COVID-19

2ww Suspected Cancer Referrals

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Note *The risk stratification criteria (appendix 2-10) are correct at the time of writing this plan but are subject to change. Local clinical teams will have the latest version for reference. Similarly the SOP for deferred cancer pathway recording (appendix 13) is subject to change with the latest version held by the local cancer team.*

Approved 3rd April 2020, Covid-19 Incident Management: Outpatients

Introduction

NHSE&I issued specific guidance on 19th March to Cancer Alliances on 2ww referral management during the Covid-19 incident. The full guidance is shown at appendix 1. This document describes the MSE management of 2ww referrals consistent with the national guidance.

It is important that during the response to the COVID-19 pandemic, appropriate clinical priority is given in the diagnosis and treatment of cancer. Service provision may need to flex as part of infection control and the national guidance advises Trusts to prioritise particularly urgent referrals. Less urgent referrals will be deferred and remain the responsibility of the provider. We need a safety-netting process to ensure these pathways re-commence as services stand-up post-incident.

GPs will continue to make 2ww referrals for suspected cancer and it remains the case that providers cannot unilaterally reject or downgrade a 2ww suspected cancer referral. This can only be done on agreement with the referring GP. This is a time consuming process so given the pressures on clinicians in all areas we will not pursue any discussions with GPs about withdrawing or downgrading individual referrals.

The aims of this process are to minimise face to face contact with patients on the basis of clinical risk through the following core processes:

1. Cease direct booking of new 2ww referrals into clinic slots

2. Clinically risk stratify patients referred on the 2ww pathway using remote (telephone or video) consultation to identify:
    - Level of suspicion of Ca (high / lower)
    - Covid-19 risk status (Shielded or vulnerable, self-isolating, none)
    - Next step for suspected Ca pathway (straight to test, examination)

3. Create a safety-netting system for all deferred patients who remain under the clinical responsibility of the Trust

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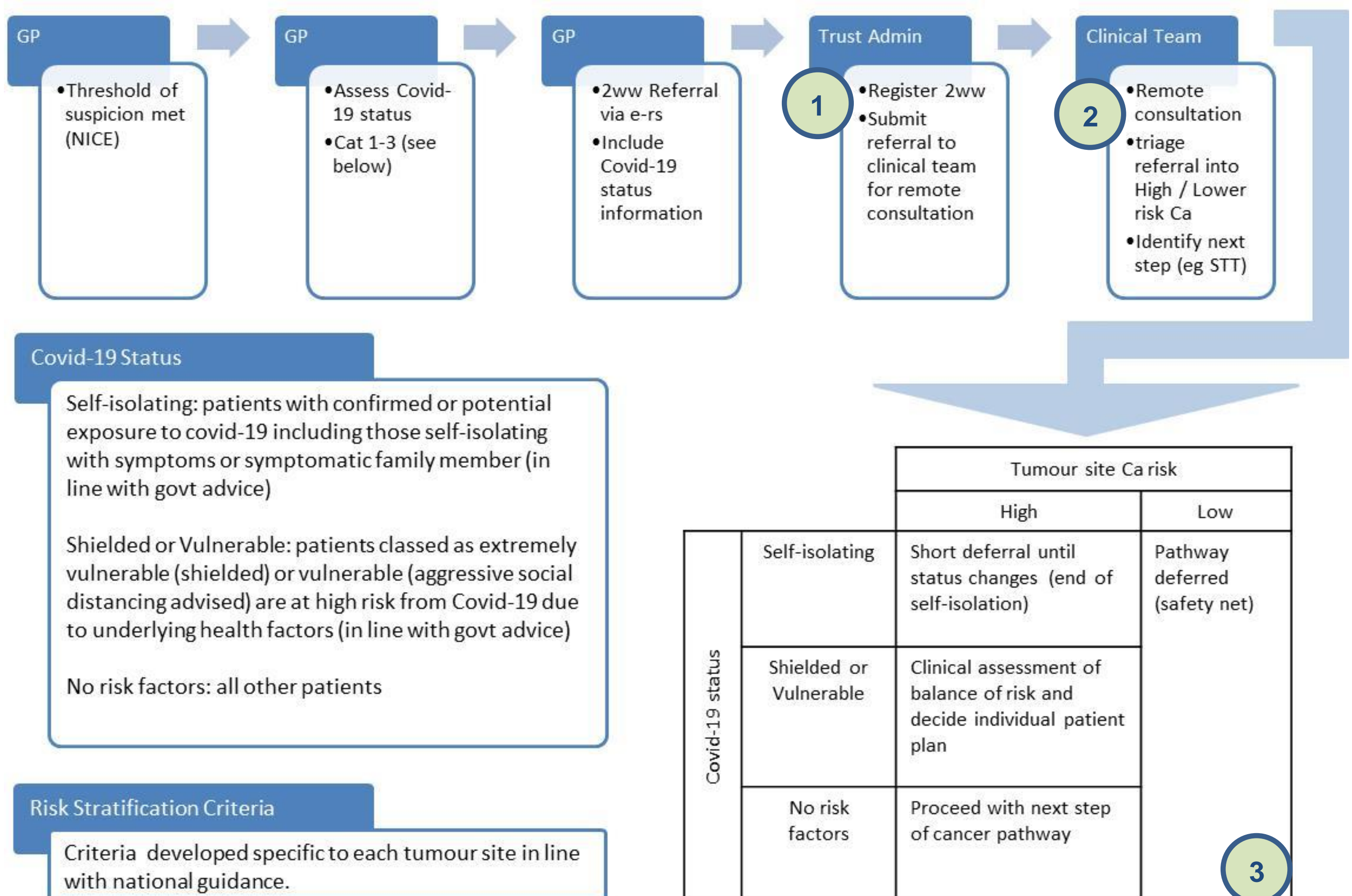
Summary of process

GPs will continue to refer on the suspected cancer 2ww pathway using NICE guidance on threshold of suspicion. Anecdotally, there has been a reduction in overall referral numbers as fewer patients present to primary care. A message has been issued to GPs on 2ww referral management during the incident highlighting the importance of good clinical history and description of presentation to support remote assessment in secondary care. GPs have also been asked to include details of any Covid-19 risk factors (ie shielded or vulnerable, self-isolation). The communication is shown in full at Appendix 11.

On the provider side, the 3 core processes outlined above are detailed in this document:

1. Cease direct booking of new 2ww referrals into clinic slots
2. Clinically risk stratify patients using remote consultation (telephone or video)
3. Create a safety-netting system for all deferred patients



Cease direct booking of 2ww appointments

Direct booking of 2ww appointments results in patients attending clinic without a clinical review of their referral. We need to cease this process in order to apply clinical risk stratification to 2ww referrals and only proceed with attendance where appropriate.

In services that operate a RAS (Referral Assessment Service) on e-rs there is already no direct booking. The RAS allows us to review referrals before making an appointment. This will continue.

	Mid Essex	Basildon	Southend
2ww e-rs services operating a RAS	Lung	Upper GI Lower GI Lung Urology Paeds	Upper GI Lower GI Lung Gynae

In services that do not operate a RAS the polling range will be set to zero days. This will ensure that no slots are published to e-rs. Any referral to these services will be “deferred to provider” on e-rs and become an ASI (appointment slot issue). This makes the referral available to us for review and clinical risk stratification.

All 2ww suspected cancer referrals will continue to be registered on SCR (Somerset Cancer Registry) as per the current process. Referrals will need to be printed from e-rs and then scanned on to local hospital systems to be made available to the clinical speciality for review.

2ww appointments staff will book 1st outpatient appointments in the usual way, making clear to patients that these are remote consultations (telephone or video) and that patients must not attend the hospital for these appointments. NHSE&I guidance is that remote consultations will count as a first appointment for CWT purposes during covid-19 incident.

It is assumed initially that all remote consultations will be via telephone though as the rapid roll out of the attend anywhere system progresses, many teams will choose to use that for video consultations. This does not change the booking process.

Booking activities will be undertaken by the usual booking teams on each site:

- Mid Essex – RBMS (except for breast which are booked in department)
- Basildon – 2ww booking team
- Southend – 2ww booking undertaken by clerks working in specialty teams (Southend are seeking to enhance cross cover and support amongst these individuals)

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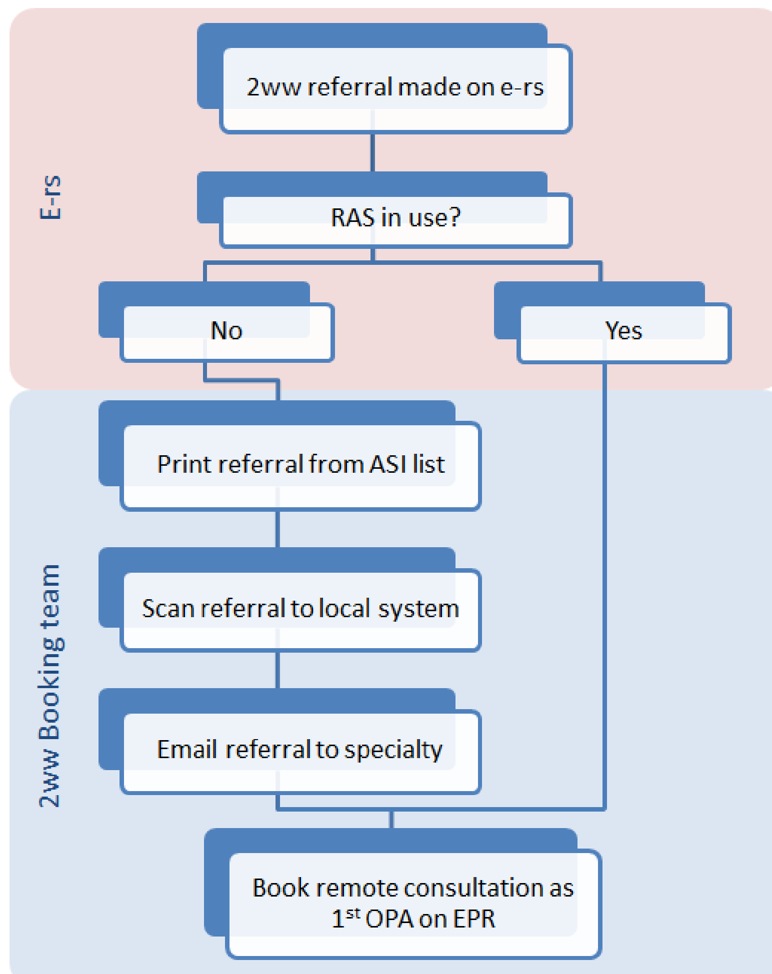
Admin process for 2ww booking:



Local system for storing referral letters:

- Mid Essex – Lorenzo
- Southend – CED
- Basildon – EMR

Clinical risk stratification via remote consultation

It is assumed initially that all remote consultations will be via telephone though as the rapid roll out of the attend anywhere system progresses, many teams will choose to use that for video consultations. This does not change the risk stratification process but for some teams this will allow a better consultation and thus better risk stratification in line with the criteria.

All patients referred on a 2ww suspected cancer pathway shall have a remote consultation in order to:

- Identify the next step on the suspected Ca pathway (straight to test, examination)
- Assess the patient's level of suspicion of Ca (High / lower)
- Assess the patient's Covid-19 risk status (Shielded or vulnerable, self-isolating, none)

It is important to capture the next step on the clinical pathway during the initial remote consultation so that pathways can be progressed following deferrals without undue additional delay and without the need for further clinical review.

Clinical risk stratification criteria have been developed within each tumour site using national guidance to categorise 2ww suspected cancer referrals into high and low suspicion based upon presentation. These have been approved by tumour site leads (chairs of network tumour group or SMDT) or clinical management leads (clinical leads or clinical directors). These criteria are subject to change and the versions current at the time of writing are appended to this document (appendices 2-10).

Based on the current government position we have identified 3 categories of Covid-19 status relevant to this assessment process:

- Shielded or vulnerable – patients classed as extremely vulnerable (shielded) or vulnerable (aggressive social distancing advised) are at high risk from Covid-19 due to underlying health factors
- Self-isolating – these are patients with confirmed or potential exposure to covid-19 including those self-isolating with symptoms or a symptomatic family member
- No risk factors – would apply to all other patients

The level of suspicion of Ca and Covid-19 status are used to decide whether or not the patient should proceed with the clinical pathway on the balance of risks. This can be summarised as follows:

- High suspicion / Shielded or vulnerable – assess balance of risk on individual patient basis and either defer or continue pathway
- High suspicion / Self-isolating – defer pathway until end of self-isolation
- High suspicion / no covid-19 risk factors – continue pathway
- Low suspicion (all) – defer pathway

<table>
<tr><td></td><td></td><td colspan="2">Suspicion of Cancer</td></tr>
<tr><td></td><td></td><td>High</td><td>Low</td></tr>
<tr><td rowspan="3">Covid-19 status</td><td>Shielded or vulnerable</td><td>Clinical assessment of balance of risk for individual patient resulting in either:

Defer pathway until govt advice changes <u>or</u> Proceed with pathway

Covid-19 in these vulnerable or extremely vulnerable groups has a high mortality, likely much higher than cancer. It is anticipated that most patients in this category will have their pathways deferred though for some patients the balance of risk will favour investigation / treatment. Where pathways are deferred this will be until the government advice changes.</td><td rowspan="3">Pathway deferred

All patients with a low suspicion of cancer will have their pathways deferred indefinitely. This will be kept under constant review in line with government advice and clinical capacity across all cancer services. It is important that GPs are notified of any deferred pathways and that patients are kept informed and are able to report any change in symptoms that may reflect an increasing suspicion of cancer.</td></tr>
<tr><td>Self-isolating</td><td>Short deferral of pathway until end of self-isolation

Pathways for patients in this category will be deferred until the self-isolation period has ended in order to protect healthcare staff and other patients from potential infection.</td></tr>
<tr><td>No risk factors</td><td>Proceed with clinical pathway

Clinical pathways for these patients should progress as per the tumour site specific pathway. In all services every effort should be made to reduce face to face contact as far as possible (such changes are detailed in local specialty plans for covid-19).</td></tr>
</table>

There is a further sub-category of patients who may have their pathway deferred due to the required diagnostic investigation being unavailable due to the covid-19 incident (for example, at the time of writing only emergency endoscopy is being undertaken with all non-emergency endoscopy cancelled due to risks from aerosol-generating procedures).

Following the remote consultation a letter should be sent to the GP in the usual way describing findings and next steps. For deferred pathways this should include advice to the GP to support management of the patient during the period of deferral. Clinicians undertaking risk-stratification should consider recording a clinical frailty score (CFS, such as Rockwood) and documenting co-morbidities in the GP letter. This is particularly relevant to shielded or vulnerable patients at high risk of mortality from Covid-19 infection.

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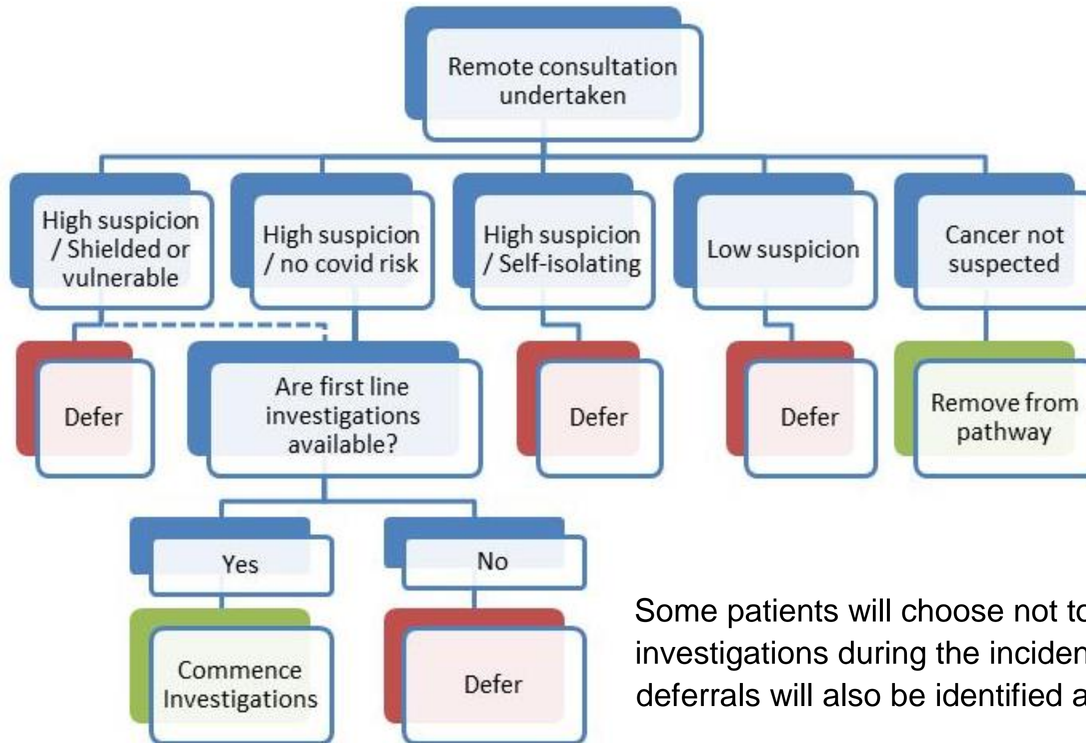
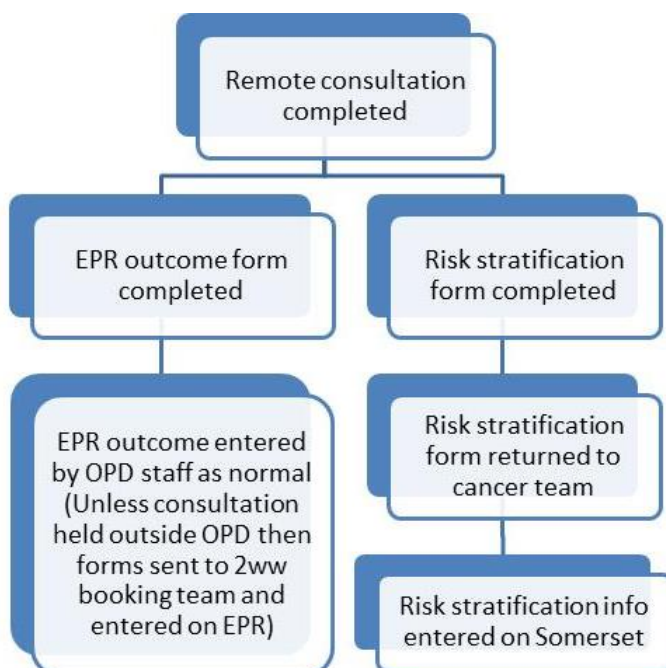
Generic clinical risk stratification process:



Some patients will choose not to attend for investigations during the incident. Patient choice deferrals will also be identified and recorded.

Admin process for remote consultation outcomes:



The risk stratification form is shown at appendix 12.

Safety netting for deferred pathways

It is essential that patients whose pathways are deferred are placed into a robust safety-netting process. All of these pathways will remain open on the Somerset Cancer Registry (SCR) to ensure that they remain on the cancer PTL for overall monitoring purposes. In addition to this underlying safety net we will capture more granular detail to ensure that pathways can proceed at the earliest opportunity as services stand up during incident recovery.

We have identified 5 distinct categories of deferred suspected cancer pathways. During the incident some patient's categorisation will change for example at the end of self-isolation or as government advice changes. Each category will have a different review period as follows:

Deferred pathway category	Review process
Low suspicion of Ca	Reviewed as urgent and routine services resume during incident recovery. Timetable will be set by incident control and likely to vary between specialties / tumour sites.
High suspicion / Shielded or vulnerable	Review in line with government advice on vulnerable and extremely vulnerable groups. The current 12 week shielding period is due to end on 21st June.
High suspicion / Self-isolating	Patients asked to notify cancer team when their self-isolation period ends. (in line with latest government advice) at which time the pathway can commence (unless investigations are unavailable or the patient chooses to defer). Cancer team will contact patients fortnightly to check this.
High suspicion / Investigations not available	Reviewed as and when there are changes in the relevant diagnostic service provision.
Patient choice	Contact patient monthly to review status.

Note – there is a descending hierarchy in the categories described above as patients could fit within more than one group. Patients will be categorised by the first group within which they fit. For example, a patient who does not wish to attend and has a low suspicion of ca will be categorised as low suspicion of ca only. A patient who is shielded or vulnerable and requires an investigation not currently available will be recorded as shielded or vulnerable only.

The cancer team will be responsible for updating information on deferred pathways and the monitoring of these.

When updating SCR with the risk stratification form from the remote consultation, any patient with a deferred pathway will be sent a letter explaining the deferral and giving contact details of the 2ww booking team. The letter will ask patients to contact the 2ww booking team if their symptoms or circumstances change.

If a patient reports a change in symptoms, their changed presentation will need to be reviewed by the clinical team. A remote consultation will be booked by the 2ww booking team and the clinical team notified that this is for a change in symptoms of a deferred patient. The consultation and outcomes will follow the process described in section 2 of this document for a new referral. The only difference being that on EPR this will be recorded as a follow up attendance.

The cancer team will be notified by the Incident Management room at each hospital of any changes in service provision so they can assess the impact on deferred pathways (For example, a change in the availability of diagnostic services).

A standard operating procedure (SOP) has been developed to record deferrals on SCR (this is shown at appendix 13 and is subject to change). We are exploring more sophisticated methods of recording an monitoring deferrals. Any changes in approach will be reflected in a revision to the deferred cancer pathway recording SOP.

For each deferred pathway we will record:

- Patient details
- Tumour site
- Date of 1st OPA (remote consultation)
- Date(s) of any follow up reviews (e.g change in symptoms)
- Level of suspicion of Ca at remote consultation
- Covid-19 risk factors
- The next step required on the pathway
- Patient availability to attend

Regular reporting shall be provided through the incident management structure including:

- Total number of deferred suspected cancer pathways
- Number of pathways in each category
- Number of pathways in each tumour site

We will need the ability to identify on an individual patient basis the reason for and duration of any cancer pathway deferral(s).

Review

This document shall be kept under review through the Covid-19 Incident Management: Outpatients group. The group will consider the impact on this plan from any changes in national guidance (from government, learned bodies, NHS bodies, etc), local service delivery or other elements of the overall incident response.

Recovery

We anticipate that there will be several hundred, possibly thousands of suspected cancer pathways deferred during the incident. It is likely that within the 5 categories of deferred pathways across the various tumour sites, services will stand up at different rates during the recovery period. So resumption of pathways will need to be carefully planned as part of the recovery process.

We aim to have sufficiently granular information on deferred patients to allow us to proceed straight to next steps investigations when possible. However if pathways are deferred for long periods we will need to consider whether a further clinical review is required. A separate recovery plan will be required for the pathways deferred for longer periods (such as low suspicion of ca and shielded or vulnerable patients). The Covid-19 Incident Management: Outpatients group will monitor the situation and assess when to commence detailed planning for recovery of these elements.

NHSE&I guidance issued to Cancer Alliances 19th March 2020

It is important that during the response to the COVID-19 pandemic, appropriate clinical priority is given in the diagnosis and treatment of cancer, and we understand that service provision may need to flex as part of infection control. The guidance below should be interpreted as modifying existing Cancer Waiting Times guidance with immediate effect (19 March 2020) until further notice:

- On receipt of a 2ww referral, providers should ensure that as far as possible telephone triage is available to stream patients directly to a test where appropriate and minimise interactions and appointments with health services.

- A telephone appointment with an appropriate specialist clinician as detailed in Cancer Waiting Times guidance will be accepted as 'first appointment' for the purposes of recording Cancer Waiting Times data until further notice.

- The policy remains that providers receiving referrals may not downgrade urgent cancer referrals without the consent of the referring primary care professional. Where capacity is particularly constrained providers should ensure processes are in place to prioritise particularly urgent referrals, including greater communication between primary and secondary care to downgrade or avoid referrals where possible.

- Where referrals are downgraded or avoided outside the usual policies and NICE guidance, providers should seek to ensure appropriate safety-netting so that if patients deteriorate or their risk of a cancer diagnosis increases, they can be appropriately referred for further investigation.

All providers receiving cancer referrals should continue to stay alert to any further changes in this advice following updates from Government and NHS England and NHS Improvement.

High suspicion of Ca:

Offer 2WW appointment for patients age > 25yrs with:

- a breast or axillary lump
- blood-stained nipple discharge
- skin changes suspicious for cancer (tethering, contour change, peau d'orange)
- symptoms on a background of very strong family history (2 or more first degree relatives affected i.e. intermediate or high lifetime risk) or a previous history of breast cancer treatment.

Lower suspicion of Ca:

Defer 3 months:

- all other symptoms not listed above in >35yrs
- age <25yrs any symptom
- age 25-35yrs with breast pain only
- Male, age <50yrs

Ms G Clayton
Consultant Breast Surgeon, Mid Essex
Essex Breast Cancer Network Group Chair

High suspicion of Ca:

Visible haematuria: Refer as per NICE guidelines. Whilst we can we will run OSHCs for these patients. If access to an US in community possible prior to referral, this will help our triage.

Prostate: PSA 15- 20… MRI (whilst available, when not will try to use US for volume estimation). Biopsy PIRADS 4 and 5 on MRI. On US biopsy PSA density > 0.15. *whilst biopsy is available.* Otherwise repeat PSA 6 months.
PSA >20- bone scan
results all reviewed remotely and patients telephoned or written to.
GPs may be asked to start hormone treatment.

Testes: Please could GPs arrange US and refer if suspicious after this. If not then we will arrange straight to test dependent on resources and then arrange face to face or write/telephone depending on results.

Lower suspicion of Ca:

Non-visible haematuria: We would ask that GPs arrange a community US and refer if significant finding (Ie cancer, obstructed kidney). If not, then check urine after Covid- 3- 6 months and refer then if persistent. If we receive these referrals we will attempt an US and then telephone/ write with results and ask GPs to refer as above after delayed retesting.

Prostate: single PSA < 15:- please could GP repeat with creatinine. If not we will before further advice.

Renal: Incidental findings of small renal masses or complex cysts will be managed with surveillance in the first instance.

Please note it is inappropriate to screen for localised prostate cancer during the COVID situation. Patients undergoing health facility visits are at risk of CV which has higher morbidity and mortality in the short term than screen-detected prostate cancer.

Mr P Acher
Consultant Urological Surgeon, Southend
Essex Urology Cancer Network Group Chair

High suspicion of Ca:

- PR Bleeding
- Change in bowel habit – loosening
- Older patients
- New onset iron deficiency anaemia

Lower suspicion of Ca:

- Constipation
- Non-specific abdominal pain

Will seek to introduce rule-out FIT testing for patients presenting without PR bleeding (this would need to be a postal service).
Telephone assessment will possibly be nurse led in line with the STT pathway

Mr J Sturt
Consultant Colorectal Surgeon, Southend
Essex Colorectal Cancer Network Group Chair

Appendix 5 – Risk Stratification Criteria – Upper GI

Endoscopy is the prime diagnostic and occasionally therapeutic instrument in the investigation of 2ww referrals for suspected GI cancer. This is supplemented by radiology but primarily for looking for non-luminal (gastrointestinal tract) cancers or staging of a proven cancer.

The British Society of Gastroenterology (BSG) statements on 23rd, 25th, 26th March have advised against all diagnostic endoscopy even for 2WW patients. No restart date has been given.

The triage process below describes the planned approach during the current period of no availability of endoscopy for suspected cancer patients. The clinical team have identified planned changes to this triage process as endoscopy services become available later in the incident.

This triage leads to 3 condition-specific protocols (Dysphagia, FIT, PR bleed) and the other areas to bespoke management based on telephone consult.

Indication	Triage	Investigations
Gastroscopy		
Dysphagia	Telephone consult	Dysphagia protocol
Worsening reflux	Refer back to GP	
Worsening dyspepsia No ALARM, <55	Refer back to GP	
Worsening dyspepsia No ALARM, >55	Telephone consult	
Worsening dyspepsia + ALARM		CT CAP, bloods
Epigastric mass		CT abdomen
Significant vomiting	Telephone consult	Ba meal
Nausea, no vomiting, NO ALARM	Telephone consult	
Non Fe++ Def anaemia	Refer back to GP	
Persistent (>6 months) Fe++ def, NO ALARM	Coeliac, FIT	FIT +ve protocol
New Fe++Def anaemia	Coeliac, FIT	FIT +ve protocol
Assessment for coeliac / EE	Empirical Rx trial	
Outpatient haemetemesis	Telephone consult	
Weight loss, no GI symptoms		CT CAP, bloods
Colonoscopy		
If clear colonoscopy in last 3 years	Refer back to GP	CRC <1:1000
Non PR bleeding	FBC, ferritin, FIT	FIT protocol
PR bleed	Surgical telephone consult	PR bleed protocol
Assessment IBD activity	Faecal calprotectin	
EMR resections	Clinical review	Early recall

Dr J Subhani
Consultant Gastroenterologist, Basildon
Clinical Lead for Rapid Diagnostic Centre – GI Project

Appendix 6 – Risk Stratification Criteria - Lung

High suspicion of Ca:

CTs showing lung cancer that is radically treatable need urgent investigation and treatment as close to normal as possible.

Non radical treatment patients should be investigated as quickly as reasonable but are lower priority, they're not going to get treatment in the short term.

Lower suspicion of Ca:

Nodules

Dr M Lawson
Consultant Respiratory Medicine, Mid Essex
Essex Lung Cancer Network Group Chair

High suspicion of Ca:

The following would make a lesion high risk:

- **Sudden** growth/change in an existing lesion
- New lesion growing/changing **rapidly**
- **Ulceration** - within a longstanding lesion
- New rapidly worsening ulcer
- **Pain**
- **Change within a previous SCC or MM scar**

Background:

- **high risk areas** so HFN (ears, eyes, perioral), acral, genital/perianal
- Skin type, photodamage
- Previous history of MM/SCC
- Immunosuppression

Lower suspicion of Ca:

All other referrals will be low priority and deferred.

Dr V Damani
Consultant Dermatologist, Basildon
Skin Cancer lead

Appendix 8 – Risk Stratification Criteria - Gynae

PMB

- Virtual appointments for all patients with TVS results available.
- If has normal cervical smear history, and ET <4mm – managed by patient initiated follow up over 3-6 months. (Keep record of these cases to see if there were any missed cancers)
- If continuing bleed, see for hysteroscopy
- Triage patients with ET >/= 4 mm by Hysteroscopist. Most experienced hysteroscopists to be deployed to the clinic for patients triaged to need Outpatient Hysteroscopy.
- If hysteroscopic impression suggest that possibility of early cancer or hyperplasia, **insert Mirena coil as first treatment as subsequent surgery may be delayed depending on situation**

OVARIAN CYSTS

- If ovarian cyst and RMI < 200, no need for clinic review UNLESS IMAGING (Ultrasound/MRI/CT) SUGGESTS ONCOLOGICAL PROBLEM – Virtual appointment
- If ovarian cyst and RMI > 200 but premenopausal, MDT discussion to see if malignant – if benign eg. Endometriosis – surgery can be deferred
- If ovarian cyst and RMI >200 and on MDT suggests malignancy, will need surgery for diagnosis and therapeutic management – follow 2 week wait deadlines or 31 day although this can be adjusted on individual basis.
- Clinical advanced ovarian cancer – need biopsy and start chemotherapy. These patients will normally have surgery after 3 months from starting chemotherapy and if not possible, possibly 5-6 months from starting chemotherapy. **Decision made on case by case basis**
    - **NB. Some of these ladies will need referral to RLH for surgery (identified at start of cancer diagnosis)**
- Any patient expected to need HDU and/or ITU may not be offered surgery depending on ITU situation and is likely to be offered not surgical management.
- Some patients may be very symptomatic with a large ovarian cyst (whether benign or malignant). If that was the case, then escalation protocol according to BGCS guidelines as suggested.

VULVAL & VAGINAL LUMPS

- Referral can only be made by Consultant to Gynaeoncology service – lesion has to be visualised by a Consultant who agrees that malignancy is likely.
- If malignancy risk is high, please biopsy at initial visit to avoid repeat invasive procedures on patient and to reduce risk to staff performing invasive procedures.
- If unsure about malignancy, proceed to biopsy in clinic and refer depending on histology results.

Mr K Razvi
Consultant Gynae-Onc Surgeon, Southend
SMDT Chair

Appendix 9 – Risk Stratification Criteria – Head & Neck

High suspicion of Ca:

Offer 2ww for patients over 35 with (unless symptoms very suggestive of lymphoma B type symptoms and multiple nodes greater than 3 cm)

- Neck node greater than 3cm
- Unilateral tonsillar enlargement
- Persistent hoarseness for greater than 6 weeks
- Severe sore throat which is localised and associated with odynophagia or true dysphagia
- A suspicious tongue ulcer greater than 1cm which has been present for more than 4 weeks
- Rapidly growing thyroid lumps or thyroid lumps associated with significant hoarseness or airway compromise.

Lower suspicion of Ca:

- Sensation of a lump/ globus
- Intermittent hoarseness/ cough
- Thyroid lumps unless documented rapidly growing or associated hoarseness or airway issues
- all other symptoms not listed above

Reduce the number of 2ww appointments to allow 30 mins between appointments to allow adequate decontamination between patients.
ALL patients requiring endoscopic and oral cavity examination the clinician must have gloves, eye protection and FFP3 protection

Mr J Philpott
Consultant Head & Neck Surgeon, Southend
Essex Head & Neck Cancer Network Group Chair

High suspicion of ca:

Possible Myeloma as suggested by Paraprotein or abnormal serum free light chain ratio of greater than 100 and end organ damage as defined below:

- Anaemia (Haemoglobin < 100g/L, all other causes excluded i.e. iron deficiency, anaemia of chronic disease etc)
- New and worsening renal function (Serum creatinine >177)
- New hypercalcaemia (Calcium >2.75)
- Destructive bone lesions on Skeletal survey or X-ray (Clearly defined lytic lesions only)

Lymphadenopathy >2cm or increasing in size and persistent for >6 weeks and NOT in neck, axilla and groin (see below).
All neck, axillary and groin lymph nodes should be sent for Ultrasound for exclusion of other causes, document measurement and to define architecture, whether benign or malignant.
Groin lymph nodes of > 2cm documented on Ultrasound can be referred directly.
A biopsy should be obtained for all suspicious lymph nodes by direct referral to ENT or Head & Neck (for neck nodes) and Breast team (for axillary nodes).
An ultrasound report should be attached with the referral request.

FBC with film report suggesting **Acute leukaemia** or **Chronic myeloid leukaemia** (Please attach FBC report).

Lower suspicion of Ca:

In the setting of an abnormal FBC and a constellation of 3 or more of the following please discuss case with Haematology via Advice & Guidance request or the Haematologist on call. Please exclude all other causes for symptoms including viral/bacterial suspected infections before seeking advice. GP to perform urgent CT NCAP (neck/chest/chest/abdo/Pelvis) if perceived as high suspicion of cancer. All symptoms in the last 6 months

- Fever (Persistent or recurrent fever >38C for at least 2 weeks)
- Night sweats (Continuing drenching night sweats only where patient has to change clothes and bed sheets at night)
- Weight loss (Recent >10% weight loss and deteriorating not stabilised)
- Intense pruritis (All allergic and reactive causes excluded)

Exclusions: All other conditions are excluded from 2 week wait including suspected **CLL** and **MPN** unless the consultant suggests urgent 2 WW referral in the blood film comment.

Dr W Nagi
Consultant Haematologist, Mid Essex
MSE Haematology Clinical Lead

26 March 2020 Mid and South Essex CCG COVID-19 GP e-briefing

ISSUE: 7

2WW SUSPECTED CANCER REFERRALS DURING COVID-19 INCIDENT MESSAGE FROM LOCAL GP MACMILLAN LEADS

NHSEI has been clear that primary care activity related to cancer should continue as normally as possible, including continuing to refer patients with suspected cancer via ERS.

In light of COVID-19, the first appointment with Trusts is likely to be by telephone triage. Therefore providing a full clinical history and completion of all pre-referral tests will be essential.

The referral will need to include information about the patients Covid-19 status such e.g. is self-isolating or in an identified high risk group. There's never been a more important time to include every bit of information particularly the performance status – GPs should also consider including a clinical frailty score (such as Rockwood or Electronic Frailty Index).

Hospital teams will risk stratify referrals. Patients will be sent straight to test whenever possible. If suspicion of cancer is low, investigations will be deferred to ensure maximum clinical resource to the Covid-19. Note: any patients deferred in this way remain under the clinical care of the Hospital who have been tasked with ensuring safety-netting procedures are in place for these groups.

Cancer patients currently receiving treatment may also find their treatment protocols are changed and newly diagnosed may face delays in the initiation of treatment. Oncologists are being asked to consider whether benefits of treatments are outweighed by the current risks of immunosuppression.

To reduce avoidable visits to secondary care it is crucial that such patients are able to utilise local arrangements for off acute site phlebotomy services for monitoring. Again, as we are doing in primary care, face to face consultation will be avoided wherever feasible and remote modalities used.

The above policies follow national guidance and will remain under regular review. Primary and secondary care need to work together to ensure cancer outcomes remain the best they can in the current situation.

Appendix 12 – Risk stratification form

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Risk-Stratification Form

Use for first appointment on 2ww suspected cancer pathway during Covid-19 incident (and for subsequent review where presentation has changed)

Patient Details or affix label	
Hospital Number:	
Patient Surname:	
Patient Forename:	
NHS Number:	

Clinic details			
Clinic date:		Tumour site:	

Risk-Stratification

Suspicion of Cancer:
- High ☐
- Low ☐
- None (off pathway) ☐

Covid-19 risk factors:
- Shielded or vulnerable ☐
- Self-isolating ☐
- None ☐

Select one tick box for risk stratification outcome ☐

Care plan	
Next step on pathway (when ready to proceed):	

Patient availability	
Tick here if the patient intends not to attend for any investigations or appointments at the current time due to the covid-19 incident	☐

Return this form to the Cancer Team

Recording COVID-19 delays on Somerset

Patients may experience COVID-19 related delays for one of many reasons, including:

- clinicians deeming patient's to be low risk and so decide to defer a patient's cancer treatment for a number of months with no detriment to their health;
- health care related delays whereby a patient may have to wait longer for an endoscopy or radiology scan;
- short term delays due to patient's self-isolating due to experience symptoms;
- shielded patients who are high risk for COVID-19 and so require long-term isolation;
- patient choice to not attend hospital during COVID-19.

These delays should be recorded on Somerset appropriately, and patients should not be removed from the 2ww pathway just because of any of the above delays.

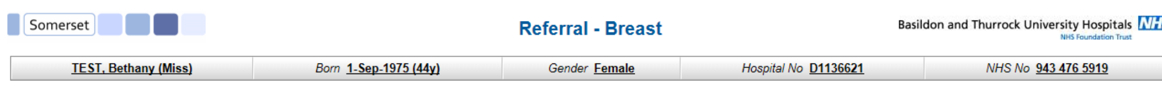
A patient can continue to be removed from a 2ww pathway where:

- an alternative treatment is given first, e.g. hormones in place of surgery;
- clinicians decide to actively monitor a patient and reassess their need for surgery later on, e.g. by sending for an interval scan in 3 months;
- a patient chooses to be discharged or refuses all diagnostics/treatment back to their GP and will be re-referred in if still symptomatic when COVID-19 is settled.

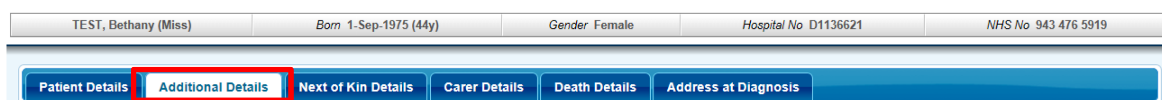
Recording on Somerset

Any patient pathway that is affected by some kind of COVID-19 delay should have an alert registered. To add an alert, follow the below steps:

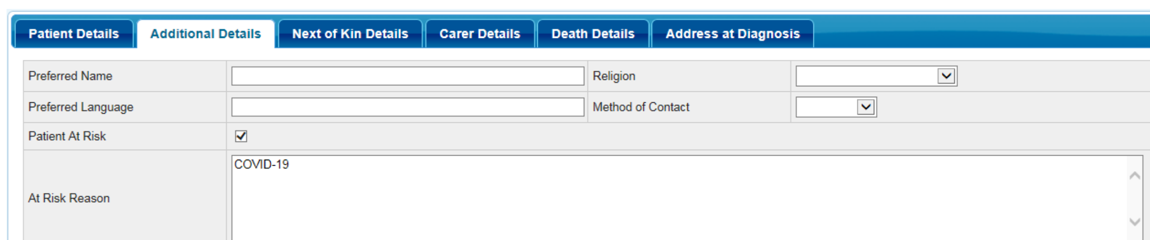
1. Click on the patient's name at the top of their Somerset referral:



2. Click on the "Additional Details" tab shown below:



3. Check the "Patient at Risk" box as shown below and type "COVID-19" in the At Risk Reason box as shown below:



Recording long-term delays

Where a patient is then going to be deferred for a long period of time (e.g. due to the clinician deeming them to be low risk, the patient being part of the "shielded" community who require long-term isolation or

patient choice not to attend hospital during COVID-19 but who aren't being discharged back to their GP), then we also need to do an additional step.

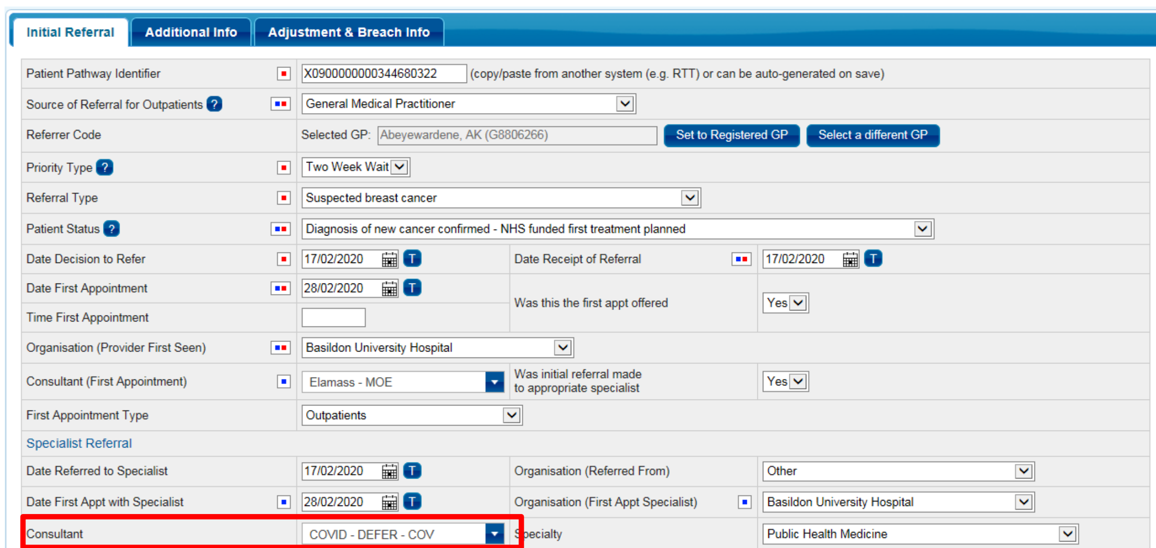
Note: this step should not be performed for patients who are only experiencing short term delays, e.g. self-isolating for 7-14 days due to showing symptoms.

1. Click "View/Edit" on the patient's referral

Referral + Add Tertiary Referral

First Appt	Priority	GP Waiting Time	Patient Status	Consultant	
28/02/2020	Two Week Wait	11 (days)	Primary - first NHS funded treatment planned	Mr Elamass	View/Edit

2. Change the Consultant in the "Specialist Referral" section to "Dr Covid – Defer (COV)"

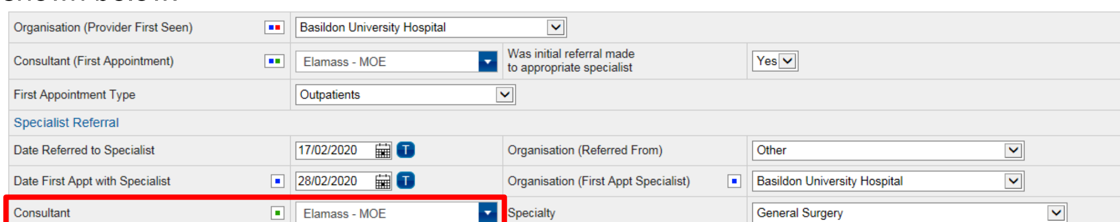


3. Click save. This will then change the consultant to "Dr Covid – Defer". This then means that when we track these patients, we can filter out all patients with a "COV" Consultant Code.

<u>Tracking Deferred Patients</u>

Once a week, a list of all patients with a Consultant Code of "COV" will be pulled from the PTL. These will be briefly tracked to ensure that no movement is supposed to have taken place, e.g. that a patient was to be contacted that week regarding treatment decisions or that the consultant specified three-month period is over and the patient now needs treatment.

When a patient is then ready to commence treatment, e.g. by being given a follow up or a treatment date, then you should change the "Specialist Referral Consultant" back to the treating consultant as shown below:



This will then change the Consultant Code back to the treating consultant, and so will no longer be filtered out by the main Cancer Team who will then continue to track these patients twice a week as normal.