

15 April – statement, overview and internal Q&A on the surgical prioritisation guidance

Commenting on the recent surgical prioritisation guidance published by NHS England, Professor Derek Alderson, President at Royal College of Surgeons of England said:

“All four surgical royal colleges in the UK and Ireland, and the surgical specialty associations, have been involved in developing this document, which complements our own Good Practice Guidance for surgeons, published last week

“The NHS is under unprecedented strain as a result of the COVID-19 pandemic, which means surgeons must prioritise the most urgent procedures. This guidance has been developed in response to frontline need, and provides clinicians with a framework for ensuring that patients with serious conditions continue to receive the treatment they need at a time when resources are exceptionally stretched.”

What is the aim of this guidance?

The guidance is designed to ensure patients in urgent need get the surgery they need, while freeing up as much capacity as possible to deal with the expected peak in COVID-19 patients. The NHS England guidance provides professional support to surgeons, supported by the four surgical royal colleges in the UK and Ireland and the surgical specialty associations, to make decisions about which operations are most urgent in a situation where resources are very limited.

It divides procedures into the following categories:

- **Priority level 1a Emergency** - operation needed within 24 hours to save life
- **Priority level 1b Urgent** - operation needed with 72 hours
- **Priority level 2** - surgery can be safely deferred for up to 4 weeks
- **Priority level 3** - surgery that can be delayed for up to 3 months with no predicted negative outcome
- **Priority level 4** - surgery that can be delayed for more than 3 months with no predicted negative outcome

This categorisation will help:

- allow managers to plan the allocation of surgical resources
- individual surgical specialties to appreciate the needs of other specialties when resources are stretched
- facilitate the development of regional surgical networks to sustain the delivery of surgery in a timely fashion.

Though delays to surgery through the COVID-19 outbreak will inevitably be worrying to patients, these guidelines make sure decisions are taken on the best clinical basis possible, taking into account each patient's circumstances and the balance of risks. Surgery during the COVID-19 outbreak also comes with the additional risk of infection with the virus, and these factors must be considered on an individual patient basis.

In time, understanding the extent of work that has been deferred will help plan the measures that need to be taken to reduce the inevitable increase in waiting times that will occur in all surgical specialties.

Q&A (internal – not for publication)

What is the evidence behind these recommendations?

This guidance was developed with expertise from the surgical specialty associations, and, where relevant, it takes into account on evidence-based commissioning guidelines around complications and long-term management of conditions. Those guidelines were themselves subject to a robust process of literature and peer review. Guidance of this kind is always kept under review and updated as new evidence emerges.

Aren't you now making decisions based on rationing resources rather than patient need?

No. Rationing implies that a fixed number of operations can be done, at which point everything stops. This is not about restricting treatment, or the responsibility of hospitals to provide it. This guidance supports risk/benefit analysis of *when* treatment needs to take place. These are broad recommendations and clinicians will always take into account the individual circumstances of each patient and the resources available at that hospital in applying them. As we also recommend in our Good Practice Guide, a risk/benefit analysis must rely on a day-to-day assessment of the changing situation for each patient.

Surely most procedures, particularly for those patients who are in great pain, will be seen as urgent to them. How are you able to decipher which take precedent?

The NHS is under unprecedented strain as a result of the COVID-19 pandemic, which means surgeons must prioritise the most urgent procedures. This guidance helps them to do that with the benefit of clinical leadership endorsed by all four surgical royal colleges in the UK and Ireland. Where an operation is delayed, clinicians will ensure patients get the best available non-invasive treatments to relieve pain in the intervening period. The operations which take priority have been categorised, in order to provide surgeons with a framework for ensuring that patients with serious conditions – threatening life, limbs or organs – continue to receive the urgent treatment they need at a time when resources are exceptionally stretched.

Does this replace the NCEPOD classifications?

No. This guidance builds on those classifications, providing further granularity for various surgical presentations.

What is classified as a serious condition which requires emergency treatment?

This guidance builds on the principles of the NCEPOD classifications, and provides further granularity specifically for surgical presentations. It classifies a serious condition is one which requires a life, limb or organ-saving operation within 24 hours. Major trauma can result in massive bleeding, airway obstruction, head injury or potential limb loss, any one of which can be a reason for urgent surgery. There are a range of other procedures which still need to be carried out within 72 hours, and this guidance helps surgeons make sure patients get the care they need.

Cancer operations are even being delayed now, surely these should ALL be prioritised as an emergency in the guidance?

Some cancer operations have been cancelled or postponed. This may have happened to allow further capacity for covid-19 patients, and/or to try and keep cancer patients away from hospital, so they are at less risk of catching covid-19. Some cancers have patterns of growth and spread that are slower than others. However, there are also some cancer operations which will need to be prioritised and operated upon, and this document helps guides clinicians to ensure that they are.

We are working with Government to establish COVID-free centres where some cancer treatment can take place with minimal risk of infection. Our priority is to keep patients safe and to provide surgeons with a framework for ensuring that patients with serious conditions continue to receive the treatment they need at a time when resources are exceptionally stretched.

Is this RCS guidance or NHSE guidance – I am confused?

This is NHSE guidance, which has been led by the President of the Royal College of Surgeons of England with support from the surgical specialty associations. It has been endorsed by all the surgical Colleges in the UK and Ireland.

Waiting times are already at breaking point. With so many operations being delayed and deferred how will the NHS cope when this is all over?

Before COVID, we were calling for a five year plan to deal with elective waiting lists, and working with NHSE to develop plans to tackle the backlog we already had. Sadly this backlog will be even greater after the crisis. We must track and record operations that are deferred. Once we've beaten the virus, we will be urging Government to follow through its support for the NHS by committing to a plan to bring waiting lists down.

Why have most transplantation surgeries been cancelled – surely these are an emergency?

Urgent heart and liver transplants are still taking place, but much activity has had to be suspended during the crisis. That's because resources are so stretched, and also because the risk of infection with COVID in hospital is increased.