Upper GI/HPB Tumour Site Specific Group meeting
Thursday 5th October 2023
Microsoft Teams
09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Jeff Lordan (Chair)	**JL**	Consultant Upper GI & General Surgeon	MTW
Alison Watkins	**AWa**	Team Leader – Faster Diagnosis	MTW
Leigh Morgan	**LM**	Pathway Navigator	MTW
Rebecca Samson	**RS**	MDT Coordinator	MTW
Heather Wanstall	**HW**	Oncology Dietitian	MTW
David Bridger	**DBr**	Upper GI CNS	MTW
Summer Herron	**SHe**	General Manager - Cancer Performance	MTW
Yvonne Gravestock	**YG**	Upper GI CNS	MTW
Wendy Brown	**WB**	Upper GI CNS	MTW
Mathilda Cominos	**MCom**	Consultant Clinical Oncologist	MTW
Chirag Kothari	**CK**	Consultant Physician & Gastroenterologist	DVH
Adeyinka Pratt	**AP**	Project Manager for MDM Streamlining	DVH
Chloe Sweetman	**CS**	Macmillan UGI/HPB CNS	DVH
Geoff Dickson	**GD**	Oncology and General Dietitian	DVH
Ben Warner	**BW**	Consultant Gastroenterologist / Clinical Lead for Upper GI Cancer	DVH
Sarah Simpson-Brown	**SSB**	Macmillan UGI/HPB CNS	DVH
Kelsi Widden	**KW**	Upper GI MDT Coordinator	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Theresa Woods	**TW**	Macmillan Upper GI CNS	EKHUFT
Hannah Bradshaw	**HB**	Upper GI STT Nurse	EKHUFT
Vicki Hatcher	**VH**	Clinical Lead – Faster Diagnosis	EKHUFT
Claire Hamilton	**CH**	Upper GI CSW	EKHUFT
James Gossage	**JG**	Consultant Oesophagogastric and General Surgeon	GSTT
Jonathan Bryant	**JB**	Primary Care Clinical Director	KMCA
Ritchie Chalmers	**RC**	Medical Director	KMCA
Cathy Finnis	**CF**	Programme Lead – 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/KMCA
Glynis Corry	**GC**	STT (Upper GI) CNS	MFT
Rakiatu King	**RK**	STT (Upper GI) CNS	MFT
Louise Black	**LB**	Macmillan Lead Cancer Nurse	MFT

Emma Bourke	**EB**	Macmillan Personalised Care & Support Facilitator	MFT
Zivile Baniene	**ZB**	STT Team Lead	MFT
Alison Mannering	**AM**	Oncology Specialist & Team Lead Dietitian	MFT
Fizza Nisar	**FN**	Student Dietitian	MFT
Jessica Tyson	**JT**	Student Dietitian	MFT
Sue Jenner	**SJ**	Macmillan Upper GI CNS	MFT
Apologies			
Sharon Willoughby	**SW**	Pathway Lead	DVH
Guy Sisson	**GSis**	Consultant Gastroenterologist	DVH
Suraj Menon	**SM**	Consultant Radiologist	DVH
Phillip Mayhead	**PM**	Consultant Gastroenterologist	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Sandra Holness	**SHo**	Cancer Pathway Tracker Coordinator	EKHUFT
Diane Muldrew	**DM**	GI Nurse Specialist & Key Worker	EKHUFT
Katherine Hills	**KH**	Consultant Gastroenterologist	EKHUFT
Pippa Enticknap	**PE**	Senior Service Manager – CCHH Care Group	EKHUFT
Anthony Adams	**AA**	Head of Operations – Theatres, Anaesthetics, Critical Care & Pain	EKHUFT
Deepika Balasubramanian	**DBa**	Upper GI STT Nurse	EKHUFT
Mark Kelly	**MK**	Consultant Upper GI and General Surgeon	GSTT
Mike Cooshneea	**MCoo**	General Manager - Liver, Gastroenterology, Upper GI, BCS & Endoscopy	King's College Hospital
Leeja John	**LJ**	STT (Upper GI) CNS	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Gabor Sipos	**GSip**	Consultant Gastroenterologist	MFT
Mark Hill	**MH**	Consultant Medical Oncologist	MTW
Emma Hughes	**EH**	NSS CNS - Faster Diagnosis Standard	MTW
Aidan Shaw	**AS**	Consultant Interventional Radiologist	MTW
Samantha Forner	**SF**	Consultant Clinical Oncologist for Neuro-Oncology and Upper GI	MTW
Victoria Earl	**VE**	Clinical Trials Coordinator - Colorectal/Upper GI	MTW
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway ICB
Joanna Meredith	**JM**	Cancer Care Coordinator	Tonbridge PCN

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. **Review previous minutes** • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2	**Introduction of new Cancer Alliance Medical Director & Primary Care Clinical Director**	**Update provided by Ritchie Chalmers** • RC believes strong collaborative clinical leadership is imperative for driving the TSSGs forward and would like to make this forum the repository of expertise in the region. • RC highlighted the importance of identifying the specific problems KMCA have and identifying what she described as 'sticking points', areas requiring more input from specialties to expedite issues. • RC stated there is an aim to develop a clinical strategy which dovetails with the ICB clinical strategy and KMCA believe the TSSG is the most appropriate forum to drive this forward for the region. • RC is keen for the TSSGs to introduce lead roles such as a Lead Radiologist, Lead Pathologist and Lead CNS and she welcomes views from others regarding implementing these. • RC emphasised the need to work more closely with operational, executive and CEO colleagues (amongst other staff roles) in order to highlight the issues which their Trusts are facing in order to further elicit their support in expediting them. • RC welcomes any feedback from colleagues regarding ideas for improvement. • RC believes it would be helpful after this TSSG round ends to review which areas of improvement are needed as this, in addition to data, will help to inform the clinical strategy. • RC highlighted the importance of triaging patients to separate those who are more likely to have cancer as all referrals are processed at the same speed. • In terms of moving forward, RC emphasised the need to review available data and set up a session whereby Trusts can advise on what their current pathways look like versus how they want them to look. • RC would like to know from the members what data they would like to see in particular as this will help to inform what areas of the pathway require the most improvement. • BW highlighted the importance of exploring alternative pathways, for example direct access pathways e.g. for patients struggling to swallow. • JL highlighted the importance of collaboration and pooling knowledge and resources (where possible) and to identify what the issues are across the Trusts in order to create alternative pathways. • SHe suggested that the Trusts plan ahead with regard to the KMCA transformational bids which require submission towards the end of the financial year, with RC stating it would be sensible for the intended strategy to support this. • DBr believes the issues relating to patients going to King's College Hospital and the lack of MDM support which a number of members raised today slows the pathway and there is a need to obtain data to reflect this. Further to this, RC stated it would therefore be helpful to explore what services Kent & Medway could provide which are currently	

		referred to London hospitals. • **<u>Action</u>: JL asked the members to send him an email regarding their current Trust pathway problems and what data they would like to see and then a meeting can be set up for January 2024.** **<u>Update provided by Jonathan Bryant</u>** • JB stated there is a drive for primary care to improve their relationship/communication with secondary care colleagues and to ensure standardised care is provided. • An area of work he is particularly interested in improving is the quality of referrals and ensuring patients are made aware they are on a cancer pathway when they are referred in to secondary care on a 2ww. • JB believes that a number of staff who attend primary care education sessions are those who would benefit least from it whereas those it would benefit most tend not to attend them.	**JL/AW/ All Trusts**
3	**Clinical Audit updates**	**<u>OG audit – presentation provided by James Gossage</u>** • JG provided the group with an overview of the National Oesophago-Gastric Cancer Audit 2022 Annual Report which GSTT, the organisation he works for, feeds data in to. • Among patients diagnosed over three years (April 2018-March 2021) who had curative surgery, there were 3632 oesophagectomies and 1770 gastrectomies performed. 30-day mortality rates for oesophagectomies and gastrectomies were 1.5% and 1.4% respectively and 90-day mortality rates were 3.3% and 2.6% respectively. • The local 90-day risk-adjusted mortality rate was 2% and the local 30-day risk-adjusted mortality rate was 0.4%. • JG provided the group with an overview of the local versus national data pertaining to pathology outcomes following surgery. • All NHS organisations achieved similar rates of positive longitudinal margins (risk-adjusted) after surgery for patients diagnosed 2018-2021. • For patients diagnosed between 2018-2021, the one-year survival after curative surgery was 83.4% among patients with oesophageal cancer and 85.9% among patients with gastric cancer. • All surgical centres had an adjusted one-year survival rate which fell within the expected range (GSTTs was 87.9%, the best in the country). • CK highlighted the importance of JG letting the Trusts know if there is anything they can do better when referring patients in to GSTT.	
4	**Strikes**	• JL highlighted the impact industrial action has had on services across Kent & Medway, particularly in relation to capacity and diagnostics (for instance histopathology) and what could therefore impact on performance. • The impact from doctors' strikes has resulted in the cancellation of diagnostic lists and tertiary MDMs. • It was noted that the STT Consultant at MFT has been proactive in picking up patients during industrial action. • Interventional Radiologists have also helped at picking up workload during the strikes at MTW. • Operations have been delayed at St Thomas' Hospital which has had a significant impact. • Industrial action has also had an impact on EUS lists.	

5	**Update from King's**	• Parthi Srinivasan did not attend today's meeting so an update was not provided. • **<u>Action</u>: JL to feed back to Parthi Srinivasan the issues pertaining to MDM support as mentioned by Trust colleagues at today's meeting.**	**JL**
6	**EUS update**	**<u>Update provided by Jeff Lordan</u>** • There have been delays with ICB/Specialised Commissioning. • The EUS service at MTW will commence on 16.10.2023 with a focus on papillary cancers to begin with. • Patients will be discussed at the Upper GI HPB MDM on a Wednesday, they will be seen on the Thursday and the EUS will be performed the following Monday. • Support from specialist teams, including but not limited to histopathology/cytology colleagues, has been obtained and a SOP with King's College Hospital is in place. • EUS lists will comprise of three patients to begin with but will increase in due course. • The MTW team will be working closely with BW and Irfan Khan at DVH who are working on benign cases already but will do more cancer work after Christmas 2023. • BW highlighted DVH currently only have one scope. He also stated the Trust should be able to share scans/images via PACS. • A business case for an additional platform at Tunbridge Wells Hospital to support the service is in process. Gallbladder drainage will be incorporated in to the service in due course. • Nurses have been trained and job plans updated to reflect this. • EUS patients will be allocated to King's College Hospital, DVH and MTW incorporating a hub and spoke approach. • JL thanked colleagues for their input and support with the development of this service over the last 2.5 years.	
7	**Anaemia pathway**	• Laura Alton was unable to attend today's meeting so an update was not provided. • **<u>Action</u>: AW will ask Laura Alton to provide a written update which will then be shared with the group.**	**AW**
8	**Liver Cancer Surveillance Pathway**	**<u>Liver Cancer Surveillance Pathway – presentation provided by Cathy Finnis</u>** • CF provided the group with an overview of the number of people with hepatocellular carcinoma or cirrhosis recorded in Kent & Medway. • The Early Diagnosis Programme wrote out to all Trusts asking about their Liver Surveillance offer to patients with known high risk for liver cancer and the information was compiled. In terms of results, this was very varied across Kent & Medway's four Trusts. One had audited their liver cirrhosis population and found only 7% were having routine surveillance. Two Trusts had recently set up databases and had 111 and 244 patients respectively. One Trust had a dedicated hepatologist who had set up a new surveillance clinic. The pilot had been audited. • KMCA had only accounted for about 360-400 patients having current liver surveillance out of approximately 5000 (to January 2022). New analysis shows KMCA can now account for nearly 6500 potentially known at risk (summer 2023). • A Virtual Clinic model has been developed to help tackle capacity issues. KMCA have asked for Early Adopters of this model and all Trusts are happy to support. As part of this model, KMCA are pump priming several roles	

		including Band 3 fibroscan technicians (to free up Band 6/7 nurses to deliver virtual clinics) in EKHUFT, MTW, and MFT. There is also a CNS Liver Nurse Specialist at DVH. • Alongside the Virtual Clinic model, KMCA have procured InfoFlex, of Civica, who already provide a lot of the cancer-related software. Four other Cancer Alliances are also interested in using the system for this work nationally. • CF provided the group with an overview of the referral pathway which all stakeholders have agreed to. • A draft Liver Surveillance SOP has been sent to the Stakeholder group and other stakeholders and there is a meeting to discuss this further on 11.10.2023 (12:00). A draft Memorandum of Understanding (MOU) has been shared and there is also a Community Health Checks Pilot Project commencing next year with the ODN (whereby a bus will be utilised to offer blood tests and deliver fibroscans). • With regard to the InfoFlex Software Model: the change notice and purchase order have been completed; the internal project team is currently being recruited; technical development task and finish groups will start soon; there will be a user testing and acceptance phase; the system will be able to track all patients through the surveillance service and will be easily audited; and all letters will be automated. • CF confirmed national funding will be in place next year to continue supporting this workstream. • CF hopes the InfoFlex aspect of this work will be complete by the end of this financial year. • With regard to funding for primary care to hold cirrhosis registers, this has yet to be agreed. • CK mentioned DVH had recently lost their fibroscan technician. CF stated she would look in to this in order to identify how KMCA can support. • CK raised a query in relation to how the InfoFlex aspect of this work could integrate with current clinical systems. In response to this, CF highlighted this would require further discussion at the new technical task and finish group. • CF stated the long-term plan for this service is for it to be a commissioned service. • CK highlighted the importance of determining whether surveillance will be done in primary or secondary care. • JB stated primary care are looking in to what aspects of this work they can commission. • A support plan is in place to support patients who DNA appointments. • Referral pathways for complex cases, for example those associated with alcohol services, requires further work. • JL noted there is a shortage of hepatologists in Kent & Medway compared to other areas nationally. CF did, however, state that a number of gastroenterologists also review fibroscan result.	
	EUROPAC - improving the detection of pancreatic cancer in those with inherited risk	**<u>EUROPAC - improving the detection of pancreatic cancer in those with inherited risk – presentation provided by Cathy Finnis</u>** • EUROPAC has now launched and is open to referrals in Kent & Medway from both primary and secondary care. • The referral form, which was circulated to the members following the meeting, needs to be completed and sent to the Europac Surveillance Coordinator, Beata Gubacsi (Beata.Gubacsi@rlbuht.nhs.uk). The referral can be sent to the London Surveillance Centre if the person filling it in requests this on the form as opposed to Portsmouth. • CF stated the KPI in relation to this piece of work is the number of people who they refer in to the service.	

9	**Performance**	**Performance Questions** • KMCA currently have the worst FDS performance, the best 62d performance and the second worst USC backlog nationally. • JL highlighted the importance of identifying what the barriers are for Kent & Medway in order to improve performance. • RC stated FDS is currently poorly recorded on InfoFlex in Kent & Medway and emphasised the need for this issue to be expedited. • CF mentioned that a video is currently being designed articulating what a patient should expect when they are referred to a cancer pathway. • RC highlighted the need to identify what Trusts should do with patients who are 'lost' in the system and the possible role of the NSS service. • RC mentioned there are issues with data collection but also problems along the pathways and therefore it would be helpful to look at redesigning them where and when deemed appropriate. • RC highlighted the importance of striving towards ensuring patients are told whether they do or do not have cancer within 28 days and a big focus in terms of achieving this is working to expedite delays in diagnostic pathways. **DVH – presentation provided by Michelle McCann** • Please refer to the performance slide pack for an overview of the Trust's data. • An alternative biopsy pathway is being set up but has yet to be enacted. • There are issues with referrals between tumour sites and the subsequent need for review at multiple MDMs, something which AP is looking to streamline as part of her role. • **Action: CK to email RC regarding his concerns relating to histopathology turnaround times at DVH/QMH.** **EKHUFT – presentation provided by Vicki Hatcher** • Please refer to the performance slide pack for an overview of the Trust's data. • Endoscopy capacity is slowly improving. • A number of Radiologists have recently left the Trust. • Industrial action has resulted in the cancellation of diagnostic lists and tertiary MDMs. • There is currently no Interventional Radiology support, although JL is currently looking at putting an SLA in place to enable MTW to support the Trust with this. **MFT – presentation provided by Emma Bourke** • Please refer to the performance slide pack for an overview of the Trust's data. • Endoscopy capacity is currently an issue, however DVH are scoping MFT patients at weekends. **MTW – presentation provided by Summer Herron** • Please refer to the performance slide pack for an overview of the Trust's data.	**CK**

		• Pathology and radiology delays have resulted in lengthening the pathway.	
10	**Identification of sticking points in UGI pathway**	**<u>Update provided by Alison Watkins</u>** • AWa recently met with JL regarding identification of sticking points in the upper GI pathway. • One area they particularly focussed on was inappropriate referrals from primary care and how they could work with GPs to try and expedite the issue. • A six month review of MTW referrals showed that less than 2% of cases identified issues requiring further investigation by the upper GI team. Finalisation of the audit details is underway and is therefore not ready to present today. • The team are looking to recruit an FDS Navigator to support the service and to speed up the pathway for patients where possible.	
11	**Research update**	• This item was not discussed.	
12	**Post MDM Nurse-Led clinic**	**<u>Post MDM Nurse-Led clinic – presentation provided by Dave Bridger</u>** • DBr provided the group with an overview of both the timeline within the nurse-led MDM clinics (which commenced in May 2021) and its potential benefits. • A retrospective audit based on a nine-question questionnaire was carried out on October to December 2022 data and was sent to 70 patients (34 of which returned them). DBr provided the group with an overview of the questions asked (the results of which are detailed on the circulated presentation) as outlined below: - Were you seen in good time following your arrival in the outpatient department? - Was the information expressed to you in a clear manner with time for questions? - Did the nurse you saw seem knowledgeable? - Did the nurse you saw have good communication skills? - Did you feel the review was conducted sensitively? - Did you feel you had a clear idea of the plan moving forward at the end of the review? - Do you feel you would have benefitted from being seen by a doctor rather than a nurse? - Have you had a good experience of contacting the CNS team following your clinic review? - Please rate your experience of the nurse-led review? • In summarising: - The 88% achieved in seeing patients in good time is a positive result. - The quality of these clinics would appear to be high with above 90% results for clarity, sensitivity and nurse knowledge. - 18% of patients stated they were not sure they had a clear idea of the plan ahead and 3% specified they did not have a clear idea. - When asked about preference between doctor or nurse review, 12.5% would prefer a doctor review, 40% were not sure and 47% preferred a nurse review.	

	CNS Update	- The results are highly suggestive that the nurse-led post-MDM clinic is effective and provides a quality service. • DBr believes continuity of care for patients is crucial. • JL praised the team for their hard work with developing this service and congratulated them on the audit results. **CNS Update** **DVH – update provided by Sarah Simpson-Brown** • The team comprises of two CNS' and one CSW (who works for the upper GI team two days a week) currently. • The team are looking to recruit an additional CNS. • There are concerns with rollout of EPIC. **EKHUFT – update provided by Vicki Hatcher** • KMCA funding for HPB and Pathway Navigator posts have been approved. • VH's role as Clinical Lead for Faster Diagnosis is now substantive. **MFT – update provided by Sue Jenner** • The survivorship service is up and running. • Honorary contracts to enable MFT CNS' to come over to support oncology clinics at MTW is currently in process. SHe stated she would discuss this further with Naomi Butcher to see if the process can be speeded up. • There is currently no support from King's College Hospital at MDMs. **MTW – update provided by Wendy Brown** • A Band 4 CSW has set up a Holistic Needs Assessment clinic. • A Band 6 Development Nurse has been in place for the service since July 2023. • Hannah Fotheringham's position as Upper GI CNS is now substantive.	
13	**Cancer Alliance update**	**Presentation provided by Cathy Finnis** • CF provided the group with an update in relation to KMCA projects/workstreams (details of which can be found on the Cancer Alliance update presentation circulated on 05.10.2023). Of particular note, CF provided an overview of: - The drive to deliver 100% population coverage for Non-Specific Symptoms (NSS) pathways. This workstream will be discussed further at the Cancer in Primary Care meeting on 17.10.2023. - Lynch syndrome. - The Be Skin Smart roadshows which were held this summer and have been shortlisted for an HSJ award. - The Ovarian Cancer campaign. - The Men's Cancer campaign which the KMCA are about to commence with, particularly focusing on upper GI, lower GI, renal and prostate cancers. - Cancer Health Inequalities Needs Assessment work, data of which KMCA have collected and can bring to a future	

		meeting with recommendations if the group would like to see this. • AD stated it would be helpful to think about how Trusts can adequately collect information on family history prior to appointments.	
14	**AOB**	**<u>Patient Partners Engagement</u>** • Tumour Site Specific Groups should ideally have two patient partners per group. • Patient Partners are experts by experience and are an invaluable part of cancer improvement and service design. • Tracey Ryan (User Involvement Manager – KMCA) would like the help of the group in finding Patient Partners as they see and know their patients, and if the time is right for them to support. • Tracey Ryan's ask is for staff to ask their patients if they would be interested in this opportunity and if they would mind her contacting them. If so, Tracey asks for their details to be sent to her so she can contact them.	
	Next Meeting	• To be confirmed.	