Is the grass really greener on the other side? – The COVID-free 'green zones' in the COVID-19 era

Editor

At the end of April 2020, the government announced that the UK was 'coming through the peak' of COVID-19 hospitalisations and that the NHS was entering the 'second phase' of its response to the pandemic. During this next phase, urgent and time critical cancer surgery should be provided at levels of capacity seen prior to COVID-19[1].

'Green zones' are being introduced as spaces where expedited surgery can be resumed in areas that are free of, or almost free of COVID-19 cases[2]. Although there remains no concrete guidance on how these theoretically low risk areas can be maintained, the concept of creating 'green zones' is supported by the international surgical community[3].

The ACPGBI have suggested several ways in which a 'green zone' can be preserved. These include screening patients and staff for symptoms (including temperature checks), before they are permitted to enter the 'green zone' and regular SARS-CoV-2 testing of staff. They also advise that both clinical and non-clinical staff who have been based in high risk 'red zones', should not be transferred to work in 'green zones', until they have successfully completed 2 weeks of asymptomatic isolation, or have had two negative SARS-CoV-2 swab tests taken at least 48 hours apart[2].

All of these recommendations clearly make sense. However, in a time when many NHS Trusts are already struggling with limited facilities and staff shortages due to the pandemic, is the implementation of 'green zone' protective measures realistic and are the zones really 'green'?

With the gradual re-introduction of the elective workload and the provision of emergency and vital outpatient services remaining paramount, many Trusts will struggle to have the staffing infrastructure in place to provide dedicated staff to high and low risk areas. This scenario is likely to be exaggerated in district general hospitals, where the staffing numbers available at tertiary centres may not be possible.

Decisions to redeploy staff during the pandemic is commonplace across the country. From week to week, junior doctors may be requested to assist on 'COVID wards', continue their on-call/ward commitments, as well as oversee the care of post-operative high-risk patients on COVID-19 free areas. Due to staffing limitations, this movement of staff between 'green' and 'red zones' is currently occurring without enforcing the recommended asymptomatic isolation period, or clearance swab screening. In the COVID-19 setting, we speculate that the utilisation of the same healthcare staff to cover surgical, medical, elective and emergency services is currently routine practice.

In addition to staffing configurations, consideration needs to be given to the logistics of safe movement around hospital sites. For Trusts that are unable to provide care for elective surgical patients at an entirely isolated site, separate entrances/elevators/corridors/transfer routes should be established to further distinguish 'green' from 'red zones'. However, questions can be raised about the practical feasibility of such processes.

There remains an ongoing need for research and evidence that NHS Trusts can adopt, in order to establish feasible mechanisms that will help develop true 'green zones'. With the potential strategic and staffing difficulties, along with the government acknowledging that COVID-19 *'looks set to be with us for some time to come'*, will NHS Trusts succeed in keeping their 'green zones' COVID-free?[1]

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