

London Cancer: **Pathway specification for** **Colorectal cancer**

November 2014

Version 1.0

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1. Introduction

1.1. *London Cancer*

The cancer care providers of North East London and North Central London and West Essex agreed in July 2011 to develop an integrated cancer system in response to the requirements of London's Strategic Health Authority and commissioners. Since April 2012 this integrated cancer system, *London Cancer*, has been commissioned to provide cancer services for a resident population of 3.2 million. Its mission is to improve outcomes and experience for our patients and local communities.

London Cancer will be underpinned by patient empowerment, research, evidence and information sharing. It will radically refocus hospitals into working in partnership with each other, primary care and patients, to deliver coordinated, comprehensive pathways of excellent care for every patient irrespective of where they access our system or the type of cancer that they have.

The agreed priorities of the integrated cancer system are:

- Being patient-focused through listening, communication, involvement, information, education, choice, and personalisation
- Optimising care along a co-ordinated pathway – earlier diagnosis, high quality compassionate care for all, local treatment where possible and empowering/supporting patients to self-manage where appropriate
- Embedding research for personalised care, equitable access to trials, the discovery of new treatments and evaluating new ways of working together with patients
- Increasing value – delivering improved 'patient defined' outcomes per pound invested.

In addition to these priorities, *London Cancer* has carried out extensive research on what matters to patients and has distilled this work into ten key themes that will be central to everything that we do:

1. **Diagnosis** – patients are diagnosed at an earlier stage
2. **Ethos** – patients are treated holistically as individuals, and with dignity, sensitivity and respect, so that they do not feel that they are treated as a set of cancer symptoms
3. **Communication** – patients receive written and verbal information about diagnosis and all treatment options, including side effects and quality of life implications
4. **Choice** – patients and carers are fully involved in the choice of hospital and treatment options
5. **Support** – patients are given information on support groups and benefits entitlement and are offered emotional and psychosocial support
6. **Carers** – carers are fully involved and supported throughout the pathway
7. **Holistic assessment** – patients have holistic assessments at appropriate stages throughout the pathway, with action to meet their needs taken as a result
8. **Seamless care** – all patients are assigned a CNS when diagnosed and a community keyworker on discharge
9. **Transport** – patients should only travel when necessary and appropriate arrangements should be made for the immunosuppressed; patients should be provided with free parking or transport vouchers
10. **Discharge** – patients and their GPs should be provided with discharge information and follow-up advice.

1.2. Pathway specifications

London Cancer will deliver a step-change in cancer services in North East London and North Central London and West Essex. It is doing this by empowering both clinicians and patients, and placing patients at the heart of cancer care. Clinically led pathway boards have been constituted for each cancer pathway and these boards will, under the leadership of a pathway director, lead service improvement and change across the pathway. The focus of pathway boards is the whole patient pathway, including:

- The diagnostic interface with the public
- Primary care and accident and emergency care departments
- Initial assessment and appropriate rapid onward referral where necessary
- The provision of various aspects of patient treatment
- Follow-up or supporting end of life care.

To instigate change pathway boards will develop specifications for the future delivery of services along their pathways within the integrated cancer system. These changes are closely aligned with local and specialist commissioning intentions and support delivery of the NHS 5-year Forward View and the London Health Commission 'Better Health for London'. The organisations of *London Cancer* that contribute to the pathway will then be invited to demonstrate how they could meet the requirements of these specifications for the components of the pathway that they wish to provide.

A full list of contributors and the dates on which they met can be found in the appendix.

1.3. Colorectal pathway specifications process

The pathway specification has been developed by expert clinicians from across *London Cancer*, who are members of the Colorectal Pathway Board. Much of the content of the document is in alignment with the clinical guidelines agreed by the Pathway Board in November 2013, but with additional information as required.

The Colorectal Pathway Board, which includes representation from all relevant clinical specialities and all partner Trusts, approved the pathway specification on 11 November 2014.

2. Overarching principles and commitments

Before we describe the technical provisions that we would expect services to be able to provide, it is important to identify the over-arching features of a high quality, integrated, patient-focused pathway to which all providers within *London Cancer* should aspire. These include strong leadership and a series of commitments to principles that support the optimum functioning of the pathway. We expect all providers participating within the pathway to commit to and embody these commitments.

Leadership

Each component of the pathway will have a named leader who takes responsibility for leading the local provider team or the specialist team and ensures system-wide collaborative working to ensure availability of relevant specialist expertise at local units and equitable access to best practice and research.

Commitment to partnership working

All providers work together as part of an integrated team, and demonstrate this commitment to partnership from the outset by working collaboratively to develop plans against the pathway specification that are focused on delivering the best outcomes and experiences for patients.

Commitment to audit, data collection and sharing

All providers collect data on clinical outcomes and patient experience (and other relevant metrics), and comply with requirements for submission to national audits (e.g. NBOCAP) and other local/regional requests for performance and outcomes data.

Commitment to gathering and responding to patient feedback

All providers must demonstrate a practical commitment to elicit feedback from patients on a regular basis and use this intelligence systematically and routinely to inform service improvement.

Commitment to research and innovation

All providers within the system participate fully in the clinical trial and research portfolio, and carry out prospective audits of services and publish transparent outcomes data. They participate in tissue banking where relevant and support the use of research nurses, as well as promote research into improving patients' functional outcomes and rehabilitation therapies.

Commitment to education and training

All providers should facilitate access to high quality training and development opportunities for staff and services—with centres working in partnership and undertaking joint training where appropriate in order to deliver education in an efficient, joined-up way. Specifically:

- Training should be available for junior medical staff, nursing staff, allied health professionals (AHPs) and multi-disciplinary team (MDT) co-ordinators.
- Recognition should be given to the importance of education for CNSs, and protected time should be offered to CNSs to enable them to access development opportunities.
- Level 2 psychological training should be available for all members of the MDT with at least one clinical core member of the MDT having completed it —with supervision in line with the requirements of Peer Review.
- All relevant staff should be supported to undertake Advanced Communication Skills Training (ACST)
- Education and training activity should be subjected to ongoing monitoring and audit to establish what works and identify opportunities for improvement.

3. Colorectal cancer pathway specification

Colorectal cancer is a very common cancer. Colorectal cancer services in *London Cancer* will therefore be delivered locally as far as possible provided Local units have the full complement of resources and expertise within their service, as outlined in the pathway in this document. Local units will work with other Trusts within the *London Cancer* system, where required. With all Trusts meeting this pathway specification, patients will benefit from improved services, care and experience.

This document has been informed by the *London Cancer* 'Standards for patients diagnosed with colorectal and anal cancer in the *London Cancer* Integrated Cancer System' (2013).

POINT IN THE PATHWAY		LOCAL COLORECTAL CANCER UNIT SPECIFICATION
Presentation	Primary care	<ul style="list-style-type: none"> Referral of patients who fulfil the referral criteria for 'red flag' symptoms of colorectal cancer should be referred using the <i>London Cancer</i> two week wait referral pro-forma. The form ensures all referrals are sent to a designated Trust diagnostic and assessment service. Patients should be referred when high risk symptoms are present for three weeks before referral is made (a lower threshold than recommended by NICE). Two week wait referral to be completed within 24 hours of a patient being seen. All symptomatic patients who do not fulfil the two week wait criteria, should be considered for referral to a consultant colorectal surgeon or gastroenterologist using the routine referral point (18 week pathway) or using available straight to test services. Patients without 'red flag' symptoms for colorectal cancer should be referred using the Choose and Book service. GPs must attach the referral letter to the Choose and Book documentation. If Choose and Book is not available, the referral should be faxed within 24 hours. All patients with new onset symptoms over 55 years of age should be referred for further investigation. This threshold should be reduced to patients over 45 years of age from 2015.
	Internal referrals	<ul style="list-style-type: none"> Referral made to colorectal MDT, via the MDT coordinator, within 24 hours of a diagnosis of colorectal cancer by investigations or clinicians outside of the colorectal MDT. The colorectal MDT, via the MDT co-ordinator, should be urgently informed of any unexpected cancer diagnoses by the histopathologist, radiologist, endoscopist or clinician who is first presented with the diagnosis. This should be included within the operational policies of the MDT and diagnostic services.
	Screening	<ul style="list-style-type: none"> Patients with cancer or polyps identified at a screening centre referred to the colorectal MDT local to the patient for treatment on 62 day pathway.
	Emergency presentation	<ul style="list-style-type: none"> Patients presenting as an emergency should have surgery under the care of a core surgical member of a colorectal MDT. This applies within and out of normal working hours. This may require innovations such as collaboration between Trusts to provide on-call rotas or reconfiguration of services.

POINT IN THE PATHWAY		LOCAL COLORECTAL CANCER UNIT SPECIFICATION
	Secondary to tertiary referrals	<ul style="list-style-type: none"> Referrals from outside the network and secondary to tertiary referrals should be routed using appropriate referral standard operating procedures from the referring MDT to the appropriate specialist MDT (e.g. Liver resection and anal cancer).
Diagnosis	Referral processing	<ul style="list-style-type: none"> Diagnosis and assessment of all patients referred from primary care on a two-week wait pathway with a possible diagnosis of colorectal cancer will be carried out by a named diagnostic service in each Trust. On receipt of a two week wait referral, patients to receive an appointment within 14 days of referral. Patients who do not attend their appointment must be offered a second appointment, with the referring clinician informed that they failed to attend the first appointment.
	Diagnostic Lead	<ul style="list-style-type: none"> Each Trust should have a colorectal diagnostic service with a named lead clinician. The named lead is responsible for the process by which patients access appropriate diagnostic tests, to deliver a definitive diagnosis. The named lead is responsible for providing a decision point at their Trust for prioritising appointments for all patients referred for investigation of large bowel symptoms. This will be facilitated by the triaged straight to test model, outlined in the Transforming Cancer Services for London 'Best Practice Commissioning Pathway for the early detection of colorectal cancer' and 'Developing cancer-specific Quality Requirements for use in 2014/15 contracts'.
	Diagnostic service (Direct access)	<ul style="list-style-type: none"> In line with Transforming Cancer Services for London Best Practice Commissioning Pathway for the early detection of colorectal cancer', patients should be referred by a GP to a Colorectal 'Diagnostic Service' A Diagnostic Service is a designated referral centre, which will triage referrals and assign the most appropriate diagnostic test which will be booked directly with the patient. It should be noted that barium enema is not considered to be an appropriate first diagnostic test. The key principles of a Diagnostic Service, include: <ol style="list-style-type: none"> Referral received to a designated referral centre ideally using a standardised pro-forma (designed in conjunction with Local Clinical Commissioning Groups (CCGs). Referrals sent to dedicated fax or email address or to a Choose and Book telephone consultation clinic (for triage) Once received, referrals are clinically triaged, this could be by a trained specialist nurse (patients may be contacted by telephone to check the indication and fitness) according to local policy (building on existing local experience) agreed with local CCGs to one of the following: <ol style="list-style-type: none"> Direct access Colonoscopy (+ OGD if the patient presents with Iron-deficiency anaemia) Direct access Flexible Sigmoidoscopy Direct access CT scan including CT Colonography

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		<p>d. Out-patient consultation</p> <ol style="list-style-type: none"> 3. Patients with investigations which do not reveal cancer, but have a symptomatic condition, e.g. haemorrhoids, diverticulosis, Irritable Bowel Syndrome (IBS), functional constipation, should be sent back to the referring GP with a full report of the investigation results including histopathology, and with advice on self-care and primary care medical management. If symptoms persist, patients should be referred via 18 week pathway to an appropriate outpatient clinic 4. Patient diagnosed with Polyps should be entered into surveillance managed at the acute trust level in accordance with the BSG guidelines 5. Patients diagnosed with cancer should go straight to staging and be referred to the Colorectal MDT 6. Inflammatory bowel disease (IBD): treated in secondary care within Cancer and IBD MDTs and followed up as per local policy, agreed with local CCG.
	Information	<ul style="list-style-type: none"> • GPs will be notified of new patients diagnosed with cancer the next working day after the patient has been informed. • The GP will be informed of the MDT decision, following discussion with the patient in the presence of a CNS and core member of the MDT. This will require an establishment of colorectal CNSs to cover a 52 week service.
	Investigation protocol for primary colorectal cancer	<ul style="list-style-type: none"> • Complete examination of the large bowel by either total colonoscopy or CT pneumocolon. • The preferred method for making the initial diagnosis of a large bowel primary cancer is by colonoscopy • All units recognised for colorectal cancer diagnosis should be JAG accredited. • All patients with a colorectal primary should have a contrast-enhanced CT of chest, abdomen and pelvis to stage the disease. • In addition, when not contra-indicated, rectal cancers require local staging by MRI. Transrectal ultrasound may also be used as an additional modality in early rectal cancer. • Radiology reporting standards must comply with the recommendations from the Royal College of Radiologists. Ideally, a proforma report of the radiology with the clinical stage should be provided. • Blood investigations should include haemoglobin, electrolytes, creatinine, liver function test and pre-operative carcinoembryonic antigen (CEA) level. • Biopsy providing histological proof of malignancy is required in most cases of colorectal cancers investigated electively.
Multidisciplinary Team (MDT)	Membership	<ul style="list-style-type: none"> • All members have a specialised interest in colorectal cancer, with one member taking managerial responsibility for the service as a whole (the Lead Clinician).

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- Core team includes:
 - At least two colorectal surgeons are required, to comply with National Peer Review. The team, however, should have enough Colorectal surgeons to run a colorectal rota for the management of colorectal emergencies, including complications, and elective surgery.
 - Clinical oncologist with responsibility for radiotherapy for rectal carcinoma
 - Medical oncologist with responsibility for chemotherapy
 - Radiologist with an interest in colorectal imaging
 - Specialist Gastrointestinal Histopathologist
 - Colonoscopist with expert skills in any the following disciplines: surgeon, physician or specialist nurse
 - At least two Colorectal Clinical Nurse Specialists (CNS)
 - Anaesthetist/ Intensivist with an interest in the perioperative management of patients with colorectal cancer
 - MDT Co-ordinator
 - An NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers.
- At least one of the clinical core members, with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers.
- One of the core MDT members should be nominated as being responsible for the integration of service improvement.
- One of the core MDT members should be nominated as being responsible for the recruitment of patients into clinical trials.
- For medically qualified core members of the MDT, the cover should be provided by a consultant in the same specialty.
- Extended team includes:
 - Gastroenterologist
 - Psychologist/liaison Psychiatrist
 - Liver surgeon who is a member of a liver resection MDT
 - Thoracic Surgeon who has a practice in lung metastasectomy, and is a member of a Lung MDT
 - A member of the palliative care MDT (doctor or nurse)

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		<ul style="list-style-type: none"> • An expert in insertion of lower intestinal stents • Consultant in elderly care • Dietitian • Urologist • Gynaecologist • Clinical geneticist/genetics counsellor • Social Worker • Clinical trials co-ordinator or research nurse • Bowel Cancer Screening Nurse • Stoma care CNS • Physiotherapist/Occupational Therapist
	Clinical Nurse Specialist (CNS)	<ul style="list-style-type: none"> • At least one core nurse member who has completed, is enrolled in, or undertaking, a programme of study in their specialist area of nursing practice, which has been accredited for at least 20 level III CAT points. • A CNS who has completed, is enrolled in or undertaking a course in communication skills which is accredited for CAT points. • The workload of a CNS should be reviewed by the Trust and shared with the Integrated Cancer System annually to ensure the needs of patients can be met. • The importance of CNSs with patient care and patient experience should be recognised by Trusts by providing designated administrative support for CNSs. • There should be an adequate establishment of CNSs to allow for cover arrangements for annual leave and study leave.
	Attendance	<ul style="list-style-type: none"> • Attendance of individual core members at the MDT meeting should be 66% with core member or cover attendance achieving 95%. • For medically qualified core members of the MDT, the cover should be provided by a consultant in the same specialty. • Written attendance records should be collected for audit. • All core members with direct patient contact should have attended advanced communications skills training.
	Workload	<ul style="list-style-type: none"> • The core surgical members of the MDT should, as a group, discuss a minimum of 60 new colorectal cancer

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		<p>cases per year (average for two years).</p> <ul style="list-style-type: none"> Individual core surgical members of the MDT should undertake a minimum of 20 colorectal cancer resections per year (average over two years).
	Information	<ul style="list-style-type: none"> For every patient, MDTs must record a clinical stage at diagnosis and a post-operative pathological stage (for patients having an operation). Annual data must be submitted to the cancer registries and NBOCAP. The MDT must comply with peer review standards, which are to be viewed as minimum standards. All MDTs must submit data to <i>London Cancer</i>, as recommended by the Pathway Board. After a patient is given a diagnosis of cancer, the patient's GP is informed of the diagnosis by the end of the following working day.
	Meeting	<ul style="list-style-type: none"> MDT meetings to be held weekly, with a quorum of core members for at least 95% of the meetings. The care of all patients with colorectal cancer should be formally reviewed by the MDT. The MDT is expected to comply with national cancer targets. An operational policy outlining that all new cancer patients will be reviewed by the MDT. The MDT may choose to have a separate pre-operative/diagnostic meeting and post-operative/therapeutic meeting. The membership of this meeting is to be named and agreed by the Lead Clinician of the MDT. Core team members meet on an annual basis to discuss, review, agree and update the operational policies. Feedback should be given to referring GPs and CCGs on the appropriateness and/or timeliness of GP referrals. The feedback may include the stage at presentation. The MDT operational policy should include a policy for identifying the named CNS (key worker) for each individual patient, which is recorded in the patient's case notes. As MDTs become larger due to hospital mergers and reconfiguration, 'virtual MDT' innovations should be considered for approving and monitoring the treatment plans of patients on 'standard pathways' and with no issues requiring discussion by the team.
	Onward referral from the diagnostic and assessment service	<ul style="list-style-type: none"> The consultant clinician managing the patients' diagnosis is responsible for making an onward referral following the MDT decision. Patients with non-malignant disease diagnosed as part of the MDT process remain the responsibility of the

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		<p>referring clinician, most commonly the GP.</p> <ul style="list-style-type: none"> • There is a requirement for rapid and efficient communication systems for liaison and cross-referral between all levels of service, including primary care, psychologists, cancer genetic specialists, social workers and palliative care. • Joint clinics involving different disciplines, to enable a patient to be seen and discussed by two or more of the team members together, may improve patient care. At all times there should be close liaison between all members of the team.
	Teenage and young Adult Pathways (TYA)	<ul style="list-style-type: none"> • The TYA MDT for <i>London Cancer</i> is based at UCLH, which is the Principal Treatment Centre responsible for delivering and overseeing the care of teenagers and young adults within <i>London Cancer</i>. • The TYA MDT at UCLH may provide care jointly with the local colorectal MDT for patients aged 13 to 24 years of age. • The treatment plan of all cases jointly agreed by the respective Colorectal MDT and TYA MDT according to the relevant clinical guidelines.
Patient notification within outpatient clinic	Diagnosis and treatment options	<ul style="list-style-type: none"> • Clinic appointments to explain the diagnosis and treatment plan should occur as soon as possible after the MDT meeting. Ideally, this should happen on the same day as the clinic appointment. • It is recommended that the patient knows they can bring someone to support them at the clinic appointment. • The patient should be informed of diagnosis by a consultant or appropriately trained team member. • A CNS should be present at the time the diagnosis and treatment plan is explained. • The Cancer diagnosis should be communicated in language the patient can clearly understand and if translation services are needed, these must be provided by a health advocate. Ideally, a family member should not be used for translation when a diagnosis of cancer is given. • Treatment options should be discussed with the patient at the clinic by the relevant clinicians, preferably consultants. The recommendations of the MDT should be explained with the alternatives discussed before the patient makes a decision. • The patient should be offered a written record of the consultation (copy of correspondence to GP). • The core members of the team communicating a cancer diagnosis should be trained in advanced communication skills.
	Nursing input	<ul style="list-style-type: none"> • Patients should be provided with support by colorectal CNS who is the designated 'key worker'. • All patients should receive a Holistic Needs Assessment prior to and at the end of treatment, in line with the National Cancer Survivorship Initiative recommendations.

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		<ul style="list-style-type: none"> • Where a patient agrees to complete the Holistic Needs Assessment, there should always be a subsequent follow-up to address any concerns that have been raised. A relevant plan should be recorded. • Time should be given by the CNS for questions, counselling and support, backed up by written information. • The type of written information provided should be documented within the patient's notes. • Patients should be given time and support to reflect on their treatment options before having to make a decision. Emotional support should be available to the patient at any stage in their pathway of care. • Patients who may require a stoma should be seen before surgery by a specialist stoma nurse. The nurse should be available to assist and advise the patient pre and post-operatively in managing the stoma.
	Patient information	<ul style="list-style-type: none"> • All patients should be offered clear and comprehensive written information on: <ul style="list-style-type: none"> • Nature of the disease • Diagnostic procedures being undertaken • Treatment options available • Likely outcomes of treatment in terms of benefits, risks and side effects • Contact Details for Coordinator of Specialist Team • Psychological Support • Information on benefits available • Contact details for their CNS • Information on support groups available and other types of support that are available • Information should be available in languages other than English, and can be provided in other accessible formats. • Patients should be offered a written copy of the consultation, when the diagnosis and treatment plan were explained on a permanent record. It should be recorded in the patient notes if this offer has been accepted or declined.
Treatment	Primary treatment	<ul style="list-style-type: none"> • Patients with a diagnosis of colorectal cancer should be discussed before treatment at an MDT meeting where the treatment plan should be formulated. The discussion may include use of neo-adjuvant therapy and entry into clinical trials where appropriate. • Cancers detected by national screening program should be referred back to the patient's local MDT, with treatment performed at local trust where possible, rather than by the Trust providing the screening service.
	Pre-operative treatment for rectal	<ul style="list-style-type: none"> • Radiotherapy and chemotherapy should be only given after discussion by MDT and under direction of clinical and medical oncologists who are core members of the MDT, working within facilities complying to national

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	cancer	<p>guidelines.</p> <ul style="list-style-type: none"> • Radiotherapy is not usually indicated if there is a small risk of recurrence (T1 or T2, N0 disease) or if death is likely before local recurrence would cause symptoms. • Radiotherapy reduces the risk of local recurrence by 30 – 40% with a marginal effect on survival. • Short-course radiotherapy is indicated for T3 disease where the circumferential resection margin (CRM) is clear. • Pre-operative long-course chemoradiotherapy should be considered in cases of T3 or T4 disease, where the potential CRM is threatened and where there is radiological evidence of mesorectal lymph node involvement. • When patients are transferred to a cancer centre for neo-adjuvant treatment they should be provided with a named CNS (key worker) for that element of their treatment pathway by the centre. • Entry into clinical trials and the use of advanced radiotherapy techniques such as IMRT is encouraged.
	Surgery for colorectal cancer	<ul style="list-style-type: none"> • Surgical management should comply with current Association of Coloproctology of Great Britain and Ireland (ACPGBI) guidelines (2007) and current NICE recommendations (2011) for colorectal cancer. • Laparoscopic surgery should only be performed by surgeons who have been recognised by national training program (LAPCO) or <i>London Cancer</i>. • Surgery should be carried out at hospitals recognised by <i>London Cancer</i> as providing colorectal surgery. • Major and complex major colorectal surgery should only be performed in hospitals with Level 3 ITU provision. • Colorectal surgery should only be performed in hospitals with CT scanning available 24 hours a day/7 days a week with on-site interventional radiology provision. • A formal Enhanced Recovery Programme should be provided for all patients undergoing elective colorectal surgery. This is best facilitated by Trusts providing designated wards or areas of wards, and specialist nurses. • Pre-operative assessment including cardiopulmonary exercise testing (CPET/CPEX) should be available at all Trusts providing colorectal surgery (unless all patients routinely go to HDU/ITU post-operatively). • Surgical teams should be supported by anaesthetists with a special interest in colorectal surgery, expert in the use of thoracic epidural anaesthesia. • Consideration should be made for specialist low rectal cancer services. Where abdomino-perineal excision for low rectal cancer is required, surgical members of MDT should demonstrate adequate training, including attendance at the national LOREC course. • If plastic surgery reconstruction needed, it should be performed in conjunction with a plastic surgeon with an interest in perineal reconstructive surgery. • The proportion of rectal tumours treated by abdomino-perineal excision of rectum (APER) should be 20% or

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	<p>less, and, if a distal clearance of at least 1cm can be achieved, a low rectal cancer should be considered for anterior resection.</p> <ul style="list-style-type: none"> • Where tumour invades an area of the genitourinary tract in the male, the decision for surgery should be supported by a consultant urologist with appropriate expertise and surgery carried out with their support. Surgery should be carried out in local trusts where expertise exists. • Where tumour invades an area of the genitourinary tract in the female, the decision for surgery should be supported by a consultant gynaecologist and/ or consultant urologist with appropriate expertise and surgery carried out with their support. Surgery should be carried out in local trusts where expertise exists. • Surgery for recurrent pelvic disease should be carried out by a surgical team specialising in this type of surgery. Pelvic exenteration should be carried out by a full surgical team in a centre providing vascular, colorectal, urological, gynaecological, plastic and reconstructive surgery. At present this type of surgery including sacrectomy is provided at Trusts outside <i>London Cancer</i>.
Surgical outcomes	<ul style="list-style-type: none"> • Commissioners should agree with London Cancer benchmark rates for surgical outcomes. • The agreed outcomes should be informed by audits, see below.
Information / data submission	<p>Each surgical team to submit the following data:</p> <ul style="list-style-type: none"> • Submission of data to the national database NBOCAP for all MDTs • Submission of data to the national APE database for all MDTs • Submission of data to the LOREC registry • Accurate surgical 30 day mortality information for colorectal cancer for each MDT • Accurate surgical 90 day mortality information for colorectal cancer for each MDT • Accurate surgical 1 year mortality information for colorectal cancer for each MDT • Accurate anastomotic leak rates for colorectal cancer for each MDT • Percentage of patients undergoing laparoscopic surgery for each MDT • MDT level data to be provided to <i>London Cancer</i> in a format that can be used for internal benchmarking across the Integrated Cancer System.
Laparoscopic colorectal cancer surgery	<ul style="list-style-type: none"> • Laparoscopic surgery delivered in line with NICE guidelines: http://publications.nice.org.uk/laparoscopic-surgery-for-colorectal-cancer-ta105 • All patients who fulfil agreed network criteria should be offered laparoscopic surgery as an alternative to open surgery for the treatment of their cancer. • All core surgical members of the MDT should have appropriate training in laparoscopic colorectal surgery. In

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		<p>MDTs where this is not the case, where there is no contra-indication for laparoscopic surgery, the patient must be referred to another member of the MDT with the appropriate skills.</p> <ul style="list-style-type: none"> • If there is no contra-indication for laparoscopic surgery, but the MDT has no core surgical member available to provide laparoscopic surgery, the patient must be referred to another MDT where this procedure can be performed within cancer waiting times. • Laparoscopic surgery can only be performed by authorised surgeons that have been trained on a national laparoscopic colorectal surgery programme or are exempt (trained before the implementation of the national programme).
	Emergency surgery	<ul style="list-style-type: none"> • Surgery for patients presenting as an emergency should be conducted by specialist colorectal surgeons and anaesthetists. Patients should not be managed for emergency complex major colorectal interventions by generalists. • Colonic stenting should be considered to treat patients presenting with bowel obstruction. There is a list of practitioners recognised to provide colorectal stenting compiled by <i>London Cancer</i>. • In <i>London Cancer</i> there should be a 7 day service for emergency colonic stenting. All Trusts should provide access to emergency colonic stenting, if necessary by transferring the patient to an appropriate facility. • There should be adequate provision of ITU beds and specialist anaesthetists for patients presenting with colorectal cancer as an emergency. • After emergency surgery, all post-operative colorectal patients must be admitted to an ITU/HDU bed. In some cases, patients will need admission to ITU/HDU for pre-operative optimisation. • Emergency colorectal surgery, including surgery to manage the complications of elective surgery, should be carried out or supervised by a consultant colorectal surgeon. • If initial life-saving surgery is not performed by a core member of the colorectal cancer MDT (for example, a member of the IBD MDT), the patient should be referred to a core member of the colorectal cancer MDT. The case should be discussed at the next colorectal MDT meeting for review and subsequent management. The patient should also be referred to the colorectal specialist nurse (and stoma nurse if required). • All patients treated as an emergency, should be discussed at the next available MDT meeting to plan further management.
Pathology	Staging and reporting	<ul style="list-style-type: none"> • Colorectal cancer should be reported and staged according to the Royal College of Pathologists' (RCPATH) national dataset for colorectal cancer (3rd edition) • Use of the RCPATH reporting proforma is advised. If this is not possible, pathology reports should include, as a minimum, all the information that would be present in the completed proforma.

POINT IN THE PATHWAY		LOCAL COLORECTAL CANCER UNIT SPECIFICATION
		<ul style="list-style-type: none"> • TNM and Dukes' staging are required. Dukes' staging is not applicable if there is no residual tumour after neoadjuvant therapy. Young patients with colorectal cancer should be screened for hereditary cancer syndromes. Immunohistochemistry for mismatch repair genes should be done if the patient is \leq 50 years of age. • Patients identified with hereditary non-polyposis colorectal cancer (HNPCC) and Familial Adenomatous Polyposis (FAP) should be discussed at the MDT meeting and managed in accordance with the London Cancer guidelines.
	<p>Histopathology outcome measures</p>	<ul style="list-style-type: none"> • Facilities should be available for the storage of histology slides for a minimum of ten years and tissue blocks for specimens indefinitely. • Pathology labs must have appropriate external accreditation. • Pathologists must participate in appropriate external quality assurance (EQA) schemes, e.g., the British Society of Gastroenterology (BSG) gastrointestinal pathology EQA. • A designated specialist gastrointestinal pathologist should attend colorectal cancer MDT meetings and be available for discussion of the patient's treatment plan. • All colorectal histology for patients with bowel cancer must be discussed at the MDT meeting. • Pathology services should complete the NBOCAP dataset in reporting. • Reporting pathologists should provide information that allows the quality of surgery to be assessed, e.g. quality of the mesorectal excision margin, involvement of the circumferential margin, and number of lymph nodes retrieved (although the latter also reflects other factors). • Each pathologist should retrieve an average of at least 12 lymph nodes from colorectal cancer resection specimens. • Adherence to the RCPATH dataset should be audited. • Pathology reports are enhanced by the inclusion of photographs of the specimen with inked margins. • Turnaround times should be based on the RCPATH key performance indicators, i.e., 80% of cases should be reported within seven calendar days and 90% within ten calendar days.
	<p>Post-operative adjuvant treatment (Chemotherapy)</p>	<ul style="list-style-type: none"> • At the post surgery MDT discussion, the indications for chemotherapy should be discussed for all patients, including a discussion regarding their medical fitness. • If clinical or pathological staging of rectal tumours reveals node positive disease, adjuvant chemotherapy should be recommended if the patient is fit for treatment. • The risks and benefits of treatment must be clearly discussed with the patient. • Chemotherapy should be delivered as close to the patient's home as possible.

POINT IN THE PATHWAY	LOCAL COLORECTAL CANCER UNIT SPECIFICATION
	<ul style="list-style-type: none"> • No patient should be travelling to medical oncology centres for standard oral chemotherapy. • All patients should be treated within 31 days of the decision to treat. • Every chemotherapy patient should have a named CNS (key worker) for this element of their pathway. The CNS should be a member of the oncology team. This will require an establishment of oncology CNSs to cover a 52 week service provided by the cancer centre. • Chemotherapy should be administered in accordance with the London Cancer clinical guidelines. The choice of chemotherapy should be based on up-to-date research. • Following treatment, the medical oncology team must provide (electronic) end of treatment summaries (including individualised care plans) in line with National Cancer Survivorship Initiative (NCSI), with an accessible record of treatment for local units, GPs and patients. • A process should be in place to enable rapid admission to a specialist centre for any patient having complications of chemotherapy. The management of chemotherapy complications presenting as an emergency should be provided by specialist oncologists. • Written information must be provided, including on whom to contact and how if problems are experienced following treatment. • All patients should be provided with appropriate information to enable (where appropriate) self-management of side-effects, or access to community-based services and allied health professionals for assistance in managing side-effects or the late effects of treatment.
Post-operative adjuvant treatment for rectal cancer (Radiotherapy)	<ul style="list-style-type: none"> • Following the post-operative discussion at the MDT, patients with positive resection margins for rectal cancer should be considered for post-operative long-course radiotherapy (with or without concurrent chemotherapy) if they did not receive neoadjuvant radiotherapy.
Rehabilitation	<ul style="list-style-type: none"> • Rehabilitation services should be aligned with the NCAT rehabilitation pathway for colorectal cancer. • All patients must have access to appropriately skilled allied health professionals (including stoma nurses, occupational therapists, physiotherapists, psychologists and dietitians) to support their individual needs throughout the cancer pathway. • Specialist rehabilitation services should be available for patients with the consequences of treatment (such as fatigue or pain) or late-effects (for example sexual function, bladder/bowel issues) with no time limit on access. • Standardised screening tools and outcome measures (where available and appropriate) should be used. • Standardised rehabilitation information should be provided.

POINT IN THE PATHWAY		LOCAL COLORECTAL CANCER UNIT SPECIFICATION																	
Living with and beyond cancer		<ul style="list-style-type: none"> All patients should receive Recovery Package interventions. The Recovery Package comprises: <ul style="list-style-type: none"> Holistic needs assessment - to be conducted around diagnosis, at end of treatment, whenever the patient's needs change or at any other time at the patient's request. Treatment summary – to be completed at end of primary treatment, ideally available electronically, and shared with the GP and patient. Health and Wellbeing events: All patients should be provided with appropriate health and wellbeing information to enable self-management of side-effects or access to community-based services and allied health professionals for assistance with managing side-effects or late effects of treatment. Health and Wellbeing events will facilitate the implementation of stratified follow-up. http://www.londoncancer.org/cancerprofessionals/living-with-and-beyond-cancer/ 																	
Clinical review and surveillance	Stratified follow-up	<ul style="list-style-type: none"> All Trusts should develop and implement plans for stratified follow-up along the lines of the National Cancer Survivorship Initiative (NCSI) recommendations. Individuals deemed at low risk of recurrence and late effects (physical and psychosocial) should be encouraged towards supported self-management, those at medium risk may receive planned, co-ordinated care and those at high risk should receive complex care from specialist services. A system must be developed for rapid re-entry to the specialist cancer service as required. Stratified follow-up involves reduction of routine appointments from the pathway. Routine surveillance tests will still be completed as outlined below. The results will be reviewed by appropriately qualified or trained staff and the patient and GP informed of the results. This information may trigger a recall of the patient back to specialist services as required. 																	
	Minimum follow-up schedule	<ul style="list-style-type: none"> Colorectal cancer follow-up is the responsibility of the specialist team as described in the schedule below. The follow-up schedule may be conducted in the form of telephone clinics or virtual clinics in place of conventional clinical visits for patients. London Cancer recommended minimum follow up schedule for colorectal cancer patients: <table border="1"> <thead> <tr> <th>Year</th> <th>Month</th> <th>Date</th> <th>Investigations</th> <th>Recommended health care provider</th> </tr> </thead> <tbody> <tr> <td rowspan="3">1</td> <td>6 weeks</td> <td></td> <td> <ul style="list-style-type: none"> CEA Post-op follow-up in clinic HNA if not for chemotherapy Treatment summary / diary completed </td> <td>Hospital</td> </tr> <tr> <td>1 - 2</td> <td></td> <td> <ul style="list-style-type: none"> Survivorship session offered </td> <td>Hospital Colorectal Nurse Specialist</td> </tr> <tr> <td>6</td> <td></td> <td> <ul style="list-style-type: none"> CEA </td> <td>Hospital Colorectal Nurse</td> </tr> </tbody> </table>	Year	Month	Date	Investigations	Recommended health care provider	1	6 weeks		<ul style="list-style-type: none"> CEA Post-op follow-up in clinic HNA if not for chemotherapy Treatment summary / diary completed 	Hospital	1 - 2		<ul style="list-style-type: none"> Survivorship session offered 	Hospital Colorectal Nurse Specialist	6		<ul style="list-style-type: none"> CEA
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POINT IN THE PATHWAY		LOCAL COLORECTAL CANCER UNIT SPECIFICATION				
				<ul style="list-style-type: none"> • CT CAP • Colonoscopy if not complete pre-op • HNA if received chemotherapy • Clinic, telephone or virtual assessment 	Specialist	
			12	<ul style="list-style-type: none"> • CEA • Colonoscopy • Clinic or telephone assessment 	Hospital Colorectal Nurse Specialist	
		2	18	<ul style="list-style-type: none"> • CEA • CT CAP • Clinic, telephone or virtual assessment 	Hospital Colorectal Nurse Specialist	
			24	<ul style="list-style-type: none"> • CEA • Clinic, telephone or virtual assessment 	Hospital or primary care	
		3	30	<ul style="list-style-type: none"> • CEA 	Hospital or primary care	
			36	<ul style="list-style-type: none"> • CEA • CT CAP • Clinic, telephone or virtual assessment 	Hospital Colorectal Nurse Specialist	
		4	48	<ul style="list-style-type: none"> • CEA 	Hospital or primary care	
		5	60	<ul style="list-style-type: none"> • CEA • CT CAP 	Hospital or primary care	
		Then five-yearly colonoscopies, if fit.				
		Surveillance	<ul style="list-style-type: none"> • Patients who contact any member of the colorectal specialist team with worrying symptoms will be seen by the appropriate team within two weeks and if necessary, the case will be discussed at the MDT meeting. • All patients following initial treatment for Colorectal Cancer, will be given information about self-care and surveillance. A list of symptoms that could be a cause for concern and a contact number for the Colorectal CNS will be given as part of the information pack developed by Trusts within <i>London Cancer</i>. • GPs and patients should also be given information on symptoms which may indicate recurrence. 			
Discharge	<ul style="list-style-type: none"> • Discharge should follow local policies devised by the Trusts. • A treatment summary should be sent to the GP and patient within 6 weeks of discharge following completion of primary treatment - surgery, chemotherapy or radiotherapy. The National Cancer Survivorship Initiative treatment summary template should be utilised. This template is available on Somerset and Infoflex systems. Follow up after surgery should focus on post-operative issues, promoting and sustaining recovery (including early detection and management of late effects), future planning, and stoma management. Patients' 					

POINT IN THE PATHWAY		LOCAL COLORECTAL CANCER UNIT SPECIFICATION
		emotional and practical needs should be assessed and appropriate care provided.
Management of advanced and recurrent disease	Systemic chemotherapy and chemo-radiotherapy	<ul style="list-style-type: none"> • Patients identified with locally advanced or with potentially curable metastatic disease, should be discussed at the MDT meeting, with appropriate HPB/Lung input and considered for neoadjuvant chemotherapy or chemo-radiotherapy as a prelude to surgical treatment. These patients require re-staging following neoadjuvant treatment and further review by the MDTs before progressing to surgical treatment. • Timing (pre- or post-surgery) and type of chemotherapy should be individualised based on MDT review and options discussed with patient, in accordance with national waiting times. • Colorectal MDTs should refer all patients with liver and/or lung metastases to the designated MDTs within <i>London Cancer</i>. Management of these patients should be compliant with the <i>London Cancer</i> guidelines. • Patients with metastatic disease of uncertain curability, should also be re-staged and reviewed by the MDT. Some of these patients may enter the curative pathway. • Patients with metastatic disease who planned to have chemotherapy should have a baseline CT scan of thorax, abdomen and pelvis performed within six weeks of the start of their chemotherapy regime. • There must be written protocols for the management of complications and toxicities. • <i>London Cancer's</i> aim is to provide chemotherapy as close as possible to the patient's home. • Chemotherapy should be given by specially trained nursing staff, ideally within a designated day case chemotherapy unit, with close supervision by Oncologists. There should be expert pharmacy and 24 hour laboratory support. • Each patient receiving chemotherapy should be given a contact number for a chemotherapy nurse. • Patients receiving chemotherapy should have access to a specialist acute oncology team, on a 24-hour basis. • All Trusts admitting emergency patients, should have established and specialist acute oncology team and an electronic flagging system for chemotherapy patients within A&E. • Patients should be encouraged to participate in nationally and locally co-ordinated trials.
	Surgery for metastatic disease	<ul style="list-style-type: none"> • Liver surgery to be supervised by HPB MDT • Lung surgery to be supervised by Lung MDT • Recurrent locally advanced rectal cancer surgery managed by sub-specialist colorectal MDT.
	Palliative chemotherapy	<ul style="list-style-type: none"> • Patients with known metastatic disease who are to commence chemotherapy should have a baseline CT scan of thorax, abdomen and pelvis performed within six weeks of the start of their chemotherapy regime. • Palliation with optimum quality of life should be the main aim of therapy in advanced disease. • Early referral to the palliative care team should be considered for every palliative patient. • Treatment options for recurrent and advanced colorectal cancer should be clearly explained to the patient.

POINT IN THE PATHWAY		LOCAL COLORECTAL CANCER UNIT SPECIFICATION
		<p>They should be given realistic information about the potential effectiveness and adverse effects.</p> <ul style="list-style-type: none"> • Patients whose symptoms are difficult to control or who have psychosocial problems should be referred to the palliative care team (Hospital Support Nurse, Social Worker, Macmillan Nurse or Hospice referral). • The use of chemotherapy should be based on <i>London Cancer</i> guidelines and current best practice. Survival may be increased by between three to six months if metastatic disease is treated early on. • ‘Up-front’ combination chemotherapy, where appropriate, should be preferred for patients in whom there is an MDT decision that conversion of metastases to surgical resectability is possible. • Patients should be encouraged to participate in nationally co-ordinated trials.
	Other treatments to improve symptom control	<ul style="list-style-type: none"> • Local treatment with palliative radiotherapy, interventional oncology, surgical bypass stoma, or endoscopic stenting should be considered alongside palliative care services. • Colorectal stenting should follow London Cancer guidelines.
	Specialist palliative care and hospice care	<ul style="list-style-type: none"> • Referral to palliative care may be undertaken by any member of the colorectal team. • Patients who will need a palliative care pathway should be identified through the weekly MDT meeting • The palliative care team will provide symptom control advice, supportive care and referral to specialist services (e.g. home palliative care, Marie Curie care, hospice care). • All of the hospices provide a range of services including: <ul style="list-style-type: none"> • Day care • Admission for symptom relief • Terminal care • Bereavement counselling • Pain clinics • Complementary medicine • Psychological support • Help with benefits and social care issues • Access to local specialist palliative (level 3/4) rehabilitation specialists
Data collection and audit	Minimum dataset	<ul style="list-style-type: none"> • MDT co-ordinators should collect the national cancer minimum dataset (Cancer Outcomes and Services Dataset (COSD)) information and clinical information in real-time and enter it to the central database. • The registry data is collected by the National Cancer Registry System (NCRS). • Cancer waiting times data is collected by the MDT co-ordinator and compiled for submission by the cancer services manager. • Responsibility for the collection of data for the national cancer minimum data set lies with the individual

POINT IN THE PATHWAY		LOCAL COLORECTAL CANCER UNIT SPECIFICATION
		<p>trusts on behalf of the MDT(s) in each Trust. Each Trust/MDT will be responsible for collecting the sections of the dataset that relate to their direct management of the patient. If a patient is referred between teams for specialist investigation/treatment, it will be the responsibility of the specialist MDT to transfer the relevant dataset they collect during the care of the patient back to the referring MDT.</p> <ul style="list-style-type: none"> • The MDT should have started to record the Minimum Data Set (MDS) or their portion of the MDS for each patient on pro forma and in an electronically-retrievable form. • The MDT records the minimum dataset or their portion of the MDS for each patient in an electronically retrievable form. The collection of data is an important aspect of our workload and includes presently: <ul style="list-style-type: none"> ○ Date of referral ○ Date of discussion at MDT meeting ○ Patient demographics ○ Diagnosis ○ Clinical question to be reviewed ○ Outcome ○ Patient plan ○ Waiting times ○ Staging
	Cancer registry returns	<ul style="list-style-type: none"> • London Cancer will monitor annually the number of registry returns being made by the constituent Hospitals to the Cancer Registry in respect of colorectal cancer as part of compliance with the standard of that cancer's returns being 95% of the average returns by all the hospitals within the ICS. • The MDT will compare the number of separate patient returns to the Cancer Registry with the numbers of patients discussed by the MDT as part of compliance with the 95% target.
	Research	<ul style="list-style-type: none"> • Across all clinical settings and stages of the pathway, patients should be offered the opportunity to be involved in local, national and international trials relating to treatment of patients with colorectal cancer. • At MDT meeting, opportunities for research should be discussed for all patients. • All diagnostic and treatment teams should take opportunities to foster basic and clinical cancer research within the auspices of the medical schools' or NHS Trust R&D portfolios, for example the establishment of tissue banks.

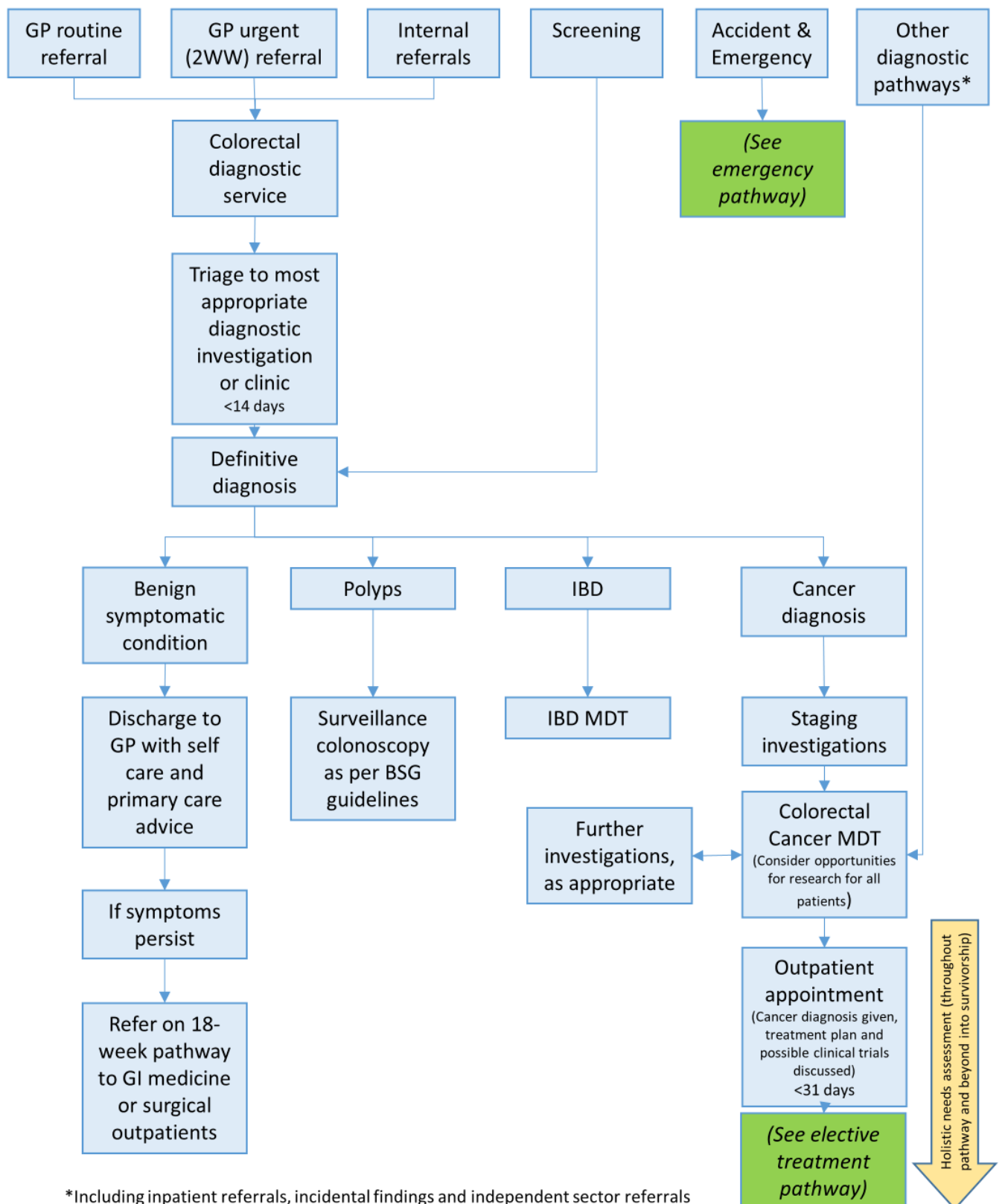
4. The Colorectal cancer pathway

The following four pathway diagrams summarise the pathways that patients will follow. These are:

- Colorectal cancer diagnostic pathway
- Colon cancer elective treatment pathway
- Rectal cancer elective treatment pathway
- Colorectal cancer emergency pathway

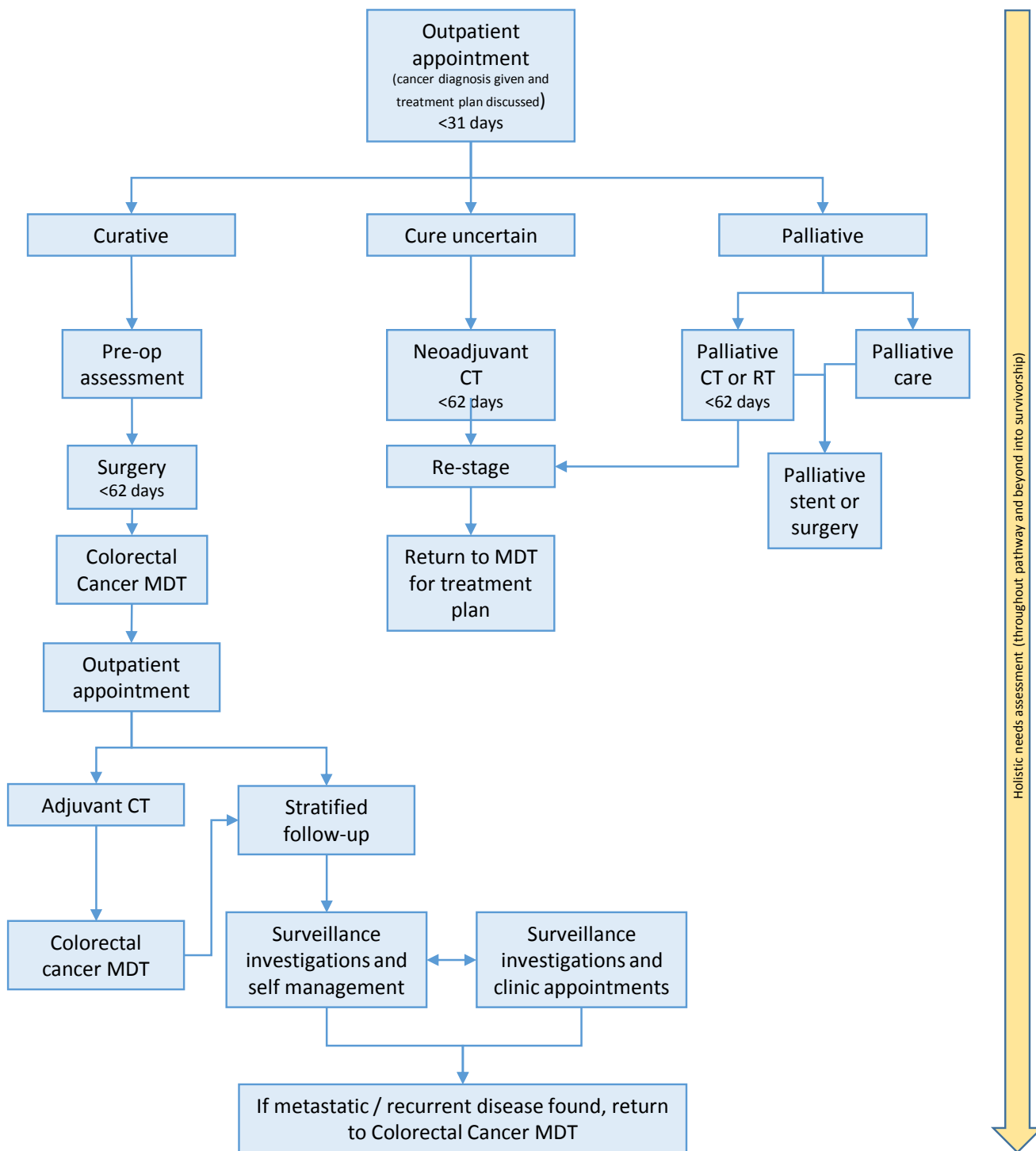
Timings on the diagrams only refer to patients on the 62-day pathway.

Colorectal Cancer: Diagnosis Pathway



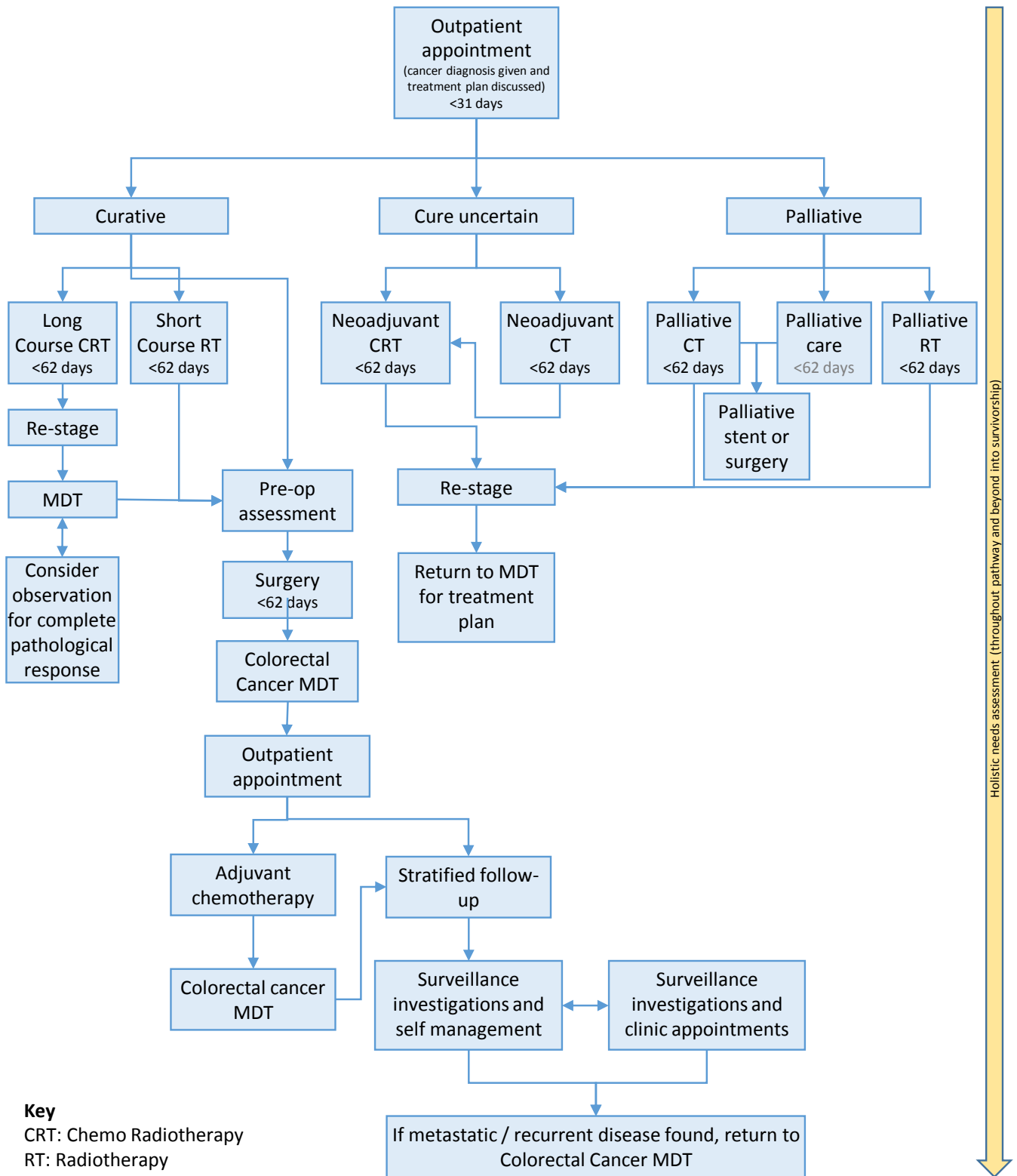
*Including inpatient referrals, incidental findings and independent sector referrals

Colon Cancer: Elective Treatment Pathway

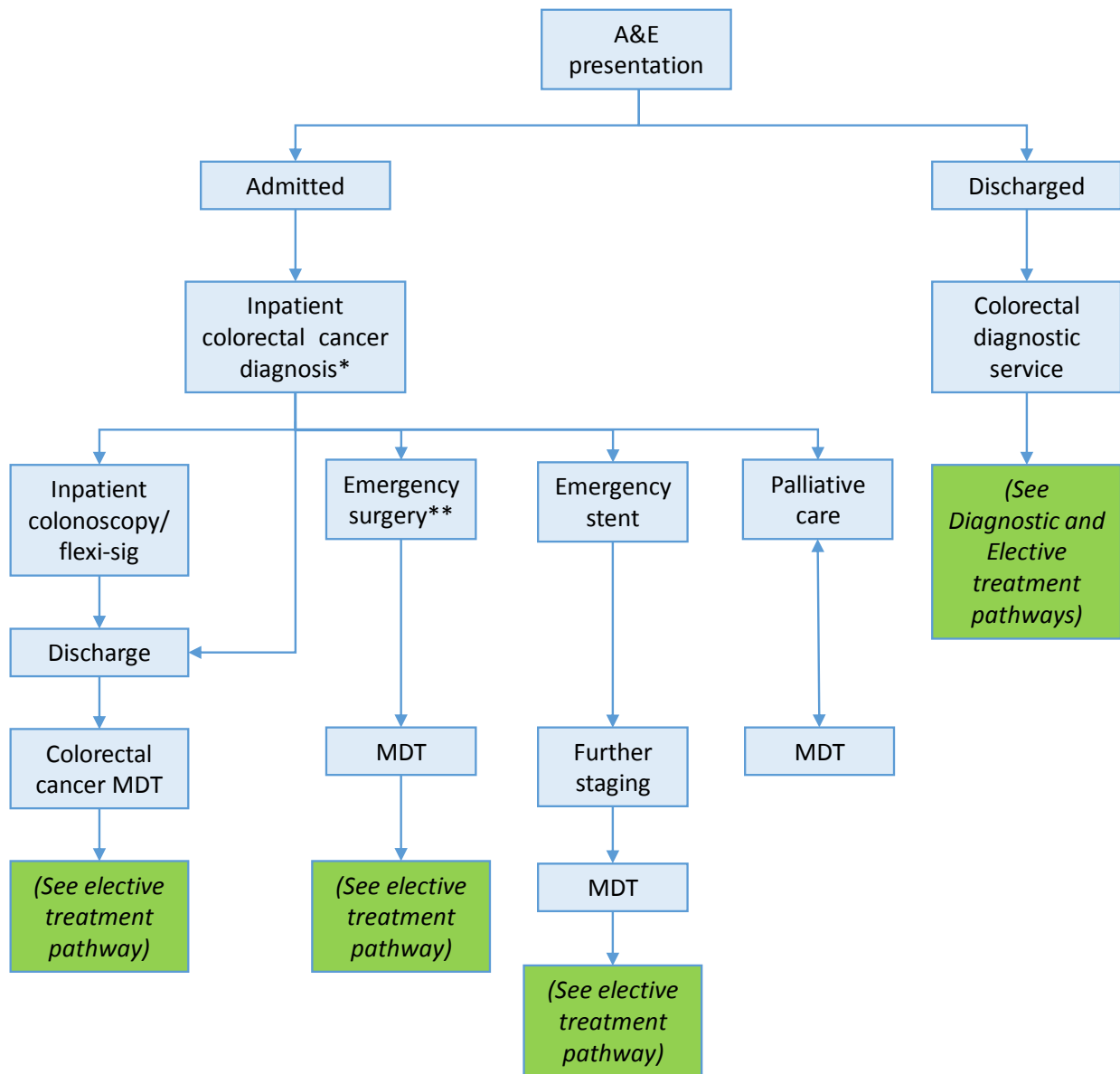


Key
 CT: Chemotherapy
 RT: Radiotherapy

Rectal Cancer: Elective Treatment Pathway



Colorectal Cancer: Emergency Pathway



*Referral to colorectal surgeon or diagnostic services within 24 hours

** For example: stoma, bypass, resection

Appendix 1: *London Cancer Colorectal Pathway Board*

London Cancer Colorectal Pathway Board members

- Michael Machesney, Pathway Director (Chair)
- Andy McMeeking, Cancer Commissioning Team Manager, Transforming Cancer Services for London
- Arthur Anderson, Patient representative
- Austin Obichere, , Director of Bowel Cancer Screening Programme, University College London Hospitals
- Daren Francis, Consultant Colorectal Surgeon, Barnet and Chase Farm Hospitals
- Edward Seward, Consultant Gastroenterologist, Barts Health
- Grant Stewart, Consultant Clinical Oncologist, Royal Free Hospital
- Hasan Mukhtar, Consultant Surgeon, The Whittington Hospital
- Helen Pardoe, Consultant Colorectal Surgeon, Homerton University Hospital
- Jacquie Peck, Colorectal and Anal Cancer CNS, University College London Hospitals
- Jessica Sheringham, Public Health Specialty Registrar, University College London
- John Bridgewater, Consultant Medical Oncologist, University College London Hospitals
- Jonathan Wilson, Lead Clinician for Colorectal Cancer, The Whittington Hospital
- Judith Shankleman, Senior Public Health Strategist, Tower Hamlets Local Authority / CCT CSU
- Kim Jaggs, Colorectal CNS, Barnet and Chase Farm Hospitals
- Lee Dvorkin, Consultant Colorectal Surgeon, North Middlesex University Hospital
- Lucia Grun, General Practitioner, NHS Camden
- Munesh Mistry, General Practitioner, Waltham Forest CCG
- Olagunju Ogunbiyi, Colorectal Surgeon, Royal Free Hospital
- Olutunde Lalude, Consultant Surgeon, Princess Alexandra Hospital
- Patricia Jupp, Patient representative
- Pauline McCulloch, Colorectal Lead Nurse, Homerton University Hospital
- Roger Feakins, Pathologist, Barts Health
- Sarah Slater, Consultant Medical Oncologist, Barts Health
- Sherif Raouf, Consultant Oncologist/Clinical Lead, Barking, Havering and Redbridge University Hospitals
- Sue Williams, MacMillan Colorectal CNS, North Middlesex University Hospital

Appendix 2: *London Cancer Service Specification for Psychological Support Services*

To access the London Cancer Service Specification for Psychological Support Services please follow this link:

<http://londoncancer.org/media/89175/psychological-service-specification-final-2014june-.pdf>