Managing clinical activity in the context of constraints on capacity in the recovery from COVID-19

British Geriatrics Society guidance

Background

Geriatric medicine is the largest medical speciality and contributes significantly to managing the acute unscheduled take, particularly for older patients with frailty. This has been shown to reduce mortality and length of stay.

Much of this work is in the emergency category and has been ongoing throughout the COVID-19 pandemic. Geriatricians have had a major role in dealing with acute inpatients with COVID-19. Ability to resume the full range of inpatient acute work will depend on control of COVID-19 and prevention of nosocomial transmission within hospitals. During this time, the British Geriatrics Society (BGS) has highlighted the particular vulnerability of older patients with frailty. Mortality figures clearly indicate the additional mortality with each decade of age, and while the virus continues to circulate we must ensure safe flow of older people attending hospital.

Outpatient and elective work

- Rapid frailty assessment for patients with weight loss and failure to thrive
- Falls and syncope clinic
- Pre-operative geriatric assessment for elective surgery and cancer therapy
• Movement Disorder Clinics
• Continence Clinics
• Delirium/Dementia/Memory Services.

In addition, the specialty and associated teams support inpatient general, orthopaedic and other post-surgical rehabilitation. We have input into intermediate care with services across the community to provide alternatives to hospital admission and to support discharge. This remains a key aspect of the Ageing Well workstream of the NHS Long Term Plan and has potential to support improved care in the care home population and enhance patient choice in a post-COVID era.

The commitments from the Enhanced Health in Care Homes workstream of the NHS Long Term Plan have been fast-tracked during the pandemic, as care homes have been particularly hard hit by the virus outbreak. This includes ‘ward rounds’ of care homes being conducted by GPs or geriatricians and care homes more easily being able to get advice from GPs and geriatricians. During the pandemic, much of this support can be provided virtually.

Older people have been among those most seriously affected by COVID-19 - 88% of deaths from this virus have been in people over the age of 65. This highlights the need for effective advance care planning and an emphasis on patient-centred palliative care.

General issues to be considered

The acute work of the specialty will continue as before. Early assessment for frailty and delirium promotes timely interventions and appropriate conversations about care. We need to advocate for early and timely screening while the virus is still circulating, appropriate shielding and encourage hospitals to monitor and minimise nosocomial spread.

Restarting non-emergency activity at 25%

We prioritise the urgent referrals to our services. Conditions requiring urgent assessment would include falls with injury, falls with syncope, sub-acute functional decline, active weight loss, new neurological signs suggesting a Parkinsonian syndrome with rapidly worsening signs.

Screening of referrals or use of virtual consultations should be evaluated but many in this category will require a face to face assessment. Use of video consultations in older people with frailty has limitations both in use of/access to technology and the ability to allow for example a detailed neurological assessment.

Clinics should be re-started with adequate protection for patients, allowing them to flow through the system without overcrowding. Pre-screening questions to ensure no active symptoms of infection are present could be asked prior to a clinic visit. We should facilitate on-the-day imaging if required, and return visits can be minimised by the use of telephone and letter consultations.
Outpatient rehabilitation and other services may need to be redesigned to be delivered in the first instance in the patient’s own home. Integrating care across Acute and Community Trust is clearly key in this.

**50% activity**

50%-75% resumption of full range of Outpatient activity to include comprehensive assessment of all patients with:

- Recurrent falls
- Assessment of a wide range of General Medical presentations in older patients
- New Movement Disorder referrals. These patients are likely to deteriorate into a more urgent category if they are not seen in a timely fashion.

These areas of specialist assessment require multidisciplinary input and this is usually coordinated in a number of hospital visits. We would advise that similar caution is taken to screening and protecting patients on their visit to a health care setting and the impact of this will be to reduce numbers seen in any one clinical session. Redesign should focus on continuing to reduce routine return appointments, instead coordinating this virtually, ensuring adequate communication and support of this patient group by nurse practitioners, AHPs and voluntary sector. Development of integration with other Community Services is again key to improving patient outcomes.

**90% activity**

Resume activity in areas that significantly impact on quality of life such as

- Assessing continence in specialist settings
- Pre-op assessment for older patients and those about to start in specific cancer therapy (OncoGeriatrics). Overlap with cancer and surgical recovery plans.