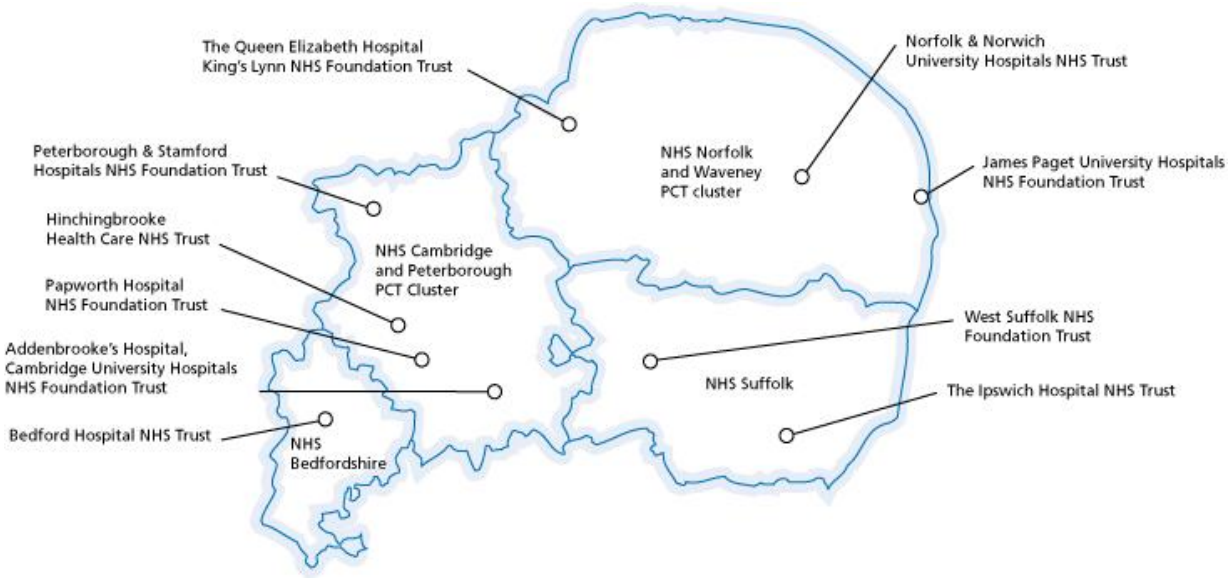
Anglia Cancer Network



Liver Metastases Service Criteria

For approvals and version control see Document Management Record on page 14

Ref: AngCN-SSG-C13

1 Introduction

This document is being provided to the Midlands and East Specialist Commissioning Group (M&E SCG) East of England Office as clinical guidance on the criteria that an Anglia Cancer Network Liver Metastases Service is expected to demonstrate compliance with, to support them in their commissioning of an IOG-compliant liver metastases service.

It is acknowledged that an overarching National Hepatobiliary (HPB) Service Specification (inclusive of liver metastases) is due to be published later this year (2012) by the NHS Commissioning Board. It is intended that this document is complementary to that national service specification.

In that context, the content of this document has been validated by members of the expert group who are drafting the National HPB Service Specification.

2 Guiding principles

This service criteria document focuses on the detail of the elements of the service that are changing and must now be provided by a single centre, and sets them in the context of the overall patient care pathway.

It is important to recognise the contribution to the current service that staff across the Network make, and a major part of the role of the single centre is to sustain this contribution to ensure appropriate local care continues to be considered in the future service model, and to ensure that all opportunities for joint working by healthcare professionals across the region are considered.

The guiding principle is that patients are cared for by healthcare professionals across the Network collaborating throughout the care pathway, with as many elements as possible of that care pathway delivered locally to the patient. By default, only surgery and immediate follow up should occur at the centre (unless the centre is also the patient's local Trust).

See section 5 and Appendix A for further detail.

3 Key service outcomes

- A greater number of patients than at present being offered surgery for their liver metastases;
- A single, high volume surgical centre for all Anglia Cancer Network patients with liver metastases;
- A single liver resection specialist MDT reviewing the diagnostic data and agreeing the treatment plans of all patients with liver metastases meeting the referral criteria;
- An increased expertise within the liver resection specialist MDT members, the surgeons and their supporting teams, generated by the higher number of patients seen and treated, enabling innovation in the treatment of patients with liver metastases;
- The majority of non-surgical care being provided at a location that is as local as possible to the patient.

See Section 8 for the details of service outcomes to be measured.

4 Service description

4.1 Scope

This service will offer patients the choice of an IOG-compliant service within the Anglia Cancer Network region. This service will be for patients who meet the following criteria:

- Adult colorectal cancer patients with suspected or diagnosed liver metastases;
- Liver resections to treat metastases in adult patients from a primary cancer diagnosis other than colorectal cancer.

It is also recognised that there are other IOG-compliant pathways from the borders of the Anglia Cancer Network region which some patients may wish to choose.

The service scope is wider than that covered by the revised colorectal measures because the network wishes there to be equality of access to safe and effective surgical practices for liver resections due to liver metastases, regardless of the patient's primary cancer diagnosis.

These service criteria do not cover liver resections arising from non-cancer treatments or primary liver cancers.

4.2 Aims

The aims of this service are:

- To ensure equitable access to surgery for patients with liver metastases;
- To continue to improve the survival rates for patients with liver metastases by commissioning a surgical service with outcomes in line with the best in this country and Europe;
- To provide information to support ongoing development of the service.

These aims are in line with the Improving Outcomes: A Strategy for Cancer 2011 publication which promotes the delivery of high quality outcomes for patients.

4.3 Objectives

The objectives are:

- To have an IOG-compliant service for liver metastases within the Anglia Cancer Network;
- To have a single surgical centre within the Network for patients with liver metastases;
- To have a single specialist MDT for liver resection within the Network, hosted at the same site as the single surgical centre, to whom all patients meeting the referral criteria are referred (see section 6.4 for referral criteria);
- To have the majority of non-surgical care provided at a location that is as local as possible to the patient.

4.4 General overview

The National Cancer Action Team's Manual for Cancer Services 2011 includes colorectal measures which have been revised to take account of service improvement recommendations for adult colorectal cancer patients in the areas of efficiency of diagnosis, minimum volumes of colorectal cancer patients to be handled by each colorectal MDT and each colorectal surgical team, and the consolidation of specialist expertise in the treatment of anal cancer and resection of rectal cancer and liver metastases.
The recommendation relevant to liver metastases for cancer patients states that:
"Specialised MDTs are defined for the surgical resection of liver metastases in selected patients. These 'liver resection MDTs' may be the same MDTs that currently manage

pancreatic cancer, or new liver resection MDTs may be established specifically for this task. For either of these two models the resulting MDT shall have a minimum of two million for referral for resection of liver metastases."

The above statement in the Manual for Cancer Services 2011 has been reinforced by the conclusions drawn within the report on the configuration of surgical services in Anglia for patients with colorectal liver metastases, commissioned by the National Cancer Action Team and published in September 2012, which states that "…one site, serving the Network population of potentially 2.9m, is the preferred service configuration."

4.5 Evidence base

NICE Colorectal IOG Guidance (Improving Outcomes in Colorectal Cancers, May 2004, (Chapter 3, Page 53) recommends a specialist MDT with facilities to provide surgery for patients with liver metastases in a Centre serving a population of two – four million and refers to research which shows that liver resection can improve the five year survival rates for eligible colorectal patients with liver metastases, raising the survival rate from approximately 3% to somewhere closer to 30%.

The Improving Outcomes in Colorectal Cancers : Research Evidence for the Manual Update (June 2004, Table 3.3) refers to research which concludes that higher volumes result in lower (30 day) operative mortality.

Surgeon volumes in oesophagogastric and hepatopancreatobiliary resectional surgery, R M Charnley and S Paterson-Brown, British Journal of Surgery 2011; **98:** 891-893 talks about the strong relationship between increasing hospital volume and reduced operative mortality for major resections, as well as between hospital volume and long-term survival.

The Association of Upper Gastrointestinal Surgeons, Provision of Services for Upper Gastrointestinal Surgery; Richard Charnley, Graeme Poston, Bill Allum, November 2011 (page 32) describes the recommended configuration of liver resection services and anticipated volumes for liver resections.

Section 8.1 of this document provides the evidence relating to current access to surgery for Anglia Cancer Network adult cancer patients with liver metastases.

5 Care pathway

Appendix A provides a diagrammatic overview of the care pathway.

5.1 Accessibility/Acceptability

The provider shall ensure that, in conjunction with the referral criteria set out in section 6.4, its services are accessible regardless of age, disability, race, culture, religious belief, sexual orientation or income levels. The provider shall deal sensitively with all service users, potential service users and their family/friends and advocates.

5.2 Responsibility for the patient

Responsibility for the patient shall remain with their primary cancer care team at all times unless and until specified differently by the specialist MDT.

Patients shall be returned to the overall management of their primary cancer site teams at the end of any treatment (and potential follow up) carried out by the surgical centre.

See section 6.5 for further details.

5.3 Diagnostics

Diagnostics for metastatic disease shall be carried out locally to the patient, under the guidance of the patient's primary cancer care team.

These must conform to NICE Guidance (see Chapter 2, Colorectal Cancer: the diagnosis and management colorectal cancer, November 2011). Reporting of all specimens must be in line with Royal College of Pathology guidelines.

The centre must demonstrate within their SMDT Operational Policy how it will coordinate the transfer and analysis of scans and test results from referring Trusts.

5.4 Entry into the service

All tumour site-specific MDTs, upon suspicion or confirmation of metastatic liver disease in a patient who meets the referral criteria for liver resection (see section 6.4), shall refer this patient to the liver resection specialist MDT who shall review the patient's diagnostic data and agree a treatment plan.

5.5 Liver resection specialist MDT

The liver resection specialist MDT shall be hosted by the same Trust that provides the liver resection surgical service.

It is expected that the liver resection specialist MDT shall be a video-conferenced MDT giving all referring Trusts and clinicians the opportunity to participate fully in the discussion of their patients.

If the liver resection specialist MDT decision is to treat the patient at the surgical centre

- a key worker shall be identified for the patient and their name recorded in the patient notes;
- the follow-up team shall be decided based on clinical/geographical need and patient choice, with due regard to the guiding principle outlined in section 3.2.

5.6 Treatment

Surgery

The surgical centre shall carry out all resectional procedures for liver metastases on the same site and shall have ITU and HDU facilities on site that support the forecast volume of patients (see section 7.2).

The surgical centre shall also have the capability to deliver radiofrequency ablation treatment for these patients, if this cannot be provided locally.

The provider shall ensure that there is an emergency care specialist surgical service available with 24/7 cover and access to expert opinion for both patients and clinicians. The emergency care pathway shall be defined within both the Clinical Guidelines for Liver Metastases (see section 6.2) and the SMDT Operational Policy.

Chemotherapy

It is expected that chemotherapy is delivered locally to the patient wherever possible.

The liver resection specialist MDT shall have a separate agreement with each referring colorectal MDT specifying which team's oncologist will be responsible for managing any chemotherapy given as combination treatment with metastatectomy.

Palliative Care
It is expected that palliative care is delivered locally to the patient wherever possible.

5.7 Follow up

It is expected that follow up activities take place locally to the patient wherever possible, with the exception of immediate post-operative follow up.

A follow up policy shall be agreed with the referring MDTs which specifies, as a minimum:

- Which team should follow up the patient after liver metastatectomy;
- Specific indications for referral back to the liver resection specialist MDT in the case of post-operative complications or issues.

6 Service model

This section details the specific criteria relevant to the surgical centre and the liver resection specialist MDT.

6.1 Liver resection specialist MDT (based on the Manual for Cancer Services)

There shall be a single specialist MDT for liver resection within the Anglia Cancer Network.

There are two options for structuring the liver resection specialist MDT:

- As a stand-alone specialist MDT;
- As a part of the pancreatic specialist MDT.

For a stand alone liver resection specialist MDT, the core membership requirements are:

- two or more hepato-biliary surgeons;
- histopathologist;
- imaging specialist;
- nurse specialist;
- an oncologist (clinical or medical) who takes responsibility for chemotherapy given in combination with metastatectomy;
- MDT co-ordinator/secretary;
- an NHS-employed member of the core or extended team nominated as having specific responsibility for users' issues;
- a member of the core team nominated as the person responsible for ensuring recruitment into clinical trials and other well designed studies.

For a liver resection specialist MDT that is part of a pancreatic specialist MDT, there are no additional requirements in terms of professional roles over and above those of the pancreatic specialist MDT.

The liver resection specialist MDT, regardless of whether it is a stand-alone specialist MDT or part of the pancreatic specialist MDT, must contribute to the colorectal minimum dataset. The dataset to be collected will be agreed as part of agreeing the Clinical Guidelines for liver metastases (see section 5.2) and will be the whole, or a subset of, the national colorectal minimum datasets (see Appendices D and E). Note that these datasets will change to the National Cancer Outcomes Services Dataset (COSD) from January 2013.

If the liver resection specialist MDT forms part of a pancreatic specialist MDT, then the MDT will need to collect both the colorectal minimum dataset and the pancreatic minimum dataset (see Appendix H).

The liver resection specialist MDT, regardless of whether it is a stand-alone specialist MDT or part of the pancreatic specialist MDT, must consider the recruitment of patients into colorectal Network trials.

The provider must ensure that the video-conferenced liver resection specialist MDT is broadcast using up to date video-conferencing equipment that is under a maintenance contract.

6.2 Clinical Guidelines

The liver resection specialist MDT shall produce, in consultation with all colleagues, detailed Clinical Guidelines for liver metastases. These guidelines will need to be agreed and signed off by the Colorectal NSSG and the Anglia Cancer Network Board, and be reviewed regularly (at least every two years). The liver resection specialist MDT may only operate under guidelines that have been agreed by the Colorectal NSSG.

A network template for Clinical Guidelines can be found in Appendix G.

6.3 Liver resection specialist MDT operational policy

The liver resection specialist MDT shall produce an operational policy for the proposed service which articulates the service vision and guiding principles, describes the high level objectives and clearly sets out the service configuration and operational model.

It is essential that the centre actively engages with the referring Trusts to ensure that best practice with respect to referrals of patients to the liver resection specialist MDT and their ongoing treatment is embedded within the Network service.

The operational model shall demonstrate how communication, joint learning and joint working amongst clinicians across the Network will be achieved (for example, through a programme of visits by the centre's clinicians to other cancer units, or through joint data collection and analysis).

The operational model shall also demonstrate that it has service accessibility for patients at its heart.

The operational policy must include the following:

- Name of Organisation;
- Type of MDT and the organisational support for MDT working;
- Clinical Leadership of the service and how this will develop to ensure appropriate clinical engagement in the patient pathway across the network, ensuring a standardised approach is achieved and maintained;
- Membership of the core MDT*;
- Extended membership of the MDT;
- Clinical expertise available*;
- Clinical facilities available*;
- Proposed working with the Colorectal NSSG and other relevant SSGs, MDTs and cross cutting groups. Demonstration of how system wide priorities for improvement will be identified and agreed;
- Referral arrangements into the MDT (including an MDT referral template) and policy for clinical responsibility for patients at different points in their pathway;

- The Model of Care and operation of the MDT and the role of local services in the following:
    - Pre-diagnostics
    - Diagnostics
    - Pre-treatment
    - Treatment
    - Emergency care
    - Follow-up
    - Supportive care
- Communication to referrers and how the MDT will manage whole system relationships, sharing information between all constituent organisations and clinicians in order to manage patients across their care pathway;
    - Key Worker policy
    - Emergency cover arrangements*
    - Re-referral arrangements
- Service User information policy which outlines how patients will be communicated with and provided with informed choice throughout their pathway;
- Service User feedback policy which will describe how patient experience data will be used to improve and develop working practice within the Trust and in the wider Network of care;
- Patient access, transport and accommodation information, ensuring these are considered across the whole Network area;
- Plans for data collection and audit;
- Evidence of a positive culture of research within the organisation and an assessment of how this is implemented for patient benefit. This should include leadership arrangements for research and the arrangements for promoting access to high quality clinical trials;
- Description of video-conferencing equipment – make, model, year of installation and duration of current maintenance contract.

*where posts need to be appointed to or facilities increased a clear recruitment/development plan needs to be available to meet the implementation date.

6.4 Referral criteria

All patients with suspected or diagnosed liver metastases are to be discussed, and have their treatment plans agreed, by the liver resection specialist MDT. Referring all patients suspected of having liver metastases in this way will support the service objective of equity of access to surgery.

Templates for referral to the liver resection specialist MDT and the specialist MDT Outcome Proforma are to be defined by the specialist MDT.

The referral template must include, as a minimum:

- Full medical history of the patient;
- Histology of primary tumour;
- Relevant imaging as defined in the liver metastases Clinical Guidelines;
- Name of referring clinician and referring MDT;
- Reason for referral.

The outcome template must include, as a minimum:

- Full description of treatment plan or rationale for endorsement of the referring MDT's recommendation;

- Name of clinician taking on responsibility for the patient at the surgical centre, if applicable.

Patients referred to the liver resection specialist MDT are considered to be covered by the Cancer Waiting Times 31 day target (Decision to Treat to start of Second or Subsequent Treatment), and the 62 day target (Consultant Upgrades).

6.5 Governance

Any patient referred to the liver resection specialist MDT shall remain the responsibility of the referring clinician until a clinician from the liver resection specialist MDT has formally written to the referring clinician stating that they will take on (temporary) responsibility for the patient.

Responsibility for the patient will be handed back to the party agreed within the treatment plan (normally expected to be the initial referring clinician) when treatment, and any agreed period of follow up at the centre, has completed.

Following discussion at the SMDT it is the responsibility of the Chair of the SMDT to ensure that a comprehensive opinion is communicated using a proforma. The completed proforma (patient details, clinical history and action plan) shall be distributed by the SMDT co-ordinator within one working day to the following:

- Electronic copy to core and extended members;
- Faxed copy to GP;
- Copy to referring clinician;
- Local key worker.

The Chair may also dictate a letter to the referring consultant with a copy to the GP and other relevant clinicians, summarising the treatment options to be recommended.

Following any treatment at the specialist centre, a detailed end of treatment record shall be returned within one working week to the referring LMDT /clinician including the operation record, radiotherapy and chemotherapy treatment, complications, final pathological stage and details of follow up requirements.

Further details of the governance principles to be embraced by this service can be found in AngCN-32 Guidelines for Governance between LMDTs and SMDTs Version 1 (see Appendix C).

6.6 Patient and carer information

The service shall describe how patients will access the centre from wherever they live across the Network.

The service shall demonstrate flexibility for visiting families and carers.
Information shall be provided on local accommodation, car parking, public transport, social support, benefits, and facilities within the centre.

Patients and their families/carers shall be provided with written information about liver metastases and its treatment.

The provider must produce the patient information, and submit it for review by the Network patient information lead.

6.7 Service dataset

The datasets defined in Appendix B, D and E shall be collected. Note that the datasets in Appendices D and E will change to the National Cancer Outcomes Services Dataset (COSD) from January 2013.

Additionally, if the liver resection specialist MDT is part of a pancreatic specialist MDT, then the dataset defined in Appendix H shall also be collected.

6.8 Key Relationships for the liver resection specialist MDT

Key relationships shall be with all Anglia Cancer Network site-specific MDTs and colorectal MDTs in particular, the Anglia Cancer Network Colorectal NSSG, and GPs.

Please refer to Appendix A for a diagrammatic representation of the liver metastases patient pathway, and how this pathway interrelates with other tumour site pathways.

6.8.1 Colorectal MDTs

A core surgical member of the liver resection specialist MDT, who carries out liver metastatectomies, must be an extended member of the Network colorectal MDTs, playing an advisory role on liver metastatectomy.

The SMDT shall ensure that they have a programme of frequent visits and communications with all referring local colorectal MDTs.

Colorectal MDTs are held at the following Trusts:

- Addenbrookes
- Hinchingbrooke
- James Paget
- Bedford
- King's Lynn
- Norfolk and Norwich (colorectal MDT and anal MDT)
- Peterborough
- Ipswich
- West Suffolk Hospital

6.8.2 Colorectal NSSG

The Network site-specific group (NSSG) relevant to the liver resection specialist MDT is the Anglia Cancer Network Colorectal NSSG.

The Lead Clinician of the liver resection specialist MDT (or their representative) must attend at least two-thirds of the Colorectal NSSG meetings.

6.8.3 Site-Specific MDTs and GPs

Referring MDTs, and the patient's GP, must be informed of the decision of the liver resection specialist MDT in writing within one working day of the specialist MDT meeting (see section 7.3 for further details).

7 Activity plan

7.1 Current activity levels within the Anglia Cancer Network

Data extracted from ERPHO in April 2011. Data relates to 2009 and selects patients who have a primary cancer code and have undergone a liver resection procedure.

62 Anglia Cancer Network patients underwent liver resections within Anglia Cancer Network Trusts.

A further 30 Anglia Cancer Network patients were referred to Trusts outside of the Network for liver resections.

This gives a total of 92 liver resections (for patients with liver metastases) that could have been carried out within the Network in 2009.

Of these 92 patients, 80 (87%) had colorectal primaries and 6 (6.5%) had other primaries (Upper GI, Head and Neck, Pancreatic). The remaining 6 (6.5%) patients had primary liver cancer.

7.2 Expected activity levels within the new liver resection service

These forecasts are based on research evidence referenced by the Colorectal IOG and have been validated by expert clinical opinion from outside of the Anglia Cancer Network. These forecasts take into account recent and future growth due to earlier presentation, improved diagnostics and more effective chemotherapy agents that allow resection following chemotherapy treatment in some patients, and are in line with the predicted numbers of candidates for resection expressed in the recent AUGIS report.

The 2009 Anglia Cancer Network five year rolling average number of new incidences of colorectal cancer is 1758.

60% to 75% of these patients will either present with liver metastases or develop them over the following three years. An annual average of 1054 to 1318.

Of this number, approximately 70% will have metastases in the liver only and would be expected to be managed according to the liver resection specialist MDT clinical guidelines and be discussed at and/or have their treatment plans endorsed by the specialist MDT. An annual average of 738 to 923.

Approximately 20% of these will have resectable disease. An annual average of 148 to 185.

To these numbers should be added a percentage (approximately 7%, based on 2009 data) reflecting the patients diagnosed with liver metastases from other primary cancers excluding liver primaries.

The Association of Upper GI Surgeons (AUGIS) guidance on surgeon volumes recommends that a single surgeon should have a caseload of a minimum of 15 liver resections per year. The provider organisation needs to ensure that the surgical team is appropriately staffed to meet the projected volumes of liver resections.

7.3 Capacity review

The service shall provide the following:

- SMDT personnel, equipment, and videoconferencing facilities to accommodate between 738 and 923 referrals per annum;

- Theatre space, staff, ITU and HDU facilities to accommodate up to 185 liver resections per annum.

The Report on the Configuration of Surgical Services in Anglia for Patients with Colorectal Liver Metastases, commissioned by the National Cancer Action Team in April 2012, can be referred to, if required, for recommendations on workforce levels to meet the above.

The provider must be able to demonstrate how they plan to meet the resource implications of this service.

8 Service improvement and outcome measurement

Service improvement shall be driven, as a minimum, by the outcome measures listed here. The M&E SCG, the Anglia Cancer Network and the Colorectal NSSG will take an active role in reviewing these standards on a regular basis.

Outcome Measure	Definition	Source
Referrals	100% of patients matching the Specialist MDT referral criteria to have been referred to the Liver resection specialist MDT	Provider data
Treatment plan timeliness	100% of patients referred to the Liver resection specialist MDT to have an agreed treatment plan within two weeks of referral	Provider data
Activity levels	Numbers of patients, and percentage of total patients, where the treatment plan is • No therapy • Chemotherapy • Surgery • Combined Chemotherapy and Surgery • Radiofrequency Ablation To reflect 100% of patients discussed.	Provider data
Key worker assignment	100% patients accepted for treatment at the Centre to have a nominated key worker documented in their patient notes	Provider data
Surgery	Laparoscopic resections to be performed in at least 10% of patients with surgical treatment plans	Provider data
Timeliness of surgery	0% of cancellations of liver metastases surgery, or inability to access such surgery at the most clinically appropriate time, to be due to lack of ITU facilities.	Provider data
30 day mortality	30 day mortality figures relating to all forms of treatment with curative intent	Provider data
Re-admission rates	100% of total number of re-admissions within 30 days of the initial clinical operative procedure to be as a result of adverse outcomes other than complications arising from liver resection surgery	Provider data

Recurrent disease	Numbers of patients and percentage of total patients, where the treatment plan for recurrent disease is : • No therapy • Re-operation • Chemotherapy • Combined Chemotherapy and Re-operation To reflect 100% of patients with recurrent disease.	Provider data
Service user experience	Annual patient experience survey with resulting action plan	Provider data
Cancer Waiting Times	< 2% of breaches of 31 day subsequent treatment and 62 day consultant upgrade measures for primary cancer sites to be due to delays caused by referrals to the Liver resection specialist MDT.	Provider data
Cancer Waiting Times Breaches	Evidence of provider taking responsibility for organising joint analysis of breaches between primary tumour site MDT and liver resection specialist MDT	Provider data
Cumulative annual survival rates	one year and five year survival rates	ECRIC/ERPHO

The service shall be subject to peer review and shall produce a Work Programme, Annual Report and Operational Policy that clearly reflect how the service is being monitored and how recommendations for service improvement are derived.

9 Evidence of Agreement

This document has been agreed by:

The Chair of the East of England Specialist Commissioning Group
Name: Carole Theobald Organisation: East of England Specialist Commissioning Group Date agreed: 26 September 2011 Note that Version 2 of this document was not re-submitted to the (now) Midlands and East Specialist Commissioning Group (East of England Office) due to the changes being either as a result of the NCAT review report which they had commissioned, or cosmetic in respect of changing the document into Network service criteria rather than a commissioning service specification.
The Liver Resection Project Steering Group Members
This document was discussed at the 29 October 2012 Steering Group meeting and was ratified by all members in December 2012. Note that Version 1 of this document was originally agreed by the Steering Group on 12 September 2011

Document management

Document history			
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Authors:	AngCN Liver Resection Project Steering Group	Document Owner:	Anglia Cancer Network www.angliacancernetwork.nhs.uk
Version number as approved and published:	2	Unique identifier no.:	AngCN-SSG-C13

Monitoring the effectiveness of the Process

a) Process for Monitoring compliance and Effectiveness - Review of compliance as determined by audit. Any non compliance to be presented by PQ Manager to the AngCN Business Meeting on an annual basis – the minutes of this meeting are retained for a minimum of five years.

b) Standards/Key Performance Indicators – This process forms part of a quality system working to, but not accredited to, International Standard BS EN ISO 9001:2008. The effectiveness of the process will be monitored in accordance with the methods given in the quality manual, AngCN-QM.

Equality and Diversity Statement

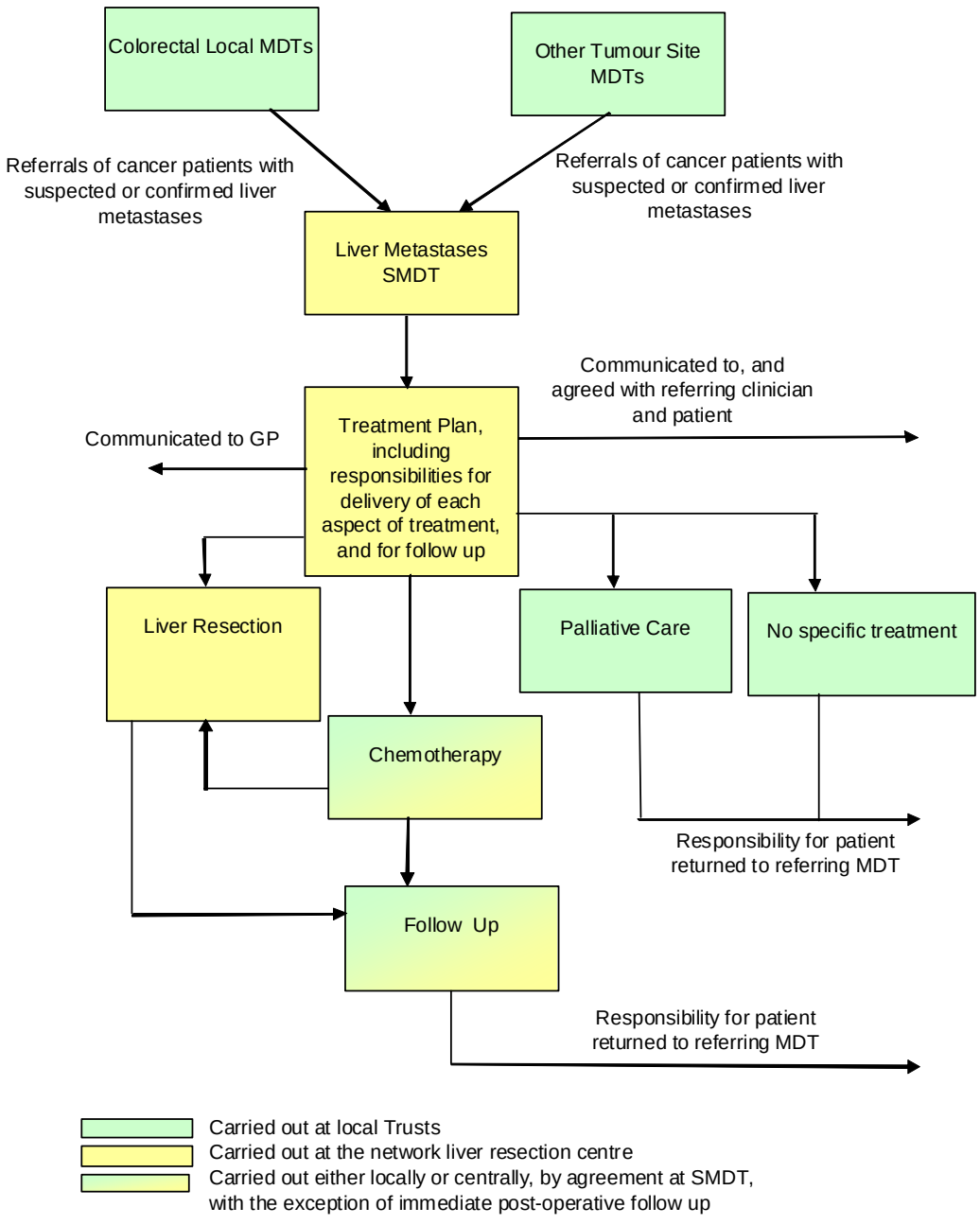
This document complies with the Suffolk PCT Equality and Diversity statement – an EIA assessment is available on request to Anglia Cancer Network PQ Manager, Gibson Centre, Exning Road, Newmarket, CB8 7JG.

Disclaimer

It is your responsibility to check against the electronic library that this printed out copy is the most recent issue of this document.
Please notify any changes required to the Anglia Cancer Network PQ Manager.

10 Appendices

Appendix A – Patient pathway



Appendix B – Proposed service dataset

To be fully defined and agreed within the Liver Metastases SMDT Operational Policy

		Number of Measurement
Temporal Relationship	Resected Simultaneous with Primary	
	Synchronous	
	Metachronous	
	Liver prior to bowel resection	
Method of Discovery	Intraoperative Incidental	
	Preop U/S	
	Preop CT	
	Preop MRI	
	Follow up CEA	
	Follow up CT	
	Follow up U/S	
Location of Metastases	Right	
	Left	
	Both Lobes	
	Border of Left and Right	
	Caudate	
Diameter of Metastases	Range	
	Median	
Number of Metastases	Range	
	Median	
R-classification (at histology)	R0 – margin not involved	
	R1 – microscopic margin involved	
	R2 – extrahepatic disease, further treatment planned	
R2 Subclass	Isolated peritoneal/omental deposit formally excised	
	Did not proceed to pulmonary resection	
	Tumour left in liver for staged resection	
	Did not proceed with staged resection	
	Primary remaining in situ for planned resection	
	Multiple pulmonary mets for future resection/RFA	
	Resection of primary post liver of and resection of Pulmonary lesion	
Other Information	Median blood less	
	Patients requiring transfusion	

Total Complications : (number and percentage of total operations)

General :
Surgical :

To be completed for each named surgeon.

	Clavien Dindo Classification				
Type of Complication	**Grade V**	**Grade IV**	**Grade III**	**Grade II**	**Grade I**
Total (number and percentage)					

Definitions :

Grade V :	Death of a patient.
Grade IV :	Life-threatening complication (including Central Nervous System complications) requiring IC/ICU-management.
Grade III :	Requiring surgical, endoscopic or radiological intervention.
Grade II :	Requiring pharmacological treatment with drugs other than such allowed for grade I complications. Blood transfusions and total parenteral nutrition are also included.
Grade I :	Any deviation from the normal postoperative course without the need for pharmacological treatment or surgical, endoscopic and radiological interventions

To be completed for each named surgeon.

Type of Resection	**Numbers and Percentages**
Right hepatectomy	
Left hepatectomy	
Extended right hepatectomy	
Extended left hepatectomy	
Segment orientated	
Wedge excision only	
Classification	
Anatomical	
Anatomical + anatomical	
Extended anatomical	
Non-anatomical	
Anatomical + non-anatomical	
Extended anatomical + non-anatomical	

Appendix C - AngCN-32_Guidelines for Governance and Communication between Local and Specialist Multi-Disciplinary Teams

Please see associated document.

Appendix D - National Dataset for Colorectal Cancer Resection Histopathology Reports

Please see associated document.

Appendix E - National Dataset for Colorectal Cancer Local Excision Histopathology Reports

Please see associated document

Appendix F – Agreed List of Colorectal Cancer Trials

This appendix is no longer required.

Appendix G – Network Clinical Guidelines Template

Please see associated document

Appendix H – Pancreatic Cancer Minimum Dataset

- Pancreatic Carcinoma Histopathology Report - please see associated document
- Ampullary Carcinoma Histopathology Report - please see associated document
- Bile Duct Carcinoma Histopathology Report - please see associated document