COVID-19 Gastrointestinal Endoscopy Guidance

VERSION 3: Reviewed and reissued 02 February 2022

Te Aho o Te Kahu (Cancer Control Agency) and Ministry of Health have worked with the New Zealand Society of Gastroenterology and clinicians to ensure a nationally consistent approach to endoscopy services during this challenging time. The priority is to support the continuity of services, whilst taking every effort to ensure safety of staff and patients and preventing the spread of COVID-19.

Gastrointestinal endoscopy (endoscopy) is a critical component of several health care pathways, including:

- Management of acute life-threatening emergencies e.g., gastrointestinal bleeding and infection
- Diagnosis and treatment of chronic diseases e.g., inflammatory bowel disease
- Cancer diagnosis, treatment, and surveillance

The following information is included in this update:

1) Overall document revision to reflect the change to the COVID-19 Protection Framework (traffic lights).
2) Removal of the Hospital Escalation Framework and introduction of Service Disruption Levels.

Ongoing of delivery of endoscopy services

Whilst the focus is on preserving the delivery of clinical care, we also need to be prepared for scenarios where delivery of care may be compromised. The guidance below supports a nationally consistent approach to changes in endoscopy. There must be a balance between risk of illness and spread of COVID-19 with the risk to patients and whānau of conditions not being diagnosed and treated optimally.

Equitable delivery of care

Māori and Pacific peoples experience multiple and disproportionate barriers to accessing cancer diagnoses, treatment and care. Consequently, these population groups are frequently diagnosed and receive treatment at a relatively later stage and have worse cancer-related outcomes. The presence of pandemic conditions has been shown to dramatically accelerate systemic drivers of inequity including access to adequate income, shelter and food security. There is good evidence that standardisation of care across treatment pathways reduces inequities[1].

We recognise that any limitation of services for patients based on survivability of their cancer will disproportionately impact Māori and other priority populations. DHBs should actively mitigate the impact of diagnostic and treatment decisions on inequity at all alert levels. This **includes supporting Māori and other priority populations to have a prioritised, efficient, coordinated and streamlined diagnostic and treatment pathway**. As capacity returns, DHBs should continue to strive for equity.

This guidance document fits into a wider framework of activity to mitigate the likely exacerbation of inequities in cancer care in the context of COVID-19. This includes the development of a monitoring framework to drive equity action during the pandemic.

[1] Seneviratne S, Campbell I, Scott N, Shirley R, Lawrenson R. Impact of mammographic screening on ethnic and socioeconomic inequities in breast cancer stage at diagnosis and survival in New Zealand: A cohort study Disease epidemiology - Chronic. BMC Public Health 2015;15(1)

Treatment provision

The guidance on endoscopy provision considers:

- The balance between the risk of conditions not being diagnosed or treated optimally with the risk of illness and spread of COVID-19.
- The impact decisions will have on our most vulnerable patients, Māori and Pacific, and patients with comorbidities.
- This guidance does not preclude the need for clinical judgement and clinicians will need to be having clear discussion on the risks and benefits of endoscopy with their patients and whānau.

Staff, patient and whānau safety

There are concerns regarding the possibility of transmission of COVID-19 between patients, whānau and healthcare staff. The Ministry of Health has provided national guidance around the use of personal protective equipment (PPE) in the context of COVID-192. Infection prevention and control, including hand hygiene, working in teams and meticulous adherence to donning and doffing of PPE, is vital as part of a broad strategy to limit spread of the virus and protect staff, patients and whānau.

The New Zealand Society of Gastroenterology recognises endoscopies as aerosol generating procedures and have released recommendations around infection prevention and control and PPE for endoscopy staff in line with this[3,4].

Safety also needs to be considered in the context of delayed or deferred treatment. Departments should consider the following:

- Have robust processes for managing wait lists to ensure patient safety is maintained. There must be timely and clear communication with patients/whānau and primary care, including a point of contact for patients and their whānau.
- Departments must have a process for reviewing wait lists to identify those whose clinical situation is becoming more urgent.
- A transparent process for auditing referrals that have been declined and sent back to GP (will be reviewed by ethnicity).
- Establish options to increase capacity to manage any backlog and anticipated surge. This may include maximising existing human and theatre resources within DHBs.
- There is recognition that in smaller regions endoscopy procedures may be provided by one or two individuals, making these regions less resilient in the event of staff illness or isolation requirements. Similarly, new ways of working will likely impact on through-put capacity. DHBs should consider options to use other sites within their network or activate regional links to improve regional equity. The New Zealand Society of Gastroenterology (NZSG) is available to support local services to create networks to smooth patient flow around a region and/or advertising requests for temporary redeployment of specialists to areas of need.

Collaborative approach

System planning around cancer care

Endoscopy is a critical cancer diagnostic and therapeutic service. This guidance is part of whole system planning for cancer care, aligning with cancer surgery, cancer imaging, medical oncology, radiation oncology and haematology guidance. The aim is to support the whole of the cancer care pathway to be operating at a consistent level at different hospital capacities.

[2] https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-advice-essential-workers-including-personal-protective-equipment/personal-protective-equipment-use-health-care

[3] Raos Z, Atkinson N, Arnold M. NZSG Recommendations for PPE during the COVID-19 Pandemic. Released 6 April 2020 [cited 15.04.20]. Available from: https://nzsg.org.nz/news-and-events/article/3485

[4] New Zealand Society of Gastroenterology. *The New Zealand Society of Gastroenterology Position Statement on Provision of Gastrointestinal Endoscopy in the COVID-19 era.* April 2020.

Multidisciplinary meetings

Multidisciplinary meetings should continue, noting that the form of meetings may change, e.g., virtual conferences. Clinical teams may face difficult decisions and if resources are constrained, care may deviate from usual pathways. Many of these pathways were already contributing to inequities. It is recognised that in times of stress biases may can be exacerbated, which may impact decision making and increase inequities. These issues should be acknowledged within multidisciplinary meetings. Where a Māori or Pacific patient's care does not follow the usual treatment pathway, the MDM should consider what can be done to maximise the potential for Māori or Pacific health gain and equity.

Endoscopy service activity levels

With the move away from an elimination strategy to manage COVID-19, the National Hospital COVID-19 Escalation Framework has been retired. This reflects the move towards the focus on maintenance of planned health care services meaning each DHB is responsible for prioritisation of services where there are disruptions.

It is possible that endoscopy services at a hospital may be facing a specific situation that limits their ability to provide care – e.g., if several staff are off or required to self-isolate. It is expected that a unit would aim to redeploy staff within its department to maintain service and/or work with another endoscopy service if possible. However, if this is not possible endoscopy services may be required to change delivery of care.

Level of disruption to endoscopy	*Examples of factors which may contribute to service disruption*	*Service activity level (see below)*
No disruption	Preparation	1-5
Some disruption	Loss of staff through illness, self-isolation, redeployment	1-4
Moderate disruption	As above plus any conversion of facilities to manage patients with COVID-19.	1-3
Significant disruption	As above plus major occurrences such as a COVID-19 outbreak in the hospital.	1 +/- 2

Service Activity Levels for endoscopy services have been set using the pre-existing endoscopy priority guidance categories Urgent (P1), Semi urgent (P2), Surveillance (P3).

Māori and vulnerable patients, who are likely to have experienced systematic barriers and delays in care, should be supported to complete endoscopy and prioritised through the pathway.

Note that the factors included above are examples of disruption only. In addition, it is important to consider the expected length of time that the disruption would occur. This is relevant in particular for planning to transfer patients to an alternative location.

Process for changing levels

If an endoscopy department believe they need to move their service (but not the whole of hospital) up a trigger level they should notify their own DHB management of this need, and the proposed impact on patients.

Service Activity Level 1

- Emergency endoscopy
- Examples include: severe upper GI bleeding, acute oesophageal obstruction, acute cholangitis, urgent nutritional support (PEG/NJ/NG)

Service Activity Level 2

- Symptomatic P1: urgent, within 2 weeks
- Examples include: urgent 'likely cancer' referrals, new suspected IBD, cancer staging EUS (biopsy and/or staging)
- Prioritise Māori and Pacific patients from level 3 to help overcome systematic delays in accessing care

Service Activity Level 3

- National Bowel Cancer Screening Programme faecal immunohistochemical test (FIT) positive colonoscopy
- P2 (Prioritised) endoscopy: semi-urgent, within 6 weeks, higher priority for more urgent clinical need
- Advanced endoscopy if benefit > risk and if capacity for managing complications

Service Activity Level 4

- P2 endoscopy: semi-urgent, within 6 weeks, standard
- P3 one year Surveillance (e.g., hereditary nonpolyposis colorectal cancer)
- Six-month site check post polypectomy
- Advanced endoscopy

Service Activity Level 5

- P3 three- and five-year surveillance