



Royal College
of Surgeons
of England

ADVANCING SURGICAL CARE

COVID-19



PROTECTING SURGERY THROUGH A SECOND WAVE

CONTENTS

- | | | | |
|----|--------------------------------|----|--------------------|
| 1 | INTRODUCTION | 16 | INDEPENDENT SECTOR |
| 3 | SUMMARY OF FINDINGS | 19 | SURGICAL TRAINING |
| 5 | RESTORING ELECTIVE
ACTIVITY | 21 | DEVOLVED NATIONS |
| 10 | COVID-LIGHT SITES | 23 | METHODOLOGY |
| 12 | TESTING AND PPE | | |



INTRODUCTION

Restoring elective services in the context of COVID-19 represents one of the most complex challenges that the NHS has ever faced. Following the suspension of non-urgent elective procedures earlier in the pandemic, planned surgery is now re-starting again in many parts of the country thanks to the extraordinary hard work and dedication of surgeons, their teams and colleagues across the health service.

RCS England's survey of 970 surgeons working in hospitals across the UK highlights the challenges that persist. Furthermore, it paints a picture of variation across surgical specialties and geographical regions. Overall, the amount of surgical 'activity' is understandably much lower than it was before the pandemic. It appears that in many cases, NHS England's target of restoring activity to **80%** of last year's levels by the end of September has been difficult to achieve. The results show too that more work needs to be done to ensure that all surgeons can access 'COVID-light' sites for their patients, with regular staff and patient testing to ensure operations can safely take place in this time of COVID. The establishment of these in regions where they are not yet available, is critical to enabling elective operations to take place safely through the coming winter.

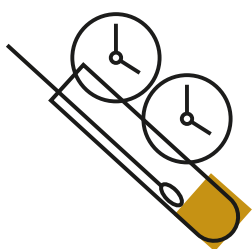
We do not underestimate the enormous difficulties of resuming the wide range of operations and planned procedures that we were used to being able to have before the pandemic. Surgeons say most critically they need additional theatre capacity, supporting services like diagnostics and regular and speedy testing. They also flag that this depends on the support of a wider professional team, the nurses, anaesthetists and theatre staff that make an operation possible.

Testing continues to be a key issue, with a quarter of surgeons telling us that members of their team are waiting more than 48 hours for a COVID-test result. This adds to the risk of staff shortages, and in turn cancelled operations, as staff may have to take time off work to self-isolate while they await results.

With winter now approaching, and waiting lists at record levels, resuming surgery must be a national priority. It is key both to the health of the nation, and our wider economic health. Hip and knee replacements help people stay active and independent, helping active economic participations. Getting these 'elective' operations up and running again is also essential to the future of the surgical workforce. Limited elective activity has been identified as one of the key barriers to enabling trainees to access appropriate time in theatre.

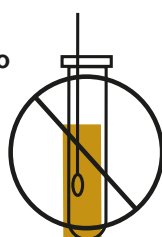
As we publish the results of our latest survey, we make five key recommendations to support the restoration of surgical services:

- 1. Funding for ring-fenced ‘COVID-light’ surgical beds in every region:** Surgeons were asked what single measure would have the biggest impact in enabling them to treat more patients. Nearly half (**48%**) said access to more theatres and facilities to limit theatre ‘downtime’ was necessary for deep cleaning. Lack of access to COVID-light sites (eg in the North East, in Wales and Northern Ireland) will become a growing problem as COVID cases rise, and must be fixed before the winter, so that surgery can keep going.
- 2. Guarantee access to speedy COVID tests for surgical teams, to keep surgery safe:** A quarter (**27%**) of respondents said it would take longer than 48 hours to get a test for a member of the surgical team. The majority (**59%**) of surgeons said that asymptomatic staff are not being tested. Regular testing of staff is essential to keeping hospitals free from COVID-19 as cases of the virus increase. Testing capacity has increased since the spring, so there are no excuses for failing to test staff on a regular basis.
- 3. Use of the independent sector to provide ‘COVID-light’ sites must be maximised, not as an alternative to, but in addition to NHS hospitals:** Over four in ten (**43%**) respondents thought that there were independent sector facilities that are not currently being used for NHS patients, which could be used to help tackle the backlog if appropriate contracts were put in place.
- 4. Ensure the equitable allocation of nursing staff, theatre staff and anaesthetic staff, to support the continuation of surgery through the winter:** We have all learnt from the first experience of COVID-19, the importance of keeping non-COVID services going, and do not want them to have to reduce down so far ever again. While a second wave will inevitably mean there is some redeployment of staff, this needs to be done equitably, so we can continue caring for all patients. Surgery is a team effort, so besides the physical infrastructure, the team around the surgeon is key to a successful operation. **53%** of surgeons said a lack of staff was a barrier to resuming surgery.
- 5. Every opportunity must be taken to support surgical trainees to gain experience and training time and complete their training.** Surgical trainees have been redeployed and worked flexibly during the pandemic to support the NHS through this difficult time. However, although surgical services have been starting up again following the peak in COVID in the spring, **67%** of surgeons in our survey said that a lack of elective activity meant there were fewer opportunities for training.



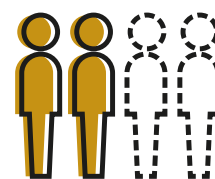
27%

of respondents said it would take longer than **48 hours** to get a test for a member of the surgical team



59%

of surgeons said that **asymptomatic staff** are not being tested



53%

of surgeons said a **lack of staff** was a barrier to resuming surgery

SUMMARY OF FINDINGS

1. Restoring elective activity

- In total **93%** of surgeons reported that it had been possible to undertake elective procedures in the four weeks preceding the survey – **15%** said this had only been possible in some specialties.
- In England, two-thirds (**65%**) of respondents did not think their trust would reach NHS England's target of restoring **80%** of last year's elective activity levels by the end of September. **39%** of respondents in England said elective activity was running at less than **50%** of the levels seen in 2019 (compared to **44%** across the UK as a whole), and **48%** said that activity levels were between **50%** and **80%** of last year's (compared to **44%** across the UK as a whole).
- **69%** of surgeons highlighted a lack of theatre capacity as a significant barrier to resuming planned procedures, and **53%** pointed to a lack of staff. **38%** said that lack of capacity in interdependent services was a problem, and a similar number thought that a lack of fast patient testing was a factor. The need for more routine and ward beds was a recurring theme in open text comments.
- When asked what single measure would enable them to see more patients in the coming weeks, nearly half (**48%**) of surgeons said there was a need for more theatres and facilities to reduce the 'downtime' necessary for deep cleaning. The need for more nursing, theatre and anaesthetic staff was also proactively highlighted in a number of open text comments.

2. COVID-light sites

- **63%** of surgeons reported that they were able to access COVID-light sites for their patients – this is very similar to the figure recorded in our previous survey in June (**62%**). The proportion of surgeons who were unable to access COVID-light sites appears to be particularly high in the North East and the devolved nations.

- Just **9%** of surgeons said that COVID-light sites are only available to cancer patients, compared to **24%** in June, suggesting these facilities are now open to patients with a wider range of conditions.
- We found a roughly even split between the proportion of respondents who said that COVID-light facilities were configured as completely separate sites away from emergency and COVID-19 patients (**42%**), and the number who said such facilities were distinct areas in the same hospital (**38%**).

3. Testing and PPE

- Half of surgeons (**50%**) said that they could access COVID-19 test results for surgical patients within 24 hours, an improvement from **41%** in June.
- When asked about test results for members of the surgical team, **40%** of surgeons said they could get these within 24 hours. However, over a quarter (**27%**) indicated that it took at least 48 hours to get results, which could lead to staff having to take time off work to self-isolate.
- The majority (**59%**) of surgeons indicated that asymptomatic staff are not being tested in their workplace. Just one in ten (**11%**) reported that asymptomatic staff are tested at least once a week.
- **11%** of surgeons did not feel that there was an adequate supply of personal protective equipment in their workplace, compared to **17%** in June and **33%** in late April. However, a slightly larger proportion of surgeons (**18%**) expressed concerns that the personal protective equipment they had been provided with was not appropriately fit tested.

4. Independent sector

- The majority (**58%**) of surgeons said that they were able to access NHS capacity in the independent sector, with a quarter (**27%**) reporting that they were unable to do so. Of those who were utilising independent sector capacity, **43%** only expected this to continue for up to three months.
- **43%** of surgeons thought that there were independent sector facilities that are not currently being used for NHS patients, which could be used to help tackle the backlog of elective procedures if appropriate contracts were put in place.

5. Surgical training

- **46%** of surgeons said that surgical training has resumed having previously been suspended due to the pandemic, and a further **41%** said training had never stopped. Just **8%** of surgeons report that surgical training has yet to resume.
- When asked about the most significant barrier to trainees gaining time in theatre, two-thirds (**67%**) of surgeons indicated that a lack of elective activity meant that there were fewer opportunities for training.

6. Devolved nations

- Responses from the devolved nations indicate that access to COVID-light sites represents a particular challenge – the proportion of surgeons who said they were unable to access such facilities was high in Wales (**30%**), Scotland (**42%**) and Northern Ireland (**46%**).
- **88%** of respondents in Wales said it had been possible to undertake planned procedures in the previous four weeks, compared to **93%** across the UK as a whole. In Northern Ireland, responses indicate that long-term issues around workforce shortages are having an impact on surgeons' capacity to re-start elective services.

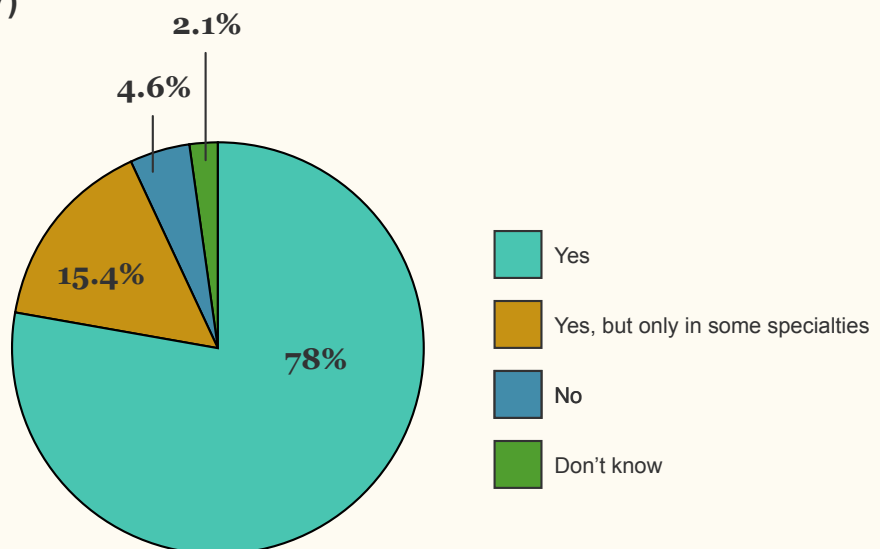
1| RESTORING ELECTIVE ACTIVITY

Restoring elective surgery is now a central priority for the NHS. During the first peak of the pandemic, non-urgent elective procedures were suspended to ensure that the health service had sufficient capacity to deal with large numbers of COVID-19 cases. While this was a necessary response to the crisis, it has inevitably led to a significant deterioration in patient waiting times which reached their worst levels on record over the summer.¹ The health service is now working exceptionally hard to re-start elective activity and ensure this is maintained through subsequent phases of the pandemic. We asked surgeons how far they have been able to go in resuming planned procedures, and what the main barriers are to undertaking more elective operations.

Most surgeons say that some level of elective activity has now resumed. In total, **93%** of those we surveyed reported that it has been possible to undertake planned procedures in the last 4 weeks (**15%** of surgeons indicated this was only possible in some specialties). This is an improvement from RCS England's last survey in June, when just **65%** of surgeons said that elective operations had been possible in the previous 4 weeks.² However, resumption appears to have been more challenging for

certain specialties. In particular, the proportion of trauma and orthopaedic surgeons who told us that planned procedures had not been possible (**9%**) was almost twice the national average (**5%**). There was also some regional variation, with nearly a quarter (**23%**) of surgeons from the West Midlands reporting that resumption had only been possible in some specialties compared to an average of **14%** across all English regions.

Has elective or planned surgery been possible in your trust/health board at any time in the last four weeks? (n = 957)



1. NHS Digital's data on *Consultant-led Referral to Treatment Waiting Times* indicate that in June 2020 just 52.0% of patients were treated within the statutory target of 18 weeks, the worst figure since records began in August 2007. This fell further to 46.8% in July 2020, with over 2 million patients waiting in excess of 18 weeks for treatment for the first time
2. n = 1,718. Note that if dental surgeons are removed from the survey results for June (see Methodology section) the proportion of respondents who said it had been possible to undertake planned procedures rises slightly to 67% (n = 1,649)

Elective activity in England

In July, NHS England asked trusts to recover 'at least **80%** of their last year's activity for both overnight electives and outpatient /daycase procedures' by the end of September, with a view to reaching **90%** by the end of October.³ Many surgeons indicated that it was unlikely they would be able to reach this. Two-thirds (**65%**) of respondents in England did not think it was realistic for their trust to meet the 80% target. Just a quarter (**26%**) thought this could be achieved.⁴

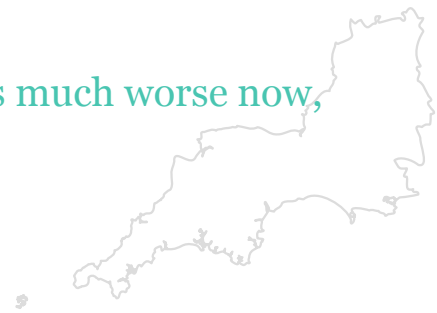
To understand this finding in more depth, we asked surgeons how much elective activity was currently being undertaken overall in their trust. Four in ten (**39%**) respondents in England said that elective activity levels were

running at less than **50%** of those achieved last year, and nearly half (**48%**) reported that elective activity levels were between **50%** and **80%** of those seen in 2019.⁵

Access to diagnostic services has been identified as a key factor in re-starting elective surgery by NHE England, and trusts were also set a target in July 'to very swiftly return to at least **90%** of their last year's levels of MRI/CT and endoscopy procedures'. We asked surgeons in England whether this had been achieved in their trust. Just over half (**51%**) indicated that the target had not been achieved, with only **16%** saying it had been met, suggesting that there is further work to do on improving access to diagnostics.⁶

“The main problem, which existed pre-COVID but is much worse now, is the lack of theatre staff and anaesthetists.”

Consultant, Oral and Maxillofacial Surgery, South West



Elective activity across the UK

Across the UK as a whole, the proportion of respondents who said that elective activity levels were running at less than **50%** of those achieved last year was slightly higher (**44%**) than in England alone. Equally, the proportion who said that elective activity levels were

between **50%** and **80%** of those seen in 2019 was slightly lower (**44%**) than in England. These findings suggest that England has fared better in terms of restoring elective activity than other parts of the UK.

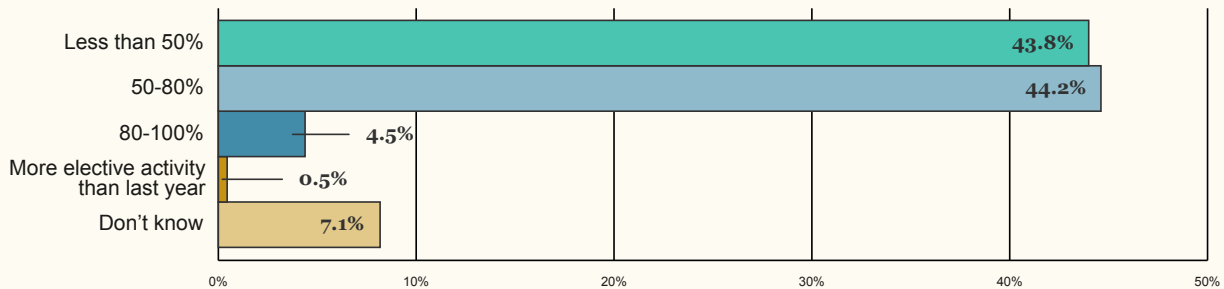
3. NHS England, Third Phase of NHS response to COVID-19 (31 July 2020), p. 4: <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf>

4. n = 745

5. n = 745

6. n = 745

What level of elective activity (overnight electives and outpatient /day case procedures) across all specialties, do you believe is being achieved now in your trust/health board, compared with the same time last year (UK-wide)? (n = 875)



We also asked surgeons about the level of elective activity taking place in their particular specialty. The proportion of respondents who said that current elective activity levels were less than **50%** of those achieved in 2019 was particularly high amongst trauma and orthopaedic surgeons (**58%**) and plastic surgeons (**55%**).⁷

In addition, surgeons reported that the number of patients they are able to treat in an operating session has reduced due to the new infection

prevention and control requirements that have been necessary to protect patients from COVID-19. Four in ten (**39%**) of surgeons said that during an operating session they were treating around **75%** of the number of patients they saw before the pandemic, and a further **29%** said they saw around half as many patients as previously. **14%** of surgeons were able to treat roughly the same number of patients as before.⁸

“While every effort to increase the provision of surgical services is being made it is important to recognise this will only be possible with a parallel increase in staff from the entire multidisciplinary team. Increased theatre capacity will not be sufficient without additional theatre support staff, recovery space and nurses, ward staff and hospital capacity.”

Clinical Practitioner, General Surgery, South East



7. This compares with an average of 42% across all surgical specialties (n = 875)

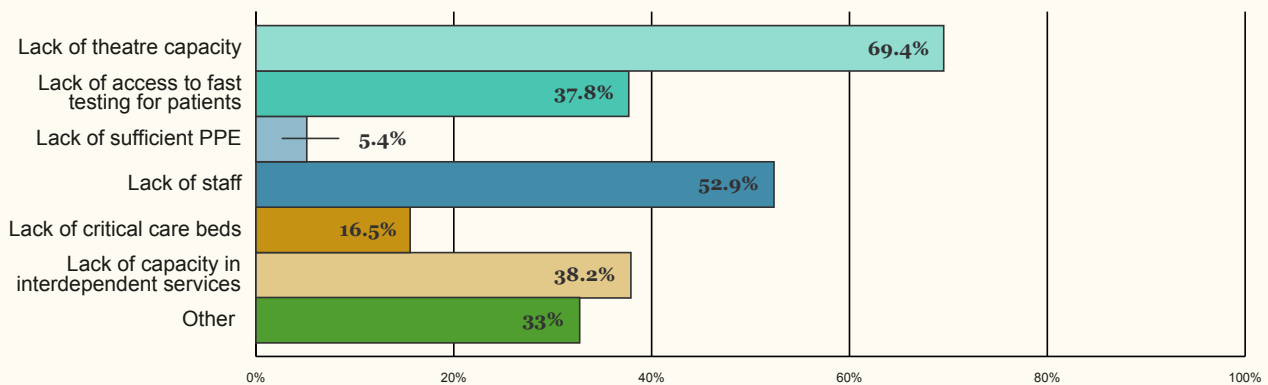
8. n = 835

Barriers to resumption

Our survey examined what surgeons saw as the most significant barriers to resumption. A sizable majority (**69%**) of those who responded pointed to a lack of theatre capacity as a key obstacle to re-starting services, and a lack of staff was also highlighted by more than half (**53%**) of surgeons. Furthermore, nearly four in ten respondents (**38%**) said that a lack of capacity in interdependent services such as diagnostics and anaesthetics was causing

problems, and a similar number (**38%**) indicated that lack of access to fast testing for patients was a factor. Lack of critical care beds was cited as a barrier by one in six (**17%**) surgeons. In open text comments, a number of respondents proactively mentioned that infection prevention and control measures were having an impact on productivity, and the need for more routine and ward beds was also a recurring theme.

Which of the following barriers do you regard as significant to the resumption of planned/elective surgery in your trust/health board? (n = 875)



“Lack of ring-fenced surgical beds is the main limiting factor on restoring 90% elective surgical capacity. The bed base was reduced to maintain social distancing between medical patients and this has had a significant impact on restoring elective surgical capacity.”

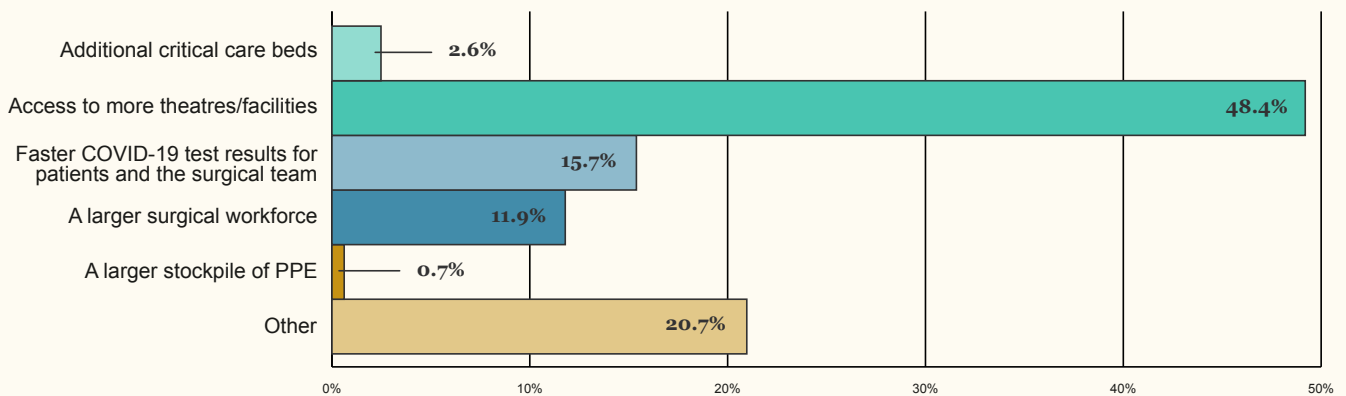
Consultant, Urology, East of England



Surgeons were also asked which single measure would make the biggest difference to increasing the number of patients they could treat in the coming weeks. Nearly half (**48%**) of respondents highlighted the need for access to more theatres and facilities in order to limit the 'downtime' necessary for deep cleaning. Around one in six (**16%**) suggested that faster COVID-19 tests for staff and patients would

help, and just over one in ten (**12%**) pointed to the need for a larger surgical workforce. Furthermore, the need for more nursing, theatre and anaesthetic staff was mentioned in a significant number of open text comments as being crucial to enabling more elective activity to take place, and the need for more ring-fenced ward beds was again mentioned several times.

Thinking about your NHS workplace(s), what single measure would most help to increase the number of patients you could treat in the coming weeks? (n = 835)



2| COVID-LIGHT SITES

Throughout the course of the pandemic, RCS England has repeatedly emphasised the importance of ‘COVID-light’ hubs for elective surgery. These are sites with additional procedures in place such as repeat testing, enhanced cleaning and distinct pathways for COVID-negative patients, to allow planned operations to continue safely. Increasing surgeons’ access to COVID-light hubs is an essential part of re-starting services, so we examined whether the availability of such facilities has improved since the last RCS England survey in June, and also sought to understand how they have been configured.

“Resilient COVID-protected sites are needed to provide at least 90% of last year’s activity through the winter or a second spike. If not the waiting list will become unmanageable.”

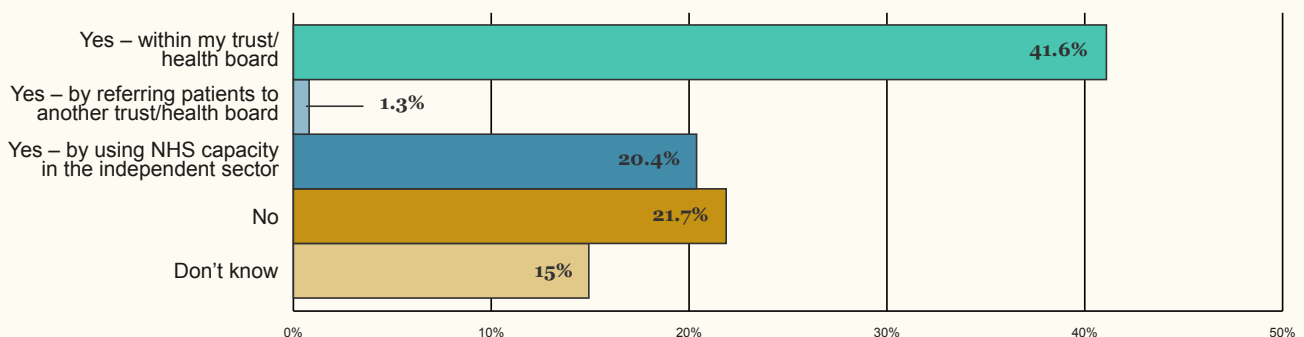
Consultant, General Surgery, London



In total nearly two-thirds (63%) of surgeons reported that they were able to access COVID-light facilities for their patients. This is very similar to the proportion of respondents (62%) who said they could access COVID-light hubs in June,⁹ suggesting that there has been limited improvement in the overall availability

of such facilities since our last survey and that more needs to be done to ensure all surgeons are able to access them. The proportion of surgeons who said that they were unable to access COVID-light sites was particularly high in the North East and the devolved nations.¹⁰

Some areas have been able to create ‘COVID-light hubs’, with repeat testing, enhanced cleaning and separate pathways, to allow surgery to continue safely. Are you able to access COVID-light facilities for your patients? (n = 798)



9. n = 1,580. Note that if dental surgeons are removed from the survey results for June (see Methodology section) the proportion of respondents who said they could access COVID-light sites for their patients rises slightly to 63% (n = 1,530)
10. The proportion of surgeons who said they were unable to access COVID-light sites was 30% in Wales (n = 61), 33% in the North East (n = 27), 42% in Scotland (n = 19) and 46% in Northern Ireland (n = 39). It should be noted that the number of responses received from some of these areas was small. Further commentary on the challenges in the devolved nations is provided in the final section of this report

“The complete cessation of normal NHS activity in the first wave must not be repeated – there has to be ring-fencing of non-COVID activity in future waves.”

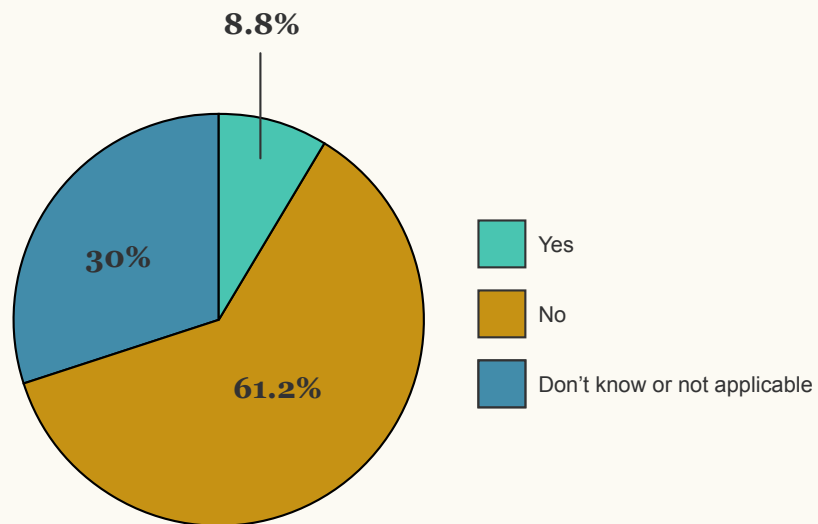
Consultant, Cardiothoracic Surgery, West Midlands



COVID-light facilities appear to be accessible for a wider range of patients than previously. We asked surgeons whether COVID-light facilities in their area were only available to cancer patients, or to the range of patients who have priority needs for surgery. Just **9%** of respondents indicated these are available only for cancer, with **61%** saying

that COVID-light facilities were open to patients with other health conditions as well. This compares favourably with the findings from our June survey, when nearly a quarter (**24%**) of surgeons reported that COVID-light facilities were only available to cancer patients.¹¹

Are COVID-light facilities in your area available only to cancer patients? (n = 796)



In addition, we sought to understand how COVID-light facilities were being configured. There was a roughly even split between surgeons who reported these were completely

separate sites away from emergency care and COVID-19 patients (**42%**), and those who said that COVID-light settings were distinct areas within the same hospital (**38%**).¹²

11. n = 1,580. Note that if dental surgeons are removed from the survey results for June (see Methodology section) the proportion of respondents who said COVID-light facilities in their area were only available to cancer patients remained at 24% (n = 1,530)
12. n = 754

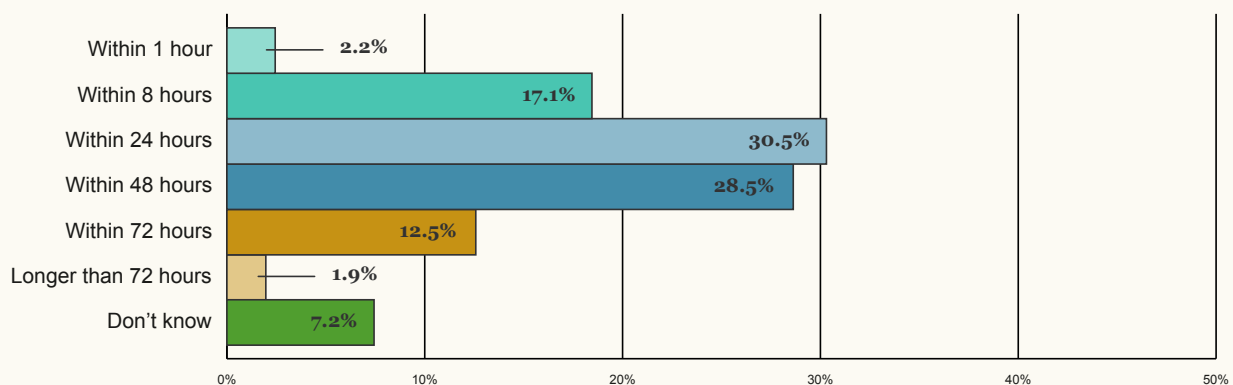
3| TESTING AND PPE

The availability of COVID-19 tests and personal protective equipment for health and care staff has been a key issue throughout the pandemic. RCS England welcomed the Secretary of State for Health and Social Care’s recent announcement that acute clinical care is the government’s ‘top priority’ for testing capacity, and has highlighted the importance of ensuring that surgical teams, their families and their patients can access tests in order to maintain elective activity.¹³ We asked surgeons about the testing regimes in place in their workplaces and, crucially, how quickly patients and staff get their results. We also sought to understand whether the availability of personal protective equipment has improved and if challenges encountered earlier this year have been addressed.

In total, half (**50%**) of surgeons who responded to our survey reported that they could get test results for surgical patients within 24 hours, with **19%** saying that results were available within 8 hours. This is an improvement from

our previous survey in June when **41%** of surgeons said they could get test results within 24 hours and **10%** indicated these were available within 8 hours.¹⁴

Within your trust/health board, how long does it take for results of COVID-19 tests on surgical patients to come back? (n = 806)



We also asked surgeons about the patient testing regime in their hospital. The vast majority (**83%**) indicated that patients were tested 72 hours before admission and asked to self-isolate before coming in, with results received in time to establish that they are COVID-free before admission.¹⁵

In total, **8%** of respondents said that they do not always receive test results in time (meaning that a procedure is cancelled or that they proceed on the assumption that the patient is COVID-positive), and less than **1%** reported that COVID-testing is not yet running in their workplace.¹⁶

13. RCS England, *RCS England President’s statement on coronavirus testing* (Press release, 17 September 2020) <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/statement-on-testing-for-coronavirus/>

14. n = 1,580. Note that if dental surgeons are removed from the survey results for June (see Methodology section), the proportion of respondents who said they could access test results within 24 hours and 8 hours rises slightly to 42% and 11% respectively (n = 1,530)

15. This is in line with the National Institute for Health and Care Excellence’s *COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services (NG179)*. This advises that patients should take a COVID-19 test ‘no more than 3 days before admission, and ensure the results are available beforehand’, and then ‘self-isolate from the day of the test until admission’ (p. 11) <https://www.nice.org.uk/guidance/ng179>

16. n = 799

“By far the main problem is a lack of COVID-19 testing capacity for staff and their family. Staff are off for days waiting for a swab or the results meaning surgery has to be cancelled last minute on patients who have been isolating with no possible replacement.”

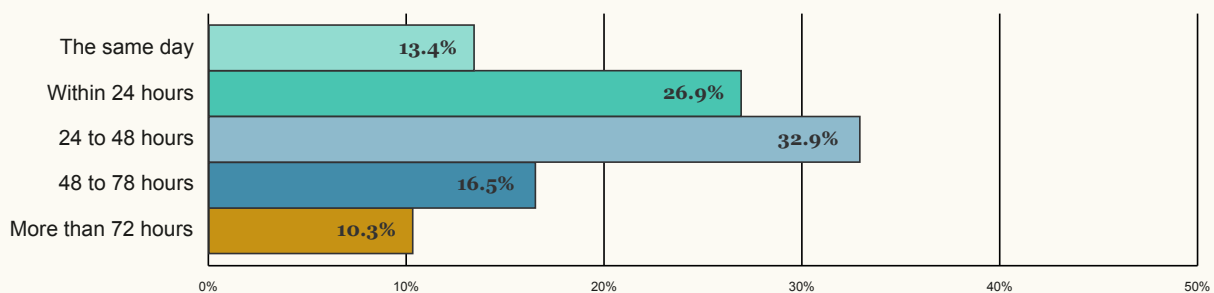


Consultant, General Surgery, Yorkshire and The Humber

When asked about testing for members of the surgical team, **40%** of respondents indicated that they could get test results back within 24 hours, with **13%** indicating that results would be available on the same day. However, over a quarter (**27%**) of surgeons reported that it would take longer than 48 hours for them to get test results for a member of the surgical team. This is concerning as long waits for test

results will lead to members of the surgical team having to take time off work to self-isolate, which may ultimately result in operations being cancelled if appropriate staff are not available. The widespread variability in staff testing regimes in different parts of the country should be harmonised across all NHS sites, with testing at least weekly, to promote COVID-light working.

When a member of the surgical team needs a COVID test, how quickly are they able to access a test and get the result back? (n = 806)



Separately, our survey also examined the extent to which asymptomatic staff are being regularly tested for COVID-19. The majority (**59%**) of surgeons told us that staff working with surgical patients are not tested if they are asymptomatic, with just one in ten (**11%**) reporting that asymptomatic staff were being tested at least once a week.¹⁷ Regular testing of asymptomatic staff is particularly important

to efforts to establish COVID-light sites, where it is vital that any staff member who develops an infection is removed from contact with colleagues and patients to maintain a secure environment. RCS England has called for staff working in COVID-light sites to be tested at least once a week, up to twice a week if capacity allows.

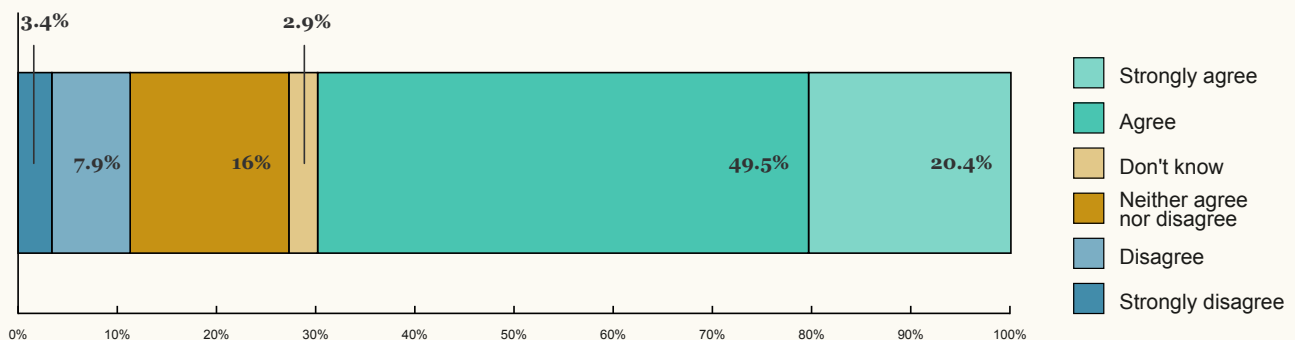
17. n = 806

Personal protective equipment (PPE)

Our survey suggests that there has been continuing improvement in the availability of PPE over recent months, although some surgeons are still not confident that they have access to sufficient protective equipment. Just over one in ten (11%) of survey respondents

did not feel there was an adequate supply of PPE in their workplace enabling them to do their job safely. This compares to 17% of respondents to our previous member survey in June¹⁸ and 33% of respondents to an earlier survey we conducted at the end of April.¹⁹

Please rate your agreement with the following statement: ‘I now believe there is a supply of adequate PPE in my workplace, enabling me to do my job as safely as possible.’ (n = 806)



“NHS facilities need to start regular staff testing ... If staff are tested, we can move to full capacity ‘green’ elective surgery. Until then, our waiting lists will never be reduced.”

Consultant, General Surgery, East Midlands



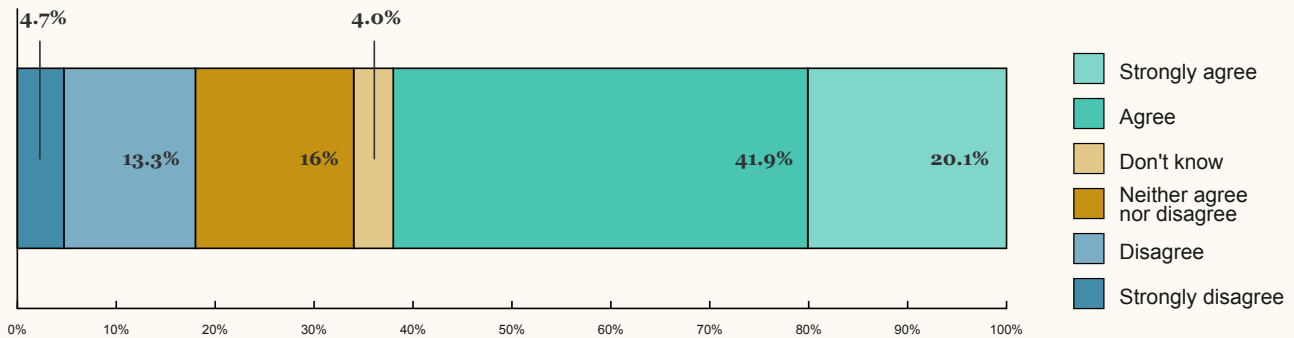
18. n = 1,551. Note that if dental surgeons are removed from the survey results for June (see Methodology section) the proportion of respondents who did not feel that there was an adequate supply of PPE in their workplace fell slightly to 16% (n = 1,503)

19. n = 1,187. Note that if dental surgeons are removed from the survey results for April (see Methodology section) the proportion of respondents who did not feel that there was an adequate supply of PPE in their workplace fell to 30% (n = 1,076)

Some surgeons also expressed doubts about whether the PPE they were provided with had been suitably fit-tested. Nearly one in five (18%) respondents said they were not confident that items of PPE they had used in the last two weeks had been adequately fit tested.

While this is an improvement from the last time we asked members this question in late April, when 27% of respondents expressed doubts about fit testing,²⁰ this issue nonetheless remains a concern for a number of surgeons.

Thinking about the past two weeks, please rate your agreement with the following statement: 'I am confident that the PPE I have been provided with has been fit-tested to an adequate standard, enabling me to do my job as safely as possible.' (n = 806)



“Staff are not tested unless symptomatic, which leaves the risk of infecting patients.”

Consultant, Trauma and Orthopaedic Surgery, West Midlands



20. n = 1,190. Note that if dental surgeons are removed from the survey results for April (see Methodology section), the proportion of respondents who did not feel that their PPE had been fit tested to an adequate standard fell slightly to 26% (n = 1,083)

4 | INDEPENDENT SECTOR

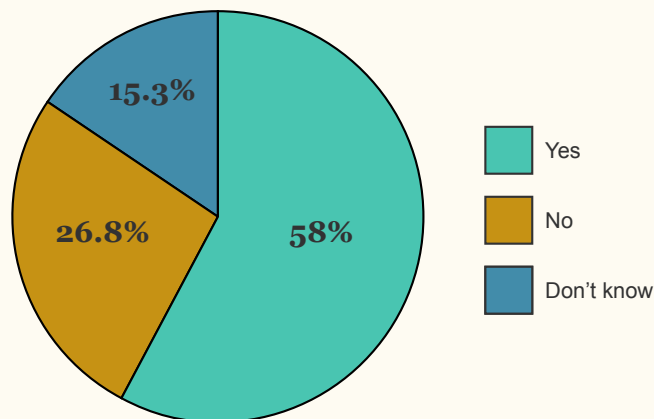
In March 2020, the NHS struck a major deal with independent sector hospitals around the country. More beds, ventilators and nearly 20,000 fully qualified healthcare staff were made available to aid the NHS fight against coronavirus, and to keep urgent non-COVID treatment going.²¹ In June, RCS England worked with Cancer Research UK to urge the Chancellor to renew this deal, keeping independent sector capacity available to help create ‘COVID-light’ sites.²² In July, NHS England confirmed that ‘a modified national contract will be in place giving access to most independent hospital capacity until March 2021.’²³

In addition, RCS England has been campaigning to ensure that medical trainees are properly accommodated in independent sector hospitals undertaking NHS work. Though the problem pre dates the pandemic, use of the independent sector to provide COVID-light sites has brought the issue into sharper focus for the government. In response, the NHS announced new principles and guidance under the national contract, under which ‘trainees of all levels of seniority should be enabled to practise across different environments with appropriate levels of education, training and supervision in place.’²⁴ RCS England welcomes this commitment and believes it must be enshrined in all further local

and national arrangements between the NHS and the independent sector in future.

Our survey shows that the independent sector continues to play a critical role in supporting the NHS. The majority (58%) of surgeons we surveyed indicated that they were able to access NHS capacity in the independent sector through their trust or health board. A quarter (27%) said that they were unable to do so. Access was particularly high in the South West (72%), and lowest in the West Midlands (47%). On a specialty basis, general surgeons had a higher access rate to the independent sector (66%) than the average.

Are you able to access NHS capacity in the independent sector through your trust/health board? (n = 792)



21. NHS England, *NHS strikes major deal to expand hospital capacity to battle coronavirus* (Press release, 21 March 2020) <https://www.england.nhs.uk/2020/03/nhs-strikes-major-deal-to-expand-hospital-capacity-to-battle-coronavirus/>

22. *NHS deal with private hospitals must be renewed, say surgeons*, The Guardian (24 June 2020) <https://www.theguardian.com/society/2020/jun/24/nhs-deal-with-private-hospitals-must-be-renewed-say-surgeons>

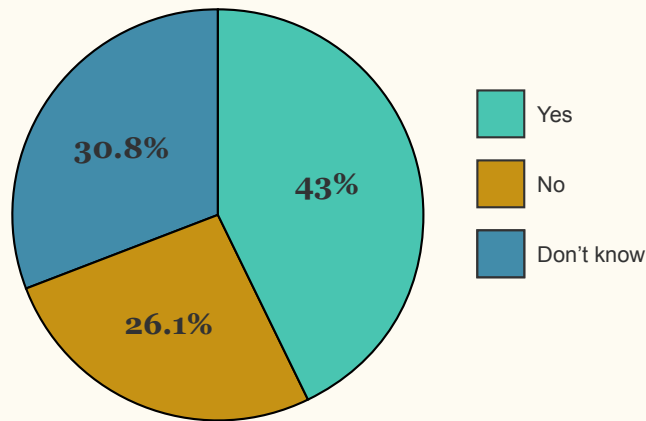
23. NHS England, *Third Phase of NHS response to COVID-19* (31 July 2020), p. 4: <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf>

24. NHS England, *Agreed principles and guidance around training in the Independent Sector for organisations working under the COVID 19 National Contract* (8 September 2020) <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/09/C0730-NHSEI-and-HEE-Joint-Clinical-Trainee-Letter.pdf>

Notably, a substantial number of surgeons thought there were independent sector facilities not currently being used for NHS patients, which could be used for elective surgery, if appropriate contracts were put in place.

More than four in ten (**43%**) survey respondents said this was the case. The proportion of surgeons in London who indicated that independent sector capacity was available but not being used (**54%**) was particularly high.

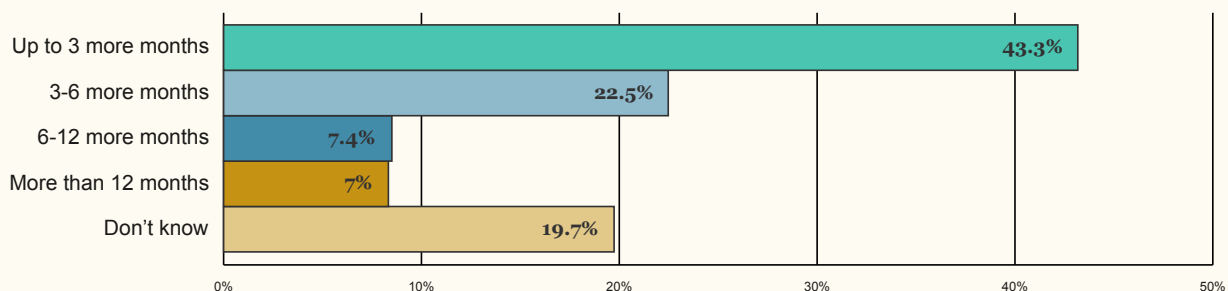
In your view, are there independent sector facilities that are not being used for NHS patients, which could be brought into play to help tackle NHS waiting lists, if appropriate contracts were put in place? (n = 788)



Meanwhile, the survey findings also reveal concern that existing independent sector capacity would end in early 2021, when the national contract terminates. Four in ten (**43%**) respondents who were accessing independent sector capacity said they only expected this to continue for up to three months. A further

23% thought they would be able to access independent sector capacity for between 3 and 6 months. Less than **15%** thought that the arrangements would be in place for more than 6 months, and 1 in 5 (**20%**) were unsure how long these arrangements would continue.

For how long do you expect these independent sector facilities to continue to be available for NHS patients? (n = 457)



“NHS elective and semi-elective cancer surgery was outsourced to the private sector initially, while the focus was on COVID-19 control. The lessons we learned were that selective centralisation, collaboration across units and seamless access to the independent sector for capacity is vital to timely patient care and better outcomes.”

Consultant, General Surgery, London

RCS England regards the use of the independent sector as a critical part of the picture for tackling the elective backlog. Independent sector contracts are not a substitute for expanding the NHS estate but should form a part of the national effort to reduce the elective waiting list. Use of the

sector for NHS patients ensures more people can be treated more quickly, on the basis of need not ability to pay. RCS England, therefore, recommends that the use of the independent sector to provide ‘COVID-light’ sites must be maximised, not as an alternative to, but in addition to NHS hospitals.

5| SURGICAL TRAINING

When the COVID-19 pandemic struck the UK, the suspension of non-urgent elective operations also saw the suspension of much surgical training around the country. RCS England has worked with Health Education England (HEE) and the General Medical Council (GMC) to establish flexibility in the training curriculum and ensure that trainees who have been moved out of programme to work on the front line are not disadvantaged and can progress in their training programme, with opportunities to catch-up on missed competencies without detriment to their career aspirations.

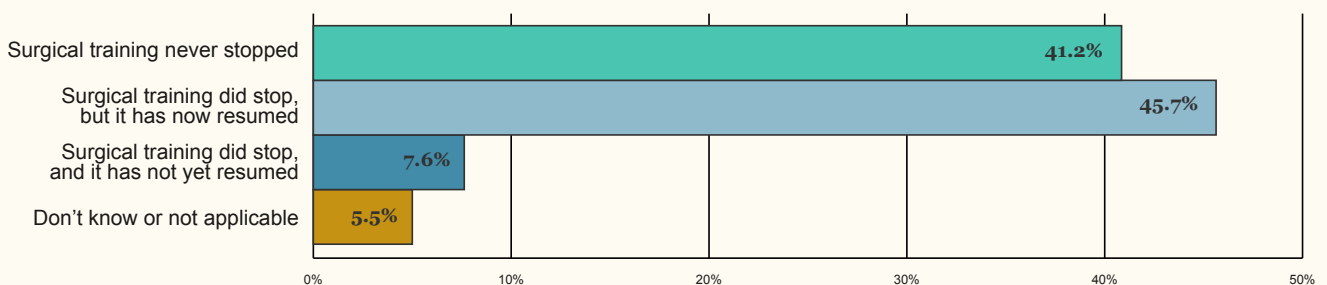
As part of this, decision aids have been provided to virtual Annual Review of Competency Progression (ARCP) panels to ensure that trainees are treated equitably and fairly during these unprecedented times. RCS England has also worked with the Statutory Education Bodies (SEBs) and the GMC to enable recruitment into programmes to continue to take place, despite being unable to undertake face-to-face interviews. Derogations have been agreed by the GMC to address the issue of examinations cancelled during the pandemic.

Moving forward, these flexibilities will remain for as long as needed. As elective surgery resumes, training in the independent sector will become crucial to our ability both to deal with mounting waiting lists and to allow trainees to catch-up. RCS England has worked with NHS England, HEE and the Independent Healthcare Providers Network (IHPN) to ensure provisions are in place to enable trainees to access opportunities in the independent sector.

In addition, the pandemic means trainees will also have missed out on being able to attend and participate in conferences, educational and training courses, all of which are essential to their wider professional development. RCS England has responded by making many of its courses and resources available online and accessible to trainees. Our MRCS examination has re-started and trainees who need the examination in order to progress have been given priority.

Encouragingly, the vast majority of surgeons who responded to our survey indicated that surgical training has now restarted following disruption due to COVID-19, or that it continued throughout the pandemic. **46%** of surgeons said that surgical training has resumed having previously been suspended, and a further **41%** said training had never stopped. Just **8%** of surgeons report that surgical training has yet to resume.

Has surgical training resumed in your NHS workplace(s) following COVID-19? (n = 794)



“There is reduced opportunity to train due to time constraints and the wish to maintain efficiency of case throughput.”

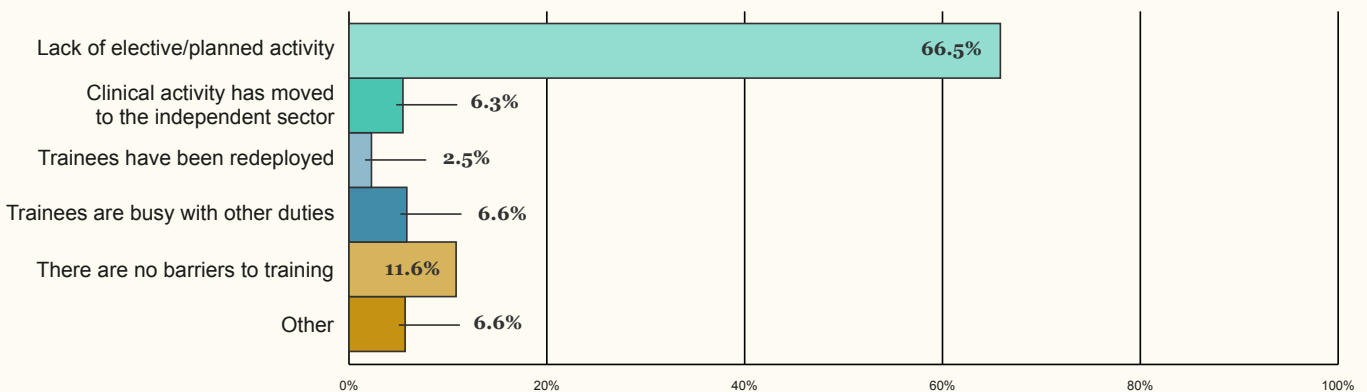
Consultant, Plastic Surgery, Thames Valley and Wessex



When asked about the most significant barrier to trainees gaining time in theatre, two-thirds (67%) of surgeons indicated that a lack of elective activity meant that there were fewer opportunities for training. Just over one in ten (12%) said there were no barriers to trainees

gaining time in theatre. Some open text comments also suggested that new infection prevention and control measures were creating challenges around training, since there is greater pressure for ‘throughput’ using the limited theatre time available.

In your NHS workplace(s), what is the most significant barrier to trainees gaining time in theatre? (n = 794)



Trainees have worked flexibly and shown their commitment to supporting the NHS through this difficult time. Since the NHS – and the public – rely on them as the workforce of the future, every opportunity must now be taken to ensure they can get back to their specialism,

catch-up where they have missed out and complete their training. Trainees are the future workforce. Delays to trainees completing their training and entering the NHS may increase locum costs, delay service delivery and impact on patient and healthcare outcomes.

“Gaps between cases mean that by the second half of the day, our training is under threat as the lists ‘have to finish on time’.”

Specialty Trainee, General Surgery, North West



6| DEVOLVED NATIONS

Our survey provided an opportunity to examine the issues being encountered by surgeons in the devolved nations. While the devolved administrations have led the response to the pandemic in Wales, Northern Ireland and Scotland, the responses we received suggested that there are some common challenges. Furthermore, the responses also highlight that particularly acute local issues that were not addressed before the pandemic, are hampering efforts to resume surgery. For instance, long-running workforce shortages in Northern Ireland before the pandemic, are showing up now in views on the most significant obstacles to the resumption of elective surgery.

“Large numbers of elective patients have accumulated on waiting lists since the start of the COVID-19 pandemic, and continue to build up. Our reduced elective capacity is dedicated exclusively to urgent cases, so routine elective patients are likely to have to wait a period of time amounting to infinity.”

Consultant, General Surgery, Wales



The availability of COVID-light sites was identified as a key issue in all devolved nations. The proportion of respondents in Northern Ireland (46%), Scotland (42%) and Wales (30%) who said that they were unable to access COVID-light facilities for their patients were all well above the average for England (19%) and the UK as a whole (22%).²⁵

In Wales, where 88% of surgeons indicated that elective surgery had been possible in the preceding four weeks (with 32% saying this was only possible in some specialties),²⁶

the need for COVID-light sites was reinforced by open text comments. These highlighted that COVID-light capacity in Wales is limited, and relayed concerns about how difficult it would be to restore elective activity to pre-pandemic levels. Responses from surgeons working in Wales reinforce that productivity has been severely impacted. Only 6% of respondents were able to treat the same number of patients in an operating session as before the pandemic due to new infection prevention and control procedures.²⁷

²⁵. It should be noted that the number of responses we received to this question varied across the devolved nations. We received 61 responses from Wales, 39 responses from Northern Ireland and 19 from Scotland

²⁶. Across the UK as a whole, 93% of surgeons indicated that it had been possible to undertake planned procedures across all specialties in the preceding four weeks, with 15% saying this had only been possible in some specialties ($n = 957$) so the figure for Wales ($n = 73$) is lower. The proportion of surgeons who had been unable to resume elective surgery was also higher in Wales (11%) than the UK as a whole (5%)

²⁷. Across the UK as a whole, 14% of surgeons said that they could treat the same number of patients in an operating session as before the pandemic ($n = 835$) so the figure for Wales ($n = 68$) is lower

“Northern Ireland had the worst waiting times pre-COVID. Elective orthopaedic procedures were stopped – so many patients are deteriorating with this inhumane wait.”

Consultant, Trauma and Orthopaedic Surgery, Northern Ireland



Responses from Northern Ireland highlighted the significant impact that workforce shortages are having on surgeons’ capacity to deliver planned care. While staff shortages existed before the pandemic, they are now a major barrier to re-starting elective activity, at a time when nearly **40%** of patients on the waiting list in Northern Ireland have been waiting more than a year for in-patient or day case treatment.

Notably, when Northern Irish surgeons were asked about the barriers to resuming elective operations, **82%** highlighted a lack of staff.²⁸ Moreover, when asked which single measure would increase the number of patients they could see in the coming weeks, almost all of the surgeons who provided an open text response specifically mentioned the need for more nursing staff to increase surgical capacity.

28. Across the UK as a whole 53% of surgeons identified a lack of staff as a barrier to resuming elective surgery ($n = 875$) so the figure for Northern Ireland ($n= 39$) is higher

METHODOLOGY

Survey fieldwork ran from 10 September 2020 to 21 September 2020. The survey received responses from 970 surgeons and surgical trainees. This report sets out the key findings. The number of respondents (*n*) to each question is shown either in the relevant chart, or else is given in the footnotes if no chart has been provided. In general the figures are given on a UK-wide basis across all specialties and career grades, although in some areas we have highlighted regional and specialty-specific trends where they are of particular interest.

Where relevant, we also provide comparisons with the results of RCS England surveys from June and April. Note that these previous surveys included data from our dental members. The latest RCS England survey did not collect responses from dental surgeons, as they were invited to take part in a separate survey on the resumption of dental services which was co-ordinated by the Faculty of Dental Surgery. For the purposes of comparison, the data from RCS England's June and April surveys are presented both with and without dental responses, with the latter generally provided in footnotes.

Full data tables are available on request. If you have any queries about this report please contact publicaffairs@rcseng.ac.uk.