# IMPACT OF COVID-19 PANDEMIC ON CANCER SERVICES IN NORTH EAST LINCOLNSHIRE & RECOVERY FROM THE PANDEMIC

## 1. BACKGROUND

Cancer services in the UK were under increasing pressure even before the coronavirus (COVID-19) pandemic, with the national target for 85% of patients to be started on first treatment for cancer within 62 days following an urgent General Practitioner (GP) referral having not been met since 2015. The national target of receiving treatment within 31 days of diagnosis also continues to be missed in all four nations of the United Kingdom (UK).[1.] The COVID-19 pandemic worsened this situation by affecting delivery of cancer care at every level, primary care, screening services, investigations, diagnosis and commencing treatment. Both patient factors and factors at service provision contributed to this situation.

The lockdown measures and shielding during COVID-19 pandemic disengaged patients with cancer from formal health care settings. Having to access life-sustaining treatment during the COVID-19 outbreak was thought to place patients with cancer at an especially vulnerable position with their immunocompromised status.[2,3,4]

The re-direction of health care staff to meet demands of COVID-19 treatment within the National Health Service (NHS), fuelled by COVID-19 related staff shortages and patients affected by Covid -19 meant that many services were unable to provide routine cancer services at the expected level. However locally, cancer services at both Hull University Teaching Hospital (HUTH) and Northern Lincolnshire and Goole NHS Trust (NLAG) continued to operate.

National data reveal alarming figures, 3 million less screening tests performed during March to September 2020, cancer diagnosis via screening dropping by 50%, and 12% less new treatments compared to pre pandemic levels.[1,5,6,7,8]

The magnitude of risk to cancer patients created by disruption to screening, delayed diagnosis and delayed treatment are not yet known. Several indirect indicators such as increase of cancer diagnosed as emergency presentations, diagnosis of cancer at an advanced stage, and increased mortality from cancer may shed light to this impact, though true effects may not be obvious for several years, given the latency of presentation of certain cancers.

In March 2021, new guidelines were published that outlined plans to fully restore cancer services, including meeting the increased demand caused by the backlog, aiming to clear backlog by March 2022.[9]

North East Lincolnshire (NEL) Local Authority area was greatly impacted by the COVID-19 pandemic. While Covid-19 prevalence might not be as high as previously, the pandemic has had a long-lasting impact on NHS services, that is, the demand on NHS services, including cancer services.[10]

## 2. IMPACT OF COVID-19 PANDEMIC ON THE EARLY IDENTIFICATION OF CANCER

To understand the impact of COVID-19 pandemic on the clinical assessment of possible cancer in primary care in the area, conversations were held with the CCG Cancer Clinical Lead. The findings from these conversations are reported below:

- There was a reduction of face-to-face appointments due to COVID-19 restrictions and the inability to examine patients may have contributed to diagnoses of cancer being missed.
- There was a pre-existing shortage in GPs in the area prior to the pandemic; however, the pandemic led to a worsening of staff shortages due to some NHS staff having to shield.
- Telephone triaging at GP practices in the area depended on the experience of clinician's/nurse specialist conducting the triage especially in the first wave of the pandemic. This is because some clinicians had to work outside their experience and comfort zone.
- There was also limited availability of investigations.
- Despite the campaign on early signs and symptoms awareness during first wave, patients were reluctant to access health care and shielding recommendation for vulnerable patients also exacerbated this.
- Some patients were reluctant to come forward in presence of suggestive symptoms due to the reluctance of knowing the diagnosis and reluctance to access treatment outside the area of residence.
- There was a disruption of cancer screening during the first wave of the COVID-19 pandemic. Cancer screening had to be temporarily suspended nationally at the onset of the pandemic and this led to a backlog of screening for eligible patients both nationally and locally in NEL.
- There were bottlenecks at Tertiary centres. Both Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH) were affected by workforce and diagnostic/surgical capacity. This has always been an issue pre pandemic, but the situation got worse during the pandemic.
- There were also IT issues with different IT systems across centres not interfacing with one another.

## 3. HUMBER, COAST AND VALE CANCER ALLIANCE

The Humber and North Yorkshire Cancer Alliance (HNY Cancer Alliance) is one of 21 cancer alliances in England and is leading the local delivery of the NHS Long Term Plan to help transform cancer care and outcomes so that, from 2028:

- An extra 55,000 people each year will survive for five years or more following their cancer diagnosis
- Three in four cancers (75%) will be diagnosed at an early stage

HNY Cancer Alliance brings together organisations that pay for and provide cancer services, to transform the diagnosis, treatment and care for cancer patients in our region

and consists of various NHS organisations; voluntary, community and social enterprise organisations, patients and members of the public. This implies that NL CCG, NEL CCG and NLaG are part of the HNY Cancer Alliance.
The HNY Cancer Alliance continues to work with the Humber and North Yorkshire Health and Care Partnership (integrated care system) to help ensure longer term recovery plans from Covid-19 can be achieved, and to transform the diagnosis, treatment and care for cancer patients across the region.

Throughout the duration of the pandemic, there has been a national, regional and integrated care system (ICS) focus on two categories of metrics which have been monitored regularly. These two metrics were also monitored by HNY Cancer Alliance. These metrics are those concerned with:

- the **recovery of cancer services** from the onset of Covid-19 through to the present time.
- the **operational performance of cancer services** – which have been applied before, during and post-pandemic environment.[10]

# 4. RECOVERY

In response to the coronavirus pandemic, HNY Cancer Alliance is supporting national plans for recovery against Covid-19. The national plans for recovery aim to:

- Restore urgent cancer referrals at least to pre-pandemic levels
- Reduce the backlog at least to pre-pandemic levels on 62-day (urgent referral and referral from screening) and 31-day pathways
- Ensure sufficient capacity to manage increased demand moving forward, including follow-up care[10]

To monitor the impact of and the recovery from Covid-19, three recovery metrics have been used from the beginning of the pandemic in 2020 and throughout 2021/22 These metrics are:

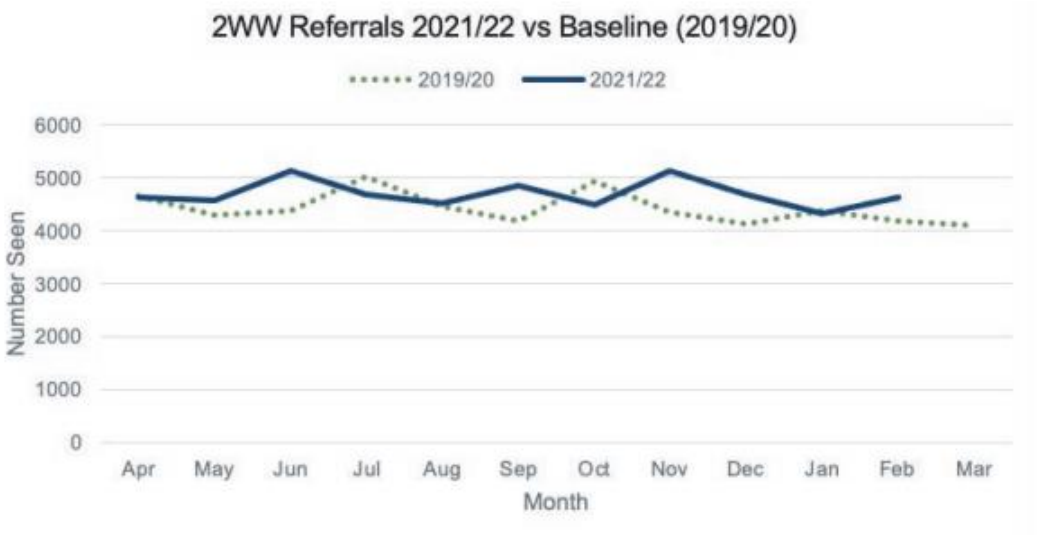
- To recover the **referrals for suspected cancer** which may have been **'lost**' to the pandemic.
- To recover the **number of first cancer treatments** which may have been **'lost'** to the pandemic.
- To reduce the **number of patients who have been waiting for more than 62 days from referral to start treatmen**t to pre-pandemic levels.[10]

## *4.1 Referrals for suspected cancer*

Many factors influence an individual's decision to make an appointment to see their GP for suspected cancer. During the early stages of the pandemic, some of these factors influencing individual's decision include the fear of contracting or transferring Covid-19 while attending a healthcare facility, or not wanting to burden NHS services already under considerable pressure. The impact of these decisions resulted in **a significant reduction in the number of people referred to hospital for tests for suspected cancer** at this time.[10] A consequence of delays in people going to their GP with suspected cancer could potentially be diagnosis of cancer at a later stage, which could have an impact on the treatment options available and chances of survival.[10]

Figure 1 shows 2ww referrals in 2021/22 against the baseline of 2019/20(pre pandemic). The figure shows that referrals are back to pre-pandemic levels and that also increased above pre-pandemic levels.

**Figure 1:**




***Source:*** *Humber and North Yorkshire Cancer Alliance (HNY CA) 2021/2022 Annual Report*

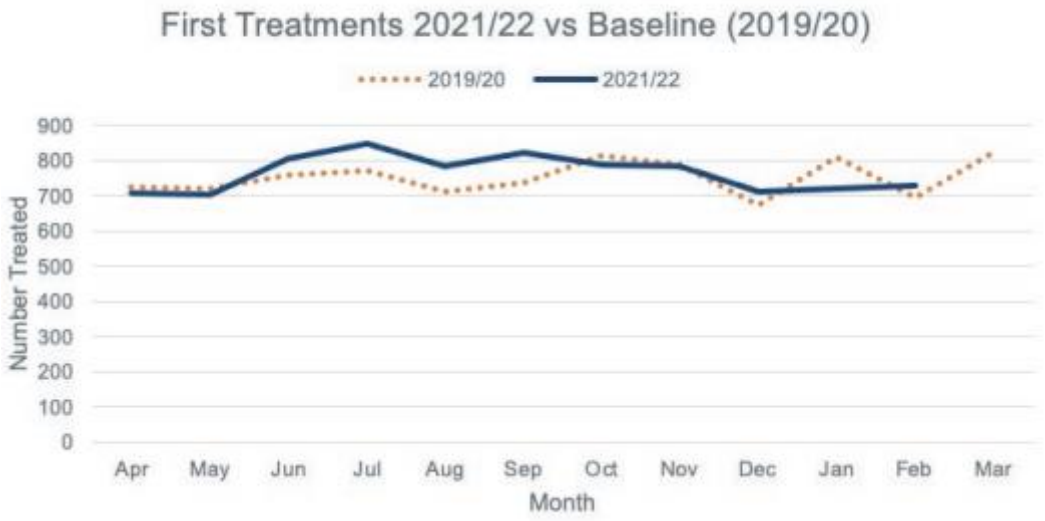
HNY Cancer Alliance reported that at the start of April 2021, the estimated number of **'missing'** referrals was approximately 7,600 in Humber and North Yorkshire and that by the end of February 2022 there were approximately 2,700 referrals more than usual, reducing the overall number of 'missing' referrals to around 5,000.[10]

### *4.2 First treatments*

Cancer services (workforce and facilities) were protected during the pandemic however, there has been a reduction in capacity to provide treatment services, for example, caused by staff absence due to Covid-19 infection. In addition, whilst suspected cancer referrals from GPs account for approximately half of all diagnosed cancers, reduced referral rates from primary care have also impacted on the number of diagnosed cancers and treatments.

The estimated reduction in the number of 'first' cancer treatments delivered to newly diagnosed cancer patients across the Humber and North Yorkshire region is estimated to be approximately 1,000 treatments.[10] Figure 2 shows that between April 2021 and February 2022, there were approximately 8,400 'first' cancer treatments in total delivered to newly diagnosed cancer patients. As a comparison, during April 2019 and February 2020, there were approximately 8,200 treatments delivered over this same period.[10]

**Figure 2:**



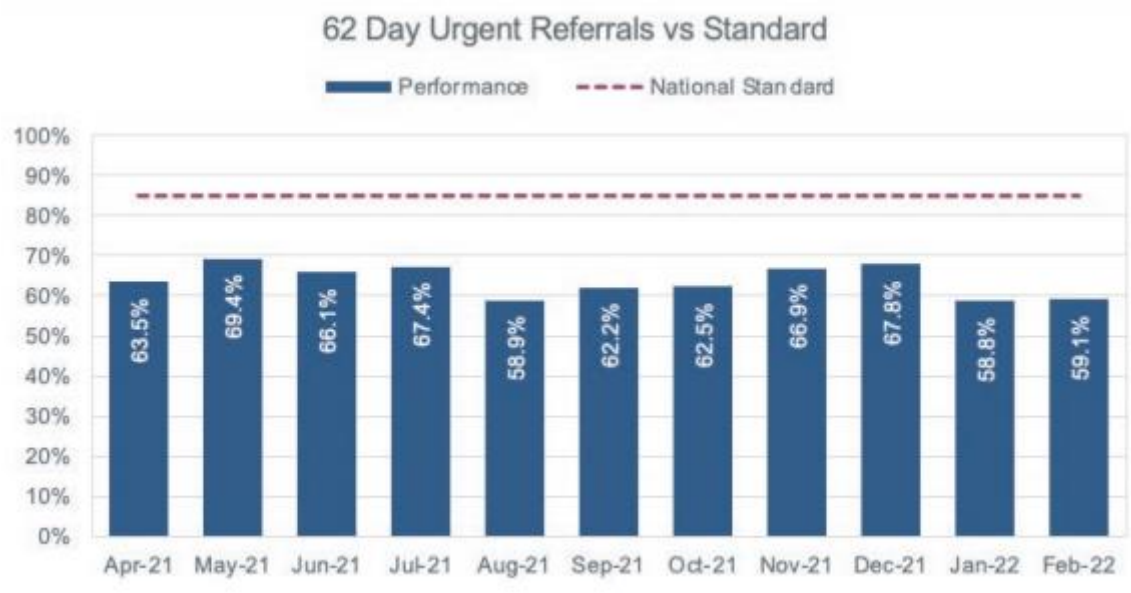

***Source:*** *Humber and North Yorkshire Cancer Alliance (HNY CA) 2021/2022 Annual Report*

Whilst the current 'over-performance' on first treatments has reduced the estimated treatment 'gap' from 1,000 to 800, this will need to continue in the foreseeable future to further reduce this 'gap'.[10]

### 4.3 *Recovery: 62-day waiting lists backlog*

The 62-day waiting list backlog consists of those patients who are waiting to be diagnosed or have been diagnosed and not treated two months since being referred from their GP for a suspected cancer. This 'recovery metric' is directly related to a performance standard which requires 85% of patients referred on these cancer pathways and diagnosed with cancer to receive their first treatment within two months from referral (Figure 3).

**Figure 3:**




***Source:*** *Humber and North Yorkshire Cancer Alliance (HNY CA) 2021/2022 Annual Report*

As the impact of the pandemic deepened, the numbers of patients waiting longer than two months for their first treatment continued to increase and this continues to be a challenge for cancer services in Humber and North Yorkshire.[10]. HNY Cancer Alliance reported that at its height, more than a fifth (22%) of all patients on suspected cancer pathways were waiting longer than two months either to be diagnosed with or without cancer, or to receive a first treatment following a cancer diagnosis. As of the middle of April 2022, this had reduced to around 16%. However, lower gastrointestinal cancer pathways are continuing to provide a challenge in this regard.[10]

# 5. RECOVERY PERFORMANCE INDICATORS – NEL CCG

Recovery metrics/indicators measured locally by NEL CCG on cancers pathway are mainly the Cancer Waiting Times (CWT) indicators. These indicators, which are monitored routinely on a monthly basis, show the CCG's performance. The main indicators being monitored are:

- 14 day wait or 2 Week Wait (2ww)
- Diagnosis of cancer through to treatment, which is the 31-day period and
- the full 62-day target which is from referral to first definitive treatment.

As at the time of writing this report, Cancer Waiting Times Power BI summary report updated to April 2022 shows the CCG performance on the following indicators (Table 1).

- **14 Day wait** or 2 Week Wait (2ww) to first Appointment - performance on this indicator was notably above the maximum target of 93%. 2ww has been consistently above target for majority of months in the last 2 years.
- **Initial 31-day** performance – Performance on this indicator is still slightly below target i.e., 93.4% as opposed to a target of 96%.
- **Subsequent 31-day** treatment for Radiotherapy & Surgery subcategory – Performance on these indicators is also well below target, 60% and 73.7% respectively.

**Table 1: Cancer Waiting Times Performance Indicators: NEL CCG**

| Ind DAC ID | Indicator | Period | Denominator | Numerator | Performance | Target |
|---|---|---|---|---|---|---|
| DAC5050 | (01) DAC5050 - 14 day referral to 1st -Appointment % (6.1) | Apr-22 | 425 | 408 | 96.0% | 93.0% |
| DAC5060 | (02) DAC5060 - 14 day referral to 1st (breast symptoms) - % (6.2) | Apr-22 | 32 | 30 | 93.8% | 93.0% |
| DAC5070 | (03) DAC5070 - 31 days decision to treatment - % (7.2) | Apr-22 | 61 | 57 | 93.4% | 96.0% |
| n/a | (04) 31 days decision to treatment (subsequent palliative) - % (7.8) | Apr-22 | 0 | 0 | #DIV/0! | 94.0% |
| DAC5100 | (05) DAC5100 - 31 days decision to treatment (subsequent radiotherapy) - % (7.8) | Apr-22 | 20 | 12 | 60.0% | 94.0% |
| DAC5080 | (06) DAC5080 - 31 days decision to treatment (subsequent surgery) - % (7.8) | Apr-22 | 19 | 14 | 73.7% | 94.0% |
| DAC5090 | (07) DAC5090 - 31 days decision to treatment (subsequent drug) - % (7.8) | Apr-22 | 33 | 33 | 100.0% | 98.0% |
| DAC5110 | (08) DAC5110 - 62 day referral to treatment (GP referral) - % (8.2) (& 8.7) | Apr-22 | 29 | 16 | 55.2% | 85.0% |
| DAC5120 | (09) DAC5120 - 62 day referral to treatment (Screening referral) - % (9.2) | Apr-22 | 4 | 4 | 100.0% | 90.0% |
| DAC5130 | (10) DAC5130 - 62 day referral to treatment (Consultant referral) - % (10.2) | Apr-22 | 0 | 0 | #DIV/0! | 90.0% |
| tbc | (TBC) - 28 Day FDS 2 week wait referral - % (18.1) | Apr-22 | 418 | 268 | 64.1% | 75.0% |
| tbc | (TBC) - 28 Day FDS 2 week wait breast symptoms referral - % (18.2) | Apr-22 | 31 | 30 | 96.8% | 75.0% |
| tbc | (TBC) - 28 Day FDS screening referral - % (18.3) | Apr-22 | 33 | 6 | 18.2% | 75.0% |
| DAC5065 | (11) DAC5065 - 28 Day FDS ALL ACTIVITY | Apr-22 | 482 | 304 | 63.1% | 75.0% |

***Source:*** *Cancer Waiting Times Power BI Dashboard*

- **62 day wait** for GP referral - Performance on this indicator remains consistently well below target (85%). Most cancer 2ww referrals come via the GPs and the CCG performance in April 2022 was 55.2%

- **62-day screening/consultant referrals -** There are always very small activity numbers for this indicator since only a handful of patients go through this route of referral. Patients referred through this route are referred through not as a suspected cancer but picked up by a consultant as a suspected cancer and then upgraded to a 2WW referral.
- **28-day** Faster Diagnosis Approach **(FDS)** performance is still below 75% target.

## 6. ONGOING CHALLENGES AFFECTING PERFORMANCE

Local cancer services face a lot of challenges which affect performance and therefore the delivery of the standards aligned to cancer treatment and care. The main challenges identified by local cancer services are:

- Workforce recruitment issues – recruitment of staff into the area has always been an issue prior to the pandemic and this still remains the case post pandemic.
- A reliance on HUTH to provide Tertiary diagnostics which is not available at NLaG, for example, endoscopic ultrasound (EUS), endobronchial ultrasound (EBUS), PET CT/guided lung biopsy, interventional radiology or treatment.
- Inability to transfer to Tertiary provider by day 38 (Patient Transfer List - PTL) due to workforce issues/delays from visiting consultant services from HUTH (urology/oncology)
- Insufficient capacity to deliver decision to treat (DTT) within 24 days – This applies to both surgical and non-surgical treatments. Workforce, theatre capacity, etc impacts this target.
- Bringing the recovery of 2ww referrals to higher levels following COVID-19 pandemic.
- Some cancer pathways are still under increased pressure - colorectal, skin, urology and breast cancer pathways are all under increased pressure due to increase in 2ww referrals as a result of the pandemic. Lung cancer is under pressure due to smaller cohort of clinicians providing cancer service to speed up pathway.
- 2ww referrals to multiple tumour sites for the same patient. GPs are unsure of which tumour site to refer to, multiple referrals are done, typically lung, upper GI and colorectal. Each 2ww has to be dealt with individually, so if 3 tumour sites, there would be 3 x 2ww for same patient received because NLaG has to offer 3 x 1 appointment for each speciality referred to. This therefore results in delay in first treatments.
- Effect of COVID-19: Patients testing positive and therefore unable to attend appointments, tests, treatments etc, thereby leading to an increase in the number of patients choosing to defer diagnostics/appointments.
- Emergency Admission rate during the pandemic converted to Cancer was a complicated piece of work and multifactorial in cause.
- Current Covid-19 rates are high with significant impact on staffing/capacity. This has led to Saint Andrew's Hospice (local Hospice) being shut to new admissions currently.

# 7. MITIGATING ACTIONS

As organisations and individuals learn to live with Covid-19, the focus of attention remains at the end of 2021/22 on the recovery of cancer services and services are being developed and transformed to achieve this objective. However, in 2022/23, this focus will increasingly be shared with delivering the performance standards aligned to cancer treatment and care.[10]

Several actions (most of which are system wide) are already being taken/implemented **jointly** by NEL CCG, NLaG and HNY Cancer Alliance to address the issues discussed earlier which are affecting the provision of essential cancer services in NEL. The actions being taken are discussed below.

### *7.1 NEL CCG*

- The CCG has funded a NEL GP as Cancer Clinical Lead to act as the interface between primary and secondary care in the area (Same for NL).
- The CCG has established a good relationship with secondary care and have set up a primary and secondary care interface bimonthly meeting where cancer is a standing agenda item.
- A work programme with Primary Care Networks (PCNs) in Northern Lincolnshire has been put in place to address Cancer Early Diagnosis Directly Enhanced Services (DES). This includes the provision of cancer performance data packs for practices/PCNs**.**
- A roll out of Lung Health Checks across Northern Lincolnshire is expected to commence in September 2023. *(**System wide joint work** - South Bank Lung Health Checks workstream).*
- The CCG has developed a protocol for 2ww colorectal referrals to be submitted with Faecal Immunochemical Test (FIT).
- Funding has been obtained by the CCG from HNY Cancer Alliance to develop a Community Breast Pain Clinic to start operating in June 2022.
- Dermatology – the CCG has secured additional funding from HNY Cancer Alliance for all practices to update current dermascopes for teledermatology referrals to the skin service and to provide additional units to larger practices.
- The CCG with support from HCV Cancer Alliance has developed a prostate-specific antigen (PSA) pathway to take Prostate Cancer monitoring back to Primary Care, relieving pressure on Urology services. The plan is to develop a pathway similar to this for Colorectal Cancer in the near future.
- The CCG has commissioned a local cancer collaborative to work with the public on signs and symptoms of cancer and support primary care in increasing the uptake of national screening programmes.
- Both NEL CCG and NL CCG are members of the HCV Cancer Alliance Primary Care Strategy Group ***(System wide joint work).***
- NEL and NL CCGs input to HCV Cancer Alliance System Board ***(System wide joint work)****.*
- The CCG is working very closely with the Humber Cancer Board on its Cancer Transformation project ***(System wide joint work).***

### *7.2 SECONDARY CARE (NLAG)/TERTIARY SERVICE (HUTH)*

- A proposal is currently being developed to bring the management of cancer services together between HUTH/NLaG. This is expected to lead to improved pathways and patient flow.
- A business case is being developed for NLaG/HUTH diagnostic issues for submission in 2022/2023 business planning.
- Work has commenced on streamlining Multidisciplinary Team Meeting (MDT) where if a patient is diagnosed with cancer, a team of health professionals work together to plan the best treatment for the patient ***(System wide joint work).***
- NLaG Cancer Transformation Workstream has been tasked with transforming the way cancer services are delivered in line with the Trust Strategy – Restructuring Cancer Services and the Humber Acute Service Review (HASR)/Humber Transformation plan ***(System wide joint work).***
    - Workforce and diagnostic/surgical capacity issues are being addressed as part of the HASR and Humber Cancer Transformation plans.
- Joint work is underway with NLaG to address the issue of patient Did Not Attends (DNAs) and GP referrals to multiple sites for same patient
- Living with & beyond cancer– This is about supporting patients to live well with cancer after treatment; having personalised stratified follow up and Remote Digital Monitoring which is about using digital solutions to monitor patients remotely.

### *7.3 HUMBER & NORTH YORKSHIRE CANCER ALLIANCE*

- HNY Cancer Alliance has responsibility for streamlining cancer pathways and is supporting the CCG on cancer pathway redesign/service improvement ***(System wide joint work)***
- Working with the Cancer Alliance, a rapid diagnostic service has been established in Northern Lincolnshire in line with national guidance and two new agreed pathways (colorectal and vague symptoms) have been rolled out across primary care. The rapid diagnostic service has been funded by the Rapid Diagnostic Service (RDS). ***(System wide joint work).***
- A new community diagnostic hub is planned for Northern Lincolnshire. This is a diagnostic centre which can undertake a series of blood tests that can generate a stratified cancer risk. ***(System wide joint work).***

# 8. DISCUSSIONS

Many cancer services were already under pressure prior to the pandemic. Cancer waiting times targets were consistently missed throughout the pandemic and also frequently missed pre-pandemic. Variable month-on-month changes in demand combined with the capacity constraints have led to bottlenecks at different points in cancer pathways in particular access to diagnostics. This has had profound impact on the rate at which cancer treatments are delivered.

The CCG is working jointly with HNY Cancer Alliance on cancer pathway redesign/service improvement and on initiatives to support the recovery of treatment capacity. The new community diagnostic hubs, cancer collaborative and cancer champions program are expected to help improve public awareness and patients accessing the screening and cancer services. The long-term impact of delayed or missed referrals caused by the Coronavirus pandemic (e.g., survival rates) remains to be seen.

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