BSUH: Outline Endoscopy Plan

1. Context

In line with national guidance, the Trust paused all non-emergency / urgent activity endoscopy in response to the CoVID pandemic. As a consequence, we have an increasing number of patients on our diagnostic waiting list – which currently stands at 1,342 as at 11th May of which 71% of patients have waited over 6 weeks

This includes a large number of undiagnosed patients on a GI cancer pathway:

- C. 350 on a colorectal cancer pathway – approx. 280 of which are on the endoscopy waiting list for a colonoscopy / flexi sig
- C. 100 on an upper GI cancer pathway – the majority of which are waiting for an OGD

The British Society of Gastroenterology (BSG) has subsequently issued updated guidance on 1st May 2020 outlining principles to support the safest possible restart of the service.

The key issues raised in the guidance are:

1) *The restoration of endoscopy rooms and redeployment of specialist staff to their endoscopy units*
2) *Extra time and space for procedures, because of increased infection control and cleaning procedures*
3) *The need to pre-screen patients to identify those less likely to have the infection*
4) *The need for "COVID-minimised" facilities, where strict patient flows separate potentially COVID-19 positive patients from those who are unlikely to have the infection*
5) *The need for secure supplies of PPE*

This paper therefore provides an initial outline of plans to re-commence endoscopy elective services as a matter of priority.

This plan is based on the latest guidance but will also need to ensure that it is in line with the Trust's guidance and protocols regarding COVID risk management and infection control.

In preparation for re-commencing, the following plans need to be agreed:

- Staffing levels – both endoscopy and scoping
- Capacity and list planning
- Patient prioritisation
- CoVID screening – SOP and capacity
- Patient flow and throughput
- PPE capacity

2. Staffing

The workforce is split into 2 categories:

a. Endoscopy nurses / staff

Currently endoscopy is only providing an emergency inpatient / urgent service with a skeleton of staff. The remainder of the workforce has either been re-deployed or are shielding / on non-patient facing duties.

A decision to release staff back to the unit is required to enable the service to recommence. An initial staffing template has been developed for PRH and RSCH. The resulting capacity will therefore be dependent on the number of staff and skill mix of the available workforce.

a. Endoscopists – medical or nursing

The Consultant gastroenterologists provide the largest part of the scopist workforce. Currently – outside of 1 inpatient list per day, they have re-provisioned their time to provide increased ward cover of medical patients. At the time of writing – the team are reportedly covering c. 50 inpatients, the majority of which are GIM. In order to re-commence scoping responsibilities – a decision to reduce their inpatient workload is required to free up required capacity.

The plan to recommence GI endoscopy would be based on 1 scopist working across 2 rooms for any planned session. Therefore, depending on what facilities we can staff (TBC) we would need the following Consultant / Clinical Endoscopists:

- RSCH : 4 rooms = 2 scopists required
- PRH: 1 room = 1 scopist
- Montefiore: 1 room = 1 scopist
- Nuffield: 1 room = 1 scopist

3. Capacity

Due to the limitations and constraints on throughput – it is estimated that we will only be able to scope 2 patients per list although throughput may increase depending on case mix.

This would provide the estimated level of throughput if all sites occupied:

Site	No of rooms	No of sessions	Est. no of patients	Comments
RSCH	4	32	64	5 sessions – inpat 2 sessions – EBUS/Bronch 1 session EUS
PRH	1	10	20	
Sub total	5	41	86	
Montefiore	1	5	10	5 session renal access
Nuffield	1	10	20	
Sub total	2	19	30	
Est. total	7	60	116	

4. Patient prioritisation

Upon commencement, the first tranche of patients who will be scoped with be those referred on a cancer pathway.

For patients referred to the lower GI service, prioritisation will follow the recently approved referral management guidelines for colorectal symptoms which sees the introduction of Faecal Immunochemical Test as a risk stratification tool. This will see priority 1 & 2 patients booked in the first instance:

- Priority 1: FIT test > 100 with symptoms
- Priority 2: FIT test greater than 120

Patients referred on an upper GI cancer pathway will be prioritised based on length of wait and outcome of clinical triage.

5. CoVID Screening

A pre-scoping SOP pathway will need to develop to ensure the necessary pre-operative assessment and CoVID screening takes place.

All elective patients will undergo RT-PCR antigen testing c. 3 days prior to attending their appointment. As outlined in the attached Standard Operating Procedure (SOP) all patients will be telephoned by the Endoscopy Nursing team to be screened by the Endoscopy team for symptoms using FTOCC/SCOTS questions outlined in the BSG guidance.

There will be a requirement for c. 100 swabs per week. Swabs for inpatient activity will continue in line with current ward guidance. Pathology has confirmed capacity to accommodate this. However, the process to support this needs to be developed.

In line with national guidelines, only CoVID negative patients will be scoped bar emergency or extremely urgent cases. In the event of an emergency the Red theatre pathway will be followed to ensure scope is completed in timely fashion and staff are protected.

Communication of results to patients will be completed by Endoscopy Nursing over the telephone.

Patients will be asked upon discharge to contact the units if they develop symptoms of COVID-19 7-14 days post procedure in line with BSG recommendation.

6. PPE usage

PPE usage will continue in line with PHE, BSG and Trust guidelines; determined by patient risk stratification, the nature of the proposed procedure and the results of patient testing. To ensure Endoscopy Enhanced level 2 PPE usages is kept to a minimum, a plastic apron and normal gloves will be put on over the full gown. Each time the staff leave the theatre they change this plastic apron and gloves whilst the rest can remain in situ for the entire list. New gloves and plastic apron will then be donned before going into the room for each case.

References

BSG Guidance on recommencing GI Endoscopy in the deceleration & early recovery phases of the COVID-19 pandemic

https://www.bsg.org.uk/covid-19-advice/bsg-guidance-on-recommencing-gi-endoscopy-in-the-deceleration-early-recovery-phases-of-the-covid-19-pandemic/?utm_source=Members&utm_campaign=20ab55dc88-EMAIL_CAMPAIGN_2019_08_05_09_59_COPY_01&utm_medium=email&utm_term=0_be5fefa54d-20ab55dc88-45492837&mc_cid=20ab55dc88&mc_eid=c4d7e42461