Exiting the pandemic: guidance for resuming ENT services

Introduction
The aim of this paper is to support ENT departments and colleagues as discussions take place regarding resumption of elective activity over the next 2-3 weeks.

The SARS-CoV-2 pandemic has led to many changes in elective ENT care in order to ensure sufficient staff and resources were available to manage the expected number of cases and to protect the population. These changes included the following:

i) Outpatient clinics cancelled where possible or changed to telephone or video consultations.
ii) Cancellation of all routine elective activity and deferment of many urgent and/or cancer cases that could be safely delayed.
iii) Cancellation of routine imaging, undertaking only urgent suspected or confirmed cancer cases.
iv) Re-deployment of staff to support ITU and management of COVID cases.

ENT UK supported colleagues by producing a range of guidance across a range of topics.

As the number of COVID-19 cases has started to plateau across the UK, restarting non-SARS-CoV-2-related activity is being discussed. Currently there is no cure or vaccine for SARS-CoV-2 and it is anticipated that there will be further peaks within the next weeks to months.

The continuing presence of SARS-CoV-2 in the population will prevent the return to pre-SARS-CoV-2 pandemic activity. Adaptations to traditional ways of working will need to be made to ensure the safety of patients and staff.

An ENT UK working group is currently preparing a position paper and guidance document to support ENT colleagues resuming elective activity.

National guidance
There is currently no guidance from NHS England, devolved Nations or the Royal Colleges regarding resumption of non-urgent elective services. This is currently being developed and likely emerge over the next few weeks.

The American College of Surgeons has released guidance on resuming elective surgery.

Staffing/workforce
Staff have been re-deployed during the pandemic and return to normal roles will vary by hospital and specialty. When deciding to resume elective work it is vital to confirm that staffing levels are sufficient to provide safe care for elective and non-elective patients. Out of-hours cover for elective and emergency patients must be adequate before elective services resume.
Preparing to resume elective activity

The decision to resume elective activity will be based on national guidance. Local plans will likely be developed from national guidance for a staged resumption of elective activity. There are a number of issues to be must be addressed, including the following:

- Triage of outpatient referrals to:
  i) request further information from GP
  ii) return to GP with advice regarding medical/non-surgical management
  iii) reject or re-direct referral
  iv) arrange telephone or video consultation
  v) arrange face-to-face consultation.

- Preparing suitable locations to undertake clinics including:
  i) telephone and video consultation, requiring access to appropriate telephone and IT system
  ii) face-to-face, requiring an appropriately-sized clinic room to enable social distancing between patient, clinician and other healthcare staff and students. There must be ready access to appropriate PPE and required equipment.

- Location for undertaking outpatient procedures especially Aerosol Generating Procedures (AGP). Departments to consider need for updating equipment, e.g. stacking units and video-nasoendoscopes to increase distance between patient and clinician and to enable accurate recording of findings to minimise repetition.

- It is advised that departments and individual consultants prioritise their current surgical waiting list. ENT UK prioritisation recommendations and MeNTS scoring system², advised by the American College of Surgeons, can assist the process.

- National and local guidance will be required, regarding testing patients and staff for SARS-CoV-2 prior to resuming routine elective activity.

Emergency ENT

ENT UK, and various specialty groups, have produced guidance for managing emergency ENT conditions during the pandemic. The majority of this guidance will remain as SARS-COV-2 will persist in the population.

The management of ENT emergencies will require close consultant leadership to minimise unnecessary admissions, minimise length of stay and manage the majority in an ambulatory setting.

Departments, based on local factors, will need to determine how this is best delivered and may require changes to job plans and timetables for consultants, SAS doctors and trainees.

Departments will need to ensure facilities and equipment (e.g. video-nasoendoscopes suitable for use out-of-hours) are available to deliver safe and effective care, especially aerosol generating procedures.
INTEGRATE are currently collecting data on ENT emergencies during the pandemic. Results of this study will help inform planning if there are further peaks.

**Outpatients**
Outpatient clinics, as services resume, will be a combination of face-to-face and telephone/video consultations, which will be determined by specialty guidance and local resources.

**Telephone/video consultations**
These consultations will require access to appropriate equipment and, if undertaken remotely, access to all medical records and relevant hospital systems for ordering tests, reviewing results, dictation, etc. Systems available to assist patients with disabilities, requiring an interpreter, etc. If not available, then patients will require face-to-face consultation.

Clinicians may opt to work remotely but trainees must always have direct or remote access to a supervising consultant to facilitate, advise and supervise.

Telephone/video consultation is different to traditional face-to-face consultation and trainees (including Fellows, MTI and locums) and SAS doctors must be sufficiently experienced and trained prior to undertaking telephone or video consultation with appropriate supervision.

Telephone and video consultations can take longer than traditional face-to-face consultations, including the consent process. Therefore, departments should consider the number of consultations per session.

**Face-to-face consultations**
These consultations will require appropriate PPE as per current ENT UK guidance, suitable for AGP. A specific room or rooms in outpatients should be identified for undertaking FNE. FNE findings must be appropriately documented or recorded to minimise unnecessary repetition. The room set-up should facilitate easy cleaning between patients and at the end of the session as per current national and local infection control guidance.

Departments should consider the number of patients for face-to-face consultations per session by individual doctors so as to:
- ensure adequate time for safe donning and doffing of PPE
- minimise overcrowded waiting rooms to ensure social distancing.

Trainees should, as a minimum, have access to an onsite Consultant for advice, support and supervision when undertaking face-to-face consultations.

**Surgery**
Decisions regarding resuming elective activity will be based on national and local guidance. Departments will need to prioritise surgical waiting lists based on clinical need, patient factors and hospital factors.
If possible, procedures should be discussed with anaesthetic colleagues and, when appropriate, avoid a general anaesthetic and intubation to minimise the risk to the patient, anaesthetic staff and other members of the surgical team.

National and local guidance will determine pre-operative testing of patients, including the need for enhanced testing (e.g. CT Chest) for high-risk procedures. Patients with a positive test for SARS-COV-2 should have surgery delayed until patient has two consecutive negative swabs.

Appropriate and adequate PPE must be available for each surgical case. As a minimum this will include:
- surgical gown
- surgical gloves
- surgical mask
- visor.

Procedures with a high risk of AGP will require more comprehensive PPE as per ENT UK guidance.

Staffing in theatres must be kept to a minimum to protect staff and patient. This is ideally discussed and decided at the team brief prior to starting a list.

Subspecialty guidance will follow in the next two to three weeks in the main guidance document, which includes recommendations from the subspecialty groups.

REFERENCES
1. Moran, Rosalyn J; Fagerholm, Erik D; Daunizeau, Jean; Cullen, Maell; Richardson, Mark P; Williams, Steven; Turkheimer, Frederico; Leech, Rob; Friston, K. Estimating required lockdown cycles before immunity to SARS-CoV-2: Model-based analyses of susceptible population sizes, S0, in seven European countries including the UK and Ireland. doi:https://doi.org/10.1101/2020.04.10.20060426