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A Framework for the Reinstatement of Cancer Services in Wales during COVID-19

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Purpose and Summary of Document:

Cancer services have been severely disrupted as a result of COVID-19 (C-19). Whilst it is very clear that there may well be further C-19 surges, we also need to minimise the harm to patients with cancer as a result of delayed presentation and reduced access to diagnostic tests and treatment.

It is likely that the full reinstatement of services impacted by C-19 will take at least 6-12 months. During this time there will still be risks relating to C-19 infection affecting therapeutic decision making and capacity to deliver care. It is vital that access to urgent and emergency treatment is maintained during this phase, but it is also important that we resume additional 'normal' activity and start to address the rapidly growing backlog of tests and treatments. Such decisions should be clinically led, based on risk stratified patient cohorts, individual patient assessment of risk and according to available capacity.

In reinstating services, there is a need for assurance that cancer services will be delivered as safely as possible, despite the ongoing risks of C-19. This will require designated hospital sites and/or zones separating acute and elective services. There will need to be major service redesign to create the capacity to meet the projected demand, especially as a result of reduced capacity due to reduced utilisation as a result of C-19 cleaning measures. Patients will need to be prepared prior to entering facilities.

Staff will need to reduce risk through careful use of rotas and serious consideration given to regular testing of frontline staff. Guidance on C-19 nosocomial transmission is being progressed by Welsh Government but service guidance will change and services will need to adapt to this and to changing levels of risk of C-19 infection.

1 Introduction

Cancer services have been severely disrupted due to the COVID-19 (C-19) pandemic. The causes and effects of this have been described elsewhere. In addition to these as a response to the risk of infection we have seen

- Patients being reluctant to present to primary care and secondary care tests/treatments, driven by the perceived risks of C-19 infection and/or an unwillingness to burden the NHS
- Reduced efficiency due to C-19 precaution measures and managing patients with C-19
- Some diagnostic tests and treatments being stopped or deferred due to the risks of C-19 infection outweighing their benefits
- Some services such as rehabilitation being stopped because the workforce has been diverted to respond to the C-19 pandemic
- The pausing of cancer screening programmes

This has had impacts across the whole of the cancer pathway, forcing it to move away from gold-standard protocols, and will undoubtedly affect patient outcomes.

It is imperative that the impact is minimised through careful service planning that adapts to the additional risks and complications of the C-19 pandemic, but minimises those risks wherever possible. We must encourage public and patients with serious or persistent symptoms to come forward, be assessed in primary and community services and to attend for investigations and where necessary treatment. To support this message we must ensure services are as safe as they possibly can be, accepting an unavoidable risk due to Covid-19 infection. This requires planned and consistent communication between primary, secondary and tertiary services and to patients regarding measures undertaken to ensure services are as safe as possible.

2 The Framework

2.1 Overview

The following is designed as a Framework from which organisations and services should plan for delivery of cancer services, as a service-specific addition to the COVID-19: NHS Principles Framework for Hospitals published by Welsh Government in June 2020. The Chief Executive of NHS Wales in a letter to Chief Executives has previously made it clear that:

Urgent and emergency cancer tests and treatment should continue recognising that maintaining integrity of cancer services and patient outcomes are important alongside acute C-19 care.

There should be adequate safety netting for patients whose pathways are affected and they are kept well and informed whilst waiting. They should also ensure that as services restart, patients with the highest clinical priority are dealt with first.

Plans should have begun to deal with a robust and prolonged recovery phase (and see below reactivation phase) encouraging the service to think boldly and beyond organisational boundaries (i.e. to consider regional and National service models where appropriate).

It is acknowledged that there may well be further peaks in C-19 demand (possibly even greater than the initial phase) and services may need to flex in response, whilst ensuring the ongoing delivery of services defined as essential.

Organisations must designate hubs, units or centres for essential cancer services so that they are as safe as possible, separating staff and patient flows as far as possible from acute services. These will be necessary to maintain access to urgent and emergency care but also begin to manage efficiently and effectively the rapidly growing backlog of cases. These designated hubs must give consideration to regional and national demand as well as local needs to ensure consistent and equitable access to care.

Organisational and site-specific principles have been developed for SACT (systemic anti-cancer treatment) and RT (radiotherapy) services. These give assurance to staff who are having very challenging conversations with patients and compromising what they would normally consider as 'standards of care'.

Whilst some urgent investigations and treatments have continued, there remains a need for access to cancer diagnostics and cancer surgery to be developed on a more transparent, consistent and equitable basis, with consideration given to regional service support and mutual aid.

The design of services to meet the extraordinary demands of the C-19 pandemic has been led by expert clinical and management groups

throughout Wales. It is vital that such collaborations across organisations, cancer site groups and services continue and respond to the effects the disruption to services will have had on staff wellbeing. It is also vital that we also listen to the views and experiences of the public and patients. Previously patients have had a very good experience of cancer services in Wales and it is vital that this experience is fiercely protected.

2.2 Actions

Organisations should ensure:

Patients

There are clear systems in place for support whilst waiting, including pro-active explanations of what to expect and access to prehabilitation, and have clear systems in place to support those who may have concerns or progressive symptoms.

There is clear advice and guidance for vulnerable patient groups.

There are clear instructions and preparations prior to attending hospital facilities for surgery, day case procedures, Systemic Anti-Cancer Therapy (SACT), radiotherapy etc. Where to attend and what to expect etc.

That instructions include isolation for 14 days prior to first procedure and clear shielding advice with reference to national guidelines following treatments, and for extended treatments (e.g. SACT and RT) during the treatment period.

That local systems are in place for patients to be tested for C-19 infection a maximum of 3 days prior to the procedure according to national guidance.

That patients have all the information required to consent (where necessarily remotely) to investigations and treatment based on risks and benefits, including those related to specific risks associated with current C-19 pandemic, and the ways in which services are being made as safe as possible.

For diagnostic tests and other interventions, that patients are given appropriate instructions corresponding with the relevant procedure.

That patients are provided with psychological and emotional support with regard to individual risk tolerance and anxieties of contracting COVID-19. Shared Decision-Making models should be promoted to ensure that patients' preferences around risk acceptance or risk-rejection are taken into account, and that they are supported to deal with the consequences of decisions.

Clinical Staff:

If delivering acute and elective care - should be separated through both weekly rotas and day-to-day working in the clinical setting as far as possible.

If frontline - should be tested for C-19 infection even if asymptomatic in line with local capacity and National guidance.

Should lead a clear process for recommencing deferred tests and treatments on the basis of clinical need (balancing risks and benefits) and be accountable to a designated clinical senior responsible officer (SRO).

Should have clear guidance how to add patients to the Shielded Patient List.

Should be provided with psychological and emotional support for all staff affected by the current -19 pandemic, including support for moral injury.

Should be supported to continue to develop, use and evaluate novel ways of working, with a view to retaining those that improve efficiency, effectiveness, and patient experience beyond the pandemic.

Health Care Systems should:

Have clear plans and processes for delivering cancer investigations and treatments in an appropriately C-19 protected environment. These should separate staff working in acute and elective services and vulnerable patients attending for elective care from attending acute care services.

Recommence complex surgery and deal with the growing backlog of deferred cases. These plans must consider the needs of the regional and national, as well as the local resident populations.

Work together and with supportive national groups (Network, DU, WHSSC etc) to share capacity and demand modelling for diagnostic and treatment cancer services.

Share activity information by service type and categories of patients stratified by risk and benefit of intervention.

Have robust safety netting processes in place. Lists of patients who have been deferred from immediate treatment must be carefully maintained (and shared with primary care) together with their priority for intervention once their care is scheduled.

Recommence cancer trials and training and development programmes according to available service capacity.

Work with the Cancer Network to ensure a consistent approach regarding access to, and delivery of diagnostics, surgery, SACT and radiotherapy within and across organisations in Wales consistent with nationally agreed best practice (and developing this as a community where this does not exist).

Ensure proposals to amend clinical pathways are undertaken using the National ethical framework.

Develop or redesign and re-establish services to support patients to keep well whilst awaiting treatment (prehabilitation) and recover following treatment (rehabilitation), to ensure safe and effective treatment during C-19 to patients.

Ensure good communications and support between primary, secondary and tertiary diagnostic and treatment services in order to support patients, including the timely sharing of information e.g. end of treatment summaries.

The Wales Cancer Network will work through the NHS Collaborative to:

Discuss the inter dependencies of proposed new treatment pathways and share experience through local multi-disciplinary teams, services (diagnostics, surgery, radiotherapy and SACT), professional groups throughout the cancer pathway (primary, secondary, tertiary, palliative) and Cancer Site Groups must:

Support the implementation of this Framework by:

Share activity and demand modelling.

Develop and share proposals through the clinical reference group, operational management, cancer site/service groups.

Provide a link with National agencies: eg the National Endoscopy Programme, National Imaging Board, National Pathology Network, All Wales Medical Genetics Service etc.

Provide a link with other key stakeholders eg WG, patient and public groups, HEIs and Wales Cancer Research Centre, Industry and 3rd sector, Improvement Cymru, Delivery Unit, Value Based Health Care Team, NWIS.

Share advice from Welsh and UK groups/professional organisations related to cancer and essential general health services.

Ensure plans deliver equitable access to diagnostics, prehabilitation/optimisation, urgent/emergency surgery, SACT and radiotherapy (in line with capacity constraints and with regard to best available evidence of the risks/consequences of COVID-19 infection) and deal with the growing backlog of deferred cases.

Support Service Specific Operational Frameworks for surgery, radiotherapy and SACT and work with the National agencies above to develop the same for Diagnostics services.

Welsh Government has issued a Principles Framework and operational guidance for hospitals to decrease nosocomial transmission during the recovery phase:

1.Careful planning, scheduling & organisation of clinical activity

Planned & Elective and **Urgent & Emergency** care pathways present different opportunities and challenges for minimising hospital transmission of COVID-19 requiring careful planning, scheduling and organisation of clinical activity.

Planned & Elective Care

- Patients should only be required to attend hospital where clinically necessary- maximise all opportunities for remote, multi-professional virtual consultations.
- ***Admission:*** Plans will need to be agreed for self-isolation and testing arrangements pre-admission based on type of procedure / treatment to be received. These should ideally be agreed with consistency across specialty / between Health Boards and Trusts.
- ***Outpatient:*** only patients who are asymptomatic should attend, ensuring they can comply with normal social distancing requirements.
- Enhanced planning and protection for patients who are clinically extremely vulnerable (shielded) from COVID-19.
- Ensure any patient who subsequently tests positive or shows symptoms can be immediately isolated.

Urgent & Emergency Care

- On arrival, ensure patients are immediately identified as either i) asymptomatic; ii) symptomatic for COVID-19; iii) COVID+ and apply appropriate Infection Prevention and Control procedures.
- Ensure within the Emergency Department and Urgent Access Clinics asymptomatic patients can comply with normal social distancing requirements.
- Ensure any patient who subsequently tests positive or shows symptoms can be immediately isolated or managed in a COVID+ cohorted area.
- Enhanced planning and protection for patients who are clinically extremely vulnerable (shielded) from COVID-19, identified from Summary Care Record or by referring clinician pre-arrival where possible.

More detailed service specific plans will be developed nationally to support organisations delivering services in a consistent and equitable manner, these will be shared as and when they become available. During the recovery phase, essential services should be maintained (urgent and emergency care) but also activity should increase to deal with the backlog of deferred patients and the expected rise on referrals. Previous prioritisation categories stratified based on clinical benefit and risk, together with clinically lead individual decisions, should still be used.