Publications approval reference: 001559

Specialty guides for patient management during the coronavirus pandemic

Clinical guide for the management of surgical patients during the coronavirus pandemic

16 March 2020 Version 1

"…….and there are no more surgeons, urologists, orthopedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us".
Dr Daniele Macchine, Bergamo, Italy, 9 March 2020

As doctors we all have general responsibilities in relation to coronavirus and for these we should seek and act on national and local guidelines. We also have a specific responsibility to ensure that essential surgical care continues with the minimum burden on the NHS. We must engage with those planning our local response. We must engage with those planning our local response. We may also need to work outside our specific areas of training and expertise and the General Medical Council has already indicated its support for this in the exceptional circumstances we may face: https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

Surgery may not seem to be in the frontline with coronavirus but we do have a key role to play and this must be planned. In response to pressures on the NHS, the elective component of our work may be curtailed. However, non-elective patients continue to need care. We should seek the best local solutions to continue the proper management of these patients while protecting resources for the response to coronavirus.

In addition, we will need to consider the small possibility that facilities for emergency surgery may be compromised due to a combination of factors, including staff sickness, supply chain shortages and the use of theatres and anaesthetic staff to produce ITU pods. This is an unlikely scenario but plans for it are needed.

Categories of patients to consider

Speciality patients can be considered in a few categories:

- **Obligatory inpatients:** Continue to require admission and surgical management, eg postoperative patients. We must expedite treatment to avoid preoperative delay and expedite rehabilitation to minimise length of stay.
- **Non-operative:**
- **Inpatient management:** Patients with conditions that can reasonably be managed either operatively or non-operatively, eg biliary colic. We must consider non-operative care if that avoids admission.
- **Day cases:** Surgery can be safely undertaken for a large number of conditions. Provision for day case surgery must be made.
- **Clinics:** Outpatient attendances should be kept to a safe minimum.
- **Surgical workforce.**

When planning your local response, please consider the following:

Obligatory inpatients

- **A consultant must be designated as 'lead consultant'.** This duty can be for one day, a few days or even five days in small units. This is an essential role during crisis management. It cannot be performed by the consultant 'on-call' or the consultant in fracture clinic or the consultant in theatre. They must be free of clinical duties and the role involves co-ordination of the whole service from emergency department (ED) to theatre scheduling and liaison with other specialties and managers.
- It can be very stressful during a crisis. Support each other and share the workload. Do not expect the clinical director to do all the co-ordination!
- **A leadership team should support the lead and include relevant members of the multidisciplinary team (MDT).**
- Establish a daily sitrep and dashboard with critical data to share across the workforce. That should include patient flows, workforce issues, stock levels and other key messages (eg state of coronavirus response, personal protective equipment (PPE) requirements).
- Use elective theatre capacity and surgeons to minimise preoperative delay.
- Emergency admissions can be the frail elderly. Work closely with geriatricians and infection control to protect these patients during their admission.
- An anaesthetic guideline for patients who are coronavirus positive and require surgery will be required.
- Make contingency plans for supply chain issues.

Non-operative management

- **A number of conditions can be managed either operatively or non-operatively.** Clinical decisions during a serious incident must take into account the available facility for the current patient and also the impact this may have on the whole community.
- As the system comes under more pressure, there may be a shift towards **non-operative care.**
- Non-operative care may reduce the inpatient and operative burden on the NHS.
- It may also protect the individual from more prolonged exposure in a hospital setting.
- It may free up beds for more urgent cases.

Day cases

- Many emergency procedures are clinically suitable to be performed as a day case.
- During the coronavirus emergency, an increase in day case surgery will:
  - avoid unnecessary admission
  - reduce the exposure of the individual to a hospital environment
  - free up beds for more urgent cases
  - allow staff from elective theatres to continue working in a familiar environment.
- It is likely that the only elective day case surgery will be for urgent cases. Careful prioritisation of day case surgery will be needed across both elective and non-elective patients, based on theatre/staff capacity.

First contact and clinics

EDs are likely to come under intense and sustained pressure. General surgeons can make an important contribution by reducing the ED workload so that clinicians in ED can focus on medical patients.

EDs will continue to take patients requiring resuscitation and the trauma team.

- We should avoid unproductive attendances at hospital.
- Senior decision-making at the first point of contact should reduce or even prevent the need for further attendances.
- A decrease in elective work will allow greater senior presence at the front door.
- Clinicians may need to work in unfamiliar environments or outside their sub-specialist areas. They will need to be supported.
- Protocols to identify those injuries that do not require follow-up should be reviewed.
- No patient should be scheduled for surgery without discussion with a consultant.
- The possibility of a seven-day service may need to be considered.

- Consider postponing long-term follow-up patients until the crisis has passed.
- Can a virtual clinic be developed in your facility?
- CT scanning may be limited as it is the investigation of choice for coronavirus pneumonitis.

Surgical workforce

- **Alternative surgical roles,** eg running non-medical EDs, trauma teams, etc
- **Non-surgical generic roles**, eg running level 2 units/medical wards, command and control, etc.

Alternate surgical roles

The surgical workforce can take on various responsibilities that will release/support non-surgical healthcare staff. Within the ED these include running:

- non-medical streamed ED patients
- minor injury units
- trauma teams in major trauma centres/trauma units.

Depending on impact of coronavirus on workforce, there may be a stage where generic, non-specialty, site-based surgical teams are required. This need would only be triggered if individual surgical specialties are unable to form coherent rotas for each specialty. In this scenario clear postoperative/non-operative instructions must be documented by the specialty surgeon

Non-surgical generic medical/non-medical roles

Some surgeons will have experience of working in/running non-surgical environments, eg level 2 units or EDs. They may be able to step into these non-surgical roles (eg front-door triage, running level 2 units) with the appropriate training/guidance/support.

It may be sensible to release medical personnel in some command and control positions to clinical duties and for appropriate surgical personnel to backfill these non-clinical roles, if non-clinical staff cannot be found.