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Scottish Government –

A Framework for Recovery of Cancer Surgery –

Version 4.2: Prioritisation of cancer surgery and new guidance on clinical decision making processes

V4.2 25 August 2020

Principles:

1. Equity of Access –

   i. Patients are treated and listed for surgery in order of Clinical Priority in the same way across NHS Scotland.

   ii. Boards work together to ensure patients are offered the earliest available appointment.

2. Safety of Service –

   i. Care is delivered safely, efficiently and sustainably whilst acknowledging the need to also care for COVID-19 patients within the acute hospital sector.

   ii. Risk of COVID-19 transmission for elective cancer surgery is minimised.

3. Prioritisation of surgery –

   i. Capacity needs to be managed in an equitable way, based on a nationally agreed clinical prioritisation framework.

   ii. Clinical Prioritisation Groups (CPGs) at local, regional and national level should oversee cancer, and other surgery services, to provide governance that ensures timely and equitable access for all cancer patients across Scotland.

4. Recovery Strategy and Implementation –

   i. Individual HBs to provide weekly update to the NCTG with summary data on all cancer patients that have (i) had surgery, (ii) are awaiting surgery, or (iii) are awaiting a date for surgery, for each tumour site.

   ii. Local HB CPGs will ensure all patients are prioritised according to local MDT recommendations.

   iii. Regional cancer network CPGs will oversee regional flow and capacity, and facilitate regional working.

   iv. National CPG (NCTG) to provide overall governance and facilitate national support for specific cancer sites or services

INTRODUCTION

This updated *'Framework for Recovery of Cancer Surgery'* approved by the National Cancer Response Group should now be applied across NHS Scotland.

PRINCIPLES

The framework provides NHS Scotland with clear guidance of how we intend to recover cancer surgery whilst ensuring appropriate COVID-19 safety measures are in place.

The framework has set out basic principles suggesting how to:

- Identify and prioritise patients appropriately
- Maintain equitable access to care for patients across NHS Scotland
- Deliver care in the safest possible environment

This paper builds on the framework paper for recovery of cancer services and provides further guidance on how NHS Scotland Health Boards and regional cancer networks should work collaboratively to maintain timely treatment for cancer patients and also to upscale surgery capacity that ensures equitable access for all patients that have had their surgery delayed or impacted upon by the pandemic.

1. SURGICAL CLASSIFICATION FOR ALL CANCER PATIENTS

All cancer MDTs should apply the same clinical prioritisation for all cancer patients listed for surgery that has been approved by SG and the Royal Colleges:

Patients requiring surgery during the COVID-19 crisis have been classified in the following groups:

Priority level 1a Emergency - operation needed within 24 hours
Priority level 1b Urgent - operation needed with 72 hours
Priority level 2 Surgery – scheduled within 4 weeks
Priority level 3 Surgery – scheduled within 12 weeks
Priority Level 4 Surgery – may be safely scheduled after 12 weeks

The agreed surgical framework can be found here. It is updated monthly. As of 07 July 2020, the latest update to it was published 29 June 2020.

2. CLINICAL PRIORITISATION GROUPS (CPGs)

As surgery services enter into the recovery phase in the coming weeks and months there will be competing demands from various surgical specialties to gain access to a limited surgery resource.

Scottish Government therefore recommends that Health Boards (and hospitals) implement local governance policies to ensure fair and reasonable access to a limited surgery resource in terms of both hospital beds and elective green-site theatre capacity.

2.1. Local Health Board Clinical Prioritisation Group (Local CPGs)

CPGs should primarily operate at Health Board level, but it is important that non-essential surgery does not re-start on an ad-hoc basis, as this may compromise the national cancer recovery program.

Hospitals and Health Boards are therefore tasked with urgent implementation of local CPGs that will oversee 'green-site' theatre allocations on a regular (weekly) basis to ensure that prioritised patients are apportioned appropriate, and preferential, access to all green-site theatres.

Local CPGs should comprise senior clinicians and managers to facilitate this process, and it is imperative that each local CPG has a senior cancer clinician represented and preferably chairing.

A typical local CPG should comprise of, as a minimum, the (i) Associate Medical Director or Clinical Director (CD) for Surgery, (ii) Clinical Lead (CD) for anaesthetics, (iii) Clinical lead (CD) for surgical cancer services, (iv) Senior manager for theatres (Head of TPG), (v) surgery capacity manager, and (vi) an independent advisor / arbitrator. The independent arbitrator may be the medical director or their deputy.

See Appendix 1 – An example structure for a local CPG (NHS Tayside).

2.2 Regional cancer network CPG (regional CPG)

Regional CPGs are to be implemented to oversee Health Board cancer surgery and support regional working. .

The regional CPG will facilitate cross-Health Board working where required, which may require transfer of patients or staff or both to adjacent and/or co-located Health Boards within the regional cancer network. The regional CPG will inform the National Cancer Treatment Group of local or regional service pressures, when local and regional solutions are not immediately available.

A regional CPG should be chaired by the regional network cancer clinical lead and may comprise of, as a minimum, the (i) regional cancer network manager, (ii) regional cancer network clinical lead, (iii) the MD or AMD for surgery from each Health Board within the network, (iv) a tumour site lead from within the network, and (v) an independent advisor / arbitrator.

2.3 National cancer CPG (NCTG)

The national CPG will inform and facilitate national support and capacity solutions when required, and be provided by the National Cancer Treatment Group.

The national CPG should comprise of (i) cancer network clinical leads, (ii) cancer network clinical managers, (iii) Director of regional planning representative (iv) Scottish Government Cancer Policy and Access (v) HPB MCN clinical lead, and (vi) National MCN network manager.

See Appendix 2. Schematic representation of CPG Framework

3. CANCER DATA INFORMATICS: CANCER WAITING TIMES / BACKLOG / CAPACITY

Health boards will be asked to provide weekly summary updates to the local CPG and regional CPGs, and the NCTG, with data on all cancer patients that have (i) had surgery, (ii) are awaiting surgery, or (iii) are awaiting a date for surgery, for each tumour site.

This will inform the NCTG and the NCRG of the demand for cancer services during the recovery phase, including outlying areas of excess demand that should be supported regionally or nationally.

See Appendix 3. Schematic representation of flow, capacity and demand.

4. REGIONAL AND NATIONAL ESCALATION TRIGGERS

Health Boards are expected to upscale elective cancer surgery capacity to meet local demands and to equitably address any backlogs that may have accrued during the COVID-19 outbreak.

However, it is recognised that this is a challenging task, and there may be significant need for collaborative working and/or national support.

The weekly summary data reports will provide assurances that capacity is meeting demand, or whether specific cancers require regional support to meet a rising demand.

Specific triggers that may impact on service delivery and capacity will likely evolve with time, and be defined by ongoing data monitoring. They will serve to inform the CPGs and National Cancer Treatment Group where, geographically, additional surgical support may be required.

Triggers that may stimulate the need for a regional collaboration may include (i) increased volume of priority patients, (ii) a reduction in cohorts of medical staff (surgeon / anaesthetist) and nursing staff (theatres and wards), (iii) a lack of theatre capacity or theatre equipment, or (iv) lack of critical care capacity.

5. GOVERNANCE

Cancer services in the recovery phase are subject to all pre-COVID governance parameters with regard to CWTs and cancer QPIs.

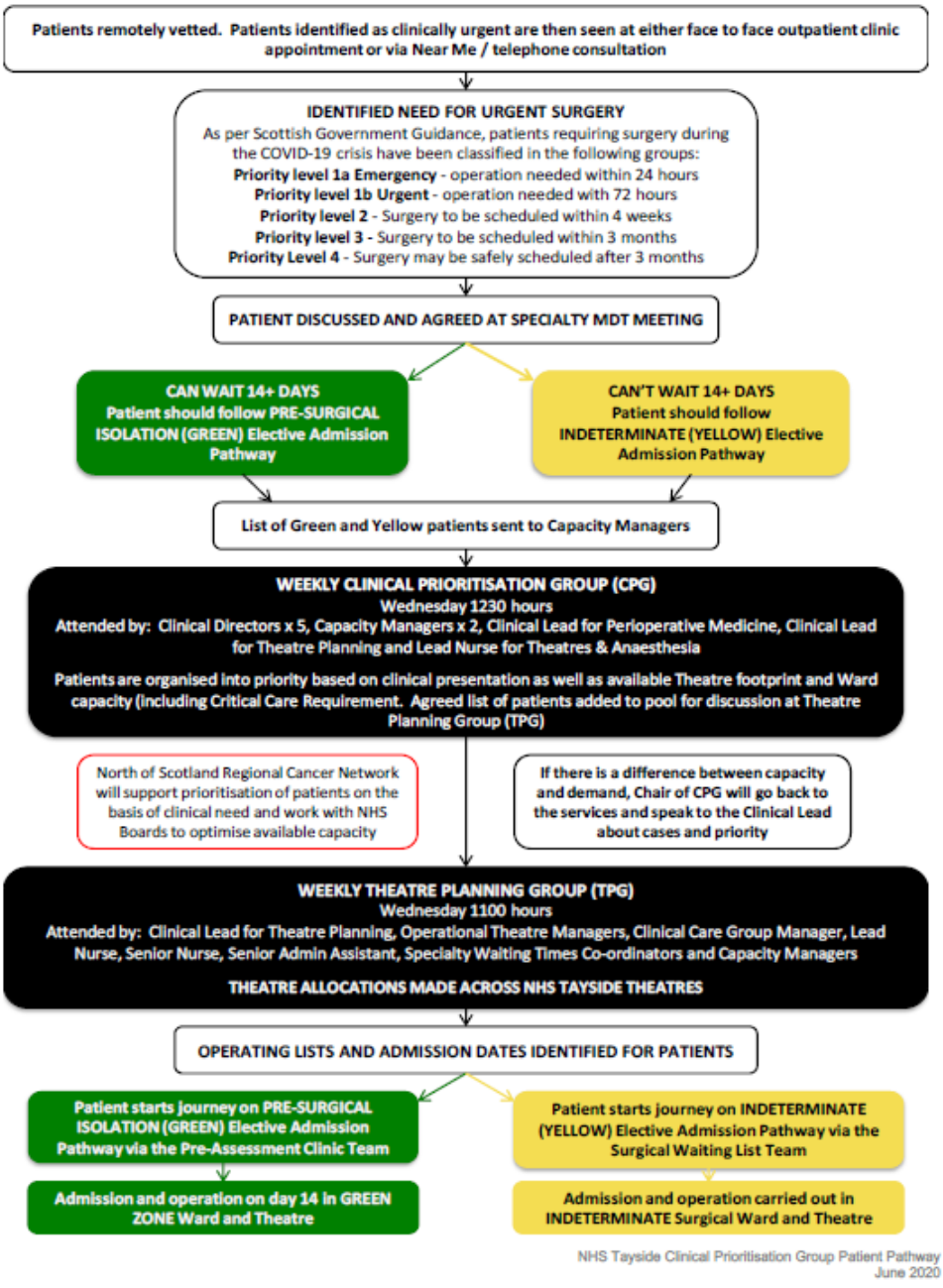
Interim solutions for cross Health Board working, and the implementation of regional and national services to support the recovery phase, must follow all HR and governance processes, which may include the need for a considerable number of honorary contracts and appointments to facilitate regional working.

Elective cancer surgery should be upscaled in ‘green sites’ with full adherence to and implementation of national policies for patient and staff testing before, during and after surgery.

Appendix 1:

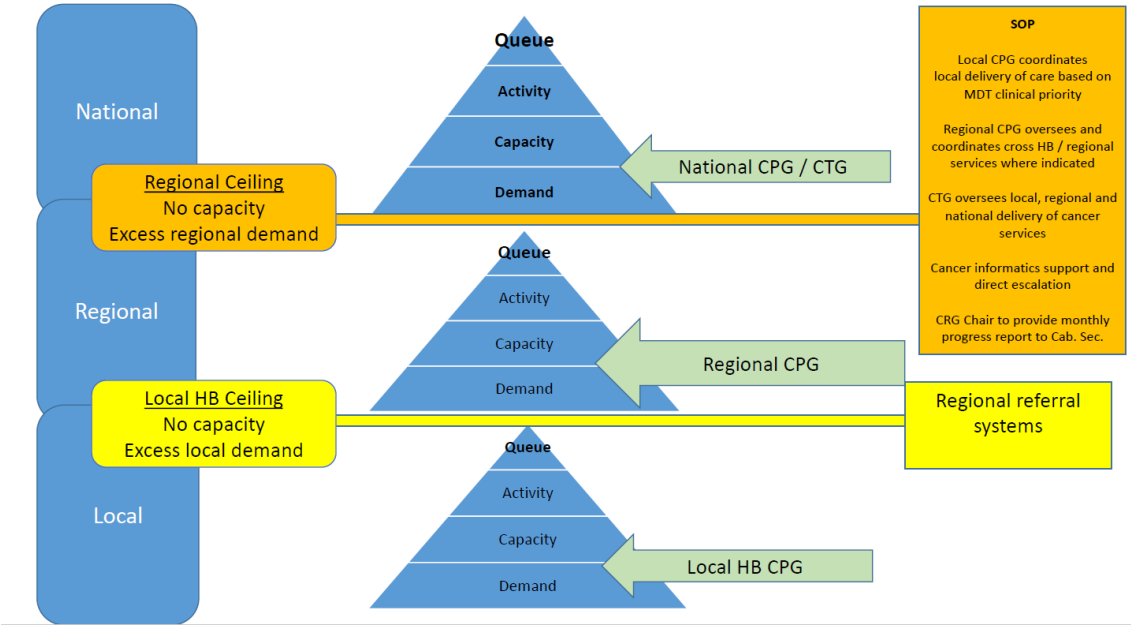
NHS Tayside

CLINICAL PRIORITISATION GROUP PATIENT PATHWAY



NHS Tayside Clinical Prioritisation Group Patient Pathway
June 2020

Appendix 2: Framework for CPG – Local, regional & national.



Appendix 3: Cancer informatics. Referrals, Backlog, Flow and Impact.