Written evidence submitted by The Association of Coloproctology (WBR0033)

The Association of Coloproctology produced a document entitled 'Legacy of COVID-19' [1]. In it we highlighted many aspects of workforce resilience that affect our specialty. Much is relevant to all surgical specialties and to the 'call for evidence' above. Below is a precis of these pertinent points.

The COVID-19 crisis has undoubtedly taken a toll on the care of patients with colorectal disease. Elective services, be that face to face contact, endoscopy or operating all but ceased during the pandemic [2]. As we move into the recovery phase the return to normal care is likely to be slow with a huge backlog of patients and ongoing limitations to services.

The psychology of a crisis is well defined. The initial heroic phase is followed by a honeymoon phase, both characterised by clear shared goals and a sense of urgency that energises the workforce to be focused and productive. Importantly , a disillusionment phase follows where uncertainty about the future reduces any sense of purpose, and productivity falls. That is the phase we are in currently and it coincides with an increased pressure to catch up on the back log [3-5].

The culture of the workforce has in many respects changed beyond recognition. In some hospitals, the temporary freedom from bureaucratic norms led to tremendous advances in a short period of time. Examples included rapid procurement, implementation of modern IT hardware and even relocation of whole departments overnight. Remote working was possible and the 'PA counting' attitude was temporarily dropped. COVID-19 highlighted what good teamwork between management and clinical staff can achieve. Progress was built on respect, trust and overall professionalism. We need to avoid a return to a normal characterized by bureaucratic hurdles and glacial slowness; rather, mutual trust should continue so that both managers and clinicians can push things forwards. There is also need for honesty in speaking out where clinicians are unable to deliver existing standards of care (e.g. NICE) due to resource constraints without fear of persecution for failing to deliver pre-existing standards in a constrained environment over which they had no professional control.

The positive cultural changes between clinicians and management have not been universal. In some hospitals, inadequacies have been magnified by COVID-19 with an increase in bureaucracy and paralysis of services due to both clinical and non-clinical management incompetence. There have been instances of surgeons being bullied regarding PPE and perceived risk. The surgical leadership shown by the Royal Colleges working with the specialty societies including the ASGBI, ACPGBI and

AUGIS has been impressive in providing a joint voice for clinicians to stand behind in this respect and future close collaboration should persist [6].

The COVID-19 crisis has highlighted the tangible benefits of working in a close surgical team particularly when providing continuity of care. Communication has been enhanced with more efficient handovers utilizing the resources available within each department. Engagement has happened with all tiers of doctors within the surgical department and has redefined referral pathways with other hospital specialties, moving away from Consultant to Consultant conversations and empowering all surgical team members to have different and flexible roles.

Although this structure has allowed for much needed moral support, the mental strain on surgeons should not be underestimated. Surgical leadership traits of organisation, emotional stability and a capacity to think fast, should naturally place surgeons in a position to respond positively to a pandemic [7]. However, rapid and sustained overload as occurs in a pandemic, can lead to burnout, especially if patient outcomes are poor and there has been an experience of loss of control [7]. Whilst surgeons rely on colleagues, family and friends for support during these times, professional bodies need to consider embedding wellness and mental health into their personnel strategies with immediate effect as the consequences from this pandemic may only just be beginning. This moral injury has still to fully play out and may cause another challenging 'wave' in healthcare.

In many hospitals, restoration of a structure resembling the old 'surgical firm' has been possible with a consultant led service allowing proper and timely decisions to occur with continuity of care paramount. The concern about such a model is its sustainability and this includes the flattening of hierarchy, which has good and bad points. Firms required long hours in the past to generate continuity. In the current model of consultant-led practice with consultant expansion, this may not be sustainable in the long term. One option is to consider job planning flexibility, which for many of us happened naturally during this pandemic. An obvious change could be using the experience of the older consultant more wisely and acknowledging that role. Older consultants are more likely to have refined decision-making skills and wisdom to impart to newly appointed colleagues that can facilitate efficient patient care and optimize outcomes. There is a danger that many older consultants move to the psychological disillusionment phase and elect to retire [3]. If not countered this may have dire consequences for the expected workforce gap that is expected in the near future [8]. We believe that job planning reviews should significantly restructure to allow flexibility according to not only the departmental needs, but to the needs of the individual surgeon at that time. Careers should be considered like chapters in a book. Discussions should include flexible working hours, part-time working, sabbaticals with a culture change that embraces this, rather than

the view that long difficult hours is ‘just something to get through’ because ‘we have all done it’. Implementation and demonstration of such a culture change may encourage more medical students to become surgeons and help address the urgent decline in surgical training application numbers.

The importance of stable colorectal nursing teams both on the ward and in theatre has been critical. Our nursing colleagues took great pride in working more closely with us and we with them; this should not be forgotten. The WHO theatre check list came into its own more than ever before as a means of focusing on the challenges of delivering surgical care in a constrained theatre environment and with a theatre team drawn from multiple backgrounds. In addition, expansion of the non-doctor non consultant workforce is key, allowing colleagues to practice to the limit of their license. This could be called the ‘Special Air Services approach’; it does not matter what your cap badge or rank, if you are an expert at delivery you can do the job.

The crisis had, and continues to have, a huge impact on trainees. There have been no examinations or face-to-face educational conferences. Dual consultant operating led to lack of operating experience. Many trainees lost access to training due to relocation of elective major cancer surgery to the independent sector, though this issue is currently being addressed at national level. Endoscopy training completely disappeared and is only just returning for the most senior trainees closest to Joint Advisory Group (JAG) accreditation. On top of this there are new curriculum changes planned, although implementation of the new curriculum has been sensibly deferred to August 2021.

However, there is an opportunity to improve education for the future. The current tick box exercise and measurement for measurement’s sake with almost no relation to actual competence should be abolished. The surgical community should accept that there is no need to produce trainees that are equal on measurements. Instead, we need to produce a workforce that can do the job. Trainees should seek to develop the building blocks of training to deliver their intended career path and service need. The trainee should focus on creating a systematic and comprehensive training programme to fit their own needs using a variety of resources that are readily available.

We should recognize and applaud the flexibility and adaptability demonstrated by our trainees during the pandemic. Consultants and trainees alike have gained many non-technical skills including stress management, support structures and team work.

Concluding Remarks

The expression “never let a good crisis go to waste” is apposite for our time. There was a crisis and we as a community of colorectal surgeons weathered the storm, were pushed to the front and got on with it. The majority stepped up and were creative and responsive. This was particularly the case when not managed by sessional working, just by getting the job done professionally and doing the right thing. There was fulfillment of working in a cohesive team. Despite the dangers involved, many colorectal surgeons, trainees and nurses have thrived in the atmosphere of just being allowed to work in a professional manner. This should be recognized.

Of course the COVID crisis exposed the inadequacies of the current healthcare system. Examples of these pre-existing inadequacies include;

- chronic underfunding of the NHS (in % GDP terms since 2010)
- massive real terms pay cuts of the past decade (in the region of 25% according to the BMA)
- huge workforce gaps in medicine & nursing leading to unrealistic and unsafe workloads [8]
- an aging population and worsening complexity of disease will necessitate more staff. Need to factor in that most consultant staff work way above their job plans for free. The NHS has survived for decades on good will.
- junior doctors' strikes (and the subsequent loss of many who have emigrated).
- failing recruitment to training posts (compare with a decade ago when competition was >3:1 for surgery).
- pensions fiasco.
- battering in the lay press based on unrealistic / inflated public expectations.

References

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