SCOT Statement

Recovering Planned Orthopaedic Care – March 2022

SCOT

SCOT represents Orthopaedic Surgeons throughout Scotland. It consists of an Executive Committee and a wider consultative body of Scottish Orthopaedic clinical leaders and representatives from all health boards. It has links with the Royal Colleges, NES and the Universities. It provides clinical representation when requested by the Scottish Government and other bodies. Scottish orthopaedic academics have also been at the global forefront of publishing data on the effect of the pandemic on this patient group.

Background and Aim

The COVID pandemic has had a severe indirect effect on patients waiting for planned orthopaedic procedures. These include procedures such as total joint replacement. It is noted that the most recent waiting time position, reported by Public Health Scotland, continues to show an increasing number of patients waiting for inpatient and daycase procedures[1]. It is recognised that even with provision of capacity in excess of pre-COVID levels, recovery of waiting times will be a multi-year process.

As we recover from the most recent Omicron variant, the ongoing detrimental impact on orthopaedic patients in Scotland is becoming increasingly severe.

The following statement is issued by SCOT to highlight the urgent steps required to recover planned care for orthopaedic patients.

Planned Orthopaedic Care

Planned (scheduled) care is otherwise known as "elective" care. It must be recognised that planned care covers a range of procedures that are life changing and restoring. They relieve pain, improve mobility and support return to function for activities of daily living, recreation, work and education. Their provision is not optional but is a fundamental requirement for a health service providing universal care. Orthopaedic patients on waiting lists have been demonstrated to have significant impairment of health-related quality of life (HRQoL), with some reporting states that are "worse than death" [2]. Deterioration in function and frailty continues while awaiting treatment. For some, it may not be possible to regain what might have been possible with earlier surgery. The increased waiting time and total size will lead to a greater overall population impact of ill health. Persisting delay in substantive recovery will lead to further increases in list size and waiting time[3].

[1] https://publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-22-february-2022/

[2] https://online.boneandjoint.org.uk/doi/abs/10.1302/0301-620X.103B.BJJ-2021-0104.R1?journalCode=bjj

[3] https://online.boneandjoint.org.uk/doi/full/10.1302/2633-1462.23.BJO-2020-0193.R1

SCOT Strategy Statement for Recovery

Core Capacity

It is vital that all pre-COVID planned orthopaedic treatment capacity (workforce, theatre and "orthopaedic safe" inpatient and day case resource) are restored as soon as possible. To prevent infection, bed provision should be in accordance with the existing statements from the British Orthopaedic Association (BOA) and GIRFT relating to the provision of orthopaedic-safe/ring-fenced beds[4].

The Scottish Government must set ambitious targets for recovery of capacity and workload and provide the resources required for this to be achieved. Failure to achieve recovery targets should lead to an investigation of the reason and targeted support. Variation of performance within and between boards should be examined. Support should be provided to understand and overcome such differences to prevent inequality of access and treatment.

Additional Capacity

To address the backlog of cases, additional capacity will be required beyond pre-COVID levels. This will be limited by availability of theatre space and workforce. Capacity should be provided through: Full utilisation of in-week sessions (working beyond 42 weeks planned care per theatre, so that every theatre is utilised to its maximum), additional capacity use (via core job plan provision where possible and additional work), and the "National Treatment Centre" programme. It is essential that the NTC programme truly delivers additionality, rather than provide an alternative setting for displaced current workload.

The Scottish Government should set ambitious targets to Boards for the provision of this additional activity.

Theatre Pathways

The use of isolation and pre-operative PCR testing has been useful to support provision of planned care and green pathways. It is recognised that testing has been used to protect patients from developing COVID in the perioperative period, along with transmission to staff and other patients. Vaccination and changes in the severity of infection now mean that the harms of asymptomatic testing need to be weighed against the benefits.

As we move to a new phase of providing scheduled care during COVID we recognise the advice of the UK Health Security Agency relating to UK Infection Prevention and Control (IPC) for Elective Services. This guidance was published initially in September 2021[5] and has recently been reiterated following receding and experience of the Omicron variant[6]. This guidance recommends that, *where patients are fully vaccinated*, lateral flow testing on the day of surgery is sufficient, rather than a PCR test and up to 3 days of isolation. It also recommends that standard cleaning regimes acceptable.

SCOT recommends Scottish adoption of this pathway as it has the potential to improve efficient use of lists and release healthcare resource that is currently utilised for testing. It will improve patient

[4] https://www.boa.ac.uk/resources/boa-and-girft-ring-fenced-statement.html
[5] https://www.england.nhs.uk/coronavirus/publication/ukhsa-changes-to-ipc-requirements/
[6] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1587-uk-ipc-guidance-for-elective-services.pdf

experience by reducing unnecessary visits and isolation. Standard cleaning protocols will reduce theatre turnover and allow additional cases to be undertaken. It recognises that PCR testing and isolation does not fully address variation in incubation time and compliance with isolation. An on-day lateral flow test is more likely to indicate true infectivity on the day, and therefore detect risk to the patient, theatre staff and other patients.

Delay in Surgery Following Previous COVID Infection

Guidance has been issued recommending a delay of 7 weeks between COVID infection and the provision of scheduled surgery[7]. This has recently been updated and re-affirmed[8]. This is based on research from earlier in the pandemic and is unlikely to reflect the current situation with widespread vaccination, exposure and less severe variants. **It is recommended that this subject is regularly reviewed as although such a delay represents the most cautious approach, it does not fully consider the harms of delaying surgery further, if a patient suffers COVID in this period prior to a planned procedure.**

Efficiency

It is recommended that all departments examine what can be done to improve theatre efficiency and post-operative length of stay. "Four-joint" lists are recommended. It is however acknowledged that deterioration in patient condition, along with loss of skilled theatre team members, and the requirement for trainee experience mean that not every list can be designated "four-joint". It should however remain a regular and reasonable aspiration.

Provision of a "Daycase Arthroplasty" programme has the potential to reduce LOS and enable the provision of joint replacement in theatres and settings that have not previously been used. These programmes are not suitable for all patients and their use should be for carefully selected patients. This will them release inpatient capacity for those patients most in need (with greatest comorbidity and complexity). **The Scottish Government should require boards to aim to meet all BADS targets for provision of orthopaedic care as daycase.**

Workforce

The pandemic has had a devastating effect on healthcare workforce and this has affected both orthopaedic wards and theatres. Retention of remaining staff is a priority. Work should be done to promote wellbeing in the remaining teams and to encourage staff who have left to consider returning. Training will be required to delivery the required new staffing at all levels. Innovation in staff roles and skills will be required. **NHS Education Scotland should be required to produce a workforce appraisal and plan for provision of orthopaedic surgical staff, taking into account planned retirement, future anticipated CCTs and changes in expected future work patterns (such as less than full time working). This should address the staffing requirements to deliver orthopaedic care and therefore the current and future requirements for NTNs.**

It is recognised that some issues of pension tax and Agenda for Change terms and conditions lead to perverse disincentives to staff undertaking additional work in support of the recovery. AfC terms and

[7] https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15464
[8] https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15699

conditions can limit the ability of non-medical staff to undertake additional work. Pension tax rules can lead to Consultants having a net financial loss for undertaken additional work. In England, some staff groups have organised partnership type approaches to provide "in-sourcing" of activity above and beyond their contractual work.

The Scottish Government and Health Boards should urgently address these issues to allow all members of staff to support recovery efforts without penalty.

Training

The pandemic has impaired surgical training, with reduced exposure to cases. As recovery occurs, departments will need to be mindful of the pressing need to expose trainees to training experiences and this will need to balance efficiency demands. It is also recognised that the current backlog and predicted future workload (including NTCs) is likely to lead to a short to medium term shortage of trained surgical staff. **The training requirements and need for provision of specific training lists and time should be assessed by NHS Education Scotland, with guidance provided to services about the necessary level of training activity required.**

Outpatient Capacity

The outpatient position has been less concerning during COVID. This has been due to a combination of redesign of outpatient pathways, along with the ability to redirect clinical time away from cancelled surgical sessions towards clinics. There is a risk that as theatre sessions are re-established, outpatient delays may also return. **Departments should continue to reform their outpatient pathways, making full use of Active Clinical Referral Triage (ACRT), Opt-In, and Patient Initiated Return (PIR). Departments should also be aware of the balance between their new and return patient waiting lists and be prepared to dynamically flex capacity as required.**

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