NICE National Institute for Health and Care Excellence

Quality standards advisory committee 2 meeting

Date: 11 September 2018

Location: Holiday Inn Manchester City Centre, 25 Aytoun Street, Manchester, M1 3AE.

Morning session: oesophago-gastric cancer – review of stakeholder feedback

Minutes: draft

Attendees

Quality standards advisory committee 2 standing members:

Michael Rudolf (chair), Moyra Amess, Gillian Baird (vice-chair), Julie Clatworthy, Allison Duggal, Jean Gaffin, Corinne Moocarme, Jane Putsey, Hannah Critten, Mark Temple.

Specialist committee members:

Luke Williams, Jo Harvey, David Simpson

Topic: Oesophago-gastric cancer

NICE staff
Mark Minchin (MM), Rachel Gick (RG), Julie Kennedy (JK), Adam Storrow (AS), Jamie Jason (JJ) (notes)

Apologies James Crick, Steven Hajioff, Robyn Noonan, Michael Varrow

SCMs – Mark Harrison, David Exon, Robert Willert

1. Welcome, introductions objectives of the meeting
The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the meeting, which was to review stakeholder comments on the quality standard. The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow.
2. Confirmation of matter under discussion and declarations of interest
The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the morning session was the oesophago-gastric (OG) cancer. The Chair asked all members to declare verbally any interests that have arisen since the last meeting and all interests specifically related to the matters under discussion.
3. Minutes from the last meeting
The committee reviewed the minutes of the last QSAC 2 meeting held on 10 July 2018 and confirmed them as an accurate record.
4. QSAC updates
MM apologised for the half a day meeting and explained to committee that it was due to the NICE team allowing more time for the preparation of the care and support of people growing older with learning disabilities quality standard, in particular the recruitment of facilitators to help with the actual meeting.
5. Recap of prioritisation meeting and discussion of stakeholder feedback
RG provided a recap of the areas for quality improvement prioritised at the first QSAC meeting for potential inclusion in the OG cancer draft quality standard. RG summarised the significant themes from the stakeholder comments received on the OG cancer draft quality standard and referred the committee to the full set of stakeholder comments provided in the papers. The committee also discussed stakeholder comments about the focus being on people who have radical

treatment and concerns that this excludes most people with OG cancers. The specialist members confirmed that the quality standard does not exclude those for whom non-curative or palliative care will be necessary because most people will receive the care described in the statements before it can be confirmed that radical treatment is inappropriate. In terms of the delivery of palliative care specifically, the committee agreed that it is covered by a separate quality standard, End of life care for adults (QS13), so it is not necessary to cover it in the OG cancer quality standard as well. It was also agreed that a link to that quality standard can be added.

It was highlighted that diagnosis was covered in the suspected cancer quality standard (QS124).

It was agreed that the committee would consider the additional areas suggested in detail later in the meeting (section 5.2).

5.1 Discussion and agreement of amendments required to quality standard

Draft statement	Discussion
Draft statement 1: Organisation of services Adults with oesophago-gastric cancer have their treatment reviewed by a multidisciplinary team (MDT) that includes an oncologist and a specialist radiologist with an interest in oesophago-gastric cancer.	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team: The committee discussed concerns that highlighting specific roles suggests other members of the MDT are not important. The committee agreed that the statement/rationale text makes it clear that all roles are important. It was suggested including a definition of MDT membership would help emphasise this point. The committee agreed the area for quality improvement is an oncologist and radiologist reviews. The committee heard that these roles are sometimes covered colleagues in other specialties. It was noted that peer review measures include a list of core members/expected attendance rates. It was suggested that the word 'specialist' is moved in the statement in order to make apparent that both the oncologist and radiologist are specialists in OG cancer. Attendance rates (minimum of 60% was suggested), it was suggested, might define an oncologist/radiologist as having a 'specialist interest' in OG cancer. It was agreed that MDT attendance by a specialist oncologist/radiologist should be used in process measures. **ACTION: NICE team to amend statement wording to clarify that the oncologist is also specialist.** **ACTION: NICE team to add a definition for the MDT, using the IOG for core members and expert consensus for co-opted/access to other members.** **ACTION: NICE team to add attendance by radiologists/oncologists at MDTs as a measure.**
Draft statement 2: Diagnosis and assessment Adults with oesophageal or gastro-oesophageal junctional tumours (except T1a tumours) that are suitable for radical treatment have staging using 18	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team: The committee discussed the timeframe, and agreed that 1 week is appropriate. RG confirmed that NHS England have agreed to adopt the timescale NICE decides. The committee discussed that all cancer scans should be reported within this timescale, and it should be included in the

fluorodeoxyglucose positron emission tomography (F-18 FDG PET-CT).	statement. The committee discussed the impact of rewording the statement on the measures; it was suggested the denominator could be people for whom the scan is requested, the numerator being the number with results reported within 1 week. It was agreed that the timeframe would begin once the decision to request the scan is made. The committee felt 'suitable' for radical treatment implies the scan is performed to assess suitability. 'Potentially suitable' was suggested. The NICE team were asked to review this. The committee discussed the resource impact of the statement and adding a timeframe that isn't in the guideline. However specialist members pointed out that the numbers are relatively small, and also that the number of unnecessary endoscopic ultrasound (EUS) scans could be reduced. **ACTION: NICE team to review the phrase 'suitable for radical treatment', e.g. to 'potentially suitable for radical treatment.** **ACTION: NICE team to amend the process measure.** **ACTION: NICE team to make clear in the supporting information that the timescale starts once the decision to request the scan is made.**
Draft statement 3: Nutritional support Adults with oesophago-gastric cancer have tailored specialist dietetic support before and after radical treatment.	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team: The committee discussed the wording of the statement and noted that the source guideline recommendation states offer 'nutritional assessment' and 'tailored specialist dietetic support'. The committee agreed that it was the tailored specialist dietetic support that was the area for quality improvement. Using the term 'nutritional' support may imply the CNS delivers this support. The committee discussed whether the dietitian role could be specified but it was pointed out that the underpinning guidance does not specify the role involved for radical treatment. The committee considered how to measure the 'before' and 'after'. The committee discussed removing the option to offer a leaflet from the definitions; this could be the only intervention offered. It was agreed it is important that patients are seen face-to-face at their first consultation. It was agreed we should add to the rationale what specialist dietetic support includes. After discussing the resource impact of face-to-face consultations, it was agreed that the first one should be face-to-face but that for further meetings this may not be necessary. **ACTION: NICE team to amend the rationale to explain the importance of the dietitian role.** **ACTION: NICE team to review audience descriptors.** **ACTION: NICE team to explore adding a measure for face-to-face meetings.**

<table>
<tr><td></td><td></td></tr>
<tr><td>Draft statement 4: Organisation of services

Adults with oesophago-gastric cancer have access to an oesophago-gastric clinical nurse specialist.</td><td>The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team:

It was agreed that caseload and arrangements for cover would be very difficult to specify.

The committee discussed the different levels of interventions from clinical nurse specialists (CNSs), and whether this could include psychological support for example. It was also noted that statements about CNSs come up in other cancer topics.

The committee discussed the lack of CNSs in some areas, and that some cover multiple sites. It may be challenging to achieve the statement because of limited resources but that it is an important area for quality improvement.

The committee discussed how often the CNS sees patients and whether emphasise (in the supporting information) that they deliver support throughout the patient journey.

The committee discussed including additional process measures to strengthen the measurement of the statement.

The committee discussed whether the ordering of the statements should be revised; it was suggested that this statement becomes statement 1, to reflect the patient journey.

ACTION: NICE team to review order of the statements.

ACTION: NICE team to review the process measures.

ACTION: NICE team to review the audience descriptors.</td></tr>
<tr><td colspan="2">5.2 Additional quality improvement areas suggested by stakeholders at consultation</td></tr>
<tr><td colspan="2">The following areas were not progressed for inclusion in the final quality standard as the committee agreed that they were not a priority in relation to the quality improvement areas already included:

• Diagnosis: covered by the suspected cancer QS.
• Patient experience / quality of life through and beyond treatment using patient-reported outcome measures: quality of life used as outcomes for some statements.
• Psychological support: within the scope of statement 4.
• Systemic anti-cancer therapy (SACT) – safety: management of OG cancer was not prioritised.
• Service quality - radiotherapy for the radical treatment of oesophageal cancer using intensity modulated radiotherapy (IMRT): management of OG cancer was not prioritised.
• Therapeutic endoscopy for early-stage disease: management of OG cancer was not prioritised.
• Transfer and referral to a specialist MDT, with a suggested timescale of 14 days: covered by statement 1; timescales not stated in the source recommendation.

The chair discussed the reasons the additional statements have not been included.</td></tr>
<tr><td colspan="2">6. Resource impact and overarching outcomes</td></tr>
<tr><td colspan="2">The committee considered the resource impact of the quality standard. This was discussed during consideration of each statement.</td></tr>
</table>

The committee confirmed the overarching outcomes are those presented in the draft quality standard.

7. Equality and diversity

The committee agreed the following groups should be included in the equality and diversity considerations:

1. Age
2. Gender reassignment
3. Pregnancy and maternity
4. Religion or belief
5. Marriage and civil partnership
6. Disability
7. Sex
8. Race
9. Sexual orientation

It was agreed that the committee would continue to contribute suggestions as the quality standard was developed.

8. Any other business

The chair reported that Ruth Studley had resigned from QSAC 2 due to work commitments and that he had written to her to thank her for her contribution to the committee.

9. Close of meeting