Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Governing Body Meeting

Date: Tuesday 6th October 2020
Time: 1:30pm
In light of Government advice regarding social distancing, the Governing Body will meet virtually until further notice. The meeting will be accessible to members of the public. Please see our website for more details.

Agenda Number :	6.2
Title:	**The impact of COVID-19 on services for cancer patients**
Purpose: To note and for discussion	
Key Points for Discussion:	
• The impact of COVID-19 on cancer 2 week wait referrals, cancer performance, cancer diagnostic pathways and screening services • The work which is in place to minimise harm to patients, and the limited information currently available to understand the impact on patient outcomes • Some of the changes which have been made to cancer services, and three ongoing areas of concern – referral recovery, screening backlogs and access to endoscopy • Plans for recovery of cancer services in line with the national aims for cancer recovery.	
Recommendations:	The Governing Body is asked to note the content of this report.
Previously Considered By and feedback :	Cancer service recovery has been covered in previous Covid-19 recovery papers reviewed by the Governing Body
Management of Declared Interest:	None
Risk and Assurance:	Risks and mitigations associated with the recovery of cancer services are detailed in this document (see sections 1 and 3). High level risks associated with recovery are also detailed in the corporate risk register.
Financial / Resource Implications:	Specific financial and resource implications associated with recovery are addressed in other updates to the Governing Body and the Strategic Finance Committee. This includes resources for increasing Endoscopy and MRI/CT capacity, which has a significant impact on Cancer pathways.
Legal, Policy and Regulatory Requirements:	Consideration will be given to any legal implications associated with recovery of services as required on a service by service basis.

How does this reduce Health Inequalities:	COVID-19 presents significant challenges and opportunities in the addressing new and historical health inequalities. These apply for Cancer services as for other services. As further information becomes available to help us better understand the impact of COVID-19 on Cancer pathways and patient outcomes, analysis of the impact on different population segments will enable development of services to minimise differential impact of the pandemic.
How does this impact on Equality & diversity	There is significant diversity within the BNSSG population. The governing body has seen previous papers which describe the direct and in-direct impact of COVID-19 on different population groups, which also applies to cancer care and services. Changes to services and actions taken to respond to the impact of COVID-19 on cancer services are being impact assessed in line with CCG polices and processes previously highlighted to Governing Body.
Patient and Public Involvement:	No direct patient and public involvement as this is a briefing paper. The cancer recovery programme is overseen by the STP Cancer Board, which includes patient participation and involvement.
Communications and Engagement:	The cancer recovery programme includes a regular communications to the general public, patients and clinicians. Local media campaigns are aligned with regional and national communications to encourage patients to attend NHS services with any concerning symptoms.
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Sponsoring Director / Clinical Lead / Lay Member:	Peter Brindle Medical Director (Clinical Effectiveness) BNSSG CCG

Agenda item: 6.2

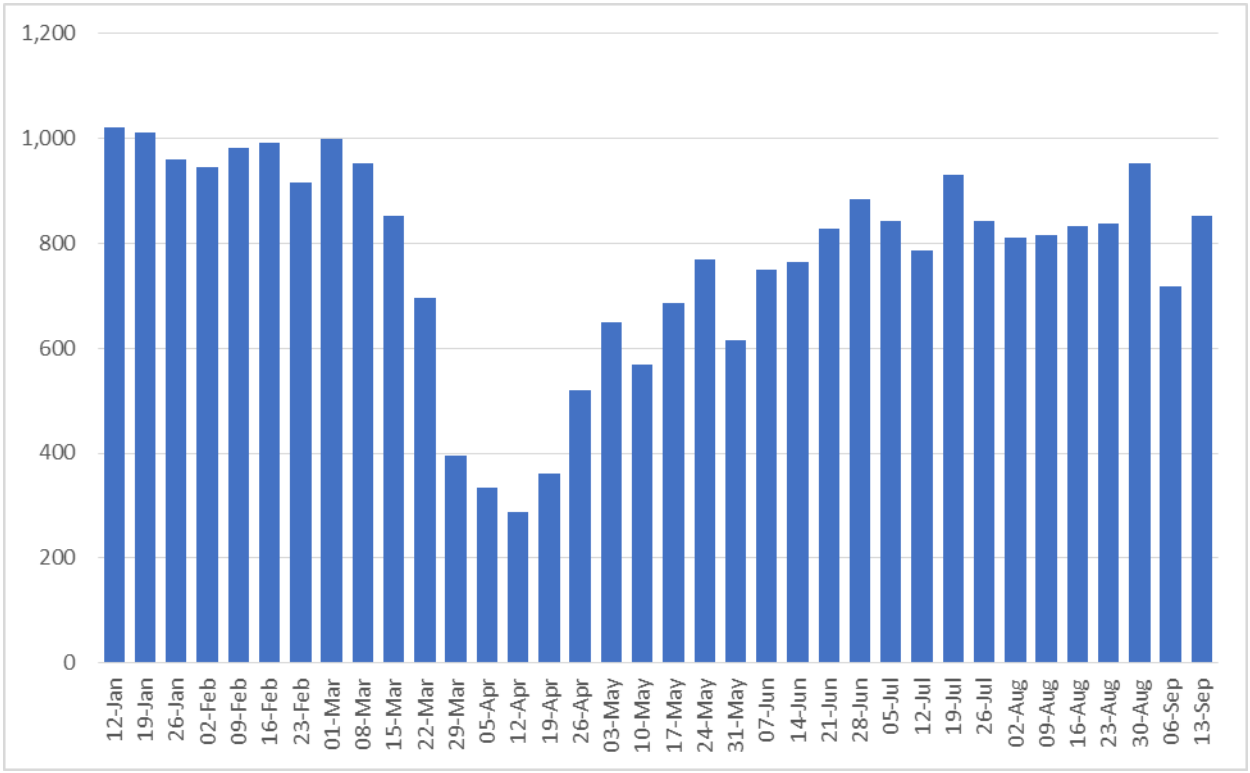
Report title: Impact of COVID-19 on services for cancer patients

1. Impact of COVID on cancer services, performance and outcomes

1.1 Impact on Cancer Referrals

Referrals from GPs for patients on cancer 2 week wait pathways fell dramatically during lockdown, but have slowly recovered to over 80% of pre-COVID activity. It is not known whether activity will return to 100%, or over 100% for some months as a result of patients who were not referred during the lock-down period. The majority of patients (94% of patients) referred on cancer 2 week wait pathways are not diagnosed with cancer after investigations, and some patients find the reasons for which they were referred have resolved by the time that they are seen in secondary care. Therefore it is expected that some patients who experienced symptoms during lockdown will have since recovered and will not require a referral at a later date.

Cancer (2 week wait) referral numbers



As the referral recovery is varied across different cancer sites, some recovery actions and communication strategies will be site specific (for example, communications targeted at specific population groups to increase the numbers of referrals for suspected lung cancer).

Referral activity by cancer site (baseline period uses activity 3 months prior to lockdown)

	Baseline	Week Ending 31/8/20	Week Ending 7/9/20	% change from baseline	week on week % change
Bookings Made	957	718	853	-11%	19%
Breast	214	164	228	7%	39%
Gynae	97	79	76	-22%	-4%
Head&Neck	102	64	99	-3%	55%
Lower GI	72	69	68	-6%	-1%
Lung	32	13	18	-44%	38%
Skin	262	208	239	-9%	15%
Upper GI	48	34	40	-17%	18%
Urological	104	65	65	-38%	0%
All Others	26	22	20	-23%	-9%

1.2 Impact on activity and performance

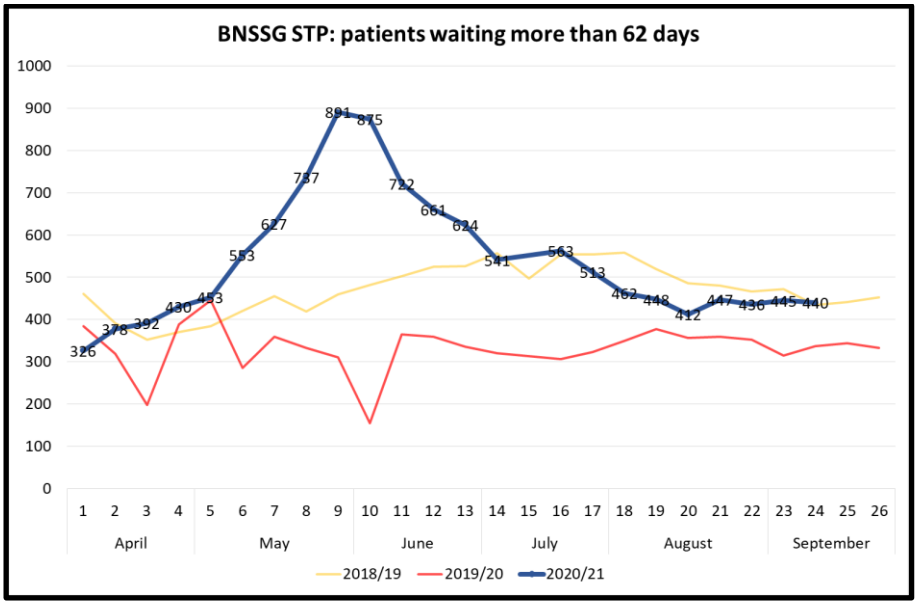
While services remained open to provide timely cancer treatment to any patient on cancer pathways, the size and shape of the waiting list has changed considerably.
The most recent data for constitutional performance targets (July data) shows that cancer standards have exceeded pre-COVID performance for the BNSSG population, and the majority of patients have received timely treatment. Effort has been put into reviewing patients who are waiting, assessing risk and contacting patients to ensure that they attend appointments and treatments in order to minimise any harm caused as a result of service changes during the pandemic.

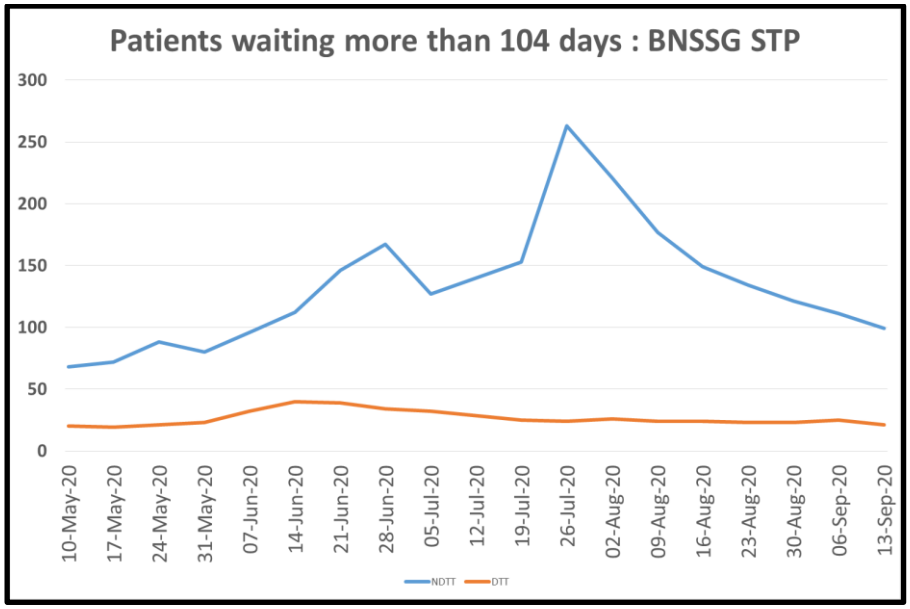
Weekly review of patients demonstrates that currently all patients fit and willing to attend for treatment are being treated within the timescale their consultant has assessed to be clinically safe. Although some patients are waiting longer than prior to the pandemic due to isolation requirements prior to surgery and changes in productivity for many services, it should be noted that the nationally determined waiting times (e.g. 62 day and 31 day cancer waiting time standards) are set to much shorter durations than those required for safety for the majority of patients.

Prior to COVID, the number of patients waiting over 104 days for treatment was low, and the majority who waited this long was primarily due to patient choice to delay investigations or treatment for a wide variety of reasons. During the lock down period the numbers of patient waiting over 104 days increased due to difficulties accessing endoscopy services, and patients choosing to not attend hospital for appointments or treatment due to concerns about the virus. The numbers of patients waiting between 63 and 104 days also increased. The number of patients waiting over 63 days and 104 days has now fallen to near usual levels.

Throughout the lock-down period, and as restrictions have been eased, all patients on cancer pathways have been regularly reviewed and assessed to minimise any harm as a result of longer

waits. The majority of patients waiting longer periods are those who are at low risk of having a cancer. Harm review is undertaken as part of the weekly review of the waiting list, and any patients who are delayed for non-clinical reasons and have not been recently assessed are passed to the clinical team for assessment. This will be done by the consultant managing them or the multi-disciplinary team (MDT), and if there is any uncertainty the lead cancer clinician will give a second opinion.





The clinically safe timescale is based on assessment of the likelihood of harm, and unlikely events can still occur. Clinical judgements are made based on the best evidence available at the time. For this reason, all pathways exceeding the national waiting times are also retrospectively reviewed for any harm caused as a result of the waiting time, in order to identify harm that would not be apparent except with hindsight e.g. identified from the histology of the tumour after

treatment. During the peak of the pandemic, a small number of potential harm cases were identified this way, mostly relating to patients affected by the endoscopy service suspension. Since that time, FIT testing is now available for suspected colorectal cancer patients, which enables more accurate assessment of risk and prioritisation of these patients. This should reduce the risk of harm should the service be suspended or more severely reduced during any second wave of Covid

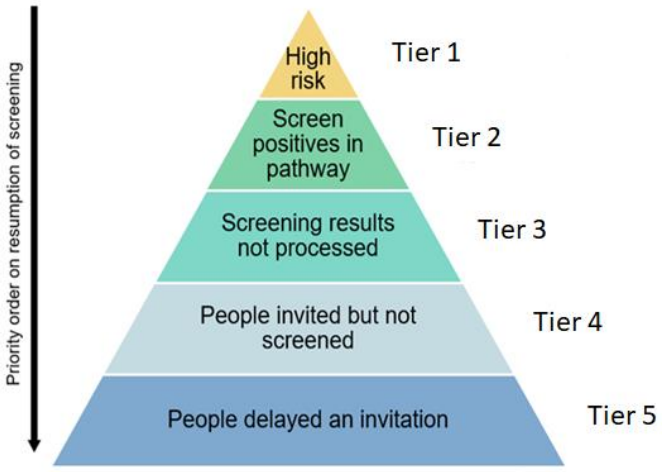
1.3 Impact on Diagnostic activity

Diagnostic capacity was significantly reduced during the lock down period. The diagnostic tests which have the most impact on cancer pathways are X-ray, MRI, CT and Endoscopy. Whilst Radiology services (X-Ray, MRI and CT) were able to prioritise cancer pathways during lockdown, Endoscopy capacity was restricted to Emergency service only due to the risks associated with aerosol generating procedures. A high proportion of endoscopy activity is for patients on cancer pathways, including 2 week wait referrals from GPs, screening and for patients on Gastro-intestinal cancer pathways. As a result, patients requiring an Endoscopy experienced longer waits for investigation and treatment.

In addition, delays for routine, non-cancer specific diagnostic investigations may result in delayed cancer diagnosis for patients in whom a cancer is found coincidentally while being investigated on a routine pathway.

1.4 Impact on Screening

Note that screening services are commissioned by NHS England, not BNSSG CCG.



Breast screening

- Delivery for those in Tiers 1-3 (high risk women, those with positive results and imaging needing interpretation) continued throughout the last 4 months.
- The Avon programme which provides Breast Screening to women living in BNSSG has all but cleared Tier 4 (People invited but not screened) and are working on Tier 5 (those delayed an appointment).
- The Avon programme has re-started delivery in both static and mobile units with full infection control arrangements in place.
- The programme have volunteered to be early implementers of a change to first appointments (open appointment with women phoning and booking compared to sending

fixed appointment date & time). This is to reduce DNA's and aim to book all slots. Extended hours, weekend working and maximising equipment usage are being explored.
- Self referrals of those over 70 and the age extension pilot have been temporarily suspended in line with national guidance
- Whilst providers are looking at ways to increase capacity, currently across the SW services are running at approximately 60% of pre-Covid levels owing to social distancing and PPE requirements. This is leading to an increasing number of women who are due an invitation.
- A number of opportunities are being explored to increase the speed of recovery, including additional equipment, working hours and staffing.

Bowel Screening
- All providers have actively managed patients at Tier 1 & 2 and invited all those with FIT positive results. All centres have restarted colonoscopy services for people with a positive FIT test.
- All providers have cleared the remainder of Tier 3 & 4 (invites have been sent and results processed)
- Routine invites in BNSSG have been sent since (Tier 5) on 10th August.
- As at 14th September, sending out invitations to the population in BNSSG is 18 weeks behind schedule. It is not known how many of these patients will be screened as this is down to individual choice, which was 65% pre-COVID.
- Work is in place across the STP to increase colonoscopy capacity, which will include capacity for screening to address the backlog. This includes ensuring full use is made of the Independent Sector, mobile units and additional capacity within current providers.

Cervical screening
- Invitation and reminder letters for early recall pathway have now returned to normal
- Invitation and reminder letters for normal call/recall pathway will continue to return to normal by the end of September 2020.
- On a national basis GP practices have been asked to offer women appointments and to contact people who couldn't get an appointment during the pandemic. Local communications have reiterated this message.
- All GP practices in BNSSG have restarted cervical screening
- Labs are at 100% pre-Covid capacity, turnaround times for reporting on tests is better than pre-COVID-19.

1.5 Impact on patient outcomes

Information is not yet available to understand the impact of COVID on patient outcomes, either nationally or locally. It is possible that reductions in 2 week wait referrals and the pausing of screening programmes may lead to a later diagnosis of some patients, leading to poorer outcomes. However, this is a hypothesis which has not been proven and is likely to be covered in future publications and a topic of further national research.

A recent Lancet paper modelled projections of lives lost and life-years lost across various cancer sites with periods of delay in presentation and diagnostic delays.
The provision of additional diagnostic capacity and targeting those patient groups most at risk was expected to result in fewer life-years lost compared to groups who experienced longer delays. The paper showed that the cancer sites most affected by delay were modelled to be bladder, liver, brain, ovary and lung. Three of the most common cancers (breast, prostate and

colorectal) were modelled to have less severe impact. These findings have not been analysed at a local level using with BNSSG data.
There was no an attempt in the paper to stratify patients by risk or harm.
Reference: https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(20)30392-2/fulltext

2. Changes implemented during the Pandemic

2.1 Services have been maintained for patients on cancer pathways

Assessment and treatment of cancer patients have remained open, with some slightly increased waiting times in some areas due to the necessary precautions to limit risk of Covid infection. As a result of less urgent and routine activity requiring hospital beds and services, some cancer patients have even benefitted from faster care than in normal times (e.g. for Hepato-billary and pancreatic cancer) . Cancer patients requiring radiology, other diagnostic tests (note above comments re Endoscopy) and treatments have been prioritised for access to these services in a safe and largely timely manner.

2.2 Ongoing review of patients waiting for care

Patients on waiting lists are reviewed to ensure that any higher risk patients are contacted and encouraged to attend appointments if choosing not to. See section 1.1 above for details of the clinical review process undertaken for patients on waiting lists.

2.3 Communications to patients and our population

Regular communications have been issued both locally and nationally using social media, radio, television and newspapers. Messages from local clinicians have focussed on encouraging patients to present to their GP with any concerning symptoms, and that NHS services are open and available as required. Patients who have been referred, and patients who are on cancer diagnostic or treatment pathways are contacted to ensure that they are aware of the importance of attending appointments, and assured that services are COVID-safe.

2.4 Changes to cancer services

A wide range of changes have been made to cancer services to ensure patients on cancer pathways are able to be assessed and treated quickly. These include:

- Cancer outpatient services have made full use non face to face options where this is appropriate, with good feedback from many patients regarding the benefits of this approach.

- New pathways have been designed to reduce the need for some appointments and procedures. For example, patients can now take their own photo of skin lesions using an app, and photos are reviewed by consultant dermatologists, often saving the need for a face to face appointment. GPs have also been issued with Dermatoscopes and training to enable them to safely manage some patients in the community as well as taking dermoscopic images to send to secondary care if onward referral is required.

- GPs and Gastroenterologists have agreed a new pathway (FIT test pathway) to reduce the number of 2 week wait cancer colonoscopy referrals by approximately 60% through use of a test (FIT test) undertaken in primary care which can identify that a cancer is highly unlikely without the need for a Colonoscopy. This is being implemented following a review of evidence to support this change to approach and has been signed off by the STP Clinical Cabinet and the CCG Clinical Commissioning Group.

3. Areas of ongoing concern

3.1 Referral recovery

Whilst it is encouraging that the number of 2 week wait cancer referrals has risen gradually to almost pre-COVID levels, it is concerning that the referral numbers have not yet fully returned to pre-COVID levels. A full recovery could see a higher number of 2 week wait referrals as a result of the large reduction during lock-down, but this 'bulge' in referrals is not been evident yet. It is also possible that many of those who would have been referred may no longer require a referral now, therefore it is not possible to accurately forecast the size or timing of any ‘bulge’ in demand.

Some cancer pathways have had a lower recovery rate than others. For example, lung cancer referrals are considerably lower than pre-COVID. This could be a result of fewer patients presenting to their GP with specific symptoms, or perhaps it may be the result of fewer routine chest x-rays being undertaken where a cancer is sometimes noticed, although suspected cancer was not the primary reason that the test was initially requested.

3.2 Impact of screening backlog

Screening services stopped during the lock down period, and endoscopy and breast screening services are currently not able to operate at full pre-COVID capacity. Depending on the impact of COVID during the winter, it is possible that full recovery and addressing the backlog could take many months. This could impact on the numbers of patients who are diagnosed with later stage cancers. The majority of patients assessed by the screening service do not have a cancer diagnosed, but many of those assessed by colorectal and gynaecology screening services will have non-cancerous ‘pre-malignant’ conditions treated, which could develop into a cancer if left untreated. As such the screening service is an important way of preventing cancer as well as diagnosing existing cancer early, and so the impact could also cause an increase in diagnosis of very early stage cancers which would otherwise have not developed.

3.3 Access to endoscopy

Access to endoscopy has been the greatest concern for cancer pathways. However, considerable work has been undertaken to increase endoscopy capacity, additional national funding has been made available to support endoscopy recovery, and the new FIT test pathway will reduce demand. As endoscopy capacity has increased, priority has been given to patients on cancer pathways who experienced delay between April and June 2020. Patients on cancer pathways or with suspected cancer will be a high priority for Endoscopy capacity, which is planned to be back to over 85% of pre-COVID activity by December 2020.

4. Recovery plans

There are 3 national aims for cancer recovery:

1. Restore urgent cancer referrals at least to pre-pandemic levels
2. Reduce the backlog (number of patients waiting longer than the national standards for diagnosis or treatment) to at least pre-pandemic levels
3. Ensure sufficient capacity to manage increased demand moving forwards including follow up care

Aim 1: Restoring urgent 2WW referrals to at least pre-pandemic levels
Working through Primary Care Networks, identify and implement Quality Improvement activity for earlier cancer diagnosis as highlighted in the primary care Quality and Outcomes Framework (QOF)
Supporting the implementation of the new Early Diagnosis Directly Enhanced Service (DES) in Primary Care
Building patient confidence around services, with a communications plan alongside national/regional public awareness campaign
Implement local approaches to increase referral levels, putting in place specific actions to support any groups of patients who might have unequal access.
Working with NHSE/I public health commissioning teams as they restore screening services, encourage take up of screening appointments and communicate clearly primary care is open
Building on projects underway with CRUK around practice initiatives to increase screening uptake specific populations with low uptake. Improving the LD primary care annual review to improve screening uptake.

Aim 2: Backlog reduction to at least to pre-pandemic levels
Continue to prioritise longer waiters in line with clinical need (including patients on screening as well as symptomatic pathways)
Implement Endoscopy and MRI/CT Adopt & Adapt programmes to increase capacity
Implement innovations to reduce Endoscopy demand, including introduction of new FIT pathway and revised clinical triaging guidance (expectation to reduces 2ww colonoscopy referrals by 60%)
Ensure clinical harm reviews are undertaken
Continue to maintain robust PTL/safety netting within secondary care

Implement the Rapid Diagnostic Service principles across pathways where appropriate – starting with the Vague Symptoms Pathway

Aim 3: Ensuring sufficient capacity is in place
Implementation of Endoscopy, MRI/CT Adopt & Adapt programmes, ensuring appropriate prioritisation of patients on cancer pathways into new capacity. Endoscopy restoration plans is now reducing the backlog.
Implementation of BNSSG Rapid Diagnostic Pathways – initially for vague symptoms pathways but rolling out to all sites (awaiting national funding)
Development of the Alliance regional 'hub' mutual aid model, and use of system PTL to diagnostics/other treatment as appropriate to maximise efficiency of capacity
Ensure full use of Independent Sector capacity for cancer pathways where appropriate- utilising Emerson's Green Treatment Centre for Cancer treatments
Alignment with the workforce recovery plan
Long term delivery of Personalised Care Services as transformation funding tapers off for these services, which enable stratified follow up pathways.

5. Financial resource implications

Specific financial and resource implications associated with recovery are addressed in other updates to the Governing Body and the Strategic Finance Committee. This includes resources for increasing Endoscopy and MRI/CT capacity, which has a significant impact on Cancer pathways.

6. Legal implications

Consideration will be given to any legal implications associated with recovery of services as required on a service by service basis.

7. Risk implications

Risks and mitigations associated with the recovery of cancer services are detailed in this document (see sections 1 and 3). High level risks associated with recovery are also detailed in the corporate risk register.

8. How does this reduce health inequalities

As described in previous papers to the Governing Body, COVID-19 presents significant challenges and opportunities in the addressing new and historical health inequalities. These apply for Cancer services as for other services. As further information becomes available to help us better understand the impact of COVID-19 on Cancer pathways and patient outcomes, analysis of the impact on different population segments will enable development of services to minimise differential impact of the pandemic.

9. How does this impact on Equality and Diversity?

There is significant diversity within the BNSSG population. The governing body has seen previous papers which describe the direct and in-direct impact of COVID-19 on different population groups, which also applies to cancer care and services. Changes to services and actions taken to respond to the impact of COVID-19 on cancer services are being impact assessed in line with CCG polices and processes previously highlighted to Governing Body.

10. Consultation and Communication including Public Involvement

The cancer recovery programme is overseen by the STP Cancer Board, which includes patient participation and involvement. An ongoing communication plan is in place (see section 2.3)

11. Recommendations

The governing body is asked to note the contents of this report