Kent & Medway Cancer Collaborative

Upper GI Tumour Site Specific Group meeting
Thursday 13th October 2022
Inspiration 2&3 – The Village Hotel
09:30-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Jeff Lordan (Chair)	**JL**	Consultant Upper GI & General Surgeon	MTW
Dave Bridger	**DB**	Upper GI CNS	MTW
Aidan Shaw	**AS**	Consultant Interventional Radiologist	MTW
Hannah Fotheringham	**HF**	Upper GI CNS	MTW
Annaselvi Nadar	**AN**	Team Leader - FDS	MTW
Ben Warner	**BW**	Consultant Gastroenterologist / Clinical Lead for Upper GI Cancer	DVH
Marie Payne	**MP**	Clinical Services Manager / Lead Cancer Nurse	DVH
Chloe Sweetman	**CS**	Macmillan Upper GI HPB CNS	DVH
Sarah Simpson-Brown	**SSB**	Upper GI CNS	DVH
Diane Muldrew	**DM**	GI Nurse Specialist & Key Worker	EKHUFT
Vicki Hatcher	**VH**	Macmillan Upper GI CNS	EKHUFT
Theresa Woods	**TW**	Macmillan Upper GI CNS	EKHUFT
Sree Kotha	**SK**	Consultant Hepatologist and Gastroenterologist	GSTT
Mark Kelly	**MK**	Consultant Upper Gastrointestinal and General Surgeon	GSTT
Victoria Couchman	**VC**	Consultant Gastroenterologist	GSTT
Sarah Barker	**SB**	Project Manager – Early Diagnosis	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Bertha Mtika	**BM**	Upper GI CNS	MFT
Deborah Horley	**DH**	Upper GI Cancer Nurse	MFT
Emma Bourke	**EB**	Macmillan Personalised Care and Support Facilitator	MFT
Sue Jenner	**SJ**	Macmillan Upper GI CNS	MFT
Alison Mannering	**AM**	Oncology Specialist & Team Lead Dietitian	MFT
Laura Alton	**LA**	Senior Programme Manager – KMCA Commissioning	NHS Kent & Medway ICB
Apologies			
Suraj Menon	**SMe**	Consultant Radiologist & Clinical Director	DVH
Sue Drakeley	**SD**	Oncology (Solid Tumour) Research Team Leader	EKHUFT
Jayshri Shah	**JS**	Consultant Hepatologist	EKHUFT
Sarah Collins	**SC**	Operations Director – CCHH Care Group	EKHUFT
Oliviana Rusu	**OR**	Oesophago-gastric Cancer Nurse Specialist	GSTT

Harvey Dickinson	**HD**	SELCA Cancer Improvement Manager - Colorectal, OG & HPB	GSTT/SELCA
Jennifer Rowntree	**JR**	Lead Nurse for HPB Oncology	King's College Hospital
Andreas Prachalias	**AP**	Consultant Liver Transplantation, HPB and Pancreatic Surgeon	King's College Hospital
Bana Haddad	**BH**	Clinical Lead – LWBC	KMCA
Cathy Finnis	**CF**	Programme Lead – Early Diagnosis	KMCA
Maines Msiska	**MM**	Clinical Research Delivery Manager	MFT
Joanne Jones	**JJ**	Oncology UGI Triage and Senior Research Nurse	MTW
Mark Hill	**MH**	Consultant Medical Oncologist	MTW
Mathilda Cominos	**MC**	Consultant Clinical Oncologist	MTW
Jelena Pochin	**JP**	Head of Performance & Delivery for Diagnostics and Therapies	MTW
Stephanie McKinley	**SMc**	Matron for Faster Diagnosis	MTW
Justin Waters	**JW**	Consultant Medical Oncologist	MTW
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway ICB
Kate Regan	**KR**	Macmillan Primary Care Nurse Facilitator Lead	NHS Kent & Medway ICB
Holly Groombridge	**HG**	Cancer Commissioning Project Manager	NHS Kent & Medway ICB
Sona Gupta	**SG**	Macmillan GP & Cancer Lead	NHS Kent & Medway ICB
Stefano Santini	**SS**	Macmillan GP & Cancer Lead	NHS Kent & Medway ICB

Item		**Discussion**	**Action**
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • JL welcomed the members to the meeting and asked them to introduce themselves. **Action log – review** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **Previous minutes - review** • The minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2	**Liver Surveillance project update**	**Presentation provided by Laura Alton** • LA stated that liver surveillance, which is part of the Planning Requirements on Cancer Alliances for 2022/23, requires the KMCA to develop equitable liver surveillance pathways across the region. • A gap analysis was carried out on current surveillance services across Kent & Medway. An audit carried out last year showed only 7% of DVH liver patients were under regular US surveillance. MFT reported a register and	

		currently have 111 patients receiving regular US surveillance. MTW also reported a new register and currently have 244 patients under regular US surveillance. Clinics have been set up under JS at EKHUFT. It is currently unclear as to what the figures are for the Trust but it needs to be expanded. • CF wishes to form a stakeholder/Task & Finish Group in order to move forward with this workstream collaboratively. She would like nominations from each of the 4 Trusts and is seeking representation from liver services, gastroenterology, radiology, US services, clinicians and managers. The group will also include members from public health, alcohol services and those with lived experience. Nominations are to be sent to cathy.finnis@nhs.net. • From primary care data the Alliance have calculated there are more than 5000 known patients with a diagnosis of cirrhosis. However, they strongly suspect this figure is lower than the actual number who are yet to be diagnosed. People who have cirrhosis are at greater risk of developing HCC and identifying it at an earlier stage could improve the success rate of treatments. The initial focus from NHSE is to establish an equitable pathway across Kent & Medway. The stakeholder group will work collaboratively with partners to develop a service specification enabling a sustainable and commissioned service proposal to be presented to the ICB. • Please refer to the below link for an overview of the NICE guidance in relation to the liver surveillance statements: https://www.nice.org.uk/guidance/qs152. • BW believes this piece of work needs to be addressed urgently, especially as Kent & Medway are the worst county in the country for liver surveillance. JL feels there needs to be a dedicated funded pathway with a link to King's College Hospital and asked the group to provide input in to this workstream. • **Action: Update on liver surveillance to be brought back to the next meeting in 6 months.**	**LA/CF**
3	**Cancer Alliance update**	**Presentation provided by Sarah Barker** • SB provided the group with an overview of the various projects relating to the following workstreams (please refer to the presentation circulated on 14.10.2022 for a detailed breakdown of what these are): - Faster diagnosis and operational improvement. - Early Cancer Diagnosis. - Treatments & Personalised Care. - Cross Cutting Themes.	
4	**Draft 'Faster Diagnostic Pathway'**	**HPB – presentation provided by Jeff Lordan** • JL provided the group with an overview of the *Implementing a timed HPB cancer diagnostic pathway: pancreatic, liver, bile duct and gall bladder* document. • This guidance sets out how diagnosis within 21 days can be achieved for the suspected HPB cancer pathway, consisting of pancreatic, liver, bile duct and gall bladder cancers. Alongside the pathway itself, resources are highlighted to support implementation of the pathways. • This standard will ensure people are told they have cancer, or that cancer is excluded, within a maximum of 28 days from referral. • The initial threshold is currently 75% although there are plans to increase this in subsequent years. • JL updated the group with regard to: - The FDS performance for upper GI (HPB and OG) versus all suspected cancer referral routes from April 2021 to June 2022.	

- The age-standardised 1 year and 5 year net survival for both males and females (aged 15 to 99 years) diagnosed with cancer in 2015 to 2019.
- Upper GI (HPB and OG) cancers referred for urgent suspected cancer (2ww standard) by volume and performance, 2018/19 to 2022/23 (up to Q1).
- Upper GI (HPB and OG) cancers referred for urgent suspected cancer and commencing treatment (62d standard) by volume and performance, 2018/19 to 2022/23 (up to Q1).

- JL highlighted the benefits of the FDS pathway for patients and carers, systems, experience of care and clinicians.
- JL provided the group with a summary of the 21-day jaundice, pancreatic, extrahepatic cholangiocarcinoma, gall bladder and 21-day liver and intrahepatic cholangiocarcinoma pathways.

DVH

- There has been a stable underachievement for the FDS despite the team striving to improve the service.
- STT triages are occurring within 72 hours.
- The endoscopy service prioritises cancer patients although time to procedure can be >7days. Patient choice delays have also occurred on a number of occasions.
- There have been tertiary centre delays for EUS'/one-stop PETs. There have also been delays with local PETs.
- Consultant involvement in the PTL helps to expedite consultant reviews. The exit pathway then sits with the CNS'.
- The new MDT coordinator is working on improving data completeness.

EKHUFT

- EKHUFT are improving on their FDS position and are working hard to embed the STT service.
- Healthcare provider delays and admin delays sighted are the largest issues to delivery.
- The service is working with the care group in order to obtain support for the benign letter templates. This will ensure timely communication with patients and for post-MDM discharges.
- The CSW is involved in patient engagement and calls patients if they DNA their first appointment to ensure they are supported and to make sure early intervention for the subsequent appointment is provided.

MFT

- MFT have struggled to meet the standard despite the STT process being in place. There is an ongoing vacancy in the STT nurse triage team.
- Over half of the 2ww breaches are due to endoscopy capacity. Other reasons include: imaging capacity, patient choice (delays, rescheduling and DNAs), staff sickness, patient sickness, inadequate preparation, clinic cancellation, HMP availability and histology delays.

MTW

- For the upper GI pathway, the multiple diagnostic tests required means the services often exceeds 28 days for diagnosis or discharge.
- Additionally, there is not a clear process of recording when the patient is informed of their diagnosis or discharge and therefore this date should be accepted with caution.

		Oesophageal Gastric cancer – presentation provided by Mark Kelly • OG cancer is currently the fifth most common cause of cancer in the UK affecting around 16000 people each year, and the fourth most common cause of cancer death. • Between 2015 and 2018 only 71.1% of patients diagnosed with upper GI cancer commenced treatment within 62 days of referral. This varied by cancer alliance with a range of 61.3% to 81.4%. • For OG cancer patients in England diagnosed between 2011 and 2015, one-year age-standardised net survival was 43.9% for OG cancer and 43.2% for gastric cancer. • In 2016, only 23% of OG cancers were diagnosed at an early stage. This varied by cancer alliance with a range of 21.2% to 33.1%. • Patients with OG cancer have some of the poorest outcomes and longest intervals between referral and commencement of treatment amongst all cancers in England at present. A streamlined and more efficient pathway will improve these avoidable delays and should reduce the considerable variation which is currently seen. • The patient pathway from referral to decision to treat for OG or gastric cancer is one of the most complex cancer pathways. The combination of endoscopy and biopsy, CT and PET-CT imaging, interventional staging and comprehensive comorbidity assessment highlights this complexity. Unlike other more common cancers, the initial diagnostics are undertaken at a patient's local hospital managed by the core MDM and the more invasive staging investigations require specialist decision and intervention with specialist MDM involvement. • MK provided the group with a summary of the 28-day best practice timed pathway. • MK outlined the service models which could be implemented to try and reduce variation and make improvements to patient flow: - Clinical triage to optimise direct access to diagnostics. - Local service agreements for faster access to radiology and histopathology reports. - Predetermined algorithms and standards of care, with simultaneous booking of all investigations. - Networking (e.g. hub and spoke) to optimise use of existing resources and expertise, particularly useful for improving radiology and histopathology reporting times and access to specialist investigations. - Workforce utilisation. • MK made a set of proposals on how this issue could be expedited. Please refer to the presentation circulated on 14.10.2022 for an overview of what these are. • **Action: JL highlighted the importance of there being radiology meetings across all Trusts.**	**All Trusts**
5	**EUS Service update**	**Presentation provided by Ben Warner & Jeff Lordan** • BW provided the group with an overview of the planned EUS service for Kent & Medway. • The EUS service will be situated at both MTW and DVH, with 4 lists planned each week (2 per site) and 4 endoscopists will be in place. • It is estimated there will be 300-400 EUS' performed each year with cross-cover arrangements in place. • There will be shared clinical governance in place and a regular review of the service. • 4 endoscopists are in training (at GSTT, KCH and PRUH) and it will take them 6-12 months to come online.	

		Competency will be assessed by the training centres and this will involve reviewing the numbers of EUS' performed, FNAs and suchlike so the centres have trust in their reports. • With regard to setting up the service, BW highlighted the following needs to be taken in to consideration: - Referral pathways. - Nurse training (how many nurses and how many sessions will be needed). - Clinical governance e.g. patient information sheets. - Cross-cover arrangements. • With regard to HPB endoscopy, BW highlighted there is a lack of ERCPists (a shared problem). He is the only person who performs this at his Trust, although there should be 2 people who can perform the procedure. The EUS services at both Trusts will come online in 2023 (January for MTW JL believes) and HPB endoscopy training will be made available in the region. BW outlined the need to establish better elective referral pathways for urgent and non-urgent but complex ERCP and EUS cases (Spyglass EHL, bilobar stenting and palliative EUS stenting). • JL stated he is working on an EUS SOP and the service will employ a hub and spoke model. • EUS cases will be discussed at the King's College Hospital MDT so there is equal access for all Trusts across the patch.	
6	**Tertiary ERCP Referrals**	**How best to refer / What to refer – presentation provided by Sree Kotha** • SK provided the group with an update in relation to the ERCP service at GSTT. • There are 5 lists a week, 2.5 of which are GA lists. • SK stated that GSTT have a robust interventional radiology service. • SK provided an update in relation to the tertiary referrals process. • SK highlighted the steps involved in the Spy+EHL+Laser, biliary RFA and complex hilar processes. • SK emphasised the importance of maintaining good dialogue between Trusts and she would be happy to discuss anything pertaining to referral processes. Her email address is Sreelakshmi.kotha@gstt.nhs.uk.	
7	**Performance**	**What can we do to improve FDS performance – 75% target** • JL stated KMCA is currently the lowest performing Alliance in England for the FDS piece but it is the highest performing Alliance for the 62d standard. **DVH – update provided by Marie Payne** • Please refer to the performance slide pack for an overview of the Trust's data. **EKHUFT – update provided by Vicki Hatcher** • Please refer to the performance slide pack for an overview of the Trust's data. **MFT – update provided by Emma Bourke** • Please refer to the performance slide pack for an overview of the Trust's data. **MTW – update provided by Jeff Lordan** • Please refer to the performance slide pack for an overview of the Trust's data.	
8	**Research update**	• This item was not discussed.	

9	**Clinical Audit update**	• This item was not discussed.	
10	**CNS Updates**	**DVH – update provided by Sarah Simpson-Brown** • There is currently no oncologist in place for Upper GI at the Trust, although a locum is due to start at the end of the month. • STT and exit clinics have been set up. • 78% of HNAs have been completed. **EKHUFT – update provided by Vicki Hatcher** • VH highlighted how the Upper GI CSW had supported the service. • 1 of the STT nurses is on a secondment for a year. • The MDT Coordinator will be returning from maternity leave on 31.10.2022. • Work has gone on to improve patient engagement. • A new oncologist is now in place at the Trust. • The STT nurses have a good link in with their equivalents across the patch. **MFT – update provided by Sue Jenner** • Support groups and a local improvement group have been set up. • The surgical clinics have stopped. • The Trust's CSW is holding HNA clinics. **MTW – update provided by Debbie Killick** • A CSW role has gone out to post. • The service currently does not have an administrator. • DK introduced HF as the Upper GI CNS. • DK will be leaving the service in December 2022. • The service currently does not have an MDT Coordinator. **Audit for the post-MDM clinic – presentation provided by Dave Bridger** • DB provided the group with an overview of the data pertaining to a post-MDM clinic audit which commenced in May 2021. • The data showed: - A total of 293 patients were seen in this clinic by DB, DK, Wendy Brown and Yvonne Gravestock. - The tumour sites affected (with pancreas the area most impacted). - The number of patients referred to outside Trusts (GSTT, King's College Hospital, The Royal Marsden and others). - The number of referrals made to a dietitian (100 patients accounting for 34% of the overall figure audited). • Please refer to the presentation circulated on 14.10.2022 for a more detailed summary of the data. • **Action: The MTW audit has now been registered and will be presented at the next meeting. BW to present**	**MTW/BW**

for DVH.

Post Whipples – patient survey report – update provided by Debbie Killick

- DK provided the group with a summary of the patient service survey for MTW patients following surgical resection at King's College Hospital by the CNS at MTW's follow-up clinic.
- The aim of the survey was to assess patient experience following the Post Whipples nurse-led clinic within its first 18 months.
- A concise survey was sent to 19 patients who had been through the Post Whipples follow-up clinic from October 2019 to June 2021. The survey asked patients clear and concise questions regarding the nurse-led follow up clinics to assess their effectiveness and to identify any changes which may be necessary. Completed surveys were sent directly to the survey department at Maidstone Hospital and information compiled for assessment.
- A total 19 surveys were sent in the post and 15 patient surveys were returned to the survey department. Unfortunately, they were mislaid for 9-10 months so therefore delayed the results being formulated.
- All of the patients who returned the survey agreed they had had surgery at King's College Hospital, went on to be referred to the Upper GI CNS nurse-led clinic and felt confident in the clinic (although 4 out of the 15 stated they would rather see a consultant whereas 8 would prefer to see the CNS). The comments were positive stating the CNS' have always been very supportive and they have access to a consultant should the need arise.
- 10 out of the 15 patients were referred for oncology treatment following their surgery and 13 out of the 15 were aware they would then be followed up by the CNS team in a nurse-led clinic.
- 100% stated they knew who their CNS/keyworker was and they were able to contact them if needed.
- 10 were aware they had been referred to other services or for further investigations, 2 were not sure and 3 stated they were not aware. The comments suggested these were for a range of investigations such as blood tests, scans and GP support for medications.
- 13 out of 15 replied they were happy with the service, 1 said they were not sure and 1 said they were not. These clinics have now recommenced face-to-face following the reduction of COVID-19 measures and lockdown.
- When asked what service they would like to choose from, some patients chose multiple answers and this revealed:
- 53% wanted to attend the local MTW CNS follow-up clinic with access to a consultant, 10.5% wanted to attend the King's College Hospital CNS follow-up clinic with access to a consultant, 21% wanted to be followed up by an MTW consultant, 5% wanted to be followed up by a King's College Hospital consultant and 10.5% did not have a preference with regard to follow-up.
- These results suggest the CNS nurse-led clinics have been successful and favoured by the patients involved in this follow-up service with access to the consultant if required. With the clinic running for nearly 3 years either face-to-face or via the telephone during lockdown, a few patients have now been discharged back to their GP as they have completed 5 years follow-up with no evidence of disease. Part of the clinic process is to assess their symptoms and request scans and/or blood following their algorithm, which has recurrence and they have been referred back to the oncologist for consideration of palliative chemotherapy.
- DK provided the group with an overview of the pathway for the Upper GI CNS-led follow-up clinic for post-operative Pancreatic/Hepatic/Bilary patients.
- DK believes it would be helpful to circulate the report and discuss it with King's College Hospital surgeon Simon

		Atkinson and the local Upper GI MDT. She also thinks it would be helpful to circulate the report to the Upper GI TSSG (which CC did on 14.10.2022). • Since originally sending out the survey in 2021, the dietetics team attend the appointments regularly face-to-face providing an invaluable service, so making the report available to the team to continue funding for ongoing dietetic support is important. • DB to continue to lead the Upper GI CNS nurse-led clinics with access to consultant support if required.	
11	**Radiologist updates**	**PTC & Liver intervention – presentation provided by Aidan Shaw** • AS provided the group with an overview of imaging and intervention in the biliary tract. His slides (circulated on 14.10.2022) include a summary of: - Biliary tract obstruction. - Percutaneous Transhepatic Cholangiography (PTC). ERCP has largely replaced PTC in the diagnosis and treatment of biliary tract obstruction. - The current role/indications of PTC. PTC is performed when ERCP is not possible. - Contraindications. - Pre-procedural imaging. This typically consists of a USS followed by CT or MRI +/- MRCP. - Pre-procedural preparation. - The sedation/analgesia required for the procedure. - A detailed breakdown of what the procedure involves. - Stent versus internal/external drain versus external drain. - Post-procedural management. - Complications (such as infection, bile leak and bleeding). - Duodenal/biliary tract obstruction. - The utilisation of biliary biopsy forceps. - Unilateral access with bilateral stenting. • AS believes PTCs are the hardest procedure for interventional radiologists to perform. He added that he is happy for other clinical colleagues across the patch to view him performing the procedure should they wish to visit his Trust. • **Action: AS to be invited to future meetings to provide further radiology updates. CC to add him to the mailing list.**	**CC**
12	**AOB**	• JL highlighted the need for there to be primary care GP engagement at these meetings. He believes it would also be helpful to have clinical governance input. **Action: JL to follow this up with Rakesh Koria and Ian Vousden.** • JL outlined the need to ensure primary care are transparent with patients if they are being referred on a suspected cancer pathway. • DK highlighted the need for the next pan-Kent CNS meeting to be scheduled.	**JL**
	Next Meeting Date	• To be confirmed.	