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LETTER

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The National Health Service (NHS) response to the COVID-19 pandemic: a colorectal surgeon's experience in the UK

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Abstract: The UK government was arguably slow to take action against the COVID-19 pandemic. However, since switching their policy from "mitigation" to "suppression", swift changes have been implemented to all aspects of life. In this unprecedented crisis healthcare has been on the battlefront across the globe. Every effort has been made in the UK to stop the National Health Service (NHS) from being overwhelmed, leading to the national slogan: "Stay at home. Protect the NHS. Save lives". In this article, a consultant general and colorectal surgeon in Southampton reports on the NHS response to the COVID-19 pandemic.

***Keywords*:** COVID-19, surgery, National Health Service (NHS), pelvic exenteration

Even as the World Health Organization (WHO) declared the COVID-19 outbreak a pandemic on 11 March and neighbouring European countries implemented lockdowns, the UK appeared relatively relaxed. On 16 March, however, the tide clearly turned. The UK government's "mitigation strategy" – to delay the spread of the disease while developing herd immunity within the community – switched to a "suppression strategy". Allegedly shocked into action by an Imperial College London report predicting hundreds of thousands of deaths and a complete collapse of the UK National Health Service (NHS) (*1*), the government moved rapidly towards locking down the country. By 23 March, with the death toll at 55 and confirmed cases at 1,543, all pubs, restaurants, gyms, social venues, non-essential retailers and schools were closed. People were limited to leaving the house for a choice of only four reasons. Deepening the sense of crisis were the announcements that HRH Prince Charles (on 25 March), and the Prime Minister Boris Johnson and Health Secretary Matt Hancock (on 27 March), had all tested positive for the coronavirus.

Life has changed dramatically since then. Social distancing – remaining at least two metres away from anyone outside of your household – impacts all activities. Neighbours help each other out with supplies to limit the number of supermarket and pharmacy trips. Children are home-schooled. Everyone – even small children – socialise over video call apps such as Zoom and House Party. Exercise is limited to one hour per day. If someone develops a high fever or persistent cough – the typical COVID-19 symptoms – the entire household must remain in quarantine for 14 days. Reminded daily by the government to "Stay at Home. Protect the NHS. Save Lives", the majority of the British public appear to accept and support these extreme restrictions on their freedom.

Drastic changes have also been introduced very rapidly across the NHS. The primary focus has been on increasing ICU capacity in anticipation of a surge in critical COVID-19 patients. Hospital services were reconfigured and big field hospitals have been set up in London, Birmingham and Manchester with the help of the military. To ramp up staffing, the rules were swiftly relaxed to allow non-intensive care specialists to be paired with specialists and to make it easier for retired doctors and nurses to join the NHS workforce. All healthcare professionals are expected to be flexible in their practice, working outside of their specialty or in unfamiliar circumstances, with regulatory bodies and Trusts covering medical indemnity.

Within our organisation in Southampton, all medical training rotations were halted and junior doctors were deployed to ICU, high dependency unit (HDU) and medical wards. All surgeons were mandated to undertake ICU training, in readiness to deliver intensive care to COVID-19 ventilated patients if needed. Our surgical rota was reconfigured splitting all GI surgeons into three acute surgical care teams with each team covering all sub-specialties and rotating through acute surgery, elective surgery and virtual clinics. All endoscopy service was halted except for emergency procedures like haemostasis or colonic stenting and the endoscopy suites were converted into medical wards. All routine benign operations for gall stones, hernias, diverticulosis and pelvic floor diseases were also cancelled and, following

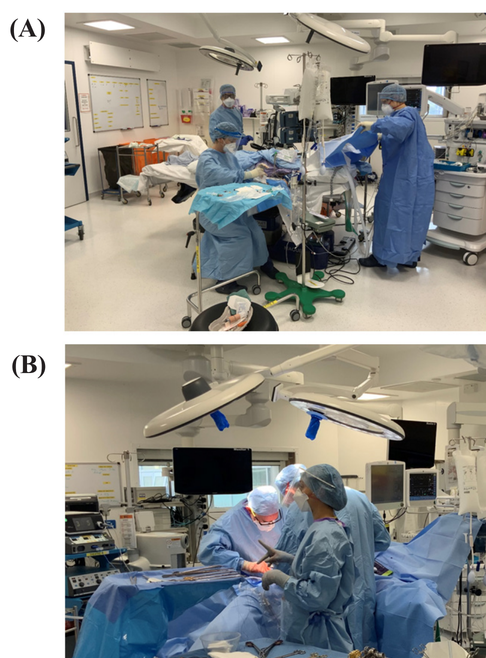

Figure 1. Performing pelvic exenteration in full PPE. (A) Anaesthetists prepping in theatre instead of the anaesthetic room and (B) Colorectal and urological surgeons.

guidance from the Surgical Royal Colleges (*2*), even acute conditions like appendicitis, cholecystitis and diverticulitis are treated as conservatively as possible. Meanwhile, nearby private hospitals have been acquired and designated as "clean" hospitals to allow critical elective care – primarily cancer operations – to continue to take place.

As colorectal and exenterative surgeons, my colleagues and I have had to make difficult prioritisation and adjudication decisions including to suspend complex surgery and to not accept any new regional referrals. This is particularly difficult and upsetting as deferring surgery is likely to compromise oncological outcomes and our patients' anxiety is evident. Nevertheless the current situation makes exenterative surgery all but impossible as it is a resource intensive procedure requiring multiple consultants/specialties and critical care beds postoperatively. As a result we have asked the referring local MDTs to consider possible holding measures such as additional neoadjuvant treatment and sought to have open conversations with individual patients on the waiting list.

My personal impression from this experience has been that the UK has been highly effective at making and implementing fast decisions – even as the details are still being clarified. On the other hand, the speed of change has caused confusion and anxiety in various areas. In particular, there has been concern over the lack of personal protective equipment (PPE) (Figure 1) and conflicting and confusing guidance over its use. There are also staff-shortage issues with many staff having to self-isolate when household members have symptoms. None of this is helped by the limited availability of testing – an issue the government is still struggling with.

Within our Trust, the Occupational Health team have conducted risk assessments on all staff with underlying health conditions known to be susceptible to COVID-19 leading to a large number being discouraged from coming into face-to-face contact with patients. This has had a further impact on staffing but is evidence of the difficult balance the Trust faces between staff safety and patient care at this time of crisis. All in all, however, there has been clear leadership with transparency and accountability and a strong spirit of working together.

It is often said that "the NHS is the closest thing the English have to a religion" (*3*). This has probably never been more true. Every Thursday people across the country stand on their doorsteps and clap to show their support for the healthcare workers fighting on the frontline of this "battle" against an invisible enemy. On his return home from three nights in intensive care, Boris Johnson declared, "We will win because our NHS is the beating heart of this country. It is the best of this country. It is unconquerable. It is powered by love" (*4*).

A "tsunami" of cases is expected to come to Southampton in the next two weeks and we are predicted to run out of beds. Regardless of what happens my faith in my NHS colleagues is strong.

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