

Peninsula Cancer Surgery Hub

April 2020

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2. Overview

It is recognised that due to the Covid-19 pandemic cancer systems throughout the Peninsula from March 2020 onwards will be unable to deliver normal levels of treatment for all its patients. For some patient cohort's treatment postponement is the safest thing to do clinically. However, for those whose treatment cannot be safely delayed without disease progression, and who are well enough to be treated, given the overall capacity available will be markedly reduced; this proposal recommends a mechanism to maximise the best use of available system capacity

NHS England has published guidance on the cancer surgery during the COVID pandemic.

1. *Advice on maintaining cancer treatment during the COVID-19 response (Publications approval reference: 001559)*
2. *Specialty guides for patient management during the coronavirus pandemic: Clinical guide for the management of essential cancer surgery for adults during the coronavirus pandemic (Publications approval reference: 001559), published in association with the Academy of Royal Colleges*

This states that: -

- Essential and urgent cancer surgery must continue. Cancer specialists should discuss with their patients whether it is riskier for them to undergo or to delay treatment at this time.
- NHS procured Independent Sector hospital capacity should be used for cancer diagnosis and treatment

The proposal outlines how this might be achieved within the Peninsula. At its core, each provider has a The Cancer Surgery Hub which has: -

1. *A prioritisation process which each Provider follows, putting their patients into a single prioritised list for surgery, pooling all specialities together, using provided guidance to support this;*
2. *An allocation and delivery process, where patients are allocated into the available theatre slots according to need*

3. Principles

Maintaining essential cancer surgery will follow these principles: -

- Equitable treatment of patients with life-threatening cancer who need access to surgical and critical care capacity, in relation to COVID-19 patients.
- In line with national guidelines, balancing the urgency of cancer surgery against the risks of the procedure, particularly the risk of complications and a requirement for intensive care support.
- Equity across local healthcare systems, with capacity maximised in dedicated NHS or independent sector hospitals to allocate patient activity based on the greatest prospects for cure.
- Safety of patients, especially with regard to infection control and access to critical care as required.
- Safety of staff undertaking surgery and other care.

4. Proposed Model

Each provider will: -

- i. Plan to continue to provide urgent and essential cancer treatments.**
- ii. Create a Cancer Surgery Prioritisation Team (CSP Team)**
- iii. Refer to the Alliance Cancer Surgery Hub all patients whose surgery is urgent or essential for which there is no capacity within the trust**
- iv. Contribute to the Alliance Cancer Surgery Hub.**

This approach will be deployed as the pandemic builds as well as during the recovery phase as described below: -

i) Plan to continue to provide urgent and essential cancer treatments.

To support the provider and Alliance plans:

- Appendix 1 lists the conditions likely to be covered by priorities 1a, 1b and 2 (urgent and essential). This is not intended to be an exhaustive list but may help with the estimation of treatment volumes.
- Appendix 2 gives an estimate of the breakdown of expected surgical activity once the prioritisation criteria are applied. Nationally, specialised commissioning is seeking to ensure appropriate coverage of rarer conditions across the emerging cancer hubs. This is estimated to be approximately 25% of normal surgical activity for cancer.

Consolidation of cancer surgery in ringfenced 'clean' facilities

- Wherever local circumstances permit, cancer surgery should be consolidated on a 'clean,' COVID-19 free site (or several sites) within the local system. This should include independent sector provision where this has been secured.
- If fully COVID-19 free sites are not available, separate COVID-19 free facilities should be designated on a site, with dedicated access and admission processes as well as inpatient areas separate from those where COVID-19 patients are being treated.
- Staffing for clean facilities will require a designated pool of anaesthetic and surgical consultants, who may need to work outside their employing trust. Appropriate governance arrangements will be required to support this, such as honorary contracts.
- Staff who have recovered from proven or suspected COVID-19 infection must follow Public Health England guidance on return to work, ideally supported by PCR testing to confirm they are negative before returning. If possible, staff in clean facilities will be tested for immunity to COVID-19 by serology, when this becomes available.
- Surgeons and anaesthetists will need to maximise use of theatre time, with consultant-delivered procedures and, where possible, dual-consultant operating to reduce theatre times and the number of people in theatres who may be exposed to aerosols.
- Adequate supplies of personal protective equipment (PPE) will be required for staff working in the designated facilities, in accordance with current national guidelines. PPE is essential to avoid unnecessary exposure and to protect patients and staff from intra-hospital transmission. This will be required even where patients have tested COVID-19 negative.
- Arrangements will need to be in place to test all potential admissions for COVID-19 at most 48 hours before surgery, with patients self-isolating for seven days before admission. Patients will need to consent to testing and self-isolation at the time of listing for surgery. Only patients who have no symptoms suggestive of COVID-19 infection, have been isolated for seven days and have a negative COVID-19 PCR test should be admitted to the designated facilities.
- For any cancer patient with symptoms or who is found to be COVID-19 positive, clinicians will need to decide locally when that patient will be considered fit for surgery; they will be considered alongside other urgent surgery within a hospital treating COVID-19 patients.
- Postoperative major cancer surgery patients should be advised to follow shielding advice, as they will then fall into the high-risk category.

Theatre capacity and workforce

- All sites must maintain existing workforce and provide mitigation against need to staff COVID-19 response. Especially theatre teams.
- Additional pool of anaesthetic, recovery and ODP staff.

- A limited number of surgeons should be specifically allocated to each site and oversee time-critical surgery activity.
- Specialties will be asked to nominate surgeons for this activity.
- Consideration will need to be given to any adverse impact on on-call 'pods.'

ii) Create a Cancer Surgery Prioritisation Team (CSP Team)

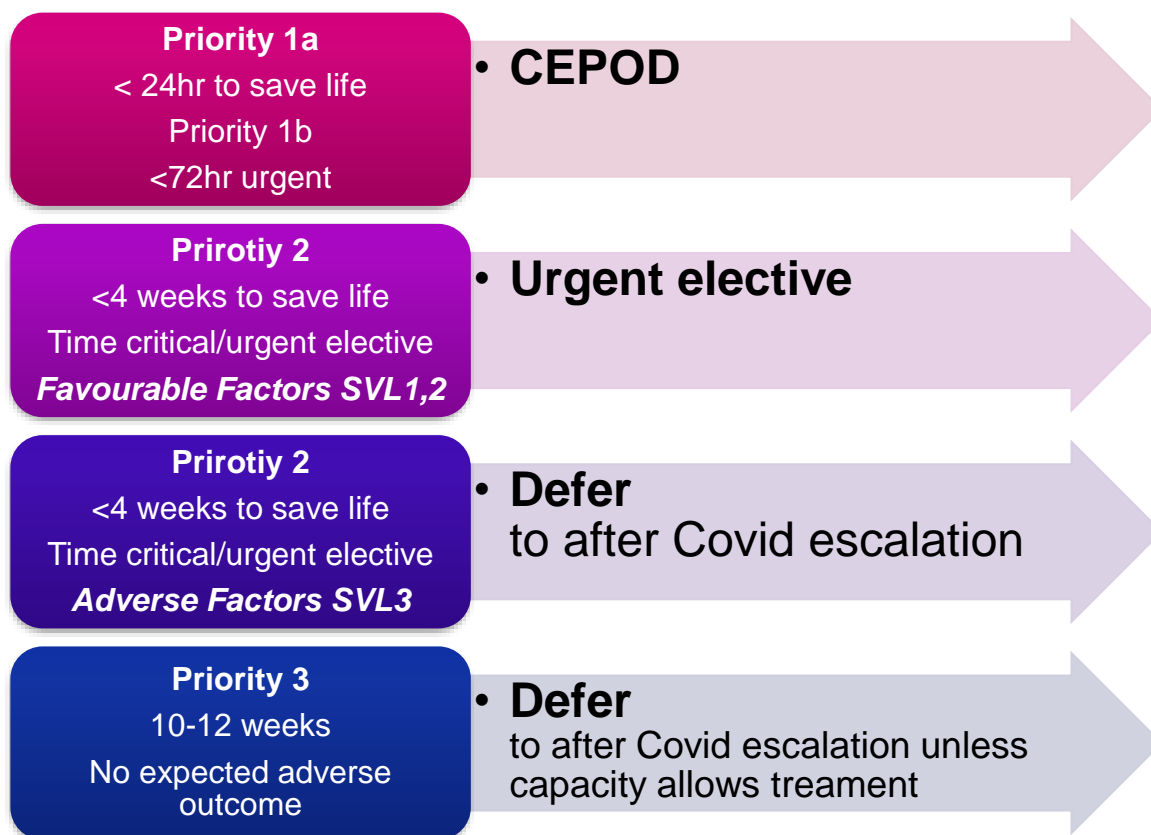
- The Team should be led by the Clinical Director for Cancer.
- The CSP Team will be staffed at a minimum with:
 - Operational lead
 - Capacity lead
 - Clinical lead
 - Cluster Managers (theatre and division)
 - Administrative support
 - Patient liaison

A business continuity plan will need to be agreed to mitigate against potential staff absence during COVID-19.

Prioritisation

- Patients should be discussed at their usual MDT, using MDT Standards of Care. Both surgical and non-surgical treatment should be considered.
- Any patients recommended for surgery should be referred to the CSP Team. Patients will only be added to the priority list when sufficient clinical and demographic details have been received.
- The CSP Teams will prioritise patients for urgent elective surgery who will derive the most benefit. This will be based on clinical need and the level of risk (patient and service related).
- Patients will be matched to appropriate local services. If the local provide is unable to provide the service the patient should be referred to the Alliance Cancer Surgery.
- The Team will also ensure risk assessments for patients who do not proceed to operation or whose surgery is rescheduled.
- Surgery will be avoided where possible in patients who are COVID-19 positive.
- Surgery will be avoided in patients whose Salford Vulnerability Level (SVL, Appendix 5) would deem them unsuitable for ventilatory support if they contracted COVID-19 post-operatively.
- Staffing is likely to represent the greatest constraint in the system, followed by lack of access to ventilators due to COVID-19 patients.
- Patients with a high likelihood of needing high-dependency care may not be able to access treatment during the peak of the pandemic.

Priorities



- Patients prioritised as level 2 require management that balances the risk from the cancer with the need for strict infection control to maximise safety. These patients should be prioritised for 'clean sites.'
- Wherever possible, operations will be deferred for patients prioritised as level 3, with arrangements in place with cancer care providers for review if their condition worsens and for tracking to ensure their treatment is prioritised as soon as capacity allows.

Approach for when surgery not offered.

- There will be groups of patients where surgery cannot be offered. These will include but may not be limited to: -
 - Patient vulnerability to COVID-19 is too high.
 - Acuity of surgery too high and constraints in access to critical care.
 - Lack of capacity in theatre due to constraints in facilities or staffing.
- The CSP Team will arbitrate on decisions that involve a lack of facilities or staff and prioritise cases by clinical need.
- In instances where a clinical team appeal the decision, the Alliance Cancer Surgery Hub will arbitrate.
- A standard form of words to use in patient correspondence when surgery cannot be offered due to constraints during COVID-19 is suggested:

I have explained to {patient} today that I would not currently recommend surgery during the Coronavirus situation, in line with Trust guidance. Specifically, this is due to: {insert below as appropriate}

- the risk for this patient of contracting COVID-19 during their hospital stay and / or
- the current constraint on high-dependency care.

Audit/QA

- Prospective audit will be undertaken on all surgical cases with weekly review of complications and length of stay to identify issues when these are beyond those anticipated.
- CSP Teams will convene weekly to review audit data on theatre activity, theatre efficiency, cancellations and loss of capacity. This information should be shared with the Alliance Cancer Surgery Hub and local IS providers.
- If the planned activity is compromised or the CSP Team have concerns regarding the accrued clinical risk then this should be escalated using existing trust governance process, with a copy to the Alliance Cancer Surgery Hub.

iii) Refer to the Alliance Cancer Surgery Hub all patients whose surgery is urgent or essential for which there is no capacity within the trust

iv) Contribute to the Alliance Cancer Surgery Hub

- This will mean contributing clinicians to the Hub to provide clinical prioritisation, with reference to the information from the referring MDT.
- Supporting other providers in the Alliance with mutual support, either by providing clinicians to work at other sites, or taking referrals of patients, so as to support the equitable delivery of urgent and essential cancer surgery. The Alliance will support planning to anticipate the need for mutual support for:
 - Anaesthetists (given the role they play in treating COVID patients and in critical care)
 - Surgeons, where there are only one or two surgeons who can carry out specific types of procedures in a provider

The Alliance Cancer Surgery Hub Will: -

The Alliance will form a Cancer Surgery Hub. This will be comprised of a group of senior clinicians from across the relevant cancer disciplines, and managers. The Hub's functions will be: -

- To carry out clinical prioritisation for patients for which there is no capacity within their local trust with reference to the information from the referring MDT. This will prioritise patients for surgery on the basis of clinical need, and the level of risk, both

patient and service-related, and to match patients with appropriate surgical specialisms and capacity across the cancer system.

- To put in place mechanisms to allow mutual support between providers to happen. This may include the movement of both staff and patients (if patients are well enough to travel for treatment.)
- Following discharge patients will be returned to the referring provider for review and further non-surgical cancer care as required. The referring centre will be provided with operation notes, discharge summary and the results of histology, laboratory and any radiological investigations undertaken.

Surgery with critical care

- It is estimated that there will be few patients whose surgery requires critical care support and their best interest is not to delay or amend surgery. The surgery that most commonly requires critical care support is Brain, Pancreatic, Lung and Upper GI surgery, all of which are only provided at UHP.
- UHP should plan to continue to provide surgery with critical care support on behalf of the Peninsula. UHP will include in its Cancer Surgery Prioritisation Team an anaesthetist.
- All providers should consider ring fenced critical care. If local providers still have suitable critical care capacity, they may continue to provide this surgery locally.
- Local surgeons should discuss with the UHP CSP Team about any potential cases that would require referring to UHP for surgery with critical care support.

Phases of Escalation

- Phase 1 – Business as normal
- Phase 2 – Peninsula wide approach with Cancer Surgery Hub in operation. sharing information and capacity and performing cancer surgery in all usual sites where resource permits. All providers now using and following the published national and local prioritisation guidance.
- Phase 3 – Reduced capacity focussed in a smaller number of sites with the Cancer Surgery Hub acting as a central coordination centre of surgical cancer treatment.
- Phase 4 – Emergency theatre provision only.

5. Risk Management

RISK	MITIGATION
Sites affected by high levels of COVID-19	Availability of COVID-19 testing to defer COVID-19 positive patients. More stringent application of Vulnerability Levels (VL3)
Insufficient staffing level	Providers to ring-fence staff, especially at cancer dedicated sites and for anaesthetics specialism Agree escalation plan with Alliance Cancer Surgery Hub to respond to COVID-19 surge.
Staff not willing to operate without full PPE equipment	NHSE to provide sufficient PPE equipment
Modelling underestimate surgical need	Re-allocate resource between specialty. Prioritise by clinical need. Overseen by CSP Teams
Facilities required for Surge response	Consider use of facilities within the wider system and apply system-wide response.

6. Appendix 1

Indicative list of conditions expected to fall within remit of this guidance

Note: This list is neither exhaustive nor mandatory. Refer to the Surgical Specialty Association guidelines for more detailed recommendations to support MDT decision-making.

See Appendix 4 for National Treatment Priorities

Tumour site	Within 1 month	Within 3 months
Breast	Breast cancer resection: ER negative/Her2+; pre-menopausal ER+ve with adverse biology	Breast cancer resection: pre-menopausal ER+ without adverse biology
Lower GI	Resection of colon cancer (if predicted aggressive biology)	Resection of rectal cancer
Gynaecology	Suspected germ cell tumours Early stage cervical cancer Pelvic confined masses suspicious of ovarian cancer High grade/high risk uterine cancer Primary vulval tumours	
Thoracic	Resectable non-small cell lung cancers	
Bladder	Bladder cancer invading muscle Upper tract transitional cell cancer surgery Bladder cancer surgery - high risk carcinoma in situ	Bladder cancer surgery not invading muscle
Penile	Penile cancer surgery including inguinal node surgery	Penile cancer surgery: low grade and premalignant
Prostate		Prostate cancer surgery: high/intermediate risk
Kidney	Renal carcinoma Partial nephrectomy on a single kidney	
Testicular	Testicular cancer non-metastatic	
Head and neck	EUA/biopsy for malignancy - hypopharynx; larynx Nasopharyngeal surgery for malignancy	Salivary gland tumours: Low grade Otological cancer surgery.

	<p>Oropharyngeal; tonsil; tongue cancer resection +/- reconstruction surgery for malignancy</p> <p>Treatment of small, high grade salivary cancers</p> <p>Treatment of sinus cancers - threatening sight</p>	
Oesophago-gastric	Oesophagogastric cancer causing obstruction	Oesophagogastric cancer surgery GI stromal tumour resection
Hepatobiliary/pancreatic	Hepatobiliary/pancreatic cancer causing obstruction (biliary/bowel)	Hepato-pancreatico-biliary cancer surgery
Endocrine	<p>Thyroid/parathyroid cancer surgery</p> <p>Adrenal cancer surgery</p>	<p>Thyroid cancer surgery: including diagnostic lobectomy</p> <p>Adrenal resections - intermediate masses:</p> <p>a) >4cm <6cm) with hypersecretion (cortisol/androgen)</p> <p>b) metastases - progressing on scan at 3/12</p>
Brain/CNS	<p>Brain tumour surgery (including gamma knife for metastases)</p> <p>Spinal tumour surgery</p>	
Orthopaedics	<p>Sarcoma surgery - any site</p> <p>Solitary metastasis - any site</p> <p>Destructive bone lesion surgery with risk of fracture (eg giant cell tumour)</p>	
Paediatrics	Surgery for nephroblastoma, neuroblastoma, rhabdomyosarcoma	
Plastic surgery	<p>Major soft tissue tumour resection (all sites)</p> <p>Skin cancer resection - all sites: melanoma; poorly differentiated cancers; nodal disease; compromise of vital structures, including the eye, nose and ear</p>	Resection of head and neck skin cancer - moderately/well differentiated with no metastases

7. Appendix 2

Estimated breakdown of anticipated workload for level 2 procedures

These figures are indicative and derived from modelling in the Royal Marsden Partners Cancer Alliance

Tumour site	%
Breast	25-30
Lower GI	15-20
Gynaecology	10-15
Thoracic	5-10
Bladder	5-10
Skin (mainly day case, local anaesthesia)	5-10
Kidney	3-5
Head and neck	3-5
Endocrine	2-3
Metastatic disease (spinal cord)	2-3
Brain	2-3
Sarcoma	2-3
Prostate	≤1
Testicular	≤1
Penile	≤1
Oesophago-gastric	≤1
Hepatobiliary/pancreatic	≤1

8. Appendix 3

Operational Processes

Referral Process

Patients identified through MDT as appropriate for cancer surgery but with no local capacity will be referred to the Alliance Cancer Surgery Hub.

- A standard referral template and email address will be provided for consideration. This will be the current Inter-provider referral form plus clinical referral letter with relevant clinical details including: -
 - Patient priority level
 - COVID-19 testing date and result
- If a referral is accepted patients referred will be managed as per existing Inter Provider Transfers.
- Referring trust will notify patients that they are being referred to another provider and provide contact phone no. for any queries. The receiving provider will then manage all forward patient communication.
- Receiving providers will record on their PTL any inter-provider transfers that have been received as part of COVID arrangements (as opposed to IPT as part of normal pathways).

9. Appendix 4 National Treatment Priorities

Priority	Surgery	SACT	Radiotherapy
1a	<ul style="list-style-type: none"> Emergency: operation needed within 24 hours to save life 	<ul style="list-style-type: none"> Curative therapy with a high (>50%) chance of success Adjuvant (or neo) therapy which adds at least 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse 	<ul style="list-style-type: none"> Patients with category 1 (rapidly proliferating) tumours currently being treated with radical (chemo)radiotherapy with curative intent where there is little or no scope for compensation of gaps. Patients with category 1 tumours in whom combined External Beam Radiotherapy (EBRT) and subsequent brachytherapy is the management plan and the EBRT is already underway. Patients with category 1 tumours who have not yet started and in whom clinical need determines that treatment should start in line with current cancer waiting times.
1b	<ul style="list-style-type: none"> Urgent: operation needed with 72 hours <p>Based on: urgent/emergency surgery for life threatening conditions such as obstruction, bleeding and regional and/or localised infection permanent injury/clinical harm from progression of conditions such as spinal cord compression</p>		
2	<ul style="list-style-type: none"> Elective surgery with the expectation of cure, prioritised according to within 4 weeks to save life/progression of disease beyond operability, based on <ul style="list-style-type: none"> urgency of symptoms complications such as local compressive symptoms biological priority (expected growth rate) of individual cancers. <p>Local complications may be temporarily controlled, for example with stents if surgery is deferred and /or interventional radiology</p>	<ul style="list-style-type: none"> Curative therapy with an intermediate (20-50%) chance of success. Adjuvant (or neo) therapy which adds 20 – 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse 	<ul style="list-style-type: none"> Urgent palliative radiotherapy in patients with malignant spinal cord compression who have useful salvageable neurological function.
3	<ul style="list-style-type: none"> Elective surgery can be delayed for 10-12 weeks with no predicted negative outcome. 	<ul style="list-style-type: none"> Curative therapy of a low chance (10 – 20%) of success Adjuvant (or neo) therapy which adds 10 – 20% chance of cure to surgery or radiotherapy alone or treatment given at relapse 	<ul style="list-style-type: none"> Radical radiotherapy for Category 2 (less aggressive) tumours where radiotherapy is the first definitive treatment. Post-operative radiotherapy where there is known residual disease following surgery in tumours with aggressive biology.

		<ul style="list-style-type: none"> • Non-curative therapy with a high (>50%) chance of >1 year of life extension 	
4		<ul style="list-style-type: none"> • Curative therapy with a very low (0-10%) chance of success. • Adjuvant (or neo) therapy which adds a less than 10 chance of cure to surgery or radiotherapy alone or treatment given at relapse • Non-curative therapy with an intermediate (15-50%) chance of > 1-year life extension. 	<ul style="list-style-type: none"> • Palliative radiotherapy where alleviation of symptoms would reduce the burden on other healthcare services, such as haemoptysis.
5		<ul style="list-style-type: none"> • Non-curative therapy with a high (>50%) chance of palliation / temporary` tumour control but < 1-year life extension. 	<ul style="list-style-type: none"> • Adjuvant radiotherapy where there has been complete resection of disease and there is a <20% risk of recurrence at 10 years, for example most ER positive breast cancer in patients receiving endocrine therapy. • Radical radiotherapy for prostate cancer in patients receiving neo-adjuvant hormone therapy.
6		<ul style="list-style-type: none"> • Non-curative therapy with an intermediate (15-50%) chance of palliation. 	

10. Appendix 5

Salford Vulnerability Levels

In the event of nosocomial COVID-19 infection

Level	Description	Assigning vulnerability levels
V1	Unlikely excess mortality compared with completely fit < 70 year old.	
V2	Likely significant excess mortality compared with completely fit < 70 year old BUT would ordinarily receive invasive ventilation for Covid-19.	
V3	Extremely likely to succumb to COVID-19 infection and would not ordinarily receive invasive ventilation for COVID-19.	<ul style="list-style-type: none"> • Rockwood Clinical Frailty score ≥ 5 (best predictor at present) • ASA ≥ 3 • Age ≥ 80 • Immunocompromised • Chronic liver disease • Heart failure • COPD • CKD • Diabetics with hypertension on ACE inhibitors (there is virus affinity for the ACE receptor with associated amplification of disease) • Anybody requiring “shielding” as per Public Health England