**Non negotiable decision criteria for policy design**

The overriding principles governing the Stabilisation Phase pathway design are as follows:

1. **Protection of patients and staff** is the key concern in defining the operational pathway.
2. **Patients must spend the shortest possible time** in hospital in order to receive their care.
3. Where possible prior to an intervention, **COVID-status should be defined** to try to distinguish between “COVID-unlikely” and “COVID-likely or confirmed”
4. Where possible, **separate physical pathways** should exist according to likely COVID status
5. **24/7 interventional cardiology and arrhythmia emergency care** should be available

It is recognised that this will require a re-evaluation of the pre-existing operational plan and changes to it where necessary. During the Stabilisation Phase of operation, a parallel process of longer term planning in 6 month steps can be formulated while being informed by national and international progress and learning made in control of the pandemic. A priority throughout is alignment of the Directorate and staff with the plan. 24/7 interventional cardiology and arrhythmia emergency care should be available at GSTT.

1. **Protection of patients and staff is the key concern in defining the operational pathway.**

Every decision taken must minimise the risk of person-to-person, person-to-surface and surface-to-person virus transmission. In the cath lab environment, this is an overarching principle and will affect every aspect of the patient pathway including, but not limited to, patient education on self-protection prior to admission, limited exposure to different hospital areas, restriction to essential point-of-care diagnostics only, appropriate staff PPE and patient reverse barrier protection (masks), patient and staff social distancing within the care environment, cohorting of patients in the cath lab environment, procedural staffing restricted to the minimum necessary for safe operation within the lab with optimised staffing patterns to expedite patient movement from admission to discharge. Stringent and regular cleaning protocols must be observed within the working environment.

1. **Patients must spend the shortest possible time in hospital in order to receive their care.**

During the Stabilisation Phase, focus should be on those patients in whom a procedure can be performed at acceptable risk with a low likelihood of exposure to COVID in hospital and a low risk of consequences if exposed to COVID in hospital. The term “acceptable” is used as patients in need of a high risk procedure should not be denied that procedure where a modified operational plan may strongly mitigate the risk of COVID exposure. This has already been effectively demonstrated for lead extraction and pacing cases during the escalation phase of the COVID response. Of necessity, this will require a move to shortened hospital stay, more day case working, a modification of the working hours to permit recovery and discharge from a low infection risk, day-case unit of all patients, efficient staffing to eliminate delays to usual admission, inpatient flow and discharge processes as well as careful planning of lists.

1. **Where possible prior to an intervention, COVID-status should be defined to try to distinguish between “COVID-unlikely” and “COVID-likely or confirmed”.**

There will be no way of knowing with certainty if a patient has or doesn’t have COVID however, in collaboration with the Trust infection control team, pre-admission screening protocols will be in place to guide patient flow through the cath lab and ward environments according to likelihood of COVID status. For the purposes of management of infection risk, treatment and the environment, all inpatients will be managed by staff as if patient COVID status is positive. The likelihood of an inpatient or transfer having active COVID is likely substantially higher than a screened, pre-isolated, elective day case.

1. **Where possible, separate physical pathways should exist according to likely COVID status.**

Although all patients will be managed as if COVID status is positive, separation into “COVID-unlikely” and “COVID-likely/confirmed” is intended from an operational perspective. This is likely to be the most challenging aspect of recommencement of low volume elective activity. Where possible, the two groups should not be in the same pre- and post-procedure environments together and their procedures should ideally be performed in separate catheter laboratories.

1. **24/7 interventional cardiology and arrhythmia emergency care should be available.**

**Key policy enablers**

*Personnel*

Cath Lab Coordinator to ensure compliance with operating plan, PPE guidance, cohorting of patients, communication between labs, operators, staff groups and wards

Day Unit Coordinator to ensure smooth and safe admission, transfer and discharge processes, responsible for ensuring timely paperwork, investigations (CXR, swabs etc) for patient to guarantee same day discharge where possible

Flexibility of staff numbers to be able to accommodate necessity to switch between different cath lab environments according to likely COVID status without incurring significant procedural delays and therefore delayed discharge

Support staff (SpRs, SHOs, Physician associates, administration, pharmacy, HCAs, porters).

*Operational*

Aligned working patterns for all staff groups to enable on time start at 8am and 4pm finish

Rapid staff testing in event of pyrexia or household illness

Streamlined and transparent scheduling process with senior clinical and DMT leadership

Daily operational plan at outset, led by Lab and unit cordinators, communicated clearly

Operational Huddle midmorning to define risks to day case discharge and appropriate mitigation plans or destination decision in event of likely discharge failure

Focus of Lab procedural team should solely be to get procedure performed as efficiently and as effectively as possible – all daily operational decisions to be made by coordinators in communication with lab teams

For device cases, streamlined process to enable post implant checks and X-rays.

**Key policy challenges**

*Personnel*

Nursing and medical service currently depleted due to redeployment

Achieving agreement on aligned working patterns

Coping with enforced absence due to symptoms or household isolation without rapid access to testing

Well-being of staff on return to regular clinical activity and unfamiliar work pattern

Prevention of nosocomial COVID transmission by asymptomatic staff or poor adherence to infection control measures

*Operational*

Rapid cultural change to a much more tightly managed operating model

Potential of an unexpected short notice COVID+ patient, emergency or staff diagnosis leading to list disruption or cancellation

Patient reluctance to attend for procedures during ongoing Pandemic

Patient attendance in early morning may require patient transport support

Disruption to pre-existing daily operational plan by admission of an unexpected emergency case