NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Oesophago-gastric cancer

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for oesophago-gastric cancer. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper are:

Oesophago-gastric cancer: assessment and management in adults (2018) NICE guideline 83

Suspected cancer: recognition and referral (2015, last updated 2017) NICE guideline 12

Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management (2014) NICE clinical guideline CG184

2 Overview[1]

2.1 Focus of quality standard

This quality standard will cover the diagnosis and management of oesophago-gastric cancer in adults.

2.2 Definition

Oesophago-gastric cancer includes cancer affecting the oesophagus, stomach, or junction between the oesophagus and the stomach. There are 2 common subtypes: squamous cell carcinoma and adenocarcinoma. Adenocarcinomas are the most

[1] Unless referenced as from another source, the information in this section is from National Institute for Health and Care Excellence (2018) Oesophago-gastric cancer: assessment and management in adults. NICE guideline (NG83).

common type of oesophageal cancer in the UK. They are cancers that develop in the gland cells that produce mucous in the lining of the oesophagus. Squamous-cell carcinoma arises from the epithelial cells that line the oesophagus.

2.3 Incidence and prevalence

There are around 13,000 new cases of oesophago-gastric cancer diagnosed in England each year. Oesophageal cancer incidence rates increased by 6% in the UK between 1993-1995 and 2013-2015.[2] Stomach cancer rates for males and females decreased by 50% in the UK between 1993-1995 and 2013-2015.[3]

In 2014, around 60% of people with oesophageal cancer were diagnosed with late stage disease in England (stage III, 29%; stage IV, 30%).[4]

In 2014, around 50% of people with stomach cancer were diagnosed with late stage disease in England (stage III, 17% and stage IV, 34%).[5]

The majority of oesophago-gastric cancers are diagnosed in older people.

Oesophageal cancer is more common in men than women. In 2012, 7,700 people died of oesophageal cancer in the UK. Twice as many men died than women.

2.4 Causes, diagnosis and management

Most oesophageal cancers are linked to lifestyle and other risk factors, mainly tobacco smoking, obesity and alcohol. Approximately a third of stomach cancers are linked to H. pylori infection, an avoidable risk factor.

Compared with other cancers, patients are often diagnosed with more advanced disease. As a result, the prognosis can be relatively poor, with only 15% of people diagnosed with oesophageal cancer surviving for 5 years or more.

Initial diagnosis of oesophago-gastric cancer is usually done by endoscopy and biopsy. This can be under the clinical responsibility of primary care, though the procedure is usually performed in secondary care.[6] Staging investigations include CT scan, endoscopic ultrasound (EUS) and staging laparoscopy. To identify people

[2] Cancer Research UK (2018) Oesophageal cancer incidence statistics – oesophageal cancer incidence trends over time [online; accessed 19 April 2018]
[3] Cancer Research UK (2018) Stomach cancer incidence statistics – stomach cancer incidence by sex and UK country [online; accessed 25 April 2018]
[4] Cancer Research UK (2018) Oesophageal cancer incidence statistics – oesophageal cancer incidence by stage at diagnosis [online; accessed 26 April 2018]
[5] Cancer Research UK (2018) Stomach cancer incidence statistics – stomach cancer incidence by stage at diagnosis [online; accessed 26 April 2018]
[6] Suspected cancer: recognition and referral (2015) NICE guideline (NG12), sections 8.1 and 8.3 (full guideline)

suitable for curative treatment, positron emission tomography (PET) is used. Treatment options should be discussed by an upper gastro-intestinal (GI) multi-disciplinary team (MDT).[7] Radical surgery is conducted within a specialist surgical unit. Around 30% of people with oesophago-gastric cancer are eligible for a curative treatment pathway.[8]

For many people, curative surgery or chemoradiotherapy is not possible and appropriate palliative care is needed. This may include radiotherapy or chemotherapy, inserting an oesophageal stent or appropriate supportive care.

[7] HQIP/RCS (2017) National oesophago-gastric cancer audit 2017 9th report. London: HQIP [online; accessed 2 March 2018]
[8] HQIP/RCS (2017) National oesophago-gastric cancer audit 2017 9th report. London: HQIP [online; accessed 2 March 2018]

2.5 National outcome frameworks

Tables 1–2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.4 Under 75 mortality rate from cancer* i One- and ii Five-year survival from all cancers *v One- and vi Five-year survival from cancers diagnosed at stage 1 & 2***
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services ii GP Out-of-hours services 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *I Primary care* *ii Hospital care* ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving the experience of care for people at the end of their lives** 4.3 Patient experience of A&E services 4.6 Bereaved carers' views on the quality of care in the last 3 months of life
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicators*** **Improving the culture of safety reporting** 5.6 Patient safety incidents reported

Table 2 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.19 Cancer diagnosed at stage 1 and 2*
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.03 Mortality rate from causes considered preventable** 4.05 Under 75 mortality rate from cancer *
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

3 Summary of suggestions

3.1 Responses

In total 17 stakeholders responded to the 2-week engagement exercise 08/03/2018-22/03/2018.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the committee.

NHS Improvement's patient safety division submitted comments and a link to a patient safety alert during stakeholder engagement, which are summarised in this paper.

Full details of all the suggestions provided are given in appendix 4 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Diagnosis and assessment	
• Early diagnosis	AAH, RCS, RCPSG, SCM4
• Sequencing of diagnostic tests	SCM5
• HER2 testing	NHSE,SCM4
Nutritional support	
• Specialist dietetic advice and nutritional support	AAH, BDA, CORE RCPSG, SCM4, SCM6
• Nutritional assessment	SCM3

Suggested area for improvement	Stakeholders
Management	
• Radical treatment	AAH, BSG/RCP, RCPSG, RCS, SCM2, SCM4
• Palliative management	RCPSG, RCS, SCM6
Other forms of support	
• Information	BDA, SCM1
• Psycho-social support	BDA, BSG/RCP, SCM3
Organisation of services	
• Specialist oesophago-gastric cancer multi-disciplinary team	BSG/RCP, SCM2, SCM5, SCM6
• Access to clinical nurse specialist (CNS)	SCM3, SCM6
• Centralisation of services	RCPSG
Additional areas	
• 4D CT planning	NHSE
• Access to clinical trials	BSG/RCP
• Audits and registries	RCS, SCM4
• Diagnosis of Barrett's oesophagus	RCPSG
• IMRT planning/delivery [Intensity-modulated radiation therapy]	NHSE
• Nationwide funding for dietetic services	CORE
• New guidance	SCM5
• Participation in a local cancer alliance	NHSE
• Quality of gastroscopy [upper GI endoscopy]	BSG/RCP
• Quality of management of Barrett's oesophagus	CORE
• Quality of survivorship initiative services	BDA
• Role of primary care	NHSE
• Thickening powder to modify fluids	NHSI

AAH, Action Against Heartburn
BDA, British Dietetic Association
BSG, British Society of Gastroenterology (endorsed by RCP)
CORE (Charity committed to fighting all digestive diseases, 'by funding research, providing expert information and promoting awareness/discussion of digestive health')
CRUK, Cancer Research UK – **responded (no comments)**
NHSE, NHS England
NHSI, NHS Improvement
RCN, Royal College of Nursing – **responded (no comments)**
RCP, Royal College of Physicians
RCPSG, Royal College of Physicians and Surgeons of Glasgow
RCS, Royal College of Surgeons
SCM (1-6), Specialist Committee Member

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 315 papers were identified for oesophago-gastric cancer. In addition, 15 papers were suggested by stakeholders at topic engagement and 14 papers internally at project scoping.

Of these papers 5 have been included in this report and are included in the current practice sections where relevant. Appendix 3 outlines the search process.

4 Suggested improvement areas

4.1 Diagnosis and assessment

4.1.1 Summary of suggestions

Early diagnosis

Stakeholders suggested that early diagnosis of oesophago-gastric cancers is an area for quality improvement. Early diagnosis is associated with better outcomes, including selection for curative treatment.

Stakeholders specifically highlighted that multiple pathways to a diagnosis of oesophago-gastric cancer exist. They suggested that increasing awareness of these different routes should improve access to endoscopy to facilitate early diagnosis. The NICE quality standard on suspected cancer (QS124 - statement 2) covers open access endoscopy for people with symptoms suggesting oesopghago-gastric cancer.

Stakeholders also specifically referred to reducing the number of people diagnosed following an emergency admission as an important issue.

Sequencing of diagnostic tests

Stakeholders highlighted the importance of promptly undertaking diagnostic tests in the correct sequence. They specifically focused on ensuring PET-CT is undertaken and reported before endoscopic ultrasound (EUS) is requested. Stakeholders suggested that this will help to avoid unnecessary tests for people having investigations.

HER2 testing

Stakeholders highlighted HER2 testing as a quality improvement area, to support cost-effective use of trastuzumab in the palliative management of metastatic oesophago-gastric cancer.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Early diagnosis	**Oesophageal cancer** NICE NG12 Recommendation 1.2.1 **Stomach cancer** NICE NG12 Recommendations 1.2.6-1.2.7 NICE CG184 Recommendation 1.12.1
Sequencing of diagnostic tests	**Assessment after diagnosis** NICE NG83 Recommendations 1.3.1-1.3.3 NICE NG83 Recommendations 1.3.6-1.3.7
HER2 testing	**Assessment after diagnosis** NICE NG83 Recommendation 1.3.8

Oesophageal cancer

NICE NG12 Recommendation 1.2.1

Offer urgent direct access upper gastrointestinal endoscopy (to be performed within 2 weeks) to assess for oesophageal cancer in people:

- with dysphagia or
- aged 55 and over with weight loss and any of the following:
    - upper abdominal pain
    - reflux
    - dyspepsia. **[new 2015]**

Stomach cancer

NICE NG12 Recommendation 1.2.6

Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with an upper abdominal mass consistent with stomach cancer. **[new 2015]**

NICE NG12 Recommendation 1.2.7

Offer urgent direct access upper gastrointestinal endoscopy (to be performed within 2 weeks) to assess for stomach cancer in people:

- with dysphagia **or**
- aged 55 and over with weight loss **and** any of the following:

- upper abdominal pain
- reflux
- dyspepsia. **[new 2015]**

Surveillance for people with Barrett's oesophagus

NICE CG184 Recommendation 1.12.1

Consider surveillance to check progression to cancer for people who have a diagnosis of Barrett's oesophagus (confirmed by endoscopy and histopathology), taking into account:

- the presence of dysplasia (also see Barrett's oesophagus – ablative therapy[NICE clinical guideline 106])
- the person's individual preference
- the person's risk factors (for example, male gender, older age and the length of the Barrett's oesophagus segment).

  Emphasise that the harms of endoscopic surveillance may outweigh the benefits in people who are at low risk of progression to cancer (for example, people with stable non-dysplastic Barrett's oesophagus). **[new 2014]**

Assessment after diagnosis

Determining suitability for radical treatment of histologically-confirmed oesophageal or gastro-oesophageal junctional cancer after endoscopy and whole-body CT scan diagnosis

NICE NG83 Recommendation 1.3.1

Offer F-18 FDG PET-CT to people with oesophageal and gastro-oesophageal junctional tumours that are suitable for radical treatment (except for T1a tumours).

NICE NG83 Recommendation 1.3.2

Do not offer endoscopic ultrasound only to distinguish between T2–T3 tumours in people with oesophageal and gastro-oesophageal junctional tumours.

NICE NG83 Recommendation 1.3.3

Only offer endoscopic ultrasound to people with oesophageal and gastro-oesophageal junctional cancer when it will help guide ongoing management.

Determining suitability for radical treatment of histologically-confirmed gastric cancer after endoscopy and whole-body CT scan diagnosis

NICE NG83 Recommendation 1.3.6

Only consider endoscopic ultrasound for people with gastric cancer if it will help guide ongoing management.

NICE NG83 Recommendation 1.3.7

Only consider F-18 FDG PET-CT in people with gastric cancer if metastatic disease is suspected and it will help guide ongoing management.

HER2 testing in metastatic oesophago-gastric adenocarcinoma

NICE NG83 Recommendation 1.3.8

Offer HER2 testing to people with metastatic oesophago-gastric adenocarcinoma (see the NICE technology appraisal guidance on trastuzumab for HER2-positive metastatic gastric cancer).

4.1.3 Current UK practice

Early diagnosis

Referral

The national oesophago-gastric cancer audit (2017) reports on 21,242 people diagnosed with high grade dysplasia of the oesophagus or oesophago-gastric cancer between April 2014 and March 2016.[9] Out of a total of 20,398 cases, routes to diagnosis were:

- GP referral: 13,315 (65%).
- Via another hospital consultant: 4,039 (20%).
- Emergency admission: 2,786 (14%).
- Open access endoscopy: 159 (less than 1%).
- Barrett's surveillance: 99 (less than 1%).

The proportion of emergency referrals is highlighted in the audit report due to its association with poorer treatment outcomes.

[9] HQIP/RCS (2017) National oesophago-gastric cancer audit 2017, 9th report, London: HQIP [online; accessed 2 March 2018]

Overall, 52% (8,820) of 17,042 referrals were made using the 'two week-wait' referral route (referral to a specialist or urgent direct access to diagnostic tests).[10] Emergency referrals (including self-referrals) accounted for 17% of diagnoses overall.

Access to upper GI endoscopy

The national oesophago-gastric cancer audit report (2017) shows that less than 1% of people are diagnosed with oesophago-gastric cancer via open-access endoscopy.

An article published in 2016 investigated the proportion of GPs in England with direct access to diagnostic tests, and the proportion delivered within the 2-week timescale specified in the suspected cancer guideline.[11] A major methodological limitation is lack of randomised sampling to identify GPs representative of each region. 511 responses were used.

Key findings:

- 72% of GPs had access to gastroscopy (upper GI endoscopy). There was considerable variation among the regions.
- 23% of GPs had direct urgent access to gastroscopy; 2 regions reported no GPs could deliver direct gastroscopy according to the suspected cancer guideline (within <2 weeks).

Primary-care led investigation prior to referral was used for 45% of all patients.[12]

Sequencing of diagnostic tests

No published current practice studies relating to the sequencing of diagnostic tests/staging investigations were identified. This area is based on the stakeholder's knowledge and experience.

HER2 testing

No published current practice studies relating to the take-up of HER2 testing were identified. This area is based on the stakeholder's knowledge and experience.

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[10] RCGP (2018) Cancer: national audit of cancer diagnosis in primary care (RCGP, Cancer Research UK, Public Health England, NHS England and Macmillan, 2016/17): 'Read the full publication about the NCDA findings' link [accessed 18 April 2018]

[11] Nicholson D et al (2016) Variation in direct access to tests to investigate cancer: a survey of English General Practitioners PLoS ONE 11(7),e0159725 doi:10.1371/journal.pone.0159725 [online; accessed 16 April 2018]

[12] RCGP (2018) Cancer: national audit of cancer diagnosis in primary care (RCGP, Cancer Research UK, Public Health England, NHS England and Macmillan, 2016/17): 'Read the full publication about the NCDA findings' link [accessed 18 April 2018]

4.1.4 Resource impact

For oesophageal cancer the Guideline Development Group noted that the recommendations for direct access upper gastrointestinal endoscopy are likely to result in a cost increase because of an increase in the number of endoscopies performed. However, some of this cost increase is likely to be counteracted by a cost saving from an optimised diagnostic process that will see an increase in the proportion of people being referred on a suspected cancer pathway who have oesophageal cancer and a decrease in the number of patients without oesophageal cancer being referred. This was also true of stomach cancer.

4.2 Nutritional support

4.2.1 Summary of suggestions

Specialist dietetic advice and nutritional support

Stakeholders suggested specialist dietetic provision and nutritional support as an area for quality improvement. They highlighted on-going access to tailored dietetic support for people with oesophago-gastric cancer, on a short and long-term basis, in order to optimise treatment outcomes and quality of life.

Nutritional assessment

Stakeholders highlighted nutritional assessment as an area for quality improvement. One stakeholder highlighted this could take place at diagnosis to support improved treatment outcomes.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Specialist dietetic advice and nutritional support	**Nutritional support** **Radical treatment** NICE NG83 Recommendations 1.6.1-1.6.2 **Palliative care** NICE NG83 Recommendation 1.6.5
Nutritional assessment	**Nutritional support** **Radical treatment** NICE NG83 Recommendation 1.6.1

Nutritional support

Radical treatment

NICE NG83 Recommendation 1.6.1

Offer nutritional assessment and tailored specialist dietetic support to people with oesophago-gastric cancer who before, during and after radical treatments.

NICE NG83 Recommendation 1.6.2

Offer immediate enteral or parenteral treatment to people after surgery who are having radical surgery for oesophageal and gastro-oesophageal cancers.

Palliative care

NICE NG83 Recommendation 1.6.5

Together with members of the multidisciplinary team and the hospital and community palliative care teams, tailor dietetic support to the person with oesophago-gastric cancer and their clinical situation.

4.2.2 Current UK practice

Specialist dietetic advice and nutritional support

No published current practice studies were identified. This area is based on the stakeholder's knowledge and experience.

Nutritional assessment

No published current practice studies were identified. This area is based on the stakeholder's knowledge and experience.

4.2.3 Resource impact

No significant resource impact identified in the underpinning guidance.

4.3 Management

4.3.1 Summary of suggestions

Radical treatment

Stakeholders suggested a number of areas for quality improvement in relation to radical treatment. They highlighted:

- The importance of endoscopic therapies in the treatment of early oesophageal cancer, in preference to surgery.
- The treatment of non-metastatic squamous cell carcinoma
- Take-up of definitive chemoradiotherapy, a treatment associated with older and frailer people with oesophago-gastric cancer.
- Use of minimally invasive surgery (including laparascopy and thorascopy) to reduce peri-operative mortality.
- Adequate lymph node extraction during surgery.

Palliative management

A stakeholder highlighted the management of non-metastatic oesophageal cancer that is not suitable for surgery as a quality improvement area. More specifically, a stakeholder highlighted regimens offered as first-line palliative combination chemotherapy to people with advanced oesophago-gastric cancer as an area for quality improvement.

More generally, a stakeholder highlighted access to palliative care as an area for quality improvement. Access to specialist palliative teams is covered by the NICE quality standard on end of life care for adults (QS13 - statement 5).

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Radical treatment	**Radical treatment** NICE NG83 Recommendations 1.4.1-1.4.2 NICE NG83 Recommendation 1.4.4 NICE NG83 Recommendation 1.4.12 NICE NG83 Recommendation 1.4.6 NICE NG83 Recommendations 1.4.7-1.4.8
Palliative management	**Palliative management** NICE NG83 Recommendation 1.5.5

Radical treatment

NICE NG83 Recommendation 1.4.1

Offer endoscopic mucosal resection for staging for people with suspected T1 oesophageal cancer.

NICE NG83 Recommendation 1.4.2

Offer endoscopic eradication of remaining Barrett's mucosa for people with T1aN0 oesophageal cancer.

NICE NG83 Recommendation 1.4.4

Offer radical resection for people with T1bN0 oesophageal adenocarcinoma if they are fit enough to have surgery.

NICE NG83 Recommendation 1.4.6

Consider an open or minimally invasive (including hybrid) oesophagectomy for surgical treatment of oesophageal cancer.

NICE NG83 Recommendation 1.4.7

When performing a curative gastrectomy for people with gastric cancer, consider a D2 lymph node dissection.

NICE NG83 Recommendation 1.4.8

When performing a curative oesophagectomy for people with oesophageal cancer, consider two-field lymph node dissection.

NICE NG83 Recommendation 1.4.12 (extract)

Offer people with resectable non-metastatic squamous cell carcinoma of the oesophagus the choice of:

- radical chemoradiotherapy or
- chemoradiotherapy before surgical resection.

Palliative management

NICE NG83 Recommendation 1.5.5

Offer first-line palliative combination chemotherapy to people with advanced oesophago-gastric cancer who have a performance status 0 to 2 and no significant comorbidities. Possible drug combinations include:

- doublet treatment: 5-fluorouracil or capecitabine[2] in combination with cisplatin[1] or oxaliplatin[3]
- triplet treatment: 5-fluorouracil or capecitabine in combination with cisplatin or oxaliplatin plus epirubicin[4].

  Discuss the benefits, risks and treatment consequences of each option with the person and those important to them (as appropriate).

Please note: View the relevant recommendations in section 1.5 of NICE guidance on the assessment and management of oesophago-gastric cancer to see the text relating to the references ([1], [2] etc).

4.3.3 Current UK practice

Radical treatment

Endoscopic therapies

The national oesophago-gastric cancer audit (2017) highlights that:[13]

- Endoscopic treatment represents 73% of selected therapies for early-stage disease.

[13] HQIP/RCS (2017) National oesophago-gastric cancer audit 2017, 9th report. London: HQIP [online; accessed 2 March 2018]

- Curative surgical resection (oesophagectomy) represents 3% of treatments for early-stage disease.

- 76% of endoscopic treatments were for endoscopic mucosal resection (EMR) and 19% were for radiofrequency ablation.

In 1% of cases, the reason for not undergoing active treatment / undergoing surveillance was lack of access to endoscopic therapy/surgery. Patient choice accounted for 45%.

Non-metastatic squamous cell carcinoma

The 2017 national oesophago-gastric cancer audit reported on data relating to treatment of oesophageal squamous cell carcinoma using data collected 2013-16.[14] The report highlighted that, although frailty was for some people the explanation for choice of definitive oncology, greater diversity existed within the groups than between them, 'suggesting' that many people would have been candidates for either treatment.

Chemoradiotherapy

No published current practice studies were identified. This area is based on the stakeholder's knowledge and experience.

Minimally invasive surgery

The proportion of oesophagostomies using minimally invasive surgery techniques has risen significantly since the 2007-09 audit. During 2014-16, as reported in the 2017 national oesophago-gastric cancer audit, minimally invasive surgical techniques were used for 41% of oesophagostomies (compared to around 30% in 2007-2008) and 16% of gastrectomies (compared to around 10% in 2007-2008).[15]

Lymph node extraction

No published current practice studies were identified. This area is based on the stakeholder's knowledge and experience.

[14] HQIP/RCS (2017) National oesophago-gastric cancer audit 2017, 9th report. London: HQIP [online; accessed 2 March 2018]
[15] HQIP/RCS (2017) National oesophago-gastric cancer audit 2017, 9th report. London: HQIP [online; accessed 2 March 2018]; HQIP/RCS (2009) National oesophago-gastric cancer audit 2009, 2nd report. London: HQIP [online; accessed 2 March 2018]

Palliative management

The 2017 national oesophago-gastric cancer audit reports that regional variation is evident in England in the use of chemotherapy regimens for palliative management of oesophageal cancer.[16]

Data on chemotherapy regimens is collected differently in Wales; the following applies to England only:

- 11 drug regimens accounted for 90% of first administered cycles of chemotherapy in cancer alliances.
- 2 of the 19 English cancer alliances used drug combinations other than the 5 most frequently-used combinations in around 50% of first cycle treatments.

4.3.4 Resource impact

No significant resource impact identified in the underpinning guidance.

[16] HQIP/RCS (2017) National oesophago-gastric cancer audit 2017, 9th report. London: HQIP [online; accessed 2 March 2018]

4.4 Information and support

4.4.1 Summary of suggestions

Information

Stakeholders highlighted the importance of providing information specific to the person's condition and treatment.

A stakeholder highlighted the need to raise awareness of specific consequences of treatments. Inhalation of gastric acid leading to scarring of the lungs was cited as an example.

Psycho-social support

Stakeholders highlighted that the nature of curative treatments for people with oesophago-gastric cancer often results in changes to physical, psychological and social aspects of life. It was suggested that support with practical and psychological issues at the point of endoscopy (diagnosis/staging/first sMDT) provides the opportunity to provide guidance and support before treatment begins. Following curative/radical treatments, support and guidance to enable adaptation to altered physical, psychological and social aspects of life is an area for quality improvement.

Stakeholders highlighted a changing emphasis in follow-up; one that moves away from assessing people with a diagnosis of oesophago-gastric cancer for disease recurrence/surveillance, to optimising recovery and supporting physical, psychological and social adaptation on a long-term basis.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Information	**Information and support** NICE NG83 Recommendation 1.1.2 **Radical treatment** NICE NG83 Recommendation 1.1.5 **Palliative management** NICE NG83 Recommendation 1.1.6
Psycho-social support	**Information and support** NICE NG83 Recommendation 1.1.4 **Radical treatment** NICE NG83 Recommendation 1.1.5 **Palliative management** NICE NG83 Recommendation 1.1.6 **Follow-up** NICE NG83 Recommendations 1.7.1-1.7.2

Information and support

NICE NG83 Recommendation 1.1.2

Make sure the person with oesophago-gastric cancer is given information, in a format that is appropriate for them, to take away and review in their own time after you have spoken to them about their cancer and care.

Palliative management

NICE NG83 Recommendation 1.1.5

Provide information about possible treatment options, such as surgery, radiotherapy or chemotherapy, in all discussions with people with oesophago-gastric cancer who are going to have radical treatment. Make sure the information is consistent and covers:

- treatment outcomes (prognosis and future treatments)
- recovery, including the consequences of treatment and how to manage them
- nutrition and lifestyle changes.

NICE NG83 Recommendation 1.1.6

For people with oesophago-gastric cancer who can only have palliative management, offer personalised information and support to them and the people

who are important to them (as appropriate), at a pace that is suitable for them. This could include information on:

- life expectancy, if the person has said they would like to know about this
- the treatment and care available, and how to access this both now and for future symptoms
- holistic issues (such as physical, emotional, social, financial and spiritual issues), and how they can get support and help
- dietary changes, and how to manage these and access specialist dietetic support
- which sources of information in the public domain give good advice about the issues listed above.

Information and support

NICE NG83 Recommendation 1.1.4

Provide information about possible treatment options, such as surgery, radiotherapy or chemotherapy, in all discussions with people with oesophago-gastric cancer who are going to have radical treatment. Make sure the information is consistent and covers:

- treatment outcomes (prognosis and future treatments)
- recovery, including the consequences of treatment and how to manage them
- nutrition and lifestyle changes.

Follow-up

NICE NG83 recommendation 1.7.1

For people who have no symptoms or evidence of residual disease after treatment for oesophago-gastric cancer with curative intent:

- provide information about the symptoms of recurrent disease, and what to do if they develop these symptoms
- offer rapid access to the oesophago-gastric multidisciplinary team for review, if symptoms develop.

NICE NG83 recommendation 1.7.2

For people who have no symptoms or evidence of residual disease after treatment for oesophago-gastric cancer with curative intent, do not offer:

- routine clinical follow-up solely for the detection of recurrent disease
- routine radiological surveillance solely for the detection of recurrent disease.

4.4.3 Current UK practice

Information

The 2016 national cancer patient experience survey reported the following for respondents with upper GI cancers:[17]

- 49% were told about side effects of treatment that could affect them in the future, rather than straight away, before they started treatment.
- 55% received information about the impact cancer could have on their day to day activities.
- 59% were given written information about the type of cancer they had at diagnosis.
- 72% had the possible side effects of treatment(s) explained to them in a way they could understand.
- 74% had their options explained before their treatment started.

Psycho-social support

- 38% were given information about how to get financial help and any benefits they might be entitled to.
- 65% were 'definitely' offered advice and support in dealing with the side effects of treatment. 6% reported they were not offered any help.
- 67% were given information by hospital staff about support for self-help groups for people with cancer.

[17] Quality Health (2016) 6th Cancer patient experience survey 2016. London: Quality Health. Data tables/report. [online; accessed 16 April 2018]

Approaches to follow-up

The 2016 cancer patient experience survey reports on aspects of follow-up care for people with upper GI cancer.[18]

In terms of adaptation to the physical consequences of treatment, 20% of people diagnosed with upper GI cancers felt that, after their cancer treatment had finished, they were given enough care and support from health or social services (for example, district nurses, home helps or physiotherapists). 28% felt they did not need this help.

4.4.4 Resource impact

No significant resource impact identified in the underpinning guidance.

[18] Quality Health (2016) 6th Cancer patient experience survey 2016. London: Quality Health. Data tables/report [online; accessed 16 April 2018]

4.5 Organisation of services

4.5.1 Summary of suggestions

Specialist oesophago-gastric cancer multi-disciplinary team

Stakeholders highlighted the role of specialist oesophago-gastric cancer multidisciplinary teams as an area for quality improvement. It was suggested that a specialist oesophago-gastric cancer multidisciplinary team should decide what care is needed for radical treatment.

A stakeholder also commented that the quality/efficacy of meetings could be improved by communication of information about the general health and preferences for management of people with oesophageal cancer, and by ensuring the presence of all members in person.

Access to clinical nurse specialist (CNS)

Stakeholders highlighted access to a specialised oesophago-gastric cancer specialist nurse for all people with suspected or confirmed oesophago-gastric cancer as an area for quality improvement. They suggested access is needed at the point of diagnosis and upon/after discharge.

Centralisation of services

A stakeholder highlighted that centralisation of specialised oesophago-gastric cancer services, including endotherapy and surgery as a quality improvement area. It was suggested that this type of service configuration supported concentration of expertise and research in the field.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Specialist oesophago-gastric cancer multi-disciplinary team	**Organisation of services** NICE NG83 Recommendation 1.2.1 NICE NG83 Recommendation 1.2.2
Access to clinical nurse specialist (CNS)	**Information and support** NICE NG83 Recommendation 1.1.1
Centralisation of services	**Organisation of services** NICE NG83 Recommendation 1.2.3

Organisation of services

NICE NG83 – Recommendation 1.2.1

Review the treatment of people with confirmed oesophago-gastric cancer in a multidisciplinary meeting that includes an oncologist and specialist radiologist with an interest in oesophago-gastric cancer.

NICE NG83 – Recommendation 1.2.2

Review the treatment of people with confirmed localised, non-metastatic oesophago-gastric cancer in a specialist oesophago-gastric cancer multidisciplinary meeting.

NICE NG83 – Recommendation 1.2.3

Ensure curative oesophago-gastric resections are performed in a specialist surgical unit by specialist oesophago-gastric surgeons.

Information and support

NICE NG83 – Recommendation 1.1.1

Offer all people with oesophago-gastric cancer access to an oesophago-gastric clinical nurse specialist through the person's multidisciplinary team.

4.5.3 Current UK practice

Specialist multi-disciplinary team

The national audit of oesophago-gastric cancer (2017) reported that the cases of 86% of people with high grade dysplasia of the oesophagus were discussed in a sMDT meeting.[19]

Clinical nurse specialist (CNS)

The 2016 national cancer patient experience survey reported that 90% of respondents with an upper GI cancer said they were given the name of a clinical nurse specialist who would support them through their treatment. This is the same percentage quoted as the figure across all types of cancer.[20] 80% of respondents said that it had been 'very easy' or 'quite easy' to contact their CNS - lower than the figure for all types of cancer.

Centralisation of services

No published current practice studies were identified. This suggestion is based on the stakeholder's knowledge and experience.

4.4.5 Resource impact

No significant resource impact identified in the underpinning guidance.

[19] HQIP/RCS (2017) National oesophago-gastric cancer audit 2017, 9th report. London: HQIP [online; accessed 2 March 2018]
[20] Quality Health (2016) 6th Cancer patient experience survey 2016. London: Quality Health. Data tables/report. [online; accessed 16 April 2018]

4.5 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 08 May 2018.

4D CT planning

A stakeholder highlighted 4D CT planning as an area for quality improvement. This suggestion is not supported by any recommendations in the source guidance.

Access to clinical trials

Access to clinical trials for diagnostic and treatment technologies was highlighted as a quality improvement area. This suggestion has not been progressed. Helping people make informed choices about taking part in clinical trials is within the remit of the National Institute for Health Research.

Audits and registries

A stakeholder suggested that the quality and consistency of data collected for the national audit for oesophago-gastric cancer could be improved by applying standards for minimum data quality. It was also suggested that other data should be collected as part of the audit.

These suggestions have not been progressed. Participation in audit is a method by which quality improvement can be evidenced. Quality statements focus on actions that demonstrate high quality care or support, not the methods by which evidence is collated. However, audits, registries and suggested methods of data collection may be referred to in the data sources for quality measures.

Diagnosis of Barrett's oesophagus

The identification of Barrett's oesophagus, along with other complications of reflux and oesophago-gastric reflux disease are already covered by a statement relating to referral to a specialist service in the NICE quality standard on dyspepsia and gastro-oesophageal reflux disease in adults.

IMRT planning/delivery [Intensity-modulated radiation therapy]

A stakeholder highlighted IMRT planning/delivery as an area for quality improvement. This suggestion is not supported by any recommendations in the source guidance.

Nationwide funding for dietetic services

A stakeholder commented that the British Dietetic Association has flagged up the role of dieticians in preventing malnutrition, which is associated with mortality and morbidity in people with oesophago-gastric cancer, and comments that dietetic services should be funded nationwide. Recommendations about appropriate funding for services are beyond the remit of NICE.

New guidance

A stakeholder felt guidance on optimal functioning of MDTs should be developed. Additional guidance is outside of the remit of quality standards. Suggestions for additional guidance will be passed on to the NICE centre for guidelines.

Participation in a local cancer alliance

A stakeholder suggested highlighted participation in a cancer alliance as priority for quality improvement. This statement cannot be progressed because quality statements relate to the effectiveness of interventions.

Quality of gastroscopy [upper GI endoscopy]

A stakeholder highlighted the importance of high quality endoscopy which follow BSG guidelines (these are not accredited by NICE). This topic is already covered by NICE's quality standard on suspected cancer (QS124 - statement 2).

Quality of management of Barrett's oesophagus

A stakeholder highlighted the need to optimise surveillance, commenting specifically on the lack of risk stratification).

Communication of the risks of endoscopic surveillance are, as acknowledged by the stakeholder, covered by recommendations in NICE's guideline on Barrett's oesophagus: ablative therapy. NICE's guideline on gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management refers to communicating the need for life-long endoscopies to people diagnosed with Barrett's oesophagus. Reviewing evidence regarding the benefits and cost-effectiveness of interventions are beyond the scope of a quality standard.

Quality of survivorship services

A stakeholder highlighted quality and availability of survivorship services as an area for quality improvement. There are no recommendations in the source guidelines to support these suggestions.

Role of primary care

The role of primary care and educational support and advice for GPs and primary care professionals on symptoms of oesophago-gastric cancer and diagnostics was suggested as an area of quality improvement.

This suggestion has not been progressed. Quality statements focus on actions that demonstrate high quality care or support, not the education and advice that enables the actions to take place. The committee is therefore asked to consider which components of care and support would be improved by increased training. However, support for GPs and primary care professionals may be referred to in the audience descriptors.

Thickening powder to modify fluids

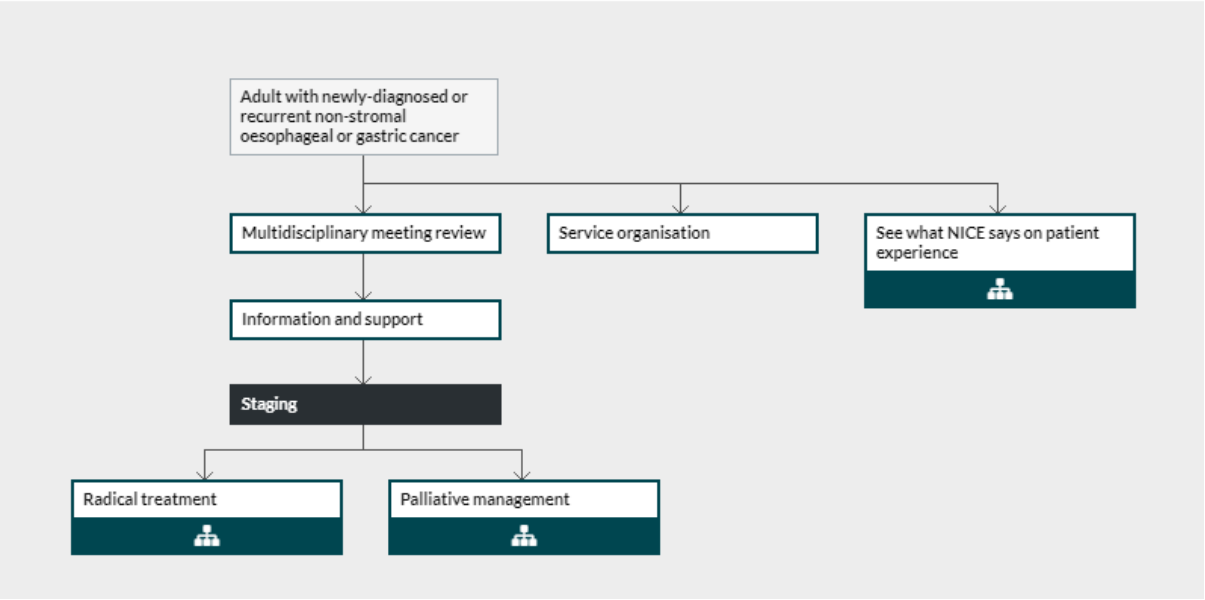
A stakeholder highlighted improving the safety of people with dysphagia using thickening powder to modify fluids in the context of training programmes (together with other contextual factors).

This suggestion has not been progressed. Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. The committee is therefore asked to consider which components of care and support would be improved by increased training. However, training may be referred to.

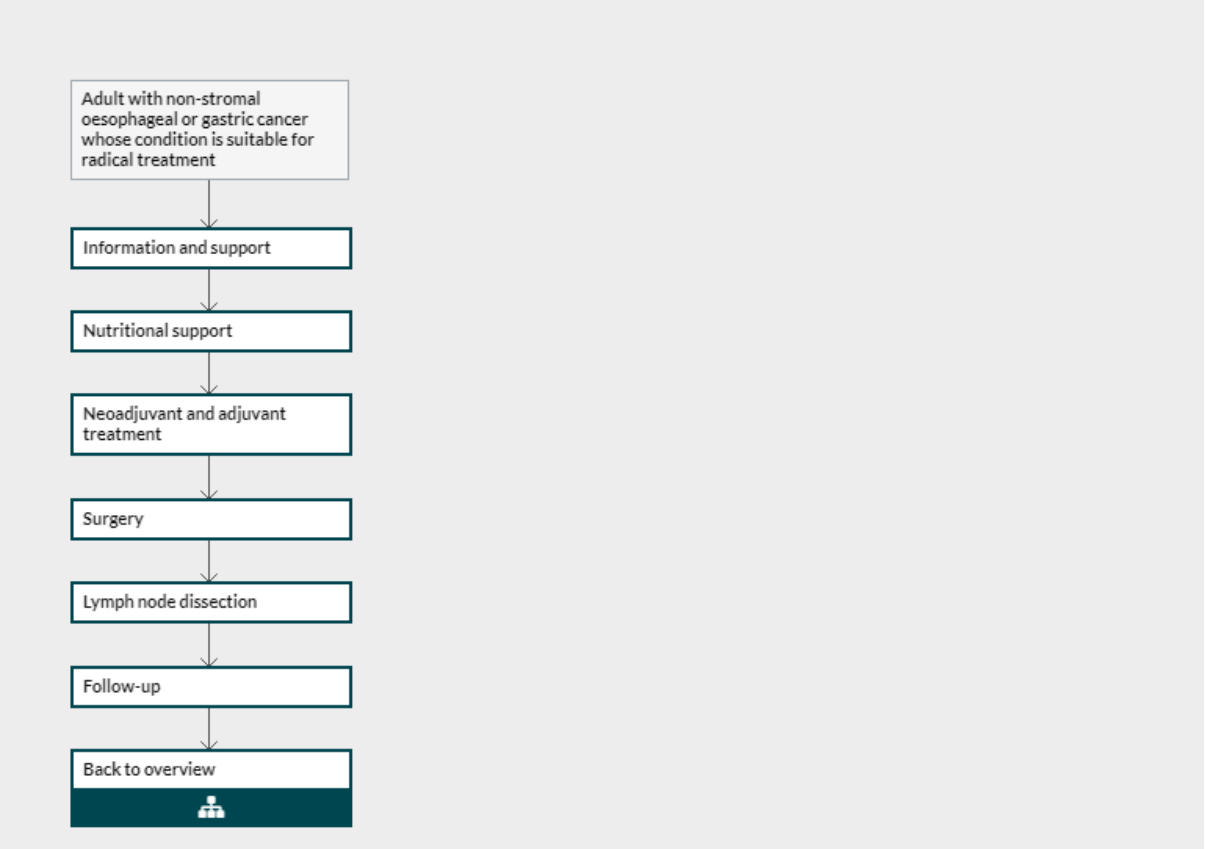
Appendix 1: Additional information

[NICE pathways for oesophageal and gastric cancer]

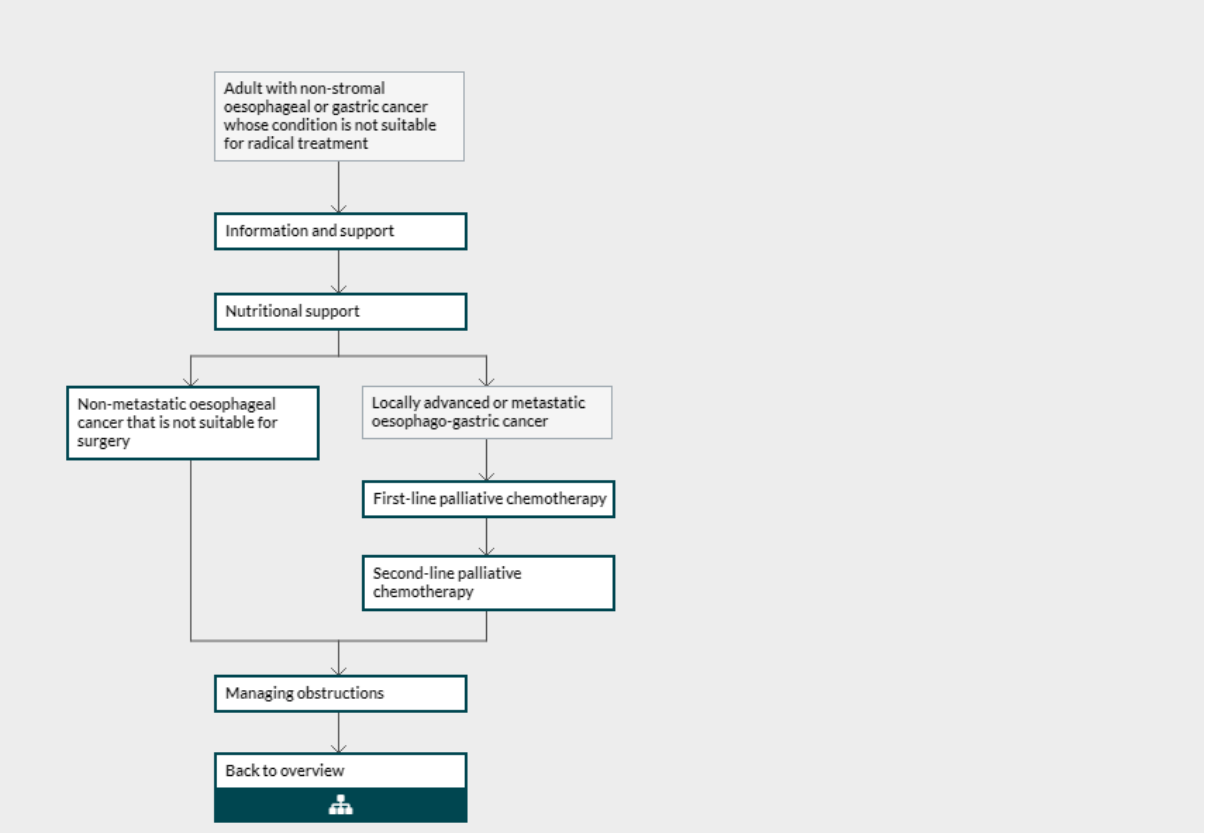
Oesophageal and gastric cancer overview



Radical treatment for people with oesophageal and gastric cancer



Palliative management for people with oesophageal and gastric cancer



Appendix 2: Key priorities for implementation

Recommendations that are key priorities for implementation in source guidelines and that have been referred to in the main body of this report are highlighted in grey.

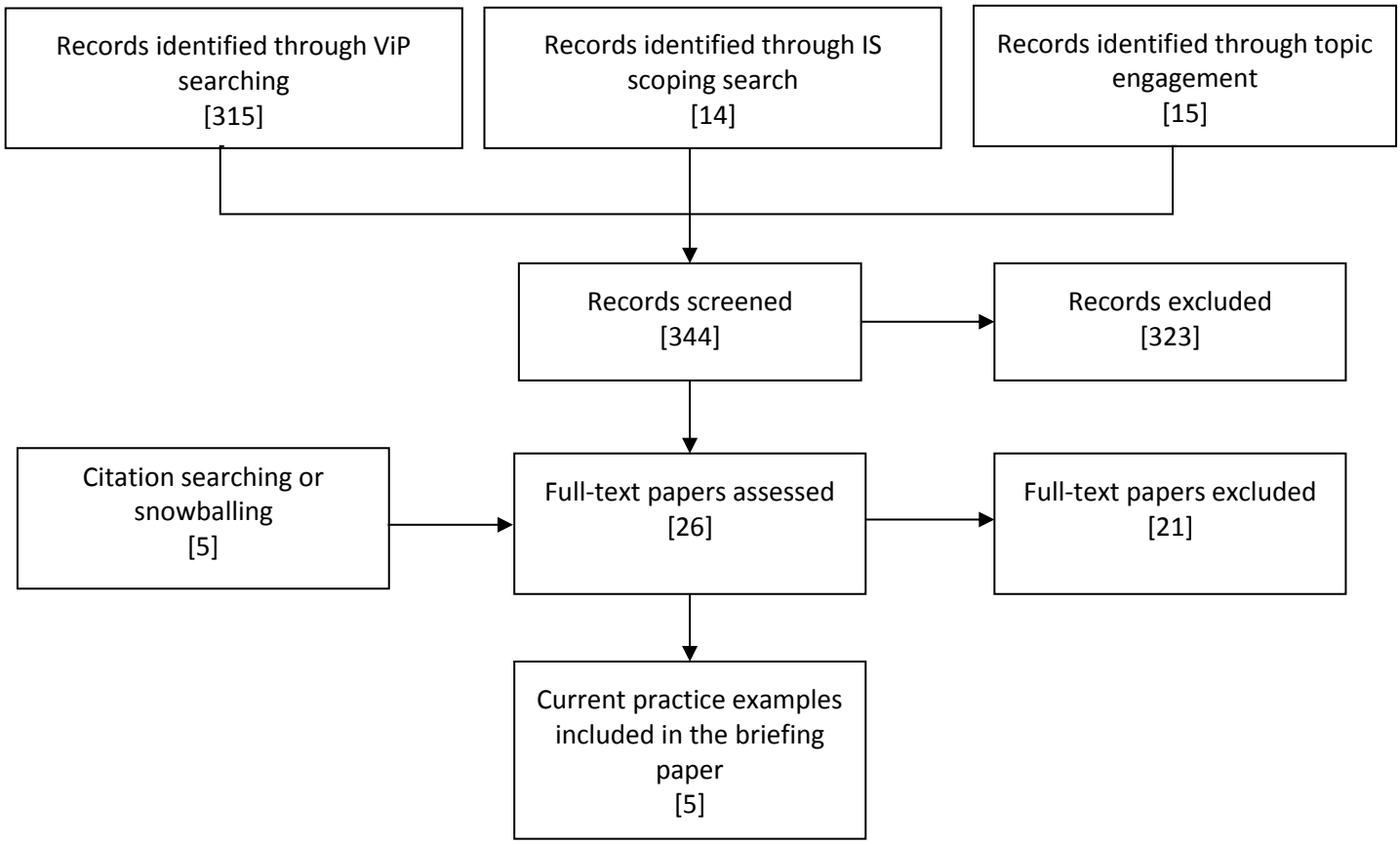
NICE CG184

Surveillance for people with Barrett's oesophagus

- Consider surveillance to check progression to cancer for people who have a diagnosis of Barrett's oesophagus (confirmed by endoscopy and histopathology), taking into account:
    - the presence of dysplasia (also see Barrett's oesophagus – ablative therapy [NICE clinical guideline 106])
    - the person's individual preference
    - the person's risk factors (for example, male gender, older age and the length of the Barrett's oesophagus segment).

Emphasise that the harms of endoscopic surveillance may outweigh the benefits in people who are at low risk of progression to cancer (for example, people with stable non-dysplastic Barrett's oesophagus). **[new 2014]** [recommendation 1.12]

Appendix 3: Review flowchart



Appendix 4: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Diagnosis and assessment					
001	SCM4	UGI symptoms referral practice	Significant change in referral mechanism for UGI symptoms; to extent that patients are no longer considered as part of the 2ww cancer referral pathway (unless presenting with an abdominal mass consistent with gastric cancer). Reluctance to implement shift from 2ww to urgent direct access. Test compliance to NICE 2015 guidance	Poor pick up rate of UGI cancer, and delayed referral. Cancer pathway creates 2-tier system for those diagnosed via 2ww and those that are incidental. Does implementation of NICE 2015, change this pick up rate / compliance with 62-day pathway. Existing quality standard, data collected in July 2015 (72% with urgent direct access) - this was likely to still be 2ww cancer pathway based.	Nicholson B D, Oke J L, Rose P W, and Mant D. (2016). Variation in direct access to tests to investigate cancer: A survey of english general practitioners. PLoS ONE, 11(7), pp.e0159725.
002	RCPSG	Early Diagnosis (e.g. % patients diagnosed after an emergency admission)	Early diagnosis may improve survival and patient experience. Patients can be diagnosed with oesophago-gastric cancer after following a number of different pathways. These include: referral from a general practitioner (GP),	The National Oesophago-Gastric Cancer Audit 2017 reports that 1/6 of patients are still diagnosed after an emergency hospital admission. These patients tend to have more advanced/later stage disease and are less likely to be suitable for curative surgery.	Please see The National Oesophago-Gastric Cancer Audit 2017: https://www.hqip.org.uk/public/cms/253/625/19/1023/NOGCA%20Annual%20Report%202017.pd

			diagnosis after an emergency admission, following referral by another hospital consultant from a non-emergency setting, or as a result of a surveillance gastroscopy. Improving awareness and increasing access to endoscopy for early diagnosis is key to improving patient outcomes.		f?realName=7rmpqc.pdf&v=0
003	RCS	Reducing the proportion of patients diagnosed after an emergency admission	Patients diagnosed after an emergency admission are less likely to have curative treatment	The National O-G cancer audit has found regional variation in rates, and reducing this event should improve outcomes.	Please see NOGCA audit report 2017 https://www.nogca.org.uk/reports/2017-annual-report/
004	RCS	Patients who have the cancer detected at stage 1-3	Patients diagnosed with stage 1-3 have a much greater chance of being selected for curative treatment	The National O-G cancer audit has found regional variation in rates of curative treatment.	Please see NOGCA audit report 2017 https://www.nogca.org.uk/reports/2017-annual-report/
005	AAH	Diagnosis of OG cancer at an early stage	The outcomes for patients diagnosed at an early stage are dramatically better than those diagnosed at later stages, as set out in the National OG Audit NOGCA.	There is variation amongst Cancer Alliances as to extent to which the cancer is diagnosed in time for curative therapy. Reducing mortality from current UK deaths of 7,600 is essential for progress on the Government's cancer strategy	% patients diagnosed with OG cancer as direct result of Barrett's Oesophagus surveillance programme. % patients diagnosed with Barrett's Oesophagus and later

					diagnosed with OG cancer outside Barrett's Oesophagus surveillance programme (missed cancers) No of patients diagnosed with high grade dysplasia (precursor condition for OG cancer)
006	RCPSG	Improved early diagnosis of oesophageal cancer related to Barrett's Oesophagus	…	No further information provided by the stakeholder.	No further information provided by the stakeholder.
007	SCM5	Key area for quality improvement 1	Diagnostic tests should be offered in the appropriate sequence and promptly. This especially applies to ensuring PET-CT is undertaken and reported prior to requesting / performing EUS [endoscopic ultrasound].	EUS is an invasive test usually requiring sedation. There is no logic in offering this test if a patient has distal metastatic disease on PET-CT. However, with the motivation to meet cancer targets these two tests are requested simultaneously in my region (Greater Manchester). Consequence can be patient's having an unnecessary EUS or attending for EUS with an unreported PET-CT that demonstrates metastatic disease and having to be informed in an endoscopy unit that they have incurable cancer making an EUS unjustifiable. Time based targets for cancer patients can have unfortunate outcomes. Ultimately need prompt access within a short time period to diagnostic tests, but availability of these resources can make this difficult; Patients with potentially curable oesophago-gastric cancer frequently get a	Essentially a resource issue (prompt access and reporting of investigations). These are investigations recommended by NICE guidelines. National Oesophago-Gastric Cancer Audit 2017 identified median time to from diagnosis to initiation of treatment being an area for improvement, with a requirement to address delays in the patient pathway (recommendation 3).

				large number of investigations (endoscopy, CT, PET-CT, EUS, laparoscopy, CPEX). This long chain of tests can make meeting targets difficult.	
008	SCM4	HER-2 screening in palliative treatment for metastatic disease	Availability of HER-2 testing not widespread across E&W	Cost effectiveness of trastuzumab for HER-2 positive metastatic gastric cancer. Prognostic indicator	NICE technology appraisal for the use of trastuzumab in metastatic OG cancer
009	NHSE	HER2 status availability	No further information supplied by the stakeholder		
Nutritional support					
010	SCM6	Specialised dietetic provision for all patients with OG cancer	No further information supplied by the stakeholder		
011	SCM4	Availability of nutritional assessment & tailored-Specialist Dietetic Support	Reduces risk of treatment & disease related morbidity and mortality. Not available currently for all specialist MDT	Tailored specialist dietetic support before, during and after radical treatment	No further information supplied by the stakeholder
012	AAH	Access to specialist dietician advice for oesophagectomy and gastrectomy	There are considerable digestive problems arising after oesophagectomy / gastrectomy which adversely affects patient quality of life, eg Swedish study: Impact of weight loss and eating difficulties on health-related quality of life up to 10 years after oesophagectomy for cancer P Anandavadivelan et al	The adverse digestive effects after oesophagectomy and gastrectomy play a significant effect in reducing quality of life for patients who are otherwise cured of cancer and who may sometimes express regret over their original cancer surgery because of digestive after-effects from their treatment. Insulin spikes and bacterial overgrowth are two examples of these problems	% patients undergoing oesophagectomy and/or gastrectomy referred to specialist dietician a) before surgery, b) after surgery and c) for those reporting digestive issues, follow-up appointments

			www.bjs.co.uk DOI:10.1002/bjs.10686	There are significant benefits in preparing patients with dietary advice before surgery This is a specialist area within dietetics.	
013	CORE	Nutritional support of oesophageal cancer patients	The condition and its treatment increase the risk of malnutrition in patients, which in turn can impact on mortality and morbidity.	BSG recommend dietetic input and nutritional support in the management of oesophageal cancer …	https://www.ncbi.nlm.nih.gov/pubmed/29016197 https://www.bsg.org.uk/resource/bsg-guidelines-for-the-management-of-oesophageal-and-gastric-cancer.html https://www.bda.uk.com/improvinghealth/healthprofessionals/malnutrition_policy_statement_2017
014	RCPSG	Improved patient access to nutritional … services.	In other areas this has been shown to improve quality of life	No further information supplied by the stakeholder.	
015	BDA	Specialist dietetic support for patients with OG cancer	Patients with OG cancer are at high risk of malnutrition because of the disease and treatment related factors. Malnutrition negatively impacts on treatment and patient related outcomes. The recent NICE OG cancer guideline (2018) recommends that patients with OG cancer undergoing curative treatment should be offered dietetic support. Dietetic support should be considered in patients with OG	Availability and quality of specialist dietetic support varies nationally.	In 2014 a workforce mapping was undertaken in allied health professionals working in OG cancer, which included dietetic support. This however, was only across South-West London http://www.londoncancerralliance.nhs.uk/media/8

			cancer receiving palliative treatment/care.		8180/ahp-mapping-and-workforce-requirement-report-2014.pdf
016	AAH	Access to specialist gastroenterological advice for those patients suffering significant unresolved chronic diarrhoea and other digestive problems +12 months after oesophagectomy and/or gastrectomy	Some patients suffer significant digestive problems as the result of surgically shortened digestive tract and long term changes to gut health from eg small intestine bacterial overgrowth	The work of Dr Jervoise Andreyev and colleagues at Royal Marsden Hospital illustrates the specialist and complex problems of long term after effects of cancer treatment on the digestive system, often many months after the cancer has been cured and surgical issues resolved. eg Managing gastrointestinal symptoms after cancer treatment: a practical approach for gastroenterologists Ann C Muls et al Frontline Gastroenterol. 2013 Jan;4(1):57-68. doi: 10.1136/flgastro-2012-100218. These problems can occur well after surgery and cancer-related issues have been resolved, but they are long term after-effects of cancer treatment affecting quality of life.	% of patients reporting chronic, unresolved digestive problems within 10 years after oesophagectomy and/or gastrectomy referred for specialist gastroenterological advice.
017	SCM3	People with Upper GI cancer should have a nutritional status /along with a tube assessment at diagnosis	Many people with cancer of the Upper GI tract lose a lot of weight as a result of the disease and its treatment; they often have difficulty eating. Assessing their nutritional status, including their need for a prophylactic tube, at the time of diagnosis will help to ensure adequate nutrition before, during and after treatment. This in turn will maximise the chances of people with cancer of the Upper GI tract to	Reducing chances of Malnutrition and preventing further weight loss will enable the people who have a diagnosis of Upper GI cancer to have the chance of receiving /curative /palliative treatment	Please see guidelines on Malnutrition and assessment/management of oesophageal/gastric cancers https://www.nice.org.uk/guidance/cg32 https://www.nice.org.uk/guidance/ng83

			access and aim to complete treatment.		
Management					
018	RCPSG	Standardised evidence based oncosurgical treatment of OG cancer	Standardised treatment and audit is likely to produce better outcomes	No further information supplied by the stakeholder.	No further information supplied by the stakeholder
019	SCM2	Patients with T1a N0 oesophageal adenocarcinoma … should be offered endoscopic therapy in preference to surgery	Prevents unnecessary surgery in most patients.	Reduces variation in clinical practice	See NICE (2010) guideline CG106 1.1.2 and compare with Oesophago-gastric cancer: assessment and management in adults (2018) NICE guideline 83 1.4.1
020	BSG/RCP	All patients with early neoplasia of the upper GI tract should be considered for curative organ-sparing endoscopic resection as per BSG guidelines on Barrett's oesophagus and European guidelines on endoscopic resection. All such cases should be discussed in a in a multidisciplinary meeting that includes an oncologist and specialist radiologist with an	No further information supplied by the stakeholder		

		interest in oesophago-gastric cancer			
021	RCPSG	Improved early diagnosis of oesophageal cancer related to Barrett's Oesophagus	…. Improved availability of appropriate endoscopic therapies for Barrett's dysplasia and T1a cancer.	No further information supplied by the stakeholder.	No further information supplied by the stakeholder.
022	AAH	Endoscopic therapy offered for patients diagnosed at early stages rather than oesophagectomy	Endoscopic therapy can sometimes remove cancer without the major effects of an oesophagectomy	There are good outcomes achievable for patients diagnosed with high grade dysplasia and T1 stage by means of endoscopic therapy (eg Radio Frequency Ablation; EMR) which can avoid the serious effects of more serious surgery ie oesophagectomy. Some endoscopic therapies appear not to be offered in some Cancer Alliances.	% patients diagnosed with T0 / high grade dysplasia and T1 oesophageal cancer assessed for endoscopic therapy. Availability of Radio Frequency Ablation equipment in all Cancer Alliances. All subject to proper clinical assessment of individual patient with proper available agreed choice of treatment
023	SCM2	Patients with T1b N0 oesophageal adenocarcinoma should all be discussed in a sMDT with stage and grade influencing management	Area of wide divergent practice and needs a clinical trial. Surgery v Endotherapy for T1b Role of neoadjuvant chemo if poor grade?	Best practice is debated	Oesophago-gastric cancer: assessment and management in adults (2018) NICE guideline 83

024	SCM2	Management of non-metastatic oesophageal squamous cell carcinoma	Currently patients may be offered chemoradiotherapy, neoadjuvant chemotherapy followed by surgery or chemoradiotherapy followed by surgery	Wide variation in clinical practice exists across and within region	Oesophago-gastric cancer: assessment and management in adults (2018) NICE guideline 83 do not recommend neoadjuvant chemo followed by surgery
025	SCM4	Uptake of definitive chemo-radiotherapy for treatment of SCC oesophageal cancer (age range)	Evidence suggests equivalence between CRT and surgery in oesophageal SCC. Limited more to frail, elderly	NICE (2018) – consider chemo-radiotherapy for people with non-metastatic oesophageal cancer that can be encompassed within a radiotherapy field (rec 32 [see full guideline p. 16]) [rec 1.5.1]	Cochrane Review (Best 2016) NOGCA
026	BSG/RCP	Reducing peri-operative morbidity – the role of minimal[ly] invasive approaches (laparoscopy, thoracoscopy)	No further information provided by the stakeholder.		
027	SCM4	Lymph node yield following oesophageal and gastric resection	Important for accurate staging and outcome predictor. Measure of quality of surgical resection	NICE recommendation for D2 lymphadenectomy for gastric cancer resection and two-field for oesophageal resection. Yield based not only on surgical operation but pathology standards (variation), such that analysis is based on staging rather than total LN harvest	NOGCA (2017) NICE (2018)
028	RCS	Patients having curative surgery are having adequate lymph nodes extracted	Adequate lymph node extraction is important for estimating prognosis and there is some evidence it improves survival	The National O-G cancer audit has found variation in the number of lymph nodes removed at the time of surgical resection.	Please see NOGCA audit report 2017 https://www.nogca.org.uk/reports/2017-annual-report/
029	SCM6	The management of non-metastatic oesophageal	No further information supplied by the stakeholder		

		cancer that is not suitable for surgery			
030	RCS	Regimens offered as first-line palliative combination chemotherapy to people with advanced oesophago-gastric cancer who have a performance status 0 to 2 and no significant comorbidities	There is reasonable evidence for NICE recommended regimens offer improved overall survival, with no difference in any reported treatment-related toxicity	The National O-G cancer audit has found regional variation in the regimens used for palliative chemotherapy.	Please see NOGCA audit report 2017 https://www.nogca.org.uk/reports/2017-annual-report/
031	RCPSG	Improved patient access to … palliative care services.	In other areas this has been shown to improve quality of life	No further information supplied by the stakeholder.	
Other forms of support					
032	SCM1	Raising awareness in patients post oesophagogastrectomy of the likelihood and dangers of the inhalation of gastric acid during sleep. Scarring of lung tissue caused by inhalation of gastric acid increases breathlessness.	Patient experience.	No further information provided by the stakeholder.	
033	BDA	Effective patient information	NICE OG cancer guidance 2018 recognises the importance of providing patients with information that is specific to their disease and their treatment. At present, there is no national standard on this and	Availability, quality and access to the necessary resources required for patients to be informed, counselled and educated on their disease and treatment.	Patients feedback – Oesophageal Patients Association

			often patients are provided with generic related to cancer.		
034	SCM3	People with suspected Upper GI cancer at the time of endoscopy should be contacted/met with a specialist cancer nurse	People at Endoscopy should be informed a cancer is suspected – local support groups (Upper GI cancer patients) state the time from endoscopy, until CT, MDT and outpatient's clinic appointment can be the most lonely, daunting time of their journey	…. Also, psychological support along with practical issues which will guide/assist the person through their journey.	...
035	SCM3	Specialist Cancer nurse follow up of people with Upper GI cancer	Many people following curative surgery/treatment recovery slowly and are physically/ psychologically/socially changed forever and adapting their lives requires support. People's fear of recurrence is big and the people feel they require routine CT's to check – having the specialist cancer nurse explain the rationales to reduce their anxieties will help.	… Providing support and guidance with their new social/physical/psychological adapted life can only aid their recovery …	Local support group findings – people's biggest fear is of "how to cope after surgery". Seek opinions of people who have had treatment/surgery on their discharge process and experience.
036	BDA	Survivorship for patients with OG cancer	The recent NICE OG cancer guideline (2018) recommends a movie away from follow up that focuses on solely disease recurrence surveillance, towards one aimed at restoring Quality of Life and promoting supported self-management. It is well recognised that patients following treatment for OG cancer (particularly surgery) have a significantly reduced quality of life.	… aims to restore QoL and promote supported self-management.	Patient feedback – Oesophageal Patients Association National Oesophagogastric cancer Audit

037	BSG/RCP	Quality of life after Oesophagos gastric resection (there are projects in Bristol and other centers)	No further information supplied by the stakeholder.		
Organisation of services					
038	SCM6	Provision of a specialised MDT for patients considered suitable for radical treatment of OG cancer	No further information provided by the stakeholder.		
039	SCM2	Patients with T1b N0 oesophageal adenocarcinoma should all be discussed in a sMDT with stage and grade influencing management	Area of wide divergent practice and needs a clinical trial. Surgery v Endotherapy for T1b Role of neoadjuvant chemo if poor grade?	Best practice is debated	Oesophago-gastric cancer: assessment and management in adults (2018) NICE guideline 83
040	SCM5	Key area for quality improvement 2	Improve quality of communication and functioning of specialist MDTs.	Ideally all individuals should be present in person and appropriately job planned to allow timely attendance. Often inadequate information about patients' general health available. Patients' desires regarding management options often not known. Guidance from NICE regarding optimal functioning of MDTs would be beneficial.	Issue not unique to oesophago-gastric cancer MDT, but given large number of diagnostic tests and treatments available, management of these patients is frequently complex. Often large number of patients makes for very lengthy meetings, especially with push for more centralisation of services.

					This is a resource and management issue. The Value of Multidisciplinary Team Meetings for Patients with Gastrointestinal Malignancies: A Systematic Review. Yara L. Basta,et al. Ann Surg Oncol. 2017; 24(9): 2669–2678.
041	BSG/RCP	All patients with early neoplasia of the upper GI tract should be considered for curative organ-sparing endoscopic resection …All such cases should be discussed in a in a multidisciplinary meeting that includes an oncologist and specialist radiologist with an interest in oesophago-gastric cancer	No further information provided by the stakeholder.		
042	SCM6	Provision of a specialised OG nurse for all patients with OG cancer	No further information provided by the stakeholder.		
043	SCM3	People with suspected Upper GI cancer at the time of endoscopy should	People at Endoscopy should be informed a cancer is suspected – local support groups (Upper GI cancer patients) state the time from	With early contact from a specialist will ensure symptom management is optimized along with the nutritional status. Also, psychological support along with practical	Please see guidelines on Malnutrition and assessment/management of

		be contacted/met with a specialist cancer nurse	endoscopy, until CT, MDT and outpatient's clinic appointment can be the most lonely, daunting time of their journey	issues which will guide/assist the person through their journey.	oesophageal/gastric cancers https://www.nice.org.uk/guidance/cg32 https://www.nice.org.uk/guidance/ng83
044	SCM3	Specialist Cancer nurse follow up of people with Upper GI cancer	Many people following curative surgery/treatment recovery slowly and are physically/ psychologically/socially changed forever and adapting their lives requires support…	… Local support groups/current practice – people following surgery feel lost after their "roller coaster journey". Providing support and guidance with their new social/physical/psychological adapted life can only aid their recovery …	Local support group findings – people's biggest fear is of "how to cope after surgery". Seek opinions of people who have had treatment/surgery on their discharge process and experience.
045	RCPSG	Centralisation of Specialist Oesophago-Gastric cancer services including endotherapy and Surgery.	This likely to concentrate expertise and research in the field to achieve best possible outcomes	No further information provided by the stakeholder.	
Additional areas					
046	NHSE	4D CT planning	No further information provided by the stakeholder.		
047	BSG/RCP	All patients should have access to currently running national trials of diagnostic … technologies	No further information provided by the stakeholder.		

048	RCS	Improve quality of routine data entry into national cancer datasets.	Minimum standards of data quality are required to assess the quality of care. Data quality indicator should include key patient characteristics such as TNM stage, and performance status.	The National O-G cancer audit has found variation in the quality of data submitted to it.	Please see NOGCA audit report 2017 https://www.nogca.org.uk/reports/2017-annual-report/
049	SCM4	Positive Resection Margins (longitudinal/circumferential for oesophageal/gastric resection)	CRM+ve adversely affects patient survival. LRM+ve implies poor surgical technique	NOGCA found wide variation in resection margin involvement across E&W. Poorer outcomes for CRM+ve patients. Longitudinal margin positivity suggests inappropriate/incorrect operation choice. Could be subdivided into longitudinal and CRM	NOGCA (2017)
050	RCPSG	Improved early diagnosis of oesophageal cancer related to Barrett's Oesophagus	… greater emphasis on Barrett's screening …	No further information provided by the stakeholder.	No further information provided by the stakeholder.
051	RCPSG	Improved early diagnosis of oesophageal cancer related to Barrett's Oesophagus	... greater emphasis on … registration of Barrett's dysplasia ….	No further information provided by the stakeholder.	No further information provided by the stakeholder.
052	NHSE	Availability of IMRT planning/delivery	No further information provided by the stakeholder.		
053	CORE	Nutritional support of oesophageal cancer patients	The condition and its treatment increase the risk of malnutrition in patients, which in turn can impact on mortality and morbidity.	…The BDA has flagged up … the need to fund dietetic services nationwide.	https://www.ncbi.nlm.nih.gov/pubmed/29016197 https://www.bsg.org.uk/resource/bsg-guidelines-for-the-management-of-oesophageal-and-gastric-cancer.html

					https://www.bda.uk.com/improvinghealth/healthprofessionals/malnutrition_policy_statement_2017
054	SCM5	Key area for quality improvement 2	Improve quality of communication and functioning of specialist MDTs.	Ideally all individuals should be present in person and appropriately job planned to allow timely attendance. Often inadequate information about patients' general health available. Patients' desires regarding management options often not known. Guidance from NICE regarding optimal functioning of MDTs would be beneficial.	Issue not unique to oesophago-gastric cancer MDT, but given large number of diagnostic tests and treatments available, management of these patients is frequently complex. Often large number of patients makes for very lengthy meetings, especially with push for more centralisation of services. This is a resource and management issue. The Value of Multidisciplinary Team Meetings for Patients with Gastrointestinal Malignancies: A Systematic Review. Yara L. Basta,et al. Ann

					Surg Oncol. 2017; 24(9): 2669–2678.
055	NHSE	Need to include reference to participating in the local cancer alliance …	No further information provided by the stakeholder.		
056	BSG/RCP	All patients referred with upper gastrointestinal symptoms under the suspected cancer pathway should have high quality gastroscopy as defined by the BSG I symptoms under the suspected cancer pathway should have high quality gastroscopy as defined by the BSG	No further information supplied by the stakeholder.		
057	CORE	Assessment and improvement of the service delivery and quality for patients with Barrett's Oesophagus (including surveillance, communication of risk, treatment, follow up)	There is some evidence that patients with Barrett's oesophagus might have received haphazard and inconsistent follow-up care.	The following questions relevant to service delivery were identified as a priority area by patients and health care professionals: • Should surveillance and new patient clinics for Barrett's oesophagus be done by a dedicated service (see Lancet paper reference to fourth priority)? How would this compare with existing standards of practice in the UK, and what effect would this have on patients (e.g., precancer diagnosis rates).	Please see the top ten priorities for patients and health professionals in BO and GORD: http://www.thelancet.com/journals/langas/article/PIIS2468-1253(17)30250-9/fulltext Lovat et al 2016: http://discovery.ucl.ac.uk/1527259/1/Frontline%20Gastroenterol-2016-Graham-316-22.pdf

				• What is the long-term effectiveness of endoscopic treatment (radiofrequency ablation) for precancerous Barrett's oesophagus or early cancers? How does this affect the need for future endoscopic surveillance in these patients? Is there a role for other methods such as cryoablation or argon plasma coagulation in these care pathways? • Is there a role for anti-reflux surgery to prevent Barrett's with no precancerous changes progressing or to prevent disease recurrence after endoscopic treatment for pre-cancer? Additionally, communication of patients' risk of cancer might not always be optimal, and some patients will search the internet for information that could portray the risk as much higher than it really is, which can lead to anxiety.	
058	CORE	Optimising surveillance of Barrett's Oesophagus (BO) to check for progression to cancer.	NICE recommends surveillance of people with confirmed BO (taking into consideration the presence of dysplasia, and the patient's risk factors and preferences). BO is increasing in incidence and is the main precursor of oesophageal adenocarcinoma. The cancer has poor prognosis, which can be improved with earlier detection.	The cost of endoscopy for BO surveillance is high and most cases of BO do not develop into cancer. NICE also notes that the harms of endoscopic surveillance may outweigh the benefits in people who are at low risk of progression to cancer needs to be emphasised. There is currently insufficient evidence to allow risk stratification of patients with BO, to optimise surveillance. Most patients will thus receive long-term surveillance with low	Please see the top ten priorities for patients and health professionals in BO and GORD: http://www.thelancet.com/journals/langas/article/PIIS2468-1253(17)30250-9/fulltext Lovat et al 2016: http://discovery.ucl.ac.uk/1527259/1/Frontline%

				evidence of efficacy. This might have an impact on patients and incurs a significant cost to the NHS. Individual risk stratification of patients with BO, the impact of the patient's genetic makeup, and the appropriateness of 'blanket' surveillance of all BO patients and the intervals and duration of surveillance have all been highlighted as areas of priority for patients and health professionals in a recent priority setting partnership (see evidence column).	20Gastroenterol-2016-Graham-316-22.pdf
059	BDA	Survivorship for patients with OG cancer	The recent NICE OG cancer guideline (2018) recommends a movie away from follow up that focuses on solely disease recurrence surveillance, towards one aimed at restoring Quality of Life and promoting supported self-management …	Availability and quality of the necessary services and resources required to provide a follow up model with aims to restore QoL and promote supported self-management.	Patient feedback – Oesophageal Patients Association National Oesophagogastric cancer Audit
060	NHSE	I would request that the guidance considers the opportunities for diagnosis and management of oesophago-gastric cancer within the context of the GP Forward View, New Models of Care and Integrated Care including social services.	No further information supplied by the stakeholder.		

061	NHSE	The quality standard needs to include advice to GPs & primary care professionals on when to suspect oesohago-gastric cancer, what diagnostics to use, and emphasis on early diagnosis and referral.	No further information provided by the stakeholder.		
062	NHSE	The standard should describe the role of primary care in the following areas of a person's cancer care pathway - psychological and mental health support - nutritional management and advice - pain management - terminal and palliative care	No further information supplied by the stakeholder.		
063	NHSE	The quality standard should not create unnecessary burden or unresourced work in primary care.	No further information supplied by the stakeholder.		
064	NHSI	Improving the safety of people with dysphagia	Whilst it is important that products remain accessible, all relevant staff need to be aware of potential risks	NHS Improvement Patient Safety identified that there is a significant risk of harm and death to patients in care homes and hospitals	NHS Improvement Patient Safety published a national Alert in 2015

		using thickening powder to modify fluids.	to patient safety. Appropriate storage and administration of thickening powder needs to be embedded within the wider context of protocols, bedside documentation, training programmes and access to expert advice required to safely manage all aspects of the care of individuals with dysphagia. Individualised risk assessment and care planning is required to ensure that vulnerable people are identified and protected	who had accidently ingested the thickening powder in its dry state	to support providers to make improvements to individual patient risk assessments. https://improvement.nhs.uk/documents/730/psa-thickening-agents.pdf
065	NHSE	Need to include reference to … adhering to the timed clinical pathway for O-g cancer when published by NHSE	No further information supplied by the stakeholder.		
066	RCN	Responded: *no comments to submit to inform on this topic engagement at this time.*			
067	CRUK	Responded: no comments to submit on this topic engagement exercise.			