Title: Cancer Services in Ireland in the context of Covid-19
Author: Department of Health and HSE, National Cancer Control Programme
Organisation: Department of Health and HSE
Date: 17 December 2020

Action required:
☒ For noting
☐ For discussion
☐ For decision

Approved for future publication: YES
1. Purpose of the Paper

This paper steps through the status of cancer incidence and the capacity of our cancer services in Ireland prior to Covid-19; examines the impact of Covid-19 on these services; outlines the actions taken to mitigate risks and minimise the impact on cancer patients; sets out the efforts being made to measure outcomes for patients; and outlines the plans for sustainable provision of services to meet patient needs.

2. Summary

Demand for cancer diagnostic and treatment services continued to grow in recent years in line with our growing and aging population. While progress has been made under the National Cancer Strategy 2017-2026, the level of funding available for its implementation was lower than originally anticipated and cancer services struggled to meet demand.

Cancer diagnostic and treatment services continued throughout the Covid-19 pandemic in line with Government prioritisation. However, the number of people coming forward to their GPs, being referred to Cancer Rapid Access Clinics and attending these clinics decreased significantly in mid-March to May largely due to the fears in regard to Covid-19, and the reaction of people to restrictions in place at that time. In addition, physical distancing and infection prevention and control measures impacted on both diagnostic and treatment service capacity.

The Department of Health (DoH) and the National Cancer Control Programme (NCCP) led a coordinated response to Covid-19 in relation to cancer services. Clear messaging was disseminated on the availability of safe cancer services. Particular focus was placed on the referral of urgent cases to diagnosis as they presented. Close engagement with clinicians enabled difficulties to be addressed, with guidelines for treatment developed to meet a changing environment. The availability of private hospital capacity was vital in facilitating cancer surgery in particular. The three National Cancer Screening programmes, which had been paused, were recommenced and invitations were prioritised for those who had waited longest for screening. Engagement across Acute services, Primary Care, the voluntary sector and cancer support centres aided the overall effort to the benefit of patients.

The impact of the Covid-19 pandemic on cancer morbidity and mortality due to delayed diagnosis in Ireland to date is not quantifiable at this point. This is due to an absence of near real time data. Reports from the National Cancer Registry cover data from approximately two years previous.

A recent collaboration convened by the Faculty of Pathology of the RCPI to evaluate the impact of Covid-19 on cancer care and cancer patients indicates that the experience in Ireland was replicated in Northern Ireland and elsewhere in the UK. We will continue to monitor, and to learn from, the international experience more broadly. Meanwhile, the fact that we have not seen the same dips in referrals and attendances through the second wave of Covid-19 is encouraging.

An allocation of €14.35m has been made to facilitate the restoration of current cancer services to 95% of 2019 capacity. This funding, combined with the allocation of €20m in Budget 2021 to expedite the implementation of the National Cancer Strategy 2017-2026, will provide a major boost in the effort to improve cancer services for all. Also, we intend to build on the levels of flexibility achieved during the Covid-19 pandemic to accelerate the development of new initiatives in cancer services.
The greatest threat to resilience in the cancer services in the short-term remains increased community transmission of Covid-19. It is important that we continue to promote the message that our cancer diagnostic and treatment services are open, and that anyone who has concerns about cancer should attend their GP.


3.1 Cancer incidence

The National Cancer Registry Ireland (NCRI) Annual Report 2020 estimates that 24,793 cancers (excluding non-melanoma skin cancer) were diagnosed annually between 2018 and 2020. Overall, the risk of developing cancer was about 22% higher for men than for women.

The Report shows that rates of cancer in Ireland, when corrected for population and age, have begun to level off, and even decline for many cancer types. As such, increases in case numbers in more recent years largely reflect population growth and ageing in Ireland. Demographic factors will lead to a substantial increase in the number of cancer cases over coming decades.

3.2 Cancer survival

The NCRI reports that survival for Irish cancer patients continues to improve, with five-year net survival for patients averaging 63% based on follow-up during 2012-2016, up from 42% for patients diagnosed during 1994-1999. Significant survival improvements are evident for most types of cancer.

Based on the international CONCORD study1, survival of Irish cancer patients ranks in the top half of EU countries surveyed for most cancer types. However, given the complications of securing comparable data across countries in a timely way, the data involved goes back to 2010-2014 and so does not reflect more recent performance.

In a report by the International Agency for Research on Cancer (IARC)2 on cancer survival rates across seven high-income countries (1995–2014), Ireland showed the greatest improvement in survival for stomach and oesophageal cancers and the second highest improvement for rectal and ovarian cancers.

The number of cancer survivors continues to increase. The NCRI estimates that over 190,000 people previously diagnosed with an invasive cancer (other than non-melanoma skin cancer) were alive at the end of 2018. This is nearly 4% of the population, and the number of survivors is likely to exceed 200,000 by the end of this year.

3.3 National Cancer Strategy 2017 - 2026

The vision of the National Cancer Strategy 2017-2026 is that ‘together we will strive to prevent cancer and work to improve the treatment, health and wellbeing, experiences and outcomes of those living

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with and beyond cancer’. Through the implementation of the Strategy, we seek to reduce the cancer burden, provide optimal care, maximise patient involvement and quality of life, and enable and assure change.

While significant progress has been made since the launch of the Strategy in 2017, the level of funding available has been less than anticipated. Challenges are arising in meeting the needs of patients, apart from implementing vital initiatives envisaged in the Strategy. The number of cancer patients continues to grow, in line with Strategy projections. These challenges exist regardless of the Covid-19 pandemic.

More emphasis on prevention measures, better access to diagnosis, increased levels of medical, radiation and surgical oncology are all needed, as well as broadened treatment services for some cohorts and tumour types, and greater emphasis on living well with and beyond cancer.

It is an overall aim of the Strategy that survival rates will reach the top quartile of European countries by the end of the Strategy period. We are currently mid-table and, while up-to-date comparative data is a challenge, there is little indication that we have progressed relative to the better performing countries.

### 3.4 Cancer service capacity

There are 8 designated cancer centres, 4 in Dublin and one in Waterford, Cork, Limerick and Galway. A total of 26 public hospitals provide systemic anti-cancer therapy (SACT) services. Radiotherapy services are provided in 5 public hospitals (3 in Dublin; Cork and Galway).

#### 3.4.1 Cancer Diagnosis

Symptomatic Breast Disease Clinics and Rapid Access Lung and Prostate Clinics in the 8 designated cancer centres (with LUH providing a satellite breast cancer service to UHG) provide a consultant-led service for symptomatic patients, offering direct and rapid access to assessment and diagnosis for suspected cancers. Demand for these services has continued to grow in line with demographic trends. This is putting increasing pressure on our ability to meet key performance indicators for time within which to be seen at a clinic.

**Table 1: Attendance & KPI Performance 2015 – 2019 at Rapid Access Clinics**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new patients attending annually</td>
<td>40,413</td>
<td>41,579</td>
<td>40,680</td>
<td>42,772</td>
<td>43,376</td>
</tr>
<tr>
<td>Access KPI - 95% seen within 10 working days (urgent) / 12 weeks (non-urgent)</td>
<td>91%</td>
<td>81%</td>
<td>73%</td>
<td>72%</td>
<td>68%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new patients attending annually</td>
<td>3,099</td>
<td>3,249</td>
<td>3,404</td>
<td>3,730</td>
<td>3,602</td>
</tr>
</tbody>
</table>
### Access KPI - 95% seen within 10 working days

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new patients</td>
<td>2,581</td>
<td>2,580</td>
<td>3,015</td>
<td>3,356</td>
<td>3,818</td>
</tr>
<tr>
<td>Access KPI - 90% seen within 20 working days</td>
<td>59%</td>
<td>54%</td>
<td>62%</td>
<td>88%</td>
<td>67%</td>
</tr>
</tbody>
</table>

While figures are not available, it is likely that trends for other tumour types are on similar lines.

#### 3.4.2 Cancer Treatment

Radiation Oncology - Radiation oncology is provided in 5 public hospitals: St. James’s, Beaumont and St. Luke’s (collectively known as the St. Luke’s Radiation Oncology Network), Cork University Hospital and University Hospital Galway. Radiation oncology is also provided to public patients in 2 private facilities in Waterford and Limerick. Services are also available to patients from the Republic of Ireland at the North West Cancer Centre in Altnagelvin Area Hospital, Derry.

**Table 2: Radiotherapy Number of Patients & KPI Performance 2017 -2019**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>4,932</td>
<td>5,131</td>
<td>4,900</td>
<td>5,394</td>
<td>5,869</td>
</tr>
<tr>
<td>Access KPI - 90% seen within 15 working days</td>
<td>76%</td>
<td>82%</td>
<td>84%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 3: Monthly daycase treatments for radiotherapy in 2019 across all hospitals (source: HIPE)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>8,926</td>
<td>8,308</td>
<td>8,620</td>
<td>9,113</td>
<td>9,411</td>
<td>8,544</td>
<td>9,824</td>
<td>8,504</td>
<td>9,120</td>
<td>9,110</td>
<td>9,015</td>
<td>8,405</td>
<td>106,900</td>
</tr>
</tbody>
</table>

Medical Oncology - Systemic anti-cancer therapy (SACT) services are currently provided at 26 public hospitals. The use of SACT has increased over the last ten years, with a variety of new effective therapeutics becoming available. The NCRI has predicted that the number of new patients receiving chemotherapy will increase by between 42% and 48% in the period 2010 to 2025.

**Table 4: Monthly daycase Systemic Anti-Cancer Treatments (SACT) in 2019 across all public hospitals (Source: HIPE)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
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<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>10,076</td>
<td>8,969</td>
<td>9,424</td>
<td>9,875</td>
<td>10,535</td>
<td>8,955</td>
<td>10,579</td>
<td>9,962</td>
<td>9,565</td>
<td>10,290</td>
<td>9,737</td>
<td>9,361</td>
<td>117,328</td>
</tr>
</tbody>
</table>
Surgical oncology - Surgery plays a pivotal role in the management of cancer and is curative as the sole treatment in a high percentage of cases. As one of the major pillars of cancer care and control, it can be preventive, diagnostic, curative, supportive, palliative and/or reconstructive. Demand for cancer surgery will increase in line with demographic trends. Last year, 83% of cancer surgeries took place in a designated cancer centre. The centralisation of cancer surgery is based on clear evidence that patients who are operated on by surgeons who carry out higher volumes of surgery in specialist centres, that themselves have high volumes, achieve better outcomes. It is a policy objective of the National Cancer Strategy that all cancer surgery will be carried out in a designated cancer centre and we will progress this further over the coming years.

Table 5: Number of cases having a primary diagnosis of cancer and associated surgical procedure blocks by month of discharge for 2019 (Source: HIPE)

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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<th>May</th>
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<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>1,154</td>
<td>1,145</td>
<td>1,293</td>
<td>1,304</td>
<td>1,429</td>
<td>1,256</td>
<td>1,347</td>
<td>1,230</td>
<td>1,345</td>
<td>1,287</td>
<td>1,391</td>
<td>1,269</td>
<td>15,450</td>
</tr>
</tbody>
</table>

4. Covid-19 & Cancer Services

4.1 Government commitment to continue cancer services throughout Covid-19

The Covid-19 National Action Plan identified the continued delivery of cancer care as a priority. From the outset of the Covid-19 pandemic, DoH and NCCP have worked closely together to minimise the impact on cancer patients. For many, treatment continued, with the implementation of essential Infection prevention and control measures but with relatively little impact on their patient experience. Indeed, some patients with Covid-19 continued to receive cancer treatment.

The agreed principles that underpinned the continued provision of cancer services included:

- continuation of treatment following consideration of the risk:benefit ratio of treatment for each individual patient;
- continuation of diagnostic services, including through the Rapid Access Clinics (RACs);
- prioritising time-sensitive treatment;
- reviewing the location of the delivery of cancer services to optimise patient safety and infection control;
- optimising the potential for providing cancer services in private hospitals;
- ensuring that cancer patients (medical, radiation & surgical) are seen and treated within a non-Covid designated clinical environment. This may be within a designated public hospital facility (separate entrance, ideally separate building to location of treatment for Covid-19 patients) or in a private hospital.

4.2 Cancer Screening

The three National Cancer Screening Service programmes, which were paused in March due to Covid-19, have now recommenced. Initial invitations for the programmes are being prioritised, generally for those who have waited longest for screening. Targeted communication campaigns are underway to encourage uptake.
CervicalCheck began a phased approach to resuming on 6th July. CervicalCheck estimate all ‘paused’ screening invitation letters will have been sent by December 2020, and all people due a screening test in 2020 will have been invited by March 2021. Over 162,000 letters have been issued to date. While initial uptake of these priority invitations was low at the start, it is slowly increasing (from 12% in September to 18% in October). Colposcopy clinics are processing follow-up appointments.

BreastCheck resumed screening on 27th October. Invitations are being prioritised for people who have waited longest for screening, and this includes new entrants to BreastCheck, the 50-52-year olds who are coming for screening for the first time. The backlog of screening must be completed prior to inviting a new cohort of women. Approximately 153,000 screening invites were paused due to Covid-19.

- The BreastCheck mobile units screen approx. 73% of clients. The Programme has completed the upgrade to mobile vans to ensure they adequately meet any infection control requirements and physical distancing guidelines;

- Due to the impact of Covid-19 and reduced capacity, the National Screening Service advise that it would potentially take three years to complete this current round of screening compared with usual 24-27 months. (There is no policy change on the two-year interval.) However, even with this lengthened timeframe, Ireland will still be within EU norms, as there is no international standard for frequency of screening, and many countries including England, screen on a three-yearly cycle. Once an individual woman gets her screening in this round, she is personally ‘caught up’.

BowelScreen resumed issuing new invitations on a phased basis on 4th August. Approx. 123,000 invitations had been paused, and at end October over 39,300 new invitations had been issued, with approx. 10,900 sample kits returned to the lab and almost 400 patients referred for colonoscopy. Three quarters of surveillance patients are within the required three-month KPI. Mitigation strategies associated with resumption of services include adding capacity by enrolling additional hospitals to provide colonoscopies and insourcing.

The focus of the National Screening Service programmes restart is to achieve a maximum screening invitation rate that is compatible with a safe and controlled follow-up assessment and treatment capacity within the health service. All screening services involve population-based screening for people without any symptoms. The NSS must balance the risk of bringing healthy asymptomatic people into areas they could be exposed. The aim is to get through the current rounds of screening in the shortest time possible. Due to the impact of Covid-19, safety measures are being implemented to protect both participants and staff. For this reason, the NSS will be unable to screen participants at the same level as pre-Covid-19.

Targeted communications campaigns are underway to encourage those who receive invitations to follow them up. The NSS is urging screening participants to come for their appointments when called, or to let them know if they cannot attend so that their appointment can be re-scheduled and/or the time slot offered to another person.

The Government has committed to provide €10m in new funding for Cancer Screening in 2021, with the following priorities:
• progress the development of a new National Cervical Screening Laboratory;
• increase colposcopy capacity;
• develop 2 new semi-permanent BreastCheck Units; and
• enhance the Client Services system to support access to records across all screening services.

4.3 Cancer referrals from Primary Care

There was a big reduction in referrals received from GPs in the early part of the Covid-19 pandemic. Current GP e-referral data indicates a strong recovery in referrals to cancer Rapid Access Clinics (RACs), with the most significant recovery in referrals to the Symptomatic Breast Disease Clinics. The data also indicates that there has been no drop off in e-referrals to RACs during the recent period of Level 5 restrictions.

Table 6: Comparison of monthly GP e-referrals sent via Healthlink to all rapid access cancer services in the eight cancer centres (plus Letterkenny for Breast) for 2020 and 2019

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<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>4,031</td>
<td>3,533</td>
<td>2,290</td>
<td>2,446</td>
<td>3,400</td>
<td>3,707</td>
<td>3,940</td>
<td>3,527</td>
<td>4,280</td>
<td>4,894</td>
<td>5,211</td>
<td>41,259</td>
</tr>
<tr>
<td>2020 as % of 2019</td>
<td>107.87%</td>
<td>100.83%</td>
<td>64.06%</td>
<td>74.35%</td>
<td>94.95%</td>
<td>127.92%</td>
<td>124.21%</td>
<td>117.61%</td>
<td>138.11%</td>
<td>124.82%</td>
<td>138.41%</td>
<td>109.90%</td>
</tr>
</tbody>
</table>

4.4 Rapid Access Clinics attendances (Breast, Lung, Prostate)

RACs have continued to operate throughout the Covid-19 period. Patients are being triaged in advance of their appointments, including through utilising virtual/telephone clinics where appropriate. Numbers were down in the March-July period. Attendance figures for the month of September show breast and lung numbers above the average monthly figures in 2019, with prostate slightly less than last year’s rate. In the year to end September, attendance numbers stand at 81% of the 2019 levels.

Table 7: Attendances at all Rapid Access Clinics (Source: Management Data Report)

<table>
<thead>
<tr>
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<th>Jan</th>
<th>Feb</th>
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<th>Nov</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>4,759</td>
<td>4,271</td>
<td>2,713</td>
<td>1,700</td>
<td>2,584</td>
<td>3,360</td>
<td>3,740</td>
<td>3,310</td>
<td>4,460</td>
<td>30,897</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>4,320</td>
<td>3,688</td>
<td>4,356</td>
<td>4,461</td>
<td>4,800</td>
<td>4,166</td>
<td>4,176</td>
<td>3,966</td>
<td>4,063</td>
<td>37,996</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020 as % of 2019</td>
<td>110.2%</td>
<td>115.8%</td>
<td>62.3%</td>
<td>38.1%</td>
<td>53.8%</td>
<td>80.7%</td>
<td>89.6%</td>
<td>83.5%</td>
<td>109.8%</td>
<td>81.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Cancers diagnosed in RACs (including urgent and non-urgent Symptomatic Breast Disease Clinics) to end September stand at 4,088 - nearing 90% of the comparable figure in 2019. With attendances for this period at 81%, this would most likely indicate that more urgent cases are being recognised at Primary Care and triage stages.

Table 8: Total number of cancers detected at symptomatic breast disease clinic and rapid access clinics for lung and prostate
4.5 Medical Oncology

While throughput has reduced, partly because of less patients coming forward and being referred, Medical Oncology Day Wards continued to operate, with some relocating within hospitals or, for a time, to private facilities. While numbers have increased, the challenges of social distancing and infection prevention & control measures will continue to impact on capacity in medical oncology. The number of new patients commencing chemotherapy up to August 2020 is at 85% of 2019 activity. There has been an increased focus on providing chemotherapy to patients in the community, in some case in the patient’s home.

Table 9: Monthly daycase Systemic Anti-Cancer Treatment (SACT) treatments in 2019/2020 across all public hospitals (Source: HIPE)

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
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<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>546</td>
<td>509</td>
<td>437</td>
<td>279</td>
<td>386</td>
<td>486</td>
<td>506</td>
<td>457</td>
<td>482</td>
</tr>
<tr>
<td>2019</td>
<td>515</td>
<td>438</td>
<td>465</td>
<td>528</td>
<td>621</td>
<td>491</td>
<td>546</td>
<td>511</td>
<td>507</td>
</tr>
<tr>
<td>2020 as % of 2019</td>
<td>106.02%</td>
<td>116.21%</td>
<td>93.98%</td>
<td>52.84%</td>
<td>62.16%</td>
<td>98.98%</td>
<td>92.67%</td>
<td>89.43%</td>
<td>95.07%</td>
</tr>
</tbody>
</table>

Figures are not available for services provided for a number of months in 6 private hospitals and this would boost the 85% total modestly.

4.6 Radiation Oncology

Radiation Oncology services have continued to treat all newly referred patients. The fact that radiotherapy is provided in purpose-built buildings, largely separate from other service provision, is a help in this regard. However, the ongoing need for physical distancing and other infection prevention and control measures is resulting in some reduction in capacity from pre-Covid-19 levels. The number of daycase radiotherapy sessions (patients would have multiple sessions) to end August is at 91% of 2019 activity. Reductions in numbers coming through surgery have had a knock-on effect on those presenting for radiotherapy, enabling the latter service to meet the needs of patients who do present.
Table 10: Monthly daycase treatments for radiotherapy in 2019/2020 across all hospitals (source: HIPE)

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>9,331</td>
<td>8,151</td>
<td>8,444</td>
<td>7,277</td>
<td>6,540</td>
<td>7,832</td>
<td>9,294</td>
<td>7,751</td>
<td>64,620</td>
</tr>
<tr>
<td>2019</td>
<td>8,926</td>
<td>8,308</td>
<td>8,620</td>
<td>9,113</td>
<td>9,411</td>
<td>8,544</td>
<td>9,824</td>
<td>8,504</td>
<td>71,250</td>
</tr>
<tr>
<td>2020 as % of 2019</td>
<td>104.54%</td>
<td>98.11%</td>
<td>97.96%</td>
<td>79.85%</td>
<td>69.49%</td>
<td>91.67%</td>
<td>94.61%</td>
<td>91.15%</td>
<td>90.69%</td>
</tr>
</tbody>
</table>

4.7 Surgical Oncology

In the early period, many hospitals moved time sensitive and complex surgeries to private hospitals that had the required facilities and support services. Public patient cancer surgery numbers for the year to August stand at 72% of 2019 levels.

Table 11: Number of HIPE cases having a primary diagnosis of cancer and associated surgical procedure blocks in public hospitals by month of discharge for 2020 and 2019 (Source: HIPE)

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>1,226</td>
<td>1,235</td>
<td>1,252</td>
<td>487</td>
<td>584</td>
<td>725</td>
<td>1,016</td>
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<td>2019</td>
<td>1,154</td>
<td>1,145</td>
<td>1,293</td>
<td>1,304</td>
<td>1,429</td>
<td>1,256</td>
<td>1,347</td>
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<td>2020 as % of 2019</td>
<td>106.24%</td>
<td>107.86%</td>
<td>96.83%</td>
<td>37.35%</td>
<td>40.87%</td>
<td>57.72%</td>
<td>75.43%</td>
<td>61.95%</td>
<td>71.74%</td>
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In April-June period the breakdown of public patient provision was approximately 50% in public hospitals and 20% in private hospitals. There is a significant time lag in getting information on cancer surgeries in public hospitals and the HSE has continued to experience difficulties in accessing accurate data on public patient treatment in private hospitals.

The Faculty of Pathology (RCPI) recently convened a collaboration to evaluate the impact of Covid-19 on cancer care and cancer patients (for publication shortly). This provides further insights into the number of public patients who underwent surgical treatment in the private sector, indicating that the fall in cancer resections overall was 12.5% in March - June compared to the same period in 2019. Surgery will remain an area of particular focus, given its significant curative role for many cancer patients and the evolving situation in regard to access for public patients to private hospital capacity.

5. Actions taken in response to Covid-19

5.1 Leadership of DoH / NCCP

DoH and the NCCP worked closely together throughout the Covid-19 pandemic with a view to responding quickly to ensure the continued provision of cancer services. Close engagement with cancer services and stakeholders also underpinned the response throughout the pandemic.

This allowed the NCCP to:
• learn quickly about issues and concerns on the ground;
• ensure broad input to guidance and rapid dissemination thereof;
• remain informed of regional service changes; and
• influence/advise where necessary to ensure prioritisation of essential cancer services.

Pre-existing networks and relationships were crucial to the timeliness and success of the response.
Engagement was partly through structured regular teleconferences across specific disciplines, as well as direct contact on a centre by centre basis.

Engagement was much broader than with hospital cancer services alone. For example, the NCCP connected with GPs through updates on the HSE website (www.hse.ie/cancer), mailshots via healthlink, direct contact with the ICGP and presentations at the ICGP weekly webinar series - particularly focussing on the ongoing provision of the rapid access services.

5.2 Guideline Development

The ability to rapidly develop, adapt and disseminate guidance on cancer care to support cancer services across systemic anti-cancer therapy delivery, radiation oncology, surgical oncology and diagnostic services was a key role for NCCP.

The guidance development process was facilitated by NCCP’s already established role in the production of national guidance, the close engagement with existing clinical networks throughout and the availability of public health expertise in-house. A new governance process was put in place for the rapid adoption of guidelines and protocols, via the HSE’s Chief Clinical Officer’s Clinical Advisory Group.

Guidance was informed by available evidence and clinical expertise on the criticality of treatments and risk; benefit to patients in the light of the unknown added risk of Covid-19; and interpretation of national public health and infection prevention and control guidance in the context of cancer care. The degree to which guidance documents were rapidly developed, revised and re-issued was unprecedented.

Areas addressed included
• treatments or services that could be safely paused/suspended;
• infection prevention and control precautions, incorporating pre-assessment, for continuing services;
• considerations when delivering essential cancer treatment to someone who is a Covid-19 close contact, has Covid-19 themselves, or is recovered from Covid-19; and
• specific guidance for cancer support centres, including on re-opening.

5.3 Private Hospital Utilisation

In the early period, many hospitals moved some time sensitive treatments and complex surgeries to private hospitals that had the required facilities and support services. This was supported by the Private Hospital Agreement in place until June 2020 and the continued provision of surgical and medical oncology (and to a lesser extent radiation oncology) benefitted from this expanded capacity. Hospitals moved quickly, on a local level, to relocate some surgery to private hospitals. There was a focus on moving time sensitive and complex surgeries to private hospitals that have the required facilities and support services (including ICU/HDU). Moves happened more readily where there are
natural partnerships or strong local relationships. All moves since September 2020 have been underpinned by NCCP principles on the relocation of care as follows:

- patients continue to have their case discussed at the multidisciplinary team meeting
- images/slides from diagnostic tests carried out elsewhere are available and reviewed at multidisciplinary team meetings
- patients have access to the full range of multidisciplinary specialist care, as if they had received their treatment at the cancer centre/usual designated treatment centre
- a clear pathway for pre- and post-procedure care (including unscheduled care) is agreed with the treating centres and communicated to patients and their carers
- a system is in place to facilitate the collection of key performance indicators and for review of quality of care

Since the agreement with private hospitals concluded in June, some cancer services continue to operate using private facilities based on local arrangements. Also, the HSE is engaged in establishing a tendering framework through which Hospital Groups will be able to seek services for public patients in private hospitals.

5.4 Monitoring Data and Reacting

DoH and the NCCP worked very closely in the initial phases of Covid-19 to monitor data on cancer services and to feed into the broader response. The identification of the continued delivery of cancer care as a priority in the Covid-19 National Action Plan was most important. The focus on monitoring the unfolding situation from the outset enabled the NCCP to identify particular gaps or requirements in the system. This led to various initiatives on the ground, including securing funding under the Covid-19 response for engaging 26 acute oncology nurses, one in each hospital providing cancer services. These nurses focused on the provision of safe treatment, and in particular on Emergency Department avoidance for those undergoing cancer treatments during the pandemic, and it is acknowledged that they had a great impact to the benefit of patients.

However, the NCCP were challenged in regard to access to timely data. Healthlink e-referral data was an exception, being reported on a more frequent weekly basis. Problems with timely data were sometimes exacerbated by staff redeployments in the context of the pandemic. While access to live HIPE streams was secured, this data was likely to be delayed relative to the norm. For the most part, data was at least two months in arrears.

The NCCP’s direct linkage with services helped to offset these delays and to ensure that they were reasonably up-to-date on how initiatives were working, aware of the status of service delivery overall and alerted to any concerns. This enabled some tweaking of responses as the situation unfolded.

5.5 Collaboration with the NGO sector

NCCP linked closely with cancer charities and advocacy organisations throughout the pandemic. This ensured evidence-based messaging to patients, survivors and volunteers in line with public health guidance. It also allowed the NCCP to harness their offers of direct support to the Covid-19 effort, which included the redeployment of the Irish Cancer Society Daffodil nurses to cancer centres to assist in the Covid-19 response.
Recognising the distress of cancer patients during this time, a virtual psycho-oncology service (Together 4 Cancer Concern) was developed by the NCCP in conjunction with Cancer Care West and the Irish Cancer Society. The NCCP linked closely with the network of cancer support centres throughout the country. Wherever possible, these centres continued to offer support to patients on a virtual basis and the NCCP worked closely with them with regards to guidance on safe re-opening of services.

5.6 Clear communications

DoH and the NCCP was keenly aware of the understandable concern among cancer patients and survivors throughout the Covid-19 period. Covid-19 was known to cause severe illness in older people and those with comorbidities, and these populations were advised to cocoon. Advice was provided to cancer patients on minimising personal risk for Covid-19. Cancer patients attending for essential cancer treatment were provided with clear guidance and messaging, including re-assurance to encourage their attendance for treatment.

NCCP quickly developed a suite of patient information material, advising patients and survivors on how to minimise their individual risk of Covid-19 (e.g. following cocooning advice) and offering reassurance in relation to the measures being put in place to protect them when attending clinical services. This material was made available on their website, shared through clinical services and disseminated by cancer support services.

Information was continually reviewed and updated in line with developing knowledge of the virus and updated national public health guidance. Through regular engagement with cancer charities, NCCP were able to ensure the most up-to-date advice was being given to patients and survivors and could address queries when required.

Two specific promotional videos were developed – one to offer reassurance to those undergoing treatment and the other to encourage anyone with potential signs and symptoms of cancer to contact their GP. These were distributed through HSE social media and the HSE press office, as well as the existing NCCP communication networks of services and support centres.

6. Measurements of Outcomes

Overall, a huge focus has been put on minimising the impact of Covid-19 on cancer services. This involved encouraging patients to follow up on any concerns by visiting their GPs and by attending for other medical appointments; continuing diagnostics services; and treating patients as they came forward, all in line with Government policy.

Cancers diagnosed in Rapid Access Clinics to end September 2020 stood at 4,088 – 11.5% less than the comparable figure in 2019. This reduction arises from less people presenting for diagnosis. While different terms are used, ‘lost’ of ‘missing’ cancers arising from Covid-19 are an international phenomenon.

Latest data shows a recovery in the numbers of people presenting in primary care, and in attendances at Cancer Rapid Access Clinics. In September, the total number of attendances at Rapid Access Clinics amounted to 4,440, an increase on the same month last year.

The Faculty of Pathology of the RCPI recently convened a collaboration to evaluate the impact of Covid-19 on cancer care and cancer patients up to mid-year. Their draft report adds an international
comparison to the Irish experience. It is clear that the experience in Ireland was replicated in Northern Ireland and elsewhere in the UK. It is important that we continue to monitor, and to learn from, the international experience more broadly.

The draft report indicates that the fall in cancer resections across both the public and private sectors was 12.5% in March - June compared to the same period in 2019. Surgery is an area on which we will need to keep a particular focus, given its significant curative role for many cancer patients and the evolving situation in regard to access for public patients to private hospital capacity. The report also references the lack of ‘near’ real time data and the need for this to be addressed.

We have not seen the same dips in referrals and attendances through the second wave of Covid-19, and this is encouraging. However, diagnostic and treatment facilities are impacted by Covid-19 precautions. One of the key aims of the NCCP’s Winter and Covid-19 plans is to bolster these services. Also, we have to ensure that, irrespective of the prospects for successful vaccination, we continue to be in a position to give confidence to patients to attend for treatment and, also, that we provide such treatment safely and effectively.

The full impact of Covid-19 on cancer survival rates and outcomes for patients, in terms of patients upstaged as a result of a later diagnosis with a resultant potential adverse prognosis will not be known until data from the NCRI is evaluated in about 2 years from now. The current focus is on encouraging people who have any concerns to come forward so that the number of ‘lost’ cancers is reduced as much as possible, and the time delay in diagnoses for individual patients is minimised.

7. Plans for sustainable provision of service to meet patient needs

7.1 Lessons from Covid-19

Experience during the Covid-19 pandemic has accelerated the development of welcome new initiatives in cancer services. It is an aim to build on the levels of innovation and adaptability achieved to continue to make improvements. This will include the increasing use of ICT in the delivery of care and the optimisation of diagnostic and treatment pathways to improve the patient experience, including to reduce footfall, where appropriate, in the acute hospital setting. It is evident that there is a lack of ‘near’ real time data available and that this is something that needs to be tackled through a comprehensive e-Health Strategy. Recruitment of personnel will also be pursued, with a particular emphasis on optimising skill mix.

7.2 Funding for the restoration of cancer services (£14.35m)

An allocation of £14.35m has been made (Restoration of Services Funding £12m; and Winter Plan Funding £2.35m) to facilitate the restoration of current cancer services to 95% of 2019 capacity. This funding will:

- facilitate the expansion of capacity in diagnostic services in the context of Covid-19;
- support virtual clinics and more accurate triage;
- facilitate the better organisation of medical, radiation and surgical oncology in the context of increased organisational focus, social distancing and the provision of infection prevention & control measures;
• fund minor capital works to enable capacity restoration in medical oncology daywards; and
• support the continued provision of psycho-social supports to cancer patients and their families, including through the Together 4 Cancer Concern patient support initiative

Even with this extra funding, it will not be possible to restore services to 100% of the 2019 levels. Given our increasing and ageing population, we know that the number of cancer patients will continue to increase. In that scenario, there will be on-going pressure on cancer services through 2021. Should Covid-19 rates persist at reasonably high levels, or fluctuate significantly, in 2021, there will be further impacts on cancer services.

7.3 Funding for the Implementation of the National Cancer Strategy (€20m)

A sum of €20m has been allocated to the implementation of the National Cancer Strategy in 2021. This will bring the overall increase in funding next year to €34.35m. This funding will be utilised for the following:

• progress cancer prevention initiatives;
• improve performance of Rapid Access Clinics (RACs) for Breast, Lung and Prostate cancers. The aim is to see all patients within the agreed KPIs;
• improve access to diagnostics for patients with cancers tumours not covered by an RAC (only covers breast, lung and prostate);
• address the increasing, and more complex, demand for radiation oncology, including the provision of essential staffing requirements for the new facility in CUH, and the development of the new facility in UHG;
• enhance medical oncology services to meet the growing need;
• improve services in the Hereditary Cancer Programme;
• development of the Cancer Genetics Service.
• increased use of previously approved cancer drugs with increasing patient numbers;
• further centralisation of cancer surgery; and
• continue the development of survivorship services, including psycho-oncology services, to improve quality of life of those living with and beyond cancer.

7.4 Broader context for the continued provision of cancer services

The increased provision of funding for cancer services in 2021 greatly boosts our efforts for the sustainable provision of service to meet patient needs. Also, the necessities of 2020 have led to some streamlining of services that will continue to benefit patients. DoH and the NCCP intend to ensure that the spirit of innovation demonstrated will be retained and built upon.

Cancer patients, and all involved in cancer services welcome the work being done on the development, and likely imminent introduction, of Covid-19 vaccines. However, the greatest threat to resilience in the cancer services in the short-term is increased community transmission of Covid-19. This would most likely lead to cancer service specialist staff contracting Covid-19, or being contacts of those who test positive, giving rise to lengthy absences from work.

It remains important that we continue to promote the message that our cancer diagnostic and treatment services are open, and that anyone who has concerns about cancer should attend their GP.