Guidance on recovery, restoration and reconfiguration for oncology departments

This guidance is aimed at all those in the UK who lead non-surgical cancer departments and cancer Multi-Disciplinary Teams (MDTs). It is intended to support them as they reconfigure services during the endemic phase of COVID-19 infection. The guidance offers high-level generic advice, drawing on the good practice and new ways of working developed within the oncology community during the pandemic period. There are links to currently available national guidance where relevant.

This guidance was written by The Royal College of Radiologists' Faculty of Clinical Oncology (CO) with particular input from CO Officers, CO Heads of Service, members of the CO Faculty Board and CO Professional Support and Standards Board. It will have wide application and relevance across the non-surgical oncology team and comments from other cancer service leads, the Society and College of Radiographers (SCoR) and the Institute of Physics and Engineering in Medicine (IPEM) have been gratefully received and incorporated.

It has been endorsed by the SCoR and IPEM.

Dr Tom Roques
Medical Director, Professional Practice, Clinical Oncology, The Royal College of Radiologists
Consultant Clinical Oncologist, Norfolk and Norwich University Hospitals NHS Foundation Trust

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Endorsed by:

1. Background

1.1 Oncology departments in the UK have continued to provide radiotherapy, systemic anti-cancer therapies (SACT) and other supportive care throughout the first wave of the COVID-19 pandemic.

1.2 Whilst individual discussions of risk and benefit have always been at the heart of oncology service delivery, COVID-19 poses a new challenge to assessing the risk of treatment and communicating this to patients in the context of the pandemic.

1.3 Nosocomial (hospital-acquired) transmission is an important cause of viral spread. Reducing the risk of virus transmission by following excellent infection prevention and control procedures is vital.

1.4 In some centres, groups of patients have had treatment deferred because the risk of possible exposure to COVID-19 outweighed the benefit of immediate treatment (e.g. skin and prostate radiotherapy, priority 5&6 chemotherapy).

1.5 Individual patients may have had radiotherapy or SACT stopped, deferred or shortened if the risks, including COVID-19 infection, were thought to outweigh the benefits. These decisions will have been discussed and agreed between the patient and the clinical team, and documented contemporaneously in the clinical record.

1.6 The Academy of Medical Royal Colleges has produced guidance on principles for reintroducing healthcare services.

1.7 COVID-19 is now endemic and oncology services must adapt to cope with this in three ways, outlined in more detail in this guidance:

- **Recovery** - recommencing treatments deferred during the pandemic where capacity exists and benefits once again outweigh risks
- **Restoration** – enabling service delivery whilst mitigating for endemic COVID-19 and changes to other services (e.g. diagnostic pathways, cancer surgery capacity)
- **Reconfiguration** – learning from the changes made to services in response to the pandemic and embedding into routine practice those which directly benefit patients.

2. Recovery

2.1 Follow NICE COVID-19 rapid guidelines on delivery of radiotherapy and systemic anti-cancer treatments. Keep checking those guidelines as they are updated as appropriate.

2.2 Follow NHS guidance on COVID-protected sites such as this operating framework from NHS England.

2.3 Encourage patients to seek help from hospital services when necessary, for example using acute oncology services.

2.4 Review the lists of deferred patients and prioritise recommencing treatment when risks have been mitigated. Consider:

- the likely benefit of treatment over no treatment, or alternatives such as a further planned delay
- the risk to patients of attending for treatment (e.g. age, comorbidities that may increase risk of severe COVID-19 infection)
- the risk to others in the patient's household (e.g. people who are shielding)
- available department capacity.

2.5 Inform all patients of the processes that will be in place to minimise risk when they attend for consultations or treatment. For people having radiotherapy, use this information.

2.6 Ensure that people who choose not to come for treatment receive information about the risks of not having treatment. Ensure they have a further appointment arranged to discuss their decision with the clinical team.

2.7 Discuss any proposed changes to standard treatment pathways and protocols with patients and their families. Record these discussions contemporaneously in the patient record.

3. Restoration

Supporting staff

3.1 Provide support for all staff. Facilitate remote or home working for staff who are shielding or where remote working promotes physical distancing.

3.2 Review government guidance on working safely during coronavirus.

3.3 Ensure high quality training opportunities are maintained for all staff in training across all curriculum domains. Ensure medical trainees have weekly virtual or face-to-face meetings with their clinical or educational supervisor.

3.4 Ensure all staff take the annual leave to which they are entitled.

3.5 Ensure staff have adequate time for continuing professional development (CPD) e.g. to attend virtual conferences, for reflection and for appraisal.

3.6 Ensure all staff have access to psychological support services.

3.7 Enable staff to make reasonable adjustments to patterns of work so that they can continue to undertake caring roles at home.

3.8 Assess the risk profile of individual staff members for COVID-19 infection and modify their patient-facing duties accordingly. Risk profiles should be reviewed regularly as the level of risk changes.

Supporting patients

3.9 Provide patients with information on the risks of COVID-19 in cancer. Record that the possible risks of COVID-19 infection and ways to mitigate this have been discussed as part of the informed consent process.

3.10 Ensure the shielded patients list is accurate, regularly updated and maintained.

3.11 Use video or telephone appointments for patients where appropriate. Offer face-to-face consultations for all new and other appropriate patients when the risk of exposure to COVID-19 has been minimised.

3.12 Consider the use of a remote consent process for radiotherapy and chemotherapy.

3.13 Discuss and record patients' priorities and wishes about emergency care and end of life care. Use the ReSPECT process and documentation where possible.

Organising the department and reducing infection risk

3.14 Follow national Infection Prevention and Control (IPC) guidance to reduce healthcare associated infections, including nosocomial transmission of COVID-19. All staff must:

- practice good hand and respiratory hygiene, keeping hands away from face
- practice physical distancing at all times including when not in clinical areas
- use the appropriate level of Personal Protective Equipment (PPE)
- clean any shared equipment frequently e.g. phones, desktops, keyboards
- reduce movement between clinical areas of differing risk where possible

- declare all COVID-like symptoms, however mild, and not attend clinical areas for work if unwell.

3.15 Review facilities, patient pathways and treatment schedules to minimise infection risk, for example in communal waiting areas and chemotherapy units.

3.16 Screen patients for symptoms of COVID-19 infection when they arrive in the department.

3.17 Follow national guidance when developing local protocols and pathways for testing asymptomatic staff and patients for COVID-19. Local protocols will depend on the prevalence of infection and availability of testing. Protocols may need to be updated depending on the impact of changes to physical distancing and shielding policies.

3.18 Ensure there are clear pathways for testing symptomatic patients and staff. Ensure symptomatic patients are isolated from others and that they are assessed for other infections where appropriate, e.g. neutropenic sepsis. Follow national public health advice in treating symptomatic infection.

3.19 Be aware that productivity and throughput are likely to be significantly impacted by safety requirements such as the use of PPE, infection control procedures and the need to be physically distant.

Continuing treatment

3.20 Review cancer pathways with site-specific MDTs to assess the ongoing impact of changes in diagnostic services and availability of other treatments (e.g. surgery) on radiotherapy and SACT services. Record variance in diagnosis (e.g. absence of histology) and treatment at an MDT level.

3.21 Audit clinical outcomes of any changes to standard treatment protocols.

3.22 Contribute data to national service evaluation projects (e.g. COVID RT) and to research of COVID-19/cancer where possible (e.g. UK Coronavirus Cancer Monitoring Project and International Severe Acute Respiratory Infection Consortium Clinical Characterisation Protocol).

3.23 Consider government advice on interim treatment regimens to minimise hospital visits for SACT (e.g. Interim NHS England Treatment Regimens)

3.24 Review department radiotherapy treatment protocols to ensure appropriate evidence-based dose-fractionation schedules are in place to minimise attendance where possible (e.g. single fractions for bone metastases, hypofractionated radiotherapy for adjuvant breast cancer).

3.25 Ensure appropriate training, quality assurance and mentoring arrangements are in place before implementing any new treatment techniques.

3.26 Work with government and national bodies to enable hypofractionated radiotherapy where clinically appropriate (e.g. stereotactic ablative radiotherapy (SABR) for lung and prostate cancers). In England this will require engagement with service commissioners and Operational Delivery Networks (ODNs).

3.27 Manage patient flows and equipment to deliver radiotherapy and chemotherapy to patients with COVID-19 infection who are well enough for treatment and for whom treatment is necessary.

3.28 Plan for a possible increase in treatment capacity as cancer pathway referrals increase. The peak of demand is expected to be in Autumn 2020. This may mean considering options such

as extended opening hours or weekend working if these are possible and not already being undertaken.

Working with others

3.29 Liaise with the local Research and Development departments to re-open cancer clinical trials as soon as capacity allows, with the support of National Institute for Health Research Clinical Research (NIHR) Networks.

3.30 Work regionally (e.g. in ODNs and Cancer Alliances in England) to plan for service continuity in possible subsequent waves of serious COVID-19 infection, particularly for specialised services such as SABR or brachytherapy.

3.31 Plan service continuity with the wider hospital team when other services are involved, e.g. anaesthetic support for brachytherapy, clinical radiology for assessment of treatment response and interventional radiology for ablative therapies.

3.32 Work with the independent sector to provide extra capacity on COVID-protected sites where possible.

4. Reconfiguration

4.1 Consider how different ways of working such as working from home may improve life/work balance and increase staff retention.

4.2 Ensure all staff have equitable and transparent access to support, training and promotion opportunities.

4.3 Ensure that staff who are retiring are offered opportunities to return to work should they wish.

4.4 Engage all staff who volunteered their services at the start of the pandemic to continue to provide assistance where possible.

4.5 Ensure those in training are considered when services, including outpatient clinics, are redesigned.

4.6 Consider innovative ways to deliver training in the workplace and on-line including that provided by professional bodies.

4.7 Recognise and address sources of inequality of access to care that some patients may experience, such as the increased reliance on new technologies in service delivery.

4.8 Review follow-up protocols, including frequency of imaging, for each tumour site. Consider patient-directed follow-up where possible.

4.9 Design clinical pathways to minimise separate visits to hospital.

4.10 Maximise workforce utilisation across traditional organisational boundaries, e.g. develop technologies to enable remote peer review of radiotherapy contours and plans; facilitate prospective arrangements to allow clinic cover between hospitals.

4.11 Enable remote attendance at meetings including operational, educational and cancer MDT meetings. Streamline MDT meetings as suggested in NHS-England guidance.

4.12 Ensure departments have an up-to-date plan for managing service continuity in the event of a local resurgence of COVID-19 or in any future pandemic.

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