All-Party Parliamentary Health Group
Policy Connect
CAN Mezzanine
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Summary of the All-Party Health Group roundtable on Surgery During COVID, held 9th December 2020

Attendees

Name	Position	Organisation
Sir Paul Beresford MP	**Chair**	House of Commons (Conservative)
Baroness Walmsley	Officer of the APHG	House of Lord (Liberal Democrat)
Baroness Masham	Officer of the APHG	House of Lords (Crossbench)
Prof. Neil Mortensen	President	The Royal College of Surgeons of England
Prof. Michael Griffin	President	The Royal College of Surgeons of Edinburgh
Prof. Ravi Mahajan	President	The Royal College of Anaesthetists
Dr Nuha Yassin	Consultant Colorectal Surgeon	The Royal Wolverhampton
Prof. Mike Grocott	Vice-Chair	Centre for Perioperative Care
Prof. Guy Nash	Consultant Colorectal Surgeon	Pool Hospital
Dr Ajay Aggarwal	Consultant Clinical Oncologist	Guy's St Thomas' NHS Trust
Dr Layla McCay	Director	NHS Confederation
Fred Dowd	Account Manager	Hume Brophy, representing Nutricia
Dr Elly Brockbank	Consultant Gynaecological Oncologist	Royal London Hospital
Prof. Freddie Hamdy	Nuffield Professor of Surgery	Oxford University
Dr Gianluca Casali, MD	Medical Director UK/Ireland	Johnson & Johnson
Rachael Truswell	Public Affairs Adviser	Royal College of Nursing
Catherine Hodgson	Public Affairs Manager	British Specialist Nutrition Association
Andrew Bonser	Government Affairs, UK & Ireland	Intuitive Surgical
Paul Ridout	Managing Director	Ridouts Professional Services
Megan Cleaver	Senior External Affairs Manager	The Independent Healthcare Providers Network (IHPN)
Robert McLaren	Head of Health and Accessibility	Policy Connect

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The picture of surgical provision

1. The COVID-19 pandemic presents an unprecedented challenge to the delivery of surgical services. After a significant reduction in provision of surgery during the 'first wave', NHS England set a target of reaching "at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October".[i]

2. NHS England confirmed at its October board meeting that the acute sector had met the phase 3 objective of conducting 80% of September 2019 overnight elective activity in September 2020. However, this target was met in aggregate, and numerous trusts and surgical specialties were not able to reach the target due to the impact of infection control measures and local circumstances (e.g. local COVID case rates and operational planning challenges posed by single-site trusts). A survey of members of the Royal College of Surgeons of England, carried out during September, found that 65% of respondents did not think their trust would reach the 80% target.[ii] In October, a survey of members of the Royal College of Anaesthetists found that "Around a third of hospitals were struggling to function (orange) or unable to function normally (red) … [and] Fewer than half of all hospitals were functioning adequately (green) with all of staff, space, stuff and systems". [iii] Public Health Scotland data released at the beginning of December 2020 shows planned procedures were down 37% from 2019.[iv] (More recently, and since the roundtable was held, reporting has suggested that the increase in Covid hospitalisations has had negative impact on capacity for elective care).[v] [vi]

3. In addition to the well documented risks associated with delaying surgical Cancer care, [vii] there is a substantial backlog of patients with benign conditions such as inflammatory bowel disease or gallstones that can worsen without surgical care, and we are now seeing this with recurrent admissions. This growing elective backlog is also compounding health inequalities.

4. There was concern that the vital efforts to meet demand for COVID care and roll out the COVID vaccines will divert resources and attention away from elective care, even as the backlog continues to grow.

Place / consistency

5. There is wide variability across the UK in how surgical services are responding to the pandemic. This includes variability in the degree to which trusts have been able to institute COVID-light sites, optimise data capacity, and maintain staffing levels. For example, the Oxford area has been able to

continue breast surgery at high levels but elective surgery capacity in Wales has been hit by staff cases of COVID.

6. **There is a need to rapidly implement the emerging best practise in providing surgical services in the context of COVID-19. Local leaders need to be empowered to meet needs on the ground while establishing joined up thinking across the health system.**

7. In his opening remarks to attendees, Prof. Neil Mortensen, President of RCS England, stated that the places that had recovered best over the summer had ring-fenced beds in COVID-light sites, along with access to the independent sector. He called on the government to **deliver a surgical 'New Deal' to help deal with the backlog**. This would include funding to deliver effective COVID-light sites, along with significant improvements to hospital capacity in the UK.

Theatres and bed

8. While space in High Dependency Units (HDUs) is scares some Trusts are making use of lower-level critical care surgical beds where appropriate, e.g., for patients receiving minimally invasive surgery. This points the **need to utilise surgical technology.** Some participants reported that use of minimally invasive surgery, including robotics, was reduced at the start of the first lockdown but that clinicians and industry have worked together to bring robotic surgery back on stream. Independent providers have also added capacity to the system, in partnership with NHS Trusts.[viii]

9. Some hospitals have implemented a traffic light system (green, red and amber) to mark COVID-light sights, and we also heard about hospitals that have instituted flexibility in job plans to utilise theatres as efficiently as possible.

10. It was **recommended that both flexibility in job plans and zoning be adopted widely across the hospitals in the UK**. Importantly, zoning requires a high degree of organisation to implement, and increased staff numbers – as staff cannot be moved across zones.

Patient visits

11. Clinicians have been able to reduce the need for patients to visit the hospital sight prior to surgery by making use of video calling and electronic consent processes. One clinician reported that the number of preoperative visits for a typical patient has been reduced from four to one by using these technologies – achieving a change that had been sort even before COVID.

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Referrals and Diagnostics

12. The number of referrals coming from primary care has fallen as some patients have not been able to see their GP and others have avoided doing so, e.g., they feel unsafe doing so or mistakenly believe that it's better for the NHS to avoid seeking care for themselves. For example, one participant reported a dramatic reduction in men coming forward with symptoms or concerns about prostate cancer. It was **recommended that public messaging reemphasises that the NHS is open, and we want people to come forward for elective care.**

13. There has been a significant fall in diagnostic activity such as CT scanning, MRI scanning, ultrasound scanning, endoscopy, colonoscopy, bronchoscopy, etc, which has resulted in a large number of patients with undiagnosed serious illnesses. This means that the waiting lists represent only a portion of the pent-up demand for surgical care. As with patients on waiting lists, patients who lack a confirmed diagnosis may see their condition worsen and face increased risk of mortality. **NHS England's recent proposals for 'community diagnostic hubs'[ix] were welcomed and one participant pointed to the need to speed up the implementation of this practice to increase diagnostic capacity by moving diagnostics to COVID-light settings (the hubs). It was suggested that new diagnostic hubs could be staffed by NHS returners.**

14. It was pointed out that effective diagnostics in primary care can reduce the number of unnecessary hospital referrals as, e.g., some who are referred due to possible cancer do not in fact have the disease. For some cancers, a new stool test has been developed which can be installed at GP-level to half the amount of referrals. **We should prioritise the implementation of diagnostics in primary care to unlock additional capacity within surgical services.**

Prioritisation

15. Participants consistently pointed to the need to re-think how we prioritise care effectively during this time when surgical activity is below normal levels. For example, using the amount of time patients have spent on waiting list as the sole or primary basis for prioritising care was seen by some as too blunt an instrument in the current circumstances[x]; **it was suggested that new ways of prioritising should be developed based on an understanding of the impact on the patient.** Risk factors from delay of surgery can be highly personalised – for example, some non-cancer patients face more substantial risks from delays then some cancer patients. In addition, it was **recommended that those on waiting lists be engaged effectively**

regarding decisions about their care, including to explore non-surgical treatments.

Pre-care / prevention

16. A key focus of the discussion was on care for patients pre-surgery. It was **recommended that greater attention be given to 'prehabilitation',** where the physical, nutritional and psychological state of a patient are optimised so that they're more resilient when they come to their surgery, to therefore outcomes are better, and waiting lists are genuinely transformed to preparation lists. Participants discussed nutrition in particular as key to improving surgical pathways.

17. Similarly, public health messaging was recognised as vital to optimising the effectiveness of surgical care – from encouraging people to come forward for elective care (as discussed above) to the government's obesity and pro-exercise campaign. **With greater pressure on theatre and surgical staff capacity, everything possible must be done to optimise all the surrounding aspects of the care pathway**.

Concluding recommendation

18. The Government should consider **establishing a sector-led taskforce on elective care** – with representation from clinicians on the ground, MedTech industry, and patient groups – to implement innovative ways of working that can, if shared across the system, not only meet the current challenge of COVID-19 but also accelerate the Government's longer-term ambitions for transforming for care in the interests of patients.

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[i] See https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf

[ii] See https://www.rcseng.ac.uk/coronavirus/protecting-surgery-through-a-second-wave/

[iii] https://www.nationalauditprojects.org.uk/Round-1-Results--NAP7-ACCC-track-Anaesthesia-and-Critical-Care-COVID-Activity-T

[iv] See https://www.thetimes.co.uk/article/coronavirus-in-scotland-waiting-lists-spiral-as-surgery-postponed-nszngh153

[v] https://www.telegraph.co.uk/news/2021/01/09/overwhelmed-nhs-hospitals-treating-less-half-cancer-patients/

[vi] These issues are replicated across the global and lessons can be learned from the responses of other health systems, see https://globalsurg.org/covidsurg/

[vii] See https://www.theguardian.com/society/2020/nov/04/four-week-cancer-treatment-delay-raises-death-risk-study-nhs-covid

[viii] https://www.ihpn.org.uk/wp-content/uploads/2020/07/Working-together-during-covid19-2-1.pdf

[ix] https://www.england.nhs.uk/2020/10/nhs-to-introduce-one-stop-shops-in-the-community-for-life-saving-checks/

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[x] Cf. PanSurg's 'The COVID-19 Aftershock Report' which suggested 'pooled waiting lists for low risk elective procedures' to enable 'increase[d] efficiency by innovatively flexing existing supply'.