Manchester Cancer

Oesophago-gastric Pathway Board

Annual Report 2013/14

Pathway Clinical Director: Mr Jonathan Vickers
Pathway Manager: James Leighton

Version 1.3

Executive summary

The Oesophago-gastric (OG) pathway board has only been in existence since its first meeting on 25th April and has only met once more since then. The attached report and work plan reflects this timescale.

The board has been responsive, positive and constructive and will look to build on this work plan with over the next 12 months.

The board has faced a number of challenges in its first 4 months. The most significant being, that it has been constituted at a time when the commissioners are about to begin a procurement process for the service.

Also, currently there is no patient representative on the board. The board are keen that this is resolved in the near future and will work with Manchester cancer to address this issue and then put in place appropriate supportive measures for the patient representative.

However even with this short time period it has made good progress such as the following –

- Started to develop a GP educational programme in collaboration with local CCGs.
- Will support the commissioners by agreeing the clinical outcomes to be used to measure the newly commissioned service.
- Will establish sub groups with non-board members from the wider OG stakeholder community to re-design the OG pathway and standardise it across greater Manchester and east Cheshire.
- It has begun a review and refresh of all clinical guidelines
- It has commenced its audit programme
- The board has offered and is planning to be a pilot pathway for standardised data entry

As part of the on-going work plan the board will agree the outcome measures or outputs that will be used to assess and monitor the patient and carer experience along the whole pathway. This will be addressed as part of this year's action plan.

As part of this it is also planning to support patients and carers better in living with and beyond their disease by getting a deeper understanding of the non-surgical elements of the pathway and designing appropriate supportive measures. It will also support the agenda of the detection, prevention and awareness cross cutting group.

The board sees this as a key function and one that it looks forward to undertaking.

In the coming year the board has set three objectives, these are –

- Standardise the Oesophago-gastric cancer pathway across Greater Manchester and east Cheshire
- Agree the key clinical outcomes and begin to measure the outputs
- Review and standardise the follow up process across Greater Manchester and east Cheshire

Introduction

2013/14 was a transitional year for cancer services in Greater Manchester and East Cheshire. The Greater Manchester and Cheshire Cancer Network ceased to exist in March 2013 when cancer networks nationally were amalgamated into strategic clinical networks as part of the NHS reorganisation. In Greater Manchester this coincided with the creation of Manchester Cancer, an integrated cancer system for Greater Manchester and East Cheshire.

Twenty Manchester Cancer Pathway Clinical Directors were appointed in late 2013 and took up their roles on 1st January 2014. They spent the first months in post forming their Pathway Boards, multi-professional clinical groups from across the region. These pathway Boards are now formed and most had their first meeting in April/May of 2014.

As such, this is a transitional annual report. It outlines the current configuration of services, the progress in forming the Pathway Board, the data on outcomes and experience that the Board took into account when setting its objectives, and what those objectives are for 2014/15 and beyond. In July 2015 every Manchester Cancer Pathway Board will publish a full annual report, outlining the work of its first full year and its progress against those objectives.

This annual report is designed to:

- Provide a summary of the work programme, outcomes and progress of the Board – alongside the minutes of its meetings, its action plan and it scorecard it is the key document for the Board.
- Provide an overview to the hospital trust CEOs and other interested parties about the current situation across Manchester Cancer in this particular cancer area
- Meet the requirements of the National Cancer Peer Review Programme
- Be openly published on the external facing website.

1. General overview

Oesophageal cancer is the thirteenth most common cancer in the UK. In 2011, around 8,300 people were diagnosed with Oesophageal cancer in the UK, that's 23 people every day. Oesophageal cancer is the eighth most common cancer in men in the UK, with around 5,600 new cases diagnosed in 2011 and the fourteenth most common cancer in women with 2,800 women were diagnosed.

More than 8 in 10 Oesophageal cancers occur in people aged 60 or over. Oesophageal cancer rates have risen by 65% in men and 14% in women since the mid-1970s.

Younger Oesophageal cancer patients have better survival rates than older patients. Overall, around 40% of people diagnosed with Oesophageal cancer survive the disease for at least one year after diagnosis.

Around 13% of people diagnosed with Oesophageal cancer survive the disease for at least five years after diagnosis. Ten year survival for Oesophageal cancer has trebled in the last forty years but it is still low. Around 1 in 10 patients are likely to survive their disease for at least ten years.

In 2011 in the UK, around 7,100 people were diagnosed with stomach cancer, that's more than 19 every day. Stomach cancer is the eleventh most common cancer in men in the UK with around 4,600 new cases in 2011. In the same period 2,500 women in the UK were diagnosed, making it the 15th most common cancer in females.

Around 9 in 10 new cases of stomach cancer occur in people aged 55 and over. Stomach cancer incidence rates in Britain have more than halved since the late 1980s.

Over the last 40 years five-year relative survival rates for stomach cancer have tripled. However Stomach cancer survival rates remain low with less than one in five people surviving the disease for five years or more.

To ensure that local service planning for the development of cancer services is in line with national and local policy guidance and service standards. Key documents are:

- Greater Manchester Oesophago-gastric Service Review (Report of the External Expert Advisory Group) 2009
- National Cancer Plan
- Cancer Reform Strategy
- North West Cancer Plan to 2012
- NICE Improving Outcomes Guidance (IOG)
- NICE Technology Appraisals
- The Manual of Cancer Services Standards

2. Background to the pathway

The OG pathway board replaces what was the Urology Network Site Specific Group (NSSG) of the previously constituted Greater Manchester and Cheshire Cancer network (GMCCN).

The NSSG was a multi-professional group chaired by Miss Laura Formela, who is a Consultant OG surgeon based at Salford Royal NHS Foundation Trust and continues to be a member of the Manchester Cancer OG pathway board.

The Urology NSSG was a well-established Network group with a consistently high attendance and representation from all MDTs and SMDTs. The catchment populations of each MDT are clearly defined and referral pathways to SMDTs were clearly defined.

However, the network continued to be non-IOG compliant throughout its lifespan. In order to address this and other non-compliant services in Greater Manchester, two cancer summits were organised to agree how to work collaboratively across institutional boundaries for the good of patient outcomes.

An agreement to resolve this has never been reached amongst provider organisations. As a consequence the commissioners will commence a formal procurement process in September 2014. The commissioners anticipate that a newly commissioned service will be operational by December 2015.

The purpose of the pathway board is to ensure that services for patients with suspected or diagnosed OG Cancer are being delivered in accordance with NICE Improving Outcomes Guidance (IOG) and Peer Review Cancer Quality Measures. As well as the Guidelines for the Management of OG tumours, 2010 (GMCCN) and the current national specifications of the OG pathway

3. Configuration of services

GMCCN agreed with the then PCT leads for their catchment population that primary care practitioners will refer all patients defined by the "urgent, suspicious of cancer" guidelines for Oesophago-Gastric Cancer to the contact point of a single named diagnostic or diagnostic / local team within an agreed pathway.

Local Oesophago-gastric teams provide local care for their own catchment area and collaborate on clinical decisions within sector-based MDTs with a full core complement of specialists. Patients will be treated in their own locality or at a specialist treatment centre, according to the decision of the MDT and by the appropriate specialist member of the MDT, in discussion with the patient.

The procedures and treatments classed as local are:

- Staging investigations – CT
- Palliative treatment options:
  - Relief of symptoms
  - Prolong good quality of life
  - Endoscopic stent
  - Nutritional assessment
  - Pain control
  - Macmillan specialist palliative care referral
    - Hospital
    - Community
    - Hospice

Specialist teams undertake the following range of treatment:

- Post-operative adjuvant chemotherapy or radiotherapy
- Radical chemotherapy
- Neoadjuvant chemotherapy
- Chemotherapy
- Radiotherapy
- Staging investigations
  - PET
  - PET/CT
  - EUS
  - Laparoscopy
- Pre-operative work up.
- Surgical resection and immediate aftercare.
- Palliative treatment options:
  - Palliative chemotherapy
  - Palliative radiotherapy

- Ablative therapy

Outreach and the maintenance of high quality local services should enable around 50% of all patients to undergo tests and treatment at their local hospital following local and centre MDT discussions. A further 25% may need to travel to the specialist centres for staging investigations or fitness assessment, but can then receive treatment at a local hospital.

There are currently 3 Specialist OG MDTs within Greater Manchester and east Cheshire.

Specialist Oesophago-Gastric Cancer Teams	SMDT Lead Clinician	Referring MDTs	Catchment Population
Central Manchester University Hospital Foundation Trust	Mr Alan Li	Central Manchester (including Trafford) Stockport Tameside	977,893
Salford Royal NHS Foundation Trust	Miss Laura Formela	Salford Pennine Bolton Wigan	1,657,793
University Hospital of South Manchester NHS Foundation Trust	Mr Andrew MacDonald	South Manchester East Cheshire	366,107
TOTAL			**3,001,793**

**Figures from NSTS Registered Populations Q3 2010-11*

4. Clinical guidelines

The Pathway Board has only been in place since spring 2014 and has not yet had the opportunity to review its clinical guidelines and patient pathways. As such, the guidelines created by the previous cancer network group have been adopted until such time as they can be reviewed and updated in the coming year.

All of the relevant documentation remains on the legacy website of the old cancer network www.gmccn.nhs.uk and will be migrated to the Manchester Cancer website over the coming months www.manchestercancer.org.

A full list of active current guidelines and their renewal dates will be produced for the updated constitution of July 2015.

5. Clinical information and outcomes

All sites have been uploading audit data to the National Oesophago-gastric cancer audit (NOGCA) which published its first report in 2006. The last published report was in 2013 and the clinical information in this report is produced from this audit.
http://www.hscic.gov.uk/catalogue/PUB11093/clin-audi-supp-prog-oeso-gast-2013-rep.pdf

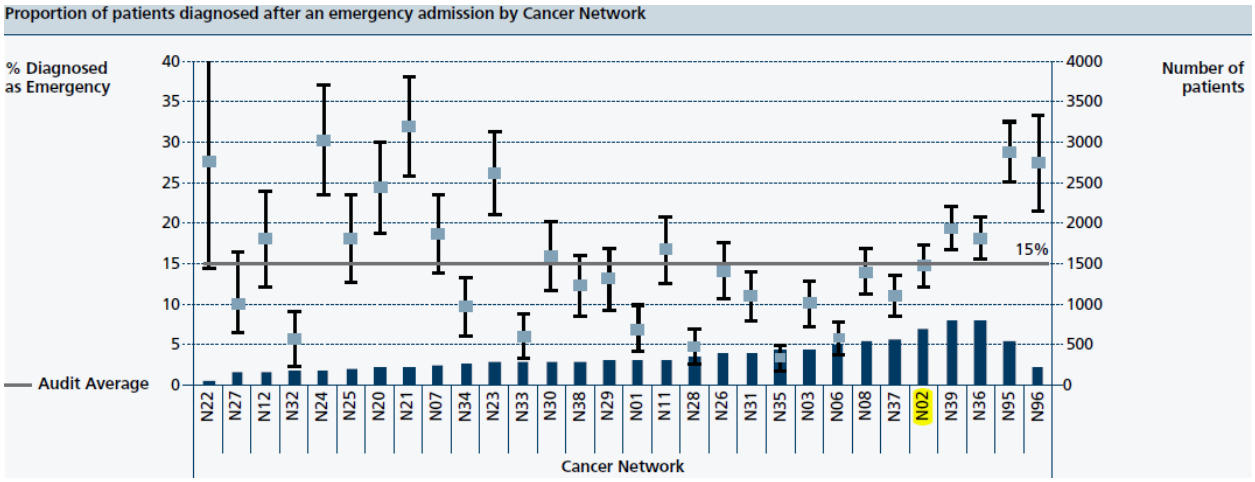
In the following report the Greater Manchester and Cheshire cancer network is identified by the network code NO2.

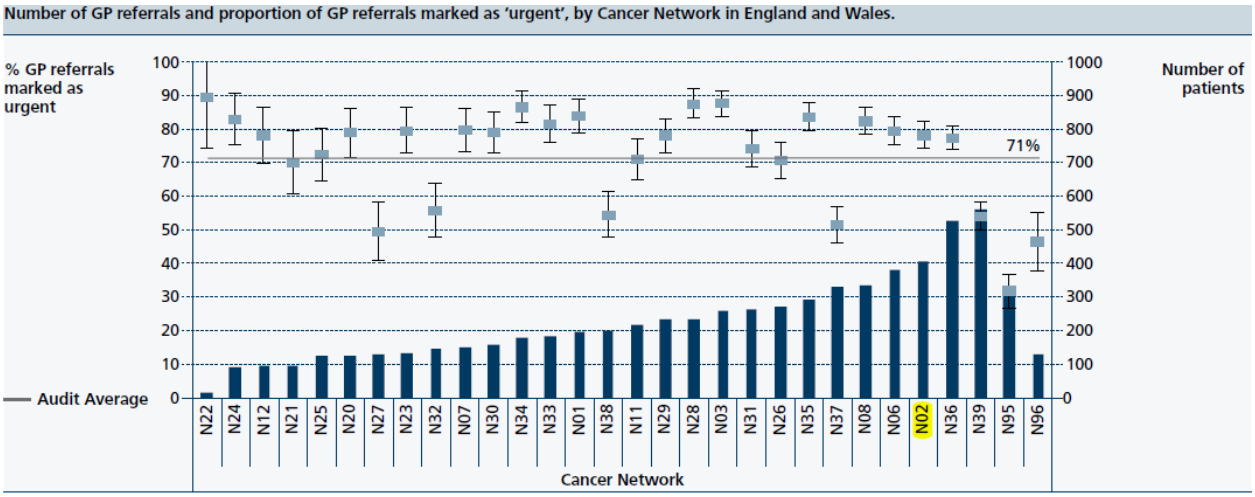
Referral patterns

Although most patients were diagnosed with O-G cancer as a result of referral from their GP a significant number are still diagnosed following an emergency admission. The percentage diagnosed after an emergency admission has not changed since the time of the first Audit in 2006.

The proportion of gastric cancers diagnosed following a GP referral was lower than for oesophageal cancers, and gastric cancers were correspondingly more likely to be diagnosed as a result of an emergency admission (25 per cent vs. 11 per cent).

Across Cancer Networks, there was a wide degree of variation in the proportion of cases diagnosed as a result of an emergency admission. Several Networks had particularly high proportions of patients diagnosed as an emergency. This is of concern as this group of patients is less likely to have a curative treatment plan.





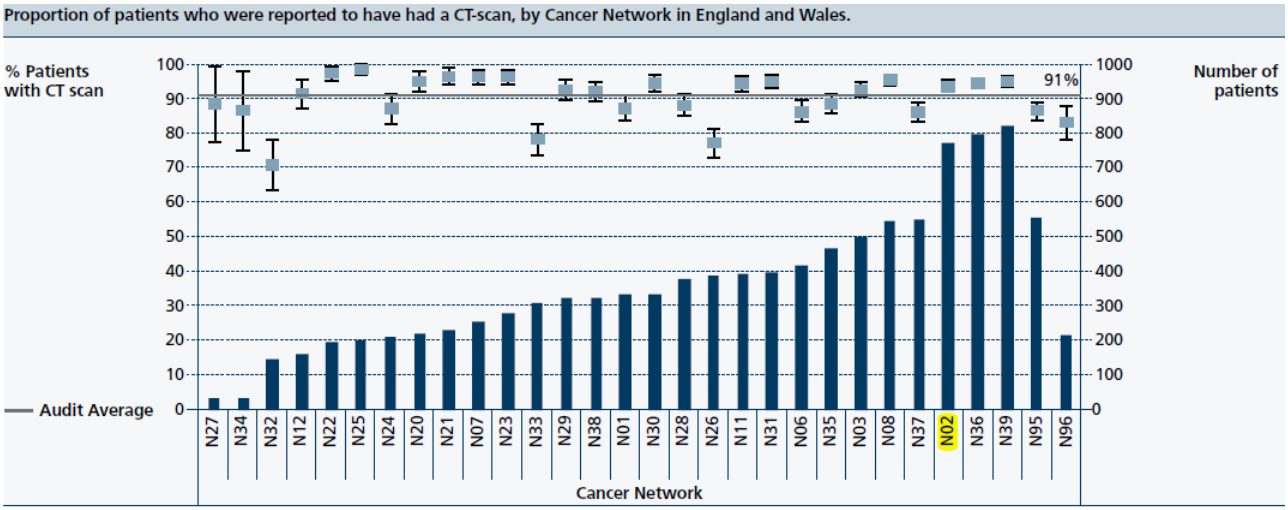
Staging investigations

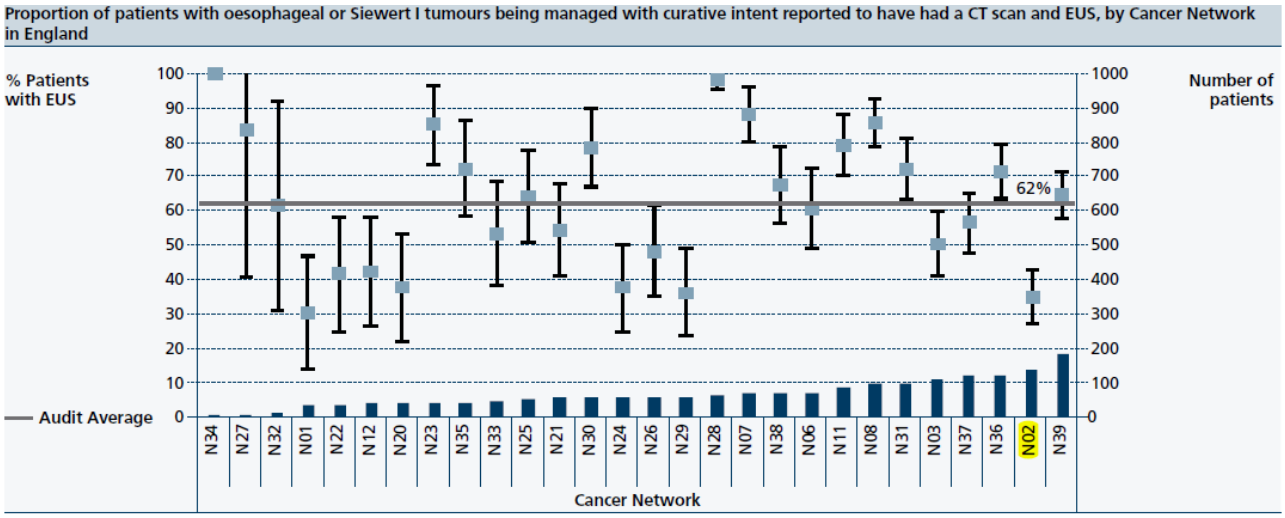
The first Audit recommended: 'O-G cancer services should ensure that all patients undergo a CT-scan plus an EUS (if oesophageal/upper junctional tumour) or a staging laparoscopy (if gastric/lower junctional tumour) before undergoing curative treatment and should improve monitoring of their use'

The first Audit suggested that with 30 per cent of patients being considered for curative therapy, it is crucial that appropriate staging investigations are used to select this group of patients.

Initial staging is aimed at ruling out the presence of metastatic disease with a CT scan and, increasingly a PET-CT scan. If curative therapy is being considered more precise local staging is recommended e.g. EUS or staging laparoscopy.

In the first Audit, use of CT was reported to be good, but use of EUS and staging laparoscopy for patients with a curative treatment plan was lower than expected (this could however have been due to under reporting of investigations by some units).





Treatment

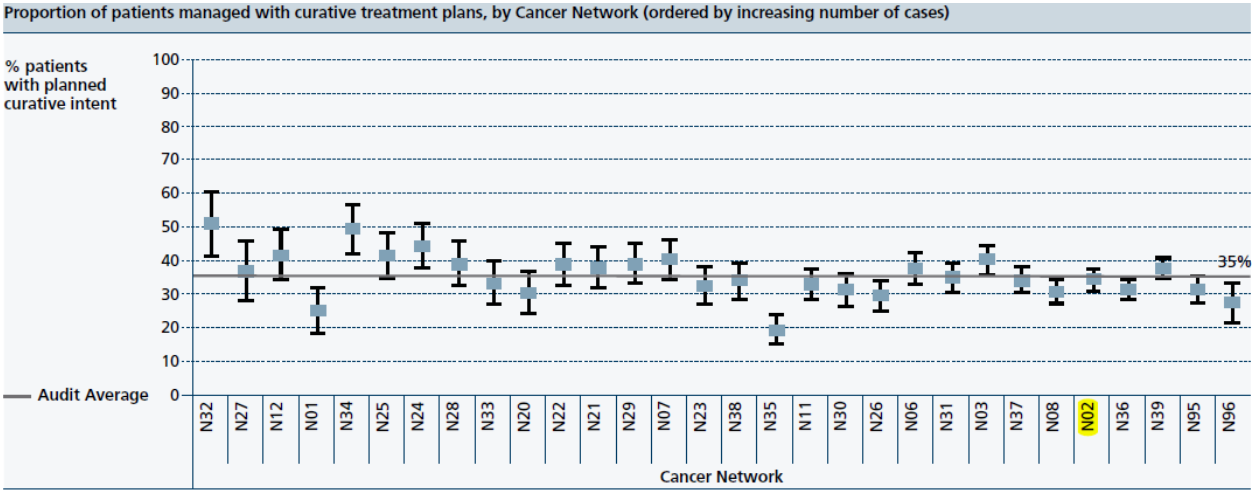
Once staging of O-G cancer has determined the extent of the disease, decisions regarding whether curative or palliative treatment is appropriate need to be taken at the relevant MDT meeting.

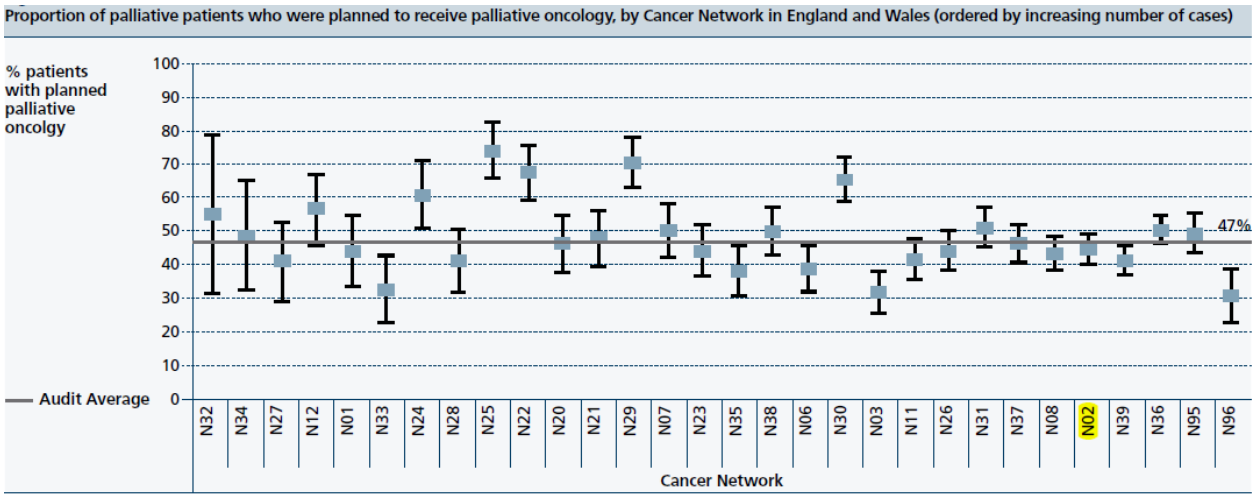
Options include surgery, oncological therapy (alone or in combination with surgery) and endoscopic therapy. Endoscopic treatment is only an option where disease is limited to the mucosa and there is little risk of lymph node spread. Studies have shown this approach is associated with good long term outcomes [Ell et al 2007, Inoue et al2002]. Once there is deeper

sub-mucosal invasion, the risk of lymphatic spread is more than 20 per cent [Stein et al2005] and so surgery with or without oncological therapy is recommended.

Patients managed with palliative intent can be considered for palliative chemotherapy. This can improve survival in patients with a good performance status. Alternatively, treatment can focus on managing symptoms such as dysphagia with appropriate endoscopic or radiological intervention (e.g. stents) or radiotherapy. Patients with non-specific symptoms who are frail and have incurable disease require a holistic approach to their treatment (best supportive care).

Overall treatment plan intent was completed for 9,895 (86per cent) patients in the Audit. Where treatment intent was documented 35 per cent had a curative treatment plan, this is very similar to the first Audit. But for patients diagnosed as a result of an emergency admission, only14 per cent had a planned curative intent compared to 37per cent diagnosed through the GP route and 43 per cent diagnosed after referral from another hospital consultant.





6. Patient experience

The experience of OG patients within GMCCN reported in the 2010 National Cancer Patient Experience Survey was discussed at the previous NSSG April 2011. The National Cancer Patient Experience Survey 2011/2012 and recently 2012/2103 provides both a national overview and Trust reviews which are yet to be discussed at NSSG.

In 2012 patient experience information within Greater Manchester & Cheshire has been collated by Sister Louise Porritt with data collected from Salford, Central Manchester (not OG specific) and Stockport. The board have not been able to discuss this yet however it does intend to devise a strategy for gathering patient feedback and using this to inform the work of the board.

7. Research and clinical trials

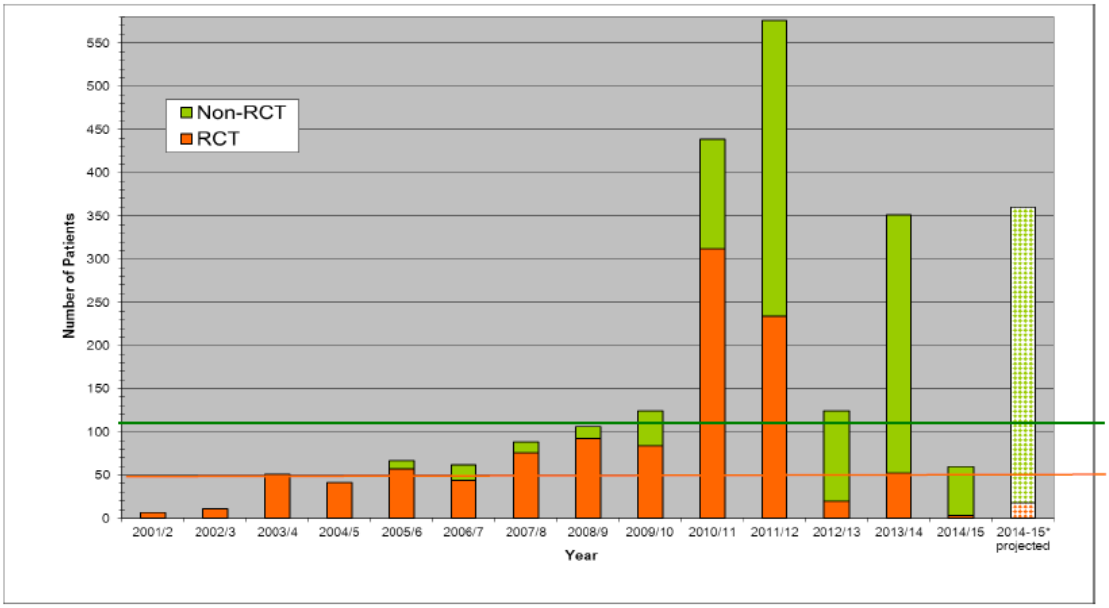
27th June 2014

OESOPHO-GASTRIC CANCER PATHWAY GROUP

CLINICAL RESEARCH NETWORK RECRUITMENT PERFORMANCE

Network Performance

Number of Oesopho-gastric Cancer/Pre-Malignant Patients Recruited to NIHR Cancer Studies by Year



*Open data Platform & EDGE 2014-15 data- Includes data reported up to 20-06-14 (01-04-14 – 20-06-14)

Recruitment Targets:

- 7.5% Cancer/Pre-malignant patients recruited to NIHR interventional trials **
- 10% Cancer/Pre-malignant patients recruited to NIHR studies

Recruitment Targets for Oesopho-gastric Cancer

2014-15 targets:

- RCT = 49 patients
- Overall = 112 patients

2014-15 Oesopho-gastric Cancer Recruitment Performance

From 1st April 2014 to date*, 57 oesopho-gastric cancer/pre-malignant patients have participated in portfolio non-RCT trials and 3 patients have participated in RCT's.

2013-14 Oesopho-gastric Cancer Recruitment Performance

In 2013-14, 299 oesopho-gastric cancer/pre-malignant patients participated in portfolio non-RCT and 52 patients participated in RCT's.

Pathway board members have had the following papers published in the last 12 months.

Ordering of mutations in pre-invasive disease stages of oesophageal carcinogenesis
Jamie M J Weaver, Caryn S Ross-Innes, Nicholas Shannon & the OCCAMS Consortium *et al*. *Nature Genetics*. 2014. doi:10.1038/ng.3013
Published online 22 June 2014.

SJ Hayes, KN Hng, P Clark, F Thistlethwaite, RE Hawkins and Y Ang. Immunohistochemical assessment of NY-ESO-1 expression in esophageal adenocarcinoma resection specimens. *World J Gastroenterol*. Apr 14, 2014; 20(14): 4011–4016.

E Harrison, S Hayes, L Howell, S Lal. All that glitters is not always gold.
BMJ Case Reports. 2014 Feb 10;2014. pii: bcr2013201963. doi: 10.1136/bcr-2013-201963.
D Vasant, S Hayes, R Bucknall and S Lal. Clinical and histological resolution of collagenous sprue following gluten-free diet and discontinuation of Non-Steroidal Anti Inflammatory Drugs (NSAIDs).

BMJ Case Reports 2013; doi:10.1136/bcr-2013-200097
S J Hayes, P K Wright, Y Ang, G L Carlson. Downregulation of CDX2 in gastrointestinal neoplasia. *J Clin Pathol* 2013;66:825-826. Online publication, May 23 2013; doi:10.1136/jclinpath-2013-201696

Gefitinib for oesophageal cancer progressing after chemotherapy (COG): a phase 3, multicentre, double-blind, placebo-controlled randomised trial.
Dutton SJ, Ferry DR, Blazeby JM, Abbas H, Dahle-Smith A, Mansoor W, Thompson J, Harrison M, Chatterjee A, Falk S, Garcia-Alonso A, Fyfe DW, Hubner RA, Gamble T, Peachey L, Davoudianfar M, Pearson SR, Julier P, Jankowski J, Kerr R, Petty RD.
Lancet Oncol. 2014 Jul;15(8):894-904. doi: 10.1016/S1470-2045(14)70024-5. Epub 2014 Jun 17.

Second-line chemotherapy in advanced biliary cancer: a systematic review.
Lamarca A, Hubner RA, David Ryder W, Valle JW.
Ann Oncol. 2014 Apr 25. pii: mdu162. [Epub ahead of print] Review.

Gemcitabine plus capecitabine in unselected patients with advanced pancreatic cancer.
Hubner RA, Worsnop F, Cunningham D, Chau I.
Pancreas. 2013 Apr;42(3):511-5. doi: 10.1097/MPA.0b013e31826c6aee.

Radiofrequency ablation for early oesophageal squamous neoplasia: Outcomes form United Kingdom registry
Rehan J Haidry, Mohammed A Butt, Jason Dunn, Matthew Banks, Abhinav Gupta, Howard Smart, Pradeep Bhandari, Lesley Ann Smith, Robert Willert, Grant Fullarton, Morris John, Massimo Di Pietro, Ian Penman, Marco Novelli, Laurence B Lovat
World J Gastroenterol 2013 September 28; 19(36): 6011-6019

Radiofrequency Ablation and Endoscopic Mucosal Resection for Dysplastic Barrett's Esophagus and Early Esophageal Adenocarcinoma: Outcomes of the UK National Halo RFA Registry Rehan J. Haidry, Jason M. Dunn, Mohammed A. Butt, Matthew G. Burnell, Abhinav Gupta, Sarah Green, Haroon Miah, Howard L. Smart, Pradeep Bhandari, Lesley Ann Smith, Robert Willert, Grant Fullarton, John Morris, Massimo Di Pietro, Charles Gordon, Ian Penman, Hugh Barr, Praful Patel, Philip Boger, Neel Kapoor, Brinder Mahon, Jonathon Hoare, Ravi Narayanasamy, Dermot O'toole, Edward Cheong, Natalie C. Direkze, Yeng Ang, Marco Novelli Matthew R. Banks, And Laurence Bruce Lovat
GASTROENTEROLOGY 2013;145:87–95

8. Innovation in clinical practice

Tameside NHS Foundation trust has designed a one stop diagnostic clinic that ensures the referred patients is seen within clinic and with the initial diagnostics undertaken within 7 days of referral.

Wrightington, Wigan and Leigh have introduced a triage system for 2 week wait referrals. Patients are now either sent straight to test or seen in clinic by a consultant. Further management is protocol based and dependent upon the assessment.

The service has continued to roll out minimally invasive surgery and Brachytherapy treatments and is giving consideration to a pathway for neo-adjuvant chemo-radiotherapy.

9. The Pathway Board

9.1. Formation of the Board

The principle of Manchester Cancer Pathway Boards is that they should be professionally and institutionally representative, yet small and manageable in size. To help Pathway Clinical Directors form institutionally representative Boards the Manchester Cancer central team sought nominations from trusts for their representative(s) on 16 of the 20 Pathway Boards. Nominations were not sought for Children's, Sarcoma, Palliative Care and Early Diagnosis as alternative arrangements were necessary in these areas.

For each Pathway Board trusts were asked to provide up to three nominations from a range of professions from which the trust representative(s) could be chosen. The team asked that nominations included a brief statement of the individual's suitability for membership of the relevant Pathway Board.

Nominations were passed to Pathway Clinical Directors who took them into account when forming their Boards. Trusts were informed during this process that Directors would not be obliged to accept all trust nominations but that, if a Pathway Clinical Director wished to appoint a trust representative that had not been nominated by their organisation, and then this would be discussed with the Trust Cancer Clinical Lead.

9.2. Membership

Trust	Nominee	Profession/ specialty
Bolton	Dr Amanda Law	Consultant Radiologist
	Dr David Bisset	Consultant Histopathologist
	Mr Joseph Varghese	Consultant Surgeon
Christie	Dr Lubna Bhatt	Clinical Oncology
	Dr Richard hubner	Medical Oncology

CMFT	Mr Alan Li	Consultant upper GI surgeon
	Dr Rob Willert	Consultant Gastroenterologist
East Cheshire	Dr Konrad Koss	Consultant Gastro-enterologist
Pennine	Dr R George	Gastroenterology
	Mr S Senapati	Surgeon
SRFT	Miss Rachel Melhado	Consultant OG surgeon
	Mrs Michelle Eden-Yates	Lead OG CNS
	Dr. Stephen Hayes	Consultant histopatholgist
Stockport	Louise Porritt	CNS
Tameside	Mr Abduljalil Benhamida 07947378383	Consultant Upper GI surgeon
UHSM	Andrew Macdonald	Consultant OG Surgeon
	Tina Foley	Lead UGI CNS
	Velauthan Rudralingam	Radiologist
WWL	Dr R Keld (Cover Dr P Begum)	Consultant Gastroenterologist
	Ann Anderton (Cover Chris Peel)	Upper GI Cancer Nurse Specialist

Manchester cancer is committed to user involvement in, and representation on, the pathway boards and Cross-cutting groups. For the Oesophago-Gastric board a patient representative has not been appointed yet.

This will be addressed in collaboration with Manchester cancer and a patient representative(s) will be invited to participate in all discussions of the group and there will be a standing opportunity for user issues to be raised at every meeting of the group for user feedback and input into the group's work programme.

9.3. Meetings

The board has met twice, on the 25th of April and the 27th June. It intends to meet 6 times each year and has planned its meeting dates for the rest of this calendar year.

An attendance record is maintained and this is available in appendix 2 of this report. The minutes of the first meeting and the draft minutes of the last meeting are contained within appendix 3.

The board has also agreed to participate in two educational events to be held later in this year.

10. Progress and challenges to date

The board has made progress with the successful establishment of the group, which has a wide range of stakeholders in a good open meetings were views are expressed freely. All board roles have been agreed and the board has agreed to support and participate in 2 educational events. The board has also commenced a guideline review to help standardise the pathway across Greater Manchester and east Cheshire.

It has however faced a number of challenges, namely there is a lack of identified uniform collection of comprehensive data on the pathway, for both the surgical and the non-surgical elements. This makes collective agreement of issues such as the treatment of advanced oesophageal disease (T3 N2/3) with a radical surgical /non-surgical approach or with palliative care, difficult or reach a consensus upon.

The board may also be compromised by the fact that there are three pathways across the area and its work is currently set against a background of city wide re-configuration of the OG service.

11. Vision and objectives

The vision of the board is in the first instance to support the commissioners in delivering an IOG compliant Oesophago-cancer service for Greater Manchester and East Cheshire. It will, in the first instance, do this by standardising the cancer pathway to ensure that all patients have the same route through to treatment.

Secondly the board feels that there is a lack of robust data collection to inform them on their patient population and their outcomes. Over the next 12 months the board will work with the relevant stakeholders to identify and measure the appropriate and meaningful outcome measures.

It is the vision of the board that they have a degree of ownership of this uniform data and its collection and to agree the means by which the information is disseminated and shared wider.

Lastly it will better understand the experiences and outcomes for those patients on the non-surgical pathway and those patients living with and beyond their disease to improve the outcomes and experience for patients and carers.

The board will amend this vision accordingly, as it becomes better informed by the outcome measures.

The pathway board intends to ensure that the OG cancer service:

- Is in line with all national guidance/standards

- Is compliant with the IOG standards.
- Considers the whole care pathway for patients, both surgical and non-surgical.
- Promotes high quality care and reduces inequalities in access and service delivery.
- Takes account of and acts on the views of patients and carers.
- Exploits the opportunities for service and workforce redesign and innovation.

Appendix 1 – Pathway Board Terms of Reference

Manchester Cancer

Oesophago-gastric Cancer Pathway Board

Terms of Reference

These terms of reference were agreed on April 25th 2014 by , Mr Jonathan Vickers, Pathway Clinical Director for Oesophago-gastric Cancer, and Mr David Shackley, Medical Director of Greater Manchester Cancer Services, on behalf of the Greater Manchester Cancer Services Provider Board. The terms of reference will be subject to future review.

1. The Pathway Board

1.1. The Oesophago-gastric Cancer Pathway Board is a cancer care specific board with responsibility to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire (a catchment population of 3.2 million). This area is synonymous with the old Greater Manchester and Cheshire Cancer Network area.

1.2. The Pathway Board is led by a Pathway Clinical Director and is formed of a multidisciplinary team of clinicians and other staff from all of hospital trusts that are involved in the delivery of Oesophago-gastric cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients representatives.

1.3. The Oesophago-gastric Cancer Pathway Board reports into and is ultimately governed and held to account by the Greater Manchester Cancer Services Provider Board.

2. Greater Manchester Cancer Services Provider Board

2.1. The Greater Manchester Cancer Services Provider Board is responsible for the service and clinical delivery arm of Manchester Cancer, Greater Manchester's integrated cancer system. Manchester Cancer has two other arms: research and education (see appendix for the structure of Manchester Cancer).

2.2. The Provider Board is independently chaired and consists of the Chief Executive Officers of the ten acute hospital trusts in the Greater Manchester area:

- Bolton NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute NHS Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust

- Tameside Hospital NHS Foundation Trust
- The Christie NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust;
- Wrightington, Wigan and Leigh NHS Foundation Trust;

2.3. The Provider Board regularly invites representatives of commissioners, the Strategic Clinical Network, and Manchester Cancer to its meetings.

3. Purpose of the Pathway Board

3.1. The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester OESOPHAGO-GASTRIC cancer pathway. Specifically, the Pathway Board aims to save more lives, put patients at the centre of care, and improve patient experience. The Board will represent the interests of local people with cancer, respecting their wider needs and concerns. It is the primary source of clinical opinion on this pathway for the Greater Manchester Cancer Services Provider Board and Greater Manchester's cancer commissioners.

3.2. The Pathway Board will gain a robust understanding of the key opportunities to improve outcomes and experience by gathering and reviewing intelligence about the OESOPHAGO-GASTRIC cancer pathway. It will ensure that objectives are set, with a supporting work programme that drives improvements in clinical care and patient experience.

3.3. The Pathway Board will also promote equality of access, choice and quality of care for all patients within Greater Manchester, irrespective of their individual circumstances. The Board will also work with cancer commissioners to provide expert opinion on the design of any commissioning pathways, metrics and specifications.

4. Role of the Pathway Board

The role of the Oesophago-gastric Cancer Pathway Board is to:

4.1. Represent the Greater Manchester Cancer Services professional and patient community for Oesophago-gastric cancer.

4.2. Identify specific opportunities for improving outcomes and patient experience and convert these into agreed objectives and a prioritised programme of work.

4.3. Gain approval from Greater Manchester's cancer commissioners and the Greater Manchester Cancer Services Provider Board for the programme of work and provide regular reporting on progress.

4.4. Design and implement new services for patients where these progress the objectives of commissioners and Greater Manchester Cancer Services, can be resourced, and have been shown to provide improvements in outcomes that matter to patients.

4.5. Ensure that diagnosis and treatment guidelines are agreed and followed by all teams in provider trusts, and are annually reviewed.

4.6. Ensure that all providers working within the pathway collect the pathway dataset measures to a high standard of data quality and that this data is shared transparently amongst the Pathway Board and beyond.

4.7. Promote and develop research and innovation in the pathway, and have agreed objectives in this area.

4.8. Monitor performance and improvements in outcomes and patient experience via a pathway scorecard, understanding variation to identify areas for action.

4.9. Escalate any clinical concerns through provider trusts.

4.10. Highlight any key issues that cannot be resolved within the Pathway Board itself to the Medical Director of Greater Manchester Cancer Services for assistance.

4.11. Ensure that decisions, work programmes, and scorecards involve clearly demonstrable patient participation.

4.12. Share best practices with other Pathway Boards within Greater Manchester Cancer Services.

4.13. Contribute to cross-cutting initiatives (e.g. work streams in living with and beyond cancer and early diagnosis).

4.14. Discuss opportunities for improved education and training related to the pathway and implement new educational initiatives.

4.15. Develop an annual report of outcomes and patient experience, including an overview of progress, difficulties, peer review data and all relevant key documentation. This report will be published in July of each year and will be the key document for circulation to the Provider Board. A template for this report is available so that all Pathway Boards complete the report in a similar manner.

5. Membership principles

5.1. All member organisations of Greater Manchester Cancer Services will have at least one representative on the Pathway Board unless they do not wish to be represented.

5.2. Provider trusts not part of Greater Manchester Cancer Services can be represented on the Pathway Board if they have links to the Greater Manchester Oesophago-gastric cancer pathway.

5.3. All specialties and professions involved in the delivery of the pathway will be represented.

5.4. The Board will have at least one patient or carer representative within its membership

5.5. One professional member of the Pathway Board will act as a Patient Advocate, offering support to the patient and carer representative(s).

5.6. The Board will have named leads for:

- Early diagnosis
- Pathology
- Radiology
- Surgery
- Oncology
- Specialist nursing
- Living with and beyond cancer ('survivorship')
- Research
- Data collection (clinical outcomes/experience and research input).

5.7. It is possible for an individual to hold more than one of these posts. The Pathway Clinical Director is responsible for their fair appointment and holding them to account.

5.8. These named leads will link with wider Greater Manchester Cancer Services Boards for these areas where they exist.

5.9. All members will be expected to attend regular meetings of the Pathway Board to ensure consistency of discussions and decision-making (meeting dates for the whole year will be set annually to allow members to make arrangements for their attendance).

5.10. A register of attendance will be kept: members should aim to attend at least 5 of the 6 meetings annually and an individual's membership of the Pathway Board will be reviewed in the event of frequent non-attendance.

5.11. Each member will have a named deputy who will attend on the rare occasions that the member of the Board cannot.

6. Frequency of meetings

6.1. The Oesophago-gastric Cancer Pathway Board will meet every two months.

7. Quorum

7.1. Quorum will be the Pathway Clinical Director plus five members of the Pathway Board or their named deputies.

8. Communication and engagement

8.1. Accurate representative minutes will be taken at all meetings and these will be circulated and then validated at the next meeting of the Board.

8.2. All minutes, circulated papers and associated data outputs will be archived and stored by the Pathway Clinical Director and relevant Pathway Manager.

8.3. The Pathway Board will design, organise and host at least one open meeting per year for the wider clinical community and local people. This meeting or meetings will include:

- An annual engagement event to account for its progress against its work programme objectives and to obtain input and feedback from the local professional community

- An annual educational event for wider pathway professionals and interested others to allow new developments and learning to be disseminated across the system

8.4. Representatives from all sections of the Greater Manchester Cancer Services professional body will be invited to these events, as well as patient and public representatives and voluntary sector partners.

8.5. An annual report will be created and circulated to the Medical Director of the Greater Manchester Cancer Services Provider Board by 31st July of each calendar year.

8.6. The agendas, minutes and work programmes of the Pathway Board, as well as copies of papers from educational and engagement events, will be made available to all in an open and transparent manner through the Greater Manchester Cancer Services website once this has been developed.

9. Administrative support

Administrative support will be provided by the relevant Pathway Manager with the support of the Greater Manchester Cancer Services core team. Over the course of a year, an average of one day per week administrative support will be provided

12. Appendix 2 – Pathway Board meeting attendance

ATTENDANCE - PATHWAY BOARD MEETING				
OG				
NAME	ROLE	TRUST	25/04/2014	27/06/2014
Dr Amanda Law	Consultant Radiologist	Bolton	Apologies	Attended
Dr David Bisset	Consultant Histopathologist		✓	Apologies
Mr Joseph Varghese	Consultant Surgeon			✓
Dr Lubna Bhatt	Clinical Oncology	Christie	✓	✓
Dr Richard hubner	Medical Oncology		✓	✓
Mr Alan Li	Consultant upper GI surgeon	CMFT	✓	Apologies
Dr Rob Willert	Consultant Gastroenterologist		✓	✓
Dr Konrad Koss	Consultant Gastro-enterologist	East Cheshire	✓	Apologies
Dr R George	Gastroenterology	Pennine		✓
Mr S Senapati	Surgeon		✓	✓
Miss Rachel Melhado	Consultant OG surgeon	SRFT	✓	✓
Mrs Michelle Eden-Yates	Lead OG CNS		✓	Apologies
Dr. Stephen Hayes	Consultant histopatholgist		✓	✓
Louise Porritt	CNS	Stockport	✓	✓
Mr Abduljalil Benhamida	Consultant Upper GI surgeon	Tameside	Apologies	✓
Andrew Macdonald	Consultant OG Surgeon	UHSM	✓	✓
Tina Foley	Lead UGI CNS		✓	Apologies
Dr Velauthan Rudralingam	Consultant Radiologist		Member post May board	Apologies
Dr R Keld (Cover Dr P Begum)	Consultant Gastroenterologist	WWL	✓	✓
Ann Anderton (Cover Chris Peel)	Upper GI Cancer Nurse Specialist		✓	Apologies

13. Appendix 3 – Pathway Board minutes to 31st July 2014

OESOPHAGO-GASTRIC PATHWAY BOARD MEETING

MINUTES

DATE: 25/04/2014

Member's attending:

Mr J Vickers	**Salford Royal (Chair)**	**Mrs M Eden-Yates**	**Salford Royal**
Dr D Bisset	**Bolton**	**Dr S Hayes**	**Salford Royal**
Dr L Bhatt	**The Christie**	**Mrs L Porritt**	**Stockport**
DR R Hubner	**The Christie**	**Mr A MacDonald**	**UHSM**
Mr A Li	**Central Manchester**	**Mrs T Foley**	**UHSM**
Dr R Willert	**Central Manchester**	**Dr R Keld**	**WWL**
Dr K Koss	**East Cheshire**	**Mrs A Anderton**	**WWL**
Mr S Senapati	**Pennine Acute**		
Miss R Melhado	**Salford Royal**		

In attendance

Mr B Decadt	**Stockport**
J Leighton	**Manchester Cancer**

Apologies

Dr A Law	**Bolton**
Mr J Varghese	**Bolton**
Mr Benhamida	**Tameside**
Dr R George	**Pennine**

- **Introductions and apologies**

Mr Vickers (JV) welcomed all to the meeting and noted the apologies received.

- **Introduction to Manchester cancer**

JV outlined the purpose of the pathway board and clarified the only role of members is in reviewing the whole pathway as a stakeholder in improving the outcomes for patients. He stressed that the priority would be to create and maintain an efficient and effective pathway.

- **Board member introductions**

The board members present introduced themselves to the meeting. James Leighton (JL) explained that there would be a patient representative on the board, however their participation would occur after an engagement event to be held in conjunction with Macmillan cancer.

(Since the board meeting the engagement event is now confirmed to take place on 23rd June)

The board also identified the need for another Radiologist to join the board.

Action – JV to discuss with Dr A Law

- **Discussion of board objectives**

In a round table discussion there were a number of outline objectives discussed –

- Improved data collection
- Development of pathway board work plan
- Design and deployment of services that will meet the needs of the patients
- Identify opportunities for change
- Maintain the guidelines for OG cancer

There was a consensus formed that the level of intelligence currently available is not of a sufficient standard to allow for proper analysis of the pathway. Gaps were identified in the numbers of OG cancers (referrals, operations, outcomes) and the split by surgical and non-surgical.

Other areas that need to be explored include population size, demographics, and the effectiveness of the range of treatments and interventions.

There was discussion on the use of the Christie database as a vehicle to gather such data. This was considered as an option and JV agreed to meet with Dr Livesey form the Christie to review.
Action - JV to meet with Dr Livesey and review the Christie database and report back to next board meeting.

The board also identified the need to review the guidance sent out by the previous cancer network. This was as a means of reviewing how standardised the processes of the pathway are. It was also discuss if there was a need to map out the pathway within each provider.

Action - JL to obtain and distribute all cancer guidelines from GMCCN
Action - Drs Bissett and Hayes to review pathology treatment guidelines
Action - Dr Law to review the Radiology treatment guidelines
Action - All clinical colleagues to review existing guidelines to discuss at next meeting

The further outline objectives that were identified were –

- Follow-up guidelines to establish uniformity of care
- Review the in-reach and out-reach provision
- Moving chemotherapy out from the centre
- Provision of surgical in-put in non-specialist sites
- Establishing joint surgery and oncology clinics
- Provision of emergency non-cancer support
- Palliative care for OG patients

- **Board roles**

It was agreed that the following will undertake a leadership function on behalf of the board –

- Early diagnosis Drs Keld and Willert
- Pathology Dr Bissett
- Radiology Dr Law
- Oncology Dr Bhatt
- Research Drs Hubner, Hayes and Senapati

- LWB Mrs Porritt and Ann Anderton
- Specialist nursing Mrs Eden-Yates and Mrs Porritt
- Data collection Miss Melhado
- Surgery Mr Li
- **Future meetings**

JL to circulate meeting dates for the remainder of the calendar year. It was agreed that all meetings would be held at Salford Royal on a Friday afternoon starting at 2pm.

- **Educational event**

Board members were asked to consider holding an educational event on OG cancer. Suggestions discussed included local science festivals and a joint meeting with the Christie on a GI cancer event that is already planned and Dr Hubner to explore this proposal.

Members agreed to consider both the topic of the meeting and the target audience. This is to be discussed at the next board meeting.

Action – Dr Hubner to feedback on having an input into the Christie GI cancer event

Action - JL to put on agenda of next board meeting.

- **Any other business**

There was no other business discussed

- **Date & Venues for Future Meetings**

The next meeting of the board will be on **Friday 27th June 14.00 hrs.**

Proposed dates for future meetings in this calendar year –

Friday 29th August 14.00
Friday 31st October 14.00

Could all board members please confirm their availability for the August meeting? As in the event of a high number of apologies this date can be re-arranged.

OESOPHAGO-GASTRIC PATHWAY BOARD MEETING

MINUTES

DATE: 27/06/2014

Member's attending:

Mr J Vickers	**Salford Royal (Chair)**	**Chris peel**	**WWL**
Dr A Law	**Bolton**	**Dr S Hayes**	**Salford Royal**
Dr L Bhatt	**The Christie**	**Mrs L Porritt**	**Stockport**
DR R Hubner	**The Christie**	**Mr A MacDonald**	**UHSM**
Mrs T Foley	**UHSM**	**Dr R Willert**	**Central Manchester Dr R Keld WWL**
		Dr R George	**Pennine**
Dr K Koss	**East Cheshire**	**Mrs A Anderton**	**WWL**
Mr S Senapati	**Pennine Acute**	**Mr Benhamida**	**Tameside**
Miss R Melhado	**Salford Royal**	**Mr J Varghese**	**Bolton**

In attendance

J Leighton	**Manchester Cancer**

Apologies

Dr D Bisset	**Bolton**	**Mr A Li**	**Central Manchester**
Dr Rudralingham	**UHSM**	**Mrs M Eden-Yates**	**Salford Royal**

- **Introductions and apologies**

Mr Vickers (JV) welcomed all to the meeting and noted the apologies received.

- **Minutes of the last meeting**

A number of typos were corrected and Louise Porritt corrected the board role assigned to her. She was assigned the LWB/survivorship role on behalf of the board. This was corrected.

The minutes were then accepted as a true record of the meeting held on 25th April 14.

- **OG guideline review**
  - **Pathology guidelines –** Dr Hayes and Dr Bisset have begun the review of these guidelines. This is on-going. A recent article on Barretts oesophagus has affected the review and these guidelines will be updated accordingly.
    Once complete it will be disseminated to pathologists across GM. There followed a round table discussion on the management of dysplasia referrals.
    Action – Drs Hayes and Bisset to complete review and disseminate to colleagues and present draft guidelines at next board.

  - **Radiology guidelines –** This is deferred to the next meeting.
    Action – Drs Law and Rudralingham to review radiology guidelines and present at next board meeting.
    Action – JL to devise a schedule for revision of existing guidelines at future meetings.

- **OG cancer surgical pathway review**

The 3 existing pathways were tabled for review as well as the comments from the cancer managers. Because of the non-uniform nature of these pathways the board asked that one standard pathway should be developed and include milestones and agreed turnaround times for diagnostics etc.

It was agreed that a draft pathway is drawn up by the cancer managers for the board to consider.
Action – JL to ask the cancer managers to draw up a standard pathway.

- **Discussion of board objectives and annual plan**

JL outlined the annual planning process, timescales and current objectives for Manchester cancer.

The board then discussed the objectives for the pathway board. The board felt that standardisation of the pathway and improved data collection were key priorities for the next 12 months.

There followed a discussion on one year survival rate and it was felt that Dr Mansoor at the Christie has a dataset on one year survival rates across the region on non-surgical treatments.
Action – JL to ask Dr Mansoor about what data is available on one year survival.

- **Research and audit**

The board noted the paper tabled by the NIHR on recruitment into clinical trials and Dr Hubner give a brief update on the status of the trials listed.
Action – Dr Hubner to present a quarterly position on recruitment at next board

- **Data**

Dr Hayes tabled a report that he undertook on the potential for data analysis from existing pathology systems across the Manchester cancer area.

He requested from each site the number of carcinomas diagnosed in 2013/14 – present. As well as a breakdown of the volumes of adenocarcinoma and squamous cell carcinoma and the data system used.

He outlined the limitations of the existing systems in extracting and reporting on data and presented the volumes of cancer types as reported by each site. These volumes were discussed by the board and one issue raised was that those patients that have a scope undertaken in the CATS service will be reported outside of Manchester and so not appear on the figures.

Dr Hayes then went onto discuss other disadvantages in getting this information and level of detail reported. He then outlined what other databases are available (Somerset, MDT data and NOGCA).

In conclusion the board took the view that as things stand at present the capture of data is not uniform across the area. There is no definitive figure for the number and type of cancers being diagnosed.

JV then reported back to the board on his meeting with Dr Livesey on the data input system currently in use at the Christie.

In order to address the issues identified, the board felt that using this data input system is perhaps the best way forward. The pathway director asked that Dr Hayes presentation is summarised in a paper for circulation to Manchester cancer so that the OG pathway can be used as a pan-Manchester pilot.
Action - JL to develop a summary paper and propose that the OG pathway is a pilot for the deployment of a standard information management system.
Action – JV to try and access Trust level data from the NOGCA database

- **Educational event**

Dr Hubner outlined the GI cancer event that is being held on Monday 15th September at the Christie. He confirmed that the event organisers are happy to collaborate with the pathway board on this event. The event is targeted to specialist nurses and trainees.

Dr Hayes has agreed to speak and the board are asked to nominate a surgeon to speak at it as well.
Action – JV to send out an email to surgical colleagues asking for a speaker at this event.

JV also raised an invitation from Sarah Duff who has suggested a GP GI educational forum in collaboration with the HPB and colo-rectal pathway boards. The board were happy to participate in this and JV to confirm the board's position.
Action – JV to respond to Miss Duff on behalf of the board.

- **Any other business**

There was a discussion about GP representation on the board. JL outlined the Manchester cancer approach to getting GPs onto the board. Dr Keld suggested a GP colleague form Wigan CCG who may be interested in joining the board.
Action - Dr Keld to forward the details of nominated GP to JL to follow up.

Dr Hubner raised the issue of the delivery of SACT away from the Christie and asked if it was possible to obtain chemotherapy delivery figures for upper GI
Action - JV to contact Gordon Jayson, Pathway Director.

Dr Bhatt informed the board that the brachytherapy for oesophagus is being established for a particular patient group, with a view to expanding to other groups over time.

- **Date & Venues for Future Meetings**

The next meeting of the board will be on **Friday 29th August 14.00 hrs** with the venue to be confirmed.

Subsequent meeting dates -
Friday 31st October 14.00

Appendix 4 – Pathway Board Annual Plan 2014/15

Oesophago-gastric Pathway Board Annual Plan 2014-15

Pathway Clinical Director:	
Pathway Board Members:	
Pathway Manager:	
Date agreed by Pathway Board:	
Date agreed by Medical Director:	
Review date:	

Summary of objectives

No	Objective	Alignment with Provider Board objectives
1	**Optimise data collection to generate meaningful outcome data**	
2	**Standardise the OG pathway**	
3	**Develop agreed and standardised follow-up process**	
4		
5		

Objective 1: Optimise data collection to generate meaningful outcome data

Objective:	To optimise data collection to allow the generation of meaningful outcome measures. We will scrutinise our data collection to enable the sustainable generation of outcome measures.
Rationale:	The Board wishes to be able to reliably generate meaningful annual outcome data, to facilitate national and international comparison, and year on year comparison of our own outcomes. This will ensure that the patient care delivered compares favourably with other centres and identify areas where care might be improved.
By (date):	31/3/15
Board measure(s):	The ability to generate outcome figures for 1 and 2 year survivals without additional task-specific audit
Risks to success:	Time and other commitments of involved personnel eg MDT lead clinicians, MDT co-ordinators, data managers, doctors, clinical nurse specialists. Mitigation: Aim for an efficient, unified, sustainable approach. Largely dependent on the deployment of a pan-Manchester data input system. Mitigated by ensuring OG pathway is initial adopter of the system.
Support required:	Recognition and protection of the vital role of existing data managers. Reflection in job-planning and appraisal of the effort and commitment of MDT clinicians in generating this data

Work programme

Action	**Resp.**	**By (date)**
Draft list of outcome measures tabled at board meeting	JV	29/8/14
Final list of outcome measures agreed	All	31/10/14
Full commencement of routine data collection	ALL	1/1/15
Audit of completeness of data collected	ALL	31/3/15

Objective 2:

Objective:	To standardise the OG cancer pathway
Rationale:	Currently there are three centres providing care each with their own locally owned pathway. This can lead to slight variations in the way patients are managed. To avoid such variations the board wish to have a unified pathway to cover greater Manchester and Cheshire.
By (date):	31 12 14
Board measure(s):	A single standard and unified pathway
Risks to success:	Time and other commitments of involved personnel eg MDT lead clinicians, MDT co-ordinators, data managers, doctors, clinical nurse specialists. Mitigation: Aim for an efficient, unified, sustainable approach.
Support required:	Support at executive level for organisational change process

Work programme

Action	**Resp.**	**By (date)**
Agree draft pathway with cancer managers	JL	15th Aug 14
Table draft at Pathway board meeting	JV	29th Aug 14
Review and consult with wider stakeholder community	Board	31 Oct 14
Agree and ratify pathway	Board	31 Dec 14

Objective 3: Develop agreed and standardised follow-up process

Objective:	To standardise the follow-up process Greater Manchester and east Cheshire to allow efficient and effective patient care.
Rationale:	The board is aware that there is significant variance on how and which patients are followed up across Greater Manchester and Cheshire. By standardising this there will be a common agreed approach to the follow-up process.
By (date):	31 / 3 / 2015
Board measure(s):	Increased patient satisfaction, more new appointment slots as follow-up slots are converted
Risks to success:	Time and other commitments of involved personnel. Aim for an efficient, unified, sustainable approach
Support required:	Support at executive level for organisational change process

Work programme

Action	**Resp.**	**By (date)**
Circulate patient questionnaire to patient within each provider	JL	Aug 14
Audit the follow-up process and patient type within each organisation and tumour type	JL	Aug 14
Collate results from both outputs	JV / JL	Oct 14
Develop potential standard follow-up process	JV / JL	Nov 14
Table at board meeting	JV	Jan 15
Implement process	Board	June 15