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THE IMPACT OF COVID-19 ON REHABILITATION SERVICES AND ACTIVITIES- LETTER TO THE EDITOR IN RESPONSE TO OFFICIAL DOCUMENT OF SIMFER

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Dear Editor

It is apparent that COVID-19 represents an unprecedented challenge to our society and to healthcare services in particular for all countries. We welcome the early recommendations by the Italian PRM societies and the guidance that it provides. We would like to share some of our early experiences in the UK and, in addition, highlight some other considerations.

The number of cases and deaths in the UK is fewer than that in Italy but it seems that the epidemic is following a similar trajectory about 2-3 weeks behind. The government has warned of a similar number of deaths unless public health measures can be implemented effectively. Hence the 2 weeks should have allowed the UK a vital window of opportunity to prepare. An earlier shutdown of retail facilities, education and minimising travel and outdoors activity may yet be shown to have a key role in reducing the spread of the virus as estimates of the likely toll are revised.

This time was also vital to allow the National Health Service to prepare. In-patient beds have been largely cleared with early facilitated discharges and most out-patient services have been cancelled to reduce viral transmission. Supply chains, in particular for Personal Protective equipment (PPE) have been reinforced; the controversies over the lack of such PPE at many centres, would have been much worse without this time to prepare. COVID-19 dedicated wards and hospitals have been created similar to the strategies put in place by Italy, China and other countries. Similarly, the availability of viral testing for staff should have been bolstered by this time.

PRM, or Rehabilitation Medicine as it is known in the UK, is largely a sub-acute specialty although more acute service involvement is increasing. Hence the main impact on PRM has been the cancellation of most out-patient clinics and elective procedures or interventions such as spasticity or joint injections. This has clear ramifications for function and disability for many of our patients especially if the “lockdown” continues for a prolonged period. Some centres are still carrying out a few procedures but the risk to benefit ratio has to be carefully considered. Many in-patients on PRM wards have been discharged to receive care either at home or in nursing and residential units and their rehabilitation cut short. Discharge pathways have been drawn up nationally with the aim of patients being discharged within a few hours of being declared medically ready. Community rehabilitation teams have been re-deployed to facilitate discharge with the necessary care and equipment provision rather than working towards any reduction in such dependence. Many rehabilitation professionals are feeling disenfranchised and marginalised, with reasonable concerns about whether rehabilitation services will be adequately reconstituted once this emergency is over

Telephone appointments have been utilised in place of face-to-face meetings for many appointments with seemingly mixed reviews. In particular it seems that many follow-up appointments are amenable to such an approach eg monitoring of symptom improvement after traumatic injury or adjustment of medication doses. However many appointments require examination and the importance of non-verbal communication or body language is lost. Some centres have access to video conferencing methods that may help with this.

Some PRM staff have volunteered or up-skilled to work in more acute settings. For those with previous acute medicine experience, this may be relatively straightforward but many such specialists have limited acute experience and it is unclear how much training would be required and how the

clinical governance would be managed. Many therapists have also been diverted to intensive care and acute wards.

It is important to consider escalation plans for all in-patients for access to critical care and do-not resuscitate orders. It is vital that this should be considered for all of our in-patients while there is a window of opportunity to have discussions with them and their family. Many of the existing tools used for these decisions are unsuitable for our cohort of patients with chronic health conditions eg Clinical Frailty Scale and we must be strong and forceful advocates for our patients for what may become a limited supply of critical care beds.

It has also been apparent in recent days that staff isolation/sickness rates can reach 50% in some areas. The challenge to provide an adequate staff complement, especially at acute interfaces, will be a major challenge to our healthcare services. Drafting in retired staff may help with this but age is a highly significant risk factor to severe COVID-19 illness.

There has also been a significant impact on many of our roles as teachers. Institutions of learning are largely closed and lectures cancelled. In some instances, remote lectures have been possible but this has been a challenge to ensure all students and staff have relevant access to talks and opportunities for interaction and questions are certainly affected. Bedside examination, a mainstay of medical education, is clearly impossible at present. If undergraduate and postgraduate exams are cancelled then the implications for individual career progression and staff numbers will be significant.

The pandemic will also leave a significant number of walking wounded survivors with long term medical and psychological problems and the PRM community worldwide should lead the way in managing these individuals and restoring their previous productive lives, a skill which comes naturally only to us and something our acute care colleagues will be expecting us to bring to this crisis

The “Churchillian” rhetoric of many of our leaders should leave no doubt as to the size of the challenge society faces. The guidance and experience of our colleagues in China and Italy should be an invaluable help in mounting a response in other countries.