GIG CYMRU NHS WALES
Rhaglen Endosgopi Cenedlaethol
National Endoscopy Programme

National Endoscopy

Programme

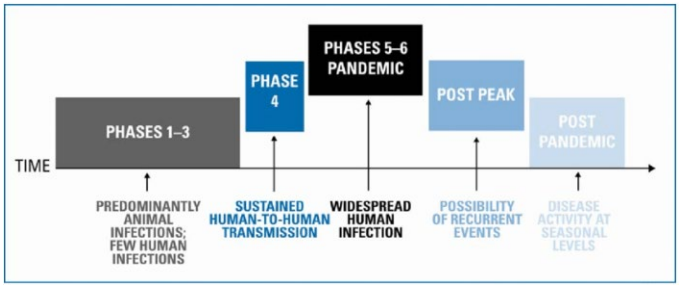
Endoscopy Services

Covid 19 Pandemic

Recovery Guidance

Contents

Summary



According to the World Health Organisations (WHO) definition of the phases of a pandemic, Wales is currently in Phases 5 and 6 of the COVID-19 pandemic, although there is regional variation. This document updates previous guidance for Health Boards to develop a recovery plan including a mitigation and planning outline strategy for a likely "new normal" for endoscopy services in Wales in the phase of gradual lifting of restrictions and post peak phase of COVID-19. This guidance draws on recommendations from Service Recovery Documents published by the British Society of Gastroenterology (BSG) but also includes information specific to Wales developed by the National Endoscopy Programme (NEP) using other evidence.

In line with previous BSG guidance, all but emergency endoscopic procedures were either suspended, halted and or individually risk assessed for prioritisation from 23rd of March 2020. Services have now resumed in a limited way and planning full recovery is imperative in order to reduce the number of delayed procedures moving forward and its consequent adverse impact on patient outcomes.

It is important to note that whilst this guidance is intended for use by all Welsh Health Boards, we understand that implementation may differ according to local circumstances and stage of pandemic and the NEP will offer support and assistance wherever possible to develop local resolution of constraints within a national framework. If your Health Board and hospital site is within a second wave lockdown area you may wish to consult with local Public Health colleagues to consider whether the previous recommendations for appropriate pre and peri-procedure steps for patients and endoscopy units are applicable and apply the ones appropriate to your situation based on new cases and prevalence in the community. We do not however envisage this to mean as for the start of the pandemic where all but emergency procedures were suspended as the current situation is very different to then.

Introduction

Service Recovery Documents were released by the BSG on the 17th of April 2020 and provide a toolkit for endoscopy services during the COVID-19 pandemic. They provide a framework for services to follow in order to plan their recovery. The NEP has considered and endorsed these Service Recovery Documents and asks that Health Boards use them alongside the guidance in this document to plan the recovery phase of their service. The Service Recovery Documents can be found here . Further guidance on recovery from the BSG was released on 26th August 2020 and is also endorsed by the NEP. This guidance can be found here.

NEP Recovery Plan

This plan sets out three phases of recovery and provides guidance on actions required in each phase along with general recommendations on practical considerations. It is anticipated that Health Boards will reach each phase at different times depending on the local impact of COVID-19.

It is important to note that we anticipate that COVID-19 infection rates could fluctuate as public health measures relax, and so it might be necessary for some units to return to the level of activity in the preceding phase of the epidemic. This will need to be judged at a local level using a cautious approach. The following escalation categories and definitions have been used in this document and local teams are asked to consider virus prevalence in their area and government advice on social restrictions to ascertain if their area is considered to be one with increased community transmission of covid 19 and which of the following categories it falls into:

- Area of no escalation - does not fall into any of the 3 categories below i.e. the prevalence of the virus us low
- Areas of concern –areas with the highest prevalence, where the local area is taking targeted actions to reduce prevalence e.g. testing in care homes
- Areas of enhanced support - areas at risk of intervention where there is a more detailed plan and additional resources to support the local team e.g. to provide additional testing capacity
- Areas of intervention – where there is divergence from the measures in place in the rest of Wales because of the significance of the community transmission rate

Phase 1:	
Procedures	• All emergency procedures should be undertaken as per BSG guidance.

Waiting list	In order to decide the appropriate action for referrals and patients already waiting, the following guiding principles are recommended:
	
	• A standardised approach to clinical management of patients waiting for procedures must be agreed. The approach must be utilised consistently by a defined small group of senior clinicians to make a clear decision on:
	  ○ Whether the patient should proceed straight to an endoscopic procedure or;
	  ○ Defer the endoscopic procedure to a post-pandemic phase i.e. when no significant restrictions are present or;
	  ○ Suggest an alternative procedure in addition to deferment or;
	  ○ Suggest an alternative procedure instead of an endoscopic procedure
	• A safety net of review by either primary or secondary care must be developed and explicitly stated in any communication of this decision to patients and primary care colleagues. The management decision must ensure that it is compatible with the individual risk taking into account co-morbidities, age etc. This process must ensure that patients advised to shield because of age or co-morbidity are not disadvantaged by any undue delay or put at higher risk because of non-adherence to strict regulations on Infection prevention and control
	• Further to the above review of referrals, a clear understanding of the following is essential in order to assist with planning the recovery process:
	  ○ Number of new referrals received
	  ○ Numbers of backlog patients
	  ○ Number of new referrals usually received

Tracking	• Units must record all tracking and booking of deferred procedures, surveillance, screening, non-urgent symptomatic patients and USC patients. All referring clinicians and patients MUST be informed of the status of their referral. • Please use the spreadsheet accompanying this document to record details of deferment of procedures or change in management (if units have already developed tracking processes to collate this information then please continue with this tracking method –ensuring that all information in the NEP's tracking spreadsheet is included).

Bowel Screening	• Refer to previous communication from BSW asking Screening Practitioners to check with all participants who are known to be FIT +ve for screening and awaiting screening colonoscopy for alarm symptoms and individual risk factors to prioritise them appropriately. * NB – some units may be implementing CT scans as an immediate mitigation procedure during the pandemic phase and this should not deter or preclude early return to screening colonoscopy for these patients as soon as considered locally feasible. • Plan lists well in advance with operators undertaking screening colonoscopy.
FIT	• The NEP is aware some HBs are planning on implementing FIT in USC groups as an interim arrangement for managing prioritisation of deferred procedures. This is a matter for Health Boards, but the NEP have developed a framework to assist Health Boards utilise FIT in the symptomatic service. NEP asks that any Health Boards using FIT in their high-risk pathway collate the data in order to contribute to the learning in this area. • The Cardiff and Vale pilot starting in autumn 2020 will be gathering evidence about the longer-term use of FIT in the high-risk cohort and this evidence will be used to inform future pathway changes. • Health Boards should start discussing the logistics for implementing FIT in low risk groups (as per NICE DG30 guidance) as this will assist with triaging of referrals from primary care. These discussions should be collective with collaboration across clinical specialities, senior management and administrative staff. Funding, logistics and timescales need to be taken into consideration.
Surveillance	• Ensure the backlog of surveillance procedures has been thoroughly validated according to the new BSG surveillance guidelines in order to create capacity. Early figures from validation carried out already show a reduction in surveillance demand by around 40% and creating this capacity will be essential in helping services recover their position.
Releasing capacity	• Start planning to release operators, suite staff and facilities from their COVID related commitments in order to plan re-start of endoscopy activity.
Other Administrative tasks	• Implement the NEP screening tool for all patients expecting procedures (Appendix 1) and all cases planned for endoscopy in the next phase. • Agree realistic points on lists planned for the next phase considering PPE change between patients, room clean between patients and IP&C regulations. (We expect list capacity to realistically be between 6- 8 points rather than 12 depending on operators and types of procedures. This will vary by case mix and environmental issues (e.g. waiting area space, recovery area space, green zone for post-procedure admissions, room airflow turnaround).

Phase 2	
Procedures	The following procedures should resume in line with IP&C regulations and local policy: • Planned EMR/ESD for high risk lesions • USC referrals – to be risk assessed on an individual basis (please see above guiding principles for review of referrals) • EUS for cancer staging/treatment planning where this will significantly impact therapy • New suspected acute colitis • Small bowel endoscopy for therapy • Variceal banding in high risk cases (recent bleeding). • Oesophageal endotherapy for Barrett's Intramucosal carcinoma (subsequently for HGD depending on local feasibility)
Bowel Screening	• Re-start screening colonoscopy initially for the risk stratified screening participants as above. • Re-start screening colonoscopy for all participants waiting following a positive screening FIT test when locally feasible, as per BSW protocols. • Ensure the screening tool (included in Appendix 1) is implemented for all screening procedures as well.
Waiting list	• Deferred procedures should be booked so that they can re-start as soon as social distancing restrictions are lifted. • Continued prioritisation of new referrals.
FIT	• Finalise plans for implementing FIT in low risk groups (NICE DG30) as above.
Surveillance	• Ensure that surveillance validation backlog is complete in order to have a clear understanding of the true demand (using the audit template that the NEP previously provided to track any removals from the waiting list and change of management).
Other Administrative tasks	• Plan for increased activity with reduced capacity due to IP&C restrictions and list capacity as outlined above in the next phase • Commence discussions with colleagues within your Health Board regarding sustainable plans for increase in capacity and liaise with NEP regarding additional support

Phase 3	
Procedures	The following procedures should start being undertaken and continued to be booked as in the previous phase: • Any procedures that were deferred in previous phases and all new referrals • All symptomatic routine referrals. *This may need discussion and individual prioritisation by the Senior Clinical group and depending on proportion of return to normal capacity as well as wider constraints • FIT+ bowel screening colonoscopy - prioritisation should be to try and ensure that all participants who have already tested positive but not been able to attend for screening colonoscopy yet prior to lockdown should be individually risk assessed and prioritised bearing the above principles in mind. • Surveillance – polyp follow-up after validation by new guidelines complete in the previous phases and as per national guidelines • Disease assessment for IBD - use Faecal Calprotectin wherever feasible and clinically prioritised. • Low-risk follow-up and repeat scopes • Elective therapeutic procedures • Bariatric endoscopy. This may need individualised discussion at a local level depending on capacity and wider considerations • Routine/non urgent small bowel endoscopy • EUS for biliary dilatation, possible stones, submucosal lesions, pancreatic cysts without high-risk features • Endoscopy as part of clinical research • ERCP (please see BSG Grid 2 for further detail) *For patients with non USC lower GI symptoms a FIT test is recommended by the BSG, and if it is <10, the procedure may not be required as per NICE DG30 guidance. Separate guidance related to FIT in Wales will be issued shortly.
FIT	• Implement FIT in low risk groups to comply with NICE DG30 guidance.
Analysis	• Each Health Board must undertake a piece of work analysing the lessons learnt from the pandemic and new ways of working. The NEP will provide a template to assist Health Boards with this piece of work.

Practicalities surrounding the booking and undertaking of lists	
Pre-procedure checks for patients	• Health Boards must monitor the prevalence of COVID-19 in their area through government data. • **If you are in an area, which falls into the "Area of enhanced support", or "Area of intervention"**, patients must be advised to self-isolate for 14 days before coming in for a procedure as a precautionary measure. This will reduce the chance of developing symptomatic or pre-symptomatic infection in the pre-procedure period • Clinical indication and judgement is required to assess exceptional situations where it isn't possible for a patient to comply with 14 days of self-isolation. An assessment of the risk and benefit for individual cases is essential and a procedure should not be denied to a patient based on compliance with the optimal self-isolation period. • **If you are in an area which either falls into the definition of an "Area of concern" or an "Area of no escalation",** patients must be generally advised to adhere to strict social distancing for 14 days before coming in for a procedure. • Ensure that patients are provided with the contact numbers for the endoscopy unit before their procedure and are aware that they must contact the unit in case they develop any specific symptoms of COVID-19 as explained to them during the booking discussion during the 14 -day period before their procedure. The procedure must be rescheduled in the event of this happening. • Patients must complete a pre-procedure screening questionnaire 3-7 days pre-procedure, which includes GI symptoms known to be associated with COVID-19 (Appendix 1). • Pre-procedure swab or antigen testing of patients being booked for endoscopy is not currently recommended in Wales. • A pre-procedure temperature check must be carried out whilst the patient is in the unit and screening questions confirmed by the admitting nurse to ensure that there are no new symptoms.
Post-procedure checks for patients	• We consider it best practice and would encourage Endoscopy Unit coordinators to call patients at both 7 and 14 days following their procedure to ask if they have developed any symptoms (question 2 of pre-procedure questionnaire) that could be attributed to COVID-19. This will also help to track any procedure related infections that might have been picked up during the period of contact in hospital and overall be important in the Test, Trace and Protect strategy for both patients and staff. Should this not be considered feasible an alternative process where patients are given clear instructions at the time of post-procedure discharge to report back through a telephone call to the co-ordinators in case of symptom development or a positive test within 14 days as well as encouraged to use the NHS COVID-19 app and or report their symptoms or test results if known through standard public health channels should be implemented.

Points per list	• As stated above, list capacity is expected to realistically be between 8 points in many instances rather than 12.
	• Whilst this is the standard advice, the specifics of this will need to be dependent on:
	  ○ The type of procedure
	  ○ The comfort of the operator (with flexibility expected around this)
	  ○ The ability to adhere to social distancing measures within the unit (please see points below) must be taken into account when booking the case mix on a list.
	• Procedure rooms will have different turnaround times due to their variance with negative pressure / air filtration systems.
	• Room downtime between procedures is not mandatory for lower GI procedures if patients has had a negative symptom screen prior to endoscopy.
	• Services should map the patient journey from their reception area to discharge room. This will determine what capacity can be safely accommodated and will suggest the optimal timing on a list. This 'mapping' needs to bear in mind constraints from the physical environment and staffing levels as well as IP&C issues (social distancing, staff usage of PPE, airflow in theatres etc.).

PPE	• Standard PPE encompasses a single pair of gloves, hairnet, protective eyewear, long-sleeved apron, shoe covers, and a fluid-resistant surgical mask. • Enhanced PPE includes all the above but requires double gloves and a FFP-3/N-95 mask instead of a surgical mask. • Lower GI procedures are not currently considered to be aerosol generating procedures (AGPs). Enhanced PPE is therefore not required for lower GI procedures if the patient has had a negative symptom screen and no history of exposure. • Upper GI procedures are assumed to be AGPs and so enhanced PPE is required. • Public Health Wales' advice on PPE can be found here. • All patients must be provided with and wear a surgical mask at all times. If visitors are allowed to accompany patients to the unit they must also wear a surgical mask. • All staff working in clinical areas of the endoscopy department should wear a surgical mask at all times.
Patient flow	• Room disinfection and turnaround time should be based on air flow changes within your unit/rooms and on the updated JAG guidance. • Separation of upper GI and lower GI endoscopy into separate patient flows may assist in increasing the flow of investigations possible for cancer diagnostics, particularly bowel screening.

	• All patients with suspected or confirmed COVID-19 infection should have their endoscopy procedures in specific areas designated only for high risk patients. • Endoscopy care (admission and recovery) for all patients with suspected or confirmed COVID-19 infection should be separated in time and/or place from non-COVID-19 patients. • Improved ventilation for endoscopy should be considered at local level and consideration given to the use of alternative facilities such as day surgery theatres.
Social distancing within units	• Waiting areas must be arranged in order to allow patients to enter and exit and sit prior to their procedure whilst maintaining a 2 metre distance from other patients. • Recovery areas must be arranged in order to allow patients to maintain a 2 metre distance from other patients throughout. • Hospital regulations must be considered with regards to allowing visitors to accompany patients to the unit.
Testing of asymptomatic staff	• The routine testing of asymptomatic staff working in endoscopy with swab (antigen) testing is not currently advised. • A system should be in place to remind staff regularly of symptoms of COVID-19 (to enable self-monitoring) and ensure staff understand the need for testing and self-isolation at the onset of any relevant symptoms. If any asymptomatic staff members have tested positive, or have been in contact with others who had tested positive for SARS-COV2 please adhere to the following guidance available here.
Shift patterns	• A 7-day working pattern may need to be considered for adoption by all units. • OOH GI bleeding rota needs to be resumed to provide 24-hour 7-day cover.
Paper Notes	• Paper notes pose an infection risk and should not be taken inside the procedure room. • Appropriate measures for checking and re-checking patient identification must be in place. Endoscopy reports must be printed and taken to the notes as soon as possible.
Computer entry of reports on a list	• Ensure the cleaning and disinfection of keyboards and consoles in between or after every case or complete cleaning of all in-room surfaces including computers and printers etc. depending on local conditions and procedures undertaken.
Telephone Assessment	• Telephone assessments of patients should continue whenever possible in order to reduce face-to-face contact between patients and clinicians.

Surveillance	• Surveillance patients are a high risk group (most have a cancer risk which is at least equal to those on a USC pathway) and so capacity must be reserved in order to ensure that patients in this cohort are still having their procedures. • Additional guidance is being developed to assist services in prioritising patients on the surveillance waiting list. Whilst this is being developed work must continue to accommodate patients on the surveillance waiting list.
STT	• The Straight to Test pathway should be followed by all Health Boards for all referral urgencies and tests. This will decrease time to procedure for patients and reduce pressure on outpatient services. • When a patient is placed on the STT pathway, the responsibility for reviewing the results of the test and arranging the appropriate follow up lies with the secondary care clinician that triaged them onto an STT pathway. • A standardised pre-assessment form is to be used by all admin staff and any "red flags" must be passed on to a pre-assessment nurse to carry out a more detailed pre-assessment. • Nurse pre-assessment is to be carried out when a red flag is raised at admin pre-assessment.

Appendix 1 – COVID-19 Pre-Procedure Screening Questions

Accompanying notes:

- *This questionnaire should be carried out with the patient 2 weeks before their procedure date*
- *The patient must be encouraged to isolate from non-family contacts as per Welsh Government guidance for 14 days before their procedure date if within a high prevalence community transmission area and appropriately socially/physically distance if within a low prevalence area*
- *The patient must be asked to inform the unit if they develop any of the symptoms discussed before their procedure*
- *When the patient attends for their procedure the admitting nurse must confirm the their answers to the below questions and ensure that they have not developed any new symptoms.*

Screening questions:

1. In the past 14 days have you been in direct contact with someone who has either been diagnosed with Coronavirus after a throat swab test or someone who has had a new cough, fever or breathlessness?

2. Do you currently have flu-like symptoms, particularly a cough or high temperature/fever or shortness of breath, or have you had these within the past 14 days?
3. Do you have any other health conditions – if so, which ones?
4. Are you on any immune-suppressive medication or treatment for cancer?
5. Are you willing to attend for your procedure currently or would you prefer to defer (postpone) your procedure for now?
6. Who will be accompanying you to your procedure? – *Please make patient aware of local hospital guidance regarding visitors*
7. *When the patient attends for their procedure please carry out a temperature check* – Confirm patient has normal temperature Yes / No