



B A S S
British Association of Spine Surgeons



Clinical guide for the restoration of spinal surgical services during & after the coronavirus pandemic

14th May 2020

EXECUTIVE SUMMARY

- Recommend local Imaging for emergency referrals 24/7 with consultant review
- All surgeons to prioritise elective waiting list as per national guidance
- All surgeons to assess each patient on waiting list as per known risk factors
- When possible consultations should be done remotely using available resources
- Elective patients to be consented as to potential risk of coronavirus
- Elective patients to be advised on self-isolating or shielding before and after surgery
- Elective patients to be tested for coronavirus 48-72 hours prior to surgery
- Regular screening of staff and surgeons in protected areas
- Spinal injections for severe radiculopathy only

Background

The coronavirus pandemic has changed the way we have worked and will continue to change the way we offer services to improve patient care. Due to the pandemic spinal surgical services across the country have been limited to emergency and time dependent procedures. As a result, there are many patients awaiting assessment as well as the requirement for imaging and possible surgical intervention.

We should seek the best regional and national solutions to restore safe and effective services while continuing to protect our patients, staff and resources. In addition, we need to consider the possibility that in order to deliver better and safer care we may have to change our working practices in the future as well as working cohesively within our spinal networks and with adjacent networks.

Restoration Planning – Regional Spinal Networks

Restoration plans for spinal surgery will need to take into account spinal regional networks as well as neurosurgical networks. There may be variation in pressures across the networks. This may be as a result of one hub centre being a major trauma centre or the regional neurosurgical centre. The spinal hub centres should work across the region and with adjacent regions to ensure equal access to all patients dependent upon priority and available clinical resource.

Restoration Planning – Emergency Care

Emergency care should continue to follow guidance as per regional spinal networks. At this time and moving forwards, we should minimise inappropriate transfers between hospitals.

The principles below should be continued to optimise patient care:

- All referrals from non-spinal centres and spine partners to spinal hub centres must be discussed and / or reviewed by a consultant to ensure appropriate for referral to a tertiary spinal surgical centre.
- All referrals must be documented between referring centres on an electronic referral system.
- All patients requiring imaging (including MRI) should have this performed at their local hospital 24/7 to prevent inappropriate and unnecessary transfer of patients to spinal hub centres.
- Only patients requiring emergency surgery or specialist care that cannot be treated locally should be transferred between hospitals.

Likely Conditions:

Spinal fractures, spinal infection, acute spinal cord compression, cauda equina, traumatic spinal cord injuries.

Restoration Planning – Elective Care

Primary Care

Primary care services were contacted and advised to limit their referrals to those that are most urgent. The link below is to the guidance published by NHSE on appropriate referrals during the coronavirus pandemic.

<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-emergency-msk-conditions-requiring-onward-referral-23-march-2020-updated.pdf>

As we increase referrals for routine conditions, each CCG / STP should ensure that a triage service is in place, in keeping with the national back and radicular pain pathway. This service will minimise patient attendance at an acute hospital site and support patients with appropriate conservative management of spinal conditions.

As there is likely to be a delay to surgical intervention for some non-urgent pathologies there should be an increased focus on conservative managements, life style changes and optimisation of care including self-management.

Out-Patient PTL

All consultants should have time allocated in their job plan to perform remote consultation for all appropriate follow-ups as well as to contact new referrals.

Patients placed on the waiting list will be directed towards national guidance for education in respect to their condition and surgical options:

<https://spinesurgeons.ac.uk/Booklets>

All patients requiring a surgical procedure will require an appointment for consent and pre-operative assessment as a single attendance. This process will optimise patient care as well as minimise patient footfall at an acute hospital site.

In-patient PTL

All consultants should review their current waiting list and priority of procedure documented, using the guidance below:

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

Waiting lists and prioritisation must be taken into account as well as risk factors for a poor outcome identified for COVID-19. Other requirements should be taken into account at this time such as length of stay and the requirement for intensive care. All these factors need to be looked at when planning restoration of services at a local and regional level.

Elective Operating

In order to restore surgical activity we need to look at risk to patients and staff.

Hospitals will be required to create a protected facility for elective / routine activity:

Patients will be required to self-isolate with family members for 14 days prior to procedure and 14 days following the procedure. A negative coronavirus_test result 48-72 hours prior to admission will be required.

For paediatric patients, the immediate attending family members should also be screened. Family members attending hospital should be minimised.

The ward, theatre, recovery and surgical staff will need to be COVID-19 free with no symptoms and negative coronavirus_swab prior to working in green zones.

All staff and patients will need to wear masks and PPE as per PHE guidance at all times when in contact with each other, when social distancing is not possible.

Patients will need to be counselled on risk and we would recommend using the following consent form:

<https://spinesurgeons.ac.uk/resources/Documents/Member%20News/200514-BASS-ConsentCOVID.pdf>

Spinal injections for severe radiculopathy can be offered following the guidance as outlined in this document:

<https://spinesurgeons.ac.uk/resources/Documents/Member%20News/200514-InformationforPatientsundergoingSpinalInjectionsduringtheCoronaviruspandemic-Update-FINAL.pdf>

The resumption of elective surgery needs to take into consideration many different aspects.

These include:

- **Hospital status and intensive care capacity**

Limited surgical activity should remain until the point that the hospital has adequate protected capacity for non-COVID cases.

These patients should be treated in a protected facility as described above with minimal risk of cross contamination.

The number of elective cases that require intensive care should be minimised and kept to only urgent / emergency cases.

- **Theatre capacity**

The theatre capacity will fluctuate during the restoration period. Theatre sessions should reflect those who need surgery as per escalation through the priority procedure list.

- **Length of stay**

Protected day-case facilities should be utilised for initially priority 2 & then released to priority 3 cases over the next few months. Day case procedures should be encouraged as much as possible with the number of in-patient stays limited to only those that are essential.

Patients should be counselled preoperatively about the advantage of rapid discharge and low length of stay to reduce COVID-19 risk.

- **Risk to patient**

All patients should be fully informed of the potential risk at this time due to the coronavirus pandemic and appropriately consented.

- **Risk to staff**

Staff must be protected at all times and PPE guidance as per NHSE and PHE must be followed, especially for AGPs and high risk areas.

Staff Screening

Regular screening of all staff will be essential. This will depend upon local availability and on discussion with infection control.

It is recommended that as much as possible, medical staff alter working patterns and rotas to create protected weeks where the risk of contracting COVID is minimised. This will reduce the risk to elective patients and other staff. Screening is recommended on a weekly basis.

COVID-19 Patient Risk Assessment

All patients are at risk of contracting COVID 19 until the point that we have clarity on immunity or a vaccine available. Every patient is at risk of severe respiratory disease and the morbidity / mortality that are attached to this condition. We do however know that certain risk factors increase the severity. The stratification below should be undertaken and used to inform the patient, their relatives and the clinicians.

Risk Factors Identified (CDC)

Asthma - Moderate to severe only

Black, Asian and Minority Ethnicity

Chronic Lung disease – COPD, Pulmonary Fibrosis, Cystic Fibrosis

Diabetes

Serious Heart Conditions – Heart Failure, coronary artery disease, congenital heart disease, cardiomyopathy,

Chronic kidney Disease – Dialysis

Severe obesity – BMI > 40

Age - > 65 years

Immunocompromised – Cancer treatment, transplant including bone marrow, immune deficiency, HIV with low CD4, medication causing immunosuppression including long term steroids.

Liver disease – Cirrhosis

Low Risk	< 65 years with no risk factors
Medium Risk	>65 years with no risk factors < 65 years with 1 risk factor
High Risk	>65 years with 1 risk factor <65 years with 2 risk factors
Very High Risk	All patients with 3 or more risk factors