Helping the NHS recover from COVID-19

A joint memorandum from the Royal College of Surgeons of England (RCSEng) and the Royal College of Emergency Medicine (RCEM)

Background

It is now two months since the government declared the UK had reached the peak of the COVID-19 pandemic, and one month since NHS England asked hospitals to start recovering routine services. However, the NHS is far from getting back to 'business as usual'. Fear is keeping patients away from Emergency Departments, PPE and testing capacity still limit how much the NHS can do, and the need to create 'COVID-light areas' separate from parts of hospitals that may be contaminated by COVID, is putting pressure on space in departments.

What is happening on the ground?

Last week's performance statistics show that 1.16m fewer referrals were made in April 2020 than in April 2019, indicating a huge 'hidden waiting list' of patients who will eventually need hospital treatment.

While demand at Emergency Departments is still well below pre-COVID levels, the most recent data also shows an increase in attendances and admissions, signalling that patients are beginning to returning to EDs, with 234,000 more type-1 attendances in May than in April, and 55,000 more admissions. Despite that increase in demand, performance has continued to improve; performance against the four-hour standard at type-1 EDs was over 90% for the first time since September 2015, and the 13,500 four-hour trolley waits was the fewest for almost six years.

As we progress beyond the first peak of the outbreak and core health services restart, it is imperative that we prevent the kind of deterioration in performance that we saw in recent years: we must never see crowding return to our Emergency Departments again. At the same time, radical changes need to be made to the delivery of care to ensure that COVID-19 can be managed safely in hospitals, and that health services for other patients are organised in a sustainable way, and will not grind to a halt if we have a second wave later this year.

Pre-COVID, there were approximately 2m elective operations taking place every quarter. The majority of these have been cancelled during the crisis. Unfortunately, collection and publication of some statistics – for instance, the number of cancelled urgent and elective operations – has been suspended. This has left it to researchers to model the extent of the decline in NHS activity. For example, the British Journal of Surgery in May estimated around 36,000 cancer operations had been cancelled in the UK by mid-May. It is critical that real-time data collection now resumes, in order that performance can be monitored as services recover.

How can surgical and emergency services recover?

In order to provide surgical and emergency services safely, it is essential that segregated facilities including COVID-light sites are made available across the country. A COVID-light site needs:

1. Good access to testing and fast results, to test patients shortly before admission and again before discharge, and weekly testing of staff. This will help lower the risk of nosocomial infections in hospitals.

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2. A good stock of PPE for all staff – not 'just in time' but including a stockpile to enable planning of operations. Staff will need to operate in PPE for the foreseeable future to manage the risk of working with undifferentiated patients.
3. Sufficient hospital facilities. This includes diagnostic facilities; scanners can't be used interchangeably for patients with COVID and patients needing operations. Hospitals need to have enough side rooms to protect patients who are at high risk of dying from hospital-acquired infections.

Surgical services

One month ago, on 14th May, NHS England published an operational framework setting out how hospital services could safely start up again, having weathered the first peak of COVID. Alongside this, The Royal College of Surgeons of England (RCSEng) published a recovery plan for surgery.

RCSEng publishes early findings today from our survey of 1,692 surgeons, conducted last week. One third (32.77%) of surgeons have been unable to resume elective/planned surgery yet. The barriers to surgery recommencing are; lack of capacity in interdependent services such as diagnostic (46.27%); lack of staff (35%); and lack of access to testing needed to establish that patients are free from COVID (33%).

While some Trusts have been able to create 'COVID-light' hubs, with repeat testing, enhanced cleaning and separate pathways to allow surgery to continue safely, one quarter (26.2%) of surgeons say they are unable to access a COVID-light hub for their patients.

The NHS cannot continue to function as a 'COVID-only' service. Given that the virus looks set to be with us for the foreseeable future, we need to organise services so that patients with other long-term conditions can safely be treated. The prospect of stopping life-saving surgery again in the autumn must be avoided by planning now to ensure continuity of service. This involves:

1. Where there are split sites, allocating one as the COVID-light facility. Alongside this, maximising use of the independent sector for planned operations, ensuring NHS patients with time-critical health needs are treated there, and that NHS contracts with the sector include provision for training.
2. Nightingale Hospitals remaining available as dedicated sites that can be used in case of a second wave.
3. Ensuring the staff who returned from retirement can stay on in appropriate roles, and work flexibly. We know a second wave will force staff to self-isolate, so making good use of this additional workforce (for instance in 111, track and trace and triage), will be important.
4. Empowering doctors to change usual working practices, to ensure the best and most efficient possible use of operating theatres and other facilities. Scheduling modifications may be required to increase hospital capacity, including extending hours of elective surgery and operating at weekends.

Surgical trainees have missed out on vital opportunities to train, progress and qualify because of the pandemic. If this is not addressed, we may lose them from the workforce. Trainees cannot indefinitely be re-deployed, so we need to ensure that as we re-start services, training starts up too, including in COVID-light independent sector facilities.

Emergency Departments

It was only in five months ago we were seeing crowding on a record scale in Emergency Departments, with record numbers of delays to admission in January (and RCEM data showed that the underlying situation was even worse). Crowding and COVID-19 are

fundamentally incompatible – we cannot maintain safe social distancing and infection control in overcrowded departments. The challenge this represents must not be underestimated; and will require a systemic transformation across our health and care service.

Many of our existing Emergency Departments are too small, run down and in need of repair. The physical size of hospitals and departments have has not increased with increasing demand. Even before the pandemic most Emergency Departments were stretched beyond the capacity they were designed and resourced to manage at any one time. Maintaining safe social distancing whilst avoiding exceeding maximum capacity in hospital represents a significant challenge. For example, St Thomas' hospital Emergency Department – like many others across the UK – has lost 40% capacity reconfiguring the department to maintain social distancing.

Emergency Departments will need to continue to operate in segregated streams, with an absolute focus on minimising nosocomial infections. RCEM members' survey shows that 69% reported that staff did not have negative pressure rooms in Emergency Departments and 72% reported they did not have enough side rooms. RCEM members also indicated a huge variation of testing turnaround times, with 43% reporting that it took 1-2 days to receive results. This is too slow to ensure effective infection control.

Alternative pathways must be in place for lower risk patients whilst maintaining access to emergency services for patients with serious health conditions. Data from Public Health England shows that attendances at EDs for several high acuity conditions remain well below what we would expect to see.

Evidence exists that lower acuity patients will use telephone services rather than attend Emergency Departments. Calls to NHS 111 in March reached nearly 3 million, over twice the number recorded the previous March. While this figure fell substantially in subsequent months, the 1.62m calls offered in May 2020 was 11% higher than May 2019, indicating that NHS 111 is being more widely used.

To maintain safe services, the following measures need to be put in place:

1. Patients who come through 'blue light' 999 or self-present with time critical illnesses will need to be assumed to have a contagious infection until more information can be gathered, so that their treatment is not delayed.
2. Emergency Departments should establish their maximum occupancy for each area that allows adequate social distancing. It is impossible for patients to maintain a safe distance if they are waiting on a trolley in a corridor.
3. Redesign and rebuild selected parts of acute hospitals to promote good flow and safe infection control.
4. Ensure there is additional bed capacity in hospitals
5. Expand alternative pathways including investment in primary care and expansion of clinical involvement in NHS 111 and national equivalents.
6. Rapidly expand Same Day Emergency Care across all acute hospitals to help relieve pressure from Emergency Departments.

PPE

The NHS workforce has responded brilliantly to the crisis, but morale has been damaged by the system failure on PPE. Productivity in Emergency Departments has decreased, and RCEM members report it is difficult to work in heavy PPE. Donning and doffing is time consuming –which adds five minutes or more to every consultation; if a department sees 200 patients in a day this adds up to two, eight-hour shifts of worker time. The RCEM member

survey showed that 97% reported PPE had an impact on their ability to communicate effectively with patients.

After widespread issues with access to PPE earlier in the crisis, surgeons now report improved access to PPE. However, if the number of COVID cases increase, there is a concern that PPE stocks will run low again, and planned surgery will not be able to proceed. To avoid this, we need to procure a ‘stockpile’ of PPE, rather than having ‘just in time’ supply, so that operations can be planned.

Professor Derek Alderson, President of the Royal College of Surgeons of England
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16th June 2020

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