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views were performed, and the information synthesised, by the authors of this abstract.

Results: Key insights from the C&YPs thoughts and ideas included:

- Lots of time is spent in hospital (as an inpatient or outpatient) with nothing to do. PA opportunities could happen in these times.
- It is helpful for C&YP with long term conditions to be given permission to be physically active by health professionals – in particular Consultants and Physiotherapists.
- Barriers to PA included lack of space, equipment, staff/support, poor timing, Coronavirus related restrictions.
- Suggestions for improvement included normalising PA within the healthcare setting, making better use of indoor and outdoor space, making equipment available, and having someone ‘non-medical’ to do exercise with them.
- Conversations about PA should be carried out with sensitivity and in a supportive manor that don’t leave the child or parents feeling judged.

Conclusion(s): Patients and their parents believe that PA is good for you and benefits the mental health of the child and the family. C&YP welcome PA conversations with their healthcare providers but the timing and style of those conversations are important. C&YP want PA opportunities to be fun and provide a distraction from their health needs. Some barriers to greater PA in the hospital environment can be easily overcome without significant financial investment. Future work will involve understanding the impact of increased PA opportunities and how PA in hospital transfers to PA engagement at home.

Impact: The findings of this patient and public involvement and engagement activity supported the employment of our Trust’s first Exercise and Physical Activity Therapist (EPAT). Trust staff will now be provided with specialist training on how to conduct appropriate PA conversations and these conversations will form part of the patient record.

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Utilising a specialist orthopaedic home support team to provide rehabilitation post fracture neck of femur during the COVID pandemic

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Keywords: Neck-of-Femur; Rehabilitation; COVID

Purpose: The national Hip Sprint audit highlighted poor mobility outcomes following neck-of-femur fractures (NOF#) with up to 60% failing to return to pre-fracture mobility level.

The standard community rehabilitation provided by our Trust included long waits and basic levels of rehabilitation provision.

Our elective arthroplasty pathway incorporates a specialist orthopaedic home-support-team (HST) whom visit patients in their homes after in-patient discharge to provide rehabilitation and joint management.

COVID-19 placed unprecedented demands on inpatient bed capacity and community service provision with the need to prevent long length of stay.

Whilst elective orthopaedics ceased during the second wave, our aim was to determine if early specialist community intervention following NOF# results in low length of stay and provides clinically significant improvements in patient outcomes.

Methods: We performed a two-month pilot study (December–January 2020/21) for all NOF# cases at an NHS district general hospital.

The inclusion criteria for specialist HST involvement were the capacity to follow commands, absence of complex social-care needs and the ability to step-round transfer with/without equipment.

Outcome measures were time to first contact, number of contacts, Berg Balance score, mobility status, ongoing referral requirement and patient subjective feedback (iWantGreatCare: questions 7,81,97,98).

Results: There were 73 NOF# cases occurring across the 2-month study period with 23 (32%) cases meeting the inclusion criteria for specialist HST. Eight patients (11%) passed away during the pilot period, one was seen by the HST. One case seen by the HST ultimately required revision-surgery.

The mean age of cases seen by the HST was 78 years (range 51–96). Surgical management comprised of hemi-arthroplasty (8), intramedullary-nail (6), total hip arthroplasty (6), and dynamic hip screw (3).

The mean length of inpatient stay was 8 days (range 1–33) with all patients returning to their usual place of residence.



All patients' received telephone contact within 24-hours and the medium time to first community contact was 4 days, with patients receiving on average 3 visits (range 1–8) over a mean 21 days.

Over 80% (17/21) of patient improved their mobility status from inpatient discharge to HST discharge (mean 20 days). Within 3-months of surgery, 15 cases returned to their pre-fracture level of mobility, including 8 who are mobilising independently. The Berg Balance score was completed in 14 patients with 11 achieving a clinically significant change (>6.5).

Thirteen patients did not require any further healthcare input and four were able to be managed in an out-patient setting.

Patient reported outcomes showed 100% patients scored 5/5 on all questions.

Conclusion(s): A third of NOF# cases were eligible for the HST service. We have demonstrated specialist HST involvement achieves significant improvements in balance and mobility with high levels of patient satisfaction.

In one case, a patient who sustained a NOF# a year previous and a second during this pilot managed to return to primary pre-injury mobility with the assistance of the HST, despite failing to achieve this after their first injury.

Impact: Utilising a specialist orthopaedic HST may reduce the strain of inpatient capacity and traditional community rehabilitation services however further investigation is required.

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Virtual Fracture Clinics: Improving the time to diagnosis following soft tissue knee injuries



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Keywords: Virtual Fracture Clinic; Patient journey; Efficiency

Purpose: Virtual fracture clinics are efficient, cost effective and safe for managing patients with fractures and soft tissue injuries. This clinical audit investigates the role of Brighton and Sussex University Hospital NHS Trusts (BSUH) Virtual Fracture Clinic (VFC) in the diagnosis of soft tissue knee (STK) injuries. Historically, STK injuries have been poorly managed with specific diagnosis taking up to 21 months. Following a STK injury, patients at BSUH are referred to the VFC from A&E. VFC referrals are reviewed by an orthopaedic consultant then telephone triage is completed by a Physiotherapist. A small number of patients have an MRI scan requested directly from VFC, dependent on con-

sultant opinion and preference. From the VFC, patients are discharged or referred into the Acute Knee Clinic (AKC), a specialist orthopaedic clinic for assessing patients with STK injuries. Many STK injuries are diagnosed through an MRI scan, however, there are often significant delays associated with this. The literature shows timely diagnosis is important following STK injuries to prevent secondary damage, long term complications and poorer outcomes post-operatively for those requiring surgery. Delays also have psychosocial impact on patients.

The aim of this clinical audit was to determine the current time taken for patients to receive a specific diagnosis following a STK injury within BSUH and the effect an early referral for MRI from VFC had on time to diagnosis.

Methods: Retrospective data was collected from 207 patients referred to the AKC from the VFC with an acute STK injury from January to July 2019. The following data was recorded: date of injury, VFC review, MRI scan and AKC appointment. The MRI referral source and the specific diagnosis was also documented.

Results: In total 144 patients were referred for MRI scans, 33 from VFC (VMRI group) and 109 from AKC (AMRI group). The mean time to receive an MRI scan from injury was 16.3 days and 36.1 days for the VMRI and AMRI groups respectively. The mean time to diagnosis was 37.4 days and 64.6 for those in the VMRI group and AMRI group respectively and 26.8 days with no MRI scan.

Conclusion(s): The results show that an early referral for an MRI from VFC reduces the waiting time for an MRI and reduces time to diagnosis following a STK injury compared to the standard AKC model.

Impact: Following STK injuries timely diagnosis is important to allow opportunity for early surgery to prevent secondary complications and allow time for pre-operative rehabilitation if required and an early MRI facilitates this. This has cost saving implications to the NHS, the patient and wider society due to fewer appointments and earlier appropriate treatment. The literature shows that patients with significant STK injuries, such as anterior cruciate ligament injuries, often have a typical injury subjective history. Further research is needed to determine a set of subjective criteria to highlight patients who would benefit from an early MRI scan. A retrospective review of the subjective history for the patients included in this clinical audit who sustained a significant injury could be beneficial to identify trends.

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