GUIDANCE FOR THE CONTINUATION OF URGENT AND ELECTIVE OUTPATIENT RESPIRATORY SERVICES

The number of people requiring inpatient care for COVID-19 has fallen and it is imperative that elective respiratory services continue safely.

This document addresses general principles which apply to all services. It covers risk assessment and ways to reduce exposure and transmission. It also contains links to information on other key areas of elective respiratory care where the continuity of service delivery is most challenging. This includes pulmonary physiology, sleep physiology, pulmonary rehabilitation and bronchoscopic procedures.

This document provides guidance about best practice for members of the respiratory community. The COVID-19 pandemic is novel and as more is discovered about the condition this guidance will be updated.

This document examines the 'principles' of how to manage and run services locally and does not provide individual or site-specific advice. Healthcare professionals need to apply this guidance to their local services to develop site and service specific plans.

The British Thoracic Society, along with many other organisations, has produced guidance for many different areas of COVID-19 management and service delivery. These will be referenced throughout this document and can be accessed at: https://www.brit-thoracic.org.uk/covid-19/covid-19-information-for-the-respiratory-community/. NHS England has also published Implementing phase 3 of the NHS response to the COVID-19 pandemic.

1. GENERAL PRINCIPLES

The primary concern is always the safety of the patient and staff. However, these must be balanced against the negative effect of not delivering appropriate care.

At present, all patients encountered (in hospital or a community setting) should be managed as at risk of having COVID-19.

Risk can be mitigated until very small but can never be entirely eliminated. All encounters have to be risk assessed and only requested and performed where benefit outweighs risk.

Some respiratory interventions are higher risk and some generate aerosols (aerosol generating procedures (AGP)) and so an understanding of the level of risk for each intervention is important.

The patient is the centre of all care and his/her/their opinion about risk is vital.

To achieve safe delivery of services with maximum efficiency requires focus on both elimination of previous practice which may be unnecessary alongside new safe and effective service delivery.

Workforce considerations, availability and type of equipment and the geography of healthcare settings are important to continuation of services.

The opportunity to innovate and improve the organisation and delivery of care and services must not be forfeited. Things learned during COVID-19 should not be forgotten.
Respiratory departments should actively endeavour to minimise the number of trips made to a hospital or healthcare facility by a patient by integrating episodes (e.g. by integrating physiological tests and clinic appointments)

People have now been living with COVID-19 for more than a year and can be expected to be aware of many aspects of COVID-19 regulations.

2. RISK ASSESSMENT

Every healthcare interaction or episode requires risk assessment including practice that pre-dated COVID-19.

Assessment of the risk to patients, carers and staff is paramount and is the primary consideration.

Healthcare professionals (HCP) should discuss the benefit and risk of any encounter with the patient, and/or carers, and the ultimate decision about whether to proceed is made by the patient.

HCP must have access to appropriate Personal Protective Equipment (PPE) recommended by PHE to deliver face-to-face interventions.

Where possible any activity that can be delivered remotely should be delivered remotely though this is not possible for many respiratory services.

Risk assessment must consider:

- What is the intended benefit of an intervention?
- What is the risk of an intervention and/or of not intervening/delaying?
- How does this apply to the individual based on the risk to that person were they to develop COVID-19?
- What is the individual's attitude to risk?

3. ENSURING ONLY PEOPLE WITHOUT SYMPTOMS OF COVID-19 ATTEND OUTPATIENT SERVICES

Reducing the likelihood that an individual with COVID-19 attends a face-to-face healthcare episode is a key strategy.

Pre-attendance questionnaires and temperature checks to assess whether the individual has symptoms of COVID-19 have a place in higher risk interactions though these are often the same interventions where prior COVID-19 testing should be utilised. If the individual has symptoms of COVID-19, they should be advised to self-isolate for 7 days.

More information about temperature screening can be found at:
https://www.artp.org.uk/News/artp-guidance-respiratory-function-testing-and-sleep-services-during-endemic-covid-19

For higher risk procedures, including all tests that are AGP, pre-screen individuals by swabbing for COVID-19. This should also be utilised for pre-operative, pre-admission and day case pathways which involve hospital admission and where pre-admission swab testing is recommended.

Vaccination against COVID-19 does not prevent an individual from contracting the virus and the same processes should apply.

4. ENSURING PATIENTS ARE NOT EXPOSED TO STAFF WITH COVID-19

Reducing the likelihood that an individual encounters a healthcare professional with COVID-19 is a key strategy.

All healthcare staff must follow NHSE guidance about isolation should they develop symptoms of COVID-19.

All staff and members of their household who are symptomatic for COVID-19 should be tested as per current practice.

Asymptomatic frontline staff should be tested routinely and strategically as part of infection prevention and control measures. This should be based on local arrangements and may include LAMP testing and lateral flow testing.
All frontline staff should be strongly encouraged to receive COVID-19 vaccination.

'Excellence in Infection Prevention and Control' for staff is examined further here: Coronavirus » Infection Prevention and Control supporting documentation (england.nhs.uk)

5. GEOGRAPHY OF SERVICE DELIVERY

Many patients and their carers still consider healthcare sites to be dangerous and that attendance increases the risk of them developing COVID-19. Carefully planning, schedule and organise clinical activity to minimise COVID-19 transmission will likely improve confidence from patients and their carers.

In some cases, use of hot and cold sites and hot and cold areas (within one site) can be used but this is dependent on the geography of local healthcare services.

Social distance must be enforced in healthcare settings including waiting areas.

One-way flow through an area or department can be useful although increasing COVID-19 maturity means that many people are experienced at navigating single entrances.

Local services should establish limits to the number of people allowed in a specific area in light of size and ventilation. This may mean that attendance at a department should be delayed until there is adequate space to safely socially distance.

Where it is possible, screens should be used to separate staff and patients.

The use of face covering within waiting areas should follow PHE guidance.

6. ADDITIONAL CONSIDERATIONS

Avoiding an individual attending hospital unnecessarily aligns with the principles of the NHS long-term plan, improves working between primary and secondary care and is popular with patients and

carers. Examine what services can be delivered in community settings such as pulmonary rehabilitation and diagnostic hubs for airway disease.

A mammoth amount of NHS work is duplicated. This is often because of stand-alone IT systems with restricted data access. Clinical teams need to work with Sustainability and Transformation Partnerships (STPs), Clinical Commissioning Groups (CCGs) and Integrated Care Systems (ICS) to highlight the challenges of data access and sharing and to address this.

Unnecessary outpatient follow-up should also be addressed. Often an individual is under follow up for the same condition at multiple healthcare sites or different departments at the same site. This duplication should be eliminated, where possible and HCP should ask "what value is added to patient care by this follow-up appointment?"

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BTS COVID guidance is available here: https://www.brit-thoracic.org.uk/covid-19/covid-19-information-for-the-respiratory-community/

Restarting Spirometry – ARTP/PCRS guidance available here: https://www.brit-thoracic.org.uk/covid-19/covid-19-resumption-and-continuation-of-respiratory-services/#restarting-spirometry/