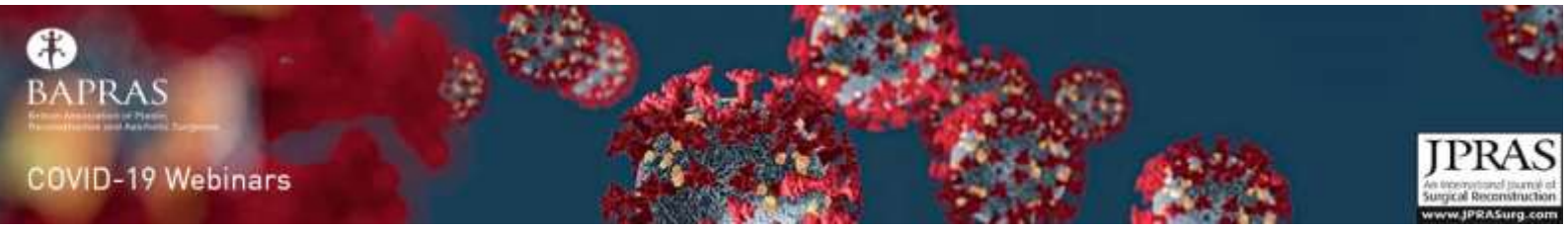

Planning the exit from COVID-19 crisis measures
23 April 2020

Main points from this webinar

- As we pass the peak of the epidemic and hospitals start to empty, we need to create a roadmap for how to exit crisis measures
- Expansion of testing is key to allowing a return to pre-crisis surgery
- It is important not to lose new, innovative ways of working post-crisis
- Pre-crisis issues, such as waiting times for breast reconstruction will need to be tackled, as the problem is impacted further by current crisis measures

Faculty

Professor A Hart, Editor JPRAS, Consultant Plastic Surgeon, Glasgow
Mr M Henley, BAPRAS President, Consultant Plastic Surgeon, Nottingham
Professor JP Hong, Consultant Plastic Surgeon, Asan, South Korea
Mr D McGill, Clinical Director, Canniesburn Unit, Glasgow
Mr N Mercer, BAPRAS Past President, President FSSA
Mr R Pritchard Jones, Medical Director, Consultant Plastic Surgeon, Liverpool
Ms J Doughty, President, Association of Breast Surgeons
Ms A Dorkes, Executive Director, BMI The Park Hospital, Nottingham
Mr D Boyce, Chair, BAPRAS Education Committee, Consultant Plastic Surgeon, Swansea
Mr M Ragbir, Chair, SAC, Consultant Plastic Surgeon, Newcastle

Points from each speaker

How to restore elective practice (A Hart) View video

- We're unsure of the size of the elective backlog in the UK: anecdotally, there are nearly 2000 delayed cases in Merseyside and BSSH shows drop in hand registry cases from 122 for 2019 to 5 for 2020 (20 March to 20 April in each case)
- As people are waiting longer for, eg cancer surgeries, cancers are progressing, leading to lengthier operations
- Research shows that for patients undergoing surgeries during the incubation period of COVID-19 infection, ICU admission rates almost doubled and mortality rates were 20%

Plastic surgery after COVID 19 peaks- Salient lessons from South Korea (JP Hong) View video

- Because of lessons learned from previous SARS and MERS outbreaks, were able to draw on experiences and put measures into place quickly to reduce COVID-19 spread
- At the heart of the approach was testing to show who was currently infected, which was implemented quickly as the country had access to robust testing infrastructure
- COVID and non-COVID hospitals were designated as soon as testing was available
    - In non-COVID hospitals, patients were tested one week prior to admission, then asked to isolate; tested again 24 hours prior and post-surgery before discharge
    - If the hospital was found to be exposed, wards were shut and anyone who had come into contact with relevant patient quarantined

- Government-based communication has also allowed understanding of areas that were COVID-19 hotspots (similar to the UK government's proposed track and trace app
- Because of the protocols that have been put in place, elective surgery has been able to continue
- There are no government restrictions on elective surgery, but people are using common sense- our department has gone from 30% cosmetic surgery to 0% over the outbreak period.

Questions
-what PPE is being used as standard?
-In COVID free hospital with COVID negative patients and staff there is no PPE in use. There has been one case of a patient who tested positive post-surgery, but the quarantine protocol was put into place to mitigate further risk
-All people coming into hospital must wear masks.

-Are you expecting a second wave of cases?
–Hopefully not, but realistically, it is expected that there to be a second wave in the next 3-4 months. No mandated government restrictions/social distancing in operation in South Korea, so it will be interesting to see if this effects the spread.

-How long after the outbreak starting did you allocate +ve and -ve hospitals?
-These were allocated when after the first outbreak in a major city.

Timeframes for recommencing elective work (D McGill) View video

- It is imagined that we'd be looking towards moving to 'business as usual' by the end of the summer, though this doesn't account for a second wave of infection
- Intention locally (Glasgow) is to deal with LA procedures first, then as theatres come back into action, deal with the more pressing elective cases first and cascade down from there
- It will be important to allow staff to pause, take a breath and, for example, use some accrued leave before resuming 'normal' caseloads
- Questions around dealing with the delayed breast reconstruction workload hasn't been resolved as yet

Principles underpinning case prioritisation during the reintroduction of elective workloads (N Mercer) View video

- Work has been ongoing in collaboration with the UK specialty associations on creating a number of guidelines for management of patients in the COVID-19 crisis (view the guides here). This advice will stay in place for as long as its' needed
- RCS England has published this document on the recovery of surgical services
- Looking further ahead, the government is looking at maintaining private sector beds for as long as possible to clear the backlog

Increasing capacity (R Pritchard Jones) View video

- Are undertaking a review of each new mechanism that has been put in place because of the COVID-19 crisis to see if we should revert to previous way of working or retain new innovation

    - (Comment from N Mercer- This is backed up by GIRFT, who will be leading on harnessing tech and the innovative approaches to have come out of the crisis)
- Reintegration of services needs to be system-wide, rather than an individual approach from each hospital or department
- In-house testing and self-isolation will be at the heart of the approach to re-opening services
- Caring for our workforce is a central message.

Breast Cancer Care (J Doughty) View video
- in UK there are 520,000 breast referrals a year- 55,000 breast cancers diagnosed from these.
- Regarding outpatients, there is a need to physically see patients and examine them- new patient clinics are still running
- ABS has produced guidance on prioritising who is offered surgery based on risk: ER-ve, her2 +ve, pre-menopausal, post-menopausal ER +ve
- For the first two categories, virtually all centres are still operating- in many areas, breast cancer surgery has moved into the private sector
- In half of the UK, oncoplastic breast surgery is still going ahead; nowhere in the UK is carrying out immediate reconstruction at present
- There will be issues in prioritising surgery for those women who are having mastectomies and delayed reconstruction during the COVID-19 crisis

Converting a private hospital for NHS cancer care (A Dorkes) View video
- From 30th March the NHS has been paying to cover the running costs of all private hospitals, to bring private beds into the NHS.
- Biggest frustration in the private sector around the UK is underuse (currently 400 out of 1400 private beds in London are being used).
- Because of a strong relationship in Nottingham with the NHS trust and medical director, The Park Hospital has increasingly scaled up to undertake NHS work in a 'clean' hospital
- Vulnerable front line staff from the local NHS hospitals have been able to continue to work in the Park Hospital
- The national contract is due to cease in England on 24 June, so are now looking to return to 'normal' services, though it's expected the private sector will be supporting the NHS for some time to come
- From a commercial point of view, surgeons will be looking to book time off from the NHS to clear a backlog in private lists.

Comment on training (M Ragbir) View video
- Current guidance is that training will continue, with different outcomes added, in the hope that individuals will be able to catch up with official training and logbooks after the peak of the crisis has passed.
- Basic CCT requirements are not being changed by GMC
- Be mindful of additional training opportunities- encourage trainees to undertake projects, audits etc

Questions and discussion

-Has there been any discussion on NHS trainees having access to training in private hospitals?

-(AD) Yes, ST8s are currently training in Park Hospital- the NHS training coordinator had to get signoff from GMC for this to happen, and hospital had to prove there was a training process in place
-There is no national expectation for this, so expect there to be regional differences

-For Amanda Dorkes- What testing are you undertaking for patients?
-We are asking all patients to self isolate for 7 days before procedure, screening takes place 48 hours before admission to hospital. PPE is being used as 'belt and braces'

-what choice do the patients get in being operated upon if they are considered high risk?
-(NM) Montgomery still pertains- all patients must be warned of the potential risks, though we may not have specific evidence to give. The parameters are the same as they were pre-COVID

-Much of the positive change has come about because of less hierarchical decision making- is there scope for the world to roll back on bureaucracy?
-(NM) Aspects of practice are fundamentally changing and hopefully the regulators and then the law will catch up with this, though this is a process that will likely take 3-4 years.
-(MH) Focus has shifted to clinical priorities rather than political ones- the politicians are very much deferring to the scientists and this has been very much accepted by society

-When do the panel think shielded colleagues might be able to return to work?
-(DB) In wales, have been told to shield for 12 weeks, but this will carry on longer.
-There's a balance as a doctor to doing your job versus protecting yourself. As testing becomes more reliable, that will afford an opportunity for shielded docs to contribute more fully

-Regarding deferred breast reconstruction patients, how will this be managed? Will deferred patients have to join the back of the queue?
-(JD)- This is a difficult situation, but unfortunately, delayed breast reconstruction will likely not be a top priority
-(DMcG)- There needs to be a national discussion on how to manage and fund this
-(AH)- This is an ongoing problem, with growing waiting lists pre-crisis. Some difficult decisions are going to need to be made regarding how to tackle this problem
-(NM)-It may be necessary to look nationally, rather than regionally, to potentially take advantage of spare capacity in different places around the country. Work will be commencing in NHS England to build up a national picture as to where priorities should be given in future.