

COVID-19 interim guidance on restarting elective work

1. Introduction

The change in workload and working patterns over the recent weeks, with increased access to home reporting, reduction in referrals and attendance for imaging investigations and treatment, has enabled clearing of reporting backlogs. This provides services an opportunity to deliver services differently and not to return to 'business as usual'. There is a clear desire not to return to long waiting lists for imaging, reporting backlogs and inexorable increases in demand well outstripping capacity in terms of equipment and staffing.

This interim guidance for RCR Fellows and members supports the return to elective and non-COVID-19 related work which has already started in a number of places. It should be read in conjunction with the [NHS clinical guide for the management of radiology patients during the coronavirus pandemic](#). As more information becomes available, it is likely to be updated or potentially withdrawn especially if national guidance is issued. The rate at which services will restart non-urgent and elective work, paused in light of COVID-19, will depend on local conditions. The availability of equipment and the ability to stratify and separate patients will also vary locally. This guidance should be interpreted and applied accordingly.

This guidance covers practical steps for imaging services to:

- identify and prioritise patients appropriately
- plan for and introduce effective, safe services that will provide appropriate distancing, cleaning and other precautionary measures and provide assurance to patients that this is the case.

Identification of COVID-19 positive patients or those suspected to have COVID-19 is complex and patients may be in the pre-symptomatic phase but still infectious. Services should therefore make all sensible preparations to minimise contact in imaging services.

National communications are encouraging patients not to delay if presenting with emergency symptoms or to defer attending urgent hospital appointments¹. These messages can be replicated on hospital websites, outlining the measures that imaging services have made to protect patients.

The majority of imaging services indicate having no reporting backlog and are providing an almost immediate imaging and reporting service. The constraints posed by COVID-19 will reduce throughput and careful thought must be given to all requests for imaging to ensure patients are not disadvantaged because imaging services have reached capacity. Essential imaging for diagnostic purposes or where it will influence management will be prioritised. The experience of the past weeks has demonstrated that not all imaging is indicated and requests may be rejected. Clinico-radiological discussions will support appropriate, timely imaging and patient management.

2. Stratification of patients

If they have not already done so, clinical directors and radiology service managers should begin having conversations with their clinical counterparts in referring teams to understand their recovery plans, particularly the areas of clinical practice they intend to open initially and in phases after that.

¹ <https://www.england.nhs.uk/2020/04/help-us-help-you-nhs-urges-public-to-get-care-when-they-need-it/>

Through multidisciplinary team meetings (MDTMs) services should establish the number of patients whose imaging has been postponed, but is still indicated; and of those, who should be prioritised. This should provide the service with information to understand demand, including the number of patients needing urgent imaging.

Patients should be stratified on degree of urgency and where imaging can facilitate prompt treatment, particularly if the latter has been delayed.

The following categories should be used to prioritise the urgency of patient need:

Priority	Description
P1	High probability of potentially life threatening condition
P2	High probability of condition potentially causing significant long term harm
P3	Possibility of potentially life threatening condition
P4	Possibility of condition potentially causing significant long term harm
P5	Unlikely to be life threatening or cause significant long term harm

People aged over 70 have been asked to be particularly stringent in complying with social distancing measures². They have been asked to discuss with their referring clinician whether it is appropriate for face to face appointments to proceed. For this reason few (if any) are being invited for routine imaging, although this position may change.

For each patient, services should validate with the referrer and/or patient the continued need for imaging deferred because of COVID19, to ensure it is still appropriate. Notwithstanding this, services should review the indication and consider alternative imaging modalities as appropriate.

Use of [iRefer](#) will support appropriate imaging referrals and reduce time needed for vetting.

For follow-up imaging, services should prioritise the first follow-up imaging test after treatment. For follow up of low risk lung nodules, the frequency of follow-up may be reduced, or the time between scans increased, with agreement of the multidisciplinary team (MDT).

3. Pre-appointment steps

Referrers should have contacted the patient and discussed their imaging with them, including the importance of attending. Services can check this with the patient when they contact them to arrange their imaging appointment.

It would be beneficial to patients and good use of resources to consider optimum timing of imaging in relation to the patient pathway.

Patients are understandably concerned about attending hospital appointments in light of COVID-19. Consider introducing a text message to the patient from the imaging department prior to their appointment urging them to attend and reassuring them that measures have been taken to reduce the risk to them and be prepared to explain those measures for those seeking further assurance.

4. Appointments

In addition to the urgency of a delayed imaging investigation in prioritising appointments, services need to consider the COVID-19 status of patients to minimise as far as possible the risk of infection.

² <https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults>

Where it is feasible, services should use a separate scanner and equipment for patients known to be COVID-19 positive. If this is not possible, COVID-19 positive patients should be offered appointments at the end of the list.

Appointments should be timed to allow for:

1. social distancing in waiting areas, minimising the risk of crowding
2. cleaning of equipment between patients, recognising the risk of cross contamination if a COVID-19 positive patient is inadvertently scanned on a 'clean' scanner.
3. cluster imaging and other appointments to minimise time in hospital and the number of visits to hospital.

Patients should be advised to:

1. phone and cancel their appointment if they experience any symptoms of COVID-19.
2. attend alone, or refrain from bringing those accompanying them into the hospital where feasible. Exceptions should be made of children and those attending with a carer.
3. in the case of patients who are shielding, such as cancer patients and those on immunotherapy, to wear a mask on attending their appointment.

Services should follow local infection control measures. In the absence of, or addition to these, to reduce the risk of infection services may wish to put in place the following safeguards:

1. designated parking spaces in close proximity to the department or scanner.
2. patients could wait in their cars and be notified by text message that the department is ready to see them.
3. providing a pre-waiting area for patients arriving by public or hospital transport
4. screening all patients before they enter the department, or at reception to ask about COVID symptoms and check their temperature
5. separate entrance, waiting areas and imaging facilities for suspected COVID-19 cases.

5. Modifying the environment to minimise risks of infection

Services should follow local infection control measures within the department. Fellows and members should pay particular attention to the following key areas of risk.

(a) Waiting areas

Waiting areas should not be overcrowded and have a minimum of two metres between seats. There should be a line on the floor two metres from the reception desk. Reception staff should wear masks (sessional) unless already protected by Perspex screens.

(b) Routes through the department

If there are dedicated scanners for infected patients, consider a route for patients from the waiting area to the scanner that includes a 'contaminated' area, a 'potentially contaminated' area, and a 'clean' area as well as routes for radiographers to travel from clean areas to contaminated areas and back.

The number of staff in the scan room/control room and passage between designated clean and contaminated areas should be minimised as far as possible.

(c) Disinfecting equipment

Equipment and surfaces should be wiped between each patient to minimise the risk of infection.

Deep cleaning, as per local infection control guidance, should be undertaken if an unsuspected COVID-19 case is found to have been imaged on a facility deemed clean.

6. Imaging capacity

There will be reduced imaging capacity because of the requirement to segregate patients and clean scanners and surfaces between patients.

(a) Equipment

Patients with confirmed or suspected COVID-19 should be segregated and imaged/scanned on separate equipment. This may be feasible if a department has facilities for separate entrances, waiting areas and at least two of all equipment with staff available to run them.

Use of mobile or independent sector imaging capacity may be an alternative for those services with single scanners. Requests for additional imaging equipment throughout the UK can be made via england.imagingcovid19@nhs.net

It is important to ensure that servicing and physics needs are addressed and met if working extended days.

(b) Staffing

Staffing rotas may need to be redesigned to account for additional precautions and likely requirement for extended days. In designing rotas, services should ensure that adequate break times for staff are factored in.

As far as is possible, services should minimise staff exposure to COVID-19 by implementing the safeguards identified above. Staff may have been advised by occupational health to self-isolate or avoid patient contact, either for their own protection or are without symptoms in a symptomatic household. Services which have enabled their workforces to work from home should encourage this in these circumstances.

Services should factor in an absentee rate of up to 25% in order to allow for appropriate cover. The rate will vary depending on the extent of infection prevalence within the local population.

As testing of staff becomes more widespread, staff should be encouraged to stay away from work if they become symptomatic and to get themselves tested.

Services should consider waiting list initiatives, home reporting and innovative rotas, for example 12 to 13-hour shifts over fewer days to support capacity and reduce burnout. It is important in any remodelled rota that it ensures adequate compensatory rest and time off, including accrued annual leave which staff may need to recuperate.

The value of team work has never been more important. Services should ensure they have access to a broad skill set to ensure appropriate cover as it may not be feasible to allocate sessional work in the recovery phase. It is equally important that services should consult with their referring teams so they understand the implications of recovery planning and can discuss this with patients.

7. Retaining good practice

The ability to 'hot' report arising from the pause of non urgent and elective work has transformed patient management appropriately and has the potential to reduce unnecessary investigations if it can be sustained.

Patient pathways which have been revised and improved in response to COVID-19 should be retained.

The British Society of Gastrointestinal and Abdominal Radiology (BSGAR) has provided [guidance on CT colonography](#)

The British Society of Thoracic Imaging has provided [guidance on chest imaging in COVID-19](#). [Guidance on limited pre-operative chest CT for patients undergoing elective cancer surgery](#) has been jointly agreed between the surgical colleges and the RCR.

MDTs

The advent of virtual attendance at MDTMs where feasible should be sustained, and services should implement the recently published [Streamlining multi-disciplinary team meetings: guidance for cancer alliances](#) if they have not already done so; only discussing specific cases where there are key decisions to be made or there are uncertainties or questions about reported findings.

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