of pandemic on activity behaviour - UK



- March 2020 ‘Stay at home order’ issued by Governments
- Ongoing social restrictions for >18 months
- Activity restriction (particularly incidental and leisure activity)
- Deconditioning
- Increased frailty (reduced access to rehab)
- Rehabilitation pandemic



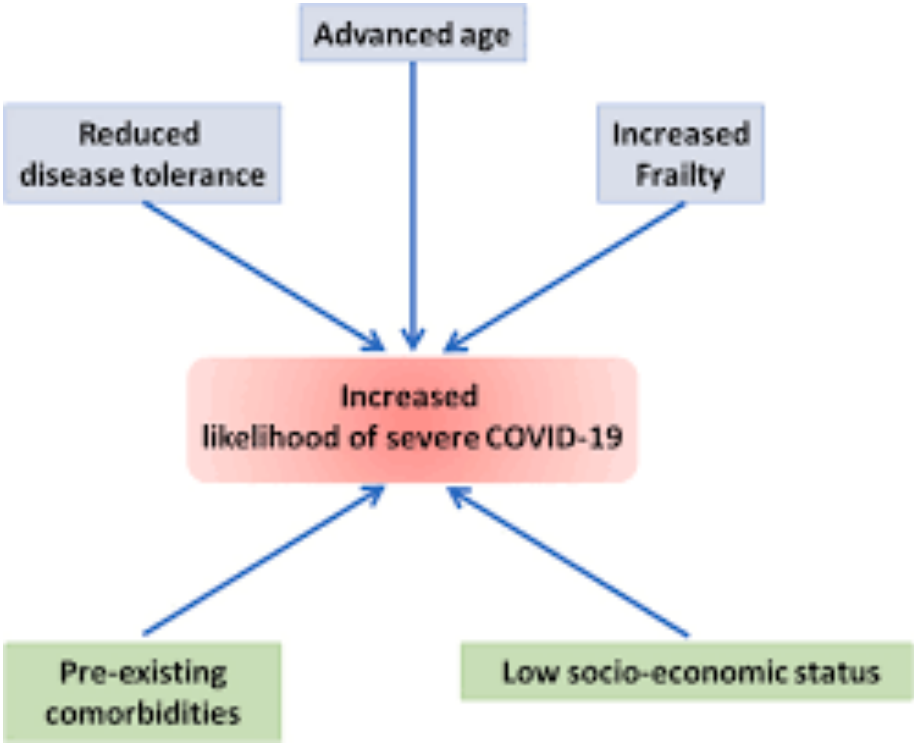
Proportion of older adults (aged 65 years and older) meeting physical activity guidelines over time (red vertical line indicates the introduction of the first UK lockdown)

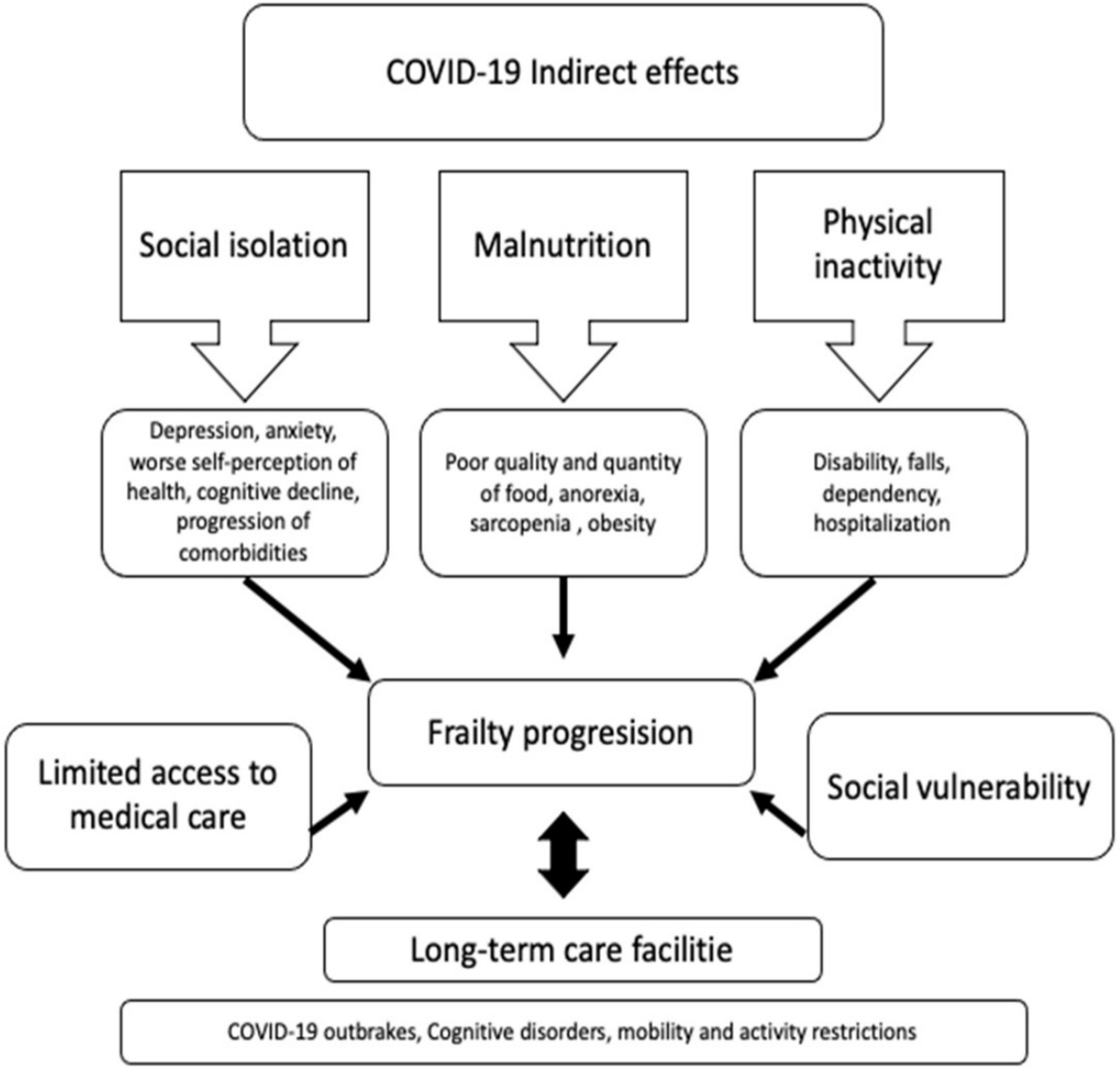
De Biase, Cook, Skelton, Witham, Ten Hove. Age Ageing 2020; Public Health England, Covid impact on falls, 2021; Christensen et al. PLOS One 2022; Hoffman et al. JAGS 2022

Elliot et al. BMC Public Health 2022

UK Household Longitudinal Study’s annual and COVID-19 studies
3,660 older adults (aged ≥ 65)

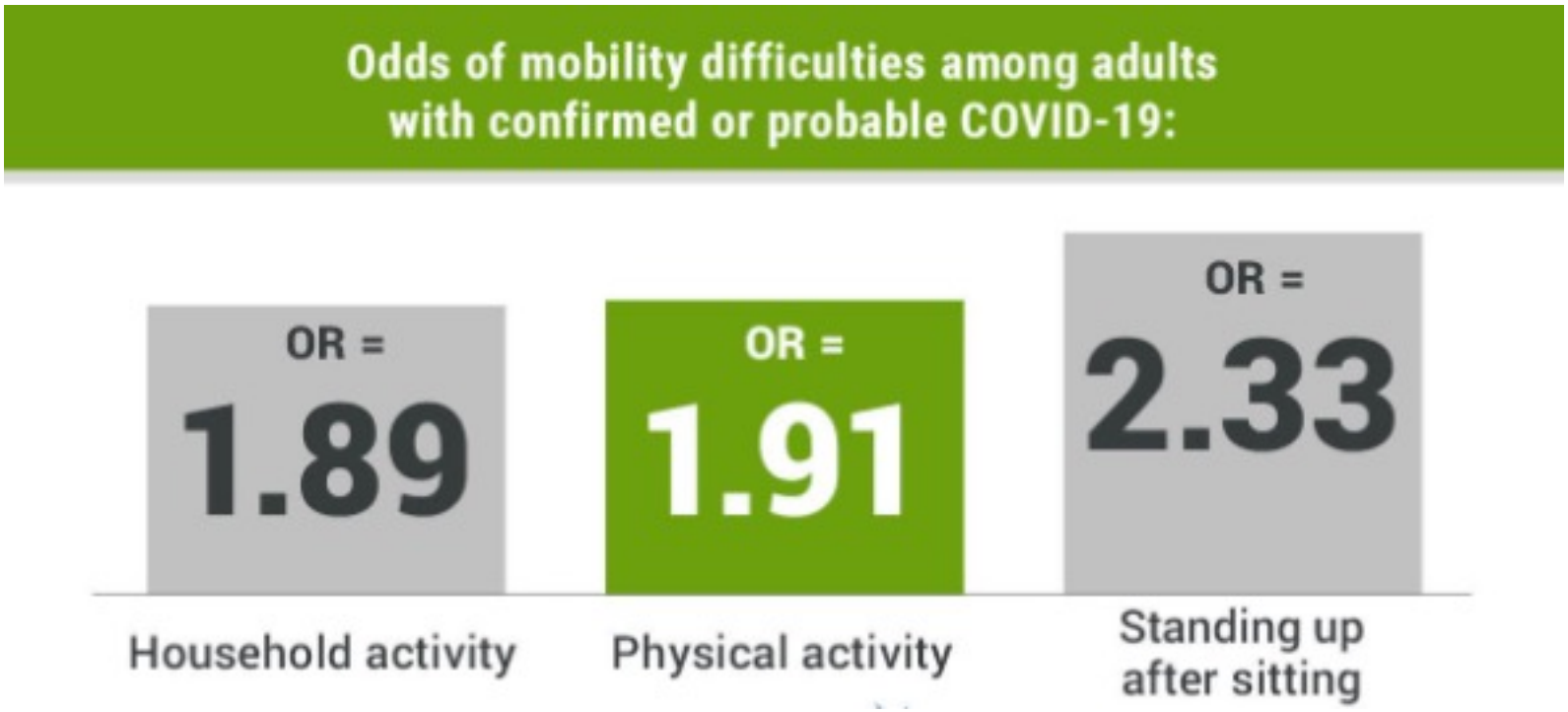
Frailty & Covid-19





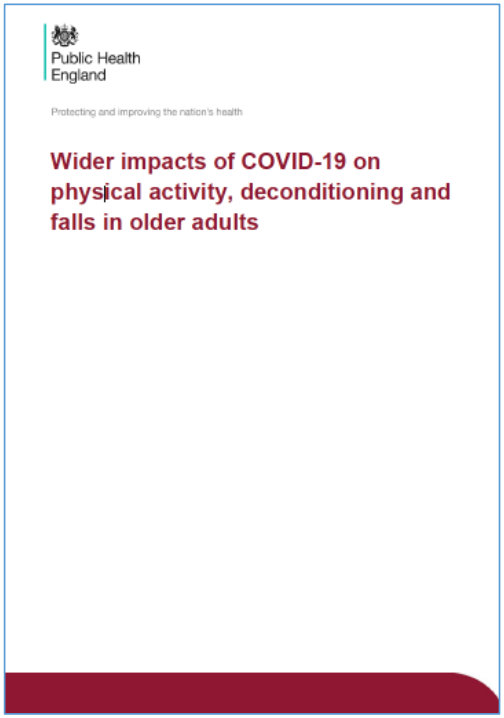
Beauchamp et al. JAMA 2022

Physical activity after Covid-19

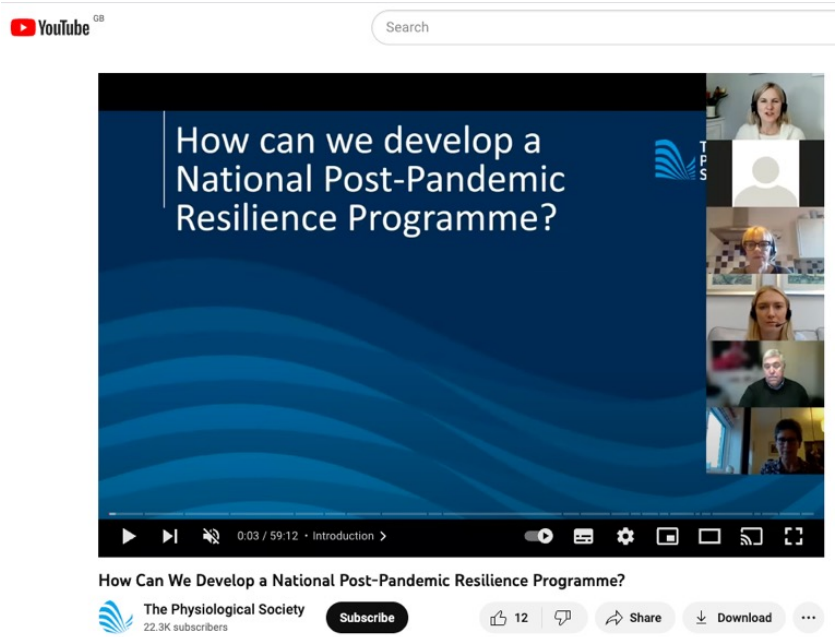


Beauchamp et al. JAMA 2022

Deconditioning is causing a rehabilitation pandemic!



De Biase et al. Age Ageing 2020

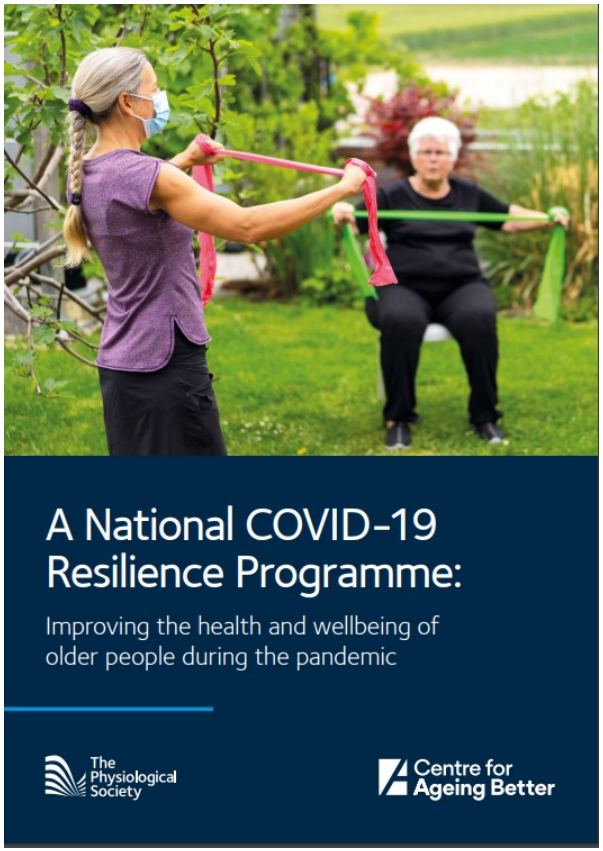


https://youtu.be/kbGik-gwf4o

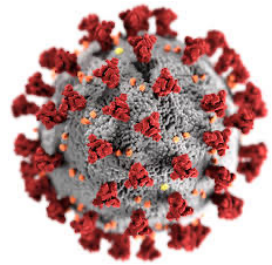
Rise in hospital falls and bed sores since pandemic

BBC

10 November



The 'cost' of reduced activity on falls

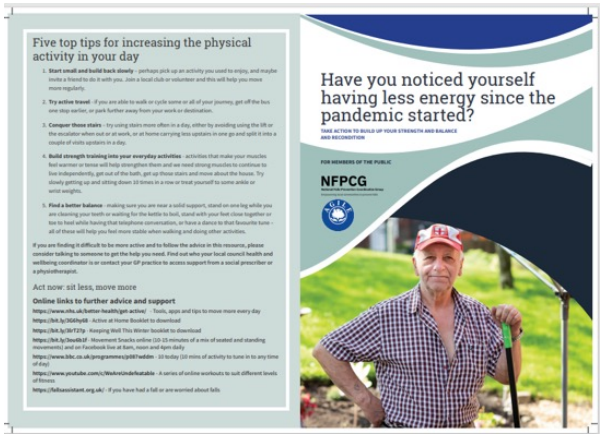


- Without mitigation, modelling predicts that:
  - 110,000 more older people (an increase of 3.9%) are projected to have at least one fall per year
  - the total number of falls could increase by 254,000
    - 124,000 for males (an increase of 6.3%) and 130,000 for females (an increase of 4.4%)
  - for each year that the lower levels of strength and balance activity observed during the pandemic persist, there is projected to be an additional cost to the health and social care system as a result of the change in predicted related falls of £211 million (incurred over a 2 and half year period)

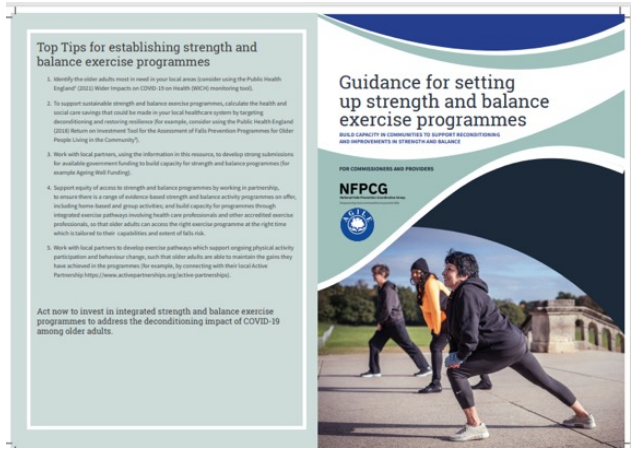
https://www.gov.uk/government/publications/covid-19-wider-impacts-on-people-aged-65-and-over

NFPCG Deconditioning Resource Suite

https://www.bgs.org.uk/resources/deconditioning-information-for-providers-of-services-for-older-people-and-the-public



Launched 19th April 2022



Eleri D'Arcy, Occupational Therapist, Swansea Bay University Health Board. Wales, Swansea Bay University Health board and member of the Welsh Falls Prevention Taskforce
Julia Clayton, AHP Dementia Specialist Physiotherapist, Betsi Cadwaladr University Health Board East, Wales

Deconditioning - What are we doing in Wales?

"No longer just a hospital issue"

Policy response:

National Rehab Framework - Health and social care services rehabilitation framework | GOV.WALES

6 goals- new hospital guidance: Six Goals for Urgent and Emergency Care - Primary Care One (nhs.wales)

Frailty Policy Position – a quality statement is currently in development

Reablement and Rehab policy position in development

Care & Repair Cymru

Steady on Stay Safe Campaign – Welsh National Falls Prevention Taskforce in Conjunction with NHS Health boards and 3rd sector partners

GIG CYMRU NHS WALES

age Cymru
Creating an age friendly Wales

DECONDITIONING IN DEMENTIA

Julia Clayton

A MULTIFACTORIAL PROBLEM

- Prolonged Bed Rest.
- Inadequate Nutrition.
- Further Reduced mobility due to inactivity, leading to Risk Of Falls
- Constipation/Incontinence.
- Confusion/Disorientation/Sensory Impairment.
- Communication/Swallowing difficulties.
- Polypharmacy.

THE ACUTE SETTING

- Relaunch of The Butterfly Scheme.
- Completing This Is Me Documents.
- Dementia Support Workers (DSW).
- Joint Working with Therapists.
- #EndPJParalysis

DEMENTIA SUPPORT WORKERS (DSW)

- Working with Dementia Improvement Team to outline and develop role of the Dementia Support Worker on the Ward.
- Ensuring DSW have the facilities to engage with patients effectively.
- Engaging patients in activities which offer stimulation, promote socialisation/group activity/daily routine.
- Working with Therapists on the ward to help run exercise/relaxation classes

IN THE COMMUNITY

- AHP Dementia Team
  - Physiotherapists
  - Occupational Therapists
  - Dietitians
  - Speech and Language Therapists

    - Working with:
      - Community Psychiatric Nurses
      - Psychiatrists
      - Consultants
      - 3rd Sector Services

AHP DEMENTIA TEAM –
A COMMUNITY APPROACH

- Working with Memory Service for referral at Diagnosis or during diagnostic process, assessments from Occupational Therapy, Physiotherapy, Speech and Language Therapy contributing to diagnosis.

- Providing information/Input from a team Allied Health Professionals to educate patients and their families and carers about the patients journey with dementia and preventing Carer Burn Out.

- Being Proactive in treating individuals with the view to pre-habilitate prior to deterioration of condition rather than being reactive.

AHP DEMENTIA TEAM –
A COMMUNITY APPROACH

- Physiotherapist- Mobility assessments/aids, resistance exercises/balance programmes, house adaptations, onward referral to 3rd sector schemes/groups.
- Occupational Therapists- Meaningful Activity, Life story work, functional assessments, house/home adaptations, enabling equipment.
- Speech and Language Therapist- Communications strategies for patients/family members/carers, Dysphagia/swallow assessments.
- Dietetics – Providing advice on oral intake, promoting appropriate foods, managing diabetes/weight gain/weight loss, food for mood, food preference changes.

CASE STUDY.

- 91 year old male.
- Under assessment with memory service.
- Reduced mobility and exercise tolerance due to isolation during Pandemic.
- Lost motivation to socialise.
- Reduced function upper limbs from past clavicle fractures.
- On assessment had communication difficulties
- Falls assessment = Low risk.

CASE STUDY.

- Exercises programme focussing on resistance exercises with upper limb rotator cuff work included.
- Regular mobility with technical instructor inside and outside.
- Referral within team to Speech and language.

- Patient now has full range of movement in both upper limbs, mobilising regularly with his wife into town to meet family and friends.
- Input from SLT has enabled patient to reconnect with family and friends with ongoing strategies so patient isn't isolated due to poor communication.
- Onward referral to 3rd sector groups/schemes has been discussed for ongoing input.

Hannah Niland, Senior Physiotherapist, Southern Health NHS Foundation Trust, England

The impact of daily exercise classes on a rehab ward

Hannah Niland, Senior Physiotherapist
Fordingbridge Hospital, Southern Heath NHS Foundation Trust

Introduction

When in hospital, elderly patients are at risk of both physical and cognitive deconditioning related to prolonged bed rest and inactivity, The World Health Organisation (WHO) recommends that, to improve health outcomes, older adults should complete 150-300 minutes of moderate intensity exercise per week– something that is difficult to meet within the hospital environment.

Methods

- 15 minute seated exercise classes were introduced on Tuesday to Friday mornings on Ford Ward at Fordingbridge Hospital.
- Classes were completed in the 4-bed bays. And 1:1 in the isolated side rooms.
- The classes focused on posture, range of movement and resistance training – with the class tailored to each patient, including potential for progression.
- Patients were excluded from the class if they were medically unwell, declined to take part, or were unavailable.

Exercise Bite Tracker Sheet

Week commencing:

Exercise	Tuesday	Wednesday	Thursday	Friday
Warm Up				
1. Neck rotations				
2. Neck retractions				
3. Trunk rotations				
4. Shoulder circles				
5. Ankle movements				
6. Seated marching with arm swing				
Main Exercises				
1. Knee extensions (3 second hold)				
2. Hip abductions				
3. Resisted knee extensions				
4. Resisted hip abduction				
5. Upper back straightener				
6. Sit to stand				
Stretches/Cool down				
1. Chest Stretch				
2. Back of thigh stretch				
	Date: Time: Sign:	Date: Time: Sign:	Date: Time: Sign:	Date: Time: Sign:

Data Collection

- The minutes of moderate intensity exercise for each patient that received face-to-face therapy input were counted. (Only data for patients who had spent Monday-Friday on the ward was included. No weekend data was included).
- The Elderly Mobility Scale (EMS) was used as an assessment of function.
- Satisfaction survey for feedback.

ELDERLY MOBILITY SCALE SCORE

Patient details.....

TASK	Date			
Lying to Sitting	2 Independent 1 Needs help of 1 person 0 Needs help of 2+ people			
Sitting to Lying	2 Independent 1 Needs help of 1 person 0 Needs help of 2+ people			
Sitting to Standing	3 Independent in under 3 seconds 2 Independent in over 3 seconds 1 Needs help of 1 person 0 Needs help of 2+ people			
Standing	3 Stands without support and able to reach 2 Stands without support but needs support to reach 1 Stands but needs support 0 Stands only with physical support of another person			
Gait	3 Independent (+ / - stick) 2 Independent with frame 1 Mobile with walking aid but erratic / unsafe 0 Needs physical help to walk or constant supervision			
Timed Walk (6 metres) approx 18 feet	3 Under 15 seconds 2 16 - 30 seconds 1 Over 30 seconds 0 Unable to cover 6 metres *Recorded time in seconds.*			
Functional Reach	4 Over 20 cm. 2 10 - 20 cm. 0 Under 10 cm. *Actual reach*			
	SCORES	/ 20	/ 20	/ 20
	Staff Initials			

Scores under 10 - generally these patients are **dependent** in mobility manoeuvres; require help with basic ADL, such as transfers, toileting and dressing.
Scores between 10 - 13 - generally these patients are **borderline** in terms of safe mobility and independence in ADL i.e. they require some help with some mobility manoeuvres.
Scores over 14 - Generally these patients are able to perform mobility manoeuvres alone and safely and are **independent** in basic ADL.

Version 2

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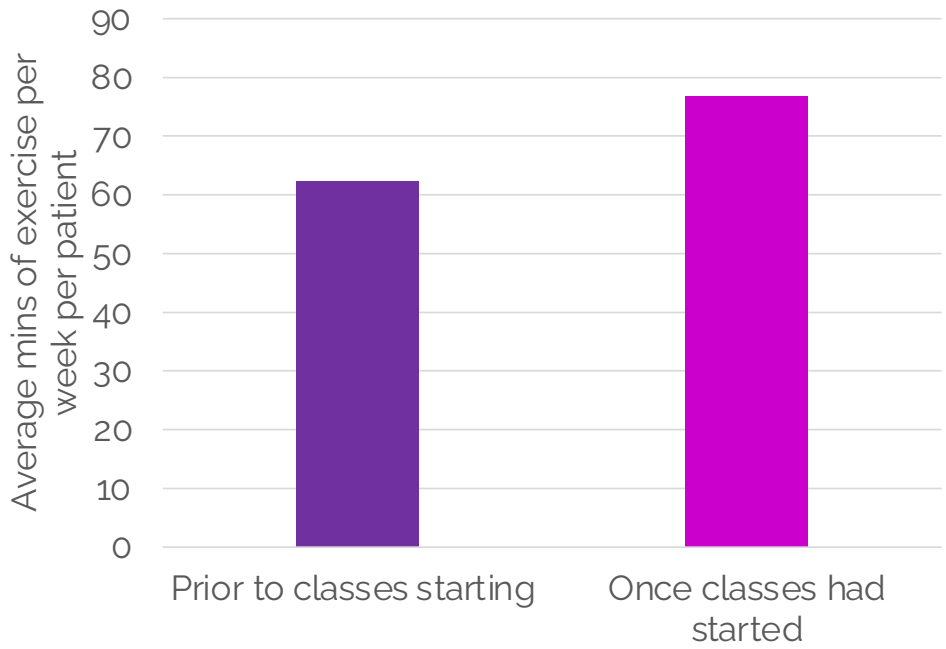
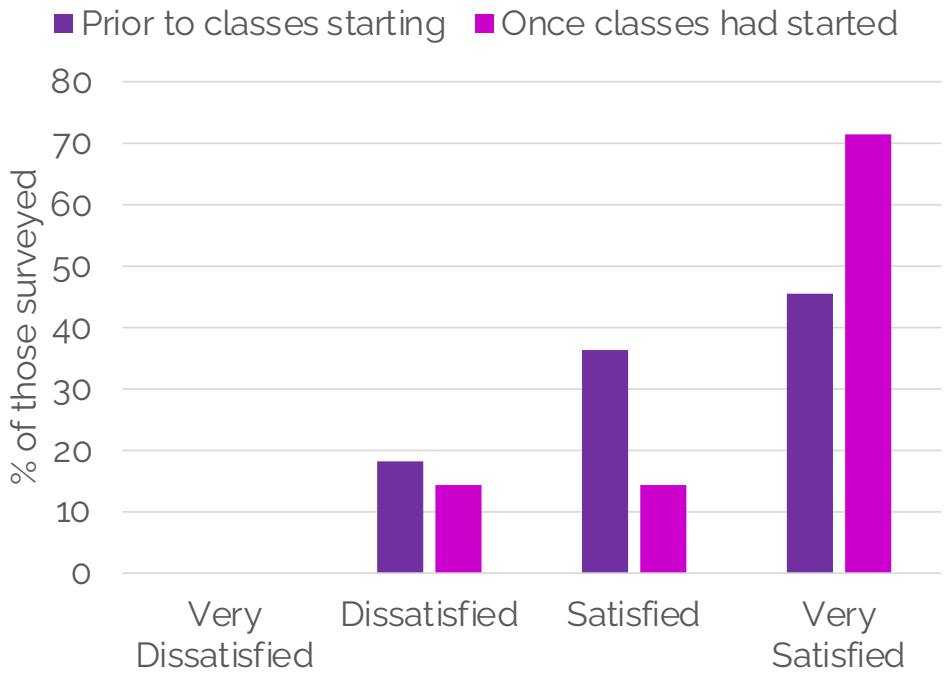
Results

The average minutes of exercise completed per week per patient, before and after the exercise classes started



Patient satisfaction with amount of therapy received whilst on Ford Ward



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Key Findings

1. The introduction of daily exercises classes resulted in:
   a) A 23% average increase in moderate intensity exercise completed by patients per week.
   b) An increase from 1 to 3 patients achieving at least 150 minutes of moderate intensity exercise per week, as recommended by the WHO.
   c) An improvement in patient satisfaction with the amount of therapy received.
   d) Positive feedback from patients about the classes themselves.
   e) An average increase of 1.75 points on the EMS scale.
   f) Increased face-to-face exercise contact time received by patients in relation to the number of therapy staff working on the ward.
2. Despite patients experiencing an increase in face-to-face therapy input through the exercise classes, the patients still requested 'more' therapy intervention.
3. Further research is needed to understand the wider impact of daily exercises classes on the patients.

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Conclusions

The introduction of daily exercise classes has, on average, increased patient activity on Ford Ward.

However, as this was only a small feasibility study, it is unclear if this increase will result in a functional impact for our patients, reduce their risk of falls or address hospital associated deconditioning.

But as the WHO Guidelines say:

Something is better than nothing!

References

AGILE (2012) Elderly Mobility Scale (EMS). Available at: https://agile.csp.org.uk/system/files/agile_outcome_measures_ems_v2.pdf. [Accessed on 05/01/2023].

Bull, FC et al (2020) World Health Organization guidelines on physical activity and sedentary behaviour. British Journal of Sports Medicine, 54:1451–1462.

Chen, Y et al (2022) Hospital-associated deconditioning: not only physical, but also cognitive. Int J Geriatr Psychiatry, 37(3):1-13.

Montero-Odasso, M et al (2022) World guidelines for falls prevention and management for older adults: a global initiative. Age and Aging, 51, 1-36.

World Health Organisation (2020) WHO guidelines on physical activity and sedentary behaviour. Available at: https://www.who.int/publications/i/item/9789240015128 [Accessed on 06.01.2023].

Thank you for listening!

hannah.niland@southernhealth.nhs.uk

Éamonn Doherty, Physiotherapist & Community Falls Coordinator, Belfast Health & Social Care Trust, Northern Ireland

Interaction between falls and deconditioning – a practical example

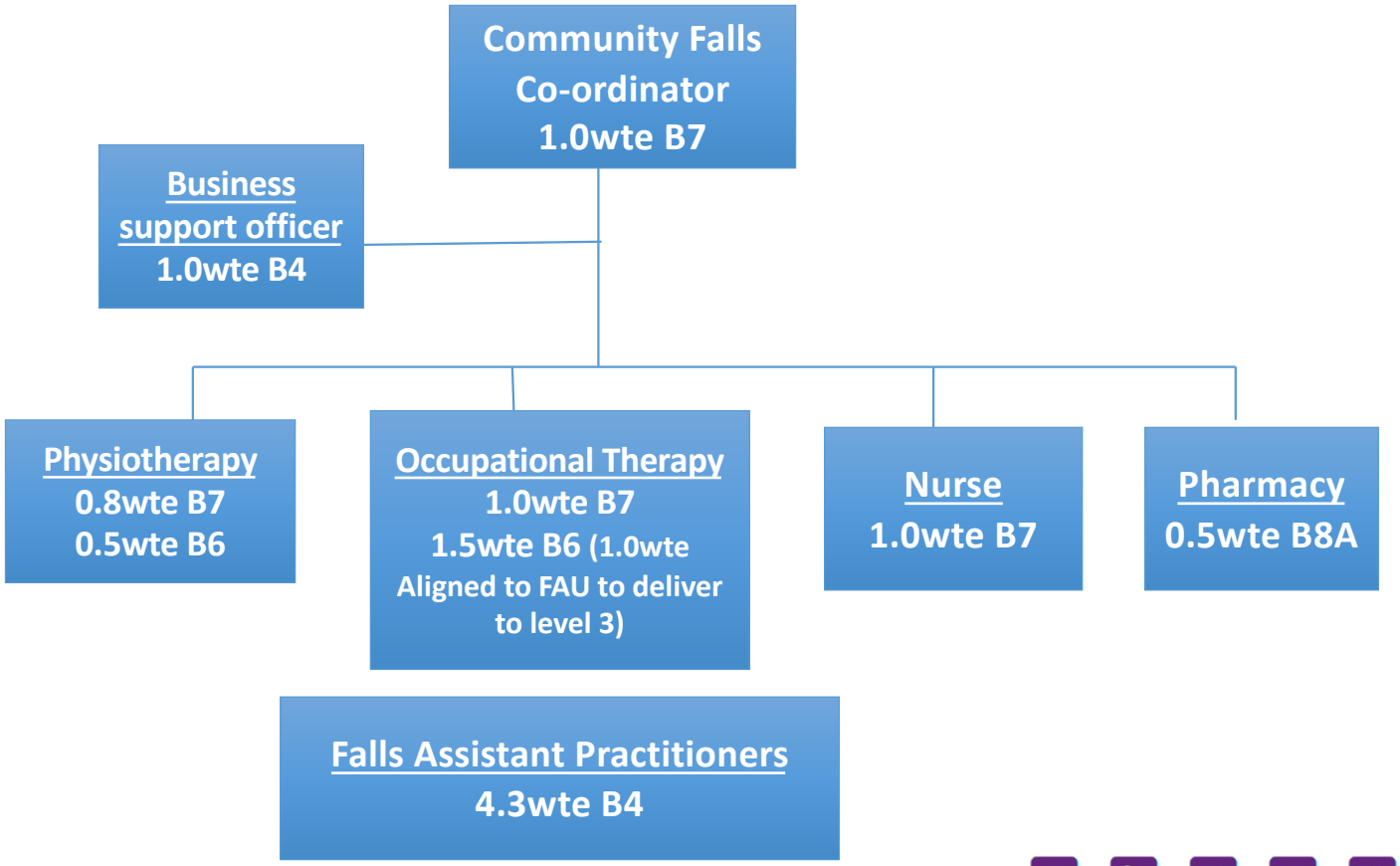
A patient case study reviewing the interaction between falls, deconditioning and exploring practical solutions to improve outcomes

Éamonn Doherty

HSC Belfast Health and Social Care Trust

respect & dignity openness & trust leading edge learning & development accountability

The Team (FSL: 11.4wte)



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Mission Statement

To provide an enhanced multi-disciplinary community facing Falls service that offers timely, safe and effective multi-factorial Falls assessment, intervention and prevention for service users within the BHSCT in line with NICE Guidelines:

"Older people who present with a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment" NICE

CFPMS helps achieve the following quality statements (QS) as outlined by NICE recommendations:

- QS1 Identifying people at risk of falling
- QS2 Multifactorial falls risk assessment for older people at risk of falling
- QS3 Multifactorial intervention
- QS7 Older people who present for medical attention because of a fall have a multifactorial falls risk assessment
- QS8 Strength and Balance training
- QS9 Home hazard assessment and interventions

**QS 4,5,6 are related to inpatient treatment only*

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Patient Journey:

- GP Referral with 3 falls and numerous near misses in past 3/12
- Triaged within 1 day of referral
- Routine waiting list
- Assessed by team nurse within 4/52

Falls Hx

- X 2 falls over night
- X fall at back door whilst putting bin out

Multifactorial risks identified

- Poor sleeper since husband RIP – getting up in dark
- Reduced social interaction since husband passed
- Anxiety++ restricting going outdoors – unable to get to shopping centre
- Varifocals – difficulty with depth perception at back door
- Knee OA pain increased on back of deconditioning

Agreed Rx Plan

- Environment advice & referral to Home Safety Repair Service – issued touch lamp for night time use
- Eye check – explored and obtained single lens glasses
- PT & FAP – HEP with view to S&B class
- OT – grab rail and explore anxiety management / confidence building

** declined onward referral for grief counselling

Outcome

- Impact of grab rail and improved depth perception with single lens reduced anxiety - able to get back to outdoor ADLs
- Anxiety also supported with relaxation – use of CD and imagery
- HEP targeted elements of deconditioning improving pain – no pain relief required at DC
- All above facilitated outdoor mobility +/- stick
- Attended & completed full12/52 S&B programme – incentivised activity with pedometer
- Walking twice weekly to local shopping centre – weekly meet with 2 class participants lessening impact of grief

Measure	Pre Class	Post Class
10 x sit to stand	40.34 secs	22.45 secs
4 Stage Balance	2/4	4/4
ABC Scale	63%	87%

- Self Referrals accepted for Community S&B programmes for moderate – low risk fallers
- CFS 3-4
- X6 community Venues: Andersonstown; Girdwood; Avoneil; Olympia; Lorag; Hanwood

"My sedentary lifestyle was not right for me – I have went from being inactive to active and I feel so much better"

"I now have the confidence to get back to driving and can collect my grandchildren from school"

- [Falls Prevention Exercise Programme – YouTube]
- [Falls Prevention Staying Safe and Staying Well at Home – YouTube]

Belfast Health and Social Care Trust

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Strength & Balance – Apr 22- Dec 22

183 referrals

Avg response time 8 weeks

216 S&B Classes Delivered (1295 contacts)
Avg 144 / month

131 Face to face Ax's
(41 remain on w/list)

63% complete 12/52 programme KPI = 40%

123 Accepted on to 12 week programme

KPI = 100% commenced with 16 weeks (PHA)

82% achieve Level 3 balance test

70% Improvement in Timed sit-stand test

64% Improved confidence

76% improvement in 360 turn test

HSC Belfast Health and Social Care Trust

Decondition Prevention Strategies

- Incentivise activity


- Linking participants in physically and socially

- Training our venue staff – step downs

OCN NI Level 3 Award in Planning and Leading a Physiotherapy Designed Exercise Programme in Fall Prevention and Strength and Balance Training

Lianne McInally, AHP Senior Manager, East Ayrshire Health and Social Care Partnership, Scotland

EAST AYRSHIRE
Health & Social Care
Partnership

south ayrshire
health & social care
partnership

NORTH AYRSHIRE
Health and Social Care
Partnership

NHS
Ayrshire
& Arran

'Understanding deconditioning and the need for prehabilitation and rehabilitation in the elective surgery waiting list population, using the electronic frailty index and complexity case finder.'

This work was based around the AHP resource required for our planned National Treatment Centre in Ayrshire and Arran.

Lianne McInally AHP Senior Manager, East Ayrshire HSCP

Elective surgery waiting times have increased due to the covid pandemic. The National Treatment Centre Programme in Scotland aims to:

- increase the ability of patients to access treatment
- increase flexibility for patients accessing treatment
- support regional working across territorial NHS health boards

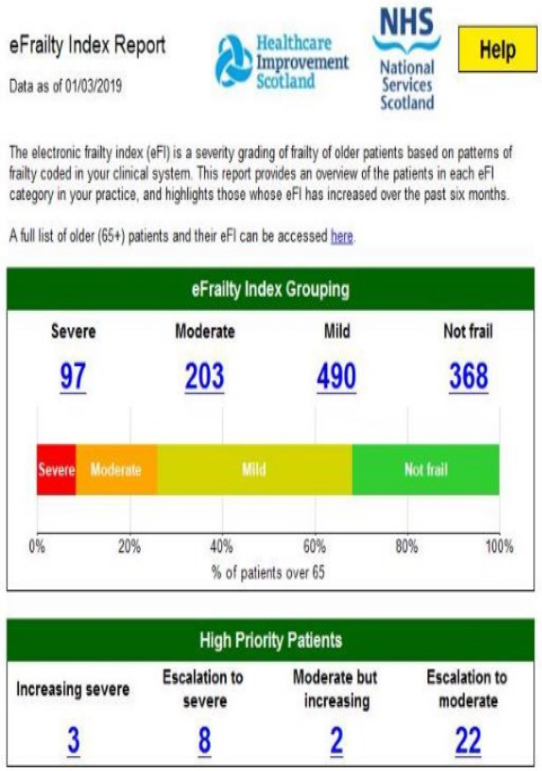
EAST AYRSHIRE
Health & Social Care Partnership

south ayrshire health & social care partnership

NORTH AYRSHIRE Health and Social Care Partnership

NHS Ayrshire & Arran

Using eFI (electronic frailty index) and complexity case finder tool



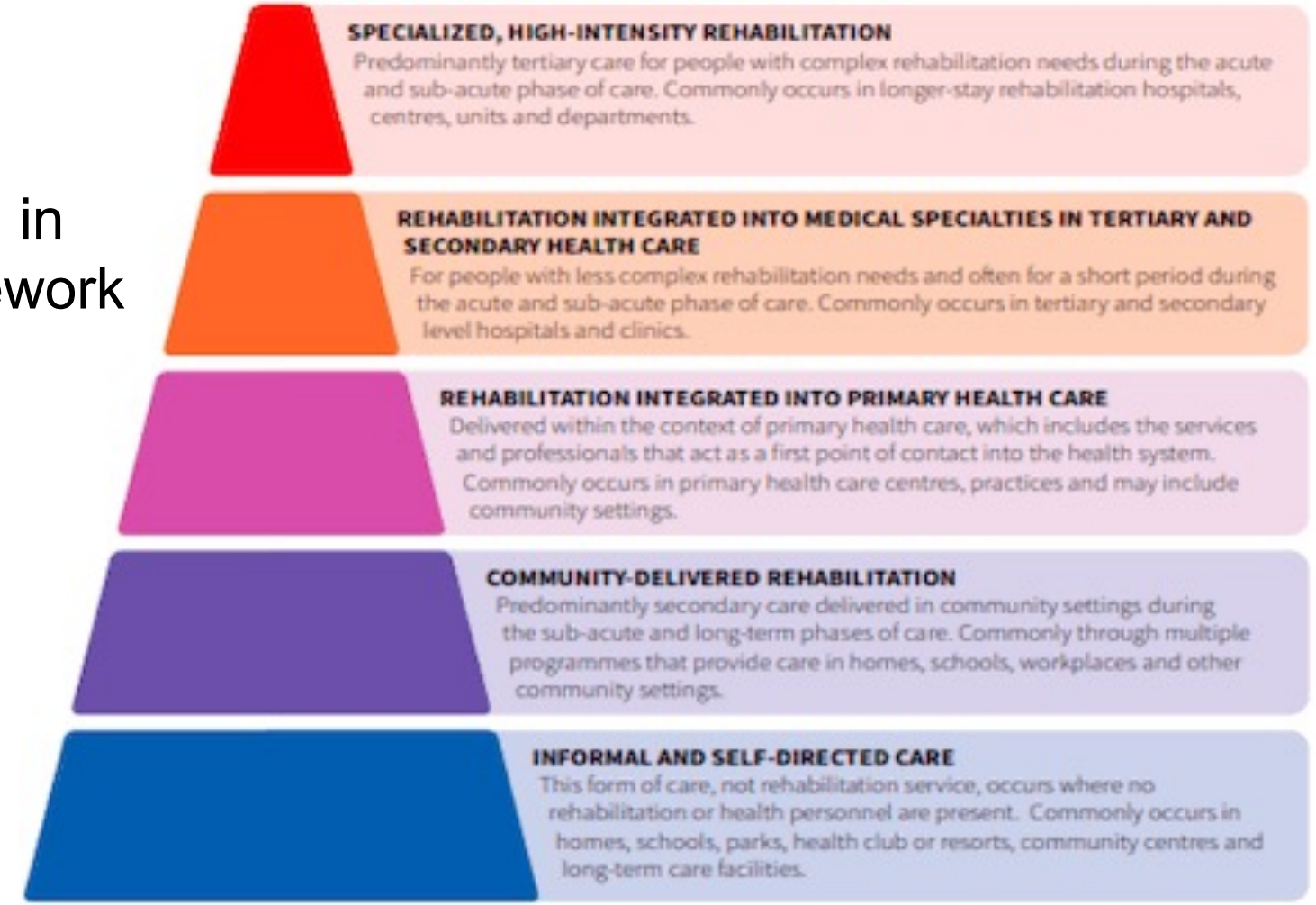
Waiting List Priority	Waiting List Patient Type	Not Avail	3%	6%	8%	11%	14%	17%	19%	22%	25%	28%	31%	33%	36%	39%	42%	44%	47%	50%	Total
Routine	Day Case	568	258	222	209	166	109	80	57	45	23	22	14	12	3	3	1		2	1	1795
Routine	Inpatient	204	104	144	138	114	108	89	66	54	23	18	20	6	4		2	1			1095
Urgent	Day Case	74	27	21	30	13	18	5	6	11	5	4	1	2							217
Urgent	Inpatient	30	21	17	20	19	31	12	6	15	3	1		1							176
X Priority 2 (Urgent admission in 4 weeks/Urgent in 4-6 weeks)	Day Case	1					1														2
X Priority 2 (Urgent admission in 4 weeks/Urgent in 4-6 weeks)	Inpatient		1			1	1		1												4
X Priority 3 (Semi Urgent admission in 12 weeks/Urgent in 4-6 weeks)	Day Case	3	1			1															5
X Priority 3 (Semi Urgent admission in 12 weeks/Urgent in 4-6 weeks)	Inpatient																				0
X Priority 4 (Routine admission)	Day Case	2	4	2	4		3		1	3	1										20
X Priority 4 (Routine admission)	Inpatient			1				1													2
Grand Total		882	416	407	401	314	271	187	137	128	55	45	35	21	7	3	3	1	2	1	3316
				1538				723				156					17				

- The eFrailty tool pulls coded data from the GP record to create a frailty score.
- The Complexity Case Finder uses a data set which uses Age, Care Home, Active Repeat Medication, Frailty Score, A&E Attendances (12m), Emergency Admissions (12m), Bed Days (12m) and OOH Contacts (12m)
- These scores give a detailed analysis of the individual's level of frailty and complexity and an indication of the level of input they may require pre and post operatively.

- Using workforce calculator tools and frailty and complexity scoring for likely suitability for levels of support required, we predict that 7% of patients will require Specialist Prehabilitation the cost of this is outlined in the table below.
- There has been a slight increase of 2% in frailty and complexity since the beginning of 2019 which is likely due to the direct and indirect impact of the pandemic.
- This increase is likely to be higher as people have not been accessing their GP practices in the usual way, this may have limited diagnosis of conditions and coding of frailty markers.

AHP Group	WTE	AFC Band	Future Investment
Physiotherapy	1.0	6	£45,345
Occupational Therapy	1.0	6	£45,345
Dietetics	0.6	6	£27,207
Podiatry	0.4	6	£18,138
HCSW	2.0	4	£67,374
Admin	0.5	3	£30,606
Total	5.5		£234,015

Rehabilitation in Health Framework

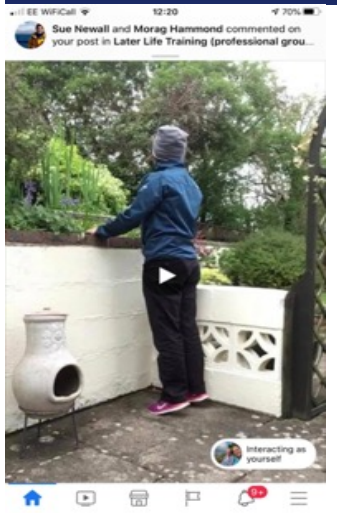


Source: WHO, 2019

- A tiered model of prehabilitation options was proposed using a "Specialist, Targeted and Universal" model of care to give the best value for money with the greatest impact for delivery of a post-operative Enhanced Recovery After Surgery (ERAS) model.
- To further improve patient outcomes by reducing BMI and increasing activity, function and food, fluid, and nutritional status before surgery, we propose the use of an assessment matrix to match patients to the level of prehabilitation they would benefit from, using frailty and complexity scoring tools alongside telephone triage where appropriate.

Key recommendations – Whole Population

- promotion and increased availability of strength and balance activity for older adults, involving a gradual increase in activity (reduce falls risk, enable safe and confident participation)
- ensuring that physical activity recovery measures reach those who stand to benefit most from them, including older adults who shielded, with multimorbidity, with dementia, in social care settings and from more deprived backgrounds
- identifying locally which older adults have reduced their levels of physical activity during the COVID-19 pandemic, with a focus on populations where the largest reductions are likely to be found.



https://www.gov.uk/government/publications/covid-19-wider-impacts-on-people-aged-65-and-over

Let’s help people be more resilient

- identifying locally which older adults have frailty and support increased physical activity
- promotion and increased availability of strength and balance activity for older adults, involving a gradual increase in activity in order to reduce falls risk and to enable safe and confident participation on other forms of exercise and physical activity
- referral of older adults with functional loss, transition towards frailty or fear of falls to appropriate rehabilitations services
  - Multi-disciplinary and community based
  - Including exercise - FaME, Otago, Tai Chi

https://www.gov.uk/government/publications/covid-19-wider-impacts-on-people-aged-65-and-over