Wales Cancer Network

Service Specification

Specification for tertiary oesophageal and gastric cancer services for people resident in Wales

December 2019

V1.0

Document information	
Document purpose	Service Specification
Document name	Specification for tertiary oesophageal and gastric cancer services for people resident in Wales
Author	NHS Wales Cancer Network
Publication date	24 September 2019 (Draft)
Version	0.67
Target audience	Chief Executives, Medical Directors, Directors of Finance, Directors of Nursing, Chief Operating Officers, Directors of Planning, Directors of Therapies and Health Sciences, Directors of Primary Care, Upper Gastrointestinal Multidisciplinary Teams, Tertiary Oesophago-Gastric Multidisciplinary Teams.
Description	NHS Wales Local Health Boards will routinely commission this tertiary service in accordance with the criteria described in this policy
Review Date	November 2022

Revision history

Date	Summary of Changes	Version
	Publication of document	1.0

Approvals

This document underwent the following approvals.

Group/Organisation	Date	Version
T&F Group	11/11/19	Final draft
NHS Wales Collaborative Executive Group		Final draft approved to become v1.0

Contents

Statement

This document has been developed to inform the commissioning of tertiary oesophageal and gastric cancer services.

In creating this document, the NHS Wales Cancer Network has reviewed the requirements and standards of care that are expected to deliver this service.

Disclaimer

Health Boards assume that healthcare professionals will use their clinical judgment, knowledge and expertise when deciding whether it is appropriate to apply this document.

This document may not be clinically appropriate for use in all situations and does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

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1. Introduction

This document has been developed as the recommended service specification to inform the delivery and commissioning of tertiary oesophageal and gastric cancer services for people resident in Wales. In setting the specification for tertiary services, it has been necessary to define linked areas of the pathway which are delivered by secondary care services.

These services are commissioned by the seven Health Boards in Wales.

1.1 Background

The patient pathway for oesophageal and gastric cancer is one of the most complicated of all cancer pathways, reflecting the role of local Upper Gastrointestinal (UGI) Multidisciplinary Teams (MDTs) and the tertiary Oesophageal and Gastric (OG) MDT, the complexity of patient assessment and treatment and the difficulties associated with advanced disease at presentation.

In Wales there were 427 newly diagnosed cases of oesophageal cancer in 2016 and 429 newly diagnosed cases of stomach cancer. Rates of cancers of the oesophagus and stomach amongst men are around twice as high as in women. The crude incidence rate in Wales for males is 280 per 100,000 for oesophageal cancer and 306 per 100,000 for stomach cancer. For females, the crude incidence rates are 147 and 123 per 100,000 for oesophageal and stomach cancer respectively. Net one year unstandardised survival estimates in Wales are 44% for oesophageal cancer and 41.5% for stomach cancer. Five year unstandardised survival estimates are 14.1% and 15% respectively (2012-2016)[1].

Further data from the International Cancer Benchmarking Partnership (ICBP) SURVMARK-2 study describes changes in cancer survival across seven comparable countries. This reports an improvement in both one and five year survival for oesophageal and gastric cancer over the past two decades in Wales but the absolute change in five year survival lags behind improvements seen in other high income countries, with one year survival for stomach cancer in Wales found to be below the UK average[2].

[1] All statistics sources from Wales Cancer Intelligence and Surveillance Unit publication: Data taken from https://publichealthwales.shinyapps.io/wcisu_cancer_survival_in_wales_1995-2016/

[2] Arnold M, et al, Progress in cancer control: survival, mortality and incidence in seven high-income countries 1995-2014, Lancet Oncology, (2019)

At a UK level, the proportion of OG cancer patients presenting through an emergency route has remained stable since 2012 at approximately 14%, although the average for Wales is higher[3].

1.2 Aims and objectives

The aim of this service specification is to define the essential requirements and standard of care that tertiary services are required to meet in order to deliver specialised oesophageal and gastric cancer care to people resident in Wales.

The objectives of this service specification are to:

- detail the specifications required to deliver tertiary oesophageal and gastric cancer services for people who are resident in Wales
- specify the minimum standards of care for the delivery of tertiary oesophageal and gastric cancer services
- ensure equitable access to tertiary oesophageal and gastric cancer services
- identify the minimum requirements that services must meet in order to provide services for Welsh patients
- improve outcomes for people with oesophageal and gastric cancer

1.3 The care pathway

The pathway from presentation to treatment is made up of a number of steps within both primary and secondary care. The National Optimal Pathways[4] (NOPs) for oesophageal and gastric cancer describe this pathway from the point of suspicion of cancer and include the referral routes, diagnosis and treatment steps based on best practice advice.

These include:

- Primary care (from point of suspicion of cancer)
- Secondary care (diagnostic process, staging and treatment)
- Tertiary Care (includes specialist diagnostic tests and treatment)

Services across these levels of care should comply with the National Optimal Pathways[4] for oesophageal and gastric cancer.

[3] "An audit of the care received by people with Oesophago-Gastric Cancer in England and Wales 2018 Annual Report ", NOGCA, available at: https://www.nogca.org.uk/content/uploads/2019/04/NOGCA-2018-Annual-Report-V2.pdf

[4] Published National Optimal Pathways are available at: http://www.cancerservicesdirectory.wales.nhs.uk/upper-gi-cancer-patient-pathways

Primary Care and referral

Local services should be available to meet the Consolidated Rules for Managing Cancer Waiting Times standard for referral for patients with suspected cancer. Patients should be referred in line with NICE referral guidelines for suspected cancer[5]. Services will include direct access for GPs to Upper gastro-intestinal endoscopy as well as outpatient appointments.

The diagnostic process

Patients should be referred into, diagnosed and staged by the Health Board team. This includes access to diagnostics including oesophago-gastroduodenoscopy (OGD) and biopsy and staging computerised tomography (CT) scan.

Positron emission tomography (PET)/CT scan should be offered to people with oesophageal or junctional tumours that are suitable for radical treatment and endoscopic ultrasound (EUS) and laparoscopy performed where they guide management[6].

Staging tests should be performed within the timelines described in the National Optimal Pathways.

All patients should be offered access to an appropriate clinical nurse specialist.

Support from a specialist cancer specific dietitian should be offered to patients and tailored to the clinical situation[6].

Other information and support should be offered in line with the National Optimal Pathways.

Secondary care

Patients diagnosed with OG cancer should be managed by a clinician with appropriate expertise.

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[5] Suspected cancer: recognition and referral NICE guideline [NG12] Published date: June 2015 available at https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#upper-gastrointestinal-tract-cancers

[6] https://www.nice.org.uk/guidance/ng83/resources/oesophagogastric-cancer-assessment-and-management-in-adults-pdf-1837693014469

Treatment should be reviewed in a local UGI MDT that includes an oncologist and specialist radiologist with an interest in oesophageal and gastric cancer[7].

Where the situation is clearly palliative, referral for palliative treatments and support services should not be delayed pending MDT review.

Treatments delivered locally include:

- Palliative endoscopic procedures including endoscopic stenting
- Palliative chemotherapy and radiotherapy
- Specialist palliative care
- Dietetic assessment and nutritional support, including nasogastric tube placement, gastrostomy or surgical jejunostomy placement
- Palliative radiotherapy
- Prehabilitation
- Health optimisation

About 75% of patients with oesophageal and gastric cancer have advanced disease at the time of diagnosis and will require palliative and non-surgical treatment such as chemotherapy, radiotherapy, endoscopic intervention and/or best supportive care. The benefits, risks and treatment consequences of each treatment option should be discussed with the person with oesophageal cancer and those who are important to them (as appropriate)[8].

Patients potentially suitable for curative pathway (those with confirmed localised, non-metastatic oesophageal and gastric cancer) should be discussed at the tertiary OG MDT.

Tertiary care

Tertiary care refers to specialist oesophageal and gastric cancer MDTs with the experience and facilities to deliver the treatments outlined below. These treatments and procedures should only be delivered under the care of a member(s) of the tertiary MDT:

- Treatment for high grade dysplasia and intramucosal cancer in Barrett's oesophagus including endoscopic mucosal resection (EMR) and endoscopic ablative therapies including radiofrequency ablation (RFA)[9].

[7] https://www.nice.org.uk/guidance/ng83/resources/oesophagogastric-cancer-assessment-and-management-in-adults-pdf-1837693014469
[8] https://www.nice.org.uk/guidance/ng83/resources/oesophagogastric-cancer-assessment-and-management-in-adults-pdf-1837693014469
[9] https://www.nice.org.uk/guidance/cg106/chapter/1-Guidance

- All tumour resection surgery, whether with curative or palliative intent. This includes:
  - Oesophagectomy – a surgical procedure to remove part or all of the oesophagus
  - Gastrectomy – a surgical procedure to remove part or all of the stomach

The following treatments should also be delivered under the care of a member of the tertiary MDT:

- Definitive Chemoradiotherapy (dCRT)
- Neoadjuvant chemotherapy/chemoradiotherapy
- Adjuvant chemotherapy/chemoradiotherapy
- Intraluminal radiotherapy

For selected patients, with early stage cancer, surgical resection offers the chance of long-term survival. The majority of patients with tumours suitable for surgery require multi-modality treatments, usually surgery and chemo/radiotherapy.

Definitive chemoradiotherapy (dCRT) is a treatment option for patients with squamous cell carcinoma of the oesophagus and for those with locally advanced inoperable adenocarcinoma of the oesophagus or those unfit for surgical resection. Patients should have the opportunity to discuss treatment options with both a surgeon and a clinical oncologist when making treatment decisions.

Some patients may have tumours suitable for treatment but are not 'fit' enough to receive it. There is increasing evidence that these patients should have prehabilitation and health optimisation in line with National Guidelines[10] as a matter of course to ensure they are offered the greatest chance of a curative procedure. This should be available as locally as practical and available.

Cardiopulmonary exercise testing should be the objective measure of fitness and should be delivered as locally as clinically possible.

1.4 Relationship with other documents

This document should be read in conjunction with the following documents:

[10] National Standards for Rehabilitation of Adult Cancer Patients, 2010, Welsh Government

- **WHSSC Commissioning Policy**
  - CP50 – Positron Emission Tomography (PET) Commissioning Policy
- **NICE Guidance and Clinical Knowledge Summaries**
  - National Institute for Health and Care Excellence (NICE) NG12: Referral for suspected gastrointestinal tract (upper) cancer
  - National Institute for Health and Care Excellence (NICE) NG83 Oesophago-gastric cancer: assessment and management in adults
  - National Institute for Health and Care Excellence (NICE) CG106 Barrett's oesophagus: ablative therapy
  - National Institute for Health and Care Excellence (NICE) TA208 Trastuzumab for the treatment of HER2-positive metastatic gastric cancer guidance
  - National Institute for Health and Care Excellence (NICE) CSG4 Improving supportive and palliative care for adults with cancer
  - National Institute for Health and Care Excellence (NICE) CG32 Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition
- **NHS Wales**
  - All Wales Policy: Making Decisions in Individual Patient Funding
  - Review of Upper Gastrointestinal Cancer services – South Wales Report, July 2017, Wales Cancer Network
  - Consolidated Rules for Managing Cancer Waiting Times, Welsh Government
  - National Optimal pathways for Oesophageal and Gastric Cancer
  - National Standards for Acute Oncology Services, June 2016, Wales Cancer Network
  - National Standards for Rehabilitation of Adult Cancer Patients, 2010, Welsh Government
  - Single Cancer Pathway Point of Suspicion Definitions, December 2018
  - Key workers for cancer patients (WHC 2014/001), 2014, Welsh Government
  - Palliative and end of life care delivery plan, 2017, Welsh Government
- **NHS England**
  - Improving Outcomes in Upper Gastro-intestinal Cancer – The Manual, January 2001, NHS Executive
  - B11/S/a Cancer: Oesophageal and Gastric (Adult) Service Specification

1.5 National and international service guidance

The following are National and International guidance from which this service specification has been drawn. However, it is important that detailed interventions for cancer patients across the cancer patient pathway should be specifically approved for support before mandating implementation in Wales.

- Guidelines for the management of oesophageal and gastric cancer, 2011, British Society of Gastroenterology
- National Oesophago-Gastric Cancer Audit, 2018, Clinical Audit and Registries Management Service
- Gastric Cancer: ESMO Clinical Practice Guidelines, 2016, European society for medical oncology
- National Standards for Rehabilitation of Adult Cancer Patients, 2010, Welsh Assembly Government
- Cancer rehabilitation pathways. Macmillan Cancer Support[11]
- Prehabilitation for people with cancer, 2019, Macmillan Cancer Support[12]

[11] These guidelines have not been formally adopted at the time of publication
[12] These guidelines have not been formally adopted at the time of publication

2. Service delivery

The aim of this service specification is to define the criteria that tertiary services are required to meet in order to deliver specialised oesophageal and gastric cancer care to people resident in Wales. Health Boards will commission oesophageal and gastric cancer services in accordance with the criteria outlined in this document.

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

The service is required to develop referral criteria, clinical protocols and diagnostic to treatment pathways, aligned to national best practice and guidelines. The service will input into the development of national criteria, protocols and pathways as part of the Wales Cancer Network Cancer Site Groups (CSGs) and will participate fully in the peer review programme and agreed national audit programmes.

The overall objectives of the services are:

- to provide an exemplary and comprehensive service, working across local and tertiary services, for all eligible referred patients with OG cancers
- to ensure endoscopic, radiological and pathological facilities are available in order to effectively diagnose, classify and effectively and consistently stage the condition prior to planning treatment
- to advise and undertake investigations to plan whether the patient is appropriate for radical or palliative approach and to provide high quality treatment of patients with oesophageal and gastric cancer
- to ensure the general health status (i.e. existing comorbidity, anaemia, lifestyle, functional capacity, nutritional status etc.) of all patients with suspected OG cancers are considered at the earliest possible time point in the pathway. Any risk identified is corrected with remedial interventions such as primary care led health optimisation and prehabilitation
- to ensure high quality supportive care and treatment for those patients not suitable for curative therapies
- to provide equity of access to clinical trials

- to carry out effective monitoring of patients to ensure that clinical treatment is safe and effective
- to provide care which promotes the optimal functioning and quality of life for that patient
- to provide appropriate follow-up & surveillance after definitive treatment
- to ensure that all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines and are monitored by objective audit
- to provide care with a patient and family centred focus to maximise the patient experience
- to support local healthcare providers to manage patients with OG cancer whenever it is safe to do so and clinically appropriate
- to provide high quality information for patients, families and carers in appropriate and accessible formats and media
- to ensure there is accurate and timely information given to the patient's General Practitioner
- to ensure that there is involvement of service users and carers in service development and review
- to ensure there is a commitment to continual service improvement
- to ensure compliance with peer review cancer measures
- to ensure compliance with Health Inspectorate Wales regulations

2.1 Access criteria

This service is for people aged 16 and over, with confirmed or suspected oesophageal or gastric cancer, requiring specialised intervention and management, as outlined within this specification.

2.2 Patient referrals

The service must manage all referrals within the cancer referral to treatment waiting time thresholds. In order to meet the 62 day waiting time standard on the Single Cancer[13] Pathway, rapid referral from the local UGI MDT and rapid decision making by the OG cancer MDTs is essential.

Referral to Health Board teams

A patient who presents with symptoms suggestive of upper gastrointestinal cancer should be referred following NICE guidance

[13] The Single Cancer Pathway specifies that patients should receive cancer diagnostic tests and start their treatment within 62 days from the very first point at which cancer might be suspected.

(NG12)[14] either Direct to test (DTT) endoscopy or to a team specialising in the management of upper gastrointestinal disease for triage prior to arranging investigation if direct to test not appropriate.

Referrals or requests for tests are accepted by a consultant gastroenterologist or upper gastro-intestinal surgeon.

If at endoscopy the patient has a high likelihood of a tumour they should follow the NOP diagnostic pathway to determine all tests and interventions required to fully stage the disease.

Those with confirmed localised non metastatic disease should be referred to the tertiary OG cancer MDT.

Referrals to the tertiary MDT

It is expected that the majority of referrals to the tertiary OG cancer MDT will be for planned/elective treatment with a minimum of emergency referrals.

Members of the local MDT will identify patients that are potentially suitable for curative treatment options and refer on to the tertiary service.

2.3 Population

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

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

2.4 Service description

Services must achieve specific quality standards and measures. The provider must also meet the standards as set out below.

[14] Suspected cancer: recognition and referral NICE guideline [NG12] Published date: June 2015 Available at: https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#upper-gastrointestinal-tract-cancers

OG cancer services meet the following criteria:

Person centred care

Services need to ensure that the patient centred care aspects of the National Optimal Pathways for oesophageal and gastric cancer are delivered.

All Health Boards should provide a key worker to patients on high suspicion of cancer and expedite pathways as quickly as possible from the date of suspicion.

Patients will be allocated a key worker around the time of diagnosis, if not before. This role should fulfil the criteria of the current key worker specification.

Each patient should be offered a holistic needs assessment (HNA) at identified intervals during their cancer pathway, from diagnosis to first definitive treatment as described in the National Optimal Pathways. HNA should also be offered at subsequent points during further treatment and/or palliative care. HNAs should be used to inform and develop a formal care plan which is shared with the patient and their care providers across care sectors. The key worker should ensure the results of patients' HNA are taken into account in the MDT decision making.

Each patient should have their multi-professional rehabilitation needs considered before, during and after treatment. These include nutrition, physical and emotional needs. Referral to local Allied Health Professionals (AHP) services should be made in a timely manner in order to meet these needs. This complies with the National Rehabilitation Standards for Wales[15].

Patients should be provided with information and given access to resources that adequately describe the diagnostic and staging interventions, particularly endoscopy.

Patients should have access to appropriate specialists and healthcare professionals to discuss all their potential treatment options.

Transitions between local and tertiary services

Transitions between local and tertiary services and between services should be planned, to ensure that they are continuous, seamless and

[15] National Standards for Rehabilitation of Adult Cancer Patients, 2010, Welsh Assembly Government

efficient. Clear communication between professionals is essential at these points.

The tertiary service must be able to access information from all of the participating Health Boards and clinicians and vice versa.

The roles of all members of the local UGI MDTs and tertiary OG cancer MDTs need to incorporate the education and development of generalists to support those affected by OG cancer.

Diagnostic tests

Endoscopy

Upper gastrointestinal endoscopy is a core diagnostic procedure for patients with symptoms of OG disease. The endoscopic services at both the local services and the tertiary service should be Joint Advisory Group (JAG) accredited.

Imaging and pathology

CT scanning is an essential element of assessing oesophageal and gastric cancers and should be available to local UGI MDT.

The tertiary OG cancer service should have access to diagnostic endoscopic ultrasound (EUS) (radial) as well as interventional (linear) EUS including Fine Needle Aspiration (FNA) and biopsy.

The wider service should have access to PET CT scanning. The service should agree imaging modalities and their specific indications.

The pathology services should comply with Clinical Pathology Accreditation (UK) Ltd (CPA)[16] and the Human Tissue Authority (HTA)[17].

HER2 testing should be available to people with metastatic oesophageal and gastric adenocarcinoma[18].

[16] CPA, the principle accrediting body of clinical pathology services and External Quality Assessment (EQA) Schemes in the UK. Modernising Pathology Services. Department of Health (2004)
[17] HTA Regulatory body for all matters concerning the removal, storage, use and disposal of human tissue. www.hta.gov.uk
[18] NICE Trastuzumab for the treatment of HER2-positive metastatic gastric cancer guidance [TA208] Published date: 24 November 2010 available at: https://www.nice.org.uk/guidance/ta208

Staging

The relevant (local UGI / tertiary OG cancer) MDT should discuss the patient for radiological and pathological correlation and agree the final diagnosis and stage of disease.

Treatment

Endoscopic treatment

Endoscopic therapies should be available for patients with earlier stage disease, including endoscopic resection and ablation therapies, particularly radiofrequency ablation. Any patient considered for endoscopic treatment should be discussed by the tertiary OG cancer MDT and the procedure be performed by experienced specialist endoscopist(s) who is a core member of the tertiary OG cancer MDT.

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

Local endoscopic services require the facilities and expertise to manage oesophageal cancer palliation and complication of treatments including oesophageal stent insertion, laser and/or APC and dilatation of benign post-radiotherapy strictures.

Surgery

OG cancer resection surgery should only be delivered in commissioned tertiary centres by teams of appropriately trained surgeons[19]. Patients should be cared for by clinical teams (nurses, allied health professionals, pharmacists, etc) that have specialist upper gastrointestinal expertise.

Access to minimally invasive approaches for oesophageal and gastric cancer surgery should be available for all clinically appropriate patients. Services should adhere to AUGIS Guidelines.

Complex elective and emergency OG surgery requires high dependency and intensive therapy facilities. Appropriate intensive care, high dependency facilities and specialist post-operative care (including dedicated 24/7 OG consultant surgeon rota) must be provided to minimise peri-operative mortality. The Association of Upper

[19] https://www.nice.org.uk/guidance/ng83/chapter/Recommendations#organisation-of-services

Gastrointestinal Surgeons of Great Britain and Northern Ireland (AUGIS) has published *Guidance on Minimum Surgeon Volumes*[20]*,* which includes the recommendation that an ".. ideal OG unit would therefore consist of 4-6 surgeons each carrying out a minimum of 15-20 resections per year serving a population of 1-2 million".

It is expected that all surgeons undertaking major resectional surgery must be an integral member of the tertiary OG cancer MDT, including any surgeons working on an in-reach basis. This means full engagement as a core member of the MDT, equal access to facilities, participation in the on-call rota, cross covering of patients and shared care of all patients. The outcome measurements for each unit should therefore reflect this practice and the in-reach surgeon's results considered together with all other members of that unit.

All surgeons undertaking major resections must participate fully in national audit and to undertake regular internal review in order to ensure the best possible clinical outcomes. Results should take into account the results of all participating surgeons as a whole, including surgeons working on an in-reach basis.

Chemotherapy and radiotherapy

The management of oesophageal and gastric cancer in both the curative and palliative setting often involves chemotherapy and/or radiotherapy. These treatments should be carried out at designated centres by appropriate specialists.

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

Mutual assistance between cancer centres should be explored to ensure adequate cover.

Acute oncology service

All hospitals with an Accident and Emergency (A&E) department should have an "acute oncology service" (AOS)[21], bringing together relevant staff from A&E, general medicine, haematology and clinical/medical oncology, oncology nursing, allied health professionals and oncology pharmacy. This will provide emergency care not only for cancer patients who develop

[20] Available at: https://www.augis.org/wp-content/uploads/2014/05/AUGIS_recommendations_on_Minimum_Volumes.pdf

[21] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/National%20Standards%20for%20Acute%20Oncology%20Services%2C%20June%202016.pdf National Standards for Acute Oncology Services

complications following anti-cancer treatment (ACT), but also for patients admitted suffering from the consequences of their cancer.

Supportive and palliative care

Services will give high quality supportive and palliative care in line with NICE guidance[22].

Once need has been identified patients who require palliative care will be referred to a palliative care team in the hospital and /or community by their GP, or any member of the local UGI MDT or the tertiary OG cancer MDT. Specialist palliative care advice will be available on a 24 hour, seven days a week basis.

End of life care

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

General health risk assessment and health optimisation

The general health status of a patient at presentation and during diagnosis and staging will affect their ability to undergo potentially curative treatment, adhere to treatments and also affects quality of life and survival.

Failure to address any health issues identified has the potential to negatively impact on the efficacy of treatment. All patients should have a general health screen as per NOPs (Making Every Contact Count recommend that this includes: anaemia, smoking and alcohol habits, review of comorbidity and screen for other morbidity etc.).

Rehabilitation

There should be appropriate assessment of patients' rehabilitative needs before, during and after treatment and the provider must ensure that high quality rehabilitation is provided in line with the network agreed rehabilitation pathway[23] and standards[24].

[22] https://www.nice.org.uk/guidance/csg4 Improving supportive and palliative care for adults with cancer
[23] Macmillan rehabilitation pathway available at: https://www.macmillan.org.uk/assets/macmillan-cancer-rehabilitation-pathways.pdf
[24] National Standards for Rehabilitation of Adult Cancer Patients, 2010, Welsh Assembly Government

Prehabilitation

Prehabilitation is a multidisciplinary pre-treatment rehabilitation programme, which aims to improve physical condition, nutritional status and emotional status.

Exercise should include endurance exercises such as walking, cycling, inspiratory muscle training and resistance training. Managing anxiety should be addressed by psychological counselling which can improve mood, improve adherence to treatments and the ability to cope with the rigours of treatment.

Nutrition

All patients with upper gastrointestinal disease are at risk of dietary problems and should have access to full dietetic inpatient and outpatient services.

Patients undergoing radical treatment should be offered nutritional assessment and tailored specialist dietetic support before, during and after radical treatments[25] [26]. Some will require immediate enteral or parenteral nutrition. Support from a specialist cancer-specific dietitian should be offered to people with oesophageal and gastric cancer receiving palliative treatment /care. This should be tailored to the person with oesophageal and gastric cancer and their clinical situation.

Outreach services

Patients increasingly have multiple medical conditions that require the input of a range of specialists. There are different ways these services can be provided, both within individual hospitals and between hospitals, by better clinical networking (involving service in-reach and out-reach which may include developing effective telemedicine links). This requires efficient coordination and cooperation between referrer and provider organisations to underpin agreed clinical models.

In addition to delivering services, outreach has an educational and service improvement role, raising awareness of existing services, research and best practice.

[25] https://www.nice.org.uk/guidance/cg32 Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition

[26] https://www.nice.org.uk/guidance/ng83/chapter/Recommendations#nutritional-support

Follow-up

The Improving Outcomes Guidance series of documents made recommendations on follow-up care. Providers will need to adhere to cancer specific guidelines for follow up agreed through the Oesophageal and Gastric Cancer Site Group and ensure patients have a follow up plan. The cancer specific guidelines will identify that some patients will need to continue receiving follow up the specialised service but it is expected the majority will be able to receive follow up locally. Rapid access to the oesophageal and gastric multidisciplinary team for review, if symptoms develop should be available.

The provider will need to ensure effective hand over of care and/or work collaboratively with other agencies to ensure patients have follow up plans appropriate to their needs. Immediate post-surgery follow up though is likely to be undertaken by the tertiary surgical team.

2.5 Interdependencies with other services or providers

The tertiary service provides a direct source of advice and support when other clinicians refer patients from local services.

The OG cancer MDTs also provide education within the NHS to raise and maintain awareness of upper gastro-intestinal cancer and their management.

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

2.6 Exclusion criteria

Patients under 16 years of age.

2.7 Acceptance criteria

The service outlined in this specification is for patients, aged 16 or over, ordinarily resident in Wales, or otherwise the commissioning responsibility of the NHS in Wales. This excludes patients who whilst resident in Wales, are registered with a GP practice in England, but includes patient's resident in England who are registered with a GP Practice in Wales.

Local UGI and tertiary OG cancer services are commissioned by Health Boards for their resident population. These services must be fully aware of the need for urgent referral and for awareness and early diagnosis initiatives as this will be the only way of increasing earlier stage disease at diagnosis to improve prognosis.

2.8 Care pathway

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

The tertiary service will ensure that:

- The tertiary OG cancer MDT plans treatment according to agreed treatment protocols for OG cancer at a weekly meeting. Individuals work together with the same aims and clinical understanding of the condition and its management to create a multidisciplinary approach. The team will ensure that:
    - All patients are discussed at a tertiary OG cancer MDT meeting.
    - All treatment options (surgical, non-surgical and palliative) are discussed for all patients.
    - All oesophageal and gastric surgery is carried out by the designated surgical teams.
    - Care plans are clearly documented in the notes and should be discussed with the referring service.
    - Patients are actively recruited to national clinical trials.
    - Audit of service provision is carried out and evidence developed to improve and enhance the delivery of the clinical care provided. All patients should be entered into the national oesophageal and gastric cancer audit.
    - All healthcare professionals involved have access to appropriate training in the management of patients with OG cancer.

Tertiary OG cancer MDT

There should be a single named lead clinician for the tertiary OG cancer MDT who should also be a core team member. The team should include the following core members:

Essential	Desirable
• A minimum of two surgeons. • Physician gastroenterologist – specialist endoscopist. • Clinical oncologist. • Medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncologist core member). • Anaesthetist/intensivist. • Histopathologist. • Image specialists (including a specialist gastro-intestinal radiologist). • OG nurse specialist. • Core member of the specialist palliative care team. • MDT co-ordinator / secretary. • Dietitian. • Prehabilitation and Optimisation team (including some of if not all of the following personal trainers, exercise physiologists, physiotherapists, dietitians, occupational therapists, anaesthetists, perioperative physician)	• Cytopathologist. • Core member of the specialist palliative care team.

Services are mandated to collect the all Wales Cancer Minimum Reporting Requirements, covering both core and tumour site specific data items to enable the appropriate national cancer reporting. This supports cancer registration, cancer clinical audits, cancer waiting times/single cancer pathway and quality outcome indicators for Wales.

The local and tertiary services are expected to monitor the following clinical outcomes:

- All Single Cancer Pathway Dataset items.
- All National Oesophago Gastric Cancer Audit (NOGCA) dataset items.
- Peer Review dataset

3. Quality and patient safety

Services must work to written quality standard and provide monitoring information to the lead commissioner. The quality management systems must be externally audited and accredited.

Services must enable the patients, carers and advocates informed participation and to be able to demonstrate this. Provision should be made for patients with communication difficulties.

3.1 Quality indicators (standards)

Services are required to:

- hold quarterly mortality and morbidity meetings
- participate in annual quality assurance
- participate in collection and submission of data into appropriate databases
- provide data to commissioners to support the assessment of compliance with the service specification

Services will be required to adopt the quality performance indicators recommended by the NHS Wales OG Cancer Site Group.

3.2 Other quality requirements

The tertiary OG cancer service will:

- Perform quarterly reviews of its functionality and performance.
- Use a recognised system to demonstrate service quality and standards.
- Use detailed clinical protocols setting out nationally (and local where appropriate) recognised good practice for each treatment site.
- participate in National Cancer Peer Review.
- Participate in the National Oesophago-Gastric Cancer Audit with a commitment to clinical ownership for the quality of submitted data and responding to the findings.
- Ensure that the quality system and its treatment protocols will be subject to regular clinical and management audit.
- Hold other meetings regularly on a quarterly basis to address clinical, service delivery and governance issues.
- Undertake regular patient surveys and develop and implement an action plan based on findings.
- Have appropriate resources in place to ensure pathways are seamless and timely and to aid the tracking of patients from

referral to treatment in order that clinicians can focus on supporting patients.
- Ensure patients have equitable access to high quality clinical research trials.

The above should form the basis of an annual report shared with Health Boards who refer to the service or participate in it.

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

Services must comply with the relevant NICE quality standards which defines clinical best practice.

4. Performance monitoring and information requirement

4.1 Performance monitoring

Health Boards will be responsible for commissioning services in line with this policy. This will include agreeing appropriate information and procedures to monitor the performance of organisations.

For the services defined in this policy the following approach will be adopted:

- Services to evidence quality and performance controls
- Services to evidence compliance with standards of care

The NHS Wales Cancer Network will conduct performance and quality reviews on an annual basis.

4.2 Key performance indicators

The providers will be expected to monitor against the full list of Quality Indicators derived from the service description components described in Sections 3.1 and 3.2.

The provider should also monitor the appropriateness of referrals into the service and provide regular feedback to referrers on inappropriate referrals, identifying any trends or potential educational needs.

4.3 Date of review

This document is scheduled for review before 2022, when we will check if any new evidence is available.

If an update is carried out the policy will remain extant until the revised policy is published.

5. Equality impact and assessment

The Equality Impact Assessment (EQIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable Health Boards to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re- assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity and language (Welsh).

This policy has been subjected to an Equality Impact Assessment.

The Assessment demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

6. Putting things right: raising a concern

6.1 Raising a concern

Whilst every effort has been made to ensure that decisions made under this policy are robust and appropriate for the patient group, it is acknowledged that there may be occasions when the patient or their representative are not happy with decisions made or the treatment provided.

The patient or their representative should be guided by the clinician, or the member of NHS staff with whom the concern is raised, to the appropriate arrangements for management of their concern.

If a patient or their representative is unhappy with the care provided during the treatment or the clinical decision to withdraw treatment provided under this policy, the patient and/or their representative should be guided to the LHB for NHS Putting Things Right. For services provided outside NHS Wales the patient or their representative should be guided to the NHS Trust Concerns Procedure, with a copy of the concern being sent to provider Health Board.

6.2 Individual patient funding request (IPFR)

If the patient does not meet the criteria for treatment as outlined in the service specification, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the IPFR Panel of the Local Health Board in which the patient is resident.

If an IPFR is declined by the Panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with the policy, arrangements can be made for an independent review of the process to be undertaken. The grounds for the review, which are detailed in the All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR), must be clearly stated.

If the patient wishes to be referred to a provider outside of the agreed pathway, an IPFR should be submitted to the Local Health Board in which the patient is resident.