



## Guidance for ENT during the COVID-19 pandemic

*The information contained in this document is subject to change in the light on ongoing developments and advice emanating from the Department of Health and others, and is intended to complement rather than replace existing advice.*

As doctors we all have general responsibilities in relation to COVID-19, and for these we should seek and act upon national and local guidelines. These are constantly evolving, and we should adhere to the latest advice available (which may change from the information contained in this document). Guidance from NHSI/E and PHE is being frequently updated as the national caseload and required response is evolving.

Your Trust will have an Incident Management Team in place and will have plans on what activity continues in light of pressure on services and staffing. Please consult with your local management team.

We have a responsibility to ensure that essential ENT care continues with the minimum burden on the NHS. We must engage with those planning our local response. We may also need to work outside of our specific areas of training and expertise, and the GMC has already indicated its support for this in the exceptional circumstances we may face.

ENT may not seem to be in the frontline with COVID-19 but we do have a key role to play, and this must be planned. In response to pressures on the NHS, the elective component of our work may be curtailed. However, the non-elective patients, will continue to need care. We should seek the best local solutions to continue the proper management of these patients whilst protecting resources for the response to COVID-19.

In addition, we need to consider the possibility that surgical facility for emergency surgery may be compromised due to a combination of factors including staff sickness, supply chain and the use of theatres and anaesthetic staff to produce ITU pods. We may be called upon to perform more tracheostomies in COVID-19 positive patients who require ventilation.

We need in particular to consider patients who are vulnerable to the consequences of catching COVID-19, including those with a tracheostomy or respiratory compromise and patients with immune suppression – such as patients with head and neck cancer – either during or soon after treatment. We also need to consider protecting ourselves and the appropriate use of personal protective equipment (PPE).

### **Personal Protective Equipment (PPE)**

Any clinician assessing patients suspected or confirmed to be infected with COVID-19 should wear appropriate PPE. Please check latest guidance from Public Health England at <https://www.gov.uk/government/collections/wuhan-novel-coronavirus>

This is currently a fluid resistant surgical mask, single-use disposable apron, and gloves and eye protection if blood and or body fluid contamination to the eyes or face is anticipated. This applies to examinations including flexible and rigid nasendoscopy.

Currently FFP3 masks are being reserved for COVID-19 positive patients / suspected positive patients requiring aerosol generating procedures – this includes intubation, open suctioning, tracheostomy, high speed drilling and bronchoscopy. Please see guidance from PHE and

consult with your local infectious diseases team if in any doubt, and note that guidance on this may change.

ENT patients can be considered in a few categories:

1. **Obligatory inpatient emergency admissions:** Continue to require admission and may require surgical management, e.g. airway obstruction. *We must expedite treatment to avoid delay in management, including any rehab that may be required.*
2. **Non-operative emergencies:** Patients who can reasonably be managed non-operatively, e.g. epistaxis. *We must try to avoid admission unless really necessary.*
3. **Elective inpatients:** These must be prioritised in line with your Trust's activity plans, with non-urgent cases postponed in order to minimise use of inpatient beds. *Urgent head and neck cancer and paediatric airway cases should continue where possible.*
4. **Day cases:** Most elective ENT surgery can be safely undertaken as a day case. *Provision for day-case surgery must be made as this is likely to continue until such time as theatres are unable to run due to the need for staff to be deployed elsewhere.*
5. **Outpatient clinics:** Elective outpatient attendances should be kept to the safe minimum. *Increase the use of telephone clinics where possible, clinic space may be needed to manage minor ENT emergencies to take pressure off ED.*

When planning your local response, please consider the following:

#### **Obligatory inpatient emergency admissions.**

- **As prevalence of COVID-19 increases, a consultant must be designated as "Lead Consultant".** This duty can be for one day, a few days or even five days in small units. This is an *essential* role during crisis management. It cannot be performed by the consultant "on-call" or the consultant clinic or theatre. They must be free of clinical duties and the role involves coordination of the whole service from ED through to theatre scheduling and liaison with other specialties and managers.
- It can be very stressful during a crisis. Support each other and share the workload. Do not expect the Clinical Lead to do all of the coordination!
- Use elective theatre capacity and surgeons to ensure minimum pre-operative delay.
- Use elective rehab services to minimise post-operative stay.
- An anaesthetic guideline for patients requiring surgery and who are COVID-19 positive will be required. Useful resources can be found on the Royal College of Anaesthetists website at [icmanaesthesiacovid-19.org/](http://icmanaesthesiacovid-19.org/)
- Contingency plans for supply chain issues as they arise.

#### **Non-operative emergencies**

- Clinical decisions during a serious incident must take into account the available facility for the current patient, and also the impact this may have on the whole community.
- As the system comes under more pressure, there will be a shift towards non-operative care whenever possible.

- Non-operative care may reduce the in-patient and operative burden on the NHS.
- It may also protect the individual from more prolonged exposure in a hospital setting.
- It may free up beds for more urgent cases

### Elective inpatients

- Many elective ENT procedures requiring overnight care can be safely postponed.
- Prioritise urgent cases:
  - Paediatric airway
  - Head and neck cancer.

### Elective day-cases

- Most elective ENT procedures are clinically suitable to be performed as a day case.
- During the COVID-19 crisis, an increase in day case surgery will:
  - avoid unnecessary admission
  - reduce exposure of the individual to a hospital environment
  - free-up beds for more urgent cases
  - allow staff from elective theatres to continue working in a familiar environment.
- During an escalation in COVID-19, it is likely that the only elective day-case surgery occurring will be urgent cases. Careful prioritisation of day-case patients will be needed across both the elective and non-elective patients based on theatre/staff capacity. Further escalation will result in the cancellation of all elective surgery.
- Local plans may include stopping all elective surgery (including day-case) to utilise space and staff for looking after critically ill patients.

### Outpatient clinics

Most routine ENT outpatient appointments can safely be postponed if required. Consideration should be given to increased use of telephone clinics whenever possible, particularly for the vulnerable patient groups previously described. Where patients are clinically urgent and need to be seen face to face, direct contact should be kept to a minimum and PPE used where required.

Emergency Departments (ED) are likely to come under intense and sustained pressure and ENT surgeons can make an important contribution by reducing the ED workload so that clinicians in ED can focus on medical patients.

**As the prevalence of COVID-19 increases, Emergency Departments will change their system and will use triage at the front door and stream patients directly to ENT before examination or diagnostics.** We are likely to be asked to take *all* patients presenting with ENT problems straight from triage. It is possible that this temporary service will need to be expanded to provide a 12-hour service, seven days per week, by expansion of your current ENT emergency clinic service. We may be asked to use alternative locations to see emergency patients where appropriate. Those who would normally be seen in minors could be seen in outpatients.

ED will continue to take patients requiring resuscitation, etc.

- We should avoid unproductive attendances at hospital.
- Senior decision making at the first point of contact should reduce or even prevent the need for further attendances.
- A decrease in elective work will allow for a greater senior presence at the front door.
- Clinicians may need to work in unfamiliar environments or outside of their sub-specialist areas. They will need to be supported.
- No patients should be scheduled for surgery without discussion with a consultant.
- Extend emergency clinics to be open-access at least from 9am to 5pm, and potentially later in the evening depending on staffing levels.
- The longer hours will allow ED access and help reduce crowding in waiting rooms.
- The possibility of a seven-day service may need to be considered.
- Using telephone clinics will not reduce ED workload, although the patient information used will be very effective in reducing follow-up visits.
- Consider postponing long-term follow-up patients until the crisis has passed.