NHS
Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance

Somerset, Wiltshire, Avon & Gloucestershire Cancer Alliance Surgical Hub

Operational Policy and

Terms of Reference

Version 3
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Contents

Aim

This document details the governance and operational processes of the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance Surgical Hub during the SARS COVID-19 pandemic. In conjunction with the mutual aid operational process map, it describes the mechanism for regional access to allow maintenance of crucial surgical oncology services, when capacity at individual Trusts proves insufficient to treat patients in a clinically safe timescale. It has been informed by clinical and operational feedback. Due to the region's geography, the hub is a virtual entity which accesses a range of appropriate physical locations.

Background

NHS England (NHSE) estimates up to 30% of surgical cases are in the highest priority category and have requested Alliances/regions to set up cancer surgery hubs to facilitate and maximise the number of patients able to undergo curative cancer surgery in a safe timescale during the pandemic. NHSE guidance endorsing and promoting the 'hub' concept and Alliance-level triage for surgery was published on 30 March 2020.

Without such intervention, the COVID-19 crisis could limit access to timely cancer surgery, resulting in a significant rise in secondary mortality from cancer deaths, as well as patient distress, and uncontrolled cancer symptoms.

The approach agreed within the SWAG Cancer Alliance is a virtual hub, based on mutual aid between its providers, facilitated centrally where necessary. The Alliance believes this allows for maximum flexibility to maintain activity within the region and allowing for the wide geographical area covered.

Paediatric services and skin cancer are out with this guidance, as are any services or procedures provided at only one provider in the Alliance region (e.g. brain surgery, thoracic surgery).

Terminology

Clinically safe timescale – the longest an individual patient can wait for their surgery before harm as a result of waiting becomes probable (e.g. tumour becoming unresectable). This is determined by the clinical team managing the patient.

CPG - Cancer Clinical Prioritisation Group

MDT – Multi-Disciplinary Team (meeting)

Referring Provider – The provider where the patient's treatment was originally planned but cannot be organised in a timely way, who requests mutual aid

SWAG - Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance

Receiving Provider – The provider who provides the surgical treatment for a patient from a referring provider

Review Date

The policy will be reviewed no later than one year after its formal approval, or at the end of routine COVID-19 precautions in the UK, whichever is earlier.

The Cancer Clinical Prioritisation Group (CPG)

CPG membership comprises:

- Chair: SWAG Cancer Alliance Clinical Director
- Cancer Clinical Director or nominated Deputy from each Trust
- Cancer Alliance Managing Director and Manager

The Group meets weekly via a virtual platform (Microsoft Teams) and notes are taken by the Alliance business support. The Group shall be considered quorate if half of the participating providers are represented.

The remit of the Clinical Prioritisation Group is to:

- Maintain an overview of surgical demand within the region and any capacity constraints
- Where required, assist providers with prioritisation of patients (individuals or groups), including a facilitating transfer to an alternative provider where necessary
- Ensure patients have equal opportunity to access cancer surgery treatment within a clinically safe timescale in the region

Operational Processes

I. Step 1 'Direct' mutual aid

A provider may find itself unable to offer surgical treatments within a safe clinical timescale to cancer patients for one of the following reasons, or a combination of the two:

1. Lack of physical capacity in terms of space within a hospital
2. Lack of appropriate personnel to deliver treatment.

When this situation arises, the relevant clinical and managerial team is expected to make an informal request for help to another nearby provider. The other provider should consider the request and do its best to accommodate it. This process is referred to as 'direct mutual aid' and is the standard process by which providers have sought assistance in the past. There are several examples of such informal

arrangements having worked in the past between SWAG providers, usually in the event of unexpected longer term surgeon sick leave.

Where such informal arrangements are put in place, the providers must ensure that:

- Each provider is clear on which parts of the pathway it is responsible for, with particular reference to pre-operative and post-operative care
- There are clear arrangements for securely transferring appropriate information and documentation
- Arrangements for clinical nurse specialist/keyworker support are clear
- The patient agrees to the transfer
- The operating surgeon agrees to the transfer and the arrangements agreed
- If personnel are to operate in a different location from their usual place, they must be in agreement with this and arrangements for proper induction must be made

It is expected that informal requests to another provider to provide treatment: 'direct mutual aid' will be initiated by the treating clinical teams with managerial support in the given speciality. Patient permission will be sought before any patient specific information is shared and also to identify which patients would be prepared to transfer to the alternative provider under consideration.

That aid may either be referral to the potential provider Trust for complete care/treatment but there is also the possibility of surgical teams in either limited or full capacity providing the operation/services in another geographical site as deemed clinically appropriate. This will be dependent on the specialty and complexity of the planned intervention.

This process encourages all Trusts within the Alliance to act collaboratively in providing tailored flexible solutions to such a problem as it arises within existing governance structures.

The intention of mutual aid is not to change treatment decisions, only to enable the agreed treatment to be carried out more promptly. However, it is recognised that most teams when accepting a patient for treatment will wish to discuss in their local MDT in order to ensure proper governance, thus, cases may be further discussed in the treating institution MDT as deemed appropriate. If there is a difference in opinion on the best treatment course, this should be discussed with the referring team/MDT and a final decision agreed between the two.

II. Step 2 'Indirect Mutual Aid'

If a provider has not been able to make adequate arrangements for any surgical cases it is unable to accommodate via 'direct mutual aid', it should notify the CPG via the weekly return made by the Cancer Manager to the Cancer Alliance secretariat. The CPG will review the returns, which include details of current capacity constraints and numbers of patients waiting on a treatment pathway and over 104 days on a 62 day GP referred pathway. Where the returns indicate a potential issue but mutual aid has not been requested, the CPG will check with the provider in question to

confirm if there are any clinical risks and if mutual aid is required. The process for mutual aid is demonstrated in the mutual aid operational process map.

Providers should submit details of the patients requiring mutual aid, to the Alliance using a fixed referral form (See Appendix 2: Referral Information for Clinical Prioritisation Group) and via a secure email route (NHS.net to NHS.net).

Prior to referral to CPG, the patient(s) concerned must have agreed that they are willing to undergo treatment at another provider. Any limitations on location specified by the patient should be noted and shared with the CPG. This conversation may well be undertaken by the clinical nurse specialist, or by any other appropriate person involved in the pathway at the referring provider. No patient identifiable data should be submitted to the CPG at this juncture.

The CPG will utilise the weekly situation reports to review if the capacity position appears to be better at any of the other providers offering the type(s) of surgery required. This will identify providers who may be able to assist. Where multiple providers are possibilities, the nearest provider geographically would be the first preference. It is recognised that surgical activity is complex and involves multiple factors, and as such to identify capacity a conversation with the specific teams will always be necessary.

The CPG will prioritise patients based on ethical, and disease-specific criteria, and using national guidance on prioritisation where available. The CPG will take into account the availability of alternative treatment options as determined by the referring MDT, resource implications, and the impact of treatment on other services.

The CPG may seek assistance in decision making from other relevant specialists including Trust Medical Directors, critical care teams and ethics authorities.

All cases will have been discussed at the local and/or specialist MDT and a treatment plan agreed prior to referral. The CPG will not review the clinical decision.

The ‘indirect’ mutual aid model does not cover surgeons moving to operate at alternative locations (the latter may be arranged under direct mutual aid).

A minimum of four members of the CPG will be required to make decisions on treatment.

Optional input from the referring surgeons at the local institution may be sought at (or in preparation for) the meeting. No patient may be transferred without the agreement of the operating surgeon and of the operational and managerial team at the receiving provider (to include staff representing theatres, post-operative care (including critical care if necessary), radiology and pathology if relevant to the procedure, and anaesthetics.

III. Step 3 Process following CPG meetings

The Cancer Alliance secretariat will ensure outcomes of CPG discussions are documented and communicated back to the referring provider. They will also facilitate communication with potential receiving providers via the Cancer Manager of the relevant organisation, who will be able to pass them to the appropriate operational team.

When a provider is approached to provide mutual aid, the relevant clinical and operational staff will consider the case and confirm within 2 working days of the request if they are able to accommodate it. The provider should consider all relevant factors including impact on any support services (radiology, pathology, Allied Health professionals), as well as nursing, theatres and bed capacity. The operating surgeon must specifically agree to accept the case. There will be a direct conversation between the referring and receiving teams (likely between service managers) to clarify any details and confirm arrangements.

If a provider is unable to provide mutual aid when requested, they should provide a reason for this and this will be documented by the Cancer Alliance secretariat for future reference. Providers are expected to make reasonable efforts to accommodate mutual aid patients.

If a provider agrees to accept the patient, the referring provider will get explicit consent from the patient that they agree to attend the alternative provider for their surgery. At this point, patient identifiable details can be shared with the receiving provider. The receiving provider will confirm what information is required, what surgical work-up is needed i.e. any additional tests by the referring provider, and the arrangements for COVID-19 testing and isolation. The referring organisation is responsible for completing all necessary tests prior to transfer, including any repeat scans if required due to the time waited.

The information agreed in the above step will be communicated to the referring provider via the service managers at the receiving and referring providers. Information transfer can be facilitated by MDT coordinators who are familiar with such processes from standard tertiary referral pathways. The post-operative follow-up arrangements (after discharge) should also be agreed at this point (see below).

The patient will be discussed at the receiving provider's relevant MDT (optional, at the discretion of the receiving provider's relevant clinical team) and will be seen in outpatients by the operating surgeon (or a member of his or her team). Pre-operative assessment will also be carried out at the receiving provider. It would be good practice for this to be a one-stop assessment on the same day as the outpatient appointment, if these are face-to-face contacts. Every effort should be made to minimise journeys for the patient, by use of virtual appointments and one-stop arrangements.

The patient will then be managed by the receiving provider as per its normal processes. Pathology will be sent to the usual lab used by the receiving provider.

Prior to transfer, post-operative follow-up arrangements should be agreed between the referring and receiving teams. In some instances, a treating surgeon may wish to undertake one or more of the post-operative appointments. In others, it may be appropriate for these to be undertaken by a member of the referring team. This should be agreed upfront. The patient's outcomes and pathology should be

discussed in the referring Trust MDT as a minimum, in order to agree ongoing care. The receiving Trust's MDT may also wish to discuss the patient, at their discretion. The patient's discharge summary, operation note and pathology report should be sent back to the referring provider.

The patient's keyworker throughout this process should remain as their clinical nurse specialist at the referring provider. The clinical nurse specialists at the receiving and referring providers should agree between themselves what level of support will be available from the receiving provider clinical nurse specialist during the patient's treatment pathway, if any. The clinical nurse specialists should ensure handover of any relevant information pertaining to the patient (aside from the information already described), at both handover points. The patient should be told clearly who to contact with any problems and what support is available at the receiving provider (or if they need to continue to contact their local clinical nurse specialist throughout).

Data pertaining specifically to the surgical operation will be the responsibility of the receiving provider to collect, in line with the normal data collection arrangements in place for cancer operations at the provider in question. All other cancer dataset items are the responsibility of the referring provider.

Risks and Mitigations

	RISK	CONSEQUENCES	MITIGATION steps
Achieving consistency and equity in cancer treatment	Hospitals and MDT unclear about criteria for Surgical Hub referral	Excess cancer deaths due to delays in treatment	1. Standardised imaging and MDT assessments for the cancer types 2. Region-wide multi-specialty promotion of the role of the CPG, and triggers and processes for referral to it
Lack of surgical or post-operative capacity	Delayed patient treatment	Delay to cancer treatment, progression, distress to patients	1. Create agility to respond to variations by establishing analysis of data in real time with situation reports for access and activity across the Cancer Alliance 2. Plan extra capacity in advance and put in place measures to be activated at certain thresholds of capacity
Nosocomial transmission of COVID-19 from Asymptomatic staff to Patients and vice versa	Surgical environment becomes high COVID infection zone	Excess cancer deaths and prolonged unplanned ICU and inpatient stays Surgical Hub fails Excess cancer deaths due to delays in surgery	Adopt Global Best Practice Model of Frequent testing of all staff and patients irrespective of symptoms, isolation and contact tracing to maintain COVID free surgical environment use of PPE for all patient facing staff
Medicolegal/Ethical concerns, equity, fairness and transparency	Lack of objective decisions with regard to risk benefit discussions of monitoring vs holding therapy vs surgery and around the	Medicolegal consequences (unlikely-Bolam test) Variation in outcomes/	Clear communications with patients and management of expectations, involvement of ethicists, transparent decision

	prioritisations process at cancer hub	and inequity of service within the NHS	making and reporting

Appendix 1: Constituent institutions

Constituent Trusts are:

1. Yeovil District Hospital NHS Foundation Trust
2. Somerset NHS Foundation Trust
3. University Hospitals Bristol and Weston NHS Foundation Trust
4. North Bristol NHS Trust
5. Gloucestershire Hospitals NHS Foundation Trust
6. Royal United Hospital Bath NHS Foundation Trust

Note: Salisbury District Hospital NHS Foundation Trust will use the Wessex hub.

Appendix 2: Referral Information for Clinical Prioritisation Group

Please complete this form fully in order to allow effective prioritisation of surgical cases during COVID-19 emergency escalation by the SWAG Cancer Alliance Clinical Prioritisation Group (CPG).

Any enquiries can be directed to england.swagca@nhs.net

Referring Trust

1. Your Name
Click or tap here to enter text.

2. Referring Trust
(Note – Salisbury District Hospital NHS Foundation Trust will use the Wessex hub)

☐ Gloucestershire Hospitals NHS Foundation Trust
☐ North Bristol NHS Foundation Trust
☐ Royal United Hospital Bath NHS Foundation Trust
☐ Somerset NHS Foundation Trust
☐ University Hospitals Bristol & Weston NHS Foundation Trust
☐ Yeovil District Hospital NHS Foundation Trust

Surgical Requirement

3. Surgical Priority Category

☐ Priority 1
☐ Priority 2
☐ Priority 3 (only if more than 6 weeks after 'target' date)

4. Tumour Site:
Click or tap here to enter text.

5. Operation Type:
Click or tap here to enter text.

6. Estimated operation time (hh:mm)
(Include approximate anaesthetic time)
Click or tap here to enter text.

7. Patient Age:
Click or tap here to enter text.

8. Patient specified treatment location limitations (if any):
Click or tap here to enter text.

9. Patient Comorbidities:
Click or tap here to enter text.