Kent and Medway Cancer Collaborative

Upper GI Tumour Site Specific Group meeting
Thursday 28th April 2022
Microsoft Teams
09:30-12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Jeff Lordan (Chair)	**JL**	Consultant Upper GI & General Surgeon	MTW
Justin Waters	**JW**	Consultant Medical Oncologist	MTW
Wendy Brown	**WB**	Upper GI CNS	MTW
Yvonne Gravestock	**YG**	Upper GI CNS	MTW
Joanne Jones	**JJ**	Upper GI FDS/STT Nurse	MTW
Olukemi Wallace	**OW**	Consultant Medical Oncologist	MTW
Naomi Butcher	**NB**	General Manager - Cancer Services	MTW
Ben Warner	**BW**	Consultant Gastroenterologist / Clinical Lead for Upper GI Cancer	DVH
Marie Payne	**MP**	Lead Cancer Nurse / Clinical Services Manager	DVH
Sarah Barney	**SBarn**	Upper GI CNS	DVH
Julie Compton	**JC**	Early Diagnosis CNS for Upper GI and Lung	DVH
Chloe Sweetman	**CS**	Macmillan Upper GI HPB CNS	DVH
Chirag Kothari	**CK**	Consultant Physician & Gastroenterologist	DVH
Philip Mairs	**PMai**	Consultant Gastroenterologist	DVH
Geoff Dickinson	**GD**	Oncology and General Dietitian	DVH
Jayshri Shah	**JS**	Consultant Hepatologist & Gastroenterologist	EKHUFT
Emma Lloyd	**EL**	Hepatology CNS	EKHUFT
Paul Matravers	**PMat**	Consultant Radiologist	EKHUFT
Ankur Shah	**AS**	Consultant Surgeon	EKHUFT
Sandra Pilcher	**SP**	Viral Hepatitis CNS	EKHUFT
Deepika Balasubramanian	**DB**	Upper GI STT Nurse	EKHUFT
Vicki Hatcher	**VH**	Macmillan Upper GI CNS	GSTT
Oliviana Rusu	**OR**	Oesophago-gastric Cancer Nurse Specialist	GSTT
Kemal Hussein	**KH**	Cancer Data Team Service Manager	GSTT
Mark Kelly	**MKe**	Consultant Upper Gastrointestinal and General Surgeon	GSTT
Jeremy Mashonga	**JM**	Senior Pathway Manager	GSTT
Rahman Nuri	**RN**	Upper GI Surgery and Emergency General Surgery Service Manager	GSTT
Simon Atkinson	**SA**	Consultant Pancreaticobiliary and General Surgeon	GSTT
Harvey Dickinson	**HD**	SELCA Cancer Improvement Manager - Colorectal, OG & HPB	GSTT/SELCA
Andreas Prachalias	**AP**	Consultant Liver Transplantation, HPB and Pancreatic Surgeon	King's College Hospital
Mike Cooshneea	**MCoo**	General Manager - Liver, Gastroenterology, Upper GI, Bowel Cancer Screening & Endoscopy	King's College Hospital
Camilla Dobinson	**CD**	Service Manager – HPB	King's College Hospital
Jennifer Rowntree	**JR**	Lead Nurse for HPB Oncology	King's College Hospital

Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
David Osborne	**DO**	Data Analyst	KMCA
Sarah Barker	**SBark**	Project Manager – Early Diagnosis	KMCA
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Tracey How	**TH**	Upper GI/Colorectal Cancer Support Worker	MFT
Glynis Corry	**GC**	Genetic Straight to Test CNS	MFT
Jennifer Priaulx	**JP**	Macmillan Cancer Transformation Project Manager	MFT
Alison Mannering	**AM**	Oncology Specialist & Team Lead Dietitian	MFT
Sue Jenner	**SJ**	Macmillan Upper GI CNS	MFT
Melanie Kot	**MKo**	STT Nurse for Upper and Lower GI	MFT
Deborah Horley	**DH**	Upper GI Cancer Nurse	MFT
Laura Alton	**LA**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG
Hannah Vincent	**HV**	GP Fellow - Kent and Medway Cancer Alliance	NHS Kent & Medway CCG
Stefano Santini	**SS**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Apologies			
Sue Drakeley	**SD**	Oncology (Solid Tumour) Research Team Leader	EKHUFT
Ioannis Bollas	**IB**	Consultant Gastroenterologist	EKHUFT
Zach Tsiamoulos	**ZT**	Consultant Gastroenterologist & Specialist in GI Endoscopy / Clinical Lead for Endoscopy	EKHUFT
Cathy Finnis	**CF**	Programme Lead – Early Diagnosis	KMCA
Mathilda Cominos	**MCom**	Consultant Clinical Oncologist	MTW
Tracey Nolan	**TN**	Upper GI STT Nurse	MTW
Mark Hill	**MH**	Consultant Medical Oncologist	MTW
Paulette Basham	**PB**	Clinical Trials Administrator	MTW
Steph McKinley	**SM**	Matron – Faster Diagnosis	MTW
Annaselvi Nadar	**AN**	Team Leader - FDS	MTW
Debbie Killick	**DK**	Upper GI CNS	MTW
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Helen Graham	**HG**	Research Delivery Manager (Cancer) Lead	NIHR

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 with the final minutes from today's meeting.	

		Previous minutes - review • The minutes from the previous meeting which took place on 07.10.2021 was reviewed and agreed as a true and accurate record.	
2	**Listening & Learning**	**Presentation provided by Tracey Ryan** • TR presented research on barriers to patients attending endoscopy appointments. • Feedback had been received from providers indicating there was a reluctance by some patients to attend endoscopy appointments. To explore reasons behind the reluctance with a view to improving attendance, TR made a successful application for research funding for system-wide co-production. • A cohort of 76 male patients included those: living in areas with high indices of deprivation, in BAME communities, living with a disability, and identifying as part of the LGBTQIA+ community. Of these 76 patients: - 92% confirmed they would attend if the need was greater than the fear. - 62% felt information about the details of the procedure could help them overcome their concerns about attending an endoscopy appointment. • The research highlighted the importance of providing patients with a detailed understanding of the procedure, and the reasons for needing it. TR proposed having a video or videos in place to provide easily accessible information which could support patient understanding. • The research identified three main issues/areas for further exploration: - Information and communication considerations (for example not knowing approximate timescales for when patients should receive the results following their procedure and what support may be available for them). - Patient anxieties (for example with regard to the nature of the procedure and feelings of embarrassment). - Hidden factors (for example people with mental health issues). • TR believes it would be helpful to involve patients in letter writing so they can advise the professionals on what content they believe would be helpful for patients to know and to use non-medicalised terms where possible in order to support patient understanding. • TR is working with endoscopy managers and screening teams to look at how to use the information collected in order to improve patient experience and hopefully increase hospital attendance/reduce cancellation and DNA rates. • TR feels it may be helpful to include a flag on referral forms for additional needs. • TR believes FAQs would be helpful to include either on appointment letters or as an accompanying document. There is a plan to trial this in one Trust for a period of 3 months as suggested by the focus group and the outcomes of this can then be reviewed. TR added that before the FAQs are sent out, the focus group can work on obtaining figures for cancellation/DNA rates at the trial Trust and then after 3 months review whether any improvements were made. • TR provided the group with an overview of proposed FAQ questions. • TR is working with a colleague named Becky from EKHUFT around the potential for filming a patient having an endoscopy in order to educate others (including those who require an endoscopy) of the procedure. • TR highlighted the importance of taking in to account that patients may prefer to be contacted in a format of their choosing, for example in the form of an easy read document. • TR highlighted the benefits of providing admin staff with training as they are normally the first port of call for patients. She believes it would be helpful if they had a script/prompts to assist them and then pass on information to clinical teams who can call patients back to answer any clinical questions they may have. • One Trust is putting on admin training so TR will link in with them, review the process and then share the findings with the other Trusts. • TR emphasised the importance of staff being aware of patient anxieties and to provide reassurance. • JP, MP and JJ stated they would be happy to link in with TR's focus group in order to support this piece of work on behalf of their	

		respective Trusts.	
3	**Research update**	**<u>Update provided by Justin Waters</u>** • JW provided the group with an overview of the KSS Upper GI Cancer Research Recruitment document supplied by Helen Graham for 2021/22. The trials mentioned include: - CIRCUS V3. - SALIVA TO PREDICT DISEASE RISK (version 1). - PLATFORM. - SCOPE 2. - OCCAMS: Multicentre Study Determining Predictive Biomarkers & Targets for Oesophageal Adenocarcinoma. • COVID has had an impact on the ability to recruit patients for oncology research trials but this issue is in the process of being expedited. • Trials actively being recruited to include ACTICCA-1 and PLATFORM. • MTW have expressed an interest in ABC-10 and a new adjuvant trial for HPB tract cancer which will hopefully follow on from the completion of ACTICCA-1 (due to complete recruitment at the end of this year). • JW stated there are some new trials in the offing for OG cancer looking at various targets including immunotherapy. • MTW are not taking part in the CIRCUS V3 and SALIVA TO PREDICT DISEASE RISK (version 1) trials.	
4	**ACN**	**<u>Update provided by Harvey Dickinson</u>** • The ACN has separate groups for HPB and OG and they meet bi-monthly. • The ACN are in the process of establishing priority areas for next year, identifying what they tried to deliver last year and looking at funding opportunities. • OG in particular has been called out in the national cancer planning guidelines (both in SEQUINS for 2023 around faster diagnosis and in the national cancer planning guide). In view of this, part of the ACN's remit will be focused on this workstream. • In the last 2 months the ACN worked with their Trusts to run a rapid diagnostic stocktake (which HD described as a kind of audit/scene setting process against the 7 national principles which all 2ww/diagnostic pathways will have to comply with in the next 2 years). The ACN would like to run a workshop on this later this year specifically for upper GI, particularly with regard to understanding the timed pathway, adherence to it, triage and STT models across southeast London (and how these vary and how they can be made more consistent). • The ACN are also undertaking work around: - Understanding routes to diagnosis. - Looking at changes in emergency presentations during the COVID period. - Understanding the outcomes of patients who had treatment during the pandemic in all modalities. • The next HPB meeting is scheduled for 11.05.2022 and there will be a focus on some plans regarding the HCC pathway. The ACN are looking to do some pathway analysis work around the HCC pathway and see what data can be pulled out. • The ACN are involved in the liver surveillance programme and they put in a joint bid along with northeast London for a liver surveillance bus. The funding for this was successfully achieved and the bus will hopefully be live in mid-May 2022 in southeast London. • A direct-to-CT pancreas pathway for GPs to access is now being piloted at both King's College Hospital and Lewisham Hospital. The first set of initial data on this will be presented at the HPB meeting on 11.05.2022. • The ACN are working with the radiotherapy ODN across the southeast of England on pancreatic SABR and they are looking to develop a SOP for this pathway (including information on fiducial insertions for EUS' and CT-guided SABR and presenting these treatment options to the MDM meetings for discussion). • The cytosponge trial remains ongoing. Dr Nashiz Inayet from EKHUFT attended the last OG meeting and provided some helpful feedback/input based on the cytosponge trial in place in East Kent.	

	KCH point of view	• The ACN are in the process of looking to recruit a new OG chair. • The ACN have a funding process in southeast London around small clinically-led QI projects. • AP encouraged relevant colleagues to join the bi-monthly ACN meetings. JL agreed this would be beneficial for all concerned and would help to foster closer links between the various sites. **<u>Update provided by Andreas Prachalias</u>** • AP outlined changes to personnel since the last meeting and confirmed the HPB service is now fully established in terms of service management. • King's College Hospital appointed a new HPB surgeon last year who will be sharing the pancreatobiliary cancer workload from MTW. • AP and his team will be visiting Leeds Castle for a referrers day on 08.07.2022. A programme for this will be circulated in due course and Kent & Medway colleagues are welcome to join the event. • EUS stagnation issues have resulted in delays in the pathways. In order to mitigate this as much as possible, King's College Hospital have employed a 3-pronged approach: 1. They are embarking on training Kent & Medway colleagues. 2. They are internally training a third person to perform EUS' and that person will be ready to go live from autumn 2022. 3. They are looking to recruit a further consultant within the next year to perform these particular types of highly specialised HPB endoscopies (which includes system gastroscopies, EUS' and complex therapeutic ERCPs) in order to bolster the team's ability to deal with problems which are not easily dealt with at the Kent & Medway sites. • Through the ACN they will be revamping and rewriting all of their clinical guidelines and hope to do this within the next 6 months. Once they have been finalised they will be shared with Kent & Medway colleagues and this should hopefully empower the local MDMs to make decisions based on these guidelines and stem the flow of patients able to be dealt with locally without sending everything to the Centre MDT. • AP stated that a lot of the cases being sent to King's College Hospital are due to the lack of appropriate radiology input in Kent & Medway. The Trust previously put in place a mentoring week for radiologists which AP would like to reinstate and which HD confirmed they would put in a bid for again. JL agreed it would be sensible to discuss the issues pertaining to radiology outside of the meeting in order to try and resolve them.	
5	**Clinical Audit**	**<u>National outcomes data – presentation provided by Mark Kelly</u>** • MKe provided the group with an overview of the NOGCA Annual Report for 2021. He believes the results are positive overall. • The report includes information on patients diagnosed with OG cancer in England and Wales and those with HGD in England. • MKe's slides provided an overview of: - Data pertaining to the diagnosis of HGD. - Data relating to initial primary treatment for patients with HGD by Cancer Alliance of diagnosis. - The percentage of patients who had active treatment/endoscopic treatment for OG cancer. - Data pertaining to routes to diagnosis for OG cancer, particularly in relation to the percentage of patients diagnosed following an emergency presentation. - Staging investigations for OG cancer. - The use of PET-CT scans among patients with OG cancer who had curative treatment. - Completeness of data on clinical stage for OG cancer. - Treatment plans for OG cancer. - The time from referral to start of curative treatment for patients with OG cancer. - 30 day and 90 day mortality rates following oesophagectomy and gastrectomy for patients with OG cancer. - The adjusted 90 day mortality rate after curative surgery for OG cancer patients.	

		- Pathology outcomes after surgery for patients with OG cancer. • JW stated there is a need for MTW to look in to why their data is not feeding in to the national audit as the PET-CT data appears to be inaccurate. MKe agreed with this and stated a coordinated response is needed.	
6	**GSTT Referrals from Kent & Medway**	**Update provided by Oliviana Rusu** • OR mentioned there has been an increase in the number of complex cases being referred in. Complex cases lead to more time being spent clarifying and optimising patients for staging investigations. In view of this, she believes it is important the referrals contain adequate information and are made as soon as possible in order for the patient's pathway to continue as smoothly and quickly as is possible. • Once a patient is discussed at the local MDM and considered for staging investigations or surgery, the referral should be sent to GSTT as soon as possible. • GSTT are occasionally able to process patients for the one-stop clinic for the following week. There are, however, limited slots allocated for this clinic so it is important patients attend these appointments. • Referrals received by Wednesday can be processed rapidly otherwise patients have to wait another 1-2 weeks to be allocated an appointment. • Post-neoadjuvant chemotherapy patients will always be discussed the following week after the local MDM but it is important GSTT receive these referrals by Thursday so the team have enough time to do the necessary clinical and administrative preparations such as: registration, scanning, data extraction for MDM summary, requests for investigations, establishing clinic arrangements, COVID test courier booking, sending relevant information to patients by post, calling patients to clarify their schedule arrangements and answering any concerns they may have. • OR highlighted the importance of radiological images being transferred, histopathology reports being sent and ITT forms being attached to referrals. • OR believes the MDM Coordinator's designation is to: - Identify, coordinate, monitor and adjust the patient's investigations pathway. - Identify any delays, proactively manage them, escalate if and when required and ensure they are resolved with the aim of facilitating the commencement of treatment. • If a patient is referred on a 2ww pathway and the findings required upper GI MDM discussion, then an onwards referral will be sent to GSTT by an MDM Coordinator. It is important that the central and coordinated route of referral is maintained. This centralisation keeps things simple, easy to trace and prevents delays between services. • JP stated it would be helpful to have specific examples of where processes can be improved. JM agreed to link in with her and will set up a meeting to discuss this further. • **Action: Update on this item to be provided at the next meeting.**	**OR**
7	**Update – EUS service**	**Presentation provided by Ben Warner and Jeffrey Lordan** • BW highlighted the need to have a robust, safe and dependable local EUS service. • A working group was put in place to determine how an EUS service could be set up locally. • The EUS service is planned for both DVH (where there will be a joint service with MFT) and MTW. These sites were chosen as they already had EUS equipment, endoscopists partially trained in performing EUS' and the capacity to provide the service. • There is an intention to have 4 EUS lists in place each week (2 per site). • 4 endoscopists are currently in training at GSTT, King's College Hospital and the PRUH and will be in place to support the service. They aim to come online in 8-12 months and will cross cover when required. • Competency is to be assessed by the training centres based on the numbers of EUS', FNAs and suchlike so these centres have trust in the MTW and DVH reports. • It is estimated there will be 300-400 EUS' performed each year on both malignant and benign cases for upper GI and HPB patients.	

		• There will be a shared clinical governance process in place and a regular review of the service to determine how it is performing. • With regard to the setting up of the service, JL highlighted the importance of: - Thinking about how to set up referral pathways. - Nurse training and determining how many nurses and sessions will be required to support the service. - Clinical governance considerations (for example patient information sheets). - Establishing cross cover arrangements. • JL stated there is an intention for the EUS service to follow a hub and spoke model with King's College Hospital and for there to be a governance process in place between MTW, DVH and King's College Hospital. • JL has worked with colleagues to look at how the service will be commissioned at both DVH and MTW.	
8	**All Trusts update on Liver Surveillance for Cirrhotic Patients**	**<u>Presentation provided by Jayshri Shah</u>** • JS' presentation provided an overview of: - What surveillance is and its aim. - Why liver surveillance should be considered. - Risk factors and the prevention of HCC. - Who should be offered liver surveillance. - How liver surveillance should be provided. - The AASLD 2018, APASL 2017, EASL 2018 and ESMO 2018 guidelines on who should be offered liver surveillance. - Why the EASL 2018 guidelines do not recommend AFP for HCC surveillance. - The role of hepatic ultrasound. - The objectives, method and results of the East Kent audit for HCC surveillance. - The nurse-led HCC surveillance clinic at East Kent which commenced in January 2019. - The nurse-led HCC surveillance clinic SOP. • BW stated DVH conducted a similar audit and had similar results to EKHUFT (only 10% of patients were on HCC surveillance) with the problem exported to GPs. He believes the CNS-led clinic (which comprises of 2 full-time CNS') at EKHUFT seems to be the way forward and he would like to try and persuade his Trust to put the same set-up in place. • After putting the clinic in place, EKHUFT increased the percentage of patients on surveillance to 30%. • EKHUFT accept responsibility for patients who are cirrhotic as they cannot be discharged back to their GP due to the ongoing need for monitoring. Non-cirrhotic patients are, however, discharged as per the BSG guidelines. • JS mentioned EKHUFT will need to run another audit to see what improvements have been made since the last one. • JS believes the network is seeing a rising incidence of liver cancer. • With regard to liver surveillance (which is included in the 2022/23 national cancer planning guidance), the cancer alliance will be working on identifying gaps (including in resource) and looking at the network's data to ensure it is accurate. LA will be working on a formal commissioning plan document so the liver surveillance piece can be formally resourced. Some pump priming resource can also be assigned from the transformational funding. LA highlighted the importance of baselining the services and ensuring adequate resource is in place. • JS believes the Trusts are dedicated on working together and informed the members that there is a Kent Hepatology meeting on 20.05.2022 (which takes place annually) and it would be helpful if relevant colleagues from across the patch could come along to discuss how they can collectively function as a network on this workstream. She added that there would also be a need to have business and operational meetings throughout the year. • The CNS' at EKHUFT have started a nurse-led non-alcohol fatty liver disease clinic and are strictly following the BSG pathway for NAFLD whereby they are urging GPs to only refer patients in after they have done the NAFLD fibrosis score. • There is a one-stop service for NAFLD at EKHUFT whereby select patients are given a fibro scan and then discharged depending	

		on the NAFLD fibrosis scores. • The EKHUFT team now have a cirrhosis surveillance service in place and are looking to set up a nurse-led haemochromatosis service. The CNS' are also being trained by JS to do the decompensated liver disease service whereby they join JS on ward rounds on a weekly basis. • The EKHUFT team will also be starting a hot decompensated liver disease service shortly. • The waiting list for new appointments at EKHUFT has gone up to 18 months and the CNS' are fully-booked until August 2022. • The team are looking to recruit a fibro scan technician in order to perform the scans. • JL stated there is a clear need for more people to support this service across the patch and once the service is formally commissioned with funding in place manpower can then be increased. • SBark stated that she is planning to do some work along with Cathy Finnis and LA to baseline what all 4 Trusts are doing in terms of current surveillance of liver patients and asked if there was someone at each Trust she could liaise with in order to take this forward. **Action: AW to email the group in order to ask the Trusts to link in with SBark.** • **Action: JS to send AW the EKHUFT nurse-led HCC surveillance SOP and invite to the Kent Hepatology meeting taking place on 20.05.2022 which will then be circulated to the group.** • **Action: JS to update on this item at the next meeting.**	**AW** **JS** **JS**
9	**Performance data**	**DVH – update provided by Marie Payne** • Please refer to the performance slide pack presentation (circulated on 03.05.2022) for an overview of the Trust's data. **EKHUFT – update provided by Vicki Hatcher** • Please refer to the performance slide pack presentation (circulated on 03.05.2022) for an overview of the Trust's data. **MFT – update provided by Jennifer Priaulx** • Please refer to the performance slide pack presentation (circulated on 03.05.2022) for an overview of the Trust's data. **MTW – update provided by Naomi Butcher** • Please refer to the performance slide pack presentation (circulated on 03.05.2022) for an overview of the Trust's data.	
10	**CNS Updates**	**DVH – update provided by Sarah Barney** • JC now works with the team full-time. • The team have recruited a part-time CNS who currently works in the Pine Therapy Unit and will be split between the 2ww and CNS teams. • The team continue to struggle with the volume of 2ww referrals, with the number of patients on their PTL almost double what it was pre-COVID. • The team are seeing an increased number of complex cases presenting and continue to receive inappropriate referrals. **EKHUFT – update provided by Vicki Hatcher** • VH has taken on a year's post as clinical nursing lead for FDS and has been looking at STT pathways within East Kent. In view of this, the team will be recruiting a Band 7 in order to backfill her hours for 1 year. • The team have a full-time CSW who is making a significant difference, especially with regard to increasing compliance and encouraging patients to come to their appointments. • The team are due to commence with the eHNA piece next week. • A new STT nurse will be starting with the team next month in order to cover a staff member who will be on maternity leave for 1 year.	

		MFT – update provided by Sue Jenner • The team will be recommencing with their support groups soon. • The team comprises of 1 Band 7 and 2 Band 6's. • A Band 6 role has gone out to advert following Joel Lorenzo's decision to leave the team. • The team's CSW, who has been shared with the lung service, will now be back with the upper GI team full-time. • The team are moving forward with the nurse-led follow-up surgical clinic which they hope to get up and running soon and a Consultant Upper GI Surgeon will be supporting this service. They have completed the protocols which need to go through clinical governance and the team are also looking at finding rooms for the clinics and recruiting an administrator to support the service. **MTW – update provided by Yvonne Gravestock** • The post-MDM CNS clinic is functioning well and when all staff members are present they have the capacity to see 12 patients at both Trust sites. The team is ready to start an audit on this. • The team lost both their administrator and CSW so will therefore be recruiting to these posts. • 2 CNS' have been on sick leave recently which has placed a strain on the team. **GSTT – update provided by Oliviana Rusu** • There have been no changes to personnel since the last meeting. • GSTT will have a new clinical pathway transformation system called Apollo live in April 2023. It will also be live for King's College Hospital in October 2023. Online demonstrations for this system are ongoing. • Video presentations for patients relating to post-operative recovery is currently on hold due to maternity leave. • LFTs will replace PCR testing as the key pre-procedure test modality for most elective patients and will need to be performed 72 hours prior to the planned procedure. Patients can self-test and register the results on the government portal or call 119 to register the results there. All Kent & Medway patients will have this modality of being given the tests by post before returning them and patients requiring an intensive care overnight recovery bed will require a PCR test. **KCH** • No update provided.	
11	**STT update**	**Update provided by Vicki Hatcher** • The Kent & Medway STT group recently met face-to-face for the first time since lockdown. • Meetings take place across the patch in order to share practice and learn from each other. • The group now have the new STT nurses at MFT on board and are helping them to develop their service. • EKHUFT are receiving a significant number of referrals, some of which are inappropriate. The team also receive a number of referrals around oropharyngeal dysphagia and have collectively looked in to how they can move forward and manage these (something which they may need support from the TSSG on). • The STT team audited referrals in January and February 2022 and identified 25 patients who had oropharyngeal dysphagia, none of which had cancer following investigations. Most patients had benign strictures or pharyngeal pouches and at least 3 required an onward referral to ENT colleagues. VH highlighted the need to think about how these cases are to be managed and whether they should remain on an upper GI pathway or a head and neck one. If they are to remain on the upper GI pathway, she emphasised the importance of establishing how to move forward with timely appointing of barium swallows and radiology. • **Action: MKe believes it would be sensible to collate data on oropharyngeal dysphagia cases across the patch within the upper GI pathways and then liaise with the respective ENT/Head & Neck teams to discuss how the issues raised can be taken forward and resolved.** • LA feels it is timely to review and refresh the referral forms and stated that more guidance is required making it clear what	**All Trusts**

		diagnostic work-ups are needed.	
12	**Cancer Alliance update**	**Presentation provided by Laura Alton** • LA provided the group with an overview of the various projects relating to the following workstreams (please refer to the presentation circulated on 03.05.2022 for a detailed breakdown of what these are): - Faster diagnosis and operational improvement. - Early Cancer Diagnosis. - Treatments & Personalised Care. - Cross Cutting Themes.	
13	**AOB**	• No-one had anything to raise under any other business.	
	Next Meeting Date	• To be confirmed.	