Statement from SCOT on T&O Services during COViD-19 crisis – 27 March 2020

As the number of COVID patients across Scotland starts to rise significantly several areas of common concern within trauma and orthopaedics are emerging. Most pertain to maximising the safety of staff and patients in the operating theatre. There is also anxiety about the level of trauma service that can be maintained as this situation progresses.

The concern about the operating environment has been elevated in recent days following the publication of the surgical colleges' intercollegiate guidelines for surgery during COVID (March 25th). It is possible to interpret the guidelines as saying that all patients undergoing surgery should be tested for COVID and where possible surgery delayed until the result known. Where the surgery could not wait the patient should be treated as presumed COVID positive and full protective equipment used. This position presents practical problems for most sites just now as testing capacity and PPE is not in sufficient supply to meet these recommendations. The collegiate advice is also not consistent with Health Protection Scotland (HPS) or Public Health England (PHE) advice which recommends using full PPE only where COVID is suspected.

Emerging evidence of potentially high levels of asymptomatic carriers of COVID may make the intercollegiate advice sound sensible but the current intercollegiate statement does not represent a policy change from HPS or PHE. The colleges are now working with these bodies and the CMOs to clarify the position but current advice remains to follow the HPS recommendations on PPE precautions.

The Intercollegiate statement also recommended not using laminar flow. Clarification was sought last night from the BOA which it should be noted did not endorse the intercollegiate statement. The BOA position remains that laminar flow should be used for all patients where available.

We are in a time when numerous groups are hurriedly producing guidance with the best intentions. Where contradictions appear anxiety and scepticism is inevitable. I thought it might be helpful to see an excerpt from a statement by the Infection Prevention Society issued yesterday:

> *"The Infection Prevention Society are experts in preventing the transmission of infection in healthcare environments. We fully support and endorse the guidance on the use of personal protective equipment (PPE) for the management of COVID-19 from the joint UK Public Health bodies" " We are therefore calling on clinical colleagues and specialist societies, whose expertise is not infection prevention, to refrain from creating confusion, anxiety and alarm by contradicting the advice from experts in this field."*

It is hoped and expected that we will soon be in a position where patients and staff can be rapidly and reliably tested for COVID and correct precautions taken. In the meantime we must rely on the best evidence we have and the use of sensible measures to protect our teams while still delivering the service our patients need.

The Scottish T&O leads have been sharing a great deal of advice and common sense via their Whatsapp group and the following may be helpful:

- Avoid being in theatre during intubation or extubation (this is the time of highest risk)
- Encourage use of regional anaesthesia in place of GA whenever possible
- Use power tools sparingly and on the lowest revs possible to reduce aerosol spread
- Use smoke extraction with diathermy if possible
- Use laminar flow
- Surgery should be performed by the most experienced surgeon available
- Keep theatre staff and traffic to an absolute minimum for all cases

The BOA's recent BOAST guidelines for COVID are important and useful and contain much of the advice above.

As pressures increase we will be facing redeployment of staff and loss of operating capacity. The BOA and SCOT fully support the position that we must protect a viable trauma service to provide life-saving surgery and avoid life changing morbidity wherever possible. That includes continuing to fix hip fractures if at all possible as we know the consequences of not doing so for most. If services feel that they are in a position where this is threatened then please communicate that via the clinical lead or director to SCOT so that we can understand the scale of the problem nationwide and raise the issues with the Scottish Government and BOA. By the same token, T&O will not shirk contributing to the general effort where our skills can be useful and redeployment not detrimental to the trauma service.

The Scottish T&O community continues to rise to the huge challenges we face. With solid mutual support and good communication between us we stand the best chance of continuing to deliver the best service we can to our patients.

Al Murray

Chairman, on behalf of SCOT