


# Challenge of maintaining the initial benefits of a ‘cold’ elective surgical unit established during the first COVID-19 peak

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Dear Editor

In August, the authors published their experience of establishing a ‘cold’ elective surgical unit (cESU) for colorectal, urological, and vascular surgery following the initial COVID-19 surge<sup>1</sup>. The initial results demonstrated a reduced duration of hospital stay for patients undergoing colorectal procedures that was attributed to the focus on perioperative care and enhanced recovery. Recently, organizational factors have led to repeated changes to patient flow that have threatened the ability to maintain these early benefits.

Initially, the cESU ran as a closed facility where patients and staff were shielded from the main hospital. This ‘honeymoon’ period demonstrated the early achievement of reducing median duration of stay from 5 to 4 days for colorectal resections and from 6 to 4 days for robotic low anterior resections. Only one of 33 patients developed postoperative ileus during this interval (Table 1).

As the number of patients with COVID-19 in the hospital decreased, the restrictions initially placed on staff working in the unit were relaxed and personnel could move more freely between the hospital zones. This led to the removal of a dedicated physiotherapist and stoma nurse. Numbers of day-case, P3, and P4<sup>2</sup> procedures were also increased, placing an extra burden on the ward staff, particularly in the morning, with admission assessments. Furthermore, staff who had been seconded from a nearby private hospital left to return to their usual posts. These changes

affected the ability of the team to maintain the initial focus that had been given to enhanced recovery, and duration of stay in this period returned to 5 days.

At the end of September, a short-stay surgical unit closed to allow reallocation of staff to other areas within the hospital and, with few exceptions, all overnight elective surgical stays were admitted and housed on the cESU. This additional case mix further increased morning admissions and added extra ward rounds for the specialties whose patients had been previously been cared for elsewhere. At this time, the duration of hospital stay for rectal cancer increased further to 5.5 days and the ileus rate increased from 1 of 23 to 4 of 38 after colorectal resections (Table 1).

Although the changes in duration of hospital stay are not statistically significant and there may be confounders, they support the anecdotal observations. The coronavirus pandemic has required rapid adaptations to be made to the way in which patient care is delivered, not least in surgery. The recent Association of Coloproctology of Great Britain and Ireland Legacy Working Group consensus statement<sup>3</sup> provides a comprehensive overview of the numerous improvements that have made in respect to colorectal disease. It is vital that as the process of recovery begins, we crystallize these ‘silver linings’ and do not allow ourselves to slowly revert to the ways of the past. Although it is imperative that the National Health Service returns to prepandemic capacity, and even surpasses it to accommodate patients who have

**Table 1** Number of colorectal procedures for the three time intervals and short-term outcomes

	Period 1 (12 May to 29 July 2020)	Period 2 (30 July to 26 September 2020)	Period 3 (27 September to 23 November 2020)
No. of days	78	58	57
No. of colorectal procedures	45	81	106
No. of colorectal resections	33	23	38
No. of robotic low anterior resections	6	4	10
Duration of hospital stay (days)*			
Resections	4 (3–4)	5 (3–7)	5 (3–6)
Low anterior resections	4 (4–5.5)	5 (4.75–12.5)	5.5 (5–12.25)
Ileus after colorectal resection	1 of 33	1 of 23	4 of 38

Values are \*median (i.q.r.).

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had treatment delayed<sup>4</sup>, clinicians and hospital management now have an opportunity and responsibility to collaborate so that the progress achieved during the pandemic continues to enhance the future of patient care.

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