PROCARE PROJECT
MEETING of the PROCARE Steering Group
29 August 2007.
Place: RIZIV/INAMI, Tervurenlaan 211, Brussels, 8th floor Delvaux room.

Start 20.00

Invited: cfr. e-mail list

Apologies: Laurent S, Spaas Ph, Haustermans K, Haeck L, Vaneerdeweg W, Bertrand Cl, Duinslaeger M, Sempoux C, Jouret A, Polus M, Deconinck D, Vandestadt J, VanCutsem E

Comments on the agenda and attached documents received from apologised members of the steering group prior to this meeting: none.

Participants: Burnon D, Claeys D, Danse E, Dercq JP, Kartheuser A, Mansvelt B, Penninckx F, Scalliet P, Van Eycken E and Thijs A.

MINUTES

1. **Welcome** to Dr Dercq JP.
As mentioned in art 9 of the contract with RIZIV/INAMI (doc sent to steering group on 28082007), future meetings of the PROCARE steering group will take place in the RIZIV/INAMI building. Approved.
Meetings will be co-chaired by Penninckx F and Dercq JP. Approved.

2. **Contract with RIZIV/INAMI**. Dercq JP The 'strategy' of the RIZIV/INAMI is not one of control, but one that aims to give the professionals the means they need to improve quality of care. The scientific data can help the Health Insurance to take good decisions for reimbursement. PROCARE also perfectly fits in the context of the efforts made by the RIZIV/INAMI to set up and improve registration. The database of PROCARE will remain in the BCRF.

Financial aspects: Members of the PROCARE financial committee and internal rules:
Adapted from Minutes of Jan 30th 2006: These rules were re-approved and will be followed.

Administrator RIZIV/INAMI funds: PROCARE p/a Penninckx F at UZ Gasthuisberg (no overhead)

Internal rules concerning financial administration:

a) the responsible administrator circulates an overview (in, out, balance, commitments) every trimester to all members of the PROCARE steering group.
b) the administrator is not supposed to take specific initiatives 'ex officio'. Initiatives should come from any society/association represented in the PROCARE working group. Deviation from the originally planned allocation of costs is not allowed.
c) In case re-allocation of planned costs would seem to be appropriate, the administrator must ask written permission, in advance (i.e. before costs or commitments are made), to a financial subcommittee consisting of: the chairmen of the project, the director of the NCR, 1 delegate per discipline (radiology, radiotherapy, surgery, pathology, oncology, internal medicine), 1 delegate of the professional organisation of specialists. The global 'welfare' of the project will have to be respected. A decision will be taken by simple majority.

Delegates in the financial subcommittee:
Chairman of the project: Penninckx F

Director of the NCR: Van Eycken E
Delegate radiology: Danse E
Delegate radiotherapy: Spaas P
Delegate surgery: De Coninck D
Delegate pathology: Jouret A
Delegate oncology: Van Cutsem E
Delegate gastroenterology: Polus M
Delegate professional organisation of specialists: Mansvelt B

3. **Information on the project to the 'public'**. In January 2004 it was concluded "*The general physicians and the public should not be informed about the project before there is a guarantee of the financial feasibility of the project !*"

Question: Should a summary be released (decision), and if so for whom: GPs? Press, …
Decision: a draft for release to the public will be prepared and has to be approved by the steering group. The content and 'style' of this communication were discussed. It should not insinuate that the actual QC in Belgium is 'poor'.

Question: Who will (wants) to do it ?
Decision: a draft will be prepared by the RIZIV/INAMI (with the collaboration of Mrs Collin I) and will be sent to the steering group for final approval.
NB. It came out that a paper on the project has already been published in Artsenkrant. Penninckx F was not asked, hence did not give approval for the text (that he never saw). The 'reportage' was made in the context of a PROCARE presentation at a meeting of the BGDO.

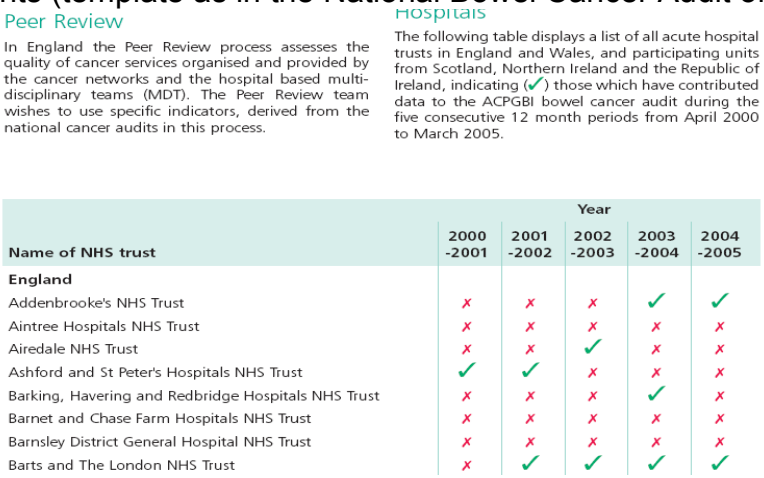
4. **Updated guidelines**.
5. **KCE project and report**
Recommendations have been discussed and approved in the meeting of Febr 22nd 2007. The The actual evidence based version (no changes in the recommendations) is being prepared by the delegates of PROCARE and collaborators at the KCE (mainly Dr. J. Vlayen) in 2007.

6. **Quality of care indicators** were discussed. Some adaptations were made (doc attached). They will be mailed to D Deconinck and Vlayen J by FP after approval of the minutes (at the latest on 15th September).

7. **Updating the data entry set** (doc attached). This doc was sent for evaluation to the KCE subgroup on July 1st 2007 (Caroline De Vleeschouwer; claeys donald; daniel@ddeconinck.be; decaestecker jochen; Ectors; Eric Van Cutsem; etienne danse; Freddy Penninckx; joan vlayen; Karin Haustermans; leonard daniel; marc.peeters@ugent.be; peter smeets; polus marc; Sarah Roels; stéphanie laurent; van eycken elisabeth); no comments were received.
The following points were discussed:
p 5 : there are 3 possible scores for risk adjustment in the context of postop mortality: the CR-POSSUM, the Cleveland score, the AFC score. In order to keep the number of data to be registered at a minimum, it was decided to add the preop Hct value to the data entry set and thus to use the Cleveland score for adjustment. The other scores require too many supplementary data.
p. 23 and 25: it was re-decided to stop PROCARE data registration at 5 yr or until an event occurs, i.e. recurrent local or distant disease or death.
p. 24: the list of examination done in the context of each follow-up visit is inserted (performance of colonoscopy 1 year after curative treatment is a QCI level 2; the other data will permit assessment of the use of investigations).

8. **PROCARE registry** at the BCR: status (Van Eycken)
Status. 899 cases have been submitted to the register from 55 hospitals (38 nl, 17 fr), from 87 surgeons (of whom 36 are candidate TME trainer). Of the cases submitted 103 were operated in 2005, 613 in 2006 and 160 in 2007 (incomplete); 14 had no operation and 9 unknown.

Newsletters. Enumeration of participating hospitals (teams) per year without giving number of patients (template as in the National Bowel Cancer Audit of the ACPGBI).



Peer Review

In England the Peer Review process assesses the quality of cancer services organised and provided by the cancer networks and the hospital based multi-disciplinary teams (MDT). The Peer Review team wishes to use specific indicators, derived from the national cancer audits in this process.

Hospitals

The following table displays a list of all acute hospital trusts in England and Wales, and participating units from Scotland, Northern Ireland and the Republic of Ireland, indicating (✓) those which have contributed data to the ACPGBI bowel cancer audit during the five consecutive 12 month periods from April 2000 to March 2005.

	Year				
Name of NHS trust	2000 -2001	2001 -2002	2002 -2003	2003 -2004	2004 -2005
England					
Addenbrooke's NHS Trust	✗	✗	✗	✓	✓
Aintree Hospitals NHS Trust	✗	✗	✗	✗	✗
Airedale NHS Trust	✗	✗	✓	✗	✗
Ashford and St Peter's Hospitals NHS Trust	✓	✓	✗	✗	✗
Barking, Havering and Redbridge Hospitals NHS Trust	✗	✗	✗	✓	✗
Barnet and Chase Farm Hospitals NHS Trust	✗	✗	✗	✗	✗
Barnsley District General Hospital NHS Trust	✗	✗	✗	✗	✗
Barts and The London NHS Trust	✗	✓	✓	✓	✓

Decision: accepted, but first to be announced to the Medical Directors of all Belgian hospitals. This will possibly boost the project and stimulate all hospitals (teams) to participate. This announcement will be done via the BCRF.

New mailing with the message that every team can join the project at any time (the sooner the better). Mailings should be sent by the BCR (to surgeons, pathologists, oncologists, … who submit cases for general cancer registration) as well as by the scientific societies to their membership (with attached documents or with documents available at the societies upon request). Decision: approved.

9. **TME training: evaluation of candidates**

The pathology review board members are: g.jouret@honet.be; claude.cuvelier@rug.ac.be; Karel.geboes@uz.Kuleuven.ac.be; Anne.horens@az.vub.ac.be; John-Paul.Bogers@ua.ac.be; pdemetter@ulb.ac.be; Christine.Sempoux@anps.ulc.ac.be; Nadine.Ectors@uz.kuleuven.ac.be

The BSCRS sent a letter to all candidate-trainers. From the letter: "It is the aim to reach at least 10 (but, preferably 15) evaluable cases before the end of 2007. Thus, please submit another x evaluable (i.e. fully documented) consecutive TME cases at your earliest convenience but, if possible, before December 2007. … if you accept to be a candidate trainer, it will be on a voluntary base. There are and will be no credentials as a trainer. In no circumstances the fact that you are a trainer can be used as credential for expertise outside the context of the PROCARE project. Therefore, we would like to ask you to confirm your commitment and willingness to assist some of your colleagues at TME surgery who would ask for it. Please, could you confirm by signing this letter and sending it back … In case you would have misunderstood the implication of trainership, you will not receive feedback related to the audit of your TME cases. However, all your cases will remain in the PROCARE database and you will receive feedback after national benchmarking, like all other participants, once about 1000 cases have been registered and analysed (probably by the end of this year). In anyway, your participation in the PROCARE project is highly appreciated."

The BSCRS decided on July 5th 2007: a meeting of a delegation of the BSCRS and the pathology review board will be organised urgently, number of trainer unlimited; TME training could start in January 2008, in collaboration with the BPSA (if an adequate number of non-academic/academic and 'north/south' trainers will be reached at that time).

10. **Data entry, control, analysis and feedback:** workdoc has been discussed and adapted at some points (actual version attached). The part on benchmarking and feedback will be re-discussed at the next meeting.

'Essential data' on chemotherapy remains to be decided. FP sends an e-mail to Peeters M, Van Cutsem E.

11. PACS platform for radiotherapy, radiology, pathology (Scalliet, Danse): With the budget available + with support from the Radiotherapy-Oncology Society, Scalliet thinks that about 25 centres (with a department of RT) could be connected; others would have to submit data on CD-roms. Scalliet will prepare a proposition and send it to the steering group asap.

12. Dr Vlayen Joan working for PROCARE at 0.2 FTE in october-december 2007 at the FBCR (Van Eycken, 5 min)

Recently, Dr Vlayen Joan, actually member of the KCE, asked whether it would be possible for him to work part-time (20%) for the PROCARE project in October-December 2007, as he is very interested in the project and will have some time to work for it in that period of the year.
He would do the following work, on behalf of Procare: write a paper on QIs: Daniel Deconinck agreed (I asked his agreement because it was originally planned that Daniel would write this part of the KCE report) to be co-author together with others but with J Vlayen as first author.
He could be paid by the remaining funds of PROCARE (from Foudation against Cancer) at the FBCR as Dr Van Eycken confirmed.
Decision: accepted

13. Publication policy document: approved.

14. Writing of review papers ao in the context of the work done for the KCE (e.g. by Roels S, Leonard D, and maybe others). Decision: these papers can only be published after publication of the KCE report and after informing the KCE (that will accept in principle); cf. contract with KCE. The authors' affiliation to their respective clinics etc. can be mentioned as usual. The authors' list should end with 'on behalf of PROCARE, a multidisciplinary Belgian Project on Cancer of the Rectum'.

Adjourn at 22.45