

Cancer Research UK's response to the Health and Social Care Select Committee inquiry on 'Delivering Core NHS and Care Services during the Pandemic and Beyond'

1. Summary

Cancer Research UK (CRUK) welcomes the opportunity to respond to the Health and Social Care Select Committee's inquiry into 'Delivering Core NHS and Care Services during the Pandemic and Beyond'. We have addressed the key questions posed by the Committee in our submission below, together with several recommendations to improve cancer services during and beyond this period.

COVID-19 is an unprecedented crisis which will continue to have an impact on all healthcare services in the UK for the rest of 2020 and the years ahead. We fully support the need for the NHS to adapt rapidly to meet the substantial challenges of COVID-19 and have been working hard to help the national effort through our research infrastructure and patient information resources. We also recognise that some cancer care will need to change for safety reasons. However, we are deeply concerned by the clear knock-on effect that this crisis is having on NHS cancer services and the patients they serve.

Cancer is the leading cause of death in the UK. Before COVID-19 there were around 367,000 new cases of cancer in the UK each year, and sadly, around 153,000 deaths¹. Cancer doesn't stop because of a pandemic. Early diagnosis followed by swift access to the most effective treatment remains as important as it's ever been for survival.

People affected by cancer remain anxious, confused and tragically, many will face worse cancer outcomes as a result of COVID-19. It is paramount that NHS organisations, healthcare professionals, charities, parliamentarians and others work together to help address the immediate and near-term challenges we face. People affected by cancer now must continue to receive the care they need, in as safe a way as possible, during this crisis. Attention must also be given to returning the provision of cancer care to pre-COVID-19 levels as soon as possible, again in a safe and effective way. Given the backlog in diagnosis and treatment we are currently seeing, this will require swift and clear action.

Prior to COVID-19, CRUK had been making the case to Government for several years that NHS staff shortages – which are particularly acute in diagnostic services – needed to be urgently addressed. Without a clear plan (which includes measures to increase staff training and education) progress on cancer survival in this country could stall and perhaps even reverse, setting cancer survival back. CRUK stands ready to work with all sectors to ensure we continue to provide for cancer patients now and in the future.

Whilst beyond the scope of this inquiry, CRUK, like other cancer charities, has been substantially impacted by COVID-19. We expect our income to fall by at least 25% this financial year. This has forced us to immediately cut our research funding by £44m and we are likely to make further cuts. CRUK funds around half of all publicly funded cancer research in the UK, so this will have a damaging, long-term effect on our collective push to improve cancer survival across the UK.

Key immediate impacts and recommendations:

- **The COVID-19 pandemic is having a significant impact on the delivery of diagnostic services and treatment for cancer patients** (further detail below). Cancer patients have increased risk of COVID-19 infection, which could have very serious health implications. We therefore fully support guidance to create designated 'cancer hubs' in England to provide

COVID-19 free facilities for safe cancer treatment – focusing initially on surgery. We understand such hubs are now fully operational in 7 Cancer Alliance areas, and partially operational in another 9.

- *COVID-free cancer hubs should be rolled out as quickly as possible. Cancer hubs are currently being asked to offer patients surgery, but this should be extended to include some diagnostic and chemotherapy services that can't be safely administered elsewhere.*
- **There is no systematic testing for COVID-19 in place for cancer patients or healthcare staff.** Cancer services must be delivered in environments as far as possible free from COVID-19. Since a significant proportion of COVID-19 cases are asymptomatic, this requires widespread and repeated testing of symptomatic and asymptomatic patients and healthcare staff – both now and throughout the recovery from the pandemic.
 - *The Government must expedite the testing of all cancer patients and healthcare staff (whether symptomatic or asymptomatic) for COVID-19.*
 - *Testing should initially focus on cancer hubs to ensure that cancer patients can receive services in a safe environment that is free from COVID-19, then roll testing out to other relevant settings in due course.*
- **Screening services in England are de-facto paused as invitations are not currently being sent out from screening hubs.** With up to 164,000 people per week no longer being screened for bowel, breast and cervical cancer following an invitation in England, there will be a substantial number of early cancers left undetected before these programmes are reintroduced.
 - *NHS England must ensure appropriate management of people affected by the suspension of cancer screening programmes to ensure these people can receive a seamless (re)integration into the screening pathway irrespective of the point they were at when services paused.*
 - *NHS England must also ensure that services are brought back online as quick as is reasonably feasible*
- **The number of people being sent on an urgent referral for diagnostic tests for suspected cancer has reportedly dropped by 75% in England,** due to a combination of people not coming forward to their doctor and doctors not referring. This could mean around 2,300 cancer diagnoses are being missed each week. This will likely contribute to more cancers diagnosed at a later stage, where curative treatment options are reduced. It is also creating an extremely worrying backlog of people that need to be assessed and we are in danger of creating another, potentially more significant cancer crisis, particularly as diagnostic services were struggling with capacity before COVID-19.
 - *Public messaging from the Government must be improved and amplified, so that people with potential cancer symptoms are encouraged to seek help from healthcare professionals. We welcome the recent 'Help us help you' media campaign and are willing to support this messaging in any way we can.*
 - *GPs should be given clear guidance and support on referring patients into hospitals whilst the COVID-19 pandemic is ongoing, and implement safety-netting procedures for those who are not referred.*
 - *Secondary care should accept and act on its responsibility to ensure patients are placed on appropriate patient tracking lists.*
- **Despite national guidelines stating that urgent and essential cancer treatments must continue, we do not believe this is happening consistently across the country.** Surgery has been impacted most severely, and whilst the development of cancer hubs will help, many patients requiring major surgery aren't getting it. The use of radiotherapy and

chemotherapy has also required changes in the current circumstances. Clearly difficult decisions are having to be made, and these must be done in consultation with the patient.

- *NHS England must continue to communicate to Trusts that all decisions regarding disruptions to cancer patients’ planned treatment should be made on a case-by-case basis; should consider possible alternate treatment regimens that patients can be offered; and should be communicated to patients with a clear rationale and appropriate safety monitoring and support put in place.*
- *NHS England should work with Trusts to ensure there is a coordinated national approach, consistently implemented at a local level, to tracking patients whose treatment has been disrupted.*
- **Clinical trials have been severely disrupted.** While some trials continue to provide for patients on active treatment, the set-up of all new cancer trials has been paused and most existing cancer trials have paused recruitment. This will understandably have a significant impact on patients who were enrolled on trials that are affected. Also of concern is the potential loss of income in trial sites, which we believe may put vital jobs at risk – jobs that will be required to support trials restarting.
 - *The Government must provide clarity on the status of jobs in trial sites, where not redeployed, and look to provide financial certainty to ensure talent is not lost.*

Key considerations for recovery and restoration:

It is vital that a clear plan is put in place for recovery and restoration of the service which focuses on ensuring: screening programmes are restarted as quickly as possible; there is enough capacity in diagnostic services to cope with the potential backlog in diagnoses required from urgent referrals, screening and other routes; that treatment provision returns to pre COVID-19 levels as quickly as possible; that clinical trials are restarted; that smokers have universal access to stop smoking services; and, lessons are learned from innovation in the service during the pandemic and that these become systemic ways of working.

Of particular concern is capacity of diagnostic services to cope with the influx of patients requiring a diagnosis. CRUK has campaigned for increases to cancer staffing numbers, particularly in diagnostics, for this reason – before the COVID-19 crisis there were around 1 in 10 diagnostic posts unfilled across the NHS. It will be important to review the upcoming NHS People Plan in light of COVID-19 and ensure that it addresses these concerns.

2. Key statistics table

Topic	Statistic
Screening	CRUK estimates that up to 1 million invitations to take part in the bowel, breast or cervical cancer screening programmes each month in England are no longer being sent out. Normally, at least 1,400 patients go on to have a cancer diagnosed through the screening programmes each month in England, and an additional number of potentially pre-cancerous conditions diagnosed and treated.
Diagnosis	We understand that there has been a 75% reduction in urgent two-week wait referrals for suspected cancer in England. This would mean around 140,000 patients are not being referred on this pathway per month, and that around 10,000 patients per month (2,300 patients per week) are not being diagnosed with cancer following a two-week wait referral in the current situation.

Surgery	While we know that some surgery is not being performed, we are yet to see data on the proportion of this decrease. It is estimated that in England more than 11,400 cancer patients undergo surgery each month as part of their primary course of treatment. Of these around 7,100 will have been diagnosed with early stage disease when surgery is more likely to be effective.
Surgery	A UK-wide survey conducted by the Royal College of Surgeons of Edinburgh shows that a third of cancer surgeons have had to stop cancer surgeries completely and that 87% have had to reduce them.
Radiotherapy	It is understood that radiotherapy has dropped by about 10% of what would normally be expected, although some surgery is being replaced by radiotherapy. Normally around 11,000 patients receive radiotherapy each month on average in England. It's expected that at least 400 patients with breast, lung, bowel and upper GI cancers aren't receiving radiotherapy for their cancer.
Chemotherapy	The proportion of patients receiving chemotherapy has reduced by around 30%. This would mean 1,200 patients with breast, lung, bowel, and upper GI cancers aren't receiving chemotherapy for their cancer every month in England.
Clinical trials	The Association of Medical Research Charities estimate that around 126,000 patients are currently unable to participate in charity funded clinical studies.

3. CRUK's contribution to the national COVID-19 effort

CRUK is committed to supporting the national COVID-19 response. We have been working alongside our research community to support the national response to the COVID-19 epidemic, as well as providing vital information to cancer patients in these difficult times.

Patient information and support

In March our helpline services saw a 20% increase in enquiries compared to an average month, which was largely due to the unfolding Coronavirus crisis. Enquiries have now levelled off but coronavirus is still a concern to our callers. At the start of the crisis about 25% of calls were largely about how coronavirus was affecting cancer patients and cancer services, this proportion rose to 45% at one point but has now dropped to 27%. Key issues for people calling the helpline are whether they are in an extremely vulnerable group, treatments delays and cancellations, and more recently fears about visiting their GP or attending hospital appointments. We have also had over 180,000 unique page views to the coronavirus pages on our website, as well as 28,000 clicks on the Covid-19 banners that feature across the site.

Provision of testing/equipment

Boosting testing capacity is a key part of the UK Government's response to the virus. At a cost of around £3million to CRUK we have repurposed laboratories across our network to respond to calls for equipment to help test for the COVID-19. This equipment has been taken to the Milton Keynes Biocentre, where samples will be sent to test for key workers. Equipment will be returned after the pandemic. In addition, researchers at several our funded Institutes and Centres are setting up their own testing hubs. For example:

- The Francis Crick Institute has been temporarily converted into a COVID-19 testing hub and shared its flexible protocols with the wider UK research community.
- Newcastle University has set up COVID-19 testing laboratories supported by CRUK and ECMC staff.

- The CRUK Manchester Institute is playing a key role in Alderley Park's national testing hub.

Voluntary redeployment

Many of our academic research staff are helping on the front line too:

- Academic laboratory staff across the UK have taken up invitations to volunteer to help with COVID-19 testing work in NHS laboratories.
- A quarter of the volunteers at the Queen Elizabeth University Hospital in Glasgow testing hub are staff from the CRUK Beatson Institute.

Innovating to beat COVID-19

Many of our researchers are facing long spells away from their main research focus. However, they are using this enforced pause to deploy their skills, technology and expertise against the virus. For example:

- Staff at our Southampton Clinical Trials Unit, led by Professor Gareth Griffiths, are collaborating with others to develop 'first-in-human' trial platforms of experimental new anti-COVID-19 drugs, and trials in the community, such as care homes and primary care, to both prevent and treat early disease.
- Cardiff University researchers, led by Dr Alan Parker, are looking to repurpose their anti-cancer viruses to generate COVID-19 vaccines.

4. The immediate impact of COVID-19 on cancer care

a) Systemic issues

Delivering cancer services in COVID-free environments

Evidence shows that the COVID-19 pandemic is having a significant impact on the delivery of diagnostic services and treatment for cancer patients. There is some evidence to show that patients with cancer harbour a higher risk of COVID-19 infection than the local population.ⁱⁱ Moreover, evidence shows that cancer patients with seasonal flu have increased risk of experiencing medical problems (including death) when undergoing cancer treatment. Similarly, clinicians are having to balance the benefits of treatment against the risks of exposure to COVID-19 infection and immunosuppression from active cancer treatment for patients who do catch COVID-19.ⁱⁱⁱ

Protecting cancer patients from COVID-19 infection is a key reason for the reduction in diagnosis and treatment rates. Unpublished NHS data suggests that there has been a 75% reduction in urgent two-week wait referrals in England, while in Scotland there has been a 72% reduction in urgent suspected cancer referrals^{iv}. Similarly, we understand that treatment rates may have fallen by as much as half in some parts of the country. A UK-wide survey conducted by the Royal College of Surgeons of Edinburgh shows that a third of cancer surgeons have had to stop cancer surgeries completely and that 87% have had to reduce them.^v

Whilst decisions about patient care should be made based on what is best for any given individual, it is clear that delaying cancer treatments will have significant implications in the longer term. With delays to their treatment, many patients will face fewer treatment options and lower chances of survival. It has been estimated that a 6-month delay to all surgical resections in England would result in the death of 10,555 more individuals with solid tumours than otherwise, and a loss of 2.2 years in the average life extension this surgery offers patients (though this does not account for the potential

use of alternative treatment options, such as radiotherapy, throughout this period). For the health service, further delays to diagnosis and treatment will create a growing backlog of demand for an already overstretched health service to address.

Therefore, it is essential that the health service rolls out COVID-free sites for cancer diagnosis and treatments services across the UK. The number of asymptomatic cases of COVID-19 is significant, which is why, to achieve this, all cancer patients and healthcare staff – whether symptomatic or asymptomatic – based at sites delivering cancer services must be tested for regularly COVID-19.^{vi}

In particular:

- Tests should be carried out on all patients (whether symptomatic or asymptomatic) 48 hours or less before any treatment procedure begins. Patients coming in for tests should be requested to self-isolate for a period beforehand to minimise their chances of testing positive. Once the test has been carried out, the patient should be put into isolation to protect them from further infection.
- Where there is ambiguity with a test result, a repeat test should be conducted.
- Healthcare staff should be tested regularly (e.g. twice a week), to help minimise the risk of false negative test results.
- Healthcare staff should be re-tested in any case where it is likely they have been exposed to a patient who goes on to develop COVID-19 from the hospital setting, to protect both other staff and future patients under their care.

Testing rates amongst staff and patients based in COVID-free sites (including cancer hubs) should be monitored to support this. We suggest data is collected and reported on a weekly basis.

Ensuring cancer staff are protected

Delivering cancer relies on the safety of health professionals, particularly so that there is enough capacity in the NHS to adopt new ways of diagnosing and treating cancer safely. It is vital to ensure that staff are protected from COVID-19 infection as far as possible in order that there are enough staff to work in vital COVID-negative cancer hubs.

The UK Government has acknowledged a need to increase the supply of Personal Protective Equipment (PPE) to NHS staff and other key workers and has set out a plan to deliver more kit. This is welcome, but the British Medical Association recently warned that doctors continue to report shortages of PPE^{vii}, while NHS Providers recently concluded that while efforts are being taken, “delays in the availability of PPE have persisted.”^{viii}

Keeping NHS staff safe will be essential to continuing to provide care for patients, both with and without COVID-19, in the immediate term. But equally, it will not be possible for the NHS to begin to recover without there being enough staff in place. For both these reasons it is vital to ensure that NHS staff are as safe as possible from COVID-19 infection.

Ensuring patients and the public have access to clear information about the impact of COVID-19 on cancer services

Over the past two months, a significant proportion of calls to our helpline have been related to COVID-19, with an increase in overall enquiries and the proportion relating to COVID-19 varying between 30 and 50%. Callers have shared concerns about:

- Whether or not they should be shielding, or questions about shielding having been issued a letter instructing them to do so
- Their treatment being delayed or cancelled

There has been a continued focus on the guidance around shielding which is welcome, as there were many ambiguities contained within the original guidance. These are being resolved but feedback suggests that some remain, such as guidance related to people with blood cancers – it is important to regularly review this guidance to ensure that these issues are resolved.

Decisions about delaying or postponing treatment are very painful and we hope that clinicians will only have taken such decisions when there was a clear risk to the patient in proceeding, or when the treatment could not be given safely during the current pandemic. National guidance states that these decisions, taken on an individual basis, should be clearly communicated to patients. However, patients are being caused a significant amount of anxiety when the date of their rescheduled appointment cannot be confirmed. The NHS should ensure that they are communicating as regularly and as widely as possible about when and how they are restoring cancer services to provide reassurance to patients who might be waiting for treatment – and that newly-established cancer hubs make it a priority to communicate to patients how quickly they will be able to resolve treatment backlogs. There is an opportunity to engage cancer charities, such as CRUK, in supporting and reinforcing this communication.

Ensuring that local decisions are guided by clear national evidence-based guidelines

The NHS is having to take many decisions rapidly in order to protect patients from the risk of COVID-19 infection as well as manage the scarce resources of a system in crisis. In this context, many areas are taking decisions or may want to take decisions for their services which may differ from current or accepted practice. For example:

- Some areas have revised their two-week referral pathways for cancer, for example by introducing triage Faecal Immunochemical Testing for patients with symptoms of bowel cancer.
- Some GPs have reported being asked to make individual decisions about cervical screening appointments, despite our understanding that screening has been paused.
- While progress is now being made in establishing cancer hubs across the country, initially some areas were more adversely affected than others in the reduction of surgical capacity.

We recognise that in the current environment decisions must be made rapidly and according to local needs. However, where local decisions are being taken, it will be important to ensure that these changes do not introduce unwarranted regional variation in the medium and long term.

Recommendations

- **COVID-free cancer hubs should be rolled out across the UK as quickly as possible. Cancer hubs are currently being asked to offer patients surgery but this should be extended to include diagnostic services and chemotherapy services that can't be safely administered at home.**
- **The Government should expedite the testing of all cancer patients and healthcare staff (whether symptomatic or asymptomatic) for COVID-19, with an initial focus on cancer hubs, to ensure that cancer patients can receive diagnostic and treatment services in a safe environment that is free from COVID-19.**
- **Testing rates amongst staff and patients based in COVID-free sites (including cancer hubs) should be monitored, with data reported on a weekly basis.**
- **The Government must continue to expand the supply of PPE to NHS staff to ensure that staff in all settings have necessary protection from infection.**
- **The NHS should communicate as regularly and as widely as possible about when and how they are restoring cancer services to provide reassurance to patients who might be waiting for treatment – and that newly-established cancer hubs make it a priority to communicate to patients how quickly they will be able to resolve treatment backlogs.**
- **The NHS should look to issue evidence-based guidance to inform local decision making and reduce the risk of variation. Where this is not yet practicable, NHS England should collect evidence of local practice to ensure that during recovery any instances of unwarranted variation can be effectively addressed.**

b) Preventing cancer

Four in 10 cancer cases can be prevented: smoking is still the single biggest factor, causing at least 15 different types of cancer, 15% of new cancer cases in the UK and more than a quarter of all cancer deaths^{ix}. There is agreement from public health bodies, including Public Health England and the Chief Medical Officer for England, that quitting smoking remains an important measure that people can take to protect their health and the health of those around them. We were pleased to see the NHS England guidance to healthcare commissioners advise that smoking cessation services continue where possible.^{xi} We are also pleased to hear, from anecdotal evidence, that local authorities continue to provide smoking cessation services via virtual channels.

However, anecdotal evidence has also indicated that referral to these services are dropping in England. Health professionals in primary care play an important role in encouraging people who smoke to quit and signposting them to services to help them make a quit attempt – this intervention can be carried out using the Very Brief Advice (VBA) model which takes less than 30 seconds. We would like to see primary care to continue VBA practice with their patients who smoke, as far as possible, as part of efforts to continue to support people in reducing their risk of getting cancer.

Recommendations

- **Primary care health professionals, including GPs and Practice Nurses, should as far as possible continue VBA practice on smoking cessation to encourage and support their patients who smoke to quit.**

c) Screening and early diagnosis

Survival from cancer detected at an early stage is substantially higher than from those diagnosed at later stages. Earlier and rapid diagnosis makes it more likely that patients will receive treatments such as surgery and radiotherapy which contribute to most cases where cancer is cured. For example, when diagnosed early, more than 9 in 10 patients survive bowel cancer compared to just 1 in 10 when diagnosed late.

Prior to COVID-19, the Government was not making sufficient progress to hit its ambition of 75% of cancers diagnosed at early stage (stage I or II) by 2028. Without action, progress will be put back even further and we fear improvements in survival will halt or perhaps even start to reverse.

Suspension of cancer screening programmes

National screening for breast, bowel and cervical cancer can detect the disease before any symptoms show, when treatment is more effective. The national cancer screening programme is the route of diagnosis for at least 5% (16,300) of all cancers diagnosed annually in England, so a significant number of cancers will be left undetected before these programmes can be reintroduced.

There has been no official announcement from NHS England on the current status of cancer screening programmes, unlike formal announcements in the other UK nations. However, CRUK understands screening programmes have effectively been suspended in England as invitations are not currently being sent out from screening hubs. For patients who required further testing due to an abnormal screening result, they have received letters from NHS England to inform them that their appointments will be 'rescheduled' to a later date. This is likely to be causing some anxiety for these patients especially those who have taken part in screening for the first time. It is vital that screening programmes are restarted as quickly as possible, once appropriate to do so.

Significant drop in number of referrals for patients with a suspicion of cancer

It is unsurprising that people are avoiding health services during this time. It is likely due to concerns about being exposed to COVID-19 or because COVID messaging may be confusing by asking people to stay at home to protect the NHS. This is particularly challenging given CRUK and the NHS has highlighted, for years now, the importance of getting cancer diagnosed early for the greatest chance of survival. Unpublished NHS data shows a 75% reduction in the number of patients being referred by GPs on the urgent pathway for suspected cancer for further testing and specialist consultation. This is largely because fewer people are going to their GP. These cancers may be diagnosed later, when patients present in the future to either their GP or at A&E. This backlog of patients who require further investigations will have a significant impact on already overstretched diagnostic services.

GP role in referral and safety-netting

Some GPs are reluctant to risk sending their patients to the local hospital for further testing for fear of exposure to COVID-19 infection. However, there have also been some great examples of accelerated pathway innovation and implementation, such as GP practices using 'triage tests' available to help determine if patients with symptoms should be referred for further tests at the current time or not. Using certain tests, such as FIT, in patients who present with bowel cancer symptoms can help GPs decide who is at higher or lower risk of bowel cancer, helping to prioritise patients who have the most urgent need for a colonoscopy. But it is important to remember that

false negative results do occur, and to be vigilant for ongoing risk of a range of cancers. If GPs, in conjunction with the patient, decide not to refer patients on, it is essential that there is a 'safety-net' in place to help manage risk and ensure no patients fall through the system. CRUK has developed guidance to support GPs safety net appropriately during this time^{xii}.

Lack of available diagnostic tests

It may not be possible for GPs to refer patients who do not meet the criteria for urgent suspected cancer but who still need investigating, as some diagnostic testing has been stopped due to concerns about the safety to carry out investigations without the potential risk of exposing patients and staff to COVID-19, and because of resourcing considerations^{xiii}. There is great concern in the inability to access chest x-rays which is required to diagnose lung cancer. While GP direct access to colonoscopy procedures vary, it is a key element in the diagnosis of bowel cancer via both symptomatic and screening routes.

Recommendations

- **NHS England must ensure appropriate management of people affected by the suspension of cancer screening programmes to ensure these people can be followed up appropriately when the services resume.**
- **Public messaging from the Government must be improved and amplified, so that people with potential cancer symptoms are encouraged to seek help from healthcare professionals. We welcome the recent 'Help us help you' media campaign and are willing to support this messaging in any way we can.**
- **GPs should be given clear guidance and support on referring patients into hospitals whilst the COVID-19 pandemic is ongoing, and implement safety-netting procedures for those who are not referred.**

d) Access to treatments

As noted above, the COVID-19 pandemic has led to delays and changes to cancer patients' treatment. The NHS has issued guidance on the clinical management of cancer patients^{xiv}, with a judgement of the relative risks and benefits of beginning or continuing treatment the key consideration for individual patients. However, despite national guidelines stating that urgent and essential cancer treatments must continue, we believe there is variation in access across the country.

Safe, dedicated sites for cancer treatment

Anecdotally, we have heard some Trusts have successfully adapted to deliver systemic treatment to patients away from hospital sites – for example through increased deliveries of medicines to patients' homes via courier services, and the expanded use of mobile chemotherapy units. However, in many places, resources to adapt chemotherapy delivery in this way are not available. In addition to the impact of concerns about the risks to patients undergoing active treatment for their cancer from COVID-19 outlined above, reports suggest in some places surgery theatre space is being converted to ITU space for ventilation, further reducing the capacity for on-site treatment. As noted above, consolidating cancer surgery into dedicated COVID-free hubs is a critical part of the solution, as this will restore some capacity to offer patients safe treatment. We understand such

hubs are now fully operational in 7 Cancer Alliance areas, and partially operational in another 9, but it is critical these hubs are fully operational across the whole country as quickly as possible. We would also wish to see commissioners explore whether additional chemotherapy services could be offered on these sites, for patients requiring systemic treatment that can't be safely given at home.

Clear guidance on, and flexible access to, appropriate alternate treatments, with appropriate safety monitoring

As well as providing safe sites for planned cancer treatment to continue, it is critical patients have access to alternate interim treatment options during this time if their planned treatment is disrupted, to allow disease and symptom control to be maintained. Examples of alterations that can be made in some cases may include increased use of hormone therapies (in oral formulations that can be taken at home) for breast and prostate cancer, or radical radiotherapy in place of surgery.

We welcome the guidance issued by NHS England on the clinical management of cancer patients, supported by rapid guidance from NICE on delivery of radiotherapy and systemic therapies, which sets out a pragmatic approach in this area. We particularly welcome NHS England's work to define interim treatment regimens that can be offered to patients where there has been disruption to their planned systemic therapy. NHS England should continue to urge Trusts to deliver treatment where possible, in line with national guidance, and work with Trusts to ensure where alternate treatments are being used (especially if patients are self-administering treatments at home) that appropriate safeguards and access to information and support is put in place, to ensure patient safety.

Ensure clear recording of patients whose treatment has been disrupted

Whenever changes are made to a patient's planned treatment schedule, it is crucial that this information is properly recorded so that these patients' treatment can be re-assessed once additional capacity has been re-established. We welcome the pragmatic steps that NHS England has already taken to minimise the disruption caused by any changes to patients' existing planned treatment schedules, for example through disapplication of the treatment break policy for systemic therapies for the duration of the COVID-19 outbreak.

However, it is not clear whether existing mechanisms to capture patients who are not receiving treatment - such as Patient Tracking Lists – are appropriate and can capture all patients whose treatment will have been disrupted as a result of the unprecedented circumstances of this outbreak. NHS England should ensure there is a coordinated approach across the country to tracking these patients, to ensure their cases can be reviewed and the most appropriate treatment decisions made as quickly as possible when appropriate.

Recommendations

- **As part of the continued roll out of cancer hubs, NHS England should explore whether additional chemotherapy services could also be offered on those sites.**
- **NHS England must continue to communicate to Trusts that all decisions regarding disruptions to cancer patients' planned treatment should be made on a case-by-case basis; should consider possible alternate treatment regimens that patients can be offered; and should be communicated to patients with a clear rationale and appropriate safety monitoring and support put in place.**
- **NHS England should work with Trusts to ensure there is a coordinated national approach, consistently implemented at a local level, to tracking patients whose treatment has been disrupted.**

e) Clinical trials

COVID-19 has severely disrupted the UK's ability to deliver clinical trials. Many categories of patients with cancer are at a high risk of developing severe COVID-19, and consequently cancer trials have been particularly affected by the pandemic:

- The set-up of most new cancer trials has been paused;
- Most existing cancer trials have had recruitment paused;
- Many cancer trials have moved to remote patient monitoring (online and telephone); and
- Some cancer trial staff and resources (e.g. beds) are being redeployed to support frontline care and COVID-19 trials.

By pausing trial recruitment and set-up, the opportunities for cancer patients to participate in clinical trials has fallen significantly, in turn reducing access to potentially life-saving new treatments. For reference, 25,000 patients were recruited last year onto trials supported by CRUK, 9,500 of which were in trials testing an active treatment.

Some trials have decided to remove patients from active treatment in order to reduce their risk of COVID-19 exposure, and to free up capacity to deliver frontline care. Insight from our research community has also shown that some patients are being withdrawn from trials even though it was safe to continue treatment. For many patients, being put on standard of care represents a downgrade in their treatment quality, and for some this standard of care will be palliative instead of remedial. In certain cases, no trials means no other treatment options. This is particularly acute in relapsed childhood cancers and is some types of advanced leukaemia.

Efforts to restarting these trials, and the potentially life-saving care they provide, face two main obstacles:

1. The disruption to clinical trials has reduced research income for universities and hospitals, as charities like CRUK have less funds available and income from commercial studies has dropped off with the reduction in trial activity. This rapid and substantial reduction in income may leave institutions with little choice but to put many staff that support clinical research at risk of redundancy, which would delay efforts to restart clinical trials after COVID-19 has peaked.
2. Some trial sites are already planning how they will restart trials; however, evidence from our research community has raised concerns over the absence of a Government COVID-19 exit

strategy for restarting clinical research. Our concern lies with the lack of clear, consistent, and nationwide guidance for how trial sites should prioritise which trials to restart. Without such guidance, there is a risk that trials that provide greater patient benefit will be deprioritised in favour of trials which provide greater income.

If unaddressed, these issues will delay the restarting of clinical trials, with those restarted being chosen according to commercial value rather than the benefit they could provide to patient care.

Recommendations

- **The Government must provide clarity on the status of jobs in clinical trial sites, where not redeployed, and look to provide financial certainty to ensure talent is not lost and trials can restart as quickly and effectively as possible.**
- **The National Institute for Health and Research, and its devolved equivalents, should provide trial sites with consistent guidance on prioritising which trials to restart first. This guidance should give priority to trials that: offer the greatest patient benefit; are viable for remote patient monitoring; and are investigating treatments that can be delivered to patients' homes.**

f) Data

The recommendations above are based on our early analysis of the impact of COVID-19 on cancer services and do not represent a complete picture of how cancer services, and cancer patients, have been affected by the pandemic. We have drawn our information from several sources including:

- Information shared with our nurse helpline advisers, as well as quantitative call data
- Anecdotal evidence from CRUK GPs and other health professionals
- Information from CRUK clinical trial sites and research centres
- Local and national guidance
- Early data shared from clinical systems
- Estimates of impact based on existing cancer data.

Taken together, these sources help to illustrate the key issues facing cancer services in light of the COVID-19 pandemic, but they are by no means exhaustive. Planning for the recovery of NHS cancer services after the peak of the pandemic will need to be informed by as much contemporary data as possible about the impact of COVID-19, including vital data on cancer diagnosis and treatment. As much as possible of this data should be published.

Recommendations

- **The Government should ensure that the collection and publication of cancer data is not disrupted by COVID-19, so that the impact on cancer services can be clearly seen and recovery accurately planned.**

5. Recovery and restoration of cancer services

The issues outlined above set out our immediate concerns about the impact of COVID-19 on cancer care. However, it is vital that we start planning for how to support the recovery and restoration of

cancer services in the near term. Any plan will have to consider the knock-on impacts of service changes outlined above – across prevention, diagnostic and treatment services.

A major concern is capacity, particularly in diagnostic services, to cope with the potential influx of cancer cases once the crisis abates. As we have highlighted above, there is likely to be a substantial backlog in diagnoses due to screening programmes being stopped and urgent referrals plummeting. There will also be a backlog in treatment provision due to the delays or cancellations that are occurring.

Prior to COVID-19 we had raised serious concerns about the capacity of the NHS workforce to meet current and future demand for cancer diagnosis and treatment. One in ten diagnostic posts in the NHS were vacant at a time when the number of cancer cases was increasing. Early indications suggested that the proposed NHS People Plan to address workforce needs would fall woefully short in meeting the needs of those affected by cancer in both the short and long term. These concerns have been exacerbated by COVID-19. We are concerned about staff burn out and the attractiveness of the profession when the system is under so much strain. We are concerned that there will be not enough specialist staff across the NHS to meet the backlog of cancer diagnosis and treatment.

Recommendations

- **NHS England should develop a clear plan to support the effective recovery and restoration of cancer services in the near term.**
- **The Government must undertake an urgent reappraisal of the NHS Long Term Plan and in particular, the proposed NHS People Plan, so that it is responsive to these changing circumstances and the urgent needs of those affected by cancer.**

Cancer Research UK, April 2020

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