



Written submission to the Health and Social Care and Sport Committee Inquiry into the Covid-19 outbreak on health and social care in Wales

Introduction and executive summary

1. The Royal College of Surgeons of England is a professional membership organisation and registered charity, which exists to advance patient care. We support nearly 700 members in Wales and 25,000 members in the UK and internationally by improving their skills and knowledge, facilitating research and developing policy and guidance.
2. Throughout the course of the COVID-19 pandemic, we have been determined in our efforts to ensure that surgeons and surgical teams are supported in delivering vital patient care and are not exposed to unnecessary risk.
3. With this in mind, we welcome the opportunity to provide evidence to the Health and Social Care and Sport Committee's inquiry into the Covid-19 outbreak on health and social care in Wales. The key points made in this submission are set out below:
 - A significant elective surgery backlog existed in Wales prior to the COVID-19 pandemic. This will only have increased, due to the necessary postponement of elective surgery. The latest waiting time statistics¹ reflect waiting times in January 2020, before COVID-19. These report a total of 462,358 people waiting to start treatment in Wales, with 76,862 waiting more than 26 weeks. These figures include a wide range of surgery essential to people's mobility, quality of life and ability to work - from hip and knee replacements, to heart and brain operations deemed not to be 'urgent'.
 - The statutory target is for 95 per cent of patients to wait less than 26 weeks and no patients should wait longer than 36 weeks for treatment. This is an ongoing matter of concern. Waiting lists will have increased substantially over the course of the pandemic, due to extensive postponement of elective surgery.
 - While postponing much elective surgery to re-direct resource at COVID-19 has been necessary and something we have supported, the NHS in Wales cannot continue to act solely as a 'COVID service.' Many patients require surgery in a timely fashion if they are not to suffer from worsening symptoms, deterioration in their condition, greater

¹ StatsWales, RTT waiting time statistics: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/patientpathwayswaitingtostarttreatment-by-month-groupedweeks>

disability and (in some cases) a significant risk of death. The delays to surgery already will have resulted in an increased need for complex surgery, as some conditions become more complex to treat if not addressed promptly.

- A recent survey of surgeons in Wales found continued concern around the supply and adequacy of PPE. The survey of over 160 surgeons and surgical trainees in Wales found that over a third of respondents did not have an adequate supply of PPE in their health board. Furthermore, 56.7% of respondents agreed that there had been shortages of PPE within their Health Board in the past 30 days². Before resuming surgical services, 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.
- An expansion of the workforce will be necessary to help recover surgical services and cover the expected reduced productivity from infection control procedures. We strongly recommend that surgeons, nurses and other healthcare workers who have returned to work should be retained to help manage the backlog of work. However, we cannot rely on these individuals alone. Many will have returned solely to help with the immediate crisis, and may not have performed elective operations for a number of years. To rely on them to address the backlog is unrealistic. We need to keep on those who are willing and able to stay, but also expand the surgical workforce as a whole, bolster training and making better use of the range of professionals that form a surgical team.
- It is now imperative that progress is made at pace to establish COVID-19 light sites across Wales so that patients requiring cancer, urgent and planned surgery can be treated safely. It is essential that these COVID-19 light sites are planned strategically and collaboratively across Health Board boundaries to ensure a consistent, transparent approach and equity of access for patients in Wales. The sites need to work alongside a significantly enhanced testing strategy including regular testing for asymptomatic front-line staff and patients.
- To enhance surgical capacity, extending the use of capacity in the independent sector and in field hospitals should be considered, along with scheduling modifications to increase hospital capacity, including extending hours of elective surgery and operating at weekends.

A backlog of demand

4. Since the beginning of the emergency response to the pandemic, a significant number of elective procedures have been cancelled as part of efforts to free up critical care beds across Wales.
5. We supported this measure and, to ensure that urgent surgery continued, we led on production of guidance³ to support Health Boards across the country with surgical prioritisation during the pandemic. This classifies patients requiring surgery during the COVID-19 crisis into the following groups:
 - Priority level 1a: Emergency - operation needed within 24 hours
 - Priority level 1b: Urgent - operation needed with 72 hours
 - Priority level 2: Surgery that can be deferred for up to 4 weeks
 - Priority level 3: Surgery that can be delayed for up to 3 months

² <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/ppe-findings-from-wales/>

³ <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf>

- Priority level 4: Surgery that can be delayed for more than 3 months
6. As of 5th May 2020, evidence continues to suggest that the UK has passed the peak of COVID-19 deaths and infections.⁴ Although COVID-19 will be around for the foreseeable future, this is encouraging news and indicates that elective surgical services can begin to recover in areas where everything is in place for it safely to recommence.

Measures to address a backlog of demand during and after COVID-19

7. We and the surgical community are under no illusions about the task of recovering surgical services and recommencing elective operations. It will require an enormous effort from a workforce already affected by illness and fatigue, along with continued vigilance to avoid a second wave of the virus.
8. To address the backlog of demand in the system and support surgeons as they prepare to re-open services including elective care, we have developed guidance⁵ on the recovery of surgical services. This includes a list of principles, recommendations and key considerations in order to facilitate elective surgery during and after COVID-19. These can be used in combination with national, specialty and local Health Board recovery plans.
9. We believe that the Welsh Government should introduce and support the following key measures in order to effectively recover surgical services and address the backlog of elective surgical procedures:

Personal Protective Equipment (PPE) and testing

10. Before resuming surgical services, 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. This is a vital step, as our recent survey of over 160 surgeons in Wales found widespread concern around the supply and adequacy of PPE. The survey found that:
 - 34.5% of respondents did not have an adequate supply of PPE in their health board.
 - 56.7% of respondents agreed that there had been shortages of PPE within their Health Board in the past 30 days⁶.
11. With regard to testing, hospitals should be aware of their diagnostic testing availability and develop clear policies for addressing testing requirements and frequency for staff and patients. We believe that testing capacity in Wales should be dramatically increased and, as in England, should extended to include asymptomatic staff.

Enhancing workforce capacity

12. An expansion of the workforce will be necessary to help recover surgical services. We cannot rely solely on recently retired staff to address the backlog. It will also be important to be prepared for an unstable workforce related to fatigue, illness or social issues.
13. We recommend those 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, if they are willing and able to stay on. Experienced retired surgeons in particular can also support in

⁴ <https://www.gov.uk/government/publications/slides-and-datasets-to-accompany-coronavirus-press-conference-28-april-2020>

⁵ <https://www.rcseng.ac.uk/coronavirus/recovery-of-surgical-services/>

⁶ <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/ppe-findings-from-wales/>

key non-patient facing roles such as collecting and quality assuring local data, and monitoring adequate levels of facilities and equipment.

Services to support surgery

14. Steps should be taken to ensure that essential perioperative services (e.g. diagnostic imaging, anaesthesia, critical care, pathology, sterile processing) are also ready to commence operations before resuming elective surgery. Where these are not ready, hospitals may need to consider engaging with external partners, including the independent sector, for temporary support.

Local co-ordination

15. Before the resumption of surgical services, local governance teams should be put together to coordinate the recovery and provide transparent and flexible oversight. The team should have clinical input and be multidisciplinary and multi-professional, with daily meetings to deal with rapidly evolving local and national issues. The local teams should undertake the oversight and clarification of policies and guidance, make real-time governance decisions, manage the whole care pathway, communicate key messages to staff and patients, and liaise with other hospitals and related specialties as needed. Consideration must be given to the prevalence of COVID in the community that patients will return to for their rehabilitation, and availability of supportive community and primary care services to support recovery. If patients are set to be discharged into a setting where there is a high prevalence of COVID in the early post-operative phase, it should be considered, on the balance of risks, whether surgery is appropriate.

Capacity and COVID-19 light sites

16. The recovery of elective surgery depends on local capacity and availability of clinical and other services necessary for the delivery of surgery. Scheduling modifications may be required to increase hospital capacity. Extending hours of elective surgery later into the evening and operating on the weekends should be considered.
17. As part of plans to re-direct resource towards tackling COVID-19, we have supported postponing elective surgery in Wales. While managing coronavirus has rightly been our focus, as we move to the next phase of the outbreak, it is vital that we help those people who have had their surgery delayed.

It is now imperative that progress is made at pace to establish COVID-19 light sites across Wales so that patients requiring cancer, urgent and planned surgery can be treated safely. As no site can be considered completely COVID free, by this we mean a site where only patients and staff have self-isolated and been tested negative for COVID-19.

18. It is essential that these COVID-19 light sites are planned strategically and collaboratively across Health Board boundaries to ensure a consistent, transparent approach and equity of access for patients in Wales. The sites need to work alongside a significantly enhanced testing strategy including regular testing for asymptomatic front-line staff and patients.
19. To enhance surgical capacity, extending the use of capacity in the independent sector and in field hospitals should be considered, along with scheduling modifications to increase hospital capacity, including extending hours of elective surgery and operating at weekends.

Virtual services

20. A wider use of virtual clinics as well as virtual patient reviews and consultations should be encouraged as the default option. 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.

Recording deferred cases

21. It is essential that hospitals keep a clear record of all surgery that is being deferred and the criteria used to do so, and regularly review this, 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; and new patients.

22. Patient population data should also be taken into account to assess population needs and potentially larger local community backlogs against available capacity.

Providing healthcare equitably, and for vulnerable groups who are shielding

23. As services recommence, a key consideration will be how to direct resource towards those with the greatest needs, in line with our surgical prioritisation outlined above. The challenge is that, depending on the structure and organisation of local resources, it can be difficult to perform complex but much-needed surgery in some areas, and easier to perform simpler but less vital procedures. A further consideration is how to provide services safely for vulnerable groups who are shielding.

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