BAPRAS

British Association of Plastic Reconstructive and Aesthetic Surgeons

Surgical support during COVID-19: thoughts on a page

1. Introduction

1.1 As COVID-19 increasingly disrupts normal patient pathways, reactive solutions need to be found.

1.2 It is essential that surgical patients requiring urgent emergency surgery are treated. This will require preserving some form of surgical capability in all scenarios.

1.3 The surgical workforce will be one of the few medical workforce groupings likely to see a decrease in their activity due to COVID-19. As such they represent a valuable resource at all levels of seniority.

1.4 There are three ways the surgical workforce could be used:

A)In their normal surgical roles, eg maintenance of emergency surgery pathways

B)In alternate surgical roles, eg running non-medical EDs, trauma teams etc

C)In non-surgical generic medical/non-medical roles, eg running level 2 units/medical wards, command & control etc

1.5 NHSE&I have drafted central guidance for A

1.6 This document is for B and C

1.7 The aim of A is to maintain surgical capability for urgent cases. The aim of B and C is to maintain non-surgical pathways and relieve the pressure on non-surgical staff.

2. Alternate surgical roles

2.1 There are various responsibilities the surgical workforce can take on that would release/support non-surgical healthcare staff.

2.2 Within the Emergency department these include:

i)Running non-medical streamed ED patients

ii)Running minor injury units

iii)Running trauma teams in MTCs/TUs

2.2 Depending on workforce impact of COVID-19, there may be a stage where generic, non-specialty site-based surgical teams are required. This would only be triggered if individual surgical specialties are unable to form coherent rotas for each specialty. In this scenario clear post-operative/non-operative instructions must be documented by the specialty surgeon

3. Non-surgical generic medical/non-medical roles

3.1 Some surgeons will have experience of working in/running non-surgical environments, eg level 2 units, emergency departments

3.2 These individuals may be able to step into these non-surgical roles with the appropriate training/guidance/support.

3.3 Examples of these roles include front-door triage, running level 2 units

3.3 It may be sensible that medical personnel in some command & control positions are released to clinical duties and appropriate surgical personnel backfill these non-clinical roles if non-clinical staff cannot be found.