Greater Manchester Cancer

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Risk Stratifying Adult Patients with Suspected or Diagnosed Cancer during the COVID-19 Pandemic for Sarcoma

Purpose of this document:	To provide clear processes for all Provider Trusts to implement with regard to the clinical management of Adult Patients with suspected or diagnosed sarcoma through the COVID-19 pandemic, in order that patients are treated consistently and equitably across the Region. Please refer to this document in conjunction with GM Cancer COVID-19 Cancer Management SOP V1 (for instruction on processes relating to management of patients in Somerset).
Exclusions:	This paper relates to Adult Patients only. Children, Teenage and Young Adult Cancers should be managed in accordance with normal protocol. Excludes National Screening Programme
Version Control:	
V FINAL	FINAL. Authors: Amit Kumar (AK) with thanks to colleagues across GM and RJAH for their contribution. In line with national guidance issued (17.03.20, 19.03.20)

1. Introduction

This document sets out the process to be implemented in relation to the cessation and risk stratification of Adult Patients with suspected or diagnosed cancer in the event that diagnostic and treatment resources are limited as a result of the COVID-19 pandemic, or where clinical risk exceeds normal treatment or diagnostic pathways.

Given the rapid changes, this document is expected to be updated, in line with any changes to National Guidance.

2. Key Message

ANY PATIENTS WHO MAY REQUIRE CANCER DIAGNOSTICS, EVEN IF THIS IS POST PANDEMIC, **MUST** BE RETAINED BY THE TRUST **AND** REMAIN ON A PTL, **AND** ON A DEDICATED COVID WAITING LIST.

ONLY PATIENTS WHO DO NOT NEED ANY SECONDARY CARE APPOINTMENTS OR DIAGNOSTICS ON A SUSPECTED CANCER PATHWAY CAN BE DISCHARGED.

3. PTL Management

Clinical Leads should risk stratify PTLs in accordance with the following criteria and categorise into the appropriate group:

Action	Criteria
Step Down	As per normal PTL management on receipt of all necessary diagnostic results and a non-cancer decision. No change to current practice. If diagnostics show no evidence of soft tissue or bone sarcoma step down and offer clinic consultation (telephone) if appropriate.
Safe Discharge	Following review and no suspicions of cancer/no further diagnostics required. Telephone Assessment Criteria: Assess features of soft tissue lump or bone symptoms, correlate history with MDT findings. Clarify PMH and presentation of symptoms. Previous treatment and

	investigations. Advise and re-assure patient. In some instances open follow up can be offered ie 12 months
Suspend	If patient cannot be seen / or undergo telephone consultation, DNA (consider discharge with GP letter). Patient declines any further input.
Active Management	i) Outpatients/diagnostics identified as appropriate ii) Manage according to current process with clear clinical engagement Changes to the diagnostic pathway that can be made in light of COVID-19. Patients going straight to test and/or biopsy. Consider face to face or telephone consultation. Treatment to be decided by clinical time within resources available in a timely manner. MDT remote attendance is being offered. Listed for surgery or other treatment as per MDT. Surgical priority stratification

4. Management of Long Term Follow Up/CNS lists/Recently treated patients (patients NOT on a live PTL)

Clinical Leads to review FU clinic waiting lists/recent treatment lists and categorise into groups to safely discharge/suspend with review date/actively manage.

Action	Criteria
Safe Discharge	Following review and no further input from secondary care required. If completed treatment with no concern or if further surveillance deemed not required.
Suspend	If patient declines further surveillance in writing or by phone
Active Management	Manage according to current process with clear clinical engagement. Adhere to sarcoma surveillance programme with remote chest x-rays (patients can defer these if they wish) and telephone consultations. Face to face may be carried out on alternate surveillance time frames.

5. **Management of New GP/Dental Referrals**

Each tumour group should ensure processes are in place for the daily triage of referrals and follow the following tumour specific guidance:

PLEASE NOTE:

Referrals cannot be rejected without discussion with primary care. Patients may be discharged after telephone appointments **if cancer is no longer suspected and there is no longer need for any cancer diagnostics**. Telephone appointments can now be counted as 'first seen appointment' as per national guidance.

1. Cancer Services / Booking Centre: distribute referrals as per tumour group decision.
2. Cancer Services / Booking Centre: Register patients on PAS as per normal process
3. Clinical leads: review emails daily in accordance with criteria of safely discharge after review if cancer no longer suspected and no further cancer investigations needed/suspend with review date/actively manage and respond to generic email.

Action	Criteria
Safe Discharge (following review and no further input from secondary care required)	If history and imaging reveals no malignant pathology with or without histopathological results. This will have MDT input.
Suspend	If patient declines further input. DNA' x 2
Active Management	Manage according to current process with clear clinical engagement If MDT decision is for surgical or other treatment – Should be listed on MFT cancer waiting list with surgical stratification as per local trust policy. Other treatments ie radiotherapy, chemotherapy dependent on treating centre policy and timescales.

MDT/sMDT Guidance:

- Maintain weekly MDT: remotely if needed
- Aim to minimise number of staff present at MDT e.g. 1 surgeon, 1 oncologist, 1 pathologist, 1 radiologist and one Clinical Nurse Specialist

6. **Annotation - delays/treatment plan changes on Cancer Tracking system**

If general delays (identified through referral management and tracking) are observed, the recording of formal clinical prioritisation (following PTL clinical review

and prioritising), and the recording of treatment types offered that would not normally be considered outside of the COVID-19 pandemic (From MDT / treatment planning) must be formally documented for each patient (see SOP).

7. Clinical Prioritisation

Surgery	• In general the sarcoma treatment pathways should remain the same in terms of structure for primary sarcomas. Surgery +/- radiotherapy remains the mainstay of treatment for soft tissue sarcoma. The biological spectrum of behaviour of sarcoma is particularly broad and it will fall to the Multidisciplinary Team to apply appropriate triaging criteria to patients' sarcoma during the period of resource constraint. There are appropriate nomograms to help with risk stratification (https://www.sarculator.com/). • Atypical lipomatous tumours and complex benign tumours, with the exception of locally aggressive tumours such as giant cell tumour of bone, should probably **not** be operated on during this period.
Radiotherapy	• As above
SACT	• Decisions regarding the treatment of patients with chemotherapy will be determined by the treating multidisciplinary team taking into account any altered risk benefit profile for individual patients who might contact COVID-19 and in line with national guidelines in development.

8. Alternative treatment given / recommended

Clinical Leads should use the following criteria when making decisions that result in changes to a patient's treatment from that which would have been offered prior to the COVID-19 pandemic.

9. Research

This will be according to local and national guidance but it is likely that entry into clinical trials could be suspended during the acute period of the pandemic.

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