The Response of a Tertiary Paediatric Urology Unit to the COVID-19 Pandemic in central London: what have we learned?

Editor

The SARS-CoV-2 pandemic presented unprecedented challenges for health-care systems; within a matter of days our busy children's hospital had to stop elective clinical activity while ensuring patients' safety[1].

We report the rapid response and the strategy adopted by our department and reflect on difficulties encountered and lessons learned. We aim to share our experience to support any surgical unit facing similar situations such in the event of a second Covid-19 wave.

In order to minimise staff exposure to Covid-19, we operated a 'Consultant-of-the-Week' rota with a second consultant on standby. This left other consultants flexible to be redeployed if necessary and guaranteed cover in case anyone became unwell.

The Junior doctors' role has been crucial: considering their broad skillset and familiarity with cross-covering other specialties, they were released from their specialty commitments and included in combined rotas with other departments or redeployed.

They faced the challenge of being out of their "comfort zone" and in more direct contact with possible Covid-19 positive patients, with implications for themselves and their familiars.

Furthermore, they experienced the loss of opportunities training in their chosen speciality[2].

As consultants, we recognised our important role in the pastoral support of juniors. We made efforts to counsel and support them both individually and collectively; we also created internal webinars, virtual teaching and simulation sessions and assured constant case-discussion exercises.

Our surgical activity dropped significantly (*Fig. 1*). Theatre capacity was severely reduced and shared between all specialities.

New theatre-flow pathways, protective personal equipment and perioperative guidelines frequently changed and evolved; adaptability was crucial.

A rapid exercise was undertaken to categorise patients into strata according to clinical priority[3].

The activity was restricted to the most urgent cases during the two weeks-peak incidence of Covid-19 cases; with the improvement of the situation, we established a plan to recover with a projection to resume less urgent cases (*Fig. 1A*-dotted line).

Laparoscopy was initially avoided in accordance with early literature and Colleges' guidelines and was reintroduced once peak crisis was overcome and more evidence of safety became available[4].

Elective surgical activity witnessed the most dramatic and rapid change.

This helped minimising patient and families' exposure and allowed reducing the need of staff making them available for re-deployment. However, it has inevitably aggravated the problem of the surgical waiting lists and generated a massive backlog that will require extra resources and funding once routine activity restarts[5].

Patients on the waiting list for outpatient consultation were also prioritised and categorised as:

1. Appointment confirmed within 6 weeks
2. Postponed for 12 weeks
3. Discharged with advice-letter sent to the General Practitioner.

All appointments were converted into telephonic unless clinically indicated.

After a thorough exercise of review, follow-up appointments were reduced while the new consultations were maintained to allow a safer control of the patients (*Fig. 1B*).

As a result of this pandemic we created new pathways and introduced a different approach to traditional care offered to our patients with the aim to minimise hospital attendance and personnel interaction. The creation of "one-stop clinics" that coordinate and concentrate multiple appointments and consultations with different clinicians is an example. This will require additional organizational effort, but will certainly generate an important improvement that we have "inherited" from our response to the crisis.

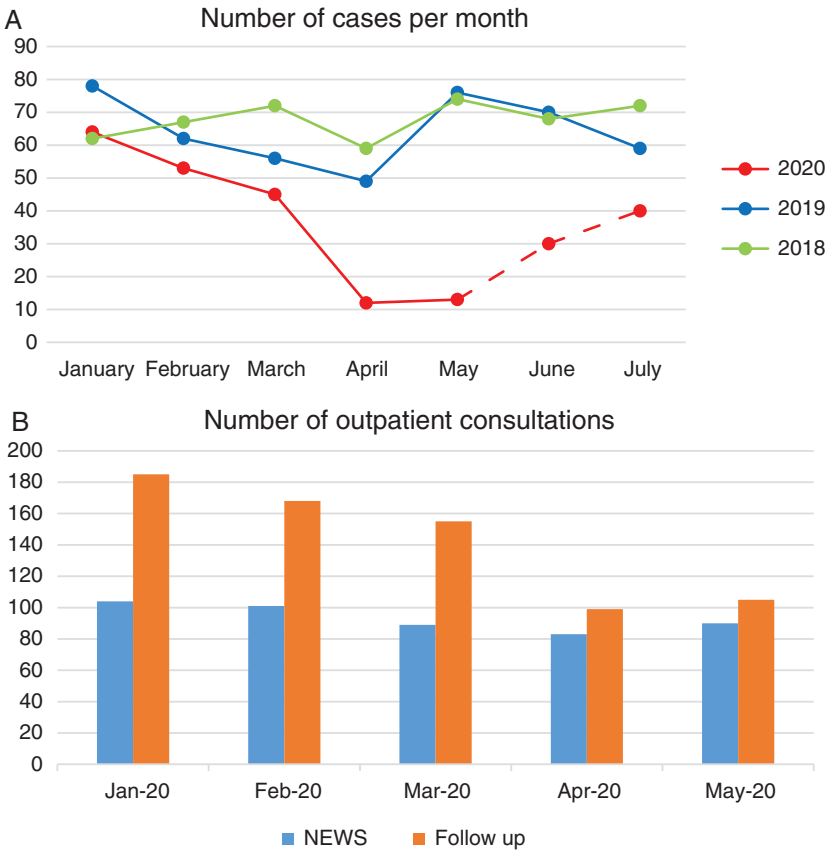
Virtual meetings were established to facilitate new working practices; although the format was novel, it quickly became the norm. Paramount among these was the daily consultant WhatsApp-video team call.

Apart from business, these meetings provided a platform for mutual encouragement and fostered team-cohesiveness.

The experience gained with the use of technological platforms during the pandemic has opened up scenarios previously never considered. The accessibility to virtual rooms for meetings represents one of the biggest innovations in regard to the interactions among clinicians. While previously a multidisciplinary meeting required the physical presence of the attendees, we have now learned that we can easily, and effectively, join and contribute to the discussion remotely. This will have a beneficial impact and improve both the productivity and the quality of care offered to patients.

The same principle applies to the interaction between patient and clinician. The wide implementation of "remote consultations" can be considered a major breakthrough in the way the medical profession is made available to the users. As consequence, they will have easier and quicker access to clinicians, removing barriers represented

Fig. 1 Activity of the department during Covid-19 crisis: A) Number of operations per month in 2020 compared to previous 2 years (dotted line for June and July is the predicted trajectory of cases as lock-down is eased) and B) outpatient activity showing new patients and follow up patients. Telephone clinics were started from the fourth week of March. While follow up appointment were reduced after a thorough exercise of review, the new consultations were maintained to allow a safer control of the patients



by the logistics and costs of the travelling to the hospital.

This, however, cannot entirely substitute the traditional face-to-face consultation. The initial experience we had with "remote consultations" (telephone and video) is that, although they are good for follow-ups and for a selected group of pathologies (i.e. urinary incontinence), they do not provide the possibility to perform an appropriate physical examination, which is essential for some conditions. Furthermore, we feel that remote consultations lack human interaction and undermines the importance of establishing patient-doctor relationship and building the necessary trust which is paramount for the success of any treatment.

The reluctance of many parents to come into hospital for consultations and operations added extra difficulties in re-organising our activity; interestingly, it also generated a reduction in emergency attendance across specialties and both in children and adults[6].

A partial explanation could be researched in the governments' measures adopted in the attempt to control the virus spread, particularly, school and public activities closure and "lock-down" policies. However, we could also speculate that, perhaps, the fear generated by the Covid-19 has unmasked a general tendency of misusing the emergency departments and/or a lack of support available in the community for what could be considered "not real emergencies".

Our response to the pandemic crisis was rapid, flexible and successful in ensuring both patient and operators' safety. While empathising with the anxieties of our patients and families, we ensured that work continued keeping patient safety as our priority. Team cohesion and communication formed the mainstay of crisis response. We used all technology available and adopted new approaches

for interactions among colleagues and with patients which will generate significant changes to future practice.

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1 Spinelli A, Pellino G. COVID-19 pandemic: perspectives on an unfolding crisis. *Br J Surg* 2020; **107**: 785–787.
2 Kapila AK, Farid Y, Kapila V, Schettino M, Vanhoeij M, Hamdi M. The perspective of surgical residents on current and future training in light of the COVID-19 pandemic. *Br J Surg* 2020; **107**: e305.
3 Amparore D, Campi R, Checcucci E, Sessa F, Pecoraro A, Minervini A *et al.* Forecasting the Future of Urology Practice: A Comprehensive Review of the Recommendations by International and European Associations on Priority Procedures During the COVID-19 Pandemic. *Eur Urol Focus* 2020; **6**: 1032–1048.
4 Mintz Y, Arezzo A, Boni L, Baldari L, Cassinotti E, Brodie R *et al.* The risk of COVID-19 transmission by laparoscopic smoke may be lower than for laparotomy: a narrative review. *Surg Endosc* 2020; **34**: 3298–3305.
5 COVIDSurg Collaborative. Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform surgical recovery plans. *Br J Surg* 2020; https://doi.org/10.1002/bjs.11746 [Epub ahead of print].
6 Isba R, Edge R, Jenner R, Broughton E, Francis N, Butler J. Where have all the children gone? Decreases in paediatric emergency department attendances at the start of the COVID-19 pandemic of 2020. *Arch Dis Child* 2020; **105**: 704.