NHS
North Yorkshire
Clinical Commissioning Group

Title of Meeting:	NY CCG Governing Body	Agenda Item: 7.1 C
Date of Meeting:	27 August 2020	
Paper Title:	COVID-19 And Cancer Referrals	

Session (Tick)	
Public	X
Private	
Development Session	

Responsible Governing Body Member Lead	Report Author and Job Title
Simon Cox Director of Acute Commissioning	John Hancock Associate Director Clinical Networks

Purpose (this paper if for)

Decision	Discussion	Assurance	Information
		X	

Has the report (or variation of it) been presented to another Committee / Meeting? No
If yes, state the Committee / Meeting: No.

Executive Summary

This report provides detail and assurance of local health service responses discussed previously under Item 7A of this meeting: Sir Simon Stevens Phase 3 Letter**.**

This report considers the impact of COVID-19 on cancer referrals (screening programmes and urgent cancer referrals from primary care) and action undertaken/ planned to restore this first step in the pathways undertaken by cancer patients.

The report provides reassurance to Governing Body members that from a mid-April 2020 low, urgent referrals for suspected cancer are on an increasing trajectory towards pre-COVID-19 baseline levels.

Recommendations

The Governing Body is being asking to:

- Note contents of this report
- Consider future reports to the Governing Body concerning recovery of cancer services as outlined in Sir Simon Stevens Phase 3 letter.

Monitoring

Recovery of cancer services is monitored at local organisation level (provider/commissioner) and at a collaborative level (e.g. in partnership with the Vale of York; Tees Valley; West Yorkshire and Harrogate Cancer Alliance; Northern England Cancer Alliance and Humber Coast and Vale Cancer Alliance).

Any statutory / regulatory / legal / NHS Constitution implications	Any implications are detailed within the Sir Simon Stevens Phase 3 Letter, dated 31 July 2020.
Management of Conflicts of Interest	No conflicts of interest have been identified prior to the meeting.
Communication / Public & Patient Engagement	In order to restoring public confidence in services, all three Cancer Alliances covering the North Yorkshire footprint have and will continue to work with the communications and engagement teams of providers and commissioners to produce media releases (of all formats) to encourage the public to make contact with services should they need to.
Financial / resource implications	No implications are identified within this report.
Outcome of Impact Assessments completed	Not applicable for this item, however the impact of cancer referrals due to Covid-19 is being closely monitored by the CCG.

North Yorkshire CCG Governing Body

COVID-19 and Cancer Referrals

1.0 Purpose of Report

This report considers the impact of COVID-19 on cancer referrals (screening programmes and urgent cancer referrals from primary care) and action undertaken/ planned to restore this first step in the pathways undertaken by cancer patients.

2.0 Background

In correspondence[i] dated 31 July 2020, Sir Simon Stevens (Chief Executive of the NHS) and Amanda Pritchard (Chief Operating Officer of the NHS) outlined NHS priorities from August 2020. In addition, they described the requirements of providers and commissioners to submit delivery plans covering the period from September 2020 to April 2021.

Under the priority of 'Accelerating the return of non-Covid health services', lies the action to 'work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels'.

3.0 Impact of COVID-19 on Urgent Cancer Referrals

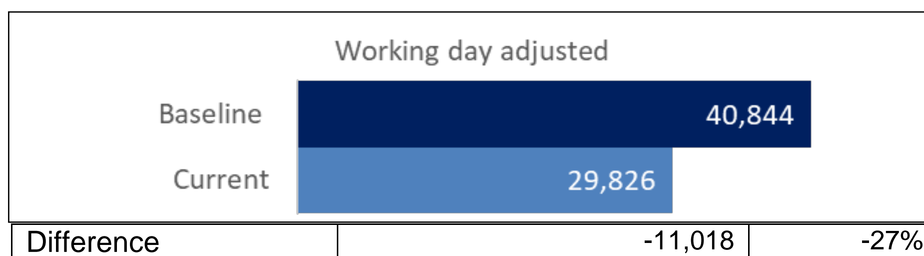
There are 8 routes in the NHS by which a patient can receive a diagnosis of cancer[ii]:

2006-2016	Screen detected	Two Week Wait	GP referral	Other Outpatient	Inpatient Elective	Emergency presentation	Death Certificate Only	Unknown
All Malignancies (excl. Non-Melanoma Skin Cancer)	5%	32%	26%	9%	2%	21%	0%	4%

(National Cancer Data Registration and Analysis Service)

COVID-19 has had a dramatic impact on the Cancer System across the Country:

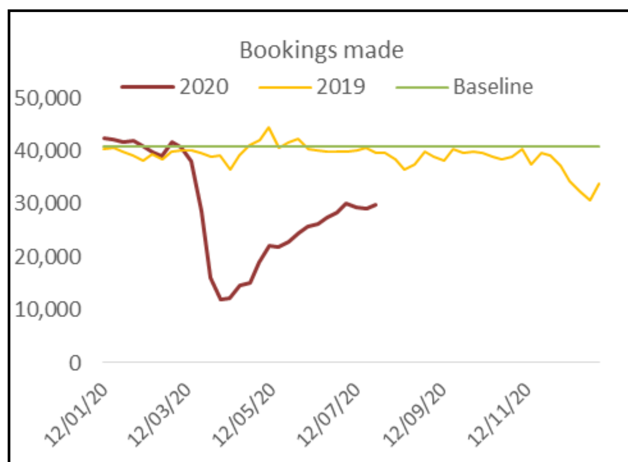
- **Two week wait referral volumes have declined markedly**
  The National Cancer Covid Update week commencing (COVID-19 Cancer Data Pack 26 July 2020) depicts referral volumes down by 36% against baseline:



Difference	-11,018	-27%

There has been significant drop in the number of urgent cancer referrals across the country largely as a result of fewer patients contacting GPs for investigation.

This position is now starting to recover (COVID19 Cancer Data Pack 26 July 2020):



All providers have experienced a similar pattern of drop in referral from 'lows' of 25-30% in mid-late April with 'recovery' toward the baseline from this point in time. A summary 'point in time' position for the main provider trusts for the population of North Yorkshire is:

Provider	Weekly Average pre COVID-19	Referrals Received/ Date*	% Return to Baseline Activity
York Teaching Hospital Trust	399	327 (03/08/20)	82%
Harrogate District Hospital Trust	200	193 (03/08/20)	96%
South Tees Hospitals Trust	415	270** (27/07/20)	65%

**Most recent date for which data is available.*
*** This data point reflects a single week's referrals. The mean referral rate for STHT is currently 309 per week which is equivalent to 71%*

Points to note:

- 2WW cancer referrals have significantly increased from the low points of the early COVID-19 response phase;
- Low referrals suggest primary cause is lower presentations to GPs - there are no obstructions to GPs referring into 2WW pathways;
- 2WW referrals are typically seen within 2 weeks, but access to diagnostic tests due to the impact of covid is the biggest constraint in the early part of suspected cancer pathways.

Further, there will be local population differences between and within provider populations that will impact on the rate of recovery – in the same way that population differences affected referral rates prior to COVID-19.

4.0 Impact of COVID-19 on Screening Services

All Cancer Screening Programmes (Breast, Bowel and Cervical) are commissioned by NHS England/Improvement.

Whilst across all cancer sites, screening services detect 5% of cases, within the 'screened cancer site' the proportions are higher. Almost a third (31%) of female invasive breast cancer cases in England are detected by screening. (Ref. Cancer Research UK). Equivalent figures for Bowel Screening are 10% and for Cervical Screening 24%.

Bowel Screening

The service is provided by regional hubs. As a result of COVID-19, all programmes were paused for new patients, however, the local bowel screening programmes continued to see prioritised risk-stratified patients, as per national guidance. Programmes in HCV have now restored to usual screening invitation processes, and are building up capacity towards meeting pre-COVID rates of invitations and to then begin to address the backlog of invitations.

Significant obstacles to full recovery of this screening service are endoscopy capacity and pressures within the symptomatic pathway.

Breast Screening

Routine invitations for breast screening were paused, but providers continued to screen high risk women and women on short term recall (e.g. cases where there is some diagnostic uncertainty), in accordance with national guidance.

An obstacle to recovery of this screening service in some cases is physical adaptation of the mobile units to make them "Covid secure", e.g. to have appropriate air circulation and other modifications to minimise COVID-19 risk. This is being addressed and restoration of usual screening processes has commenced, with an initial invitation rate at 50% of that in place before COVID-19.

Cervical Screening

Invitations for cervical screening were paused due to COVID-19 but began again on 6 June. Colposcopy services have continued based on risk stratification (high risk patients). Intervals for invitations for individuals on a normal call/recall pathway have now been returned to normal.

A potential obstacle to the full recovery of this screening service will be the capacity of primary care to undertake the testing.

5.0 Actions to Address Impact of COVID-19

Regional and Local Actions:

- **Referrals/ Restoring Public Confidence in Services:** All three Cancer Alliances covering the North Yorkshire 'footprint' have and will continue to work with the communications and engagement teams of providers and commissioners to produce media releases (of all formats) to encourage the public to make contact with services should they need to.

- **Safety Netting:** Providers have ensured appropriate safety netting processes are in situ in both primary and secondary care settings ('Safety netting' means ensuring patients who are unable or choose not to receive diagnostics or treatment due to risk or self-isolation/shielding are followed-up later).

- **Virtual Clinics/ Clinical Triage:** To protect both patients and staff, where possible and appropriate initial consultations have been conducted 'virtually'. This innovation has taken place in both primary and secondary care services. In addition several cancer pathways have implemented a 'clinical triage' of referrals prior to booking (e.g. colorectal).

- **Clinical Assessment:** Expanded application of FIT testing in primary and secondary care to prioritise access to endoscopy for lower gastrointestinal suspected cancer referrals.

- **Referrals/ Rapid Diagnostic Centres (RDC):** The introduction of Rapid Diagnostic Pathways was a national priority for the transformation of services prior to COVID-19. The introduction of these services has been accelerated and the scope will be expanded to include increasing numbers of cancer sites (and non-cancer) going forward. Realised benefits will include: reduction in diagnostic tests, reduction in face to face assessments and increased compliance to Cancer Waiting Times (e.g. 28 days from referral to diagnosis).

  A significant development is also the anticipated introduction of 'Pinpoint' - a machine learning based clinical decision support tool which has evidenced that 20% of cancer referrals can be saved by ruling out cancer prior to referral. Each Integrated Care System/Integrated Care Partnership is currently assessing opportunity for uptake and rollout.

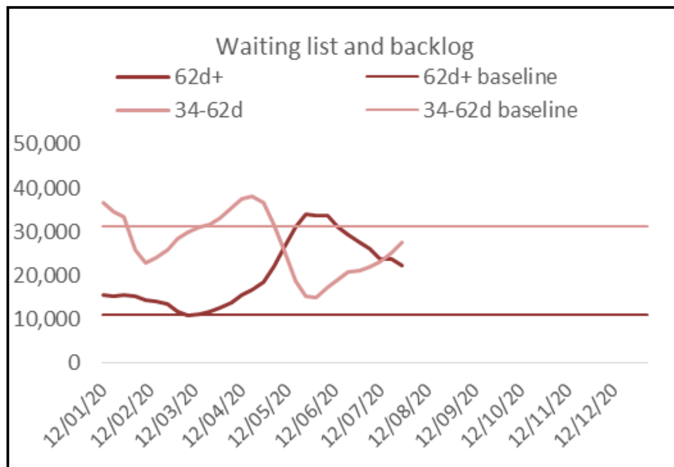
- **Diagnosis/ Diagnostic Capacity:** Increasing demand for diagnostic capacity was acknowledged prior to COVID and was a significant factor in diagnostic delays. Funding has been made available to Cancer Alliances to create more effective and efficient services with access to additional equipment and support for the development of new roles. The utilisation of all available diagnostic capacity has been undertaken across NHS and the independent sector to support maximum use.

  In recognition of the significant 'backlogs' in endoscopy, national and regional 'networks' have been established to address and manage access to endoscopic services over the short to medium term.

- **Utilisation of the Independent Sector:** The NHS has commissioned additional capacity from the Independent sector to provide a range of services, including additional diagnostic/treatment capacity and the separation of 'hot' and 'cold' sites across services.

6.0 Conclusion

Whilst COVID -19 has had an impact on the rate/number of urgent cancer referrals, it has also had a significant impact on diagnostic and treatment capacity. Whilst urgent cancer referrals could be considered as the 'front end' of the cancer pathway parallel work in this 'downstream' service areas will also continue at pace to continue to reduce the size of the patient tracking lists.



(Graph taken from National Covid Report 26 July 2020)

7.0 Recommendations

The Governing Body is being asking to:

- Note contents of this report
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John Hancock, Associate Director Clinical Networks

[i] Phase 3 Correspondence

[ii] NCIN Routes to Diagnosis