

Upper GI/HPB Tumour Site Specific Group meeting
Thursday 15th October 2026
Microsoft Teams
09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Jeff Lordan (Chair)	JLor	Consultant Upper GI & General Surgeon	MTW
Adrian Barnardo	ABar	Consultant Gastroenterologist	MTW
Tracey Spencer-Brown	TSB	Head of Nursing for Oncology & Cancer Performance	MTW
Wendy Brown	WB	Upper GI CNS	MTW
Sarah-Jane Taylor-Seres	SJTS	Associate Director Endoscopy Network - NHS Kent and Medway	MTW
Justin Waters	JW	Consultant Medical Oncologist	MTW
Sam Enefer	SE	Consultant Clinical Oncologist	MTW
Ryan Johnson	RJ	Pathway Navigator	MTW
Julie Compton	JC	Upper GI STT Nurse	DGT
Amanpal Brar	ABr	HCC Surveillance Nurse	DGT
Chloe Sweetman	CS	Macmillan UGI/HPB CNS	DGT
Geoff Dickson	GD	Senior Oncology Dietitian	DGT
Marie Payne	MP	Lead Cancer Nurse	DGT
Jennifer Keys	JK	MDT Coordinator	DGT
Dawn Stewart	DS	Cancer Pathway Lead	DGT
Chirag Kothari	CK	Consultant Physician & Gastroenterologist	DGT
Sithu Khin-Maung	SKM	Consultant Gastroenterologist	DGT
Emma Lloyd	EL1	HPB CNS	EKHUFT
Kopinath Kathirvetpillai	KK	Consultant Histopathologist	EKHUFT
Diane Muldrew	DM	GI Nurse Specialist & Key Worker	EKHUFT
Stella Grey	SG	General Manager - General Surgery, Colorectal, Gastroenterology and Endoscopy	EKHUFT
Katherine Hills	KH	Consultant Gastroenterologist	EKHUFT
Mohd Wani	MW	Consultant Gastroenterologist	EKHUFT
Ioannis Bollas	IB	Consultant Gastroenterologist	EKHUFT

Pippa Enticknap	PE	Deputy General Manager - CCHH Care Group	EKHUFT
Mark Kelly	MK	Consultant Upper GI and General Surgeon	GSTT
Georgia Mundle	GM	OG & ERP CNS	GSTT
Lydia Capon	LC	Lead Oncology Dietitian	KCHFT
Sarah Selemani	SS	Clinical Nurse Specialist	King's College Hospital NHS Foundation Trust
Mohamed Elmasry	ME	Consultant Surgeon - HPB & Pancreatic Surgery	King's College Hospital NHS Foundation Trust
Alara Bailey	ABai	Service Manager – HPB	King's College Hospital NHS Foundation Trust
Jo Jackson	JJ	Project Manager – Early Diagnosis	KMCA
Jo Bailey	JBa	Programme Lead – Early Diagnosis	KMCA
Emma Lloyd	EL2	Cancer Pathways Improvement Manager	KMCA
Laura Alton	LA	Senior Programme Manager – KMCA Commissioning	KMCA
Jonathan Bryant	JBr	Primary Care Cancer Clinical Lead	KMCA
Karen Glass	KG	PA/Business Support Manager	KMCA/KMCC
Colin Chamberlain (Notes)	CC	Administration & Support Officer	KMCC
Samantha Williams	SW	Administration & Support Officer	KMCC
Deborah Horley	DH	Upper GI Cancer Nurse	MFT
Mihaela Zdrinca	MZ	Upper GI STT CNS	MFT
Jesse Loganathan	JLog	Upper GI CNS	MFT
Apologies			
Suraj Menon	SM	Consultant Radiologist	DGT
Phillip Mayhead	PM	Consultant Gastroenterologist	EKHUFT
David Austin	DA	Consultant Gastroenterologist	EKHUFT
Hannah Bradshaw	HB	Macmillan Upper GI CNS	EKHUFT
Ann Courtness	AC	Macmillan Primary Care Nurse Facilitator	KMCA
Gabor Sipos	GS	Consultant Gastroenterologist	MFT
Mathilda Cominos	MC	Consultant Clinical Oncologist	MTW
Hannah Fotheringham	HF	Upper GI CNS	MTW
Rahel Mahmud	RM	Consultant Gastroenterologist	MTW

Vickie Gadd		VG	Lead CNS – Gynae-oncology, Genetics & Family History	MTW	
Sally Craven		SC	Endoscopy Nurse	MTW	
Helen Graham		HG	Research Delivery Manager (Cancer)	NIHR	
Item		Discussion			Action
1	TSSG Meeting	<p><u>Introductions</u></p> <ul style="list-style-type: none">JLor welcomed the members to the meeting and asked them to introduce themselves. <p><u>Apologies</u></p> <ul style="list-style-type: none">The apologies are listed above. <p><u>Action log review</u></p> <ul style="list-style-type: none">The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. <p><u>Review of previous minutes</u></p> <ul style="list-style-type: none">The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.			
2	Upper GI pathway update IPMN Guidance	<p><u>Update provided by Adrian Barnardo</u></p> <ul style="list-style-type: none">A significant proportion of gastroscopies are low yield. The Beaton study cited in the presentation found that 73% of gastroscopies nationally were performed in patients with less than a 1% risk of significant pathology, compared with the 3% risk threshold cited for USC pathways under NICE NG12.Cancer risk varies substantially by age, sex and symptoms. Upper GI cancers are more common in older people and men. Dysphagia remains a key indication for urgent investigation, whereas isolated symptoms such as reflux or weight loss may carry a much lower risk.Endoscopy demand is increasing. Local data from Kent and Medway broadly mirror national trends, with increasing gastroscopy activity across age groups and approximately 30% classified as low yield.Unnecessary biopsies are placing pressure on histopathology. Biopsy rates exceed guideline expectations, increasing costs, workload and delays for clinically important specimens.			

		<ul style="list-style-type: none"> • Repeat investigations highlight gaps in patient care. Patients often undergo multiple gastroscopies without receiving a clear diagnosis, management plan or adequate reassurance. • Improving quality matters as much as reducing volume. Better equipment, sufficient procedure time, appropriate sampling, improved reporting and identification of pre-malignant conditions are essential. • Alternative pathways could improve efficiency. TNE, Cytosponge, non-invasive H. pylori testing and better referral triage may reduce unnecessary conventional gastroscopies. • Artificial intelligence could support triage and audit. Potential applications include identifying previous investigations across Trusts, checking referral completeness and monitoring biopsy appropriateness and endoscopy quality. • ABar proposed the following actions: <ul style="list-style-type: none"> - Educate primary care and referral teams on updated guidance and symptom-specific cancer risk. - Reduce low-yield gastroscopies in line with the Kent and Medway target of a 10% reduction in each of two consecutive years. - Follow biopsy guidelines and avoid unnecessary sampling, particularly of uncomplicated oesophagitis and non-specific gastric erythema. - Provide patients with a positive diagnosis, treatment advice and a clear follow-up plan rather than simply reporting “no cancer.” - Improve access to previous endoscopy, histopathology and imaging results across organisations. - Develop consistent referral and endoscopy standards across the regional network. - Use local outcome data to evaluate changes and ensure that reducing investigations does not compromise patient safety. • The group emphasised that reducing unnecessary procedures must not become indiscriminate rationing. Clinical judgement remains essential because cancer risk is never zero. • Members highlighted the need for better endoscopy equipment, adequate procedure time, human clinical assessment and appropriate use of artificial intelligence. 	
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		<u>Overall conclusion</u> <ul style="list-style-type: none"> The objective is to investigate the right patients, perform higher-quality endoscopies, reduce unnecessary biopsies and provide patients with meaningful diagnoses and treatment plans. This could improve cancer detection, reduce pressure on histopathology and release capacity for other important diagnostic pathways. 	
3	Audit of the number of PTCs MTW do for EKHUFT	<ul style="list-style-type: none"> Deferred to the next meeting as Aidan Shaw was unable to join today's meeting. 	
4	CRG update	<u>Update provided by Jeff Lordan</u> <ul style="list-style-type: none"> The CRG continues to meet regularly to review progress and improve gastroenterology and cancer services across Kent and Medway. Key areas of work include improving MDT processes across Kent and Medway, identifying delays and reviewing data to improve patient flow, expanding the use of capsule sponge testing and TNE, increasing access to endoscopic ultrasound services and continuing work to improve the quality of liver services. Work has also taken place to develop four approaches to screening and early detection: <ul style="list-style-type: none"> - K-PAC (Kent and Medway pancreatic cancer initiative). - The SAFE-D trial (focusing on changes in diabetes status). - A pathway for patients with new-onset diabetes and weight loss. - Artificial intelligence-based risk identification to target patients for CT scans. 	
5	OG Cancer Referrers Day: Key Highlights	<u>Update provided by Mark Kelly</u> <ul style="list-style-type: none"> MK provided a summary of the recent OG cancer referrals day, covering clinical developments, service improvements and proposals to improve MDT working across South East London and Kent. <u>Clinical updates</u> <ul style="list-style-type: none"> With regard to perioperative chemotherapy and immunotherapy, discussion focused on the transition from the established FLOT chemotherapy pathway to a regimen incorporating durvalumab, informed by the MATTERHORN trial, which demonstrated improved EFS. Adoption of the immunotherapy component was not yet consistent across all centres. 	

		<ul style="list-style-type: none"> • In relation to Barrett's oesophagus surveillance and treatment, the established therapeutic endoscopy service continues to provide an important alternative to oesophagectomy for selected patients with high-grade dysplasia and early cancer. Treatment decisions depend on depth of invasion, histological type, lymphovascular invasion and other pathological risk factors. • The importance of psychological and nutritional support after treatment was highlighted, including management of small intestinal bacterial overgrowth, pancreatic insufficiency, anastomotic strictures and pyloric dysfunction. • The expansion of the EUS service in Kent was recognised. EUS remains important for targeted assessment of suspicious lymph nodes and FNA, although its role in routine OG cancer staging has become more selective. • The transition towards robotic surgery was discussed as part of the wider minimally invasive surgical approach. Outcomes were described as comparable in terms of complications and oncological results, with a higher lymph node yield compared with conventional approaches. <p><u>Service and pathway improvements</u></p> <ul style="list-style-type: none"> • The meeting considered shared challenges across the Alliance, particularly around faster diagnosis, communication, referral data quality and local leadership. • Key areas for improvement included: • Standardising MDT practice. Alliance leads should work with MDT chairs across South East London and Kent to refresh and define agreed standards. • Minimum datasets. There is a need to establish consistent information requirements for MDT discussions, including adequate histology and baseline staging CT results before treatment decisions are made. • Reducing repeat discussions. There is a need to improve the completeness of referrals to avoid unnecessary repeat MDT discussions and delays to patient management. • Standards of care. There is an ambition to develop agreed pathways for appropriate patient groups, such as low-grade Barrett's dysplasia, allowing suitable patients to be managed outside the main cancer MDT while maintaining oversight and tracking. • Reporting standards. It remains important to promote consistent radiology and histopathology reporting, potentially using standardised templates. 	
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		<ul style="list-style-type: none"> Audit and evaluation. Implementation timelines should be set and audits on the impact of changes on pathway efficiency and clinical outcomes is vital. <p><u>Overall conclusion</u></p> <ul style="list-style-type: none"> The OG cancer referrals day was considered a success with strong engagement and useful clinical and operational discussions. MK highlighted the importance of translating these discussions into consistent Alliance-wide standards, better-quality referral information, streamlined MDT processes and measurable improvements through audit. 	
6	Liver Pathway update	<p><u>Update provided by Emma Lloyd and Laura Alton</u></p> <ul style="list-style-type: none"> A clinical stakeholder group and SOP have been established. Additional nursing, Fibroscan Technician and Liver Navigator posts have been funded by KMCA. A bespoke InfoFlex call-recall system automates patient tracking and surveillance invitations. All four Trusts have engaged with the programme, and patient attendance is increasing. Work is underway to link surveillance data with cancer datasets to track patient outcomes. Key challenges include recruitment and retention, limited long-term funding, and the sustainability of posts funded for a maximum of two years. Ultrasound capacity is being monitored. Future plans include developing sustainable business cases, delivering surveillance through CDCs and expanding staff roles through dual training. DGT raised concerns about losing its HCC surveillance nurse due to funding ending. Participants agreed that Trusts should share business case approaches and explore long-term funding options. Fibroscan tariffs were highlighted as a potential opportunity, although current block contracts may limit additional income. The programme has made good progress in establishing a consistent surveillance service, but securing permanent staffing and sustainable funding remains the main challenge. 	
7	Dashboard	<ul style="list-style-type: none"> The FDS showed some improvement overall but remained inconsistent across Trusts. The 62d cancer treatment standard had declined over the previous six months despite historically strong performance. 	

		<ul style="list-style-type: none"> • In terms of variation between Trusts, significant differences were identified in diagnostic waiting times, including CT scans, gastroscopies, EUS and MRCP investigations. EKHUFT had notable imaging delays, while staffing issues and the loss of a funded follow-up clinic may have contributed to performance difficulties at DGT. • Trusts differed in the proportion of patients receiving treatment according to cancer type, age, gender and performance status. These differences may reflect variations in clinical practice, patient populations or incomplete data recording. • The quality of data was discussed with incomplete recording of performance status and other information in InfoFlex having the potential to distort the results. More consistent and accurate data entry is needed to support reliable comparisons. • High referral volumes, repeat referrals and potentially unnecessary endoscopies were highlighted. Better guidance for GPs and improved investigation pathways could help ensure patients receive appropriate investigations. • Reported conversion rates varied between Trusts. For OG cancers, rates ranged from 5.1% to 7.8%. HPB rates were generally higher. <p><u>Key conclusion and actions</u></p> <ul style="list-style-type: none"> • Jlor emphasised the importance of prioritising the reduction in unwarranted variation in cancer diagnosis and treatment across the four Trusts. • Suggested actions include investigating Trust-specific diagnostic delays and capacity issues, improving the completeness and accuracy of cancer pathway data, reviewing referral criteria and reducing inappropriate or repeat investigations, sharing best practice and working towards more consistent treatment decisions and reviewing the dashboard data in greater detail to identify targeted improvements. 	
8	MDM streamlining update	<p><u>Update provided by Tracey Spencer-Brown</u></p> <ul style="list-style-type: none"> • MTW received 1,908 referrals over six months, including 1,675 urgent cancer referrals and 233 pathway upgrades. The MDT discussed approximately 35–50 patients weekly. • A draft SOP is being developed to improve referral quality, meeting efficiency, clinical decision-making and communication. 	

		<ul style="list-style-type: none"> • New referral and triage templates, weekly clinic capacity meetings, revised CNS job plans and improved cross-site nursing support have been introduced. • The work followed a cluster of incidents involving delays in diagnosis and inter-provider pathways. Early indications suggest fewer incidents and complaints following the changes. • Workforce capacity, surgical clinic availability, inter-provider referrals and delays in tertiary-centre MDT discussions remain concerns. • Next steps include finalising the SOP following clinical and governance review, completing pathway mapping, auditing inter-provider referrals and developing improved pathways for interventional investigations. • Participants highlighted inconsistent attendance by tertiary centre representatives, particularly King's College Hospital, across the regional Trusts. This can delay treatment decisions and affect pathway efficiency. The group called for more consistent tertiary centre representation. • As an overall conclusion, the work has demonstrated promising early improvements in patient safety and service efficiency. Further audit is needed to measure the quality of MDT discussions and patient outcomes before and after implementation. • Action: Finalise the MTW MDM SOP following clinical and governance review and circulate to the group with an update to be provided at the next meeting. 	TSB
9	King's update - Pancreatic cyst pathway	<p><u>King's College Hospital Pancreatic cyst pathway - update provided by Mohamed Elmasry</u></p> <ul style="list-style-type: none"> • ME presented the updated King's College Hospital pancreatic cyst protocol, developed under Professor Menon's supervision and circulated to SELCA for regional feedback. • The protocol aims to standardise assessment, management and surveillance of incidentally detected pancreatic cysts. <p><u>Key discussion points</u></p> <ul style="list-style-type: none"> • Decisions should reflect cyst type, imaging features, symptoms, malignant potential and patient fitness. • Main-duct IPMNs, particularly with a duct diameter of 10mm or more, warrant consideration of surgery. EUS and cyst-fluid analysis can help clarify diagnosis and guide management. • The group recommended clarifying which cases require MDT discussion before investigation or treatment, enabling straightforward cases to proceed through agreed pathways and reducing unnecessary repeat MDT reviews. 	

		<ul style="list-style-type: none"> • A more streamlined surveillance pathway should be developed, potentially using the CNS-led model at GSTT. Guidance is needed on reducing surveillance frequency or stopping follow-up, with decisions individualised according to cyst stability, patient fitness and preferences. • Initial clinician consultation is important to explain the diagnosis and surveillance rationale. Subsequent scan requests can follow local departmental policy, with a CNS-led service considered a potential model. • Surveillance scans should ideally be reported by radiologists experienced in HPB imaging, with access to previous scans to ensure accurate assessment of cyst growth and progression. • Key priorities and next steps: <ul style="list-style-type: none"> - Clarify criteria for mandatory MDT discussion versus direct investigation under an agreed protocol. - Reduce unnecessary repeat MDT discussions once diagnosis and surveillance plans are established. - Develop a consistent, streamlined surveillance pathway and clarify when follow-up can be reduced or discontinued. - Explore a CNS-led pancreatic cyst surveillance service. - Promote consistent expert reporting and comparison of surveillance imaging. - Circulate the updated protocol for regional feedback and review progress at the next meeting. <p><u>Overall conclusion</u></p> <ul style="list-style-type: none"> • The meeting identified opportunities to improve regional HPB services through more reliable tertiary centre representation at MDTs and a clearer, more efficient pancreatic cyst pathway. • <u>Action:</u> Circulate the updated King's College Hospital pancreatic cyst protocol for regional feedback and review progress at the next meeting. 	ME
10	Pathology update	<p><u>Background and audit findings – update provided by Kopinath Kathirvetpillai</u></p> <ul style="list-style-type: none"> • An audit of 92 cases, comprising 75 oesophageal and 17 gastric carcinomas, was conducted to assess the consistency and completeness of ancillary biomarker testing. • The audit found that 53 cases (57.6%) had at least one biomarker test recorded, 39 cases (42.4%) had no recorded testing and only 24 cases had all three biomarkers assessed: mismatch repair (MMR), human epidermal growth factor receptor 2 (HER2) and programmed death-ligand 1 (PD-L1). 	

		<ul style="list-style-type: none"> These findings highlighted variation in testing practices and the need for a more consistent approach to ensure clinically relevant biomarker results are available to support treatment planning and minimise delays. <p><u>Proposed improvement and implementation</u></p> <ul style="list-style-type: none"> In response to the audit findings, KK proposed a selective reflex biomarker testing pathway, which was approved and implemented on 16.06.2026. The pathway aims to improve the completeness and consistency of testing at initial diagnosis. The agreed testing strategy is based on tumour histology: <ul style="list-style-type: none"> Adenocarcinomas: MMR, HER2 and PD-L1 testing. Squamous cell carcinomas: PD-L1 testing only. Automatic reflex testing is excluded for recurrent cancers, intramucosal adenocarcinomas, cases without definitive evidence of invasion, and cases where the relevant biomarkers have already been assessed on another specimen. These exclusions are intended to avoid unnecessary or duplicate testing while retaining clinical flexibility. Importantly, recurrent cancers may still undergo biomarker testing when clinically indicated, taking account of the patient's circumstances and previous results. <u>Action:</u> Audit to assess the consistency and completeness of ancillary biomarker testing to be shared with pathologists across the region to communicate the rationale for the new pathway and encourage consistent application of the agreed recommendations. <p><u>Conclusion</u></p> <ul style="list-style-type: none"> The audit identified opportunities to improve ancillary biomarker testing in oesophageal and gastric carcinomas. The introduction of selective reflex testing provides a standardised approach to appropriate biomarker assessment at initial diagnosis, with the aim of supporting timely treatment planning, reducing avoidable delays and minimising unnecessary repeat testing. Sharing the findings across the region will support consistent implementation and ongoing improvement in diagnostic practice. 	KK
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11	Pancreatic oncology services in England workstream review	<p><u>Update provided by Jeff Lordan</u></p> <ul style="list-style-type: none"> The review identified significant variation in pancreatic cancer treatment across providers in England: <ul style="list-style-type: none"> Stage 1–3: treatment rates ranged from 15% to 89%. Stage 4: treatment rates ranged from 10% to 76%. Patients treated at specialist hubs appeared more likely to receive treatment and access clinical trials than those treated in non-specialist settings. Key factors contributing to variation included specialist workforce capacity, diagnostic delays, clinical trial access, specialist radiotherapy, coordinated services and CNS provision. Implications for Kent and Medway include: <ul style="list-style-type: none"> Reviewing current pathway delays, improving access to specialist input and increasing participation in research and clinical trials. Obtaining stakeholder agreement, particularly from radiology, before K-PAC goes live. Communicating the launch date and referral arrangements to relevant teams. Developing sustainable long-term funding and service capacity. Identifying eligible high-risk patients for surveillance. 	
12	Kent Familial Pancreatic Cancer Surveillance Service (K-PAC) SOP	<p><u>Update provided by Jeff Lordan</u></p> <ul style="list-style-type: none"> K-PAC is a proposed surveillance programme for people at increased genetic or familial risk of pancreatic cancer, modelled on the existing EUROPAC programme. The programme aims to provide an equitable surveillance pathway across Kent and Medway. Surveillance will involve specialist clinical reviews and tailored imaging, including MRI, CT and EUS, as appropriate. Initial funding has been secured from KMCA for two years. However, long-term commissioning through the ICB will be needed to sustain the programme. Approximately 50 new patients are anticipated annually, with the number under surveillance accumulating over time. <u>Action:</u> Communicate the K-PAC launch date and referral arrangements to relevant teams. 	JLor
13	CNS Updates	<u>EKHUFT</u>	

		<ul style="list-style-type: none"> • Issues include significant CNS workforce shortages across a large Trust, with insufficient staffing to meet service demand. • Recruitment challenges include a combination of funding constraints and difficulties recruiting. • Equity with King's College Hospital was raised as a concern. • The team has undertaken pathway streamlining work to improve efficiency. • Regular pre-MDM triage meetings are now held, attended by a consultant and a CNS. • This process has helped identify and remove patients from the MDM pathway who do not need to be discussed, improving efficiency. <p><u>DGT</u></p> <ul style="list-style-type: none"> • Issues include increasing referral numbers and insufficient CNS capacity. • The team has limited staffing, with one full-time CNS and one part-time team member. • CNS staff are balancing support for oncology clinics with their other responsibilities, creating significant workload pressures. • Two new oncology registrars have joined, increasing oncology capacity. This has enabled more patients to be seen promptly, although CNS staff face additional pressure supporting multiple clinics. • From an FDS CNS perspective, the team faced issues with the loss of a CNS to maternity leave during the previous year. This was not adequately covered by bank shifts, contributing to delays in triage. • Improvements included the CNS returning from maternity leave in January 2026 and there is now a substantive consultant recruitment opportunity. More consistent job plan arrangements have improved service cover. <p><u>MFT</u></p> <ul style="list-style-type: none"> • The service experienced a difficult start to the year following Sue Jenner's retirement, restrictions on recruitment and another nurse's long-term sickness absence. The vacancy was placed on the risk register. 	
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		<ul style="list-style-type: none"> Approval was subsequently granted to recruit a replacement, and JLog joined the team at the end of September 2026. Her appointment has strengthened the team, with the hope of bringing outstanding work under control. <p><u>MTW</u></p> <ul style="list-style-type: none"> High levels of staff sickness are affecting CNS service delivery. The team supports services across two sites, with a significant requirement to provide cover at Maidstone Hospital. Breaking Bad News clinics have been stopped, with CNS staff instead supporting consultants. The team can run up to four clinics per week for MDM patients but struggles to maintain cover because of staffing shortages. 	
14	AOB	<ul style="list-style-type: none"> No-one had anything to raise under any other business. 	
	Next Meeting	<ul style="list-style-type: none"> Thursday 29th April 2027 (09:00-12:30) – Auditorium at Maidstone Academic Centre 	