Introduction to the LCA and Oesophago Gastric Cancer
A Way Forward

12th July 2013
Welcome and Introduction

Professor George Hanna
Chair, LCA Oesophago Gastric Pathway Group

– Welcome

– Purpose of the event

– Housekeeping
Agenda

9.00am - LCA, Vision, Structure, Progress - Prof Arnie Purushotham

9.15am - How can I make a difference - Dr Shelley Dolan

9.35am - OG – A National Perspective and Focus – Mr Bill Allum

10.00am - Data Collection and Metrics - Stephen Scott

10.20am - Future Challenges and Priorities – Prof George Hanna

10.50am - Round Table Discussion and Feedback - All

11.55am - Summary and close – Prof George Hanna
London Cancer Alliance – Vision, Structure and Progress

Professor Arnie Purushotham
LCA Clinical Director
London Cancer Alliance (LCA)

• The LCA was established in 2011 as the integrated cancer system across west and south London.

• We work collaboratively with 17 NHS provider organisations, including two academic health science centres, and the voluntary sector.

• We provide comprehensive, integrated cancer patient pathways and services within formal, governed structures to drive improvements in patient cancer outcomes and experience for the population we serve.
The 2 Integrated Cancer Systems:
London Cancer & London Cancer Cancer Alliance
Vision

To provide:
‘Equitable, world-class cancer care, health outcomes and patient experience for Londoners’

Delivered through:
‘Comprehensive and seamless pathways, based upon national and international standards, research, and evidence’.
The LCA is all of us

working together
London Cancer Alliance

Working with all 17 NHS provider organisations, the LCA has developed the following governance framework:
Governance Appointments December 2012

- Dr Neil Goodwin - Chair Members Board
- Dame Gill Morgan - Chair Clinical Board
- Prof Arnie Purushotham - Clinical Director
- Dr Shelley Dolan - Associate Clinical Director
Importance of Cross cutting groups

1. **Palliative Care**: Dr Nigel Sykes, Medical Director, St Christopher’s Hospice, Sydenham

2. **Radiotherapy**: Dr Peter Ostler, Clinical Oncologist, MVCC

3. **Patient Experience & Information**: Mairead Griffin GSTT/June Allen SGH

4. **Survivorship**: Natalie Doyle RMH & Mr Nick Hyde, SGH

5. **Mental Health and Psychological Medicine**: Prof Amanda-Jane Ramirez, KCL & Dr Andrew Hogkiss, GSTFT

6. **A.O.S.**: Dr Tom Newsom-Davis, Medical Oncologist, Chelsea & Westminster NHS Foundation Trust

7. **Chemotherapy closer to home and Medicines Optimisation**: Dr Jamie Ferguson, Public Health Consultant, KCL, GSTFT
LCA - Objectives

• Promote prevention/early detection by supporting GPs and influencing public health messages

• Ensure equitable access to excellent clinical care through integrated pathways across primary, secondary, tertiary, community and third sectors

• Provide local services where possible and centralised services where necessary

• Collaborate in world class research and innovation in cancer care raise the quality and profile of clinical education across the system

• Collaborate in world class research and innovation in cancer care

• Raise the profile and improve clinical education across the system
Improving Quality Across the LCA – our mission

The overarching objective of the LCA is to:

• Reduce variation standardise and improve quality of care, outcomes and experience for 4.8 million Londoners.

• Quality is everything that together ensures:

  Safe, Effective, Care and results in a positive patient experience.
Performance and Escalation

Quality Assurance

- LCA Quality Assurance Framework - focus on a core set of measures to provide a baseline assurance of the quality of services across the LCA
- Role of Clinical Board and Pathway Groups to identify general or service specific performance issues and escalate as appropriate

Escalation Protocol

- Escalation Protocol is the first statement of how performance issues relating to the quality of cancer services in the LCA will be addressed
- The LCA will offer support and work with the provider to develop an action plan which will include necessary actions, required resources and specified milestone dates
- Performance issues which cannot be resolved of which present a significant risk will be escalated to the Members Board
LCA - Priorities

- User strategy
- Increasing awareness and health promotion
- Early diagnosis
- Informatics
- Research
- Quality assurance framework
- Improving patient experience
- E – prescribing
- Compliance and how do we measure this
What would we like from you?

• Speak and act on behalf of the London Cancer Alliance
• Own the agenda
• Work effectively through the OG Pathway Group
• Deliver LCA programme across & through MDTs
• Focus on priorities
• Build strong relationships across LCA, share ideas
• Be proactive and responsive
• Be supportive, collegiate, influence & reason
• Please call Professor George Hanna, members of the Oesophago Gastric Pathway Group or Programme team to discuss issues anytime you need to
Questions
How Can I Make a Difference within the London Cancer Alliance

Dr Shelley Dolan
LCA Associate Clinical Director
Objectives: Be the Best you Can, Be the Best Teams across the LCA, Moral Imperative always to do better

- Improve Outcomes
- Reduce Unwanted variation
- Increase Safety
- Increase Effectiveness
- Improve the Patient Experience

**What does this mean for the person with OG Cancer?**
Improve Outcomes for OG Cancer

• Prevention – raising awareness / lifestyle
• Earlier diagnosis
• NAEDI Programmes
• LCA OG Awareness campaign
• Educational events across the pathway
  Primary Care secondary care tertiary care
Research: CTIMP, Radiotherapy / Surgery

• Potential research population 4.8 million
• Harmonised research applications across organisations
• MHRA / EMEA/ HRA: Multi-centre studies made easier / quicker
• Also Health Services Research – Implementation of ERP in OG, Critical Care Follow Up, Patient Experience, Early Diagnosis of sepsis
Reduce unwanted variation

- Harmonise guidance across all the secondary / tertiary care centres to ensure rapid assessment pre diagnosis but also at recurrence or problems.
- Coordinate the pathway especially when difficult events, stricture formation requiring dilatation, bleeds, sequela of complex major treatments.
Increase safety

• OG surgical outcomes ? to be published in the Autumn
• BUT actually its not just surgical safety:
  • LCA Quality Framework:
  • WHO Surgical Safety Safety Checklist
  • ISO 9001 Chemotherapy / radiotherapy
  • Reduction in Medication errors
  • Reduction in ITU days or avoidable returns to ITU
• Reduction in HCAIs
Statistics prove prescription drugs are 16,400% more deadly than terrorists

Tuesday, July 05, 2005 by: Jessica Fraser

America was rudely awakened to a new kind of danger on September 11, 2001: Terrorism. The attacks that day left 2,996 people dead, including the passengers on the four commercial airliners that were used as weapons. Many feel it was the most tragic day in U.S. history.

Four commercial jets crashed that day. But what if six jumbo jets crashed every day in the United States, claiming the lives of 783,936 people every year? That would certainly qualify as a massive tragedy, wouldn't it?
Prevention of HealthCare Associated Infections: Bench marking ourselves “Matching Michigan”
Funnel plots of mortality ratio - ICNARC (2011) model
Your unit compared to all other units last 3 months of available data

- Your unit, this period
- Other units

© ICNARC 2012
Improve Effectiveness: Reduction in LOS (safely)

Enhanced Recovery Programme:
• Careful and effective pre-assessment
• The walk shuttle test / CPX
• Psychological preparation – long pathway
• ERP joined up multi-professional care plan
• Effective discharge arrangements that have been planned before admission
• Reduce in LoS with no avoidable readmissions
Improve the Patient Experience
Michel Angelo Petrone: The fear and pain of cancer
Michel-Angelo Petrone: I’m confused, I’m lost as to which way to turn to – who to turn to?

The Maze of trees
I’m confused. I’m lost as to which way to turn – who to turn to. Before, everything seemed so clear. Now, which way to turn, which path to follow? Help me, please somebody. Show me the way.
Findings

• Over 8862 patient comments were analysed (5067 LCA; 3795 LC)

• 5332 were positive comments about patient experience (3053 LCA; 2279 LC)

• 3530 were comments for improvements (2014 LCA; 1516 LC)
Findings

1. Was there anything particularly good about your NHS cancer care?

• Quality of care

• Quality of professionals (knowledge, skills, manner)

• Speed and efficiency of getting treatment

• Quality of particular teams
Quality of care

All Trusts without exception had comments concerning how excellent the quality of care was. This was by far one of the largest categories.

‘Fantastic all round care’

‘Always felt listened to and valued’

‘Can’t praise enough – incredibly professional and excellent standards’

‘First class’

‘I felt special’

‘Treated with dignity and respect’

‘Seamless care – excellent’

‘I was treated with care and consideration’

• It does seem for the most part, that care was experienced as excellent by most of the patients regardless of tumour group.
Findings

2. Was there anything that could be improved?

Most frequent comments relate to:

• Waiting times
• Poor care
• Understaffing
• Poor communication
• Environment/hospital site
Findings

2. Was there anything that could be improved?

Other areas include:

- Delays in treatment
- GP and community
- Support
- Food
- Access to resources/clinicians
- Liaison between depts
- Parking
In Outpatient Departments (OPD), it seems that the average waiting time in clinics is up to 2 hours. Some of this was caused by clinics not starting on time and clinicians being late.

- You know its going to be bad when the clinic says its running an hour late and the doctor isn’t even there yet.

- Waiting time to see oncologist was, on average, 1.5 to 2 hours to be seen for 5 minutes and rushed through because they were behind schedule.
Poor care

The patient comments which were among the most worrying, especially in the light of the Francis Report (2013), were those concerning poor care and attitude.

- **My stay in hospital both times was a horrendous experience. I never want to stay in hospital ever again.**
- **Nurses - not very nice, not helpful and quite rude.**
- **Nurses and Doctors attitudes have got to be improved drastically.**
- **Some of the receptionists are a disgrace; they are rude and unhelpful and should not be the first port of call.**
- **I know it’s a training hospital but some doctors treat you as if you are a practice animal or slab of meat**
Understaffing

There were many comments relating to staff shortage, lack of permanent staff and the quality of agency staff.

- **Staff levels were poor especially at weekends! The nurses are not always caring. But I think they are overworked.**
- **It seems to me that nursing staff are often over stretched…I think more nursing staff are needed.**
- **There is a huge emotional/psychological side to cancer care which cannot be dealt with because of shortage of staff. There never seemed to be enough staff and those who were there worked flat out for long hours.**
- **There should be more regular nurses than bank nurses and agency nurses.**
Despite Advanced Communication Skills training being a requirement for Peer Review, there were many comments and examples of poor communication. Although some focused on diagnosis, there were examples given across the pathway.

- I was told my diagnosis via mobile voicemail!
- I would have like to have been told that I had cancer prior to being in the anaesthetic room
- Medical terminology needs to be translated so the ordinary person can understand
- Doctors and nurses spent little time in explaining ones illness and procedures
- When my daughter came there were never any doctors available and the nurse was either busy or had little information.
Quality of care; Speed of treatment; Quality of professionals;

Particular teams esp. Radiotherapy Chemotherapy

To be improved
All tumour groups
All (except Gynae)

Particularly Good
Gynaecology
Head & Neck
Lung
Colorectal
Upper GI
Haematology
Sarcoma
Brain/CNS

Waiting;
Understaffed;
Poor communication;
Access to Dr/CNS; Support;
Parking;
Food

Poor in-patient care
There were more comments about the 2011/12 National Cancer Patient Experience Survey itself.

- The questionnaire seems to presuppose a poor level of care completely at odds with our experience.
- I am fed up filling out questionnaires which don’t seem relevant to my experience.
- I want to spend my last time with my family so please no more surveys, thank you.
- The questionnaire is not really suitable for my experience.
- I have filled this out as far as I can but most of it doesn’t apply to me.
- This survey is too long (40-60 minutes). It needs to be shorter, online and not so general. Answers don’t always fit.

The comments do seem to indicate that the survey may need revising and adjusting.
Patient and Family Centred Care (PFCC) and Experience Based Co-Design (EBCD)

1. Understanding experiences:
   - shadowing patients
   - doing structured observations of care
   - interviewing and filming
2. Setting patient-based goals
3. Using driver diagrams to work out what to do
4. Measuring for improvement rather than judgment
5. Working groups of patients and staff make the changes using commonsense plus small tests of change
6. Celebrating success and starting again
Critical Care Follow Up survey: Questionnaire
(Pattison, Dolan et al 2009)

• Having the opportunity to talk about critical care
• Opportunity to discuss problems
• Able to ask unanswered questions
• Having the opportunity to visit CCU pre-operatively
• Being referred to other specialists

All participants benefited from having an outreach nurse visit on the ward at Day 1 and 5.
The Strength of the LCA

• You are all amazing Clinicians / Teams in your own right – however the strength of the LCA is what we can do Across Organisations / Across the pathway.

• Seize the opportunity

• Collaboration, Innovation, Research from prevention, diagnosis, treatment, rehabilitation, survivorship, palliative care, advanced care planning.
Michel –Angelo Petrone always recognised the strength of Clinicians and all who “Care”
Thank You for Listening
Any Questions
Oesophago-Gastric Cancer
- a National Perspective and Focus

William Allum
Chair
Oesophago-Gastric Clinical Reference Group
Aim of Presentation

- Organisation of specialised commissioning in NHS England
- Outline of aims and outputs of CRGs
- Overview of Governance Structure
- Overview of CRG membership, roles and responsibilities
- Outline of CRG products (outputs)
- Overview of CRG work programme
Maps / Geography of NHS
England
Geography of NHS England

- 10 Specialised Commissioning Hubs
- 12 Clinical Senate Areas / Strategic Clinical Network Areas
- There are 27 Area Teams
Specialised commissioning hubs

- North East, north Cumbria, and the Hambleton & Richmondshire districts of North Yorks
- Yorkshire & The Humber
- East Midlands
- Thames Valley and Wessex
- South West
- South East Coast
- East of England
- London
Clinical senates map

- North East, north Cumbria, and the Hambleton & Richmondshire districts of North Yorks
- Greater Manchester, Lancashire and south Cumbria
- Cheshire & Mersey
- East Midlands
- Thames Valley
- West Midlands
- East of England
- South West
- Wessex
- South East Coast
- London
# Local Area Teams

Population, number of CCGs and number of Health and Wellbeing Boards

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<th>Popn (1,000s)</th>
<th>CCGs</th>
<th>HWBs</th>
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**Total**

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Local Area Teams

- 27 Local Area Teams

- Core functions:
  - Primary Care,
  - Public Health including CCG development and assurance, and quality and safety.

- 10 LATs lead on contracting specialised services.
  - Setting priorities and strategic direction is done nationally
  - All contracting is through the ten LATs.
Local Area Teams (Specialised Commissioning)

- Cumbria, Northumberland, Tyne and Wear
- South Yorkshire and Bassetlaw
- Cheshire, Warrington and Wirral
- East Anglia
- Leicestershire and Lincolnshire
- Birmingham and Black Country
- Bristol, North Somerset and South Gloucestershire
- Wessex
- Surrey and Sussex
- London
Commissioning Specialised Services

- Responsibility of NHS England - £12bn budget for specialised services from April '13

- Specialised Services are ‘Directly Commissioned’
  - primary care, screening, military health & offender health

- Specialised Services were previously commissioned by multiple PCTs / Specialised Commissioning Groups - so significant variation in requirements & policies
Commissioning Specialised Services

• The specialised commissioning function of NHS England takes place at 3 levels:

  • **National** - National Clinical Director for Specialised Services within Medical Directorate and National coordinating team.

  • **Regional** – Regional Programme of Care Managers working as part of National Programme of Care – maintain balance between national consistency and local delivery.

  • **Area Teams** – 10 Area Teams have responsibility across England to contract and deliver national frameworks with local providers
Commissioning Specialised Services

5 Programme of Care:

• **Mental Health** (Secure and specialised mental health)

• **Internal Medicine** (Digestion, renal and hepatobiliary and circulatory system)

• **Cancer and Blood** (Infection, Cancer, Immunity and Haematology)

• **Trauma** (Traumatic Injury, Orthopaedics, Head and Neck and Rehabilitation)

• **Women & Children** (Women & children’s health, congenital and inherited diseases)
Clinical Reference Groups (CRGs)

- Specialised Services Clinical Reference Groups (CRGs) have been established to cover the full range of specialised services that are directly commissioned by NHS England.
- These groups will be leaders in developing the products required for the effective commissioning of specialised services.
- CRGs aim to ensure *clinical and patient led development and delivery of commissioning ‘products’.*
- Each CRG has an *identified ‘core’ set of products* to develop in 2013/14 with a *defined timeline* for completion.
CRG Membership

• 1 Clinical Chair
• 1 Accountable Commissioner
• 14 Clinical Members (1 from each Senate Area and 2 additional from London)
• 4 Patient and Carer Representatives
• 4 Affiliated Organisations

• National Clinical Director (where applicable)
• Access to public health and pharmacy expertise
• Registered list of stakeholders
<table>
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<th>Seat</th>
<th>Name</th>
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<tr>
<td>Chair</td>
<td>Bill Allum</td>
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<td>Sukhbir Ubhi</td>
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<td>Muntzer Mughal</td>
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Role of CRG Members…..

- Expert advice and guidance to develop and shape products
- Communication with wider professional groups
- Development and completion of specialised services during 2013/14.
- Horizon scanning, identifying and short-listing potential innovations within the relevant service area.
The Products

- **Scope** – Defining the scope of a given specialised service & setting out how best the specialised element of a service could be defined and quantified.
Scope for OG

- OG Cancer
- Complex Benign OG Services
- Gastro-paresis
The Products

- **Service Specification** - Forms part of the contract with each provider. Determines the key requirements of the service to be commissioned from the provider.

- **Commissioning Policy** – describes the healthcare treatment that the NHS proposes routinely to commission for a defined patient group with a particular illness within a defined financial year.
OG Cancer Service Specification

- Draft circulated end of 2012
- Draft available currently on line
- Revised Specification for 2013/14 contracting
- Annual review
OG Cancer Service Specification

- Service Outline
- Improving Outcomes based
- Peer Review Measures
- Links across the Patient Pathway
The Products

• Commissioning for Quality and Innovation (CQUINS)

• An incentive scheme which forms part of the contract between commissioner and provider.

• Links successful delivery of specific outcomes and actions with the release of an additional payment to the provider.
## Resident Population of Network (2009):

<table>
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<th>Level</th>
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<th>#</th>
<th>Indicator</th>
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<th>Cancer Network/()Specialist Centre</th>
<th>England</th>
<th>Trust rate or percentage compared to England</th>
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<td>Upper 95% confidence limit</td>
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### Cancer Network

#### Oesophago-Gastric cancer characteristics and survival

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### Stomach cancer characteristics and survival

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### Cancer Service Profiles for Oesophago-Gastric Cancer

Data displayed are for patients for which the trust of treatment can be identified. For a full description of the data and methods please refer to the ‘Data Definitions’ document. For advice on how to use the profiles and the consultation, please refer to ‘Profiles guidance’. Please direct comments/feedback to service.profiles@ncin.org.uk

Pan Birmingham CN - Heart of England NHS Foundation Trust
The Products

• Quality, Innovation, Productivity and Prevention (QIPP)

  • developing productivity and efficiency through a programme of clinically approved schemes

  • specific quality standards to be achieved for individual services.
The Products

- Innovation Portfolio

- Links to Research and Service Improvement
LCA OG Cancer Services

• Commissioned by London LAT

• Reflect Service Specification

• Links to CCGs
LCA OG Cancer Services

- Consider CQINS, QIPP and Quality measures
- Baseline audit of best practice
- Outcomes audit

- Research and Service Improvement
Conclusions

• Early days

• Process for 2014 starts in October 2013

• Evolutionary process
Questions
Data Collection and Metrics

For more information contact Stephen Scott, LCA senior cancer information analyst
stephenscott@nhs.net
Future Challenges and Priorities for the LCA Oesophago Gastric Cancer Services – How does this affect me

Professor George Hanna
Chair, LCA OG Pathway Group, Head of Division of Surgery, Imperial College London
Vision for LCA Oesophago Gastric Cancer

• An OG strategy where there is a single LCA OG cancer centre with multiple sites
• The single centre would have single:
  – clinical guidelines
  – operational policy
  – Morbidity and Mortality meetings
  – database
  – education/ training programme
  – strong research collaboration
Work Groups – Seeking your active involvement

- CNS
- Surgical
- Oncology
- Pathology
- Imaging
- Research
- Dietetics
- Palliative Care
- Early Diagnosis/Endoscopy
## CNS Challenges and Priorities

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Patient Experience</td>
<td>Maintaining a high quality of patient experience</td>
</tr>
<tr>
<td>Ensure provision of Holistic Needs Assessment document and treatment summaries</td>
<td>Lack of administration support and capacity to provide this new aspect of nursing care</td>
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<tr>
<td>CNS training needs</td>
<td>Current lack of specific training for upper GI senior nurses</td>
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<tr>
<td>Improving awareness of upper GI related emergencies and management</td>
<td>Ensuring all teams that may encounter these patients are aware of the correct pathways and specialist team contact details</td>
</tr>
</tbody>
</table>
Points for discussion

• Need to explore new ways of working to encompass health needs assessments

• E.g. Clinic space / telephone clinics / volunteer support

• Explore / research specialist nursing courses that are relevant to upper GI nursing

• Ensuring patient satisfaction survey is targeted to the evolving upper GI pathway and the challenges that patients face due to it’s complexity

• Implementation of awareness sessions / training days and dissemination of upper GI guidelines
## Surgery Challenges and Priorities

<table>
<thead>
<tr>
<th>Priorities</th>
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<tbody>
<tr>
<td>To provide a consistent surgical service across all three resection sites</td>
<td>Common guidelines</td>
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<tr>
<td>To deliver a comprehensive service for complex benign upper GI Surgery in addition to cancer resection and salvage surgery for failed resection</td>
<td>Different pathways exist for cancer and benign disease</td>
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<tr>
<td>To develop an out of hours service for complex upper GI surgery</td>
<td>? Shared rota</td>
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<tr>
<td>Joint research and audit</td>
<td>Already between GSTT and RMH</td>
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<td>Succession planning</td>
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</table>
Points for discussion

• Three sites or will there be pressure to reduce?
• Threat to complex benign and revisional surgery if not considered as integral to any cancer centre
• The effect on other services in an AHSC v specialist centre
• How can we work better together?
• Uncertainty and lack of certainty for the future
## Oncology Challenges and Priorities

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Standardised guidelines for chemotherapy</td>
<td>Standardise the supportive treatments related to chemotherapy administration</td>
</tr>
<tr>
<td>Identify potential SACT (Systemic Anticancer Therapy) pilots that can be</td>
<td>Understanding the current pathways and explore how they can be redesigned</td>
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<tr>
<td>delivered in a closer to home setting</td>
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<tr>
<td>Optimise equity of access to CDF</td>
<td>Explore issues around funding, commissioning and clinicians choice of therapy</td>
</tr>
<tr>
<td>Map access to specialised RT services</td>
<td>Allowing equal access to SBRT, IMRT, IGRT and brachytherapy</td>
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</tbody>
</table>
Points for discussion

- Understanding current pathways and what needs to change or be standardised.
- Share best practice and improve patient care
- Ensure an evidence based service
- Being involved in the pathway design
- Ensure submission into the SACT dataset
# Pathology Challenges and Priorities

<table>
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<th>Priorities</th>
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<tbody>
<tr>
<td>Audit of workload</td>
<td>Acquiring adequate resources (including exploring BMS cut up)</td>
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<tr>
<td>Audit of lymph node yields</td>
<td>Improving lymph node yields</td>
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<tr>
<td>Improving the process of reviewing slides for MDTs</td>
<td>Setting up a digital network</td>
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<td>Adoption of TNM 7 - clarification of definitions</td>
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</table>
Points for discussion

• Sharing experience and expertise of other pathologists
• Potential for improving the standards of OG Cancer pathology
• Potential for improving the efficiency of the LCA OG Cancer service
# Imaging Challenges and Priorities

<table>
<thead>
<tr>
<th>Priorities</th>
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<tbody>
<tr>
<td>Reporting Radiologists to use standardised proforma when reporting the initial staging of suspected Gastric Cancer, to facilitate data collection within the LCA</td>
<td>Reducing reporting variation</td>
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<tr>
<td>Waiting time for imaging</td>
<td>Reviewing demand and capacity</td>
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Points for discussion

• Being involved in the pathway design
• Implementation of best practice protocols and guidelines
• Have the capacity to reduce waiting time
## Dietetics Challenges and Priorities

<table>
<thead>
<tr>
<th>Priorities</th>
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<tbody>
<tr>
<td>Develop an LCA wide OG dietetic referral criteria</td>
<td>• Developing referral practices based on need rather than available support  &lt;br&gt;• Develop and undertake audit nationally to inform robust referral criteria</td>
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</tbody>
</table>
Points for discussion

There is a recognition by the LCA OG Pathway Group that more dietetic support is needed – this needs to be substantiated by clearly defining the role of nutrition across the entire pathway

We need your support and involvement:

• Opportunity to share best practice and improve patient care
• Opportunity to develop an evidence based service
• Opportunity to drive research in areas where a lack of evidence exists
• Opportunity to improve collaborative working, training & education between centre/unit/community dieticians
• Opportunity to enhance collaborative working amongst the multidisciplinary team, both clinically and through research
**Palliative Care Priorities and Challenges**

<table>
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<tbody>
<tr>
<td>Timely referral to specialist palliative care services</td>
<td>Engagement of professionals LCA wide</td>
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<tr>
<td>Timely management of dysphagia</td>
<td>Engagement of individual Trusts within LCA</td>
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<tr>
<td>Education – professionals &amp; patients</td>
<td>Engagement of community workforce</td>
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<td>Specialist knowledge</td>
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</table>
Points for discussion

• Involvement in audit across LCA and at individual trust level
• Improving communication with local community workers
• Increasing awareness of different needs of palliative care patients
• Education of others as to specialist needs of OG patient group
# Early Diagnosis Challenges and Priorities

<table>
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<tbody>
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<td>Gastroscopy Strategy</td>
<td>Demand and capacity</td>
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<tr>
<td>Improve early awareness</td>
<td>Poor ‘alarm’ symptoms</td>
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<tr>
<td>- Public</td>
<td>Developing partner organisation relationships to help deliver awareness programs</td>
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<td>- Primary Care</td>
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<tr>
<td>Appropriate use of 2WW referrals</td>
<td>Population – transient, SES</td>
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<tr>
<td>Primary care education and training</td>
<td>Encouraging engagement and attendance</td>
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<tr>
<td>Requirement for endoscopic therapy in the early cancer management</td>
<td>Lack of capacity and expertise</td>
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<tr>
<td>Improved procedure technique</td>
<td>Lack of endoscopy capacity</td>
</tr>
<tr>
<td>Improved reporting</td>
<td>Inappropriate procedures</td>
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</table>
Press release

Poorer outcomes for oesophageal and gastric cancer linked to ‘huge variation’ in endoscopy referral rates between GP practices

Organisation: Public Health England
Published: 13 June 2013
Policy: Helping more people survive cancer

Patients from GP practices with low endoscopy referral rates are at increased risk of poor outcomes from oesophageal and gastric cancers.
Points for discussion

• Developing closer links and joint strategies with your primary care colleagues
  – How do we engage our GP colleagues?

• Be involved in the planning and design of referral criteria and new pathways
  – How do we triage?
  – How do we examine?
  – How do we report?
  – How do we audit?

• Available to deliver educational seminars
Questions
The London Cancer Alliance West and South

Round Table Discussion

Your group task is to identify or progress the top 3 Key Priorities for the management of Oesophago Gastric Cancer in 2013/14

<table>
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<th>Facilitator</th>
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<td>Prof Bob Mason</td>
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<td>Dr Mark Harrison</td>
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<td>Prof Robert Goldin</td>
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<td>Nisha Shaunak</td>
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<td>9</td>
<td>GP/Primary Care</td>
<td>Pre-seated table in Cornwall</td>
<td>Prof George Hanna</td>
</tr>
<tr>
<td>10</td>
<td>Managers</td>
<td>Crown</td>
<td>Amy Sherman</td>
</tr>
</tbody>
</table>
Round Table Feedback

Top 3 priorities from each group
Summary and Close

- Round table feedback will be written up and circulated
- Complete feedback forms
- Certificates available on exit

Thank you for your valuable contribution