British Orthopaedic Association

BOA statement regarding NICE COVID-19 rapid guideline on arranging planned care

3 August 2020

The BOA supports the implementation of the COVID-19 rapid guideline 'Arranging planned care in hospitals and diagnostic services'[1]. It is hoped that the changes will reduce some of the barriers to restoring the delivery of planned care whilst maintaining necessary levels of patient and staff safety.

The major changes are the reduction in requirements for self-isolation before surgery and the increased role of local decision-making on pathways of care largely influenced by the prevalence of COVID-19. We have reviewed the guidance in detail and wish to highlight areas that will have a specific impact on planned orthopaedic care.

1. It is made clear that application of the guidance is not mandatory and should take into account the responsibilities of local commissioners and providers in the context of local and national conditions and priorities.

2. The guidance refers only to adult planned care. Services for children and adolescents are covered by guidance published by the RCPCH in collaboration with other professional bodies including the RCS England.[2]

3. Patients must be made aware of the risks and benefits of any planned procedure alongside reasonable alternatives and the impact of postponing or cancelling any intervention. The implications of the Montgomery consent ruling may be particularly relevant.

4. Discussions on the risks of developing COVID-19 must be personalised to the individual patient, their circumstances, and both local and national COVID-19 prevalence data.

5. Steps must be taken by the patient to minimise the risk of exposure to coronavirus and the risk of transmission to other patients or healthcare workers by comprehensive social distancing and hand-hygiene for 14 days prior to admission. However, higher risk patients need to be identified in order to discuss with them whether they should consider 14 days self-isolation. Decisions on assessing those at higher risk will need to be made on an individual basis by the clinician and patient.

6. All patients must have a SARS-CoV-2 test from 3 days pre-surgery and should self-isolate from then until admission.

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[1] Available at https://www.nice.org.uk/guidance/ng179/resources/covid19-rapid-guideline-arranging-planned-care-in-hospitals-and-diagnostic-services-pdf-66141969613765 or one-page summary at: https://www.nice.org.uk/guidance/ng179/resources/visual-summary-pdf-8782806637.

[2] RCPCH, National guidance for the recovery of elective surgery in children, July 2020: https://www.rcpch.ac.uk/resources/national-guidance-recovery-elective-surgery-children

7. Adherence to UK guidance on infection prevention and control along with the use of personal protective equipment must be maintained.[3]

8. Planning of the surgical pathway must include the application of enhanced recovery protocols, early but safe discharge, and the provision of appropriate rehabilitation, aftercare and follow-up without the need for return to hospital or face to face consultations if feasible and suitable. Patients and their carers must be given clear information on how to contact the surgical team if they are concerned about progress as well as what they should do if they develop COVID-19 symptoms in the post-operative period.

Other relevant points to consider

1. In this document NICE defines 'planned care' as: 'elective surgery (day surgery and inpatient stays), interventional procedures, diagnostics and imaging.' The BOA also considers that the components of the recommendations should apply to all patients equally as the interval between when the decision to operate is made and the procedure being carried out allows.

2. The guidance does not cover precautions to minimise the risk of exposure to COVID-19 in the post-operative period, but it seems appropriate to continue comprehensive social distancing for all patients and a return to self-isolation for 14 days for designated high risk patients.

3. Resources are available to assess local disease prevalence[4] and the risk of a false negative after a single, negative PCR test result.[5]

4. The BOA, BSSH and BOFAS have produced jointly-badged advice on local anaesthetic day-case procedures (published 3 August 2020), which can be found here.[6]

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[3] UK Government Infection Prevention and Control guidance online at:
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

[4] Local disease information is available from:
For England, Map according to 'Medium Super Output Area (MSOA)'
https://phe.maps.arcgis.com/apps/webappviewer/index.html?id=47574f7a6e454dc6a42c5f6912ed7076
For England, Mapping tool based on local authority: https://lginform.local.gov.uk/reports/view/lga-research/covid-19-case-tracker-area-quick-view-1?mod-area=E07000105&mod-group=AllDistrictInRegion_SouthEast&mod-type=namedComparisonGroup

[5] The following tool can be used based on local or national disease prevalence:
https://calculator.testingwisely.com/playground/0.1/70/95/negative.
The ONS calculate the risk of a false negative at 15-20% but 30% can be used to give a very conservative estimate (i.e. 70% sensitivity).
At the time of writing, the latest data for England suggested 7.8 infections per 100,000 per week (https://www.gov.uk/government/publications/national-covid-19-surveillance-reports published weekly). Using the prevalence figure 0.000078 in the online tool, suggests that a negative result after a test indicates a 0.00002% chance that the patient has the disease – this is a 1 in 50,000 chance. Local data may be available from your hospital or local public health team and can be used to provide a localised figure.

[6] https://www.boa.ac.uk/resources/boa-la-pathway-guidelines.html