**Covid-19**

**Cardiothoracic Surgery Escalation Framework**

Covid-19 pandemic is expected to put UK Health services under escalating pressure. Initially decision making may be within current ethical/practice standards. However, if conditions continue to escalate as has been seen in other countries decision making may be more extraordinary. **In these circumstances it is important that when decisions are made both the decision process and the decision made is well documented**. At more normal working levels the decision making may seem easy, at extraordinary working levels these decisions are difficult, staff will be under severe stress and it is well recognised that this will impact on staff mental health and resilience.

This framework is designed to support that decision-making process. The decision-making process should bring together available information, assess the risks, legal position, policies and procedures and then recommend and support shared decisions (individual clinician, organisation and (where appropriate) patients).

The phases of any incident response will overlap. Different hospitals and units may be at different stages at different times (although all decisions made should take account of the wider local, regional and national position). The table below should not be considered rigid (columns may overlap) and these are not mandatory instructions.

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| **Phase** | **Preparation** | **Escalation** | **Crisis (compensated)** | **Crisis (uncompensated)** | **Resolution** | **Recovery** | **Normal Working** |
| **Likely prevalence** | Low | Medium | High | Very High | Reducing | Normal post-endemic levels | Normal post-endemic levels |
| **Impact** | Normal winter pressuresBusiness as usual | Limited ITULimited beds | No ITUTheatre ITU podsNo bedsEmergency discharges | Severe pressure across the health serviceStaff, skill, equipment, capacity shortages Emergency surgery limitedIsolation limited | Health services under severe pressure but improving | Enhanced working levels | Normal workingBusiness as usual |
| **Stage** | Prepare to respond | Stop routine elective | Major incident (compensated)Prioritise very urgent/emergency | Major incident (decompensated)Absolutely essential only, prioritised use of resources supported by ethical/legal framework | De-escalation; capture improved working | De-escalation; capture improved working | Normal working with learnt improvements |
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| **Elective operating** | Normal but focus on priority patients and non-vulnerable patients | In-house urgent (see notes below) cardiac surgery and patients deteriorating from home/peripheral hospitals. Urgent thoracic surgery and cancers that can’t waitIncrease day-case, alternative pathways/ management Increase day-caseExpedite urgent transfers, priority cases from clinics | All elective surgery stops Ambulatory management, non-operative management only | All elective surgery stoppedOnly life-threatening in-house cardiac surgery.Cardiothoracic surgeons may need to support intensive care patients being cared for in anaesthetic rooms / theatres | Recommence elective surgery for priority cases onlyRecommence elective i.e. all the in-house patients that were sent home, delayed cancer patients | Enhance elective surgery capacity to manage backlog | Normal elective capacity |
| **Emergency operating** | Normal | Emergency surgery possible but consider using alternative pathways | Emergency surgery limited, if possible, use alternative pathways | Only very selected emergency surgery,prioritised use of resources supported by ethical/legal framework | Emergency surgery possible but consider using alternative pathways | Normal emergency surgery  | Normal emergency surgery |
| **Elective clinics** | Maximise use of telephone/video conferencingMinimise face-to-face appts, postpone non-urgent referrals, follow-upsReduce number of clinics to free senior staff for planning, in patient management  | Maximise clinic reduction - stop review appointments unless there are problems. No new patients unless urgent. | Cancel all elective clinics  | Cancel all elective clinics | Restart limited clinic resources as capacity permits | Enhanced clinic capacity | Normal clinic capacity |
| **Emergency clinics** |  | Consider emergency clinics only for urgent referrals / triage (tel/video-conferencing only) | Emergency clinic attendance only | Emergency clinic attendance only (aimed to avoid admissions) | Emergency clinics continue | Emergency clinics can stop | Normal clinic capacity (utilising learnt improvements eg tel/video follow-up |
| **MDTs** | Provide MDT support, minimise attendance whilst focusing senior decision making; prioritise efficient use of pathways to maximise efficiency and reduce foot-fall  | Reduce MDT to essential cases only, minimise attendance, video-conferencing preferable  | MDT discussion by cons to cons communication | MDT discussion by cons to cons communication – emergency cases only | Reduce MDT to essential cases only, minimise attendance, video-conferencing preferable | Enhanced MDT capacity | Normal MDT capacity |
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Notes:

In-House Urgent:

In-house surgery is currently for patients who are more at risk of e.g. adverse cardiac events going home rather than staying in hospital.

However, where there is a shortage of facilities for surgery, due to pressure of Covid-19 patients needing ITU care, it would be possible to divide these in-house patients into two groups:

* 1st group who have critical disease or unstable symptoms and should stay in hospital.
* 2nd group who have symptoms controlled on medication and do not have critical disease. This second group could go home knowing they can contact the unit if symptoms deteriorate and that they will be prioritised for their surgery as normal service is resumed.