British Orthopaedic Association

Re-starting non-urgent trauma and orthopaedic care:

Summary guidance

v1.1 15 May 2020. Full guidance document available at: https://www.boa.ac.uk/resources/boa-guidance-for-restart---full-doc---final2-pdf.html.

BOA update note (15/5/20): NHS England document published on "Operating framework for urgent and planned services within hospitals" (here). We had been awaiting this guidance and will be reviewing carefully. This guidance will be updated soon.

This Summary document provides core principles about resuming aspects of Trauma and Orthopaedic care that have been suspended because of COVID-19. It comprises three sections: capacity issues for resuming surgery; infection prevention and control measures for planned surgery and prioritising patients for surgery. **For more detail on each of the points, please refer to our full guidance document.** This document will be updated as needed over the coming weeks and months.

Capacity issues for resuming surgery

When considering resuming surgery and what capacity there will be, factors include:

- Likely theatre throughput (considering that theatres often will work at a slower pace, each requiring more staff and the increased use of consumables).
- Materials needed for surgery, including PPE and anaesthetic drugs.
- Availability of staff and facilities for all stages of the treatment pathway, including post-operative care, post-discharge care and rehabilitation.

Infection prevention and control measures for planned surgery & 'Green pathways'

Changes to previous care pathways should include the creation of 'green', COVID-free pathways in order for planned surgery to be safe. Evidence so far is limited but if a patient undergoes a procedure and experiences COVID-19 infection soon after operation, this increases their likelihood of needing ICU care and of dying, hence the need for measures to reduce infections prior to and after surgery.

In these green areas, measures to ensure COVID-free facilities could include:

Patients

- Self-isolation or shielding for 14 days prior to surgery (and 14 days after discharge in order to avoid infection in the post-operative period).
- Attend pre-admission clinic prior to the 14 day period wherever possible.
- Testing (RT-PCR) for COVID-19 72-48 hours prior to surgery
- Screening for symptoms, temperature testing, and whether household members have had recent symptoms.
- Social distancing measures to reduce contact at reception, waiting rooms and other communal facilities.
- No visitors during inpatient stays.
- For child patients, special consideration of appropriate measures needed.

Staff

- Daily screening for symptoms and temperature testing, and whether household members have symptoms.
- Regularly (weekly?) RT-PCR testing for COVID-19 (as testing capacity expands).
- Follow social distancing principles.
- Changes to work patterns/rotas to avoid interaction with COVID-unknown pathways

Facilities

- Different levels of COVID-19-free settings likely to exist, and gold/silver/bronze criteria are discussed in full guidance document.
- Regional and local decision making will be needed as to how best to use the

buildings/facilities available to establish COVID-free pathways in a given locality.

Prioritisation of patients for surgery

NHSEngland has a prioritisation list of surgical procedures based on 4 main groupings – 1a, 1b, 2, 3 and 4.[1] Using these priorities, the next steps for resuming operating are:

Priority 1a & 1b (surgery needed within 24 or 72 hours, respectively)	
Situation	Procedures should have continued throughout the COVID situation and remain the top priority.
Next steps	• If these were impacted during the COVID peak, they need to be fully restored. • Anticipate and plan for increasing trauma workload when lockdown restrictions ease, meaning more patients in these categories. • Operating theatre throughput expected to be low. (Patients at this priority level cannot be adequately screened and tested for COVID-19, and therefore full COVID precautionary conditions will be needed, including PPE and theatre staffing – discussed further in full document).
Priority 2 and 3 (surgery needed within 1 or 3 months, respectively)	
Situation	Some Priority 2 procedures will have occurred in recent weeks but most Priority 3 ones will not have, and so next priority after '1a/b' will be these patients.
Next steps	• Consider changes needed to previous care pathways due to COVID-19 infection control and prevention. • Plan for this activity to resume in the short term as capacity permits (see section below on capacity), particularly the priority 2 patients. • Review waiting lists to assess urgency of cases • Establish 'green' (COVID-free) pathways and appropriate facilities (requirements discussed later), which are particularly important for higher risk patients and major procedures. • Resume cautiously, expecting initial throughput to be low. • A management oversight team should regularly review how the green pathway is running, and particularly if any COVID+ve patients occur. • Audit outcomes for all patients.
Priority 4 (surgery clinically necessary but not needed within 3 months)	
Situation	Plan to resume this activity in the medium term
Next steps	• In the short term, review waiting list and maintain contact with patients including signposting to support resources if appropriate. • Green pathways and appropriate facilities should be fully established, incorporating learning from priority 2/3 cases to minimise risk. • Start with lower risk patients and lower risk procedures, in order to further assess the green pathways/facilities. • Continue to evaluate regularly and audit outcomes.

Other very important considerations discussed in our full document:

- Consenting patients.
- Referrals in and triage.
- Dual surgeon operating at point of initial restart.
- Mental health and wellbeing for surgeons and surgical teams.

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf.