**London Cancer Upper GI (OG) Pathway Board**

**Date:** Thursday, 13 November 2014, 15:00 – 16:15  
**Venue:** Meeting room 1, 3rd Floor, 170 Tottenham Court Road, London, W1T 7HA  
**Chair:** Professor Muntzer Mughal, Pathway Director

1. **Welcome, Apologies and minutes of last meeting**
   MM welcomed members of the board, introductions were made and apologies heard. The minutes of the last meeting were accepted as an accurate record of proceedings.

   **Actions and matters arising:**
   - *Actions related to Dietetic audit on the agenda*
   - David Holden (DH) reported the Awareness Campaign (13 October) lobby at Westminster to continue the awareness programme around the country; 30 MPs signed the petition but all ministers attended and made policy decision that Oesophageal Cancer awareness campaign would go nationwide (24 January to end February). This is a very welcome decision. Trusts should be informed. Good to highlight this from Patient Representatives’ perspective. An impact for GPs with an increase in patient concern resulting in checks but also a good opportunity for GP to teach patients techniques for self-examination.
   - Liz Crisp (EC) reported that Charlton Football club, who run a roadshow on men’s health, were interested in running it as a part of the National campaign.
   - 03 December meeting in London as part of the Be Clear on Cancer campaign, specifically for Oesophageal/Gastric cancer – MM will circulate that information.

2. **Dietetic Audit (MM, KW)**
   **Discussion points:**
   - Dietetic review conducted and now complete – this can form part of peer review to show a network wide audit previously not achieved.
   - 3 Trusts returned 29 responses, i.e. PAH, Barts and UCH, no new cases at RFLH during that time – there have been lessons learned for future repetition of the audit including use of follow-ups to capture required data. The responses highlighted the difference in practices within Trusts.
   - Nutrition screening – formal nutritional screening is not happening across the Board, a proper structure needs to be in place. This is only a screen not an audit.
   - Of those 29 patients screened only 4 required no dietetic intervention.
   - Of the 25 given dietetic intervention, nearly 30% could only have access to that via telephone, i.e. no face-to-face consultation at the point at which the referral is made. 1 patient was only sent written information.
   - The aim is for referral to be made as early as possible so that the dietetic input is there to support the patient through whatever treatment pathway(s) they go through.
The data analysis shows a big gap of when patients receive dietetic advice, the majority do not get pre-treatment dietetic counselling or the optimisation of their nutritional status before going on for treatment although we know that is important for all modes of treatment.

Type of treatment and point where patient sees the Dietician was looked at, no particular pathway had this sorted for dietetics. To incorporate nutritional management into medical management needs to be considered earlier on.

Point of Dietetic assessment – referral and dietetic assessment was at the same point, no delays but not all areas had that face-to-face access and telephone consultation, assessments can be quite challenging depending on what patients can remember.

Band of Dietician – Banding was very variable, from a Band 5 (not recommended in guidance) to Band 6 to Band 7. A level 3 practitioner, at least 75% caseload with cancer patients, should be the recommendation. This data evidence reinforces the need for guidelines.

Presumption that a wider audit would yield similar result pattern.

Shortfall of Dieticians and not always of the level recommended in the service specification.

EC agreed that this would reflect patient experiences reported, and often difficult to see Dietician when actually needed. That relationship needed to be established, to get it right and express the timeline in some way to patients about what might happen during their treatment.

DC expressed frustration about efforts to recruit experienced specialist Dieticians. BHR keen, although data not returned.

What triggers would ensure that dietetic intervention occurs at the right time for appropriate treatment. Providers need to be proactive and establish measures, a guideline/tick-box/score-sheet to monitor and resolve this.

Look at the consequence of the screening undertaken. Most of the pathways Guidelines say that the Dietetic referral should be made. Suggestion made to add something to the MDM pro-forma to ensure that the referral is done.

MM to contact Trusts asked to report to enquire why they had not responded – just to record as a Pathway Board not to point finger.

KW to provide that data once complete to circulate for all to see.

Specification to be more stringent and to set out how dietetics was to be managed. MM recommended both short-term and long-term outcomes be considered.

Cate Simmons (CS) confirmed that it was likely that CNSs had actually completed the Audit forms which might be why some Dietetic information was missing.

DK recommended MM inform Trusts’ senior managements of this as a potential area of risk.

Consider involving Commissioners in these conversations as a possible way solve the situation.

A common issue across all Trusts, seemed to be confusion about reporting funding lines within Trust Directorates. Writing to the Trust to that effect it might help.

Put the data collated and guidelines together and circulate to the trusts management, to prove / establish case for requirement.

**ACTION:** MM to contact Trusts who were asked to report on Dietetic Screening and query why they did not provide a return and point out potential area of risk

**ACTION:** KW to circulate Dietetic data once complete for all to see – MM to confirm who in Trust this data should go to.

**ACTION:** Collate data and agreed guidelines and circulate to Trust management as evidence to prove/establish case for requirement of best provision of service/Best Practice.
**London Cancer**
Minutes from the Upper GI (OG) Pathway Board meeting held on 13 November 2014

<table>
<thead>
<tr>
<th>ACTION:</th>
<th>Revise specification to set out a more stringent process of dietetics management, both short-term and long-term outcomes to be considered.</th>
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<td>MM to advise Trust senior management of potential risk in area of Dietetics, using collated data and the Guidelines to establish case for requirement of robust Dietetics service.</td>
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3. **Dietetic Guidelines (MM)**

**Discussion points:**

- Claire Levermore (CL) had drafted guidelines, the Board needed to review and ratify the content before issuing these guidelines. From an evidence base of dietetic and nutritional management, this is not robust enough as scientific evidence, these Guidelines are to be peer reviewed before the Board approve them.
- DH and BH (Patient Representatives) were consulted to clarify recommendations for patient Information, a few minor amendments had been made.
- In Nutritional management, percentage weight change is a much better indicator that BMI, but thought would not be taken forward by clinicians with all the other requirements they need to consider, patients may struggle to give accurate information making accurate percentage calculations difficult. Clinicians in attendance suggested an objective measure:
  - Weight loss is the ideal goal for obese patients, but at same time aim to preserve muscle mass.
  - Ideal weight loss result for Patients would be 2 lbs / week (approx. 500 Calories).
  - KW will amend Guideline to add the agreed Patient Information, and will then send to GOSH and Guildford for peer review (approx. 2 weeks). Once these are Peer Reviewed, MM will write to the Trusts so that all possible background (guidelines and shortfall data from the audit) can be included as a more robust way to inform re Best Practice which is currently not being followed. Data from GOSH on Oesophageal Cancer to be added as a benchmark.
  - Liz Crisp suggested a workshop for patients to inform on the importance of dietetics.

| ACTION: | KW will peer review audit data, and will amend guidelines as outlined and bring back to Board for approval |
| ACTION: | MM will write to Trusts regarding Best Practice as per the specification and outlining the data shortfalls in current Dietetic service along with benchmark data from GOSH |

4. **Barrett’s Surveillance - update (MM)**

**Discussion points:**

- Meeting of senior Upper GI Gastroenterologists conducting Barrett’s Surveillance around the region took place directly after the last Pathway Board meeting, chaired by Lawrence Lovatt (LL) and MM. Unanimous decision made to limit Barrett’s Surveillance to fewer Gastroenterologists with the appropriate training, interest and equipment to carry this out properly.
- All of the Gastroenterologists at the Trusts were written to asking them to identify their Lead Gastroenterologist and how many cases of Barrett’s Surveillance they carried out, etc. We have had no response to that request, although everyone thought it was a good idea.
- Trusts currently very busy with JAG? Plans, recommendation made to contact the attendees of the meeting again to get confirmation of names of the dedicated Leads for Barrett’s, not the data at this point, or perhaps saying “thanks for nominating yourself as the person who attended that meeting (therefore the Lead)” unless someone else nominated. Suggested to assume that those who attended would be the Leads.
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- DK will ensure a response from BHR.
- DH pointed out that this should be done locally if eventually there is to be a national registry.
- MM agreed, LL runs the registry and so the data gathering capabilities are in place. BSG guidelines are very clear on the matter so it is the right time to push this forward, and there is also willingness from the clinicians to run with this.
- MM will write asking for confirmation of Leads for Endoscopy lists and Barrett’s Surveillance list.

**ACTION:** MM to write to ask for confirmation of Leads for Endoscopy lists and Barrett’s Surveillance lists in Trusts.

**ACTION:** Work with LL to populate the registry locally within London Cancer

5. OG Operational Steering Group (OSG) - update (MM)

**Discussion points:**
- The OSG has met now several times, mainly made up of people from Barts and UCH involved in the centralisation, with Queens also involved. DH has been linked in via speaker phone. OSG reports to the Cancer Unification Board (Board at UCH to which all the OSGs report).
- The Steering Group identified 3 particular workstreams to make this possible, MM looking at the workstream that deals with timetables of the Consultants at Barts Health and UCLH and producing the new timetable for how surgeons will work together from elective work, from the SMDT, for on-call arrangements, for Upper GI, for Trauma, for General Surgery - very complex.
- Frances Hughes (FH) has been charged with the pathway dealing with patients who start off in Barts Health and then who are sent for resection and who end up at UCLH. We don’t want the pathway to become longer because of the transfer, information to get lost, etc.
- Bijendra Patel (BP) is dealing with other support service, pathology, anaesthetics, CNSs, etc. that has to marry together.
- Surgeons’ timetable is now complete with consideration for each individual surgeon, extra lists needed have been identified, the on-call timetable is worked out, trauma and emergency cover was addressed also. Over the next few weeks more detail will be added to that timetable and will then be passed over to HR in the 2 areas, to look out the transfer of activity.
- FH has created a very clear pathway for patient starting off in Barts Health patch and coming over for surgery, and follow-up will be done within Barts Health.
- Dietetics has been considered but comes under BP’s remit so in due course he will be contacting affected colleagues. He is dealing initially with Anaesthetics and Pathology and then CNS, Dietetics, and quite a lot of other support services that need to be meshed into this. RS will be contacted very soon by BP.
- In Barts currently there are 3 surgeons, within their larger patch, operating, i.e. FH, BP and Ashish Rohatgi (Whipps Cross). An extra Thursday list has been produced in the week (at UCLH, to matches their current Thursday list), so there is very little disruption to their working plan with their other benign surgery - the Wednesday list for the 3 UCLH Surgeons, the Thursday list is for the Barts Health surgeons. UCLH surgeons will use the Wednesday list on a 1 in 3 surgeons rota, the same will apply to the Barts surgeons on the Thursday list. Still working in some flexibility to accommodate variations that might arise in arrangements and resource. For now the anaesthetist from Barts Health will come across with the surgeons this considered a good thing to keep the expertise up, and patients will be looked after by the entire team afterwards. Follow-up will be done where the patient came from originally, after discharge Patients from
Barts Health patch will be followed-up at Barts Health. Oncologists will stay at Barts, so all that therapy, treatment will be given at Barts. We are anxious that there aren’t too many visits to UCLH, there will be definitely 1 visit before the operation for the patient to have their bloods and cross-match done, to go see the wards, and meet the staff, etc. Barts patients will stay will stay at UCLH for the full duration, they will be discharged home from Barts Health rather than discharged from UCLH.

- This consensus achieved by the clinicians who came up with this solution. Barts Health surgeons will continue their Emergency and Trauma commitments and not to have it taken away.
- All consideration being taken to avoid a repetition of issues (lack of HDU beds and cancellations) that have occurred in the past, many of which negatively impacted patient’s time and finances.
- UCLH have a huge agenda with centralisation of Head and Neck, etc. JG explained that in terms of practicalities the service transfers depend on the service moves of out the Heart Hospital (Cardiac moving to Barts), the creation of an ICU ward at the Heart Hospital to facilitate the required capacity. The rotations needed to run smoothly otherwise everything would be out of kilter with the wrong Trust surgical team on the wrong day.
- Discharge mechanisms have been built-in to consider, what happens when patients go home, if somebody develops complications who do they ring, etc.
- 2 centres approach is still the plan Some opposition to this was expressed by LC and DK, but DK assured that BHR will collaborate with whatever is the plan. DK pointed out that this was a rationalisation of the current catchment areas within the London Cancer. Part of NHS England’s own remit was that we should take more of the Essex and the Thames corridor by patient choice. Further discussions need to happen at NHS England level.
- LC reported that patient groups mobilised, they have talked to MPs all down along the Essex and the Thames corridor who have all written to NHS England, there is ongoing communication between the MPs and NHS England because those patients living in that corridor do not want to go to Chelmsford centre.
- BHR are supporting making sure that Patients are well cared for in the new Centre. BHR gives UCLH their support in this process, which has got to go seamlessly and got to go well. MM agreed and mirrored the sentiment. the BHR team are kept involved in the OSG discussions; from the technical point of view the timetables are to do with those Surgeons and Pathologists, etc. but the wider Patient Care issues are been taken into account at every stage, and progress is being made but with the Patient in mind.

**ACTION:**

6. AOB

**Discussion points:**

- DK and Andrew Millar (AM) are starting a Pilot project that would involve UCLH, BHR and Barts looking at Colorectal Straight To Test (STT) but in addition as a pilot in Upper GI we are very keen to move forward on. This involved developing a new pathway for GPs to refer Patients early into the pathway, e.g. patients who have been to a GP x3 times without diagnosis; patients who present to A&E with abdominal pain without a diagnosis, etc. to gain a rapid entry into the pathway with a view to rolling out a comprehensive new pathway from GPs and direct from the public into our services and to diagnose even earlier. Hoping to roll out the pilot early 2015, if
that is successful perhaps to roll out with more specific pathway, to the entire network, and also there is interest on a nationally level.

- Research projects, spoken about previously – Breathe testing (GH) and the sight of sponge to be part of the new pathway described above.
- February meeting to cover Early Diagnosis themes will invite ??? to present an update on his Breathe Test. DK reported that the new machine has arrived, it is a big machine. 1st stage will be testing patients and controls in hospitals as part of a network. To be rolled out February. MM will also provide an update on OSG reporting.
- Awareness Day possibility – London events tend to inspire national event – LCA interested – MM suggested DH speak to GH officially and see if LC can get involved with any patient reps from LCA and from there to try put something together. DK suggested DH speak to LL. Very positive response from patients to the suggestion about this so don’t want to waste the opportunity. Possibly for summer event.

**ACTION:** February meeting to have Early Diagnosis theme, MM to invite ?? to present on Breathe test at the February meeting.

**ACTION:** DH to contact GH and LL regarding possibility of doing pan-London Awareness event.

### 7. Next Meeting(s)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Meeting</th>
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<tbody>
<tr>
<td>Tues 10-Feb-2015</td>
<td>15:00-17:00</td>
<td>Upper GI (OG) Pathway Board</td>
<td>Meeting Room 1, 3rd floor, 170 Tottenham Court Road W1T 7HA</td>
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<tr>
<td>Wed 20-May-2015</td>
<td>15:00-17:00</td>
<td>Upper GI (OG) Pathway Board</td>
<td>Meeting Room 1, 3rd floor, 170 Tottenham Court Road W1T 7HA</td>
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<tr>
<td>Wed 02-Sep-2015</td>
<td>15:00-17:00</td>
<td>Upper GI (OG) Pathway Board</td>
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<td>Thu 26-Nov-2015</td>
<td>15:00-17:00</td>
<td>Upper GI (OG) Pathway Board</td>
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### ACTION LOG

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Attendees

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<th>Name</th>
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<tbody>
<tr>
<td>Muntzer Mughal, Pathway Director</td>
<td>Consultant Surgeon</td>
<td>University College London Hospitals</td>
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<tr>
<td>Brian Hill</td>
<td>Patient Representative</td>
<td>Patient Representative</td>
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<tr>
<td>Cate Simmons</td>
<td>Clinical Nurse Specialist</td>
<td>Princess Alexandra Hospital</td>
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<tr>
<td>Clive Onnie</td>
<td>Consultant Gastroenterologist</td>
<td>Whittington Health</td>
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<td>David Holden</td>
<td>Patient Representative</td>
<td>Patient Representative</td>
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<tr>
<td>David Khoo</td>
<td>Consultant Surgeon</td>
<td>Barking, Havering and Redbridge University Hospitals</td>
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<tr>
<td>Elizabeth Crisp</td>
<td>Patient Representative</td>
<td>Patient Representative</td>
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<tr>
<td>Hassan Al-Ashimi</td>
<td>GP</td>
<td>GP</td>
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<tr>
<td>Jonathan Gardner</td>
<td>Programme Director Cancer Change</td>
<td>UCLH</td>
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<tr>
<td>Karen Molloy</td>
<td>Senior Administrator</td>
<td>London Cancer</td>
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<tr>
<td>Katie Walker</td>
<td>Dietician</td>
<td>Royal Free London - Hampstead</td>
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<tr>
<td>Rashmi Soni</td>
<td>Dietician</td>
<td>Barts Health</td>
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<tr>
<td>Samrod Mukherjee</td>
<td>Upper GI SpR</td>
<td>BHRUT - invited by Clive Onnie as observer</td>
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Apologies

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<tbody>
<tr>
<td>Andrew Millar</td>
<td>Gastroenterologist and Hepatologist</td>
<td>NMUH</td>
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<tr>
<td>George Hanna</td>
<td>Research Lead</td>
<td>Imperial</td>
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<tr>
<td>Rosemary Phillips</td>
<td>Consultant Gastroenterologist - in place of Cate Simmons</td>
<td>Princess Alexandra Hospital</td>
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<tr>
<td>Sharon Cavanagh</td>
<td>AHP Lead UCLP</td>
<td>London Cancer</td>
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No Apologies

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<td>Barts Health</td>
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<tr>
<td>Daniel Hochhauser</td>
<td>Consultant Medical Oncologist</td>
<td>University College London</td>
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<td>Frances Hughes</td>
<td>Consultant Surgeon</td>
<td>Barts Health</td>
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<tr>
<td>Jamshed Bomanji</td>
<td>Trials and Research - Imaging</td>
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<td>John Bridgewater</td>
<td>Trials and Research - Chemo/Radiotherapy</td>
<td>UCL</td>
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<td>Marc Winslet</td>
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<td>Royal Free London - Hampstead</td>
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<td>Martina Kelly</td>
<td>Clinical Nurse Specialist</td>
<td>Homerton University Hospital</td>
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<tr>
<td>Mike Pine</td>
<td>McMillan Lead Cancer Nurse</td>
<td>Royal Free London - Barnet and Chase Farm</td>
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<tr>
<td>Sherif Raouf</td>
<td>Clinical Oncologist</td>
<td>Barking, Havering and Redbridge University Hospitals</td>
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