Royal College of Surgeons
ADVANCING SURGICAL CARE

Recovery of surgical services during and after COVID-19

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Introduction

COVID-19 will be around for the foreseeable future and infection rates may fluctuate as public health measures relax. A significant backlog of surgical work is being created in addition to those patients on waiting lists before the present crisis. Retaining an expanded workforce and resources to deal with all of these patients is essential, but illness, fatigue and social issues among healthcare workers all threaten the necessary increase in surgical activity that is needed.

This document provides a list of principles, recommendations and key considerations in order to facilitate elective surgery. These can be used in combination with national, specialty and local trust recovery plans.

These recommendations are structured under nine themes to allow services to provide safe and efficient patient care, but also to ensure that when surgery resumes, it does not have to stop again.

Short-term recovery of surgical services

1. Key considerations before resuming elective services	2. Developing cohesive leadership and process of frequent communication	3. Assessing surgical workload and patient population
• **Timing:** There should be a sustained reduction in the rate of new COVID-19 cases for a period of time past the peak to ensure necessary staff and associated facilities (eg ITU) are available. • **Testing:** Hospitals should know their diagnostic testing availability and develop clear policies for addressing testing requirements and frequency for staff and patients. • **PPE:** Hospitals should be satisfied they have adequate PPE and surgical supplies appropriate to the number and type of procedures performed, and clear policies on how and when to use them. • **Availability of core interdependent services:** Care needs to be taken so that essential perioperative services (eg diagnostic imaging, anaesthesia, critical care, sterile processing) are also ready to commence operations before resuming elective surgery. Where these are not ready, it might be useful to consider engaging with external partners for temporary support. • **Local coordination:** To ensure the above requirements are in place, and the patients' care pathway is appropriately managed so that the resumption of services is safe and efficient (see also section 2).	• **Local recovery management team:** A local governance team should be put together to coordinate the recovery and provide transparent and flexible oversight. This should include the oversight and clarification of policies and guidance, making real-time governance decisions, managing the whole care pathway, communicating key messages to staff and patients, and liaising with other hospitals and related specialties as needed. • The team should have clinical input and be **multidisciplinary and multiprofessional** with **daily meetings** to deal with rapidly evolving local and national issues. • **Decisions** should consider prioritisation of patients, policies around referrals, COVID assessment and relevant protection, in the context of local availability of resources. • **Wider use of virtual meetings** should be made for staff and team communications as well as for consultations and communications with patients (see also sections 6 and 9).	• **Record of deferred cases:** It is essential that hospitals keep a clear record of all surgery that is being deferred and the criteria used to do so, so that there is an accurate estimate of deferred surgery and current waiting lists. Numbers of patients should include those who are: » waiting for elective surgery; » on stalled care pathways; » new patients. • **NHS England data:** NHS England is undertaking gap analysis on data from all trusts in England to estimate delays in referrals to secondary care compared to last year. This information will be helpful for planning a more efficient delivery of surgical services. • **Patient population data** should also be taken into account to assess population needs and potentially larger local community backlogs against available capacity. Useful tools for assessing patient population needs are provided by the Provider Public Health Network. • **Patient prioritisation:** There should be clear prioritisation protocols that reflect local and national needs, alongside availability of local resources (see *RCS COVID-19 Good Practice Guide, 2020* for guidelines).

4. Ensuring adequate hospital capacity and facilities	5. Enhancing workforce capacity	6. Reconfiguring services
• The recovery of elective surgery depends on local capacity and availability of clinical and other services necessary for the delivery of surgery. Some suggestions for enhancing facilities and bed capacity are as follows: • **Hospitals from the independent sector** will continue to support NHS services in the short term during the recovery period – as of the time of publishing this document, the NHS contract has nine remaining weeks, so hospitals can continue to use the additional capacity for this time. Hospitals can also consider what ongoing needs they may have beyond this period where they can draw upon independent sector capacity. Independent hospitals can be developed as COVID-19 light facilities to deliver NHS work. • **Nightingale hospitals** should remain in operation during the recovery period as dedicated COVID-19 sites. • **Scheduling modifications** to increase hospital capacity, including extending hours of elective surgery later into the evening and on the weekends should be considered. • **Revising clinicians' job plans** to allow more direct patient care while reducing administrative workload (see section 5). • **Additional time in theatre should be taken into account,** due to the increased time necessitated by managing COVID-19 related risks. This is particularly the case in lists with multiple procedures.	• **Temporary expansion of the workforce will be necessary.** It will also be important to be prepared for an unstable workforce related to fatigue, illness or social issues. • **Temporary retention of additional staff:** We strongly recommend that surgeons, nurses and other healthcare workers who have returned to work should be retained for the time period necessary to manage the backlog of work. Experienced retired surgeons in particular can also support in key non-patient facing roles such as collecting and quality assuring local data, monitoring adequate levels of facilities and equipment, assisting training at ARCPs, etc. • **Reassigning surgeons, junior doctors and surgical care team staff,** based on their competencies, to work in inpatient units, clinics, A&E departments, or trauma centres. Care should be taken that this does not further impact on surgeons in training (see section 9). • **Revising existing job plans,** to ensure surgeons are able to spend more time in the operating theatre treating patients and delegate non-direct surgical care to other staff. • **Appropriate cross-trust indemnity** will need to be in place to facilitate flexible working.	• Where possible, there should be a physical separation of COVID-19 positive and COVID-19 negative patients. COVID-19 free sites might be created at independent hospitals, within designated areas in NHS hospitals or for an entire hospital functioning as an NHS network hub. • **Where COVID-19 light facilities cannot be created,** dedicated COVID-19 operating theatres should exist to help contain the spread of the disease. These should be out of high traffic areas and emptied of non-essential materials or personal items. A clearly demarcated area should be available for donning and offing of PPE and exchange of equipment, medications and materials. Where feasible, the patient should be recovered by dedicated staff. • **Care pathways and protocols** for COVID-19 positive patients should be clearly developed and specific to the needs of each hospital – this should include identification of dedicated team members to manage these patients. • **For COVID-19 positive patients who require acute surgery,** consideration should be given to surgical approaches that decrease operating staff exposure and shorten the duration of surgery. Staff in the operating theatre should be limited to essential members. • **A wider use of virtual clinics as well as virtual patient reviews and consultations is encouraged where appropriate.** This includes technical considerations and required hardware/ software. Integrated system facilities ensure tracking and record keeping, but mobile devices and videoconferencing can also be used as back up. Back up options and administrative support should also be on hand in the early stages of implementation. • **Triage, referrals and service reconfigurations** between trusts and at a regional or national level should be considered to deliver surgical care efficiently.

7. Supporting the surgical workforce	8. Patient communication	9. Supporting training
• Secure adequate **PPE** to protect both patients and members of the surgical team. • Ensure adequate **testing** and appropriate frequency of testing is available. • Continued adherence **to universal precautions such as handwashing, social distancing.** • Consider levels of **stress and fatigue** in otherwise healthy workers. Also, workers returning to work following a COVID-19 infection may be more at risk for physical and emotional exhaustion. • Signpost **mentoring and coaching** projects currently available. • **Regular clear communication** should be in place including service reconfiguration updates, updates on policies and signposting to relevant resources (see also section 2). • **Training** should be made available on new ways of delivering healthcare, including virtual clinics.	• There should be local system-level coordination of key messages and instructions to patients (see also section 2), in alignment with broad national patient communications. This can include: » sharing plans to accelerate elective treatment with the public and reassure the public that their conditions will be treated; » sharing procedure prioritisation criteria; » having a standardised information sheet with a clear explanation of safety risks for patients receiving care in hospitals during COVID-19; » visitor guidelines; » post-discharge care/follow up pre-discharge testing in patients with vulnerable family/cohabitees; » advance directives; » carrying out virtual consultations; » guidelines for when to visit the hospital, when to go to the A&E, when they can consult remotely, and when they should access online/local pharmacy support (eg for minor injuries) and help themselves out without needing further input.	• A robust plan should be in place to support the next generation of surgeons. Where possible, additional opportunities for training and for more surgical and clinical exposure should be identified. • Delivery of surgical training needs to be matched to the need for increased surgical activity and should be undertaken at all sites involving NHS patients (including independent sector settings). • In the recovery phase, decisions surrounding progression based on the modified ARCP process should be flexible to ensure individual trainees progress through the programme at an appropriate pace in line with the change to a competency-based curriculum. • Earlier appointments to posts with mentoring supervision should be considered, alongside with earlier appointment to mentored consultant posts. • Opportunities for simulator training should be identified. • Training should also be made available on new ways of delivering healthcare, including virtual clinics. • Support the wider use of online resources (continue to increase availability to build on what has already been done well).