Scottish Government
Riaghaltas na h-Alba
gov.scot

COVID-19 Cancer Treatment Response Group

18 March 2020

AGENDA

Time: 10:00 – 12:00

Venue: SHSC, Edinburgh / VC

Opening remarks ○ Response group remit, scope and membership ○ Other areas requiring response
Reducing Unnecessary Risk ○ Converting all FU appointments to tele-consultations ○ Visiting ○ Prostate RT ○ Telephone chemo pre-assessment
Cancer Surgery ○ Surgery that requires post-op HDU/ITU ○ Surgery that doesn't require post-op HDU/ITU
SACT Decisions ○ Use of G-CSF ○ Adjuvant treatments ○ Neo-adjuvant therapy ○ Management of patients mid cycle
Palliative ○ 3 cycles or more ○ symptomatic or at high risk of death if treatment stopped ○ asymptomatic or don't have rapidly progressive disease
Radiotherapy ○ Palliative ○ Radical ○ Adjuvant ○ Curative primary- shorter fractionation regimens
Immunotherapy
Trials
Patient Advice and Information
Updated Advice from Royal Colleges and Other Professional Bodies
AOB ○ Primary care- pre-SACT bloods ○ Dates of Future Meetings
Close

Scottish Government
Riaghaltas na h-Alba
gov.scot

COVID-19 Cancer Treatment Response Group

27 March 2020

AGENDA

Time: 10:00 – 12:00
Date: 27 March 2020
Venue: Teleconference

Opening remarks ○ Group Membership
Updates ○ Scottish Government – [redacted] ○ SACT / Any other UK Linkages – John Murphy ○ Radiotherapy - Rafael Moleron ○ Surgery - James Mander ○ Specialist services - Craig Wheelans ○ MCNs - Craig Wheelans
Emerging Issues / Considerations ○ COVID-19 symptoms post RT and testing ○ BMT services
Escalation Status Discussion
Patient Info ○ NHS24
AOB ○ Letter - Patients at Particularly High Risk / Shielding ○ JAG/BSG Guidance for Endoscopy
Close

Scottish Government
Riaghaltas na h-Alba
gov.scot

COVID-19 Cancer Treatment Response Group

18 March 2020

Minutes

18 March 2020, 10am-12noon

Present:

(in person)

[redacted]	Senior Medical Officer (Oncology), Scottish Government (Chair)
[redacted]	Cancer Policy Lead, Scottish Government
[redacted]	Cancer Access Team, Scottish Government
[redacted]	Cancer Access Team, Scottish Government
[redacted]	Senior Policy Officer, Scottish Government
[redacted]	Public Health Registrar, Scottish Government
[redacted]	Rare Diseases/ IT support, Scottish Government
Larry Hayward	Associate Medical Director, NHS Lothian

(by V/C)

Alan James	Clinical Director, Beatson, NHS GGC
Sophie Barrett	SACT Lead, Beatson, NHS GGC
Mary McLean	National Lead Pharmacist, Beatson, NHS GGC
Cara Taylor	Nurse Consultant, NHS Tayside
Carol McGregor	Clinical Director, Inverness Cancer Centre, NHS Highland
Rafael Moleron	Clinical Director, Aberdeen Cancer Centre, NHS Grampian
John Murphy	Haematologist and National SACT lead
David Cameron	Medical Oncologist and SACT Lead, NHS Lothian

(by T/C)

Seamus Teahan	MCN Lead, WoSCAN
Catriona Farrell	SACT Lead, NHS Forth Valley

Agreed Actions

Action	Lead
Tumour leads to be identified from each of the 5 cancer centres who along with the network leads for each tumour type will get together and: 1) assess NHS England document[1] for applicability to Scotland and amend if felt appropriate 2) Agree contingency plans for SACT/RT in the event of substantial staff absences.	All present at meeting today to send details of tumour leads for each network to Cancer Policy inbox

[1] *NHS England, Specialty guides for patient management during the coronavirus pandemic. Clinical guide for the management of cancer patients during the coronavirus pandemic. 17 March 2020 Version 1*

3) Any changes to radiotherapy fractionation should be nationally agreed across the 5 cancer centres. 4) Identify which professional guidance has been produced from Royal Colleges and other sources at a UK level and share amongst relevant colleagues to agree national positions.	
SG will share letter to immunocompromised individuals with cancer centres when it is released	SG
TRG chair and Cancer Policy Lead will feedback to CMO clinicians' concerns about Coronavirus testing for healthcare staff and also for family members of staff as a priority (to avoid unnecessary self-isolation and the impact on service delivery)	GM and AS
Clinicians request that junior medical staff are redeployed to Cancer Services, to reflect priority of cancer treatment.	NB will pick this up as mobilisation plans are due today
Surgical planning and use of Golden Jubilee hospital / private healthcare sites to be developed through the networks	Seamus to take forward
Consider who else should be included in these discussions and let Chair know - e.g should clinical leads through SACT be included in these meetings?	All

<u>Agreed positions</u>

- Lower threshold for prescribing G-CSF but no blanket policy to prescribe for all patients due to risk of supply issues. In addition, noted that G-CSF will not prevent COVID-19 infection (although it may reduce risk of secondary infection).
- Where possible, staff and patients should be cohorted. Ideally patients attending for pre-SACT blood test will do so at a site separate from the local NHS facility accepting suspected COVID-19 admissions.
- There should not be a blanket cessation of recruitment to clinical trials – will be an individual board level decisions on what they can or cannot keep open.
- Any media enquiries to individual boards about cancer treatment should be referred directly to SG.

COVID-19 Cancer Treatment Response Group

18 March 2020

The TRG Chair stated the aim of this group is to bring clinicians together to develop consensus on current treatment approaches and treatment principles going forward in this rapidly changing situation. Priorities are patient safety, consistent messaging and minimisation of disruption to cancer services.

Cancer Policy Lead reminded those present that modelling and specific advice will change regularly to reflect the most up-to-date data available. Cabinet Secretary for Health has said cancer treatment will continue to be a priority and we must co-ordinate our messaging to the public to maintain confidence in the service. It has been reported that individual patients have not attended for cancer treatment for fear of exposure to coronavirus in healthcare facilities and we must reassure the public we are doing the utmost to protect them from that risk.

It was noted that a letter will be going out to 200,000 patients in Scotland identified as having compromised immunity which will include, but not exclusively be, cancer patients. This is a public health, not clinical, exercise. AS (Chair) has been included in discussions of this letter at Scotland level. Unfortunately, since things are moving at pace, it will not be practicable for this letter to be shared with this whole group before it goes out but a copy will be sent to all cancer centres when it is released. In addition, SG will be providing a patient-facing FAQ document for all cancer patients (including those who do not receive the letter).

Cancer Access Team updated that further communications from SG will follow in relation to provision of cancer screening programmes. For the meantime, 31 and 62 day waiting targets will remain as they are both an important track of timely service delivery and a useful barometer of the impact of the current situation on cancer service provision (although this may change in the coming period).

Cancer Policy Lead stated that given the uncertainty of the situation and multiple other relevant questions outwith this group's remit then further groups addressing questions on cancer diagnostics and primary care may need to be set up going forward.

All boards currently have various measures or plans in place to cohort patients where possible (keeping 'hot' and 'cold' sites separate where possible). IT is set-up to enable working and prescribing from home.

Guidance is sought about whether SG will support for different systemic treatment options that prioritise less immune compromise but incur higher cost.

Discussions took place around deferring radiotherapy for prostate cancer and treating with hormone therapy at this time. Note concerns raised about

managing a very high volume of both new and delayed patients at a point in the future when the country has recovered from the epidemic.

It was suggested that all specific tumour type clinical teams agree protocols between clinicians expert in treating a particular tumour type in the spirit of the Keel review. This suggestion was broadly supported but it was noted that modifications to treatment protocols may vary from site to site depending on capacity at any one time. Chair noted that while developing clinical guidelines usually takes time due to discussion of varying opinions, it may be likely that consensus is reached far quicker for contingency guidelines in these extreme circumstances.

Since Cancer Services are a priority for NHS, clinicians request junior medical staff redeployment to cancer services. Cancer Access Team will take this back to Directorate once they have reviewed board mobilisation plans.

The group will meet on an ongoing basis by t/c and v/c once per week.

Scottish Government
Riaghaltas na h-Alba
gov.scot

COVID-19 Cancer Treatment Response Group
27 March 2020

Draft Minutes and Action List

27 March 2020, 2pm – 4pm

Present (by t/c)

[redacted]	Senior Medical Officer (Oncology), Scottish Government (chair)
[redacted]	Cancer Policy Lead, Scottish Government
[redacted]	Cancer Access Team, Scottish Government
[redacted]	Cancer Access Team, Scottish Government
[redacted]	Public Health Registrar, Scottish Government
David Cameron	Medical Oncologist and SACT Lead, NHS Lothian (vice chair)
John Murphy (JM)	Haematologist and National SACT lead, WoSCAN
Rafael Moleron	Clinical Director, Aberdeen Cancer Centre, NHS Grampian
Craig Wheelans	NHS National Services Scotland
James Mander (JMA)	Cancer Network Clinical Leads Representative

Agreed Actions

Action	Lead
Follow up with Tumour Leads to clarify what consensus agreement there is around the Royal College of Radiologists recent publications[1]	Cancer Policy Team, SG
Clinical concern raised about the impact of not widely enough testing patients, and staff, in particular: ▪ The risk of those attending radiotherapy to themselves if undergoing treatment while asymptomatic with COVID-19 ▪ The risk to other patients using the RT machine after an unknowingly infected patient ▪ The risk of a cohort of cancer patients potentially carrying and shedding virus for longer than patients without cancer ▪ The impact on service delivery when many staff self-isolating due to symptomatic household member	Craig Wheelans will get up-to-date position on this from Jim McMenamin at Health Protection Scotland Cancer Policy Lead will get latest position on this from SG COVID-19 Hub
Contact Prof Sarah Wild at University of Edinburgh to get epidemiology predictions of how long situation may last as regards impact on clinical surgical decisions about treatment	David Cameron to contact Sarah Wild

[1] The Royal College of Radiologists Coronavirus (COVID-19): cancer treatment documents . March 2020. https://www.rcr.ac.uk/college/coronavirus-covid-19-what-rcr-doing/coronavirus-covid-19-resources/coronavirus-covid-19-1

Larry Hayward is producing a document reviewing escalation status of cancer patients in relation to currently used 9-point frailty scale for escalation to ITU care and ventilation	David Cameron will circulate document when he has it
Clinical query around structures for communication between Scottish Cancer Networks and NHS Board Chief Executives at this time. Cancer Policy Team could make a national recommendation that there is a structure in place.	David Cameron to forward a model by Jan McLean to [redacted]
Wording to be generated as regards messaging on treatment options for cancer patients going forward in the circumstances of pandemic.	John Murphy, David Cameron and [redacted] to work on this weekend then share with [redacted]
Letter to be sent to CMO mailbox highlighting CTRG discussed emerging guidance from British Society Gastroenterologists and Joint Advisory Group and there was uniform support for endorsement of this guideline while acknowledging the potential for other action according to clinical need.	[redacted]
Administrative	
Group expressed preference for video rather than teleconference where possible.	Cancer Policy Team to explore for next meeting.

Opening remarks

Chair highlighted that the Group Membership had been reviewed to keep the group tight and turnaround of decisions timely.

Scottish Government Update – [redacted]

Cancer Policy Lead GM updated that National Clinical Guidance agreed by this group was approved CMO 23/3/20. The Cabinet Secretary made her statement on 24/3/20 stating that vital cancer treatment will go ahead but will change due to the effects of the pandemic. An updated patient info leaflet will be published today, reflecting the changes in guidance since last week.

GM met with SCC Thursday, who are keen to support NHS service. They are aware treatment plans will need to change. They plan to update the treatment pathways illustrated on their websites to help align patient expectations.

SG noted that the messaging from Cancer services is evolving, and while vital treatments will continue, individual plans will need to change due to COVID-19. Clinician input around messaging was invited.

Lead for Cancer Access NB highlighted that communications have been continuing about how to use private hospital capacity (e.g. Golden Jubilee) to cope with impact on NHS hospitals, as per England. It has been negotiated to take them over for cancer and urgent treatment. The aim will be to keep these COVID-free and for cancer treatment. It was noted many patients have been in touch with questions about what is being offered. Media enquiries also came in the last week.

SACT / Any other UK Linkages – John Murphy
SACT CTRG Guidance is being enacted across networks. Once for Scotland approach being enacted. JM stated he feels activating a move from not treating priority level 6 or 5 would be a Medical Director decision, at board level, with advice from the cancer teams.
JM looking for agreement between cancer clinicians around treatment escalation. DC updated Larry Hayward working on this currently. JM keen for more linked-up discussions between cancer teams and admitting staff. CW suggested participation in Safety Huddles – JM confirmed oncology staff were involved in these in Lanarkshire.

JM gave a meeting update from Informal UK Group sharing experiences
High level discussion around letter sent to high risk groups and the difficulties of distributing letter. Noted the recent NHS England Speciality Guide and NICE guidelines both been updated to Version 2 since last week. Transplant and RT due out soon. Noted British Society of Gastroenterologists and Joint Advisory Group recommending pause of non-emergency endoscopy. Some lack of clarity around surgical approaches at this time.
JM aware of some step down of cancer screening. Discussions around telephone consent for procedures and treatments. Official confirmation of pause on screening is expected soon.

Radiotherapy - Rafael Moleron
The five radiotherapy leads met earlier today. Nearly universal agreement in Scotland re: changes to treatment that have been implemented. For prostate, breast and urological cancers, protocols have been changed to reduce visits. Different tumour sites changes needing more assessment. Also discussed brachytherapy – change to this being offered since short stay hospitals have been closed and there is a need to explore how to approach with theatres.
RM expressed concerns that since treatment involves people in small confined place, they are very keen for patient testing/ screening for COVID.

Rafael Moleron forwarded more details after the meeting to be included in the minutes, as per below:
Treatment
To minimise the impact of COVID-19 in cancer patients and their treatment, it is agreed
-Prostate: Delaying patients on hormonal therapy
-Breast: Omitting low risk >65
26Gy/5# in node -ve
Omitting boost in those aged 41-50

-Rectal: 25Gy/5# instead of 25# schemes
-Neuro: Use hypofractionated treatment when possible
-Palliative: Use as short fractionation as possible
These changes will progressively decrease workload by ~40-50%

Brachytherapy
The issue relates principally to the requirement for a general anaesthetic and availability of anaesthetists as COVID numbers requiring ventilation increases.
Also some patients require an inpatient bed.
Gynaecological brachytherapy needs to be provided as core to treatment of those malignancies. Individual risk to be assessed, particularly in low risk cases.
Prostate brachytherapy when monotherapy can be deferred by the administration of hormonal therapy. When combined with external beam needs to be case-by-case

COVID-19 testing
All symptomatic patients should be tested
Ideally, this should include self-isolators and household transmissions
If category 1 patient is confirmed positive, could continue treatment if deemed clinically safe for the patient in a COVID designated machine (different arrangements in place for the different cancer centres) if benefit to patient felt to outweigh risk to patient and staff.
Treatment gaps will be compensated in category 1 patients as per RCR recommendations. Gaps of more than two weeks need to be approached on individual basis, and in most cases will not be compensated.
Non category 1 patients will resume treatment when clinically safe

All symptomatic patients who have not started radiotherapy should be delayed until recovery

Communication
Direct communication between the clinical team and their patients provides with reassurance and allow patients and clinicians to identify and understand individual risks. This approach is strongly recommended rather than circular letters that address very general circumstances not always applicable to individual patients.

GM thanked RM for work on RCR documents. RM explained different tumour sites are at different levels of consensus. Action generated for Cancer Policy Team to follow up. RM re-iterated need to testing patients. GM explained global supply issues relevant. JM, DC agreed.

Actions generated for CW and GM to escalate clinician's concerns about testing to HPS and CMO respectively.

Surgery - James Mander
JMA reported intel that screening paused locally. USC patients are being triaged, using radiological investigation instead, which may be less accurate. JMA reports no surgery going on that needs level 3 or level 2 beds but cancer surgery is still going on across country in selected patients. Concerns expressed that accessing private facilities may increase inequity given their distribution geographically.

JMA gave an update from Chief Executives meeting
CEs expecting hospitals overwhelmed and ITU facilities full. JMA concerned there will be some pts who will miss out on the opportunity of a curative cancer operation.

DC was also in attendance at CEs meeting. DC suggested stratification of patients based on risk could possibly be produced? JMA agreed considering treatment modalities other than surgery may be helpful; for instance, stenting colonic tumours. CW asked if patients could access cross-border options. JMA asked for epidemiology intel on how long situation likely to last, as it will impact clinical decisions. Action generated DC to contact Prof S Wild at Edinburgh University to ask for advice on this.

GM noted the risk to curative surgery is an important one. GM asked for time frames for working out stratification and suggestions from clinicians on how this can be progressed.
JMA stated this would require to be done by Board Clinical Directors and MDTs going forwards. AS suggested that a virtual national surgical unit/network would ensure equity of access but wondered whether this would be possible in time available.

Specialist services - Craig Wheelans
Proton beam therapy – still accepting referrals. Continuing in Christie in Manchester but prioritisation is happening since no one can travel to Germany. Molecular RT is continuing in Glasgow with a waiting list. Allogeneic service is continuing with prioritisation. Ophthalmic oncology patients needing treatment urgently and new patients will be seen but those on long term follow up will be delayed. England bone marrow transplant ongoing but plans to move all work to the bigger of two centres. Autologous transplants ideally will be set up so Scottish and English can travel for treatment. JM reported delays locally in Lanarkshire.

MCNs - Craig Wheelans
National sarcoma work continues but long-term strategic work of cancer networks has been cut back.

Emerging Issues / Considerations

COVID-19 symptoms post RT and testing
Actions agreed as above.
BMT services

Escalation Status Discussion

Larry Hayward is producing a document reviewing escalation status of cancer patients in relation to currently used 9-point frailty scale for escalation to ITU care and ventilation. Cancer clinicians may need to log discussions with patients about treatment escalation if they have incurable cancer (but not yet terminal). Action generated for DC to circulate document when he has it.

JM reported work on anticipatory care planning pre-COVID in Lanarkshire has been happening and medical directors interested in this.

Patient Info

NHS24

SG have produced info leaflet (updated) and are working to get more info to NHS Inform. We will share our SG patient info with Cancer treatment line contacts.

AOB

Letter - Patients at Particularly High Risk / Shielding

Letter was mentioned last week and publicly discussed for a while now. 4 CMOS have decided they would write to all groups of patients affected, including a cancer group. Some difficulties in logistics of sending. Letter contains advice on shielding and extra help for extremely vulnerable to support isolation. Now some re-visiting of which groups identified as high risk.

JAG/BSG Guidance for Endoscopy

NB explained the previous guidance was somewhat ambiguous.
VD updated the group that yesterday BSG and JAG issued an update on the guidance, recommending stopping everything except emergency procedures. Working out currently how to manage USC patients and those already in system with positive bowel screening.

VD asked the group for opinions on following this guidance. CTRG offered consensus that BSG guidance should be followed.

AOB

DC noted the CTRG are developing subgroups for SACT and RT which works well.
JMA confirmed no clear surgical groups but clinical leads are surgeons so form de facto subgroup.
JM concerned that lack of mechanism exists for WoSCAN and NCA. GM offered support. Action generated that DC to forward model of a structure to GM.

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000
E: scottish.ministers@gov.scot

NHS Chairs
NHS Chief Executives

By Email.

24 March 2020

Dear Colleague

Following my statement in Parliament on 17 March I am writing to provide some more detail on what will be expected from NHS boards in the management of cancer patients throughout the Covid-19 outbreak.

The impact of Covid-19 on cancer patients has been a priority in all our planning, and we must ensure that all appropriate measures are undertaken in the present situation to protect those living with cancer.

We have been clear that vital cancer services will remain in line with clinical priority. However, we recognise that for some cancer patients treatment and management plans may have to change over the coming weeks and months due to the risks associated with Covid-19. This must be clearly discussed and communicated with each patient and should never comprise patient care and outcomes.

You'll be aware that we recently convened a National COVID19 Cancer Treatment Response group. This group met on 18 March to agree national guidance on the management of individual patients who require cancer treatment. This guidance, which is attached in appendix A, has wide clinical consensus and has been endorsed by the Chief Medical Officer and will be kept under constant review.

In addition we have produced a patient facing FAQ and distributed to clinicians across Scotland on Friday 20 March to provide their patients with. The FAQ (Appendix B) provides important advice for people with Cancer about how the Coronavirus/ COVID-19 might affect them.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Throughout this time the recording and tracking of cancer waiting times standards will remain for this priority group. To suspend these targets would not be fair to patients and will aid us in measuring the impact of Covid-19.

I thank you and your teams for their dedication through these very difficult times.

Kind regards

Jeane

JEANE FREEMAN

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot