WCA Board meeting |

Wessex Cancer Surgical Hub

Executive summary:

- **Context:** In line with national requirements, we set-up the Wessex Cancer Surgical Hub to maintain delivery of cancer surgery across Wessex
- **Model:** At first instance surgery should be provided locally by trusts – only where demand exceeds local capacity and mutual aid arrangements, patients can be referred to the Cancer Hub
- **Status (as of June 9th):** We have set-up clinical and operational protocols, circulated the model with the trusts and initiated formal go-live, with referrals starting this week
- **Next steps:**
  - Monitor performance and improve Hub operations
  - Set-up automated data collection system
  - Explore opportunity for a pan-cancer patient prioritisation process for all patients

Ask to the Board:

- **Support** for the application of the national cancer hub model by the Wessex Cancer Alliance and **agreement** on the proposed way forward

Context & aim of Wessex Cancer Surgical Hub

The Covid pandemic has placed an **unprecedented amount of pressure on NHS systems**, including a loss of surgical capacity

In response, NHSE has issued guidance across all Alliances to set-up **cancer surgery hubs** with the aim to **maximise the number of patients receiving curative surgery**

In line with NHSE guidance, we have set-up the **Wessex Cancer Surgical Hub** to:

- **Maintain urgent elective cancer surgery during the Covid crisis** for patients with life-threatening cancer in a Covid-free environment
- **Manage the backlog of patients awaiting treatment**, as referrals are likely to increase once the acute phase passes

As part of the Wessex Cancer Surgical Hub model, we have:

- **Created a process to prioritise and coordinate surgical demand** and capacity across Wessex trusts
- **Set-up a physical Cancer Hub site** (hosted at Spire / UHS) to provide additional Covid-free surgical capacity beyond what is available within trusts

Wessex Cancer Surgical Hub (WCH) process

1. All trusts will **prioritise their cancer surgery patients** according to a standardised prioritisation framework

2. **Where possible**, patients will receive **treatment in a Covid-free environment[1] at a local provider** (incl. IS sites), or via **mutual aid arrangements**

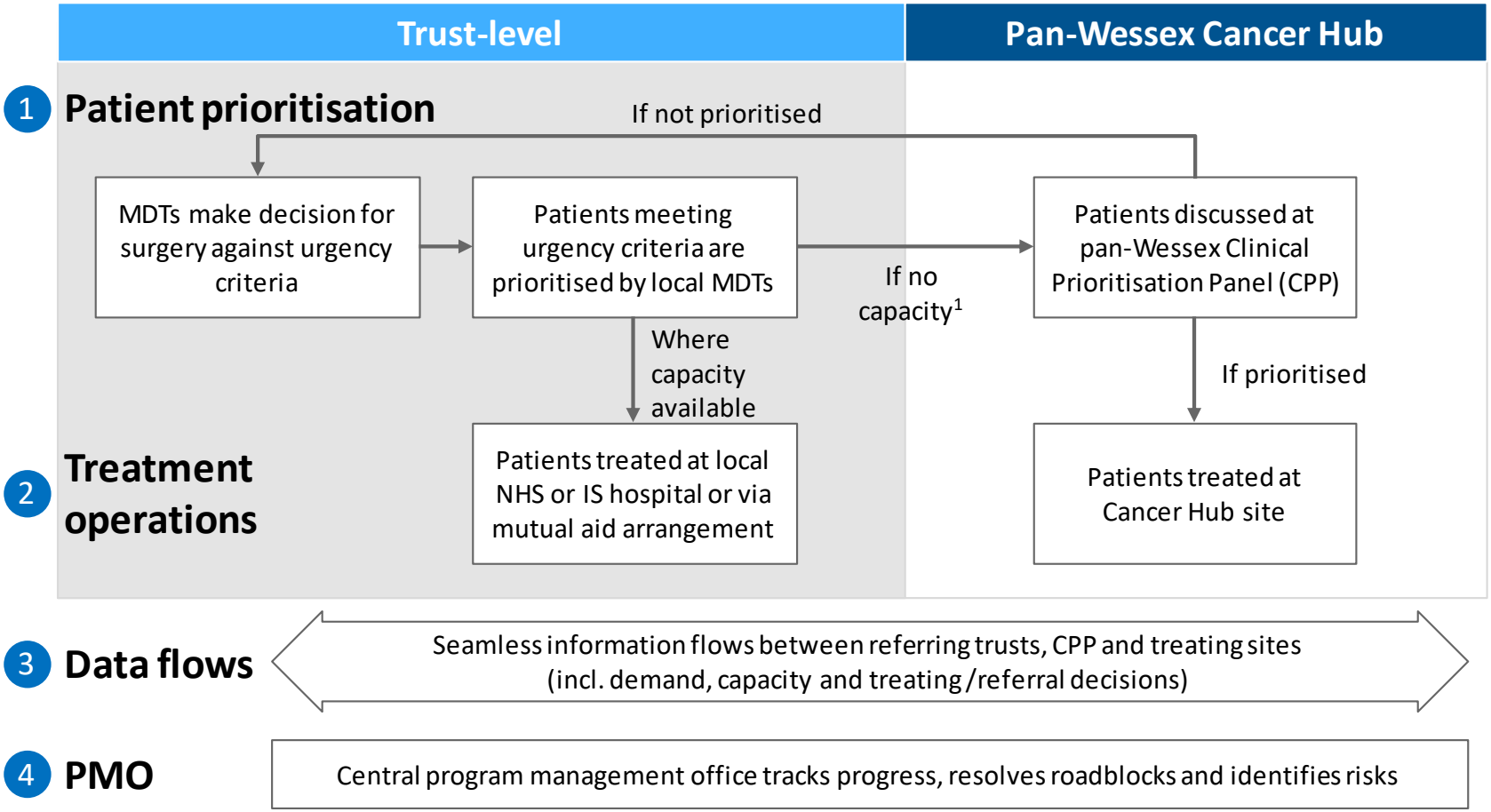
3. **Where local demand exceeds capacity**, and where current mutual aid arrangements are insufficient, **patients will be referred to the Wessex Cancer Surgical Hub**

4. Referred patients are prioritised against referrals from other trusts by a **pan-Wessex Clinical Prioritisation Panel[2]**, which will include broad representation across all trusts[3]

5. Prioritised patients will **receive surgery** through the **Cancer Hub**

1. See Appendix 2 or further details on Covid-free sites
2. See Appendix 3, for the Clinical Prioritisation Panel
3. See Appendix 4 for a list of participating trusts

To implement the WCH, we have been working across four workstreams



1. Prior to referring patients to the CPP, trusts are encouraged to continue making use of any mutual aid arrangements – patients that are re-allocated under a mutual aid arrangement do not need to go through the Cancer Hub process

WCA = Wessex Cancer Alliance
WCH = Wessex Cancer Surgical Hub

Within each workstream, a number of requirements were implemented to allow go-live

Category	Requirement	
1 Patient prioritisation	• Create standardised **prioritisation framework**	✓
	• Set-up a **referral system** to allow referral into the **Cancer Hub**	✓
	• Set-up **Clinical Prioritisation Panel**, with representation from all Wessex trusts	✓
	• Set **meeting cadence and process** at CPP	✓
2 Treatment operations	• Ensure available **theatre space** that fulfils COVID-free requirements	✓
	• Decide on **staff model** and fill requirements (Surgeons, anaesthetists, admin)	✓
	• Set-up **Covid testing protocols** for staff and patients	✓
	• Ensure **processes for E2E patient care** (pre-admission, admission, discharge)	✓
3 Data flows	• Set-up a system to action and disseminate **referral** decisions	✓
	• Define **minimum data set** (patient information) required for prioritisation	✓
	• Collect information on **expected demand on a trust-level**	✓
	• Set-up an automated system to regularly collect **trust-level demand data**	✓[1]
4 PMO	• Define **membership** of a Cancer Centre team	✓
	• Set-up **PMO tools**, incl. demand / capacity dashboard and KPI trackers	✓[1]

✓ Done ✓ In progress

1. Automated system to collect and process demand data in development and expected to be rolled out in a later iteration

Next steps for the Wessex Cancer Surgical Hub

Context:

- Surgical Hub model outlined in this paper, responds to the immediate COVID19 pressures
- However, the model of having an equitable system of allocating surgical capacity across the region would have benefits for Wessex:
  - Reduces health inequalities – a clear aim in the NHS Long Term Plan
  - Would ensure surgical capacity is matched with clinical prioritisation
  - Would reduce variation in terms of performance, where surgery is the limiting factor
  - Promote greater collaborative working across Wessex
  - Would help ensure that clinical resources are used to the most affect across Wessex

Next steps for the Wessex Cancer Surgical Hub

Proposed way forward:

- Between now and the end of August review how the Surgical Hub works in practice and where necessary, review and improve the process
- Work with providers across Wessex to develop proposals on how a longer-term Cancer Surgery Hub could work – with the potential way forward to be presented to the next Wessex Cancer Alliance Board. By this time, greater certainty will be known about the use of the independent sector going forward and any amendments needed to the Surgical Hub model. This will include to review what resources the Surgical Hub would require

Appendices

Appendix 1 | Centralised model was considered as an alternative to WCH's hub and spoke model

Hub and spoke model – surgery performed locally and at Cancer Hub

- **Dedicated local sites identified at each trust** that meet Covid-free requirements
- **Surgeries proceed locally**, where trusts have available capacity
- **Patients only referred to Hub** when local capacity and mutual aid arrangements are unable to meet demand

Model chosen for WCH

Centralised model – surgery only at dedicated cold site

- **Dedicated cold site** reserved for cancer surgery which receives all referrals across the network
- **Full segregation from Covid activities**, including dedicated staff and building
- **Provision of all aspects of cancer surgery** (incl. pre-operative assessment and initial post-op follow-up) – diagnosis, initial staging and routine post-op follow-up undertaken by the referring trust
- *Exemplified by the RM Cancer Hub model*

WCH = Wessex Cancer Surgical Hub
RM Cancer Hub = Royal Marsden Cancer Hub

Appendix 1 | Centralised model is limited by Wessex' large geographical footprint

Assessment of centralised cancer hub model

Pros

- **In line with Italy and Wuhan recommendations** of separating cold and hot staff and facilities
- **Public potentially more comfortable** attending treatment at a dedicated Covid cold site

Cons

- **No existing cancer hospital within Wessex** – ring-fencing a facility would require diverting other activity
- **Extensive travel times** for some patients, due to large catchment area and limited options for dedicated sites[1]
- **Vulnerable to second Covid wave** which could put pressures on local workforce and capacity for Covid services – would require a strong mitigation plan to divert patients
- **Lack of co-location with other clinical expertise** could lead to worse service – e.g. access to dialysis support or cardio-thoracic expertise is beneficial for some types of surgeries

Conclusion

Overall, **hub and spoke model deemed more suitable to Wessex**, as the centralised model is limited by the dispersed patient population and provider sites

Appendix 2 | Clinical Prioritisation Panel (CPP) with broad representation and flexible process

Broad clinical membership & ethical representation on CPP

- **Constituents** to consist of **cancer-treating clinicians** with representation across specialities and all Wessex trusts, **ethicists**, **management** and **administrative staff**
- CPP meetings are considered **quorate with a minimum of 4 members**, including 2 surgeons, 1 ethicist, and 1 management team
- To ensure timely implementation, **initial CPP membership has taken place by invitation** and in consultation with Cancer Clinical Leads across the trusts

Flexible process to provide agility depending on actual demand

- Meetings will occur virtually, typically **on a weekly basis**, but with the flexibility to increase or decrease frequency as demand fluctuates
- The CPP will **prioritise all referred patients** against all other referrals, and where required, against existing local non-cancer patients
- CPP decision-making but not prioritisation/ranking will be **documented** and fed back to the referring trusts

Note: further details on clinical governance & processes in development and to be circulated

Appendix 3 | All sites should follow processes to ensure a Covid-free surgical environment

A set of processes need to be implemented at all cancer surgery sites (incl. the WCH site and local provider sites) to reduce risk of contamination and harm for patients
(non-exhaustive – to be updated in line with national guidance)

- **Test all potential admissions** for COVID-19 at most **48 hours** before surgery, with patients **self-isolating according to site-specific governance procedures** before admission
- **Ensure consent** to testing and self-isolation at the time of listing for surgery
- **Admit only patients** who have no symptoms suggestive of COVID-19 infection, have been isolated and have a negative COVID-19 PCR test
- Implement **clear and consistent consent** in line with recommendations from the WCA, ensuring the patient is fully aware of the **increased risk of surgery** during the pandemic

Trusts are responsible for the assessment and maintenance of Covid-free status at local sites

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Appendix 4 | WCH to include the following trusts

1. Dorset County Hospital NHS Foundation Trust
2. Hampshire Hospitals NHS Foundation Trust
3. Isle of Wight NHS Trust
4. Poole Hospital NHS Foundation Trust
5. Portsmouth Hospitals NHS Trust
6. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
7. Salisbury Hospital Foundation Trust
8. University Hospital Southampton NHS Foundation Trust

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Appendix 5 | Wessex Cancer Hub demand & capacity dashboard

We plan to create **a dashboard,** that visualises **expected surgical demand and capacity** across all Wessex sites, and enables **pan-Wessex coordination** in a way to optimally **support all our patients**

Input live pseudonymised patient level data …

- **Trust PTL by priority category and tumour site**
- **Number of locally scheduled procedures**
- **Available surgical capacity**

… visualised in a dashboard to support capacity planning

- Overview of demand and activity across the 8 trusts
- Projected requirements of Hub capacity
- Planning to ensure sufficient capacity to support all trusts across Wessex

Note: In the first instance, this dashboard will require weekly manual input from trusts via a pre-set Excel format sheet; over time we will aim to fully automate the dashboard via a common data platform to support real-time 24/7 live demand and capacity updates