Peninsula Cancer Alliance – Surgical Capacity - Clinical Prioritisation Group

Terms of reference

1 Statement of Purpose
Prioritise patients needing time-critical cancer surgery and aligning to operational capacity across the network.

2 Terms of Reference
• The role of the CPG will be to prioritise urgent cancer surgery patients from the network.

• All cases will have been discussed at the local and/or specialist MDT and a treatment plan agreed.

• The CPG will not review the clinical decision.

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

• The CPG will prioritise cases based on the principles and decision framework

• Prioritisation of cases will need to be aligned with available capacity across the cancer network. The CPG will have operational support to identify capacity across the network and will decide where best to carry out the urgent cancer treatment.

• The meetings will be held at least weekly but frequency may be increased to meet demand.

• The CPG will be chaired by the Alliance Clinical Director.

3 CPG Membership
CPG will require surgical, oncological and operational input from Alliance partner providers. Decision-making is assigned to the quorate group. Trusts should ensure that they are able to be represented at each virtual CPG meeting. Members of the quorate group will meet on a rotational basis. Ad-hoc specialist clinical input may be required on a case by case basis which will be obtained by consultation with the relevant site specific group Chair. Membership will consist of:

- Chair: Peninsula Cancer Alliance Medical Director
- Cancer Clinical Director or nominated Deputy from each Trust
- Surgical Operational Representative from each Trust.
- Cancer Alliance Manager and Project Manager

Quorate will be made of a minimum of 3 consultants at each meeting excluding the Chair

Representatives of the Devon and Cornwall CCGs will be invited to participate.

4 Clinical Prioritisation Group Process

Weekly returns from providers will be received indicating current capacity using RAG system. Also identifying advanced knowledge of impending risks to specific tumour site services.

All accepted and vetted referrals will be collated and circulated to CPG members prior to each meeting. An update on theatre capacity for the following week will be provided at each meeting.

Cases meeting levels of the urgency criteria 1a, 1b and 2 are accepted.
Urgency criteria 3 cases will not be considered until there appears to be capacity within the system for these patients to be treated. Criteria 3 cases who have waited for more than 6 weeks for treatment will be regarded as category 2 urgency.

All cases will have been prioritised for surgery by their local MDT and treatment undertaken in usual treatment site where possible.

Patients will be advised to self-isolate for AT LEAST 7 days and arrangements will be in place for COVID swab testing within 48 hours of any planned admission date. This will normally be arranged by the Trust referring patient for surgery.

Patients will be informed if capacity is not available in usual treating Trust and asked if they would be prepared to travel within Devon and Cornwall for treatment.

Cancer Hub Referral form sent to Amy Noonan, Project Co-ordinator via the Cancer Alliance COVID e mail portal england.pcae@nhs.net

Project Co-ordinator will upload case information to the cancer hub discussion PTL spreadsheet. This will be updated and circulated to the group members before each meeting.

Patients allocated to capacity for surgery

> Referring unit informed and will communicate with patient ensuring no change in medical condition.
>
> Referring unit arranges transfer of clinical information including any pre-operative assessment.
>
> Receiving MDT informed and all relevant information provided to confirm treatment plan.
>
> Receiving unit to contact patient confirming date for surgery and pre op assessment and isolation/shielding arrangements.

Patients not allocated to surgery.

> Referring unit informed and reason for non-allocation (capacity or not prioritised)
>
> Referring MDT to review and consider other options for treatment or reprioritisation.
>
> Request review again if further information becomes available.

5 Decision framework

Prioritisation for cancer treatment will include consideration of both outcome and urgency based criteria to enable patients to continue to undergo time-critical cancer treatment during the COVID-19 pandemic.

The focus of this group is for the prioritisation and management of cancer patients requiring time-critical cancer treatment. The framework will support the work of a clinical prioritisation group who will collectively lead the decision-making for patients requiring time critical cancer surgery.

Criteria included in decision framework
The following criteria will be used to prioritise patients for time critical cancer treatment.

1. Urgency based criteria

Disease specific criteria are available and may be referred to if site specific support is required.
The group will prioritise patients with the greatest prospects of cure whose outcome would be seriously compromised by delays in treatment and for whom there is no other acceptable or available treatment.

The National Guidance on prioritisation will be followed

- National guidance on prioritisation; surgery, SACT, radiotherapy (see Appendix)

The group will also take into account

- Impact of doing nothing
- Alternative treatment available – recognising this may not be usual standard of care
- Impact on other services

- Requirement for ITU / HDU

Outcome criteria

- Stage
- Treatment intent - palliative or curative
- Expected outcome of treatment; mortality and morbidity
- Risk of immunosuppression

b) Consider health benefit and vulnerability risks

- Co-morbidities
- Assessment of co-morbidities associated with COVID-19 vulnerability using Salford Vulnerability Score.

3. Resource Implications
Resource implications of treatment will be evaluated and categorised as

- Day case
- Overnight stay
- High dependency Unit
- Intensive care Unit, 1 day only
- Intensive care Unit, 2-3 days
- Extended intensive care stay, >3 days

The group will refer cases where they feel ethical challenges arise to the Ethical Reference Group of the referring Trust for each case in the event of a single Trust issue.
Wider ethical concerns will be referred to the SW Regional Ethical Reference Group for advice.
The Peninsula Medical Directors Group will be the route of escalation of issues which the group cannot resolve and where patient safety or risk is identified.

6 Clinical Governance & Assurance

All hospitals within the Cancer Capacity Hub network will agree to the terms of reference of the CPG. A situation report will be circulated regularly to the CPG and exceptions discussed at the meetings.

All patients treated outside the normal location will be subject to audit of outcomes including completion of planned treatment, reasons for cancellation if occurs, length of stay, post operative complications and surgical resection data. Any clinical incidents and risks will be managed and reported through the governance processes of the receiving trust. A report of this review will be submitted to the Cancer Alliance Board and Peninsula Medical Directors.

Appendix : Clinical guide for the management of cancer patients during the coronavirus pandemic [2]

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf

NHSE published guidelines for the management of cancer patients during the coronavirus pandemic.

Cancer surgery

Priority level 1a. Urgent operation needed within 24 hours to save life

Priority level 1b. Urgent operation needed within 72 hours (urgent emergency surgery/permanent injury)
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

Priority level 2. Elective surgery with the expectation of cure, prioritised according to:
- within 4 weeks to save life/progression of disease beyond operability based on
- urgency of symptoms
- complications such as local compressive symptoms
- biological priority (expected growth rate) of individual cancers

Local complications may be temporarily controlled, for example with stents if surgery is deferred and /or interventional radiology

Priority level 3. Elective surgery can be delivered for 10-12 weeks which will not have predicted negative outcome

Priority level 1 and 2 patients must have likely curative conditions and will be triaged based on likelihood of uncomplicated recovery.

Prognostic classification based on National SACT prognosis guidance.

Priority level 1:

- Curative therapy with a high (>50%) chance of success.

Priority level 2
- Curative therapy with an intermediate (20- 50%) chance of success.

Priority level 3:
- Curative therapy of a low chance (10 – 20%) of success
- Non-curative therapy with a high (>50%) chance of >1 year of life extension.

Priority level 4:

- Curative therapy with a very low (0-10%) chance of success.
- Non-curative therapy with an intermediate (15-50%) chance of > 1 year life extension.

Priority level 5:

- Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1 year life extension.

Priority level 6:

- Non-curative therapy with an intermediate (15-50%) chance of palliation; Temporary tumour control and < 1 year life extension.