COVID-19 rapid guideline: delivery of systemic anticancer treatments

NICE guideline
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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.
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Overview

The purpose of this guideline is to maximise the safety of patients with cancer and make the best use of NHS resources during the COVID-19 pandemic, while protecting staff from infection. It will also enable services to match the capacity for cancer treatment to patient needs if services become limited because of the COVID-19 pandemic.

This guideline links to a table of NHS England interim treatment regimens during the COVID-19 pandemic. Check the table for updates.

12 February 2021: We have reviewed the evidence on the effects of systemic anticancer treatment on risk of severe illness or death in patients with cancer and COVID-19 and made new recommendations.

This guideline focuses on what you need to stop or start doing during the pandemic. Follow the usual professional guidelines, standards and laws (including those on equalities, safeguarding, communication and mental capacity), as described in making decisions using NICE guidelines.

This guideline is for:

- health and care practitioners
- health and care staff involved in planning and delivering services
- commissioners.

The recommendations bring together:

- existing national and international guidance and policies
- advice from specialists working in the NHS from across the UK. These include people with expertise and experience of treating patients for the specific health conditions covered by the guidance during the current COVID-19 pandemic.

We developed this guideline using the interim process and methods for developing rapid guidelines on COVID-19 in response to the rapidly evolving situation. We are reviewing and updating the recommendations as the knowledge base develops using the interim process and methods for guidelines developed in response to health and social care emergencies.
1 Communicating with patients and minimising risk

All patients

1.1 Communicate with patients and support their mental wellbeing, signposting to charities and support groups where available, to help alleviate any anxiety and fear they may have about COVID-19.

1.2 Minimise face-to-face contact by:

- offering telephone or video consultations (particularly for follow-up appointments and pre-treatment consultations)
- cutting non-essential face-to-face follow-up
- using home delivery services for medicines if capacity allows
- introducing drive-through pick-up points for medicines
- using local services for blood tests if possible.

1.3 Advise all patients to contact their local cancer chemotherapy helpline (rather than NHS 111) if they feel unwell to ensure their symptoms are appropriately assessed.

1.4 Tell patients who still need to attend services to follow relevant parts of government advice on social distancing (this may differ across the UK), or UK government guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from COVID-19. [amended 26 May 2020]

1.5 Discuss with patients the individual factors that may affect their risk of becoming severely ill with COVID-19, including underlying conditions, older age, male sex, ethnicity, cancer symptoms and vaccination status.

See the UK Chemotherapy Board’s clinician frequently asked questions and guidance on COVID-19 vaccine for patients receiving systemic anti-cancer...
therapy (SACT). [12 February 2021]

Patients without COVID-19

1.6 Ask patients to attend appointments without family members or carers, if they can, to reduce the risk of contracting or spreading SARS-CoV-2.

1.7 Minimise time in the waiting area by:

- careful scheduling
- encouraging patients not to arrive early
- texting patients when you are ready to see them, so that they can wait in their car, for example.

Patients with known or suspected COVID-19

1.8 When patients with known or suspected COVID-19 have been identified, follow appropriate UK government guidance on infection prevention and control. This includes recommendations on patient transfers, transport and options for outpatient settings.

1.9 All healthcare workers involved in receiving, assessing and caring for patients with known or suspected COVID-19 should follow UK government guidance on infection prevention and control. This contains information on using personal protective equipment (PPE), including visual and quick guides for putting on and taking off PPE.
2 Patients with symptoms of COVID-19 at presentation

2.1 If a patient not previously known or suspected to have COVID-19 shows symptoms on presentation, the general advice is to follow UK government guidance on investigation and initial clinical management of possible cases. This includes information on testing and isolating patients.

2.2 Be aware that patients having systemic anticancer treatments are immunocompromised and may have atypical presentations of COVID-19. Also, symptoms of COVID-19, neutropenic sepsis and pneumonitis may be difficult to differentiate at initial presentation.

2.3 Screen and triage all patients to assess whether they are known or suspected to have COVID-19, or have been in contact with someone with confirmed infection.

2.4 If patients have fever (with or without respiratory symptoms), suspect neutropenic sepsis because this can be rapid and life-threatening, and follow the NICE guideline on neutropenic sepsis, which recommends:

- referring patients with suspected neutropenic sepsis immediately for assessment in secondary or tertiary care
- treating suspected neutropenic sepsis as an acute medical emergency and offering empiric antibiotic therapy immediately.

2.5 If COVID-19 is later diagnosed in someone not isolated from admission or presentation, follow UK government guidance on management of exposed staff and patients in health and social care settings. [amended 26 May 2020]
3 Systemic anticancer treatments

Shared decision making with individual patients

3.1 Discuss with all patients the risks and benefits of starting, continuing or deferring systemic anticancer treatment. Include in the discussion:

- factors that may affect their risk of becoming severely ill with COVID-19, including underlying conditions, male sex, ethnicity, cancer symptoms and vaccination status
- that there is uncertainty whether patients who have received systemic anticancer treatment are at increased risk of becoming severely ill with COVID-19
- the possible greater risk of poor outcomes for patients with haematological cancers from COVID-19
- the possible greater risk of poor outcomes from COVID-19 with increasingly immunosuppressive systemic anticancer treatments.

Reach a shared decision with the patient about their treatment. [12 February 2021]

3.2 If a patient has COVID-19, reach a shared decision about treatment but if possible defer systemic anticancer treatment:

- until at least 10 days after a positive test for SARS CoV 2, and
- until any significant symptoms have resolved. [12 February 2021]

Prioritising systemic anticancer treatments

3.3 If systemic anticancer treatments need to be prioritised, use table 1 to help make these decisions. Take into account:

- the level of immunosuppression associated with individual treatments and cancer types, and any other patient-specific risk factors (including vaccination status) [amended 12 February 2021]
- capacity issues, such as limited resources (workforce, facilities, intensive care, equipment)
• balancing the risk of cancer not being treated optimally with the risk of the patient being immunosuppressed and becoming seriously ill from COVID-19.

Table 1 Prioritising systemic anticancer treatments [amended 3 April 2020]

<table>
<thead>
<tr>
<th>Priority level</th>
<th>Treatment</th>
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</table>
| 1              | Curative treatment with a high (more than 50%) chance of success  
Adjuvant or neoadjuvant treatment which adds at least 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse |
| 2              | Curative treatment with an intermediate (20% to 50%) chance of success  
Adjuvant or neoadjuvant treatment which adds 20% to 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse |
| 3              | Curative treatment with a low (10% to 20%) chance of success  
Adjuvant or neoadjuvant treatment which adds 10% to 20% chance of cure to surgery or radiotherapy alone or treatment given at relapse  
Non-curative treatment with a high (more than 50%) chance of more than 1 year extension to life |
| 4              | Curative treatment with a very low (0% to 10%) chance of success  
Adjuvant or neoadjuvant treatment which adds less than 10% chance of cure to surgery or radiotherapy alone or treatment given at relapse  
Non-curative treatment with an intermediate (15% to 50%) chance of more than 1 year extension to life |
| 5              | Non-curative treatment with a high (more than 50%) chance of palliation or temporary tumour control and less than 1 year expected extension to life |
| 6              | Non-curative treatment with an intermediate (15% to 50%) chance of palliation or temporary tumour control and less than 1 year expected extension to life |

Table adapted from NHS England’s clinical guide for the management of non-coronavirus patients requiring acute treatment: cancer.

3.4 Make prioritisation decisions as part of a multidisciplinary team and ensure each patient is considered on an individual basis. Ensure the reasoning behind each decision is recorded.
3.5 Clearly communicate, with written documentation if possible, what prioritisation is and the reason for the decision to patients, their families and carers.
4 **Modifications to usual service**

4.1 Think about how to modify usual care to reduce patient exposure to COVID-19 and make best use of resources (workforce, facilities, intensive care, equipment).

4.2 Make policy decisions about modifications to usual care at an organisational level.

4.3 Try to deliver systemic anticancer treatment using different and less immunosuppressive regimens, different locations or via another route of administration where possible. Options include:

- switching intravenous treatments to subcutaneous or oral alternatives where this would be beneficial (subject to agreement with commissioners)

- using shorter treatment regimens

- decreasing the frequency of immunotherapy regimens, for example moving to 4-weekly or 6-weekly

- providing repeat prescriptions of oral medicines or other at-home treatments without patients needing to attend hospital

- using home delivery of oral and subcutaneous medicines where possible

- using treatment breaks for long-term treatments (possibly for longer than 6 weeks)

- providing interim treatment regimens. [amended November 2020]

4.4 Ensure each patient is considered on an individual basis by the multidisciplinary team. Record the reasoning behind each decision.

4.5 Discuss the risks and benefits of changing treatment regimens or having treatment breaks with patients, their families and carers, and reach a shared decision. [amended 12 February 2021]

4.6 Think about retraining nurses who have moved to other cancer nursing specialist roles to be systemic anticancer therapy (SACT) nurses (using the UK
Retrain nurses who:

- have administered SACT within the previous 2 years
- have completed theoretical training (such as the passport or accredited course)
- complete the relevant passport clinical competencies with a practice assessor.

Interim NHS England treatment options

Be aware that to allow for flexibility in the management of cancer during the COVID-19 pandemic, NHS England has endorsed interim treatment options for some cancer medicines. This is to reduce the need for direct patient contact for administration of drugs and to minimise potential side effects that make people more susceptible to viral infections and other ill-health effects that may add pressure to the health system. These interim treatment options are based on clinical opinion from members of the NHS England Chemotherapy Clinical Reference Group and cancer pharmacists (see the interim treatment regimens for details). [9 April 2020]

Be aware that treatment regimens will revert to the standard commissioned position once the emergency measures put in place to address the COVID-19 pandemic are no longer necessary. [9 April 2020]

Discuss the risks and benefits of interim treatment regimens with patients, their families and carers. [9 April 2020]

All patients who start on an interim treatment regimen during the COVID 19 pandemic should be allowed to continue the treatment until they and their clinician jointly decide it is appropriate to stop or to switch to a different treatment. [9 April 2020]

Treatment breaks

It is proposed that the current treatment break policy, which applies to both Cancer Drugs Fund (CDF) and non-CDF treatments, will not be applied during
the COVID-19 outbreak.

4.13 Where a treatment break is needed, clinicians should complete the approval form to restart treatment, indicating that the patient had a break because of COVID-19. The request will be approved even if their disease has progressed, providing the clinician indicates there is a reasonable chance that disease control can be regained on restarting treatment. It is expected that the response to treatment will be reviewed 2 or 3 cycles after restarting. If disease control has not been regained treatment should be stopped.
5 Staff who are self-isolating

5.1 If a healthcare professional needs to self-isolate, ensure that they can continue to help by:

- enabling telephone or video consultations and attendance at multidisciplinary team meetings
- identifying patients who are suitable for remote monitoring and follow-up and those who are vulnerable and need support
- carrying out tasks that can be done remotely, such as entering data.

5.2 Support staff to keep in touch as much as possible, to support their mental wellbeing.
Recommendations for research

We have made the following recommendations for research.

1 Risk of systemic anticancer treatment in people with cancer and COVID-19

Are patients with cancer and COVID-19 who are receiving/have recently received systemic anticancer treatment (SACT) (that is, within the 4 weeks preceding a diagnosis of COVID-19) at increased risk of severe COVID-19 illness or death? [12 February 2021]

It is recommended that this research should also consider:

- if there are specific types of SACT carrying increased risk of poor outcomes from COVID-19
- if there are specific types of cancer for which SACT may carry increased risk of poor outcomes from COVID-19
- if there is a difference in any risk of poor outcomes from COVID-19 between people who have received SACT alone, radiotherapy alone, or both SACT and radiotherapy
- if there is a difference in any risk of poor outcomes from COVID-19 between children and young people who have received SACT and adults who have received SACT.

2 Duration of risk of systemic anticancer treatment in people with cancer and COVID-19

Are people who have had SACT recently (that is, within the 4 weeks preceding a diagnosis of COVID-19) at increased risk of poor outcomes from COVID-19 compared with those who had SACT less recently? [12 February 2021]
Update information

12 February 2021: We have reviewed the evidence on the effects of systemic anticancer treatment on risk of severe illness or death in patients with cancer and COVID-19 and made new recommendations. We added vaccination status to the first bullet point of recommendation 3.3 and emphasised the importance of reaching a shared decision in recommendation 4.5.

9 November 2020: We amended recommendation 4.3 because deferring treatments that prevent long-term complications is no longer recommended. We added subcutaneous medicines to the medicines that can be provided by home delivery.

27 April 2020: We updated the table on interim treatment options in line with new advice from NHS England and NHS Improvement. Check the table for updates.

9 April 2020: We amended recommendation 4.3 to include NHS England interim treatment options as an option. We added 4 recommendations on these interim treatment regimens and linked to the table on interim treatment regimens on the resources tab.

3 April 2020: We amended table 1 in line with new advice from NHS England on prioritising treatments.

Minor changes since publication

26 May 2020: We aligned recommendation 1.4 with current government advice on social distancing and recommendation 2.5 with current government advice on managing exposed staff and patients in health and social care settings.

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