Updated ENT UK Guidance to Support the Return of Elective ENT Surgery within the COVID-19 Pandemic – October 2020

ENTUK working group membership

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Forward

A group of representatives from the ENT UK Council met to discuss any changes that may be required to the ENT UK COVID-19 escalation plan, in view of the increasing COVID-19 levels in the UK community and the renewed drive to operate electively rather than solely on emergency and time critical cases. Please note that there is updated guidance from the FSSA which states ‘where local arrangements for prioritisation are in place and working well, they should continue and the guide used for reference to check if the national priorities have changed and local arrangements need to be revised.’

The 31 July 2020 letter from NHSE states ‘clinically urgent patients should be treated first, with the next priority the longest waiters, specifically those breaching the 52-week wait by the end of March 2021’. The consequence of this is that some teams are currently performing priority 4 cases that may breach their 52-week wait. There are examples from around the UK of ENT patients being postponed due to the perceived greater need of specialties with longer waiting patients following these renewed financial pressures. All departments have been able to use the guidance provided by ENT UK in the ‘Graduated Return to Elective ENT within the COVID Pandemic’ document, as well as the FSSA guidance
regarding prioritisation of surgical cases. The new waiting time recommendations add an additional level of complexity to our decision making.

NHSE released advice on 1 October, proposing new patient choice categories 5 and 6 for patients who wish to be deferred for COVID or non-COVID reasons. This does not apply to the whole of the UK but supports further validation of our waiting lists.

It is clear that all patients on our waiting lists need to be reviewed and prioritised clinically, taking into account if an extended wait may be detrimental to their long-term outcome.

**Are ENT patients undergoing surgery at increased risk of contracting or becoming unwell from COVID-19?**

The group considered whether patients undergoing elective ENT surgery were at increased risk compared to other surgical patients. The consensus, taking on board advice from an infectious diseases specialist (personal communication) was that there was no increased risk of catching perioperative COVID-19 for the ENT patient compared to other surgical procedures. It is acknowledged, however, that there is an increased risk of poor outcome for all patients undergoing general anaesthesia with COVID-19 at the time of GA. This risk can be mitigated against by a negative COVID-19 test and the requirement to self-isolate, but with false negatives the risk is not entirely eliminated and therefore needs to be discussed in relation to the COVID-19-specific consent. Given that a significant proportion of ENT surgery involves the upper airway (including the ear), there is of course an increased risk to the operating surgeon compared to most other specialties, which we need to continue to mitigate with the appropriate PPE and patient preparation. There appears to be no justification, based on current evidence, for stopping elective ENT surgery as COVID-19 prevalence in the community increases, leaving aside issues such as the potential need for redeployment of key staff, availability of ITU beds and patient reluctance. Some units around the country are managing to provide a near normal service despite high COVID-19 levels in their region. We now therefore support maintenance of elective services throughout the UK if this can be done in a manner that mitigates risk for all concerned (see below).

**Are all category 4 patients equal?**

There were concerns regarding the prioritisation of cases in light of the new directive from NHSE to consider the 52-week waiting times in addition to the clinical prioritisation. This has led to pressure in some regions to undertake procedures that are not really time-critical in favour of those that are. It was felt by the group that category 4 was very broad and could be helpfully more nuanced, to take into consideration whether the category 4 procedures were dealing with conditions that have some degree of long-term potential risk, or that impact significantly on the quality of life, e.g. septal deviation impacting on sleep, tympanic membrane perforations causing persistent or frequently recurrent aural discharge. The subcategorisation of category 4 as proposed by the BSO may be helpful to consider (these do not form part of the formal RCS categories). It has been proposed that Category 4a includes cases where the outcome of the surgery may be adversely affected by a long delay in operating. Examples may include, but are not limited to, conditions associated with repeated
infections, where infection may cause harm, e.g. surgery for suppurative OM. The 4b categorisation may include cases where the outcome of the surgery will not be adversely affected by a delay in operating, although the patient will continue to suffer with impaired quality of life while waiting for surgery (examples might include stapedectomy).

The proposed categorisation for Otology can be found here.

Clinical judgement is key to all of these decisions, and in general 4b cases should give way to those of a higher priority. Colleagues are invited to consider an alternative approach for conditions such as chronic rhinosinusitis (where there is evidence that delays of greater than 12 months are detrimental to outcomes), for which we advise movement from level 4 to level 3 after 9 months on a waiting list, with structural nasal surgery remaining at level 4. This is in keeping with the new FSSA guidance which allows for a more flexible approach and local variation depending on resources. BRS would also like to remove the ‘complex/compound’ wording from nasal fractures in the classification.

We recommend a review of any ENT cases who are approaching 52 weeks to discuss supportive care and alternative options.

**Changes in where surgery is delivered**

Some regions are currently defining elective pathways with the aim of establishing a protected site for elective work. We anticipate that this may mean that surgeons will work at different locations and the shared elective work may allow surgery to be planned and delivered in a more predictable way.

We would support such changes in service delivery as long as appropriate facilities, including surgical equipment and appropriate PPE are available. One particular example of local variation is the use of local anaesthetic to facilitate manipulation of nasal fractures. As noted previously, the safe delivery of an outpatient-based LA management of fractured nose cases is recommended to remove waiting list pressures and release theatre capacity. Developing TNO and voice procedures in the outpatient setting have been transformative in some units.

**Review of patients where surgery is delayed**

Patients who cannot be offered a date for surgery within an appropriate timeframe should be reviewed, either remotely or face-to-face as appropriate, to consider if ongoing medical treatment needs to be modified or reissued (particularly as patients may have difficulty accessing their GP) or if there are any alternatives that could be offered. In some cases, in-office procedures may be possible if there is a suitable outpatient facility with adequate ventilation. For example, some patients awaiting a septoplasty and turbinate reduction could be offered an office-based turbinoplasty and therefore avoid the risk of anaesthesia. In other cases, complications may be detected where the clinical prioritisation needs to be escalated to avoid further risk of harm.
Training impact

It is important to note that many of the level 4 procedures are required for trainees to progress, and we support trainees continuing involvement in these cases for as long as possible during the pandemic, as long as they can be safely performed. All precautions as per current NHS guidance should be taken, including the use of appropriate PPE and pre-operative patient screening, testing and self-isolation. The opportunity to operate on NHS patients in the independent sector and at hospitals other than the usual sites at which surgeons operate has increased the potential to undertake elective cases of lower clinical priority in larger numbers compared to earlier in the year. We encourage members to consider the impact that changes in the location of surgical services might have on training. This should include medical students who would require appropriate fit testing in order to attend the operating theatre. It is important to note that medical student funding streams follow their deployment and a change in the location of their placement to observe ENT surgery may result in reallocation of funding streams. This needs to be addressed at the planning stage.

It is clear that COVID-19 has impacted training in different ways around the UK, with many having reduced exposure to appropriate training cases, as well as, of course, time lost due to illness themselves. It is encouraging to see that many trainees have managed to accumulate adequate cases for their stage of training in some regions throughout the last 6 months. The trainee members of the group were still having challenges operating in the independent sector on NHS patients, and requested that certain cases or lists could be formally identified as training lists to manage the expectations of all concerned in a case. We would support this approach.

PPE

It was noted during the discussion that in certain regions the level of PPE required by the surgical team has been downgraded as the level of COVID-19 in the community has decreased. This approach is not supported by ENT UK which feels that the FFP3 (N99) protection is required for all potentially aerosol generating procedures. FFP3 masks can often be used for a whole session in an outpatient clinic in order to maximise efficient use of this limited resource.

Escalation policy

We encourage members to perform surgery as much as they safely can throughout the pandemic. We would like to draw attention to a revised version of the escalation policy to take into consideration the change of strategy to operate if feasible, throughout the pandemic.
**Covid-19: ENT Escalation Policy regarding elective surgery and clinics throughout the pandemic.**

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very High</th>
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| Elective operating  | COVID testing of patients  
Pre-operative isolation  
Clinical prioritisation for listing | COVID testing of patients  
Pre-operative isolation  
Clinical prioritisation for listing | COVID testing of patients  
Pre-operative isolation  
Clinical prioritisation for listing | All elective surgery may need to stop |
| Elective clinics | Telephone/remote clinics or face to face appointments but only if deemed safe with appropriate environment control and PPE | Urgent and Cancer cases as a priority with Telephone/remote clinics or face to face appointments, but only if deemed safe with appropriate environment and PPE | Urgent and Cancer cases as a priority with Telephone/remote clinics or face to face appointments, but only if deemed safe with appropriate environment and PPE | Urgent and Cancer cases as a priority with Telephone/remote clinics or face to face appointments, but only if deemed safe with appropriate environment and PPE |