Changes to service practices and processes during COVID-19

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What was the problem?

In 2019, the Health Board was facing unprecedented pressure within its Emergency Unit due to rapidly increasing non-scheduled attendances, poor flow through the hospital and increasing elective surgery demands. The Surgical Clinical Board had begun a programme aimed at managing attendances, reducing bed occupancy and length of stay, which included participation in the Surgical Ambulatory Care Network. The impending impact of the COVID-19 pandemic transformed this into an urgent priority, with a pressing need to reconfigure beds and reduce admissions. Ambulatory surgical care suddenly became a crucial means of achieving these objectives.

What was the solution?

A phone triage-line for GPs had already been established and it rapidly developed in importance to enable clinical conversations with GPs before patients were sent to the hospital. Previously, GPs were worried about calling ahead. Now they were able to call a dedicated mobile telephone held in the ambulatory emergency care unit by Consultants, registrars or advanced nurse practitioners. A triage form was created to guide conversations with GPs. The clinical discussion became vitally important, not only as a tool to ensure patients were seen in the right place according to likely COVID-19 status, but the team was also able to plan a patient's care before they arrived at hospital. This included identifying who was best placed to see the patient, what diagnostics would be necessary and, when patients could wait, identifying a suitable time to see them. Patient care became much better coordinated. In addition, surgical admissions were concentrated onto two or three wards and supported by seven-day working and twice-daily consultant rounds.

What were the results?

GP attitudes towards phone triage were almost overwhelmingly positive. As many of them themselves were using phone consultations with patients, it allowed some discussion on which patients could be managed at home and which required face-to-face consultation. GPs became acutely aware of the need for admission avoidance and this was also supported by a change in patient's wishes and expectations of not attending hospital unless absolutely required. On calls, GPs now frequently discuss how to keep patients out of hospital, for example by early virtual follow-up. The discussion is now about what can be done outside of hospital. Of great importance was the governance and support that have been wrapped around the process. Having support and advice from secondary care easily available via telephone has reduced concerns about medico-legal risk and means that GPs are more willing to manage patients in the community.

What were the learning points?

The unit's staff are confident that they can extend ambulatory surgical care much further than when they initially started. GPs have also learnt that they can do much more without admission to hospital. Providing GPs are satisfied that there is a clear plan for a patient, they are content professionally and medico-legally that this is safe. The phone line has been crucial in achieving this. Other enablers include investment in IT infrastructure, such as upgrading the Wi-Fi network and buying *Attend Anywhere* software, which, for example, has enabled stoma care to be done by video, thus preventing readmissions.

The hospital has noticed that patients don't always like video, with some preferring telephone consultations. It is questionable whether video consultations add value to all consultations but clearly there are situations where it is helpful (e.g. for assessing a wound). Data protection has been a concern for some patients and this would be the major reassurance that virtual consultation software developers would need to provide. Face-to-face contact is seen as important for assessment, particularly in preoperative patients. Patients need to be carefully risk-assessed and detailed explanation of the risks need to be given, in particular around the potential for developing COVID-19 perioperatively. It is important that the patients trust the surgeon and the surgeon trusts that the patient understands the information given, which can be difficult without face-to-face contact.

The unit has been aware that some patients have presented later than before the pandemic, with more serious or complex illness as a result. This has been noted with cases of appendicitis, bowel obstruction and perianal sepsis in particular. The late presentations have nearly all been a result of patient choice rather than hospital processes and a publicity campaign has been undertaken by the health board to encourage people not to delay presentation. Undoubtedly, the "surgical takes" have taken on a different character, with much more serious pathology requiring intervention being the norm and a decrease in the numbers of patients with low-acuity symptoms. To allow expansion of medical beds during the COVID-19 pandemic, the surgical footprint has shrunk considerably. This has presented challenges as emergency surgical attendances have come back to near normal levels. The reduction of elective surgical sessions and changes to the emergency rota has allowed for seven-day working and daily consultant-led ward rounds, which has demonstrably helped to reduce length of stay and bed occupancy.

There have been patients who have developed COVID-19 post operatively, with cases of elective and emergency deaths due to presumed hospital-acquired coronavirus. Overall, this has been a very small percentage and the cohorting and streaming of patients according to risk and test results has clearly helped. Elective surgery has continued through the pandemic, but in much smaller volume, through the use of protected 'green zones' in the hospital and the use of the local private sector hospitals. All patients are required to self-isolate for 14 days prior to elective procedures. They are swabbed 72-hours prior to admission, with a requirement for negative results before operations take place. Only about 1-2% of patients swabbed in this way have had positive COVID swabs and been cancelled. Less than 0.5% of patients having elective surgery have developed COVID perioperatively.

The unit now plans to extend the indications for surgical ambulatory emergency care with all referrals deemed ambulatory until proven otherwise. There are plans to build on the developments of good communication with GPs by using a novel smartphone app, 'Consultant Connect', to allow GPs to easily contact consultants for advice. The unit is also looking to use Adastra scheduling software so that all triaged referrals can be booked into timed slots to reduce surges of attendance and allow safe, socially-distanced waiting areas. In addition, by using video consultation software to facilitate early discharge or virtual inpatients follow-up, the unit will aim to manage more patients without admission and reduce the length of stay for those that require intervention.

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