Northern England
Strategic Clinical Networks

Oesophago-Gastric (OG) NSSG

Annual Report 2015

Document Information

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This Annual Report has been agreed by:

Position:	OG NSSG Chair
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Organisation:	Newcastle Hospitals NHS FT
Date Agreed:	26.06.15

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Date Agreed	26.06.15

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NSSG members agreed the Annual Report on:	
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1 Introduction

This report relates to the operational period January to December 2014. This period has seen a number of issues, challenges and successes as outlined in this report.

The OG NSSG met twice during 2014, February and June. The group also held a very successful 12th annual audit event in November 2014 which showcased activity and performance across the Network.

The group continues to be pre-eminent in raising public awareness for oesophageal and gastric cancers. The Northern Oesophago-Gastric Cancer Unit held its Cancer Awareness Week in May 2014 and various events and publicity took place around the North East. A national awareness campaign was scheduled for February 2015 and its impact on referrals and diagnoses will be considered in later reports.

2 Key Challenges

- To continue to advance the case for early diagnosis of OG cancer through public awareness and education
- To provide access and resources for the adoption of new treatment modalities such as radio-frequency ablation for Barrett's oesophagus
- To improve recruitment to clinical trials across the region
- To maintain the high volume and excellent outcomes at both central multi-disciplinary teams (MDTs)
- To share best practice to bring diagnosis and treatments within target waiting times.
- To continue to comply with requests for clinical outcomes data by HQIP following on from the launch of this processes in 2013.

3 Key Achievements

- Dr John Painter has been appointed as Vice-Chair OG NSSG from 2014.
- Northern Oesophago-Gastric Unit in collaboration with the Network continue to run a very successful public awareness campaign
- Well attended audit day with positive feedback from delegates
- Clinical outcome data from surgical resection for OG cancer for the two units and for the individual surgeons has been collected from the National OG Cancer Audit, verified by the units and released to the public by HQIP in October 2014. The data demonstrates some of the highest volumes and best results in the UK.
- Audit of surgical complications and inoperability has been completed and presented at the annual audit day
- The review of the cancer waiting times audit has proved very useful and will be repeated annually
- In response to concerns regarding delays in HER2 status reporting, there was a Network wide audit on waiting times and pathology pathways which has resulted in an improvement in reporting times

4 14-1C-103f, NSSG Meetings

The group has met twice during 2014 and also had an audit day on 6 November 2014.

A full breakdown of NSSG attendance for the year is included in Appendix 1.

5 Activity Overview / Waiting Times

Data is derived from Open Exeter Waiting Times System. Cancer Waiting Times data is extracted from Open Exeter report data, which presents a snapshot of activity within a given time period. Treatments data is extracted from the active cancer waiting times database and therefore may not correspond exactly with reported data, due to amendments entered after report generation. Treatments data is for OG cancers while performance data is for all Upper Gastrointestinal Cancers as defined by Cancer Waiting Times.

Treatment Summaries for OG Cancers (ICD Codes C15-C16): January – December 2014

First Treatments – by Quarter: January – December 2014

	First Treatments						
	NESCN - All Trusts						
	Surgery	Drugs	Radiotherapy	Palliative	Other	Total	All Treatment Declined
Jan-Mar	38	79	29	42	1	189	0
Apr-Jun	42	69	33	40	0	184	0
Jul-Sep	58	74	33	44	1	210	0
Oct-Dec	55	60	31	35	1	182	0
Totals	193	282	126	161	3	765	0

Subsequent Treatments – by Quarter: January – December 2014

	Subsequent Treatments						
	NESCN - All Trusts						
	Surgery	Drugs	Radiotherapy	Palliative	Other	Total	All Treatment Declined
Jan-Mar	45	32	45	3	1	126	0
Apr-Jun	46	53	48	3	1	151	0
Jul-Sep	38	44	50	6	1	139	0
Oct-Dec	45	34	47	7	0	133	0
Totals	174	163	190	19	3	549	0

Cancer Waiting Times Performance – Upper Gastrointestinal 2014 by Trust

Performance – 14 Day Standard – GP referrals for suspected cancer

Upper GI	Total Referrals	Seen in 14 Days	Breaches (seen > 14 days)	Performance %
South Tyneside FT	702	667	35	95.0
City Hospitals Sunderland FT	1328	1180	148	88.9
University Hospitals of North Cumbria	1290	1244	46	96.4
Gateshead Health Care FT	1253	1127	126	89.9
The Newcastle Hospitals FT	1943	1801	142	92.7
Northumbria Healthcare FT	2337	2173	164	93.0
South Tees Hospitals FT	2045	1896	149	92.7
North Tees & Hartlepool FT	1449	1307	142	90.2
Co Durham & Darlington FT	2481	2317	164	93.4
Total - NECN	14828	13712	1116	92.5

Performance – 31 Day Standard – first definitive treatments

Upper GI	Total Treatments	Treated within 31 Days	Breaches (treated > 31 days)	Performance %
South Tyneside FT	27	27	0	100.0
City Hospitals Sunderland FT	73	73	0	100.0
University Hospitals of North Cumbria	125	125	0	100.0
Gateshead Health Care FT	59	59	0	100.0
The Newcastle Hospitals FT	508	506	2	99.6
Northumbria Healthcare FT	102	102	0	100.0
South Tees Hospitals FT	275	274	1	99.6
North Tees & Hartlepool FT	70	70	0	100.0
Co Durham & Darlington FT	117	117	0	100.0
Total - NECN	1356	1353	3	99.8

Performance – 31 Day Standard – subsequent treatments

Upper GI	Total Treatments	Treated within 31 Days	Breaches (treated > 31 days)	Performance %
South Tyneside FT	6	6	0	100.0
City Hospitals Sunderland FT	32	32	0	100.0
University Hospitals of North Cumbria	51	50	1	98.0
Gateshead Health Care FT	5	5	0	100.0
The Newcastle Hospitals FT	473	460	13	97.3
Northumbria Healthcare FT	28	28	0	100.0
South Tees Hospitals FT	224	222	2	99.1
North Tees & Hartlepool FT	13	13	0	100.0
Co Durham & Darlington FT	37	36	1	97.3
Total - NECN	869	852	17	98.0

Performance – 62 Day Standard – urgent referrals to first treatment

Upper GI	Total Treatments	Treated within 62 Days	Breaches (treated > 62 days)	Performance %
South Tyneside FT	18	12.5	5.5	69.4
City Hospitals Sunderland FT	46	37.5	8.5	81.5
University Hospitals of North Cumbria	74	51	23	68.9
Gateshead Health Care FT	31	24	7	77.4
The Newcastle Hospitals FT	142.5	96.5	46	67.7
Northumbria Healthcare FT	74	58	16	78.4
South Tees Hospitals FT	123.5	97	26.5	78.5
North Tees & Hartlepool FT	52.5	44.5	8	84.8
Co Durham & Darlington FT	74.5	51.5	23	69.1
Total - NECN	636	472.5	163.5	74.3

6 14-1C-1079f, Network Audit

Audits 2014

This group held an audit day on 12th November 2014 at which a number of audits were presented. See appendix 2 for summary.
Link to presentations on the network website - OG NSSG Audits

National OG Cancer Audit

The 2014 annual report of the second National Oesophago-Gastric Cancer Audit (NOGCA) was published in November 2014 and covers results from the first two years of data submission – relating to patients aged over 18 years diagnosed with invasive epithelial oesopago-gastric cancer between April 2011 and March 2013.

Key Recommendations from the Report

1. Case-ascertainment for surgical cases is excellent, but the overall case-ascertainment has fallen. Trusts need to tighten up local protocols to ensure all patients are submitted to the audit.
2. Use of minimally invasive and hybrid surgery continues to rise. There is some evidence that patients undergoing minimally invasive surgery tend to have a shorter length of stay post-operatively, compared to patients having open surgery. But further research is needed to assess whether they recover more quickly overall compared to those undergoing open surgery.
3. As surgical mortality continues to fall, increased focus should go on other potential quality indicators such as longitudinal margin status, length of stay and complication rates. These outcomes should be monitored prospectively at a Trust level.
4. Nearly one in ten patients having a gastrectomy has incomplete resection of their cancer (a positive longitudinal margin). This has not changed since the 2010 report. All Surgical Centres should know their rate for this quality indicator and consider ways that it can be reduced.
5. Further investigation needs to go into the variation in dosing regimens used for definitive chemoradiotherapy, to see whether this variation is due to an issue with data quality or truly represents lack of adherence to published guidelines.
6. It is important to ensure all patients are considered for curative treatment options based on both the extent of the disease and also patient factors (e.g. patient preference and comorbidities), irrespective of their age.
7. Across SCNs there was significant variation in the proportion of cancers diagnosed at an early stage. This should be investigated at a local level, with Networks focusing on increasing the proportion of patients diagnosed at an early stage, as these patients are significantly more likely to be managed with curative intent. Where patients are diagnosed early, Trusts should consider referral to centres with endoscopic expertise in removal of such lesions.
8. Data quality needs to be reviewed at a trust level. It is key that any queries regarding correct response to each field are checked with a clinician in order to optimise data quality. Issues were most common in the oncology dataset.

Network Overview

- All network trusts have over 80% case ascertainment with 8/9 over 90% - higher than the audit average of 78.6%.
- Data completeness for key data items in Surgical and Pathology records at the 2 surgical centres is generally good.
- The network has a high proportion of patients with locally advanced disease who received curative surgery with additional oncology treatment
- Successful data linkage of audit cases with RTDS is very good for network trusts.
- 30 and 90 day mortality following curative surgery is lower than the national average at the two surgical centres in the network.
- Post –operative complication rates are in line with the audit average and lengths of stay are comparable at the two centres.
- 82% and 95% of surgical patients had adequate lymph node resection at South Tees and Newcastle respectively.
- 14.8% of surgical patients at South Tees are reported as having positive resection margins – but only 2.1% of Newcastle Patients.

Audits planned for 2015

- National OG Cancer Audit

1. 14-1C-116d Clinical Outcomes/Indicators

The clinical outcomes and indicators for the Upper GI cancer MDTs within the NSSG are consistently high as evidenced in the National OG cancer audit and the yearly annual audit day presentations (NESCN website). The network was one of only a few that achieved completeness of the benchmark for estimated case-ascertainment at all sites. All Upper GI MDTs are contributing again to the current round of the National OG cancer audit and it is anticipated that data input will be consistently high. The results for oesophageal and gastric resections in Middlesbrough and Newcastle continue to demonstrate some of the highest volumes and some of the best results in the country with in hospital mortality rates below 1%.

Key Points - Derived from 2013/14 Oesphago Gastric Cancer Service Profiles (CCT) – published March 2014

- About 800 newly diagnosed patients per year across network trusts – this equates to 7% of total cases in England - in line with the network population which is about 7% of the total population for England.

Demographics

- 61% of patients diagnosed are aged 70+, just below the England average of 62% – trust values range from 54% at Co Durham to 66% at North Cumbria.
- Levels of ethnicity recording is high – over 90% in all trusts; typically less than 3% of patients are recorded as not White British - less than the England average of 7% - although this is 6% for Newcastle patients.

- Generally, a higher proportion of patients treated in the network are income deprived when compared to the national average. For most trusts this proportion is between 17% and 19% - nationally the rate is 15%.
- 66% of those treated across the network were male, in line with the national average. Individual trust values rang from 53% in North Tees to 74% in Co Durham.

Throughput

- In 2011/12 there were a total of 9,663 urgent GP referrals for suspected upper GI cancers across the network – this number represents almost 9% of the total in England – slightly higher than the network population.
- Nationally it is estimated that 23% of cases in 2011/12 were emergency presentations. Across the network estimates for individual trusts range from 17% at North Cumbria to 27% at North Tees and Co Durham.

Waiting Times

- Latest published data (Q3 2014/15) for cancer waiting times shows most network trusts fail to achieve the operational threshold of 93% for the 14 day target, although 4 are above in this period, for suspected upper GI cancers.
- In the same period for the 31 day target for first treatments all trusts treated every patient within 31 days – exceeding the 96% threshold.
- The 62 day target for those patients urgently referred for suspected cancer presents more of a challenge, and 7 trusts are below the operational threshold of 85% in this period - but numbers are small in some trusts.
- Experimental data for conversion rates (GP urgent referrals diagnosed with cancer) range from 3% at Northumbria and Newcastle to 6% at North Cumbria – compared to a national average of 5% - rates are derived from cancer waits data for 2013.
- Nationally 36% of cases treated in 2011/12 were urgent GP referrals – network trust rates range from 19% at North Tees to 49% at Northumbria.

Practice

- Nationally Oesophageal cancers account for 55% of cases, with 45% Stomach cancer. Across the network cases are more evenly split – 49.9% Oesophageal; 50.1% Stomach.
- Nationally 93% of Oesophageal and 91% of Stomach cancers are histologically confirmed; most trusts are broadly in line with this.
- Nationally 18% of cases are treated by resection – rates in individual network trusts range from 11% in Sunderland to 30% in Newcastle.
- 95% of network patients received a CT scan – this is higher than the national average of 91%.
- 71% of network patients had EUS investigation – compared to 62% of patients nationally.
- The proportion of network patients with palliative treatment intent, 50%, is higher than the national average of 47%.

Outcomes and Recovery

- Network 1-year survival for Oesophageal cancer is 43.3% - there is no national rate, but rates range nationally from 36.5% to 46.9%.
- Network 1-year survival for Stomach cancer is 45.1% - compared to a national rate of 42.2% and a range nationally from 37.1% to 51.6%.

8 14-1C-110f, Annual Discussion of Clinical Trials

Research Representative is Mrs Penny Williams Research Delivery Manager Division 1 (Cancer) Clinical Research Network: North East and North Cumbria (CRN:NECN) represent NIHR at theOG NSSG meetings

In line with the NIHR strategic aims and objectives, we continue to ensure that commercial trials are prioritised within the OG portfolio.

CRN:NENC has a good working relationship with the NSSG and Network and continues to work to promote the integration of research into routine practice and ensure there is equity of access to clinical trials for patients across our large geographical area. A list of clinical trials is available on the NESCN website www.nescn.nhs.uk

9 14-1C-108f Patient & Carer Involvement

The user representative is Mr C Bayliss who is currently a member of the OG NSSG group. He is invited to and actively participates in meetings. Relevant issues are reported back to the NESCN Patient and Carer Group for comments and feedback. User involvement is actively encouraged and promoted throughout the NESCN.

Patent Survey Results 2014 - Upper GI

Responses were received for all trusts but very low numbers in 6 trusts mean responses have been suppressed, leaving analyses from 3 trusts only. Total number of responses are in line with previous years.

Key aspects of better experience:

- Both South Tees and Newcastle have high numbers of questions where responses are ranked in the top 20% nationally.
- Generally levels of satisfaction with information provided are high – especially around treatment and treatment choices is; involvement in care decisions; potential side effects and financial issues.
- Generally respondents felt staff treated them with dignity; they had enough privacy and that they were not misled in the information they were given.
- Satisfaction levels with collaboration between secondary and primary care are generally good and respondents felt that GPs were provided with the correct information.

Areas for improvement:

- North Cumbria has answered 36 of the 70 questions with all 36 in the bottom 20%, with a high number of responses being suppressed.
- The group should consider information for patients and how this might be equitably addressed across all trusts – information provision on free prescriptions is quite low in the 3 trusts reported.

- All trusts should encourage patients to respond which would give a better understanding of the patient experience.

Key Results:

- Respondents who rated their care aS excellent or very good was 80% or above in all cases (though 80% places N Cumbria in the bottom 20% nationally).
- Satisfaction with treatment is good at both S Tees and Newcastle.
- There is variation between trusts in results for verbal and written information, although overall satisfaction is high.
- Small numbers of patients discussed participation in clinical trials, but most had seen information around the hospital suggesting that availability or appropriateness of trials may be an issue.

Participation is good with a high level of responses for this survey. Network performance is consistently good with 3 network trusts ranked in the top 10 of 153 trusts nationally.

Overall, network performance in this survey was very good and participation will continue on an annual basis.

Appendix 1 – NSSG Attendance 2014

OG NSSG Attendance Sheet 2014

The Manual for Cancer Services states that the MDT should send a team member as a representative to at least two thirds of the Network Site Specific Group meetings

First Name	Surname	Role	Organisation	Attendance	10/02/13	10/06/13	06/11/13
Jessica	Green	UGI CNS	CDDFT	33%	1		
Nicola	Hewitson	CNS	CDDFT	67%	1	1	
Jane	Osbourne	CNS	City Hospitals Sunderland	67%	1		1
John	Painter	Gastroenterologist	City Hospitals Sunderland	67%	1	1	
Rory	Farrell	Consultant Surgeon	Gateshead Health Trust	33%	1		
Alison	Chivers	Research	NCRN-S	33%	1		
Christopher	Baylis	Patient & Carer Representative	NECN	67%	1		1
Kath	Jones	Service Improvement Facilitator	NECN	33%		1	
Jo	Preston	Service Improvement Facilitator	NECN	33%			1
Leonie	Armstrong	Palliative Care Nurse	Newcastle Hospitals	33%	1		
Maria	Bliss	RGN	Newcastle Hospitals	67%	1	1	
Nick	Hayes	Consultant	Newcastle Hospitals	100%	1	1	1
Kath	Houghton	Upper GI Research Nurse	Newcastle Hospitals	33%			1
Arul	Immanueal	Consultant Uper GI Surgeon	Newcastle Hospitals	33%			1
Charles	Rayner	Foundation Year 2 Doctor	Newcastle Hospitals	33%			1
Claire	Sedgewick	OG Clinical Nurse Specialist	Newcastle Hospitals	67%	1		1
J	Sultan	Consultant Upper GI Surgeon	Newcastle Hospitals	33%			1
Shajahan	Wahed	Research Fellow	Newcastle Hospitals	33%			1
Claire	McNeill	Peer Review CO-ordinator	NHS England	100%	1	1	1
Carol	Mayes	Network Delivery Facilitator	NHS England	33%			1
Penny	Williams	Researcg Delivery Manager	NIHR CRN	33%		1	
Nanos	Kumar	Consultant	North Cumbria	33%			1
John	Robinson	Consultant UGI Surgeon	North Cumbria	33%	1		
John	Wayman	Consultant Surgeon	North Cumbria	67%	1		1
Jackie	Brown	cancer Manager	North Tees & Hartlepool	33%		1	
Natalie	Robson	CNS	North Tees & Hartlepool	33%			1
Jayesh	Vasani	Consultant Gastroenterologist	North Tees & Hartlepool	67%	1	1	
Alexander	Phillips	Speciality Trainee	Northern Region	33%			1
Dawn	Elliott	UGI Cancer Clinical Nurse Specialist	Northumbria Healthcare	33%	1		

Sarah	Robinson	Consultant Surgeon	Northumbria Healthcare	33%		1	
Rhys	Jones	Research	NUTH/ Newcastle University	33%			1
Stuart	Allen	Teaching Fellow	RVI	33%			1
Peter	Davis	Consultant Surgeon	South Tees Hospitals Trust	33%			1
Sam	Dresner	Consultant Surgeon	South Tees Hospitals Trust	67%	1		1
Lorna	Dunn	SPR Surgery	South Tees Hospitals Trust	33%			1
Helena	Hinde	Upper GI Support Sister	South Tees Hospitals Trust	33%			1
Kate	Lamballe	UGI Dietitian	South Tees Hospitals Trust	33%			1
Anantha	Madhavan	Core Trainee, Surgery	South Tees Hospitals Trust	33%			1
Chetan	Parmar	SPR	South Tees Hospitals Trust	33%			1
	Vikanauau	SpR	South Tees Hospitals Trust	0%			
Yks	Viswanath	Consultant Gastroenterologist	South Tees Hospitals Trust	33%			1
Helen	Wescott	Upper GI CNS	South Tees Hospitals Trust	67%		1	1
Dave	Wilson	Clinical Oncologist	South Tees Hospitals Trust	33%			1
Claire	Anderson	Upper GI /HPB CNS	South Tyneside	33%	1		
Carolynne	Hardy	Upper GI Clincial Nurse Specialist	South Tyneside	33%	1		
				Total	17	11	28

Appendix 2 – Evaluation Report

Northern England
Strategic Clinical Networks

Oesophago-Gastric NSSG Annual Audit Day

Wednesday 12th November 2014
12:30pm to 5:00pm

The Durham Centre, Durham, DH1 1TN

Convener: Mr N Hayes, Chair OG Network Site Specific Group

EVALUATION REPORT

Introduction

The Oesophago-Gastric NSSG Annual Audit Day was held at the Durham Centre, Durham. This event was aimed at practitioners working in the challenging field of Upper GI cancers.

The event was convened by Mr Nick Hayes, Consultant Upper GI Surgeon and Chair of the OG Network Site Specific Group. The event attracted an audience of 32 delegates ***(see appendix 2)***.

The programme of the half-day was in the form of showcase plenary presentations ***(see appendix 1)***.

Evaluation

The number of completed evaluation forms received totalled 22 (69%) and have been summarised within this report.

Presentations

All presentations can be accessed at: http://www.nescn.nhs.uk oesophagogastric-og-nssg

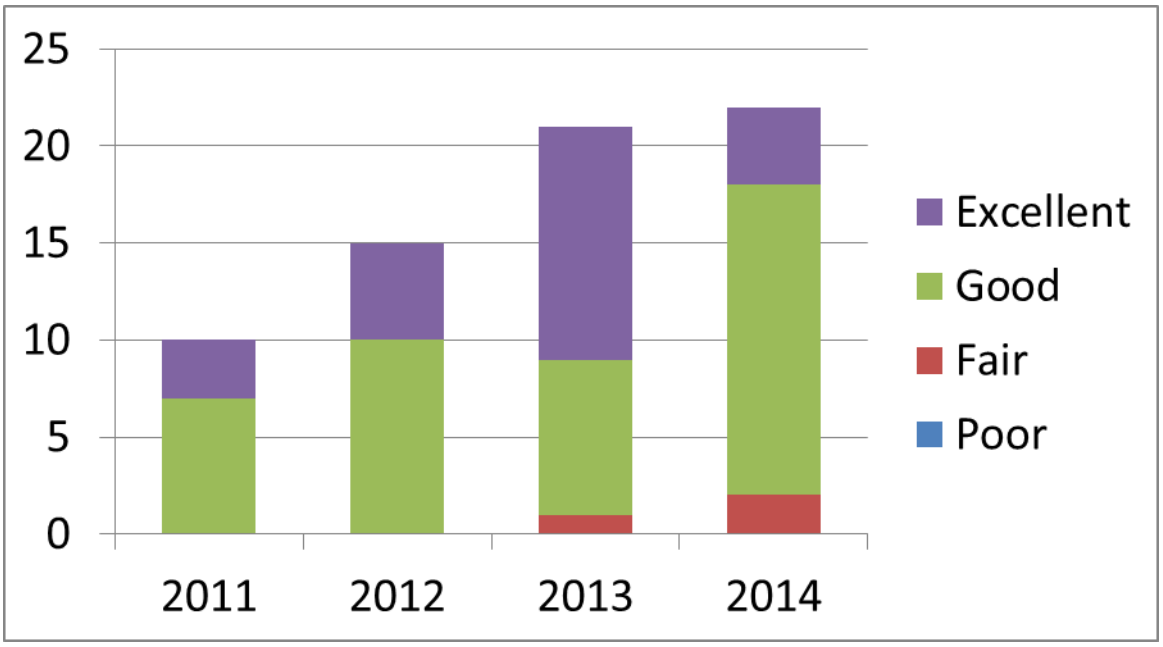
Conclusion

Feedback from the event will be discussed at the next OG NSSG meeting.

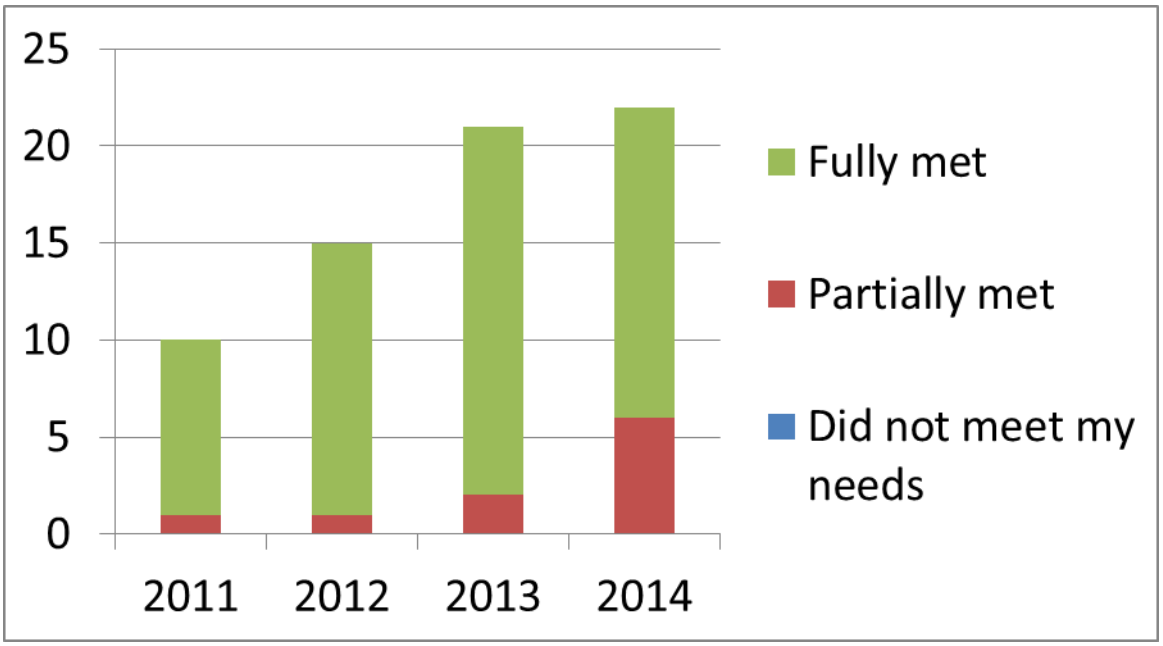
On behalf of the North of England Cancer Network and Mr Hayes, appreciation goes out to all those who participated in making the event a success.

Evaluation

What was your overall opinion of the day?



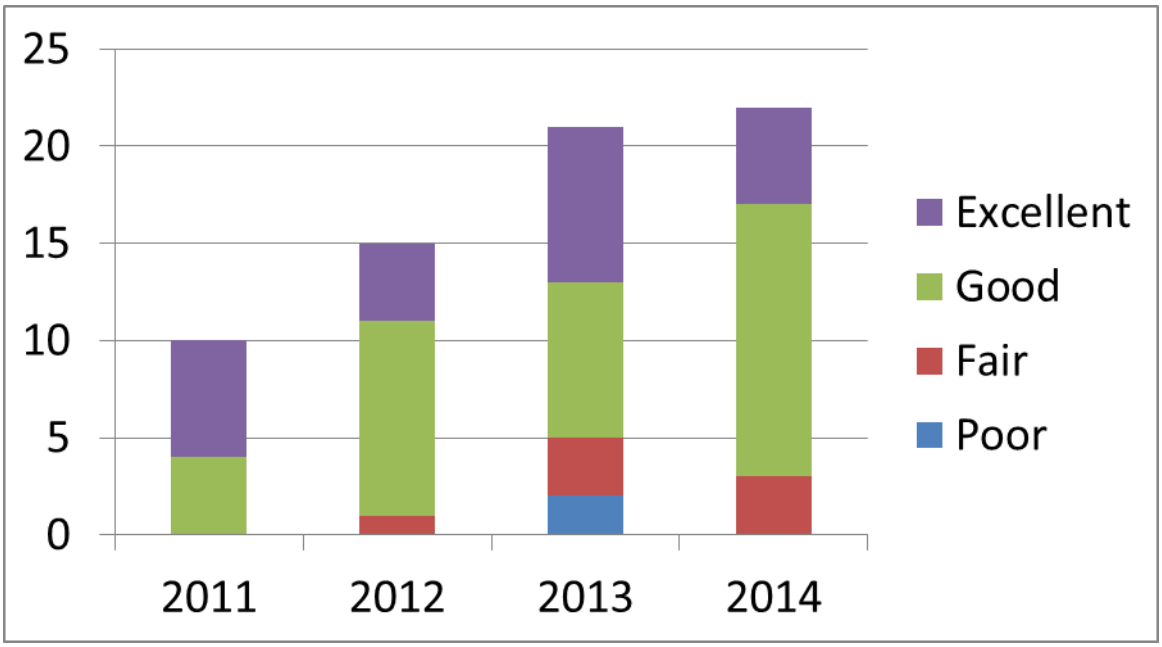
How did the programme meet your needs?



Which aspect of the day was most useful to you?

National Campaign
Barretts Guidelines Updates
Review of the 62 day pathway
OG workload
Early cancer awareness campaign
Radical radiotherapy audit
Follow up
Barretts
National Awareness campaign
Starting the day wiith different talks on
62 day pathway
Brachytherapy patients presentation
Data figures
Audit presentations
RFA update
EMR Presentation
Globally useful afternoon
Barretts
Good overview of various current issues
All
Good session on Barretts
Bo presentation
Surgical figures
Audits
EMR

What was your opinion of the venue?



Have you any other comments/suggestions about the day?

- Please encourage more clinicians and nurses providing the OG service to attend these meetings
- Suggested future audit; Peri-operative chemotherapy for resectable gastric / junctional caners- survival data/ rated of not proceeding to curative surgery as compared to Magic Trial
- Good to start central audit date as a series over time (5 years) father than single year data
- Meeting room was cold
- Excellent presentations
- “symposium” aspect was a good idea
- To include Oncology data in detail
- Standardise presentation
- Local trust level date not just centre.

Appendix 1- Programme

Northern England
Strategic Clinical Networks

OG NSSG Audit Event
12th November 2014
12:30pm
The Durham Centre
Belmont Industrial Estate, Durham, DH1 1TN: 0845 481 2191

12.30 – 13:30	**Lunch on arrival & Registration**	
13:30 – 13:35	**WELCOME & INTRODUCTION**	Nick Hayes
13:35 – 14:05	**OG Specialist Workload Audit** South Tees Data Newcastle Upon Tyne Data	 Sam Dresner Maziar Navidi
	Audits	
14.05 – 14.15	**Gist Audit**	Anjan Dhar
14.15 – 14.30	**Re-audit of Radical Radiotherapy**	Jin H Tee / Paula Mulvenna
14.30 – 14.40	**Cumbrian Brachytherapy**	Robert Thomas
14.40 – 14.45	**Follow Up after OG Resection Survey**	Shaj Wahed
	OG Service Updates	
14:45 – 15.05	**62 Day Pathway**	Roy McLachlan/ Linda Wintersgill
15.05 - 15.25	**National Campaigns –** *Be Clear On Cancer*	Amanda Boughey / Jeff Porter
15:25 – 15:50	**Tea & Coffee**	
	Barrett's Management Symposium	
15.50 - 16.05	**Update on Barrett's Guidelines**	Anjan Dhar
16.05 – 16.20	**RFA: evidence and technique**	David Nylander
16.20 - 16.35	**RFA Outcome Data**	Amy Light
16.35 – 16.50	**EMR for Barrett's and Early Cancer**	Barry Dent
16:50 – 17:00	**Evaluation and Close**	

Northern Oesophago Gastric Cancer Unit MDT data

Each of the 2 specialist MDTs presented activity data from their individual trusts.

The epidemiology, clinicopathological characteristics and outcomes of GISTs in Durham and Tees Valley

Aim

The aim of this retrospective audit was to review clinical presentations and pathological characteristics of these rare tumours; consider treatment outcomes over a five year follow-up period and analyse prognostic factors associated with adverse outcomes

Methodology

The audit looked at GIST presentations in Durham and Tees over a period of 5 years.

Findings

- 42 patients with GISTs diagnosed over a 5 year period - annual incidence 8pts/yr/1.2million population
- Stomach was the commonest site.
- Patient demographics, clinical presentations and tumour characteristics are similar to those reported previously in literature.
- Age, tumour site and tumour size are the most important predictors of overall survival in our cohort.
- AFIP risk-stratification system performed the best in relation to overall survival but recurrence was unfortunately noted in 2 patents deemed at low risk by this and other scoring systems, suggesting that further work into these prognostic models is perhaps needed

Reaudit of the use of Unimodality Radical Radiotherapy for the Treatment of Oesophageal Cancer

Aim

The aim of this retrospective audit was to determine the survival outcomes of patients 5 years after the first audit and to show a demonstrable survival benefit is maintained for this group of patients.

Methodology

A retrospective notes assessment was carried out and data from hospital letters and notes was analysed with results plotted on a Kaplan-Meier curve. Results were compared with those of the previous audit and recent research papers.

Findings

- Radical radiotherapy offers potentially durable survival to oesophageal cancer patients.
- Nodal staging has an effect on the overall survival of the patients
- Consider radical radiotherapy treatment for this group of patients where their co-morbidities would preclude standard treatment
- In order to continue improving the oesophageal cancer patients' healthcare, another re-audit will help ensure the standard is maintained.
- For discussion: Should we confine unimodality RT to N0 patients only?

Oesophageal Brachytherapy Audit: Cumbria (and Lancashire) data

Aim
The aim of this retrospective audit was to examine management of early cancers in the two centres.

Methodology
Data relating to patient cohorts for each of the 2 specialist centres were examined to identify mode of identification, treatment modality and accuracy of staging.

Findings
Results were presented to the group and findings included:
- Brachytherapy relatively simple and safe
- Survival suggests appropriate use in those with a better prognosis
- No data on effect on symptoms, QoL etc

Patient Follow Up After Oesophagogastric Cancer Surgery

Aim
To assess follow up policies across the cancer network

Methodology
Survey of follow up processes in network trusts

Findings
Surgical follow up
- Year 1: 6 weeks, 3 months, 6 months, 9 months, 12 months
- Year 2: 4 monthly
- Year 3: 6 monthly
- Year 4: annual
- Year 5 annual

Oncology follow up
- ?6 weeks after any adjuvant treatment completion
- Dietician follow up

No role for routine imaging/endoscopy currently
GIST follow up as per guidelines

Radiofrequency Ablation in Barrett's

Aim

To audit our outcomes and complications of Radiofrequency Ablation and to assess if providing this service is cost effective

Methodology

Retrospective data collection including patient demographics, histology and extent of Barrett's pre and post treatment and any other treatments. Basic cost analysis as per procedure and per patient cost

Findings

- In our experience RFA has been safe and effective.
- Need longer term follow-up to assess if this is longstanding
- High financial cost however

The Newcastle Experience of Endoscopic Mucosal Resection in the Management of Early Oesophageal Cancer

Aim

Review the introduction of EMR in the Northern Oesophago-Gastric Unit

Methodology

Retrospective review of:

- All oesophageal EMRs since 2006
- All patients discussed in MDM
- Suction cap technique
- All EMRs performed by surgeons
- Circumferential biopsies taken after EMR performed
- Surgery recommended for patients with submucosal disease or involved resection margins

Findings

- 86 EMRs performed on 66 patients
- Median age 71 years (range 38-84)
- Overall complication rate 3.5%
    - 2 patients had radiological evidence of perforation
    - 1 repeat endoscopy for bleeding
- Adenocarcinoma identified in 33 specimens
- Represented upstaging from HGD in nine patients

Appendix 2 – Delegate List

	Name		Title	Organisation
1.	Stuart	Allen	Teaching Fellow	RVI
2.	Chris	Bayliss	Patient Representative	
3.	Peter	Davis	Consultant	South TEES
4.	Sam	Dresner	Consultant Upper GI Surgeon	JCUH
5.	Lorna	Dunn	SPR Surgery	South Tees Hospitals
6.	Nick	Hayes	Consultant Upper GI Surgeon	Newcastle Hospitals
7.	Helena	Hinde	Upper GI Support Sister	JCUH
8.	Kath	Houghton	Research Nurse	NHS NOACU
9.	Arul	Immanuel	Consultant Upper GI Surgeon Northern Oesophago Gastric	Royal Victoria Infirmary
10	Rhys	Jones	Research	NUTH/ Newcastle University
11	Nanos	Kumar	Consultant	NCUH
12	Kate	Lamballe	Upper GI Dietitian	JCUH
13	A	Madhavan	Specialty Trainees	Northern Region
14	Carol	Mayes	Network Deliver Facilitator	Northern Clinical Networks
15	Claire	McNeill	Peer Review Co-ordinator	Northern Clinical Networks
16	Jane	Osborne	Gastro Specialist Nurse	City Hospitals Sunderland
17	Chetan	Parmar	SPR	JCUH
18	Alexander	Phillips	Specialty Trainee	Northern Region
19	Jo	Preston	Network	Northern Clinical Networks
20	Charles	Rayner	Foundation year 2 Doctor	RVI
21	Natalie	Robson	Lead Upper GI CNS	North Tees and Hartlepool NHS Trust
22	Claire	Sedgwick	Upper GI CNS	RVI
23	J	Sultan	Consultant Upper GI Surgeon	RVI
24	Shajahan	Waheed	Specialty Trainee	Northern Region
25	John	Wayman	Consultant Upper GI Surgeon and Clinical Director	North Cumbria University Hospitals
26	Helen	Westcott	CNS	JCUH
27	David	Wilson	Clinical Oncologist	STHFT
28	Viswanath	Yks	Consultant	South Tees

Appendix 3 – Recruitment to Trials 2014

NHS
National Institute for Health Research

Clinical Research Network
North East and North Cumbria

Number of Participants in NIHR Trials - Upper Gastro-intestinal Cancer Group (Oesophagogastric), Jan - Dec 2014

Data extracted from NIHR ODP as at 23 January 2015

		CDDFT		CHSFT	GHFT	NCUHFT		NHFT		NTHFT		NUTHFT		STFT	STFT	
Study Acronym	Int/Obs	BAGH	UHND	SRH	QEH	CI	WCH	NTGH	WGH	UHH	UHNT	FH	RVI	JCUH	STGH	TOTAL
A Phase I trial of AZD3965 in patients with advanced cancer	Int											4				4
BEST-2	Int	1											3			4
CUP ONE	Int											5		2		7
GO2	Int					4	3							2		9
ST03	Int											4				4
Industry (2 studies)	Int											4				4
		1	0	0	0	4	3	0	0	0	0	17	3	4	0	32

CUP ONE - Closed 01/12/2014
Industry studies - Closed

Appendix 4, OG Action Minutes 10 February 2014

Name of Group / Meeting:	**OG NSSG**	
Date:	**10 February 2014**	
Time:	**4.30pm -6.30pm**	
Venue:	**Evolve Business Centre, Houghton Le Spring**	
Present:	Claire Anderson, Upper GI/ HPB CNS , South Tyneside FT	**CA**
	Leonie Armstrong, Palliative Care Nurse, Newcastle Hospitals	**LA**
	Christopher Baylis, Patient & Carer Representative, NECN	**CB**
	Maria Bliss, RGN, Newcastle	**MB**
	Alison Chivers, Research	**AC**
	Sam Dresner, Consultant Surgeon, South Tees Hospitals Trust	**SD**
	Dawn Elliot, UGI Cancer Clinical Nurse Specialist, Northumbria Healthcare	**DE**
	Rory Farrell, Consultant Surgeon, Gateshead Health Trust	**RF**
	Jessica Green, UGI CNS, Co Durham and Darlington	**JG**
	Carolynne Hardy, Upper GI Clinical Nurse Specialist, South Tyneside	**CH**
	Nick Hayes, Consultant, Newcastle Hospitals	**NHa**
	Nicola Hewitson, CNS, CDDFT	**NHe**
	Jane Osborne, CNS, City Hospitals Sunderland	**JO**
	John Painter, Gastroenterologist, Sunderland	**JPA**
	Jo Preston, Network Delivery Manager	**JPR**
Video link 5.45 pm- 6.30pm	John Robinson, Consultant UGI Surgeon, Carlisle	**JR**
	Claire Sedgwick, OG Clinical Nurse Specialist, Newcastle Hospitals	**CS**
	Jayesh Vasani, Consultant Gastroenterologist, North Tees	**JV**

	Sarah Robinson, Consultant Surgeon, Northumbria	**SR**
Video link 5.00pm – 6.30pm	John Wayman, Consultant Surgeon, North Cumbria	**JW**
In attendance:	Claire McNeill, Peer Review Co-ordinator, Northern Clinical Networks,	**CM**
Apologies:	YKS Viswanath, Consultant Gastroenterologist, South Tees Hospitals Trust	**YKS**
	Bridget Workman, Research Manager, NECRN-North	**BW**
	Linda Wintersgill, Information & Audit Manager	**LW**
	Kath Jones, Service Improvement Facilitator, NECN	**KJ**
	Sarah Robinson, Consultant Surgeon, Northumbria	**SR**
Brief Summary of Meeting:	**NSSG**	

ACTION POINTS:

Agenda Item	Subject	Actions	Target date	Person responsible
1b	**Minutes from 10.06.13**	**Professor Mike Griffin job title is incorrect, should read Consultant Surgeon.**		
1c	**2ww Referral Forms**	**Discussions took place regarding a network wide referral proforma and the Willie Hamilton Risk assessment tool. JPa felt the Willie Hamilton risk assessment had increased number of referrals but without additional diagnosis being made. NH confirmed they are seeing more patients at earlier stages. Group agreed all areas should monitor impact rates and feedback to group. IP to forward electronic version to be circulated with minutes. JPr advised staging data takes some time to obtain so we are unable to prove if earlier diagnosis are**		

Agenda Item	Subject	Actions	Target date	Person responsible
		being made. JPr informed the group Cancer Unit Managers will be collecting data regarding increased volumes due to the awareness campaign. Cancer Unit Managers will also collect details of treatment offered to patients. CS felt the 2ww referral forms should be standardised and group agreed as more referrals were being received from outside the area. JPr to take back to Network.		
	Vice Chair	**JPa volunteered to be vice chair with immediate effect.**		
	Radiology Update	**No data had been received from the Nurse specialists. Nurse Specialists to forward the data to KJ by 21.02.14.** **Mathew Trewhella, Chair of the Radiology group was taking this forward. KJ to chase MT.** **CS discussed the increased work load of CNS in processing the number of PET scans requested; process should be radiologist to request PET scan. Referring hospital should request PET referral if they know it is required. NH confirmed standard CT would be first. NH to discuss with radiologist quality of CT image and also to look at costs involves. NH to feedback at next meeting.**	**21.02.14** **17.02.14** **02.06.14**	**CNS** **KJ** **NH**
2a	**Peer Review**	**OG is expected to be internal validated self-assessed in 2015 with external verification due 2016.**		
	Constitution	**All to provide any further updates to CM by 28.03.14**	**28.03.14**	**All**
	Clinical Guidelines	**JPa discussed breaches in Sunderland due to patients still taking PPI NH asked if GPs could asked patient to stop while waiting 2ww date and look to standardise the 2ww forms. SD advised this was already**		

Agenda Item	Subject	Actions	Target date	Person responsible
		included within form. JP advised of work undertaken with GPs and the campaign message is for GPs to look to stop patients PPI and work will continue to get this message across to GPs.		
	Work Programme	**SD advised the Network Oncology Group are working to ensure standardised radiotherapy and chemotherapy is received across the network. Network to obtain an update from radiotherapy and chemotherapy chairs to ensure all treatments are the same across the network.** **CS discussed any delays in a patient pathway which resulted in the CT scan being 6 to 8 weeks old would cause a further delay and increased costs as a further CT scan would need to be obtained. Group acknowledged a problem.** **RFA – JW confirmed RFA being carried out in Carlisle, but no audit been carried out as this is part of the national audit. NH suggested all to undertake an audit and present findings at the November meeting. NH asked if JW could discuss colleagues to progress this. JW agreed.** **Group agreed EMR should also be considered for an audit. SD to liaise with Anjan Dhar and Mike Griffin and present an audit at November meeting.**	**02.06.14** **02.06.14** **02.06.14**	**KJ** **JW** **SD**
2b	**Research**	**AC updated on current trials available and also updated on the changes taking place in the research networks. Dr Anne Lennard has been appointed as Clinical Lead for Division 1. The speciality Leads are yet to be confirmed. The Interviews for Division Research**		**Enclosure attached for information**

Agenda Item	Subject	Actions	Target date	Person responsible
		Delivery Managers are taking place 10.2.14. NH asked if trial recruitment could be compared to other networks. AC will investigate to see if this information is available. AC also asked all to be realistic when setting targets as these will be monitored going forward.	**02.06.14**	**AC**
	Programmes of Improvement	**Programmes of Improvement discussed and group agreed to endorse the document relating to 2012 recruitment.** **2013 recruitment figures are due to be circulated and Group agreed to discuss them at the June meeting.**	**02.06.14**	**MDT Leads**
2c	**OG Audit event Evaluation**	**SD advised overall feedback positive. Group agreed to hold the next audit day at The Durham Centre. CM to action.**	**02.06.14**	**CM**
2d	**Patient and Carer**			
	Survivorship	**Tony Branson had emailed all NSSG chairs to discuss survivorship. Attached for information** **Other NSSG were considering the following steps to address survivorship issue;** • **an end of treatment summary form,** • **MDTs to consider appointing a survivorship lead.** • **Holistic needs assessment to be incorporated within pathways.** **SD suggested scooping what processes are in place across the network.**		

Agenda Item	Subject	Actions	Target date	Person responsible
		CH informed the support group in South Tyneside was very well attended and if anyone had patients to refer to their group please contact her. CS discussed the services provided at Maggies. LA advised of Newcastle support group. **JP advised network had received funding from Macmillan to look at the survivorship issue. It was stressed the importance of Patient input into this.** **There is great variability of follow-up provision across the network for patients. NH suggested undertaken a patient survey regarding follow up and what patients received and what they would like and also what clinicians would like. SD advised all his follow ups are seen by a CNS and only sees patients who request to see him. CH has suggested south Tyneside have a separate nurse led follow up clinic. JPa suggested assessing the service and ensure a standardised support system is available across the network.** **Group agreed to undertake a survey of all OG consultants on how they follow up and address patients survivorship needs for curative patients only. Group agreed Chemotherapy and radiotherapy should also be included. SD to draft proforma and send to NH for approval.**	**24.02.14**	**SD**
2e	**Audit**	**Thromboembolic complications or pre-operative chemotherapy update** **NH informed this has been presented and should be reviewed and data to be presented at the audit event in November.** **Oncologist also to be involved.**	**24.02.14**	**NH**

Agenda Item	Subject	Actions	Target date	Person responsible
		NH to identify someone to take this forward.		
3a	**Clinical Governance Issues**	**NH advised quality of video equipment at Newcastle is still an ongoing issue**		
3b	**Any other business**			
		• **62 day breaches** **JW discussed breaches due to complex investigation pathway. JPa suggested improve access across the board, bring as many people direct to tests, try getting patients to tertiary referral centres as soon as possible.** **JW asked if Carlisle should be doing more tests before being referred in to prevent further delays. NH advised protocols would need to be amended and agreed pathways are complex but this is for a reason and patients should not be put through inappropriate treatments. However any suggests to improve the pathway would be considered. JW suggested Neck ultrasound could be added in before referral to SMDT. JW to forward email to NH to be considered.** **JPa asked if there was a system to calculate what percentage of breaches were due to patients delaying treatment. KJ to take back to the network to discuss.** **JPr advised cancer unit managers were considering a protocols for fitness for treatment and once agreed would then take this to the Clinical Advisory group for approval. OG Lung were the biggest issue.**	**24.02.14**	**JW**

Agenda Item	Subject	Actions	Target date	Person responsible
		JW informed Carlisle were keen to offer follow up locally in Carlisle. • **National Campaign** **National Campaign launched today and JPr expected a lot more media cover and asked if anyone experienced huge increases in activity to please let the network know and this would be feedback.**		
12.	**Close of meeting**	**Next meetings;** **Monday 2 June 2014, 4.30-6.30 Evolve Business Centre, Houghton Le Spring** **Wednesday 12 November 2014, 12.30 -17.00 (Audit Event) The Durham Centre**		

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