Written evidence submitted by The Federation of Surgical Specialty Associations (WBR0034)

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The FSSA, which comprises the 10 legally recognised Surgical Specialty Associations, represents their views to the Royal Colleges of Surgery in the British Isles, to the NHS of the devolved nations and to other organisations involved in the regulation of surgical services in Great Britain and Ireland.

What happened to surgery and surgeons at the start of the pandemic?

At the outset of the pandemic, the Federation of Surgical Specialty Associations (FSSA.org.uk) was asked by the President of the Royal College of Surgeons of England, on behalf of the Medical Director of NHSEngland, to produce a document, which would allow all surgical procedures to be prioritised according to the timeframes in which they had to be performed during the pandemic. Those time frames were;

P1a - Emergency (less than 24hrs),
P1b - Urgent (less than 72hrs)
P2 - Less than 1 month
P3 - Less than 3 months
P4 - Over 3 months

The FSSA took on the task of producing the 'Clinical Guide to Prioritisation of Surgical Procedures during the Covid Pandemic'. All the legally recognised Surgical Specialty Associations were asked to work with their sub-specialty societies to produce a list of all the procedures they provide, allocated to the time frames set by NHSE. Many procedures are provided by a number of different, core specialty groups and it was stressed to all contributors that the prioritisation was about 'when, and not by whom' and submitted procedures would appear in the table but not against every group who perform it. Procedures were listed, in practice, according to who submitted the 'cell' first.

The aim was to produce one table for each priority so that theatre managers could, at a glance, match the cases needing to be performed with their respective priority. To help prioritise with in one time frame, an A4 sized matrix (the Recovery Prioritisation Matrix) was also produced to use to help compare between procedures. All who contributed understood the absolute need for cooperation. All surgeons in the United Kingdom complied, including those working completely in private practice who potentially faced financial ruin, as do many small business owners. Access to private beds was, and still is almost impossible, due to the NHS contract.

The Royal Colleges of Obstetrics and Gynaecology and of Ophthalmology were also asked to contribute to the Guide and gave their agreement for their prioritisations to be included. The Guide was published on the NHS website in early April with the undertaking that it would be updated monthly.

Subsequently, the NHS passed the publication of guidance to NICE and the FSSA was requested to publish the master copy of the Guide, with the Royal Colleges and Surgical Specialty Associations posting links and the sections pertinent to their work on their websites. In one month, the guide received over 7000 views on the Royal College of Surgeons of England's website alone and all the specialty associations have found the document useful 'on the ground'.

The ‘Family of Surgery’ came together for the common good of patients during the pandemic. The Guide is updated monthly. It is continuing to be of use but it is not designed to be a long term solution.

The direct effect of the pandemic on surgeons

As a result of the prioritisation, many surgeons’ elective workload ceased and they were redeployed to other tasks, turning patients in ITU or running Covid medical wards. This ‘cross skilling’, at a moment’s notice, was accepted without question but put enormous strain on the individuals because there was, effectively, no up-skilling performed apart from ‘fit testing’.

The anxiety caused by operating on emergencies and cancer cases in the early phase of the pandemic cannot be overestimated. Many surgeons had to shelter due to co-morbidities, putting their colleagues under even greater strain. The knowledge that some colleagues had died of Covid made the situation much worse. Those working in the operating theatre, respiratory care, ED and ITU were very aware that they were at significant risk, especially with the debacle about PPE. The failure of the NHS to provide adequate PPE and for PHE to define, and then to regularly update information about Aerosol Generating Procedures caused very significant anxiety. The significant delays in this information being published worsened anxieties and uncertainties because the medical profession was having to rely on information published from China, Korea and Italy instead.

The continuing failure of the NHS to Covid test its staff regularly is a major concern in maintaining Covid lite pathways.

It was made clear at the onset of the pandemic that the Supreme Court ruling in Montgomery (2015) still applied to shared decision making and consent. As a direct result, surgeons have felt very exposed, medico-legally, during the pandemic. Never-the-less, they remain very keen to ‘get operating again’ but have needed to expand their view on risk and gaining informed consent. It was clear at the outset that catching Covid peri-operatively could be fatal in many major surgical cases and that post-operative care pathways had to be completely re-thought due to Covid. This produced, what I have described as the ‘Titanic Syndrome’ amongst surgeons. The patient and operation might be in excellent condition when they left the operating theatre but, like the Titanic, they could hit a ‘Covid Iceberg’ during their post-operative recovery period that could cause enormous damage to the patient.

Anaesthetic techniques and theatre practices changed radically. Access to HDU and ITU facilities, effectively, evaporated. As a result, statistics from before the pandemic could no longer be relied upon because they could well be invalid. In addition, the risks of catching Covid post-operatively and developing a chronic cough would both severely affect the outcome of any procedure but also mean any minor complication of the operation would potentially be more difficult to treat and may need admission to another facility. As a result, surgeons have been very concerned that they would be held accountable for Covid related complications, outcomes, and inadequate provision of surgical procedures. This has enormously added to their stress.

Surgeons have also been very aware of the problems with cancer patients not presenting for care due to fear of hospitals and of the spiralling waiting lists for surgery. Both have increased the feeling of helplessness amongst surgeons and increased stress levels. The problems with hospitals getting back to work has also increased stress amongst surgeons enormously. There are vast differences across the country and the reason will be slightly different in each unit, ranging from condemned estate to staff sickness. The FSSA is working with the Royal Colleges of Surgery, the NHS and other agencies to help address this enormous problem. Various mechanisms are being worked on, including a clinician led waiting list review and looking to use the existing Invited Review Mechanism (IRM) to both set out what best practice looks like in re-

energising surgical services and, in conjunction with the NHS Confederation, to advise struggling units on how to get up and running again.

Surgeons have also had their contracts changed to reflect the challenges of the pandemic, with many now working across 7 days to maximise scares resources. Some trusts have told surgeons that they will not be paid for any work performed over and above their contracted hours and those who do receive payment are still caught in the 'pension trap', which remains essentially unresolved. As a result, few are willing to perform additional work.

In all this, the plight of the trainee surgeon must not be forgotten. Many trainees were re-deployed. Training has, effectively, been halted for most surgical trainees and the stress on them has been, perhaps, even greater than on consultants due to the uncertainty about their futures. Every aspect of their working lives has been thrown into doubt during the pandemic, with uncertainties about career progression, the cessation of exams and the inability to take up fellowships for higher specialist training, for example. For all healthcare workers with children, there was also the impossible task of balancing childcare and home schooling with the requirement that they go to work, potentially, putting their families at risk due to their occupation. The stress of this has been very considerable and cannot be overestimated.

The inability to take planned holidays has affected surgeons of all grades, as it has every other individual in the country, but the knowledge that the places they work have been responsible to 1:8 case of Covid has worsened the sensation of being trapped. The general public have had no real concept of how bad things have been despite it all happening within a few miles of where they live. The psychological effect has been likened to entering the trenches, but those trenches were not in some foreign land, they were in the local hospital. Even in hospitals that were relatively unaffected, the fear factor was significant.

The immediate future

Surgeons are very concerned about the immediate future for the Health Service. The message has been given out that the NHS did not succumb in the pandemic. Whilst that may have been true for ITU and hospital bed capacity, despite the reduction in trauma that needed to be treated, the overall effect on surgical services has been little short of 'collapse'.

The 'Family of Surgery' is very clear that surgical services must not stop if there is a second wave and we suggest the following;

1) Surgeons have been very significantly affected by changes in their work necessitated by the pandemic. However, resilience is often very high in surgeons so long as they have the facilities to use their skills for their patients. Please give them those facilities and they will deliver.

2) Help needs to be given to units struggling to re-energise.

3) Regular testing of NHS Staff (at least weekly) should be mandatory.

4) Surgeons are acutely aware that patients may be stuck in P4, despite the ability to move them through the priorities if their condition changes. That is also adding to the stress they are under, because they 'own' their waiting lists and feel responsible for their patients. The waiting list review will help but perhaps the time has come for Parliament to look at the NHS Act. The wording was changed in 1977 and now the

Secretary of State only need ‘promote’ a ‘comprehensive health service’. Perhaps the pandemic provides the opportunity to be honest with the public and state that not every health condition can or should be treated by the NHS in future?

5) A Royal Commission should urgently examine provision of healthcare in the wake of the pandemic.

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