BRITISH SOCIETY OF GASTROENTEROLOGY

British Society of Gastroenterology Guidance

Rebooting Gastroenterology and Hepatology Outpatients in the wake of COVID-19: Renewal, Redesign and establishing the "New Norm"

Executive Summary

The COVID-19 pandemic presents a unique opportunity in the history of the NHS to redesign outpatient services utilising digital technology and remote consultations. This guidance is a consensus of expert opinion which has been developed by the BSG Clinical Services and Standards Committee (CSSC), BSG executive and co-opted members.

It sets out how to reconfigure outpatient gastroenterology and hepatology services using a toolkit of pre-existing and innovative technologies.

It should be emphasised that this guidance is the first step in rebooting outpatient services - a process that will continue to evolve over time. The key recommendations and flow chart of the patient journey are summarised below:

RECOMMENDATION 1: In order for care to be optimal, patients must be signposted to the correct pathway from the outset, - which may include remote, face to face or asynchronous consultations (defined as a consultation where the patient and clinician interaction occurs at different times)

RECOMMENDATION 2: Enhanced triaging with all the prerequisite information is used to signpost the patient to the correct pathway

RECOMMENDATION 3: Doctors undertaking remote consultations should ensure that they have read and are familiar with GMC guidance

RECOMMENDATION 4: Face to face (F2F) consultations remain essential for particular situations. It should be recognised that there will be some patients who do not have access to a telephone or appropriate information technology and will require F2F consults

RECOMMENDATION 5: Remote consultations should be seen as equivalent to F2F consultations in terms of the remuneration process by commissioners

RECOMMENDATION 6: In order to introduce successful remote consultations there needs to be appropriate information technology (IT) support. Infrastructure varies between hospitals but following COVID-19 it is now essential that all NHS trusts and Boards should be able to provide a level of service that is reliable and sufficient to facilitate and encourage remote consultations

RECOMMENDATION 7: Providing the appropriate skill mix of staff, including specialist nurses, allied health professionals and non-clinical administrative staff, is essential if redesigned outpatient services are to function efficiently and productivity is to be improved

RECOMMENDATION 8: Job planning, including the recognition of flexible working, is key to ensuring that remote consultations are successfully implemented, especially outside standard working hours

RECOMMENDATION 9: Remote consultations will evolve over time. It is essential that accessibility to remote consultations is monitored to ensure that equality and diversity legislation is met. Patient satisfaction and evidence of efficacy is needed through audit and quality improvement projects. These innovative ways of working lend themselves to further clinical research

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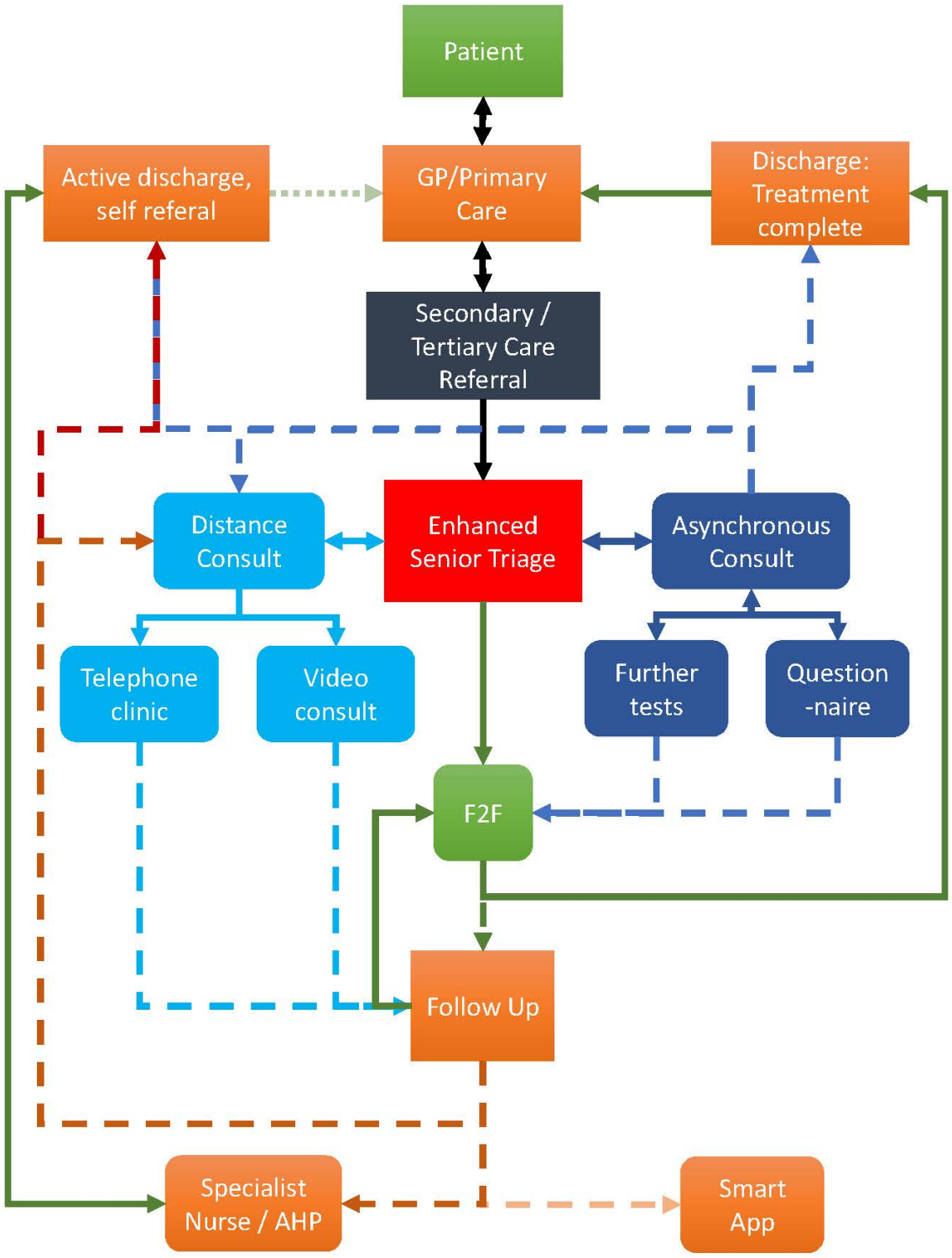

FIGURE 1: FLOW CHART DEMONSTRATING PATHWAY OF PATIENT.

More information about this pathway can be found in appendix 1.

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Introduction.

The COVID-19 Pandemic is potentially the most powerful catalyst for changing outpatient services that has occurred within the working lifetime of most NHS staff. The risk of human-to-human transmission has resulted in an urgent need to establish non-face to face (F2F) consultations and the willingness of the NHS workforce to initiate the extensive changes in working practices required, has been impressive. Some generic national guidance has been provided by the GMC (1), RCP (2), NHS Improvement (3) and the BMA (4) but the BSG now wishes to present pragmatic, specialty specific advice for Gastroenterology and Hepatology services.

BSG advice on patients presenting with GI or hepatology symptoms was issued in the service recovery Documents 'the What, When and How' published on 17th April 2020 and is available on the BSG website (5).

The following guidance on restarting and redesigning outpatients has been developed by the BSG CSSC executive in conjunction with the BSG executive and Dr John Thomson (consultant gastroenterologist and Digital Health Lead for the Modern Patient Pathways Program of the Scottish Government). In drafting this guidance, the CSSC recognises that there is a paucity of high quality data to support the redesign of services. It is, therefore, of necessity, a consensus of expert opinion. The document outlines the patient journey from referral to discharge, including types of remote consultations that are potentially available, how and when to perform them and their advantages and disadvantages. It also discusses the situations where face to face consultations are still indicated and how new ways of working and future innovations, can be incorporated into existing job plans.

The BSG has already published advice on endoscopy services during the COVID-19 crisis. This included guidance on pausing endoscopy during the acceleration phase and was supported with advice on restarting services as the epidemic plateaued and decelerated. (6).

The same considerations apply to outpatient services, although the outcomes have been less planned. During the acceleration phase, many gastroenterologists were redeployed to acute wards and the acute take, to handle the influx of COVID 19 patients. In some areas, outpatient facilities were repurposed for other activities. Limited data available from the BSG CSSC survey and individual units suggest that new outpatient activity may have fallen by two thirds and return activity by 40%. Specialist liver and IBD nurses have been redeployed to other parts of the system. (7).

During the crisis, the number of patients presenting to GPs with non-COVID disease has fallen substantially, so the onward referral to clinics has reduced, making the reduction in outpatient capacity less obvious. As Government restrictions on movement and self-isolation are lifted and the public fear of COVID 19 reduces, referral rates will increase. COVID-19 is, therefore, a powerful incentive to redesign services.

Other reasons why outpatient services should be redesigned.

- COVID-19 is unlikely to resolve completely in the near future and there are growing concerns that there may be a second peak. Returning to previous ways of working is not tenable and it is, therefore, essential to look at innovative ways of delivering outpatient care

- There were significant waiting times for GI outpatients before the crisis. Demand for GI services already exceeded capacity. This has been documented in repeated surveys of BSG regional representatives from the 4 nations with many units unable to meet demand pre-COVID-19
- Travel to and from hospital constitutes a significant transport cost, including a large carbon footprint. Reducing unnecessary attendance is vital for sustainability
- Patients give time to attend hospital with costs in terms of missed work, childcare, and care of relations
- New ways of distance working may be more efficient and flexible, potentially improving the productivity of out patient services to the benefit of patients and clinicians
- Many gastroenterologists want to change the way they work and their work-life balance

COVID-19, therefore, represents both a threat to GI services, but also a real opportunity to change.

Basic principles: Patient-centered care.

- The patient should be at the centre of high quality care whatever pathway is adopted
- Services cannot be considered in isolation. Pathways must be developed jointly with general practitioners, and primary care services as equal partners
- Service redesign requires new ways of working. These have the potential to increase productivity and patient satisfaction. They have to be incorporated into job plans, and have to be seen as part of normal patient-facing activity rather than as voluntary "extras" (8)
- The process should be evolutionary and not all change can be introduced at one time. It will be necessary to try out new ways of working and adapt them to local needs

Enabling measures

The redesign of outpatient services needs a selection of tools to meet the demands and clinical needs of patients. The following "toolkit" describes some of the measures that are currently available.

The Toolkit

The Toolkit includes the following:

- Enhanced triage by a senior clinical decision maker
- A wider choice of consultation methods including teleclinic, video clinic, face to face (F2F) and asynchronous clinics
- Pre-testing
- Questionnaires
- Smart apps
- Staffing with a range of skills deployed in a flexible responsive way

RECOMMENDATION 1: In order for care to be optimal, patients must be signposted to the correct pathway from the outset - which may include remote, face to face or asynchronous consultations (defined as a consultation where the patient and clinician interaction occurs at different times)

Enhanced Triage

Definition.
A process where referrals are reviewed by a senior clinical decision maker and assigned to a treatment or diagnostic pathway.

Rationale.
Triaging, which can done remotely, by a senior clinical decision maker is essential in signposting the patient to the correct pathway. Enhanced triaging uses a variety of techniques including distance consultations to make sure that the patient moves as efficiently as possible for a diagnostic or treatment pathway.

Prerequisites.
In order to triage appropriately there are some essential prerequisites including:

- A GP referral letter/ 2week wait request (Urgent Suspected Cancer (USC)/ secondary or tertiary referral letter
- Access to previous clinical notes, endoscopy records, GP summary sheet of Past Medical History (PMH), current medication and allergies
- Access to tests results including relevant haematology and chemical pathology results, imaging and pathology

After reviewing all the relevant documentation, the senior clinical decision maker will be in a position to decide an oucome for the referral which might include;

- advice and guidance to the GP (an asynchronous consultation or "GP" clinic)
- allocate the patient to a telephone clinic, a videoconsultation, or a conventional face to face consultation
- request a questionnaire
- arrange further tests before deciding on the next action

The potential pathways are highlighted in the flowchart above (Figure 1.)

RECOMMENDATION 2: Enhanced triaging with all the prerequisite information is used to signpost the patient to the correct pathway

Consultation Methodology

Telephone and video clinics

Definition.
Telephone and video clinics are usually classed as "synchronous" remote consultations in which the patient and doctor are not geographically in the same location, but are communicating in the same time period in a "live" system. (9)

General principles for remote clinics.

- It is essential for successful telephone and video clinics that the clinical team agrees how the consultations will be conducted and recorded. Clinical Nurse Specialists in many hospitals have been running telephone clinics and IBD patient helplines for many years and their practical experience can be invaluable to avoid pitfalls and enhance success
- Remote consultations are not a shortened interaction or a brief discussion, but a formal clinical consultation, including a thorough history, which should be recorded contemporaneously in accordance with GMC regulations and which result in clear management plans and follow up arrangements, that are agreed with the patient
- The length of the remote consultation is usually, therefore, the same as a F2F consultation, with 20 mins for a standard follow-up and 30 mins for a standard new patient appointment. These timings may need to be adjusted for complex patients
- Early experience suggests that remote clinics take as long as conventional F2F consultations. It is therefore important to agree the length of new and follow-up virtual appointments as soon as possible with funding bodies so that it is reflected in the tariff. Failure to do so could potentially result in loss of income for a hospital which in turn may lead to caution about adopting new methods of working. With experience over time it may be possible to alter the length of appointments. There is therefore a real possibility that productivity will improve. The process should not be driven primarily by financial considerations
- The time taken should be reflected in the remuneration for hospitals/ Boards which should remain the same for virtual clinics as for F2F clinics. This will need to be clarified in the next funding round and the tariff arrangements as described above or their equivalent in the 4 nations are recommended in the interim
- The GMC have issued specific guidance on which patient groups may not be suitable for remote clinics and will require F2F consults (with PPE as agreed for that setting). This group is described under F2F consultations see p.9. (1)
- NHS Trusts are currently asking for likely numbers of F2F patients. This remains to be determined as the numbers will depend on the complexity and needs of patient groups and healthcare setting (e.g. secondary versus tertiary units). The numbers of F2F patients should be agreed with clinicans expected to provide those clinics
- In practical terms a clinic list should be available for each clinic with expected appointment times for each patient as is the standard process for F2F clinics
- Patients will need to be contacted by the Booking Team to ensure that they agree to a virtual clinic appointment, determine if there are any communication issues that need to be considered and clarify the most appropriate telephone number or video link address
- Analysis of this “non-value added time” has highlighted other benefits including a significantly lower carbon footprint
- Traditionally breaking bad news has always been a subject for F2F consultations, but it is an increasingly common practice to break bad news via remote consultation. It requires sensitivity, a careful consideration of the individual patients circumstances, and good communication skills. The BMJ provides excellent advice on this subject (10)
- For further top tips and advice on how to conduct a successful remote consult see Appendix 1

Pros:

- Avoids patient coming to hospital with potential risk of acquiring or transmitting COVID-19
- High sustainability- lower carbon footprint than F2F consult
- Avoids patient time off work, getting childcare
- Allows clinician time to work more flexibly
- Increased clinic physical capacity if consult performed from home

Cons:

- Some patients are not suitable for remote consults (as defined on p9) and will require F2F consult
- Depends on reliable IT services and high speed broadband which may not be consistently available

RECOMMENDATION 3: Doctors undertaking remote consultations should ensure that they have read and are familiar with GMC guidance

Face to Face (F2F) Consultations

Definition.

The traditional model for outpatients. F2F consultations are still appropriate for many situations:

- Where examination is essential, for example in evaluating perianal symptoms or when assessing difficult abdominal pain, or where a physical sign such as an abdominal mass is thought to be present
- If there are significant communication difficulties
- Complex or high risk cases particularly if significant concomitant disease is present
- When patients do not have a telephone or access to appropriate information technology
- Circumstances where it may not be clear if patients have all the information they want or require about treatment options, or their capacity to make informed decisions about treatment is not certain

Pros:

- A tried and tested system that clinicians are familiar with
- Still essential for many situations as discussed above

Cons:

- Requires the patient to attend a clinic or hospital with a higher consequential risk of COVID-19 infection
- Involves significant patient time, including travel, time off work and on occasions long journeys
- Low sustainability - higher carbon footprint than remote consultations
- Becomes inefficient when capacity is limited due to lack of physical space to perform clinics. This is relevant when there is a requirement for social distancing

Recommendations regarding social distancing:

- Spacing out appointments to reduce the number of patients attending at any given time to avoid overcrowding in the waiting area so that they can be kept apart according to government guidance
- Ensure that the registration process is swift, by collecting as much relevant information as possible before the appointment is made. This can reduce waiting time and contact with reception staff

- Encourage patients to attend alone, whilst recognising that they still retain the right to be accompanied by a family member or friend, particularly if there are issues of communication or capacity
- Ideally the administrative team should remain offsite so that they are not exposed to COVID-19. The number of reception staff who are F2F with patients should be minimised and appropriate screens should be in place to limit their exposure to the virus
- Appointments should be staggered and patients should be asked to wait outside the clinic if possible
- Appropriate notices for the consulting rooms to maintain privacy during the consultation, eg "Do not enter, consultation in progress"

Recommendations for cleanliness:

Specific guidance may vary across the 4 nations and is prone to regular updates on government websites (11)

- Screening patients for COVID-19 symptoms before they attend
- Temperature check at the point of entry into the premises according to national policy
- Encourage patients to wear masks according to Government recommendations
- Hand sanitising procedures as patients enter and leave the environment
- A one way system of patient movement
- Surfaces of furniture and equipment to be wiped cleaned with disinfectant between patients to avoid cross-contamination
- Remove as much clutter/equipment/items from the consulting room as possible. Anything left in the room should have hard surfaces or stored in enclosed, cleanable box
- Healthcare professionals to wear a mask and a plastic apron in accordance with Government recommendations
- As a consequence it is likely that longer appointment times will be required to allow for cleaning between patients. The length of time rooms should be left between patients will vary according to local factors and should be risk assessed with hospital infection control teams

RECOMMENDATION 4: Face to face (F2F) consultations remain essential for particular situations. It should be recognised that there will be some patients who do not have access to a telephone or appropriate information technology and will require F2F consults.

RECOMMENDATION 5: Remote consultations should be seen as equivalent to F2F consultations in terms of the remuneration process by commissioners

Asynchronous Consultation

"Asynchronous" consultations are defined as a consultation where the patient and clinician interaction occurs at different times - Based on Royal College of Ophthalmologists definition, 2016 (12).

Typical examples of this are where the patient - clinician interaction uses a questionnaire or smart app as detailed below and where a referrer requests clinical specialist advice about the management of a particular patient and the specialist writes or emails back to the referrer with their clinical opinion. This Nature article summarises the options well (13).

Asynchronous consultations of course commenced originally by a GP letter asking for advice but have now evolved into electronic “Advice and Guidance” systems and detailed written management plans in lieu of a traditional out-patient appointment.

Pros:

- Avoid unnecessary F2F consults
- Avoid long waiting times
- Sustainable
- Allows patient and clinician flexibility as they do not need to be present at the same time

Cons:

- Can lead to prolonged backwards and forwards communications while awaiting further investigations with a potential delay in diagnosis

Screening tests

Gastroenterologists and hepatologists have a number of very helpful tests available to them for assessing patients’ symptoms. Ideally these should be done before triaging the patient depending on the patients clinical presentation

- Helicobacter faecal antigen
- Faecal Calprotectin
- QFIT
- Ig ATTG
- FIB 4 score
- Intelligent LFTs
- Transient elastography

Questionnaires

Questionnaires which incorporate key facts required to assess patients who may have IBD, liver disease or nutritional issues may be developed and issued to patients. They may also be useful to gauge patient expectation. Patients may be signposted to undertake these questionnaires after triaging. See Figure 1.

Smart apps

Smart apps which incorporate key facts required to assess patients who may have IBD, liver disease or nutritional issues may be developed and issued to patients. Patients may be signposted to utilize these apps after triaging.

Information Technology (IT)

Having appropriate reliable, secure IT systems is essential in providing high quality enhanced triage and remote consultations.
The hospital needs to provide local and remote secure computers with up to date software to allow videoconsultations in the workplace or at home.
Adequate infrastructure including internet connectivity with appropriate optimisation for video will be essential.
Reliable IT service desks with regular maintenance of IT equipment is mandatory.
Consideration must be given as to how to provide out of hours IT support for clinicians working flexibily.

RECOMMENDATION 6: In order to introduce successful remote consultations there needs to be appropriate information technology (IT) support. Infrastructure varies between hospitals but following COVID-19 it is now essential that all NHS trusts and Boards should be able to provide a level of service that is reliable and sufficient to facilitate and encourage remote consultations.

Staffing

(Reference: RCP Document on Outpatients; the future, 2018) (14)

Medical

Demand for an outpatient service should meet the available capacity. Capacity should take into consideration fluctuations in demand and staff availability (eg due to leave entitlements). A service should not rely on flexible or additional capacity for any extended period of time as this is unsustainable and ultimately unsafe as staff begin to fatigue.

Specialist nurses and allied medical professionals

Many of the functions delivered in outpatient services, previously considered to be in the domain of doctors can now be safely delivered by appropriately trained medical associate professionals such as physician associates and specialist nurses. All care pathways should optimise their staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design.

Administrative staff

For any system to work, the flow of communication between primary and secondary care and patients must work seamlessly. Administrators provide much needed consistency and system navigation for patients. Dedicated non-clinical support staff develop a key understanding of clinical processes and pathways related to the specialist area that generic administrative teams cannot be expected to learn.

RECOMMENDATION 7: Providing the appropriate skill mix of staff, including specialist nurses, allied health professionals and non-clinical administrative staff, is essential if redesigned outpatient services are to function efficiently and productivity is to be improved

Job Planning

Job planning is integral to redesigning efficient, effective outpatient services. The following needs to be considered when job planning. Direct clinical care: any session that is involved in providing clinical care. This may be "patient-facing" (e.g. clinics, ward rounds or endoscopy lists) or "non-patient-facing" clinical activity (e.g. patient-related administration or MDTs). New ways of working which include asynchronous clinical time and enhanced senior triage are considered as direct clinical care.

An out-patient event (e.g. video or telephone consultation) will comprise:

- Preparing to remotely invite the patient into the clinic room including reviewing referral letters, last clinic letter (if applicable) and any relevant results.
- The consultation with the patient
- The ordering of on-going tests and management (including prescribing) and the recording of the visit (including the generation of a letter usually through dictation)
- Most new patients require at least 30 minutes each. Follow up patients should be allocated 20 minutes each.
- An out-patient clinic taking four hours in total (3.75 in Wales) is equivalent to 1 Programmed Activity (PA) of Direct Clinical Care (DCC) and should include time for all necessary administrative tasks such as making notes, dictating and ordering investigations.

The volume of patient related administration varies from sub-specialty to sub-specialty and post to post. Clinical administration can be divided into that ***related to fixed direct clinical care sessions (and therefore more predictable)*** and administration that is ***un-related to fixed direct clinical care sessions (and therefore less predictable)***.

Clinical administration related to fixed direct clinical care sessions.

- For example, for direct clinical care sessions such as outpatient clinics there will be a predictable amount of associated administration (such as letters to write and validate and results to review). This should also include review and oversight of work/results undertaken by doctors in training and nurse specialists.

Clinical administration unrelated to fixed direct clinical care sessions

- Relates to clinical work unconnected to existing direct contact clinical activity. This will include asynchronous clinical time and enhanced senior triage. Consultants who are regularly involved in this kind of activity should usually have this separately recorded and often as fixed timetabled sessions.
- The BSG recommends that patient related administration is allocated a minimum of 1.5 PA (DCC) for a 10PA job plan for a full-time Gastroenterologist or Hepatologist
- Considering the increasing number of patients each Consultant is responsible for, despite not physically meeting many of them, it is quite possible for 2.5 PAs (DCC) or more to be required to appropriately manage the workload

Flexible working

- Consultants may choose to work flexible sessions for several reasons such as for those with young families with child care needs, who may then choose to work more sessions (PAs) during term time and take more time off during school holidays
- Consultants can, with agreement from their employer, "bank" extra sessions and take time off as a sabbatical. Annualised job plans can accommodate such a working pattern including week to week timetable variation, other commitments that can occur on a slightly unpredictable basis, and the need to have flexible sessions to help back fill endoscopy for example

For further details about job planning relevant to gastroenterology, the BSG will in the near future be publishing a completely revised and updated BSG Consultant Gastroenterologist Job Planning Guidance document.

RECOMMENDATION 8: Job planning, including the recognition of flexible working, is key to ensuring that remote consultations are successfully implemented, especially outside standard working hours

Primary & Secondary Care Interface Groups

The interface between primary and secondary care has been less than optimal due to various political drivers over a number of decades. COVID-19 affords an opportunity to re-engage with primary care colleagues to develop new pathways of care. It is essential to have GP representation when developing any new pathway.

Pathway Development

This is to be encouraged. There are numerous examples of development and implementation of new pathways. Please see examples of "Success stories" on BSG website (15)

Training

Trainees

Outpatient consultations are a very significant part of the higher specialist training programme. Historically, trainees frequently do not recognise or utilise the learning opportunities available to them from outpatient clinics and see this as a purely service provision. It is important for trainees to acquire the knowledge, skills, attitudes and behaviours needed for this essential part of their future independent practice. Trainer and trainee need to align their agendas, set appropriate learning objectives and tailor opportunities to allow progression through the stages of Miller's pyramid of assessing clinical competence: knows (observation), knows how (participate), shows how (demonstrate) and does (independent practice).

The COVID-19 pandemic has provided a unique opportunity to redesign outpatient services and the flexibility now available by better utilisation of digital technology and remote consultations should increase training opportunities, rather than reduce these. Limitations of availability of clinic rooms will be largely removed. The significant reduction in non-value added time for patients being assessed remotely should result in patients being even more amenable to a trainee or trainer 'sitting in' on their consultation, or having a call back later to update them on a management plan once a trainee has been able to discuss more complex

cases with their trainer. Good verbal, non-verbal and written communication skills are all essential for a successful outpatient consultation. The lack of non-verbal communication from telephone clinics may be more of an issue for trainees, but could be managed by the use of video consultations.

Training staff to use new technologies

It is imperative that hospitals provide staff training in using new technologies to optimise enhanced triage and remote consultations. Additionally facilitation and ongoing support for what to many are new ways of working will be essential to ensure an optimal experience as the new norm evolves. This can range from simple tips such as ensuring the video window is positioned close to the camera on screen to maximise virtual eye contact through to virtual real time support for clinician and patient that can be called upon when needed. More detailed guidance on ensuring an optimal consultation is provided in Appendix 1.
Staff must also be up to date with information governance mandatory training programmes.

Training patients

If patients participate in video consultations they need to be provided with instructions on how to use the technology. Demonstration material should be sent to them prior to their consult and the process tested to ensure that they have the appropriate IT and ability to use it effectively. This is particularly important for certain elderly and vulnerable patient groups. The ability to provide patient facing support and training would be ideal but may not be possible depending on hospital resources.

Future Opportunities

Overall the adaptation to virtual clinics has been rapid but successful and many clinicians who were wary of replacing traditional clinics have found telephone and video clinics surprisingly easy to set up and run efficiently. Although the change to virtual clinics has been forced upon us by COVID-19, a number of patients seem to prefer this new system and ask for their next appointment to be along similar lines. In order for there to be ongoing refinement of remote consultations there needs to be:

- Further development of IT systems to support virtual consultations and ideally link directly and harmonise with Primary Care IT systems which in some respects have advanced at a greater pace than Secondary Care systems.
- Formal audit of remote clinics is required and should be encouraged with feedback requested from Primary Care referrers in addition to our patients. Patient access to remote consultations should be monitored. Particular patient groups such as the frail and elderly, ethnic minorities and those with disabilities are vulnerable and it is vital to ensure they are not disadvantaged by innovative outpatient redesign.

RECOMMENDATION 9: Remote consultations will evolve over time. It is essential that accessibility to remote consultations is monitored to ensure equality and diversity legislation is met. Patient satisfaction and evidence of efficacy is needed through audit and quality improvement projects. These innovative ways of working lend themselves to further clinical research

Conclusions

COVID-19 has given the gastroenterology and hepatology community a unique opportunity to restart and redesign our outpatient practice. The guidance described above highlights the ways in which services can be reconfigured to implement new ways of working. The utilisation of the proposed toolkit is the first step in the process. It should be emphasised that this will be an evolutionary process and it is likely that there will be several iterations as the clinical situation may rapidly alter over time eg if there is a second wave of COVID-19 infection. Many of the proposals in this guidance have come from individual units and the BSG CSSC wishes to learn of examples of good practice from centres throughout the 4 nations so that experience can be shared. It is highly likely that Sections of the BSG will utilise this advice and adapt it to their own specific needs eg. The IBD section is currently producing an IBD service recovery document including specific advice on optimal outpatient services post-COVID.

Acknowledgements

This guidance was written by the BSG CSSC Executive (Andy Douds, Rupert Ransford, Tony Tham), the President (Alastair McKinlay) and co-opted members Dr John Thomson (Consultant Gastroenterologist and Digital Health Lead for the Modern Patient Pathways Program of the Scottish Government) and Dr Bev Oates (Chair, BSG Training committee)

We are grateful to Sarah Marshall (IBD nurse specialist) and the BSG Executive* for their helpful comments in preparing this guidance.

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Appendix 1

Figure 1. The patient pathway.

The new approach to outpatient consultations is inevitably more complex than the traditional linear scheme, in which GPs referred patients to secondary care, where they were prioritised to either a conventional face-to-face consultation (F2F) or direct to test. Follow-up was often initiated routinely and frequently continued long-term.

In a modern patient pathway, the choices are more complex and involve a range of techniques from "the toolbox".

The relationship between the GP and patient is if anything more important and may involve advice and discussion with secondary care before a referral is made.

Enhanced senior triage is central and may result in:

- A distance consultation, such as a telephone clinic or video consultation.
- A conventional F2F consultation.
- An asynchronous consultation, with the patient going for further tests or completing a questionnaire to give more details of their condition, before a distance, or F2F assessment is made. In some cases, the asynchronous consultation may answer the clinical question and the patient can be discharged.

Following the initial interaction, the patient might be discharged or attend for a face-to-face or distance or an asynchronous follow up.

"*Active discharge and self-referral*", is an agreed process where patients initiate their own follow-up if they think that their condition has changed. Contrary to expectation, this may result in fewer appointments than the conventional approach.

There are, therefore, many routes through the outpatient pathway and an individual patient may follow different routes at different times during their condition.

Top tips on how to conduct a successful remote consultation

- **Ensure A Professional Environment**

  Before the first "live" clinic it is essential to test the remote consultation system to iron-out glitches that might occur. Although there are advantages to home-working, running a virtual clinic from your dining room table needs some careful planning. Patient information should be handled in the same confidential manner as required by the Information Commission and the GMC using secure IT systems and with consultations recorded in a contemporaneous manner. The virtual clinic room should be free from interruptions and have secure, reliable telephone or internet connections. If IT systems alone are used, there should be a backup system available and IT support to resolve issues. There has been some discussion about the use of clinicians' own mobile phones. It is recommended that the "Caller ID" function is disabled and that no recordings or images are stored on non-NHS devices or on "Cloud" server systems.

- **Landline, mobile or video?**

  Most patients seem to prefer to be contacted on their mobile phones and a direct dial to mobile facility needs to be enabled from wherever the virtual clinic is to be conducted. The patient's preferred contact number needs to be updated onto the clinic list along with any communication issues (such as hearing limitations) or the requirement for an interpreter. A 3 way interpretation system is available for the NHS which requires pre-booking, but often works well. Some patients with limited capacity or memory impairment can also be assisted with telephone and video consultations in a similar manner to face to face consultations, although consent to share information with next of kin or care-givers should be clarified and recorded. On a practical note, telephone headsets enable both hands to be free during a virtual consultation and may help to prevent Repetitive Strain Injury (RSI) and neck issues when using landline phones repeatedly. RSI is often neglected as telephone clinics are usually viewed as passive and non-exertional. Fatigue and posture problems are real and need to be recognised early.

- **IT Support**

  In addition to the clinic list, the Consultant should have the referral letter, with access to relevant radiology and laboratory results for each patient. The clinician should take clinical notes during the consultation ideally electronically. If the NHS IT systems are not capable of clinical note taking, then a paper system needs to be agreed which should be uploaded as soon as possible to the IT patient system. This part of the NHS IT infrastructure is well developed in many Trusts and Boards but needs to improved in some areas as the need for virtual clinics increases.

- **Communication and Structure of the Virtual Consultation**

  The identity of the patient should be confirmed at the beginning of a virtual consultation with the Specialist introducing themselves, ensuring the patient can hear satisfactorily and then clarifying the patient's name and address or date of birth. It should also be stated whether the patient is alone and that any other persons present are there with the patient's consent. Many patients place their phones on "speaker phone" mode, so be prepared for your voice to be heard by everyone in earshot. Conversations can be recorded very easily on mobile phones so ask whether a recording is being made.

The consultation should then proceed along traditional lines with the presenting complaint and relevant history, followed by past medical history and family history. Medications are usually listed on GP referrals, but it is surprising how many patients are not taking all their prescribed medications, a point worth clarifying. Anticoagulants and diabetic medications are particularly important if planning any Endoscopic procedures.

Social histories are crucial in virtual consultations along with the patient's performance status. This is often assessed from "non-verbal communication" when the patient walks into a consulting room for a traditional face to face consultation. This is lost in virtual consultations, but can be assessed by direct questioning. It is also important to be clear if patients are willing and able to undergo further investigations and procedures if required.

Physical examination is very limited in a telephone consultation but can be undertaken to some extent in a video consultation. Some patients are surprisingly keen to show views of their bloated abdomens but sometimes also graphic pictures of their stools which unfortunately do not tend to be informative.

The limitations of any examination in a virtual consultation should be formally recorded. Unfortunately self-examination by patients during a consultation is often of limited value and should not be encouraged.

- **Investigations and Follow Up Arrangements**

A differential diagnosis list should be considered with appropriate investigations arranged. At present, even routine blood tests can be difficult to undertake, due to the on-going COVID-19 crisis, but should still be requested if they are deemed necessary. Radiological investigations are currently limited to mainly plain CT scanning, because of concerns that CO2 insufflation during CT Colonography might spread Coronavirus.Upper GI Endoscopy, Colonoscopy and ERCP are subject to a separate BSG Guidance which is updated regularly.

Towards the end of the consultation the specialist should summarise the history, differential diagnosis and options for investigation. Following the Montgommery ruling, it is important to outline the options for investigation and management, balancing the information with the patient's requests and expectations. The role of the physician is to advise and to respect the patient's right to make up their own mind. The patient's views should be recorded with an option to change their mind after speaking to others.

If there is uncertainty, particularly with virtual consultations, then it is usually wiser to arrange an early follow up consultation to clarify issues rather than leave an unhappy patient facing investigations or treatment that they do not wish to undergo. On-line patient information sheets, moving to on-line consent where appropriate, can help in these circumstances and can complement virtual consultations by giving the patients additional time and resources to weigh up the risks and benefits open to them.

- **COVID-19 Postponement of Investigations**

Patients "self-isolating" or "shielding" during the COVID-19 pandemic require particularly careful assessment. Shielding advice is regularly updated and will change according to the level of COVID-19 circulating in the population. Many "at risk" patients, however, are very wary of attending hospital (or even GP surgeries) for blood tests, because of their fear of contracting COVID-19 infection. Patients may, therefore, sometimes decline to attend for "straight to test" OGD even when this is

indicated and has been prioritised as urgent. Initial reports suggest that 30% of patients decline to attend for C2WW investigations due to COVID- 19 fears. These patients should be reviewed by virtual consultation with an assessment of their symptoms, advice about the proposed investigations and recording of the their wishes.

Three outcomes are sometimes encountered:

- some patients may want their investigations postponed until they are no longer required to self-isolate
- some patients do not wish to undergo invasive investigations at all
- others may not actually require investigations after detailed assessment by a specialist at a virtual consultation

- **Communication**

The consultation should be documented and forwarded to the referrer and unless there are particular sensitivities, to the patient as well. It should include a problem list with relevant dates, a list of medications and a summary of the outcome. The clinical opinion, the recommended management and the patients's own views should be recorded. The mantra of "no decision about me, without me" is often relevant. Ideally, letters should be dictated and investigations ordered at the time of the clinic.

- **Avoid Professional and Personal Isolation**

Virtual clinics can potentially result in professional and personal isolation, so maintaining multi-professional contacts is important. The benefit of team working In gastroenterology and hepatology has been recognised for many years and discussing interesting or difficult cases with colleagues remains as important with virtual clinics as with face to face interactions, particularly for clinicians who have to shield or self isolate themselves at present.