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NATIONAL OPTIMAL PATHWAY FOR ENDOMETRIAL CANCER: 2nd EDITION (2024)

Point of Suspicion to First Definitive Treatment in Adults (aged 16 and over)

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Owner: Gynaecological Cancer Site Group

FOREWORD

The NHS Wales National Optimal Pathways (NOPs) have been developed as part of the Single Cancer Pathway (SCP) programme of work. They aim to establish consistent generic and site specific pathways that describe all routes of entry onto the pathway from the point of suspicion (PoS) of cancer. They describe good practice diagnostic and treatment pathways, the diagnostic pathway, including staging, should be performed within 28 days from PoS; and definitive treatment commenced within 21 days from date of Decision to Treat (DTT). The pathways also describe where patients should receive consistent information and support, tailored to meet their needs.

The NOPs aim to provide a platform to standardise care, reduce unwarranted variation and drive improvement whilst increasing quality across each of the cancer pathways in order to:

- meet the SCP cancer waiting time of 62 days for patients presenting with a suspicion of cancer,
- improve cancer patient experience, and,
- improve cancer patient outcomes throughout Wales to that comparable with the best outcomes in Europe.

The Endometrial NOP is designed to help endometrial cancer service providers and their commissioners see the basic structure of an effective and efficient endometrial cancer pathway. In essence, this optimal pathway is about ensuring that each stage of the pathway happens quickly, that communications with patients are effective and that the entire team works in a coordinated but flexible way, focusing always on the patient's journey. It is recognised that the introduction of the National Optimal Pathway for Endometrial Cancer may present challenges for the gynaecological multidisciplinary teams. However, introducing a nationally agreed, clinically endorsed pathway will support service improvement. They will also provide clarity and consistency for primary care around the referral process into secondary care, including access to diagnostics, to ensure the patients move through the system in a timely manner.

Group Consultation

The Gynaecological Cancer Site Group (CSG) is led by Dr. Louise Hanna, Consultant Oncologist at Velindre Cancer Centre. The Pathways work has been led by Prof Kerry Lutchman Singh, Consultant Gynaecology / Oncology Surgeon. The group includes representation from the full range of professions involved in delivering cancer services. They were all able to contribute and comment on the development of the optimal pathway during a range of pathway workshops, CSG meetings and educational days, which commenced in October 2019. An early draft was sent to Gynaecological Multidisciplinary Teams (MDTs), Health Boards and Velindre NHS Trust in August 2019. Separate workshops were also held with the Clinical Nurse Specialist (CNS) and Allied Health Professional (AHP) members to embed the Rehabilitation and Person-Centred Care (PCC) into the pathway, ensuring all patient's needs are assessed and met in a timely manner. Wider consultation was sought in November and December 2019 from NHS Wales's stakeholders, including National Imaging and Pathology Networks and the Third sector; 46 responses were received across all four Gynaecology pathways, and these were all carefully considered during the revision process, prior to a final version being issued in January 2020.

This second edition (2024) of the NOP reflects the changing developments in the treatment of endometrial cancer since the initial version was first described.

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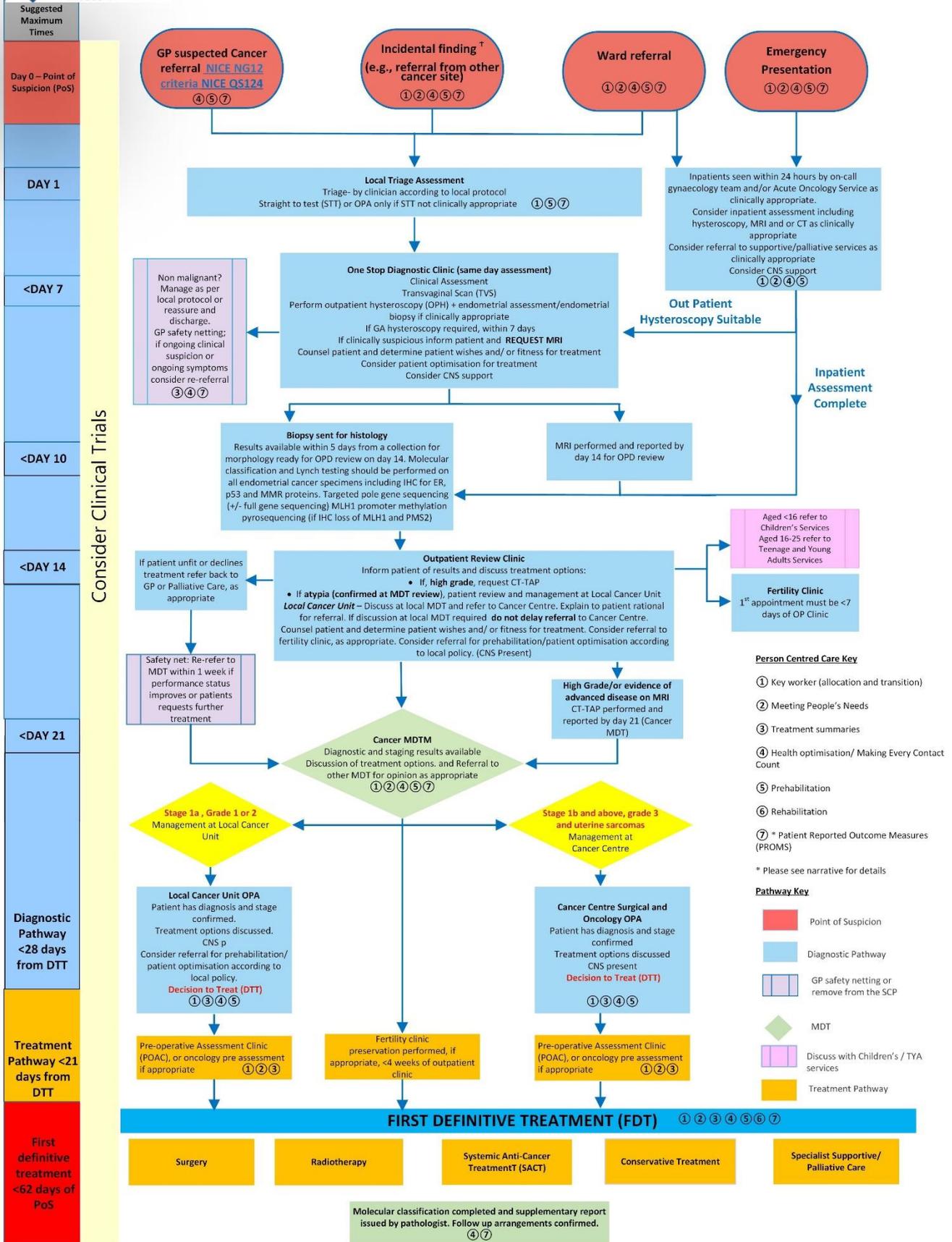
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Professor Tom Crosby (National Cancer Clinical Director - Wales Cancer Network)

Date 15/01/2024

National Optimal Cancer Pathway for suspected and confirmed Endometrial cancer: Point of Suspicion (POS) to First Definitive Treatment (FDT) for patients aged 16 and over



BEST PRACTICE GUIDANCE

<p>Vetting & Triage</p>	<p>It is recommended that the triage of referrals is undertaken using an electronic system (e.g. Welsh Patient Referral Service) to improve the timeliness, traceability and governance of pathways.</p> <p>Referrals received as suspected cancer (USC) should be prioritised within 1 day and urgent / routine referrals within 3 days due to the potential need for upgrade to suspected cancer (pathway entry date: date referral originally made by primary care).</p>
<p>Direct booking diagnostics</p>	<p>It is recommended that for patients attending a hysteroscopy, where there is suspicion of endometrial cancer, an immediate booking should be made for an MRI. For those who are unfit/ineligible for an MRI should be booked for a CT as an alternative.</p> <p>A one-stop model with pelvic USS, outpatient hysteroscopy and clinical assessment performed on the same day is considered best practice. Referral criteria should be compliant with NICE NG12 guidance and separate national guidance on women on HRT should be developed and adopted. Compliance with referral criteria and diagnostic pathway utilisation should be the subject of regular audit for every health board.</p>
<p>Accelerated Imaging</p>	<p>It is recommended that following suspected malignant findings at hysteroscopy; patients should have an MRI performed (or CT TAP if MRI not appropriate) and reported by day 14 of the NOP.</p> <p>If high grade pathology or advanced disease on MRI confirmed, a CT TAP should be performed and reported by day 21 of the NOP.</p>
<p>Key worker role</p>	<p>It is recommended that key workers facilitate additional staging radiology (e.g. MRI liver, PET) and contact the pathology department to request NGS testing (stage IV tumours) if indicated following accelerated imaging to support MDT discussions.</p> <p>It is recommended that the key worker facilitates discussions with the relevant MDT members as timely as possible, without needing to wait until the next MDT meeting.</p>
<p>Physiological optimisation</p>	<p>It is recommended that if diagnostic investigations (hysteroscopy or radiology) identify a suspected cancer, that teams give thought to patient fitness optimisation to run concurrently with pathological staging investigation. This could include consideration of the need for respiratory or cardiology (e.g. echocardiogram) investigation.</p> <p>Patients should undergo an objective assessment of peri-operative risk to help inform peri-operative care requirements. They should also have access to peri-operative optimisation resources such as nutritional support, smoking cessation advice, exercise prehabilitation and intravenous iron.</p>
<p>Abnormal straight to test radiology results</p>	<p>If any other abnormal results/incidental findings are suspected, then USC referral should be arranged straight to the relevant MDT.</p>

Preservation of tissue for genomics	It is recommended that the preservation of tissue for genomic testing is taken into account when preparing the initial biopsy sample. Optimal fixation time for genomics requires the specimen not be in formalin for more than 24 hours. Cutting sections up front, (to reduce waste at the microtome) and/or splitting the material over more than one block may also reduce the amount of waste at the microtome (as well as speeding up subsequent requests). Each Health Board can identify their own practice for this that is suited to local arrangements.
Genetics	<p>Referral to clinical genetics should considered after biopsy has taken place.</p> <p>All documents and guidance can be found on the All-Wales Genomic Service Website.</p> <p>AWMGS - Home (medicalgenomicswales.co.uk)</p> <p>If the patient is found to be MMR deficient and a risk of Lynch Syndrome is confirmed, the consultant responsible for the patient refers directly to genetics.</p>

DEFINITIONS

Decision to Treat	<p>The DATE on which a Decision to Treat is made. For the cancer data sets, the DECISION TO TREAT DATE is the DATE that the consultation between the PATIENT and the clinician took place and a Planned Cancer Treatment was agreed.</p> <p>Source: NHS Data Dictionary</p>
Direct to Test	<p>GPs have direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people suspected of cancer.</p> <p>Source: National Institute for Health and Care Excellence, Quality Standard 2016 (QS 124)</p>
First Definitive Treatment	<p>First Definitive Treatment is the first CLINICAL INTERVENTION intended to manage a PATIENT's disease, condition or injury and avoid further CLINICAL INTERVENTIONS. What constitutes First Definitive Treatment is a matter of clinical judgement in consultation with others, where appropriate, including the PATIENT.</p> <p>Source: NHS Data Dictionary</p>
Safety Netting	<p>“Safety netting is a management strategy of patients, tests and referrals used in the context of diagnostic uncertainty in healthcare. It aims to ensure patients are monitored until signs and symptoms are explained or resolved.”</p> <p>Source: Royal College General Practitioners</p>
Straight to Test	<p>“Following clear referral criteria into secondary care (usually NICE guidance) the secondary care clinician (defined as per local protocol) will arrange a diagnostic procedure as the first episode of care in place of an outpatient episode. The</p>

	<p>clinician will retain clinical responsibility for the result including acting on the result.”</p> <p>Source: Delivering Cancer Waiting Times NHSE</p>
Teenagers and Young Adults (TYA) Service	<p>Young people (aged 16-24 years) with cancer have their diagnosis treatment and support agreed and delivered by a cancer-site specific multidisciplinary team and a teenage and young adult multidisciplinary team.</p> <p>Source: National Institute for Health and Care Excellence (NICE), 2014. Cancer services for children and young people (QS55)</p>

CLINICAL EVIDENCE

Point of Suspicion/ Referral	<p>Single Suspected Cancer Pathway Definitions (December 2018)</p> <p>National Institute for Health and Care Excellence (NICE) NG12 Suspected Cancer Referral Guidance</p> <p>Cancer Risk Assessment Tool (RAT)</p> <p>Q Cancer Risk Assessment Tool</p>
Diagnosis and Management	<p>All Wales Gynaecology Clinical Guidelines</p>

PERSON CENTRED CARE

Person-centred cancer care is culturally embedded and supported by a common approach to assessing and managing people’s needs and care should be co-produced to ensure people affected by cancer to achieve the outcomes that matter to them’ (Cancer Quality Statement, 2021).

Key Worker	<p>QS 14: Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs. National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</p> <p>A cancer key worker is “a person who, with the patient’s consent and agreement, takes a key role in coordinating the patient’s care and promoting continuity, ensuring the patient knows who to access for information and advice”.</p> <ol style="list-style-type: none"> 1. All cancer patients must have an allocated key worker 2. Allocation / Review of key worker to take place at key time points including: <ol style="list-style-type: none"> a. Around the time of diagnosis <i>*please note: allocation of key worker may occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy.</i> b. Commencement of treatment <p>Key workers for cancer patients (Welsh Health Circular /2014/001) GOV.WALES</p>
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	<p>Cancer Improvement Plan for Wales</p>
<p>Meeting People's Needs</p>	<p>QS 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.</p> <p>QS 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.</p> <p>National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</p> <p>Assessment and discussion of patients' needs for physical, psychological, social, spiritual and financial support should be undertaken at key points including:</p> <ul style="list-style-type: none"> • Around diagnosis <i>*please note: undertaking a Holistic Needs Assessment may occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy; and it is supported by professional judgement.</i> • At commencement, during, and at the end of treatment. <p>National Institute for Clinical Excellence (NICE, 2004) CSG4 Improving Supportive & Palliative care for adults with cancer</p> <p>Ideally Holistic Needs Assessments should be undertaken electronically. Cancer Improvement Plan for Wales The Macmillan eHNA is <i>one</i> tool which is both valid and reliable. Snowden A & Fleming M (2015) Validation of the electronic HNA.</p>
<p>Health Optimisation / MECC</p>	<p>QS 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.</p> <p>National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</p> <p>Health Optimisation refers to a proactive approach to supporting people who present to NHS services with concurrent comorbid health conditions (e.g. anaemia, diabetes), or health risk behaviours (e.g. smoking, physical inactivity).</p> <p>Welsh Government (2018) A Healthier Wales.</p> <p>Welsh Government (2015) Wellbeing of Future Generations Act.</p> <p>Making Every Contact Count (MECC), is a behaviour change approach that helps health and social care professionals to help people to improve their health and wellbeing through prevention and early intervention. Public Health Wales Strategic Plan 2018-2021</p> <p><i>Lifestyle advice / resources are available from Making Every Contact Count (MECC)</i></p> <p><i>*Please note: Whilst addressing concurrent comorbidities and health risk behaviours is the responsibility of all health and social care professionals, at every contact throughout the pathway; earliest possible intervention may impact on cancer treatment choices / outcomes (especially in respect to tobacco smoking). National Institute for Clinical Excellence (NICE, 2018) NG92 NICE Guideline Stop Smoking Interventions and services.</i></p>
<p>Prehabilitation</p>	<p>All patients should be given multimodal prehabilitation advice and support covering physical activity, emotional wellbeing, eating well, stopping smoking and reducing alcohol intake prior to undergoing treatment in order to enhance patient outcomes. Patient needs and goals should be evaluated on an individual basis and appropriate levels of support, from universal self-management advice to specialist support which includes timely access to allied health professional should be provided."</p>

	<p>Patients should have the opportunity to take part in evidence-based education and rehabilitative activities, including self-management programmes, <i>where available</i>, that promote their ability to manage their own health if appropriate.</p> <p>National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services Welsh Government (2018) A Healthier Wales. Welsh Government (2015) Wellbeing of Future Generations Act. The Quality Statement for Cancer.</p>
Rehabilitation	<p>All patients will have their needs for rehabilitation services assessed, with referral to an appropriate level of rehabilitative support, throughout the patient pathway, including timely access to allied health professional to meet individual holistic patient needs and goals</p> <p><i>*Please note: not all patients will require specialist cancer rehabilitation services. Referral into non-cancer rehabilitation, self-management, and fitness services may be suitable to meet some patients' needs.</i></p> <p>National Standards for Rehabilitation of Adult Cancer Patients (2010) GOV WALES National Institute for Health and Care Excellence (NICE) CSG4 (2004) resources for improving supportive and palliative care for adults with cancer.</p>
Patient Reported Outcome Measures (PROMs) / Patient Reported Experience Measures (PREMs)	<p>Patient Reported Outcome Measures (PROMs) are questionnaires that patients are asked to complete before and after treatment to assess the impact on health and wellbeing.</p> <p><i>Some</i> of the Cancer Site Groups (CSGs) have been working with the International Collaboration for Health Outcome Measurement (ICHOM), Value Based Healthcare Team, National PROMS, PREMS, & Effectiveness Programme (NPP&EP) and other partners, to pilot tools and data capture methods, which will inform a consistent approach to PROMS & PREMS for cancer. Welsh Government. Cancer Delivery Plan for Wales 2016-2020.</p> <p><i>*Please note: there are outstanding questions relating to tool selection, data capture intervals, data capture methods and data analysis / reporting which may prevent the implementation of PROMS & PREMS across all pathways at this time. PROMS & PREMS have been included in the pathways, in recognition of this work, and will be updated pending further advice from the CSGs.</i></p> <p>Patient Reported Experience Measures (PREMs) are questionnaires that patients are asked to complete at any time during their pathway to help professionals to understand their experience of NHS services. This information is crucial to understanding the value of healthcare as perceived by patients. Welsh Government (2018/19). Chief Medical Officer Annual Report.</p> <p><i>*Please Note: Whilst it is good practice to collect PREMS throughout the pathway, there is no current standard for cancer PREMS in Wales; further advice regarding this will be sought via the CSGs in due course.</i></p>
Communication	<p>Clinicians must ensure patients are kept up to date about their care pathway and are supported to make individualised choices about their treatment.</p> <p>Clinicians should consider the value of interventions and discuss with the patient the likely outcome of treatment options.</p> <p>Clinicians in secondary and tertiary care must ensure that all decisions relating to a patient's care or treatment are communicated to the patient and their primary care clinician in a timely manner and within 24 hours of diagnosis.</p>

	<p>Clinicians must ensure that the clinical intention of any intervention such as tests or treatment is clear to patients, and whether it is just a stage of the agreed pathway or considered start of first definitive treatment and as such ends the pathway.</p> <p>Clinicians must make contemporaneous records of discussions and decisions and include reasons for deviations from recommended clinical practice in the patient’s clinical record. Decisions should be made in a timely manner, and any onward referrals be completed promptly, according to local/national guidelines and optimal pathways and include adequate information to allow the receiving clinician to initiate appropriate interventions with the minimum of delay. Referrers must ensure that the patient is aware and agrees for a suspected cancer referral to be made.</p> <p>Suspected cancer pathway: guidelines (WHC/2023/025) GOV.WALES</p>
Research	<p>Patients should have the opportunity to take part in research and clinical trials where available.</p> <p>People in research Health Care Research Wales (healthandcareresearchwales.org)</p> <p>EC Trial Finder ECMC (ecmcnetwork.org.uk)</p>