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Multidisciplinary Team – Management in Long COVID Rehabilitation

City & Hackney Post COVID Assessment and Rehabilitation Service

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Symptoms present more than 12 weeks after initial virus. Not explained by another diagnosis

Symptoms are not necessarily same as when initially developed COVID

Symptoms can be wide ranging

Symptoms can affect any body system

Symptoms presented as a cluster common

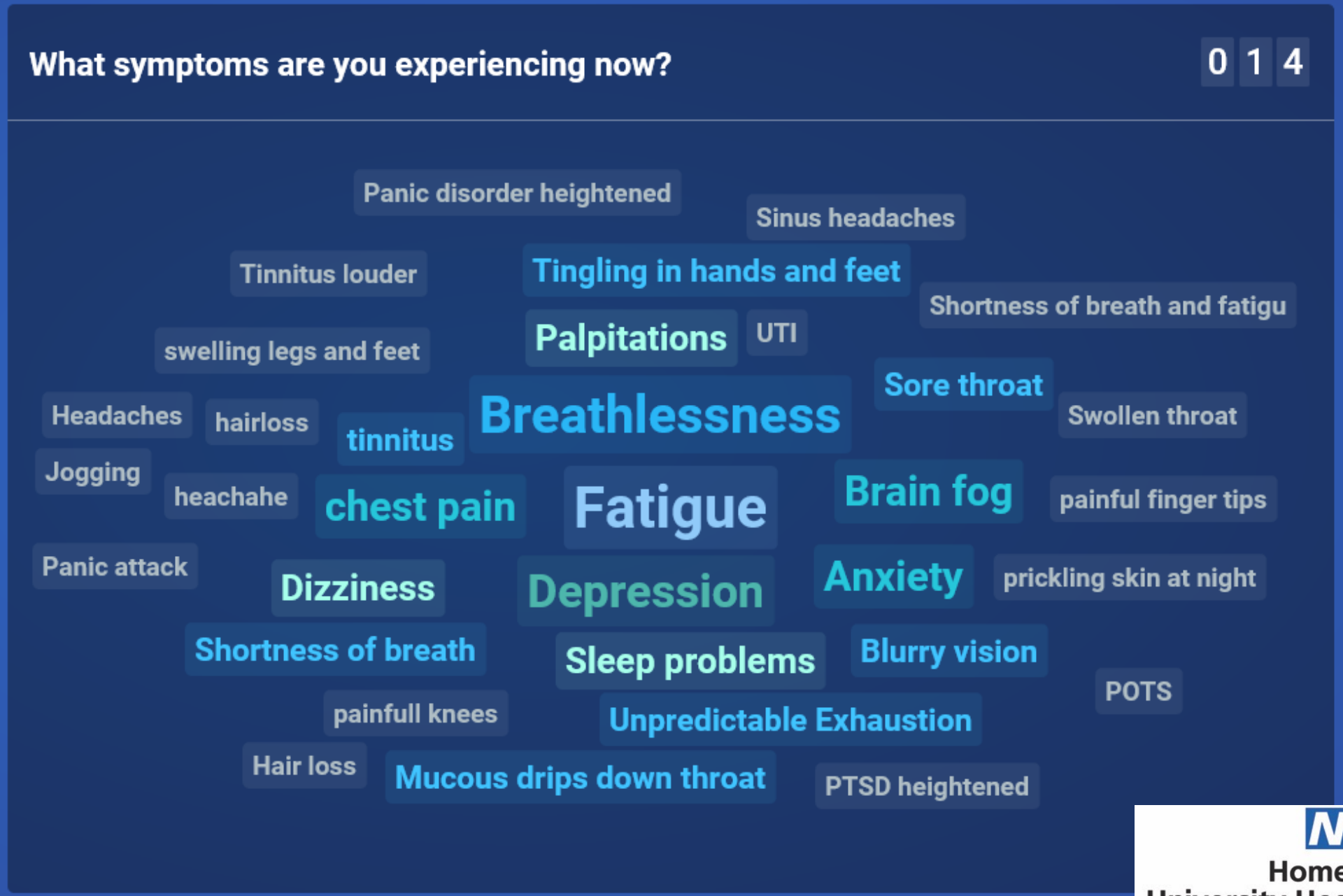
Symptoms can fluctuate and change over time

NICE, 2021

Example of the symptoms people report experiencing:

Active poll

Join at
slido.com
#91539



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Active poll

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What do your symptoms get in the way of?

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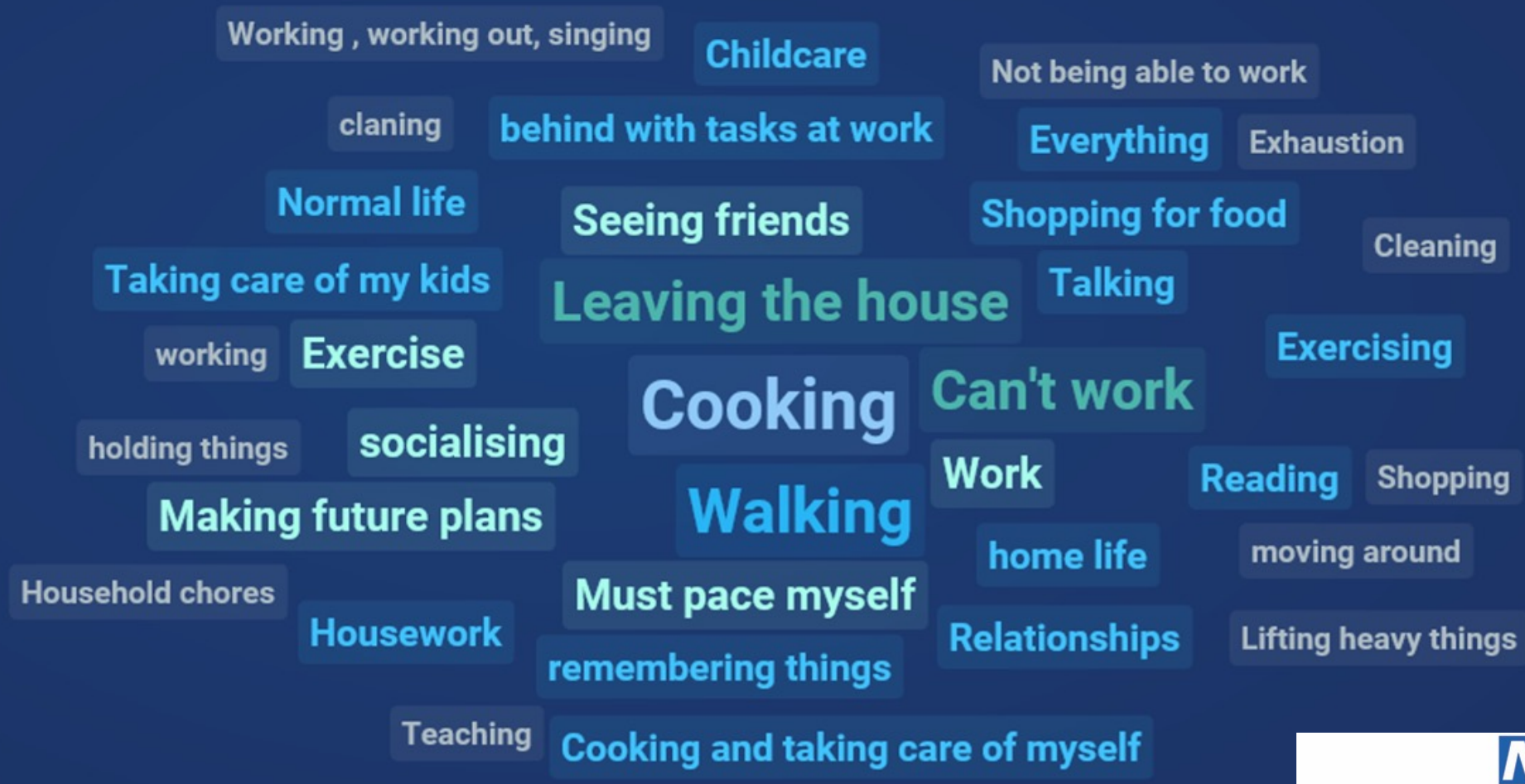

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What might help someone with Long COVID?

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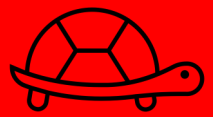
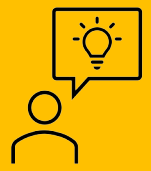
Nurturing an environment for the body to get back into balance



Knowing that recovery takes time – patience and persistence



Gaining insight, knowledge and awareness of the condition and the interplay of individual triggers/impact

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Being believed, validated, supported

(CoRe thematic analysis & Moving Forwards group feedback 2021)

Service Aims

To help clients understand their symptoms

To help clients learn strategies to manage problems such as fatigue, pain, changes in thinking and breathlessness

To help clients to manage difficult thoughts and feelings

To identify and work towards goals that are important to the clients

To signpost to other community services

To investigate symptoms further and refer to other specialist medical services if needed

The Team

Occupational Therapist

Cognitive Behavioural Therapist (Integrated with IAPT LTC)

Psychological Wellbeing Practitioners (integrated with IAPT LTC)

Physiotherapists

Dietician

Administrator

Commissioner/GP support

Clinical Lead Respiratory Consultant

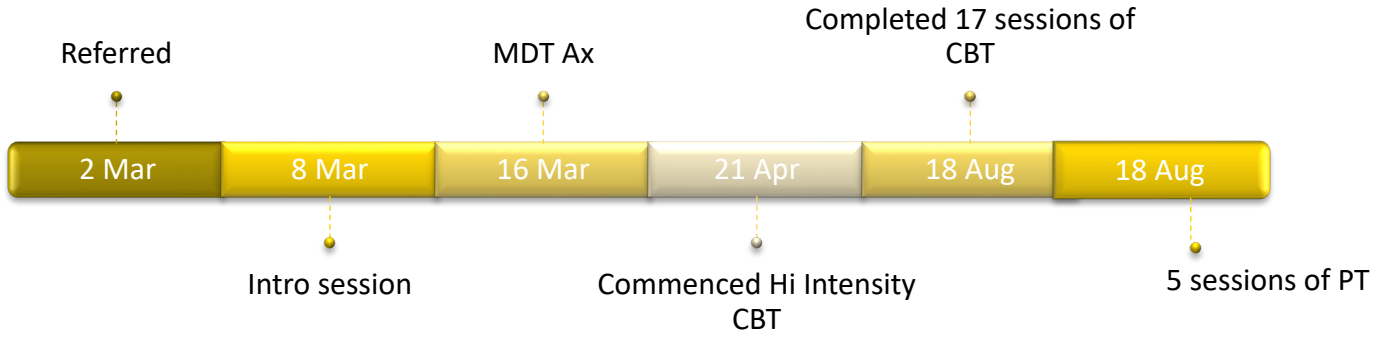
Access to secondary care specialties A&G/direct referral - cardiology, gastroenterology, neurology, rheumatology

Operational lead

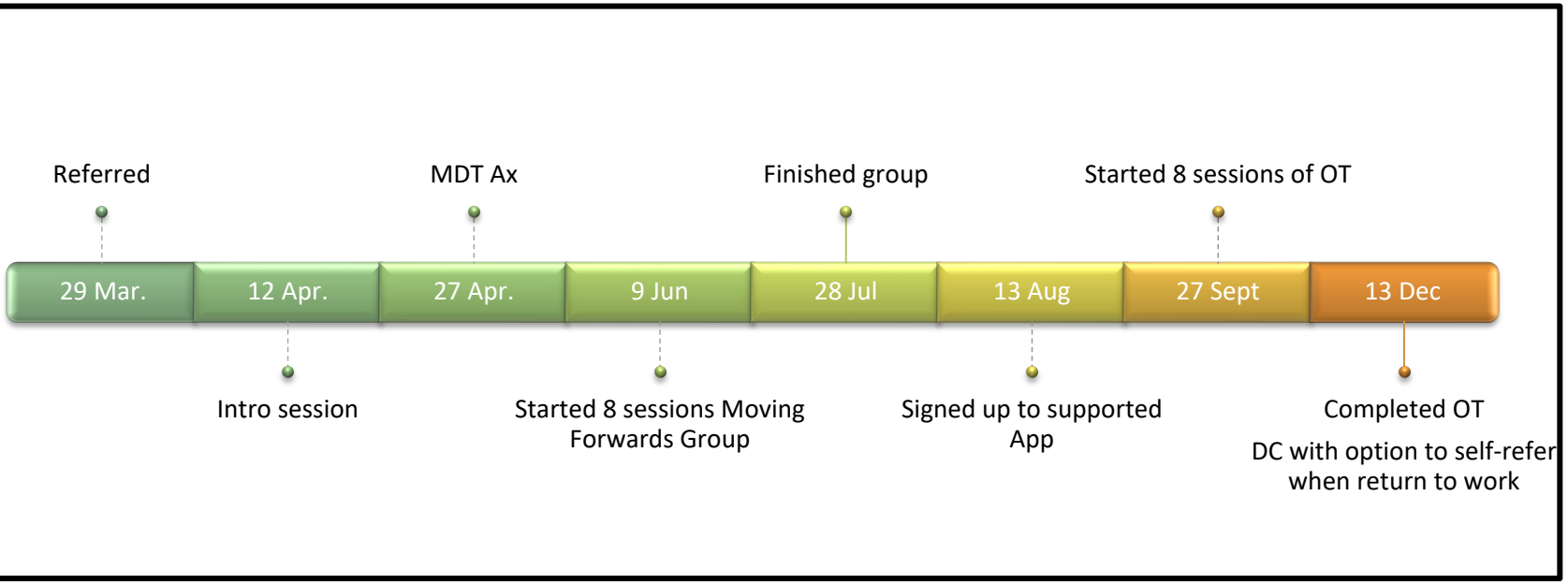
Access to Neighbourhood navigation/ voluntary sector support services

Service users

Examples of a patient journey



1. Presented with anxiety, low mood, fatigue



2. Presented with fatigue, brain fog

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Moving Forwards Group Feedback

This course helps manage the condition and take charge of your mental health in dealing with such an unexpected and life changing change in your health rather than offering medical solutions

The group helped me to connect with others who had similar experiences, managing emotional side of things, and opportunity to gain useful advice and tools.

You will find a safe space where you can exchange thoughts and ideas, find some community and learn strategies to cope with symptoms

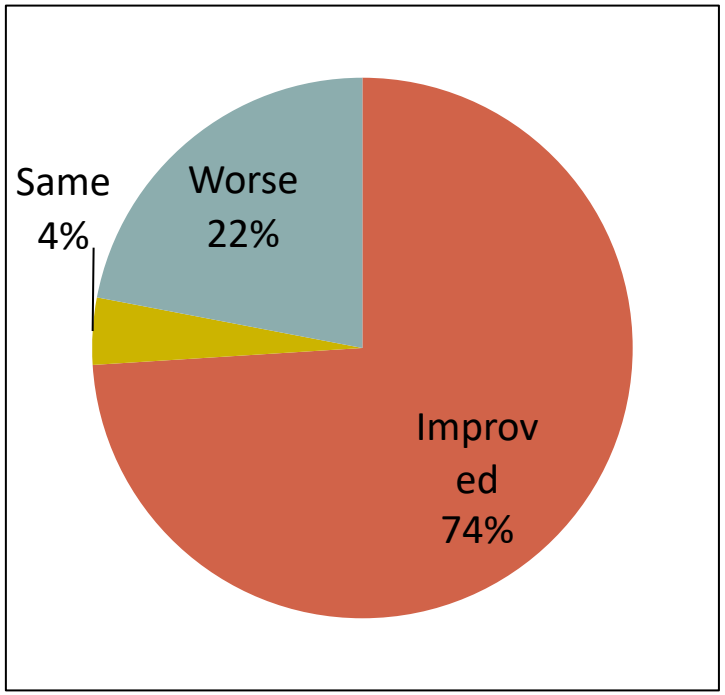
Don't be frustrated that this might not take the Long COVIDE away. Listen to the science, be open, turn up even when you don't want to, don't expect a quick fix but more of a slow awakening

Expect to be supported and understood and actually have positive suggestions to overcome the Long COVID symptoms

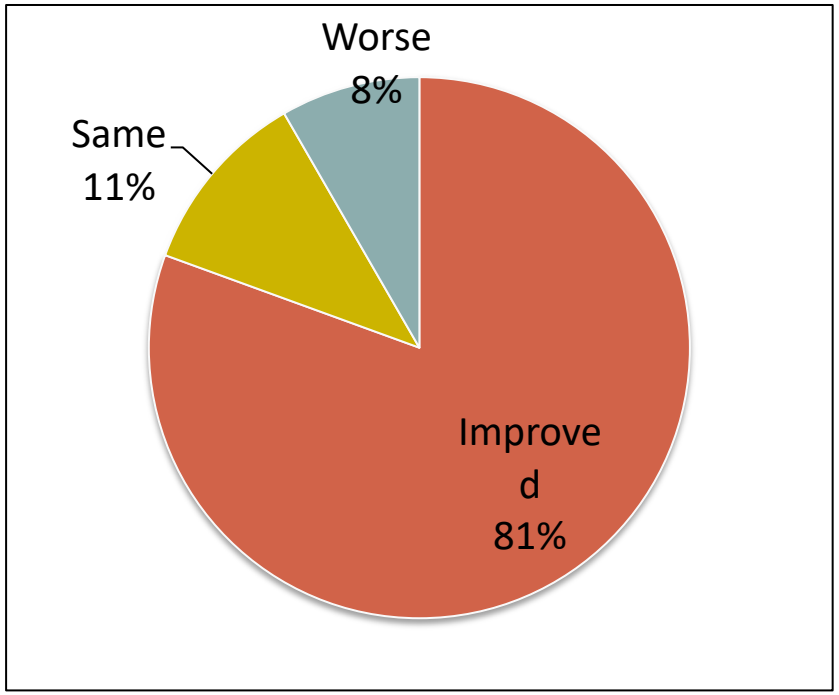
Integrating pacing with mindfulness practices, tools for better analysing task 'stressors' and their impact.

Outcome Measures across MDT

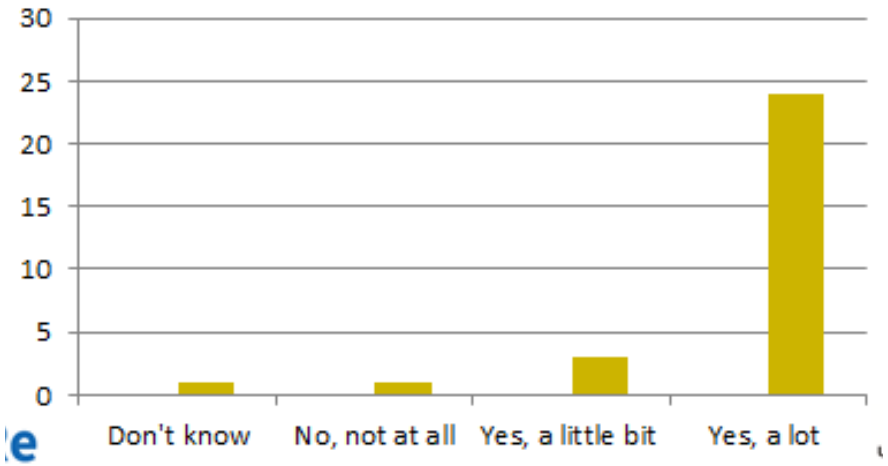
Generalised Anxiety Disorder Assessment



Work and Social Adjustment Scale



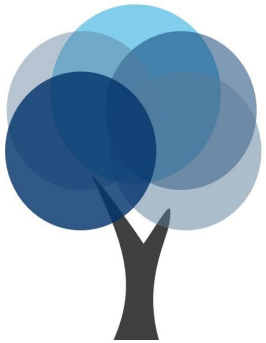
Confidence Rating Scale



Key Themes from stakeholder consultations looking at equitable accessibility of service.

1. Case Finding (Awareness Raising)

2. GP as gateway into Service



3. Access issues - cultural competency

4. Access issues - intersectionality between health and social wellbeing

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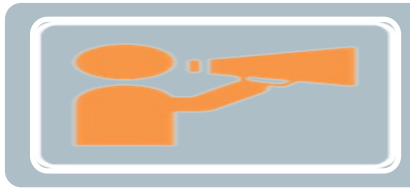
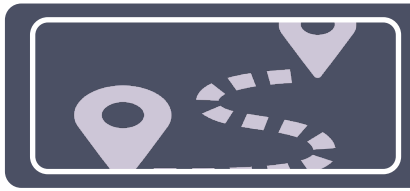


Information sessions with various community organisations, resident groups, community NHS services

Successful bid for Community Partnership Grants (NHS Charities Together) to develop community partners (e.g. Peer support, exercise, healthy cooking) .

Recruitment of care coordinator and community engagement lead roles

Joint working opportunities with community organisations (e.g Derman, Bikur Cholim)



NEL homeless pathway

Digital advocacy - Locomotor has partnered with Age UK to offer ipad loan and volunteer support to engage with health teams online

NHS
North East London
Clinical Commissioning Group

MULTI-DISCLIPLINARY TEAM MANAGEMENT OF LONG COVID & PERSONALISED CARE

NATASHA SUTTON

Date: 5TH April 2022

Tower Hamlets, Newham
and Waltham Forest

AGENDA

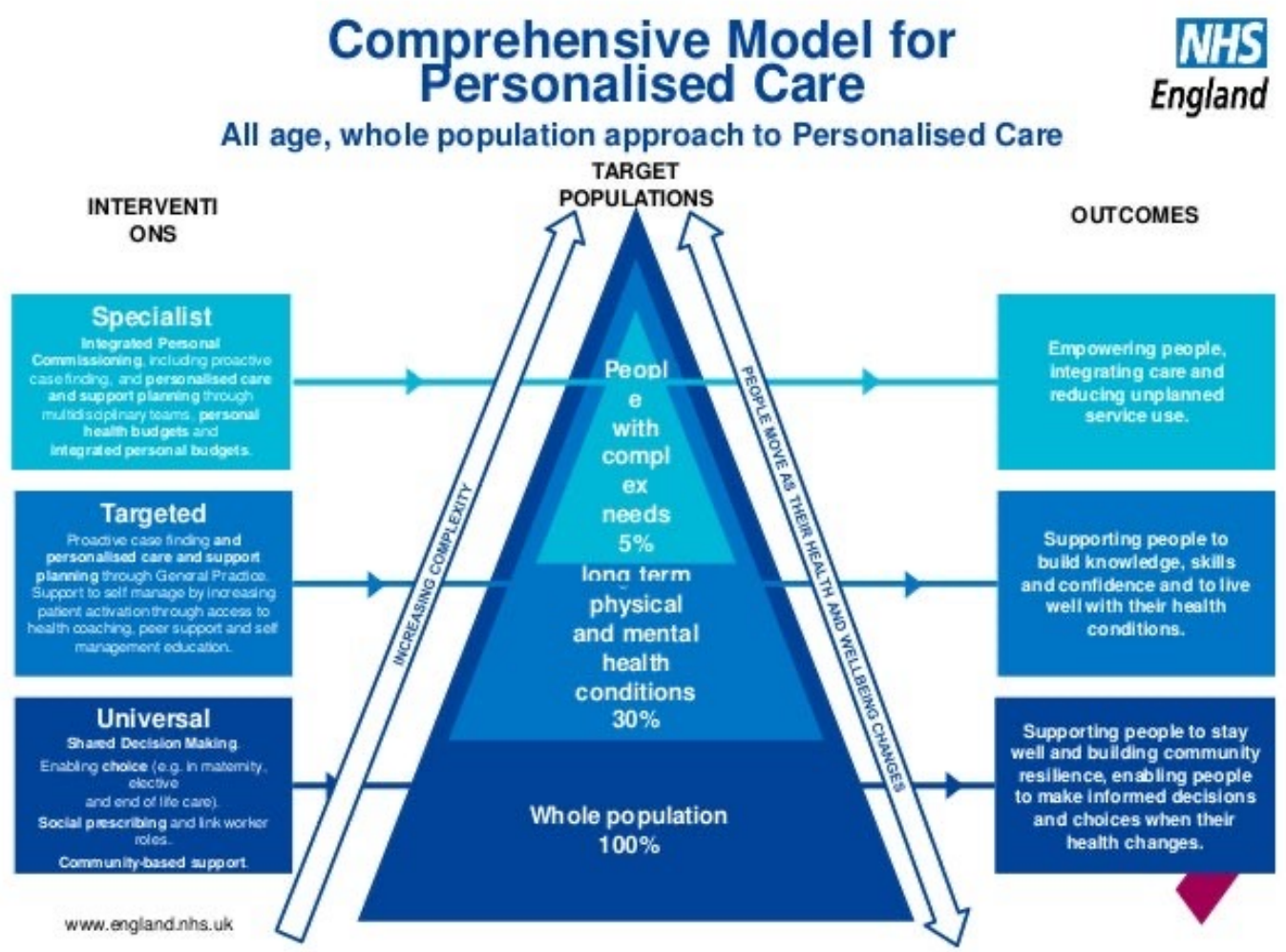
- PERSONALISED CARE
- SOCIAL PRESCRIBERS
- Case study
- CARE COORDINATORS
- HEALTH AND WELLBEING COACHES
- SUMMARY

PERSONALISED CARE- 6 components

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets

PERSONALISED CARE

- Personalised Care gives patients choice and control over their mental and physical health
- Based on ‘what matters’ to people and their individual strengths and needs.
- The personalised care roles offer an alternative, providing time to explore the needs and wants of the patients, using patient knows best approach
- Long COVID patients vary in presentation, meaning one size does not fit all



PERSONALISED CARE PRACTITIONERS in PRIMARY CARE

- 3 NEW PERSONALISED CARE ROLES
- SOCIAL PRESCRIBERS
- CARE COORDINATORS
- HEALTH AND WELLBEING COACHES
- MAJORITY OF PCN WILL HAVE AT LEAST ONE OF THESE ROLES IN PRACTICE

SOCIAL PRESCRIBING

- Help patients to link in with the community
- Offer time to develop a Personalised Care Support Plan, focusing on ‘what matters to them’
- Provide ongoing support for up to 6 sessions
- Refer patients to required support in community
- Have knowledge of community, voluntary, faith based organisations within their local area.

SOCIAL PRESCRIBING

- Feedback suggests Long COVID patients are hard to manage as they often feel helpless
- Medication is not always offered
- Patients struggle to adjust to change in their ability and lifestyle, meaning they can no longer engage in previous enjoyed activities
- Many SPs offer welfare calls, reassurance, and explore ways to utilise self help tools to increase self management, exploring new alternatives e.g. new hobbies.

SOCIAL PRESCRIBING case study

- Women aged 48 years previously no health problems until she had COVID
- Reason for referral – suffering with Long COVID not able to return to work, having financial difficulties due to decrease in income causing increase in stress and anxiety
- A Personalised Support Care Plan was developed

CASE STUDY continued

- Patient goal- return to work and feel happy
- SP referred to financial support services, received voucher for utilities and Argos to purchase a new washing machine
- SP referred to Talking Therapies for psychological support
- SP offered fortnightly, reducing to monthly ongoing reviews / welfare calls
- During this time, she disclosed her hair falling out was causing significant distress (many tears were shed)

CASE STUDY continued

- Explored alternatives, signposted to Holland and Barrett for supplement advise
- Supported in process of getting her hair cut
- Discussed realistic goals and steps towards returning to work
- Health Outcomes- patient received funds to purchase a new washing machine, and vouchers towards utility bills, reduction in stress levels
- Patient given time to explore underlying cause of distress (hair loss) resulting in taking some control over next steps reduced anxiety, increased confidence

CASE STUDY continued

- Patient offered welfare calls over a period of 5 months (total of 6 consultations) improved overall wellbeing
- Patient returned to work part time with a plan to increase hours over 3 months improved financial situation, reduction in stress, low moods and anxiety
- Patient was offered CBT from Talking Therapies increase happiness

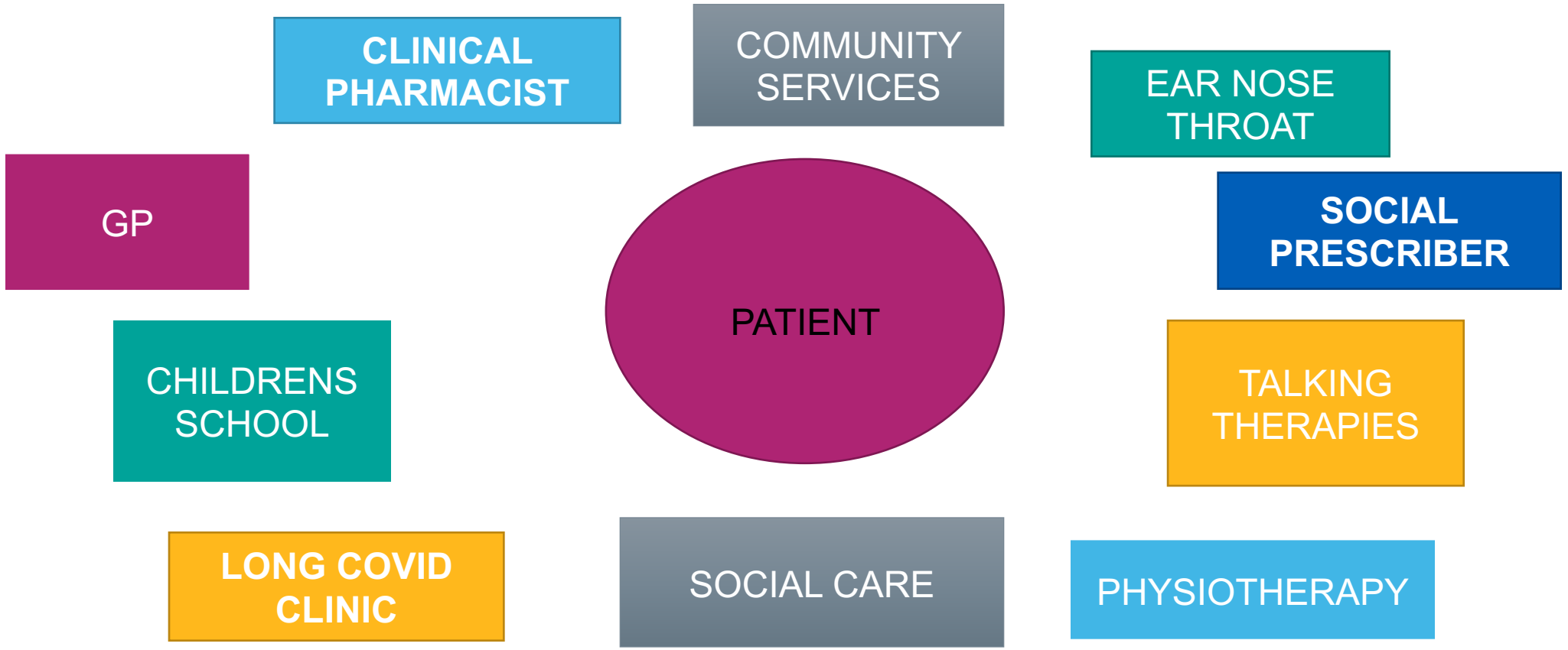
CARE COORDINATORS

- Health professionals can refer to CCs via the GP practice
- Develop a personalised care support plan
- Act as a middle person, liaising with the patient, primary, secondary, public and community, health care services. (Anyone involved in patients care)
- Offer reminders of appointments and update on outcomes; gives time to patient to discuss and clarify care plan, pending appointments and outcomes. Regular updating health professionals.

CARE COORDINATORS

- Integral part of a multidisciplinary team as they liaise with both primary and secondary services
- Care coordinators sit best in MDT as the middle person between primary and secondary care
- Holding knowledge and insight of the patient care plan
- Work with patient over long duration until patient has engaged with or completed interventions.

CARE COORDINATOR help patients navigate services



HEALTH AND WELLBEING COACHES

- Focus on health behaviour change – e.g. weight loss, increasing exercise, sleep disturbance, pain management, mental health
- Support patients to self manage their health
- Helping people gain and use the knowledge, skills and confidence to become active participants in their care
- Helping them to reach their self-identified health and wellbeing goals.

SUMMARY

- PERSONALISED CARE PRACTITIONERS EXPAND THE MULTI-DISCIPLINARY TEAM TO INCLUDE COMMUNITY BASED SUPPORT – INCREASING CHOICE AVAILABLE
- PCPs OFFER AN ALTERNATIVE APPROACH WITHIN PRIMARY CARE
- FOCUSES ON WHAT MATTERS TO THE PATIENT
- HELPS THEM TO WORK TOWARDS THEIR IDENTIFIED GOALS AND IMPROVE HEALTH OUTCOMES

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