Intelligence

National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Colorectal Clinical Lines of Enquiry

Briefing Paper for National Cancer Peer Review

2012-2013

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Following the release of the Breast and Colorectal Service Profiles, these Service Profiles are being used in the Breast and Colorectal Clinical Lines of Enquiry (CLEs) for 2012 - 2013 as the entry point for meaningful dialogue. The Service Profiles identify key metrics that reflect the quality of local cancer services, in line with the ethos of the Clinical Lines of Enquiry. Many MDTs will be familiar with these profiles as there was a period of consultation with breast and colorectal MDT teams before they were released to the wider NHS.

The profiles provide comparative information for benchmarking the tumour specific Multidisciplinary Teams (MDTs) across England. Although much of the data within these profiles is already available within the NHS, it is the first time this range of indicators has been brought together in a profile format.

The profiles help quantify the variation across the cancer specific MDTs for both the patient experience and the quality of patient care. The indicators included have been discussed with cancer commissioners and clinicians working in MDTs as being important elements for objective dialogue in terms of clinical practice and service delivery. The profile will highlight areas where an MDT is doing well and may also highlight other areas for improvement, although it is also important to consider recent progress against the indicators in the dialogue.

The inclusion of benchmarking to identify whether a particular indicator is significantly at variance to the national mean is a helpful way to identify those aspects of service delivery which might be the focus of initial discussion. It is anticipated that many trusts will be significantly different to the mean on one or two indicators. In general for any trust, the more indicators that are significantly at variance, the greater the need for understanding why this should be the case. This explanation may be grounded in the population age and socio-economic status. It is also important to note that whether a higher value or a lower value than the mean is regarded as “good” is dependent on the individual indicator.

Some indicators are relatively straightforward to interpret (e.g. cancer waiting times) whereas other indicators may need more discussion and local intelligence to understand the context and case mix of patients managed within the particular service. Documents for both the general guidance on the service profiles, and the data definitions, will be provided alongside the Service Profile to inform their interpretation and discussion.

MDTs should discuss their profiles with reference to the areas where benchmarking shows there are areas for improvement. All the profiles and further background information can be found on the Cancer Commissioning Toolkit www.cancertoolkit.co.uk.

Additional Colorectal Metric

Proportion of newly diagnosed colorectal cancers being radiologically staged with CT scanning (and, in the case of rectal cancer, with MR imaging of the pelvis)

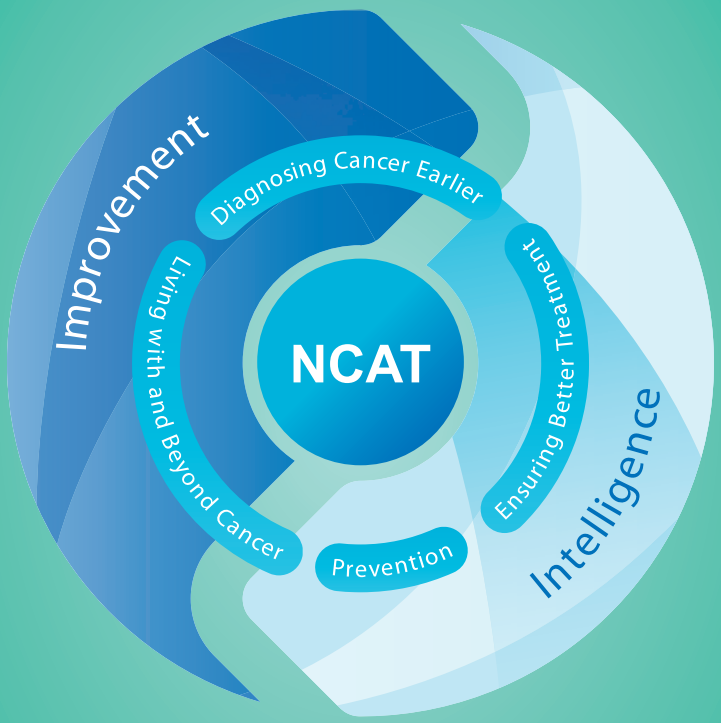
Both of these items are requested by NBOCAP but local audits may have also been performed. There is firm guidance from the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and COG guidelines that both pre-operative CT imaging in all cases, and additionally MR imaging for cases of rectal cancer, are the radiological investigations of choice. Not only do they allow appropriate selection of patients for neo-adjuvant treatment but the results, coupled with the pathological examination of the resected specimen, allows the MDT to record an integrated clinico-pathological stage for each tumour. There will also be patients, identified as having advanced disease on CT imaging, who will be recommended palliative chemotherapy rather than initial surgical excision.

The proportion of patients who are recorded as having had a CT scan, either by having a CT scan result reported or by having a date of CT scan reported was over 80 per cent in the 09/10 reporting period and was similar across cancer sites. In 79 per cent of trusts at least 80 per cent of patients are recorded as having had a CT scan. NICE guidelines recommend that 100 per cent of patients should have a CT scan.

It is reported that over 80 per cent of rectal cancer patients undergoing major surgery had an MRI scan, although not all of these patients had a result recorded. In 65 per cent of trusts at least 80 per cent of rectal cancer patients undergoing major surgery had an MRI scan. NICE guidance is that patients with invasive rectal cancers for whom surgery is being considered should have magnetic resonance imaging (MRI) scans before treatment begins.

Where teams fall below the NICE guidance reviewers should enquire about what is being done to increase the proportion, as well as the impact on patients locally who are not gaining access to this radiological staging. In discussing the NBOCAP data it is important to note that poor uptake may be a reporting issue rather than a failure to perform CT and MR.

The National Bowel Cancer Audit Report 2011 is available on the NHS Information Centre website www.ic.nhs.uk.



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