To: Cancer Alliance leadership teams
Cc: regional teams

7 May 2020

Dear Colleagues,

We are contacting you to ask for your help in reminding the clinical teams in your areas of their role in identifying patients at highest clinical risk to COVID-19 and advising them to shield. The list of conditions that put someone at highest risk of being severely ill if they were to catch COVID-19 is set out in Annex 1.

As you will be aware, the process for identifying those at highest clinical risk of COVID-19 has been taking place in three parts.

Parts one and two involved centrally identifying patients using hospital and then primary care data. These patients were then sent letters and text messages centrally.

The current phase – part three – gives GPs and hospital specialists an opportunity to add or remove individual patients who have been identified as high risk.

By now, many additional patients will have been added to the registry by GPs and hospital specialists and most clinically extremely vulnerable patients will have been captured through these processes. However, we are still receiving reports of cancer patients who believe that they should have received a shielding letter but have not yet received one or have not been added to the national list.

It is crucial that those who are clinically extremely vulnerable receive a letter advising them to shield. As well as ensuring their safety through shielding, the letter provides evidence to employers and enables these patients to access government support to the shielding cohort.

The submission methods for adding and removing any new patients remain open to GPs and Trusts and will continue to be open throughout the COVID-19 incident. We are therefore asking that you remind GPs and hospital Trusts in your Alliance areas to continue to identify patients who they consider, in their professional judgement, to be at high clinical risk and should therefore be shielded.

The process for adding patients to the national list was set out in letters to GPs and to hospital trusts. It is critical that any patients identified locally are added to the national list through these routes, or they will not be able to access the government support. A set of frequently asked questions on this process is also available.

Thank you in advance for your support in helping ensure that we identify these patients and ensuring that they receive the guidance and support that they need to keep them safe.

Kind regards,

Professor Peter Johnson

National Clinical Director for Cancer

Annex 1:

1. Solid organ transplant recipients.
2. People with specific cancers:
    - people with cancer who are undergoing active chemotherapy
    - people with lung cancer who are undergoing radical radiotherapy
    - people with cancers of the blood or bone marrow such as leukaemia, myelodysplastic syndromes, lymphoma or myeloma who are at any stage of treatment[1]
    - people having immunotherapy or other continuing antibody treatments for cancer
    - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
    - people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs [2]
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD).
4. People with rare diseases that significantly increase the risk of infections (such as SCID, homozygous sickle cell).
5. People on immunosuppression therapies sufficient to significantly increase risk of infection.
6. Women who are pregnant with significant heart disease, congenital or acquired.

[1] This means before, during or after treatment, including those being managed expectantly
[2] When applying these criteria locally, clinicians should take into account the new Covid-19 NICE guidance on haemotopoietic stem cell transplantation which states that patients should follow shielding advice:

- if they had an autologous HSCT within the last year
- if they had an allogeneic HSCT within the last 2 years, or they are having continuous immunosuppressive therapy, they have chronic graft versus host disease (GvHD) or there is evidence of ongoing immunodeficiency (or for other extremely vulnerable groups based on clinical assessment).