

B11/S/a

**2013/14 NHS STANDARD CONTRACT
FOR CANCER: OESOPHAGEAL AND GASTRIC (ADULT)**

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	B11/S/a
Service	Cancer: Oesophageal and Gastric (Adult)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National context

The patient pathway for oesophageal and gastric cancer is one of the most complicated of all cancer pathways reflecting the role of local diagnostic units and specialist treatment centres, the complexity of patient assessment and treatment and the difficulties associated with advanced disease at presentation.

Squamous cell carcinoma is a cancer which starts in the cells of the skin- like lining of the oesophagus. Just under a half the oesophageal cancers diagnosed are squamous cell carcinomas. This type of cancer is found mainly in the upper third and middle of the oesophagus.

Adenocarcinoma is a cancer that has started in the gland cells which make mucus in the lining of the oesophagus. The incidence of adenocarcinomas has increased in the last 20 years. They now make up just over a half of all oesophageal cancers diagnosed. Adenocarcinomas are found mainly in the lower third of the oesophagus. This is the type of cancer that is most associated with acid reflux, obesity and Barrett's oesophagus.

Gastric cancer causes dyspepsia, anaemia and difficulties swallowing if located near the entrance to the stomach or nausea and vomiting by blocking the exit to the stomach.

Oesophageal and Gastric cancers are rarely diagnosed early as symptoms of early tumours are very vague and not specific for cancer. It is not uncommon for

symptoms to have been present for some time before medical attention is sought or further investigations / referral are initiated.

There were over 6,700 newly diagnosed cases of oesophageal cancer in England in 2009 and nearly 6,200 newly diagnosed cases of stomach cancer. Rates of cancers of the oesophagus and stomach amongst men are around twice as high as in females. The crude incidence rate in England for males is 17.7 per 100,000 for oesophageal cancer and 15.8 per 100,000 for stomach cancer. For females the crude incidence rates are 8.5 and 8.2 per 100,000 for oesophageal and stomach cancer respectively. One year relative survival estimates in England are similar for both cancer sites at 41% for oesophageal cancer and 42% for stomach cancer.

There are three defined levels of care to manage oesophageal and gastric cancers:

- The diagnostic process
- Local care
- Specialist Care

The diagnostic process

Local services should be available to meet the two week standard for referral for patients with suspected cancer. Patients should be referred in line with NICE referral guidelines for suspected cancer. Services will include direct access for GPs to Upper gastro-intestinal endoscopy as well as outpatient appointments.

All patients who are diagnosed with oesophageal and gastric cancer should initially be discussed by the local multidisciplinary team. Each patient should then be presented by the local team to the specialist multidisciplinary team with diagnostic details including endoscopy and histology, basic staging from CT scanning and detail of the patient's co-morbidity. This should be in line with the network's own guidelines.

Local care

The treatment and procedures classed as local care are:

- Palliative stenting
- Palliative chemotherapy
- Palliative and supportive care, not involving active, tumour shrinking or debulking therapy.

Procedures classed as local care may be delivered locally but only after discussion at the specialist multidisciplinary team and subject to network clinical guidelines.

Specialised care

Specialised care should only be delivered under the care of a member(s) of the specialist team and according to the network's own guidelines.

The treatments and procedures classed as specialist care are:

- Endoscopic therapies – including endoscopic mucosal resection and endoscopic ablative therapies

- All tumour resection surgery, whether with curative or palliative intent. In addition to being under the care of specialist team members, this should only be carried out in the host hospital of the specialist team.
- The following treatments, which should be delivered under the care of a member of the specialist team but the site of delivery is subject to agreement in the network's guidelines:
 - Chemo/radiotherapy.
 - Neoadjuvant or perioperative chemotherapy.
 - Intraluminal radiotherapy.

A team with a population base of 1 million could expect to manage at least 100 patients with oesophageal cancers and 85 with gastric cancer who might require specialist treatment each year (Based on Cancer Research UK Incidence rates for 2009 – oesophageal 9.6 per 100,000 and stomach 8.4 per 100,000). National audit findings indicate that resections would be appropriate for about 45 of these patients.

Surgical resection offers the chance of long-term survival for selected patients with early stage cancer. The majority of patients with tumours suitable for surgery require multi-modality treatments, usually surgery and chemotherapy. These operations should be undertaken in a centre where the surgical team carries out a minimum of 60 oesophageal and gastric resections per year. The professional association (the Association of Upper Gastrointestinal Surgeons - AUGIS) recommendation is that an individual specialist surgeon should undertake a minimum of 15 to 20 resections per year¹ working within centres comprising 4-6 surgeons.

About 75% of patients with oesophago-gastric cancer have inoperable disease at the time of diagnosis and will require palliative and non-surgical treatment such as chemotherapy, radiotherapy or endoscopic intervention to relieve symptoms. These treatments should be determined by the specialist multidisciplinary team but may be provided in local units according to network clinical guidelines (see above local care)

Local context

Evidence base

This specification draws its evidence and rationale from a range of documents and reviews as listed below:

Department of Health

- Improving Outcomes (IOG) in upper gastro-intestinal cancers. Department of Health (2001)
- Improving Outcomes; a Strategy for Cancer – Department of Health (2011)
- Cancer commissioning guidance - Department of Health (2011)

NICE

- Improving supportive and palliative care for adults with cancer - NICE(2004)

¹ Guidance on Minimum Surgeon Volumes. The Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland.

- Referral guidelines for suspected cancer – NICE clinical guideline 27 (2005)
- Quality standard for end of life care for adults – NICE (2011)
- Quality standard for patient experience in adult NHS services – NICE (2012)

National Cancer Peer Review

- National Cancer Peer Review Handbook – NCPR, National Cancer Action Team (2011)
- Manual for Cancer Services: Upper gastrointestinal measures, version 2.0 – NCPR, National Cancer Action Team (2011)
- Manual for Cancer Services: Acute oncology measures NCPR, National Cancer Action Team (April 2011)
- Manual for Cancer Services: Chemotherapy measures NCPR, National Cancer Action Team (June 2011)

Other

- Chemotherapy services in England. National Chemotherapy Advisory Group (2009)
- The provision of services for upper gastrointestinal surgery, The Association of Upper Gastrointestinal Surgeons (AUGIS), November 2011
- National Oesophago-Gastric Cancer Audit. First annual report 2008. The Information Centre for Health and Social Care (2008)
- National Oesophago-Gastric Cancer Audit 2009. Second annual report. The Information Centre for Health and Social Care (2009)
- National Oesophago-Gastric Cancer Audit 2010. Third annual report. The Information Centre for Health and Social Care (2010)

2. Scope

2.1 Aims and objectives of service

The aims of the specialist oesophageal and gastric cancer service is to deliver high quality holistic care for patients with oesophageal and gastric cancer in order to improve survival for those with disease suitable for radical treatment and improve quality of life for those with locally advanced and metastatic disease. In addition services should maximise a patient's functional capability and ensure ready and timely access to appropriate supportive care for patients, their relatives and carers. The service will be delivered through oesophageal and gastric multi-disciplinary teams which closely collaborate and coordinate their networks for patient benefit.

The oesophago-gastric (OG) cancer service should serve a population of 1 million people or more, though it is noted that professional association (AUGIS) recommendations relating to minimum numbers of resections and surgeons would require a minimum population of 1.3 million. The service is required to agree the following areas with their local cancer networks:

- Service configuration and population coverage.
- Referral criteria, clinical protocols, network policies and treatment pathways.
- Engagement with the local network groups and National Cancer Peer Review for oesophageal and gastric tumours.

The overall objectives of the services are:

- To provide an exemplary and comprehensive service, working across cancer units and cancer centre, for all eligible referred patients with OG cancers.
- To ensure diagnostic, radiological and pathological facilities are available in order to effectively diagnose, classify and effectively and consistently stage the condition prior to planning treatment.
- To advise and undertake investigations to plan whether the patient is appropriate for radical or palliative treatment and to provide high quality surgical treatment of patients with oesophageal and gastric cancer.
- To ensure high quality supportive care and treatment for those patients not suitable for curative therapies (75 per cent of patients with oesophageal and gastric cancer present with locally advanced and/or metastatic disease)
- To carry out effective monitoring of patients to ensure that clinical treatment is safe and effective
- To provide care which promotes the optimal functioning and quality of life for that patient
- To provide appropriate follow-up & surveillance after definitive treatment.
- To ensure that all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines and are monitored by objective audit.
- To provide care with a patient and family centred focus to maximise the patient experience.
- To support local healthcare providers to manage patients with OG cancer whenever it is safe to do so and clinically appropriate.
- To provide high quality information for patients, families and carers in appropriate and accessible formats and media.
- To ensure there is accurate and timely information given to the patient's General Practitioner.
- To ensure that there is involvement of service users and carers in service development and review.
- To ensure there is a commitment to continual service improvement.
- To ensure compliance with peer review cancer measures.
- To ensure compliance with Care Quality Commission regulations².

2.2 Service description/care pathway

The specialised OG cancer service is commissioned to provide high quality clinical care to patients with suspected OG tumours and provide specialist treatment (radical, non-radical or palliative) for patients with a confirmed diagnosis of OG cancer. The specialised service will ensure that:

- The specialist multidisciplinary team plans treatment according to agreed treatment protocols for OG cancer at a weekly meeting. Individuals work together with the same aims and clinical understanding of the condition and its management to create a multidisciplinary team approach. The team will ensure that:
 - all patients are discussed at a specialist multidisciplinary team.

² CQC are the independent regulators of all health and adult social care services in England from June 2009

- all oesophageal and gastric surgery is carried out by the designated surgical teams.
- all treatment options (surgical, non-surgical and palliative) are discussed for all patients.
- Care plans are clearly documented in the notes and should be discussed with the referring service.
- The providers will hold other meetings regularly on a quarterly basis to address clinical, service delivery and governance issues.
- Patients are actively recruited to national clinical trials.
- Audit of service provision is carried out and evidence developed to improve and enhance the delivery of the clinical care provided. All patients should be entered into the national oesophago-gastric cancer audit
- All healthcare professionals involved have access to appropriate training in the management of patients with OG cancer

Members of the specialist OG cancer multidisciplinary team

The specialist multi-disciplinary (multidisciplinary team) includes the following core members:

- Two or more surgeons.
- Physician gastroenterologist – specialist endoscopist.
- Clinical oncologist.
- Medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncologist core member).
- Histopathologist.
- Image specialists (including an interventional radiologist).
- OG nurse specialist.
- Core member of the specialist palliative care team.
- Multidisciplinary team co-ordinator / secretary.
- Dietitian.

There should be a single named lead clinician for the specialist OG cancer multidisciplinary team who should also be a core team member.

In addition the extended team members, if not already on the core membership, should include:

- Cytopathologist.
- Anaesthetist/intensivist.
- Core member of the specialist palliative care team.

Patient experience

The service should be patient centred and should respond to patient and carer feedback. Excellent communication between professionals and patients is particularly important and can avoid complaints and improve patient satisfaction. The service should be in line with the markers of high quality care set out in the NICE quality standard for patient experience in adult NHS services.

Patient experience is reported in the National Cancer Patient Survey. In this survey patients with a clinical nurse specialist (CNS) reported much more favourably than

those without on a range of items related to information, choice and care. The national programme for advanced communications skills training provides the opportunity for senior clinicians to improve communications skills and all core multidisciplinary team members who have direct clinical contact with patients should have attended this.

Patient Information

Every patient and family / carer must receive information about their condition in an appropriate format. Verbal and written information should be provided in a way that is clearly understood by patients and free from jargon.

The information must cover:

- Description of the disease.
- Management of the disease within the scope of the commissioned service as described in the specification, clinical pathways and service standards.
- Drugs and other treatments commissioned in the clinical pathway.
- Self-management and care.
- Dietary and nutrition information.
- Contact details of the patient's allocated key worker.
- Support organisations or internet resources recommended by the clinical team.

The service must also provide education to patients and carers on:

- Symptoms of infection.
- Wound healing problems.
- Contact in case of concern.

A useful reference is the Information Prescription Service (IPS) which allows users, both professional and public, to create information prescriptions (IPs) for long-term health needs. <http://www.nhs.uk/IPG/Pages/AboutThisService.aspx>

Referral processes and sources

- All referrals are to be managed within the cancer waiting time thresholds.
- In order to meet the 62 day waiting time standard, rapid referral from the local multidisciplinary team and rapid decision making by the specialist multidisciplinary team is critical.
- It is expected that the majority of referrals will be for planned/elective treatment with a minimum of emergency referrals.
- Patients are usually referred from primary care and emergency departments into secondary care and from secondary care to the specialist multidisciplinary team. 22 per cent of oesophageal cancer patients and 33 per cent of stomach cancer patients present through an emergency route on their way to be diagnosed with cancer.

It is standard practice for patients to be examined initially by endoscopy.

Histological and cytological confirmation of the diagnosis should be sought with a biopsy of suspect lesions. The biopsy and endoscopy should be performed by the local oesophago-gastric cancer diagnostic team

Referral to local/diagnostic teams

A patient who presents with symptoms suggestive of upper gastrointestinal cancer should be referred to a team specialising in the management of upper gastrointestinal disease.

Specific recommendations

An urgent referral for endoscopy should be made for patients of any age with dyspepsia who present with any of the following:

- Chronic gastrointestinal bleeding.
- Dysphagia.
- Progressive unintentional weight loss.
- Persistent vomiting.
- Iron deficiency anaemia.
- Epigastric mass.
- Suspicious barium meal result.
- Aged 55 years and older with unexplained and persistent recent-onset dyspepsia alone.

Referrals to the specialist team

Referrals are accepted by any qualified doctor from the specialist oesophageal/gastric cancer team where the patient has confirmed or suspected oesophageal or gastric cancer.

The receiving clinician at one of the providers may request the referrer to carry out further investigations to aid the proper diagnosis of the patient's condition.

Endoscopy

Upper gastrointestinal endoscopy is a core diagnostic procedure for patients with symptoms of OG disease. The endoscopic services at both the local services and the specialist centre should be JAG accredited³.

Local services should be available to provide direct access for GPs to upper gastrointestinal endoscopy and protocols for urgent assessment of potential upper gastrointestinal cancer as part of the "two week" referral system.

The specialist service should have enhanced endoscopic diagnostic and therapeutic facilities to identify dysplastic pre-cancerous lesions and early (intra-mucosal cancers). This should include narrow band imaging, facilities for chromendoscopy and new modalities for therapeutic endoscopy to facilitate endoscopic resections and mucosal ablation.

Imaging and pathology

³ The Joint Advisory Group on Gastrointestinal Endoscopy assumes an active role in the quality assurance of endoscopy training and services across the UK www.thejag.org.uk

CT scanning is an essential element of assessing oesophageal and gastric cancers and should be available to local upper gastrointestinal teams.

The specialist service should provide diagnostic endoscopic ultrasound (EUS), (radial) as well as interventional (linear) EUS including Fine Needle Aspiration (FNA), and biopsy.

The service should ensure that combined Positron Emission Tomography PET CT scanning is available. The service should agree imaging modalities and their specific indications.

The responsibility for the scan, its interpretation and any decision to inform treatment lies with the specialist OG multidisciplinary team.

The pathology services should comply with Clinical Pathology Accreditation (UK) Ltd (CPA)⁴ and the Human Tissue Authority (HTA).⁵

All oesophageal and gastric cancer pathology specimens should be examined for HER-2 expression.

Staging

The staging and spread of tumour is assessed using EUS, laparoscopy, CT and PET CT in appropriate combinations.

If the patient is fit to undergo radical treatment and imaging produces no evidence of widespread or metastatic disease an endoscopic ultrasound should be available to assess the depth of the presenting tumour. Laparoscopy should be available to use where clinically indicated to assess intra-abdominal metastatic disease not detectable by external imaging.

Following staging, the specialist multi-disciplinary team should discuss the patient for radiological and pathological correlation and agree the final diagnosis and stage of disease.

Providers must include staging information in their cancer registration dataset. Staging data are essential for directing the optimum treatment, for providing prognostic information for the patient and are also essential to the better understanding of the reasons behind the UK's poor cancer survival rates. Cancer stage is best captured electronically at multidisciplinary team meetings and transferred directly to cancer registries. Staging and other pathological data can also be extracted direct from pathology reports and sent to cancer registries.

Treatment and surgery

The specialist multidisciplinary team should determine which patients should be offered radical interventions (surgery and/or chemotherapy / chemo- radiotherapy), non-radical interventions (chemotherapy or chemo- radiotherapy) or palliative care. Treatment should be subsequently planned, agreed and carried out by the specialist or the local multidisciplinary team.

⁴ CPA, the principle accrediting body of clinical pathology services and External Quality Assessment (EQA) Schemes in the UK. Modernising Pathology Services. Department of Health (2004)

⁵ HTA Regulatory body for all matters concerning the removal, storage, use and disposal of human tissue. www.hta.gov.uk

Endoscopic therapies should be available including endoscopic resection and ablation therapies, particularly radiofrequency ablation. Any patient considered for endoscopic treatment should be discussed by the multidisciplinary team and the procedure be performed by experienced specialist endoscopist(s) who is a core multidisciplinary team member

OG cancer resection surgery should only be delivered in designated specialist centres by teams of appropriately trained surgeons. Patients should be cared for by nursing teams in theatres and nursing teams on wards that have specialist upper gastrointestinal expertise.

Surgeons in the specialist multidisciplinary team should provide an emergency service to local hospitals for complex benign and malignant oesophago-gastric disease including spontaneous and iatrogenic perforation.

Minimally invasive approaches for oesophageal and gastric cancer surgery are being introduced and centres offering this service should adhere to AUGIS Guidelines⁶.

Many of these patients have significant co-morbidity. There should be comprehensive facilities for formal pre-operative assessment of co-morbidity with ready access to other specialties e.g. cardiology, respiratory medicine.

Enhanced recovery is starting to be adopted in oesophageal and gastric surgery and providers are encouraged to adopt this approach where possible.

Complex elective and emergency OG surgery requires high dependency and intensive therapy facilities. Adequate intensive care, high dependency facilities and specialist post-operative care (including out of hours consultant cover) must be provided to minimise peri-operative mortality. The key to improving outcomes lies in ensuring that careful assessment and treatment of these patients allows for clinical needs to be identified and acted on by specialists in the various forms of management.⁷

Chemotherapy and radiotherapy

The management of oesophago-gastric cancer with intent to cure involves chemotherapy in the majority of cases. Treatment may also involve radiotherapy. Palliative treatment frequently involves chemotherapy and/or radiotherapy. Chemotherapy and radiotherapy should be carried out at designated centres by appropriate specialists as recommended by a specialist OG multidisciplinary team.

Audits of compliance with these protocols will need to be demonstrated.

Refer to the following documents for more detailed description of these services:

- Adult Systemic Anti-Cancer Therapy (SACT/chemotherapy) service specification
- Radiotherapy model service specification 2012/13

⁶ A Consensus View and Recommendations on the Development and Practice of Minimally Invasive Oesophagectomy, The Association of Upper Gastrointestinal Surgeons (AUGIS) and The Association of Laparoscopic Surgeons of Great Britain & Ireland (ALS), 2008

⁷ Improving Outcomes Guidance in Upper GI cancers. NHS Executive (2001)

All treatment outcomes should be subject to careful audit either internally or as part of the national oesophago-gastric cancer audit. There should be evidence that the audit results are discussed annually

Follow-up

The Improving Outcomes Guidance series of documents made recommendations on follow-up care. Providers will need to adhere to cancer specific guidelines for follow up agreed through the NSSG and ensure patients have a follow up plan. The cancer specific guidelines will identify that some patients will need to continue receiving follow up from the specialised service but it is expected the majority will be able to receive follow up locally. The provider will need to ensure effective hand over of care and/or work collaboratively with other agencies to ensure patients have follow up plans appropriate to their needs. Immediate post surgery follow up though is likely to be undertaken by the specialist surgical team.

Dietician and nutritional support

All patients with upper gastrointestinal disease are at risk of dietary problems and should have access to full dietetic inpatient and outpatient services. Dieticians should be available to see patients during regular outpatient clinics and available for consultation on ward rounds and multidisciplinary team meetings.

Rehabilitation

There should be appropriate assessment of patients' rehabilitative needs across the pathway and the provider must ensure that high quality rehabilitation is provided in line with the network agreed upper gastrointestinal rehab pathway at: www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation

Supportive and Palliative Care

The provider will give high quality supportive and palliative care in line with NICE guidance. The extended team for the multidisciplinary team includes additional specialists to achieve this requirement. Patients who are managed by an OG cancer multidisciplinary team will be allocated a key worker.

Each patient should be offered an holistic needs assessment at key points in their cancer pathway including at the beginning and end of primary treatment and the beginning of the end of life. A formal care plan should be developed. The nurse specialist(s) should ensure the results of patients' holistic needs assessment are taken into account in the multidisciplinary team decision making.

Patients who require palliative care will be referred to a palliative care team in the hospital and the team will be involved early to liaise directly with the community services. Specialist palliative care advice will be available on a 24 hour, seven days a week basis.

Survivorship

The National Cancer Survivorship Initiative (NCSI) is testing new models of care aimed at improving the health and well being of cancer survivors. The new model stratifies patients on the basis of need including a shift towards supported self management where appropriate. In some circumstances traditional outpatient follow-up may be replaced by remote monitoring. The model also incorporates care coordination through a treatment summary and written plan of care.

It will be important for commissioners to ensure that work from this programme is included and developed locally to support patients whose care will return to their more local health providers once specialist care is no longer required.

End of Life Care

The provider should provide end of life care in line with NICE guidance and in particular the markers of high quality care set out in the NICE quality standard for end of life care for adults.

Acute oncology service

All hospitals with an Accident and Emergency (A&E) department should have an “acute oncology service” (AOS), bringing together relevant staff from A&E, general medicine, haematology and clinical/medical oncology, oncology nursing and oncology pharmacy. This will provide emergency care not only for cancer patients who develop complications following chemotherapy, but also for patients admitted suffering from the consequences of their cancer. For full details on AOS please refer to the service specification for chemotherapy which is currently being developed.

Care pathways

The local care pathway for oesophageal gastric cancer should be consistent with the national pathway on the Map of Medicine. The process of producing the pathways and subsequent updates has been accredited by the National Cancer Action Team. http://eng.mapofmedicine.com/evidence/map/upper_gastrointestinal_gi_cancer1.html

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

- *Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

Specifically, this service is for adults with a suspected OG cancer requiring specialised intervention and management, as outlined within this specification.

The service is accessible to all patients with a suspected OG cancer regardless of sex, race, or gender. Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in multiple languages.

The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation

2.4 Any acceptance and exclusion criteria

The role of the specialist OG cancer service is described in this document but the detailed specification for local OG cancer services will be described in a separate document as these services are expected to be commissioned by the clinical commissioning groups. The local service must be fully aware of the need for urgent referral and for awareness and early diagnosis initiatives as this will be the only way of increasing earlier stage disease at diagnosis to improve prognosis.

2.5 Interdependencies with other services

The specialist OG cancer multidisciplinary team is the leader in the NHS for patient care in this area. They provide a direct source of advice and support when other clinicians refer patients into the specialist services.

The specialist OG cancer multidisciplinary team also provides education within the NHS to raise and maintain awareness of upper gastro-intestinal cancer and their management.

The specialist OG cancer multidisciplinary team will form a relationship with local health and social care providers to help optimise any care for OG cancer provided locally for the patient. This may include liaison with consultants, GPs, community nurses or social workers etc.

Co-located services – Intensive/critical care services may be required for some patients undergoing complex surgery and providers will be required to refer to the service specification for critical care.

Cancer Networks

There are currently (at July 2012) 28 cancer networks across England. Each cancer network will have a Network Site Specific Group (NSSG) covering upper gastrointestinal cancer. This group is made up of clinicians across the network who specialise in upper gastrointestinal cancer. It is the primary source of clinical opinion on issues relating to upper gastrointestinal cancer within the cancer network and is an advisor to commissioners locally. The specialist OG team should ensure they fully participate in the cancer network systems for planning and review of services.

The NSSG is responsible for developing referral guidelines, care pathways, standards of care and to share good practice and innovation. They should also collectively implement NICE Improving Outcomes Guidance including the use of new technologies and procedures as appropriate and carry out network and national audits.

Each cancer network should agree an up-to-date list of appropriate clinical trials and other well designed studies for oesophago-gastric cancer patients and record numbers of patients entered into these trials/studies by each multidisciplinary team.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

Care delivered by the specialist OG multidisciplinary team must be of a nature and quality to meet the CQC care standards and the IOG for OG cancers. It is the Trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards. Where there are breaches any consequences will be deemed as being the Trust's responsibility.

OG cancer services are required to achieve the two week wait for all patients where OG cancer is suspected. In addition the services are required to meet the following standards for all OG cancer patients,

- 31 day wait from diagnosis to first treatment.
- 31 day wait to subsequent treatment.
- 62 day wait from urgent GP referral or screening referral or consultant upgrade to first treatment.

Teams should as a minimum aim to achieve the median value for compliance with the cancer peer review measures, and if a team had immediate risks or serious concerns identified then remedial action plans should be in place. Further details are available at www.cquins.nhs.uk

The provider must be able to offer patient choice. This will be both in the context of appointment time and of treatment options and facilities including treatments not available locally.

The service will comply with the relevant NICE quality standards which defines clinical best practice.

4. Key Service Outcomes

The service is expected to monitor the following clinical outcomes:

- Stage of disease is recorded for all patients.

- Survival rates of patients who undergo radical surgery, with information on
- cancer stage, co-morbidity, age and other features of case mix, at 30 days,
- one year and five years - this data should be recorded for each surgeon and team.
- Survival rates of patients who undergo other types of radical treatment, with information on case-mix short term, one year and five year.
- One year survival rates overall.
- Adverse effects of treatment.
- Is any curative resection performed outside a specialist team centre? (There should be none.)
- What are the curative resection rates for gastric and oesophageal cancers? (Overall rates should be about 20–25 per cent for oesophageal and gastric cancer).
- What proportion of patients undergoes pre-operative chemotherapy?
- What is the frequency of resection line involvement?
- What is the anastomotic leak rate?
- What percentage of patients returns to theatre?
- What is the average length of stay for patients with oesophago-gastric cancer undergoing radical resection?
- Waiting time to first palliative intervention (31 day subsequent treatment (palliative) standard performance).
- All patients with non-curable cancer to be known to palliative care services; seen in the community within 2 weeks after discharge

The National Cancer Intelligence Network site specific clinical reference group has developed a set of clinical lines of enquiry and provider organisations will be able to collect and audit the following areas:

- Number of new cases treated and recorded in national audits.
- The number of cases with confirmed histology.
- The proportion of patients in whom stage of disease is recorded.
- The percentage of patients having a surgical resection.
- The morbidity and mortality following surgery.
- The percentage of patients having palliative interventions.
- Postoperative length of stay.
- The rates of survival from diagnosis and with or without intervention.

5. Location of Provider Premises

The service is delivered across England by the following nominated cancer centres and which provide cover across all regions in England for the national caseload. The provider's premises are located at:

Trust Code	Trust
RXN	Lancashire Teaching Hospitals NHS Foundation Trust
REM	Aintree University Hospitals NHS Foundation Trust
RBQ	Liverpool Heart and Chest NHS Foundation Trust

NEW	North East Wales??
RAE	Bradford Teaching Hospitals NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RWA	Hull and East Yorkshire Hospitals Trust
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust
RR1	Heart of England NHS Foundation Trust
RKB	University Hospitals Coventry and Warwickshire NHS Trust
RWG	West Hertfordshire Hospitals NHS Trust
RQN	Imperial College Healthcare NHS Trust
RRV	University College London Hospitals NHS Foundation Trust
RF4	Barking, Havering and Redbridge University Hospitals NHS Trust
RNJ	Barts and the London NHS Trust
RJ1	Guy's and St Thomas' NHS Foundation Trust
RPY	The Royal Marsden NHS Foundation Trust
RK9	Plymouth Hospitals NHS Trust
RDZ	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
RA7	University Hospitals Bristol NHS Foundation Trust
RTE	Gloucestershire Hospitals NHS Foundation Trust
RTH	Oxford Radcliffe Hospitals NHS Trust
RHW	Royal Berkshire NHS Foundation Trust
RHU	Portsmouth Hospitals NHS Trust
RHM	Southampton University Hospitals NHS Trust
RA2	Royal Surrey County NHS Foundation Trust
RXH	Brighton and Sussex University Hospitals NHS Trust
RWF	Maidstone and Tunbridge Wells NHS Trust
RJE	University Hospital of North Staffordshire NHS Trust
RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust
RGT	Cambridge University Hospitals NHS Foundation Trust
RQ8	Mid Essex Hospital Services NHS Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
RTR	South Tees Hospitals NHS Foundation Trust
RX1	Nottingham University Hospitals NHS Trust
RTG	Derby Hospitals NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust

Quality and performance standards

The following standards are suggested as developmental and require further discussion.

Performance Indicator Quality	Indicator	Threshold	Method of Measurement	Consequence of breach
	% of cases discussed at multidisciplinary team	100%	Reported within national audit reports	
	Follow Up Ratios			

	Other Quality Measures	TBC	TBC	
	Percentage attendance by individual core members or their agreed cover at multidisciplinary team	67%	Reported in Peer Review Submissions	
	Attendance at advanced communications course	100%.	Peer Review	
IOG Compliance	Compliance with specified measures		Compliance with specific measures for tumour site as set out in IOG documentation	
Compliance with Peer Review	Compliance with all other Peer Review measures (other than where agreed with commissioners when the Provider should have an action plan in place that has been agreed with the Commissioner)		National median compliance level National reports	
Performance & Productivity	The Provider should ensure that these targets are achieved for the part of the patient pathway that it delivers and that when the patient pathway crosses outside the locality border, appropriate scheduling of patients/activity supports achievement of the target by other providers in the pathway wherever possible, except when informed patient choice or clinical appropriateness mitigate against this.			
Performance Indicator Quality	Indicator	Threshold	Method of Measurement	Consequence of breach
Waiting Time Compliance				
	62 day wait - % treated in 62 days from GP referral, consultant	>~86%		
Aggregate Measures	14 day suspected cancer referral standard performance (A20)	93%	Reported on cancer waits database	
	31 day first treatment	96%	As above	

	standard performance (A15)			
	31 day subsequent treatment (Surgery) standard performance (A16)	94%	As above	
	31 day subsequent treatment (Drugs) standard performance (A16)	98%	As above	
	31 day subsequent treatment (Radiotherapy) standard performance (A17)	94%	As above	
	31 day subsequent treatment (Other Treatments) standard performance	TBC	As above	
	31 day subsequent treatment (Palliative) standard performance	TBC	As above	
	62 day standard from 14 day referral performance (A18)	85%	As above	
	62 day standard from consultant upgrade performance (A19)	TBC	As above	
	Diagnostic Test Waiting Times	TBC	Some national data	

Activity performance indicators

Activity Performance Indicators		Threshold	Consequence of breach
	Annual review conducted		
	Participation in National Audits	100%	
	Additional Audits undertaken	N/A	
Activity	Threshold for number of procedures	Establish baseline cancer activity data for :- number of procedures for elective, day case , non elective non	
	Length of stay benchmarking		
	Level of admissions		

	Choice	emergency, non elective emergency, outpatient follow-up attendance, outpatient follow-up, outpatient procedures all by speciality	
Service User Experience	National Cancer Patient Experience survey (ref A46 main contract)	National survey report when published	If the provider does not take part they will be required to meet with the commissioners to explain reasons for not doing so and activity planned to enable the information to be captured through alternative mechanisms
	Improving Service User Experience	Of responses received 75% should express overall satisfaction with the service .Trust to evidence the measures it has taken to improve service user experience and outcomes achieved and numbers / percentages stratified	
Activity Performance Indicators		Threshold	Consequence of breach
	Addressing Complaints	Trust to evidence the measures it has taken to address complaints and outcomes achieved	
	Patient involvement	Trust to evidence the actions it has taken to engage with patients and demonstrate where this has impacted	
Staff survey	Staff survey results		
Trial Activity	Recruitment into trials	Patients eligible for an existing clinical trial should be offered to the chance to be	

		treated in a clinical trial	
Outcomes	Post surgery mortality	Numbers and percentages baseline to be set in year	
	30 day mortality		
	One year survival		
	Five year survival		
	30 day readmission rates for cancer patients	Numbers and percentage baseline to be set in year	
Data Submission	Registry dataset submission status	As required by Registry	
	DCOs		
	Staging data	As required by Registry	

Additional information

ICD10 codes

Oesophago-gastric tumours are categorised using the international classification of diseases version 10 (ICD10) as:

C15: malignant neoplasms of oesophagus - approximately 6,750 newly diagnosed cases per year

C16: malignant neoplasm of stomach - approximately 6,200 newly diagnosed cases per year

Incidence rates are for patients diagnosed in 2009 in England. Source: UK Cancer

Information System, data extracted August 2012. Emergency presentation data for patients diagnosed 2006-2008, source: National Cancer Intelligence Network.

Cancer waiting times

Oesophago-gastric tumours are included within the larger “upper gastrointestinal” group within cancer waiting times.

OPCS-4 codes

The following OPCS-4 codes have been agreed within the NCIN as operations that, if undertaken on a patient with oesophagus or stomach cancer, would be a major surgical resection:

Oesophageal cancer

G011 Oesophagogastric resection and anastomosis of oesophagus to stomach

G018 Other specified excision of oesophagus and stomach

G019 Unspecified excision of oesophagus and stomach

G021 Total oesophagectomy and anastomosis of pharynx to stomach

G022 Total oesophagectomy and interposition of microvascularly attached jejunum
G023 Total oesophagectomy and interposition of jejunum NEC
G024 Total oesophagectomy and interposition of microvascularly attached colon
G025 Total oesophagectomy and interposition of colon NEC
G028 Other specified total excision of oesophagus
G029 Unspecified total excision of oesophagus
G031 Partial oesophagectomy and end to end anastomosis of oesophagus
G032 Partial oesophagectomy and interposition of microvascularly attached jejunum
G033 Partial oesophagectomy and anastomosis of oesophagus to transposed jejunum
G034 Partial oesophagectomy and anastomosis of oesophagus to jejunum NEC
G035 Partial oesophagectomy and interposition of microvascularly attached colon
G036 Partial oesophagectomy and interposition of colon NEC
G038 Other Specified partial excision
G039 Unspecified partial excision

Stomach cancer

G012 Oesophagogastrectomy and anastomosis of oesophagus to transposed jejunum
G013 Oesophagogastrectomy and anastomosis of oesophagus to jejunum NEC
G271 Total gastrectomy and excision of surrounding tissue
G272 Total gastrectomy and anastomosis of oesophagus to duodenum
G273 Total gastrectomy and interposition of jejunum
G274 Total gastrectomy and anastomosis of oesophagus to transposed jejunum
G275 Total gastrectomy and anastomosis of oesophagus to jejunum NEC
G278 Total excision of stomach, Other specified
G279 Unspecified total excision of stomach
G281 Partial gastrectomy and anastomosis of stomach to duodenum
G282 Partial gastrectomy and anastomosis of stomach to transposed jejunum
G283 Partial gastrectomy and anastomosis of stomach to jejunum NEC, Billroth II
G288 Partial excision of stomach, other specified
G289 Unspecified partial excision of stomach