Kent & Medway Cancer Collaborative

Upper GI Tumour Site Specific Group meeting
Thursday 20th April 2023
Activation Room - The Village Hotel (Maidstone)
09:00-12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Jeff Lordan (Chair)	**JL**	Consultant Upper GI & General Surgeon	MTW
Hannah Fotheringham	**HF**	Upper GI CNS	MTW
Bernadette Jenkins	**BJ**	Macmillan Cancer Support	MTW
Yvonne Gravestock	**YG**	Upper GI CNS	MTW
Aidan Shaw	**AS**	Consultant Interventional Radiologist	MTW
Wendy Brown	**WB**	Upper GI CNS	MTW
Leigh Morgan	**LM**	Pathway Navigator	MTW
Ryan Johnson	**RJ**	Pathway Navigator	MTW
Summer Herron	**SHe**	General Manager – Cancer Performance	MTW
Adrian Barnardo	**AB**	Consultant Gastroenterologist	MTW
Justin Waters	**JWa**	Consultant Medical Oncologist	MTW
Rebecca Samson	**RS**	Upper GI MDT Coordinator	MTW
Chloe Sweetman	**CS**	Macmillan UGI/HPB CNS	DVH
Sarah Simpson-Brown	**SSB**	Macmillan UGI/HPB CNS	DVH
Michelle McCann	**MM**	Operational Manager for Cancer & Haematology	DVH
Ben Warner	**BW**	Consultant Gastroenterologist / Clinical Lead for Upper GI Cancer	DVH
Geoff Dickson	**GD**	Oncology Dietitian	DVH
Diane Muldrew	**DM**	Upper GI CNS	EKHUFT
Georgia Mundle	**GM**	Upper GI CNS	GSTT
Mark Kelly	**MK**	Consultant Upper GI and General Surgeon	GSTT
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Louise Black	**LB**	Macmillan Deputy Lead Cancer Nurse	MFT
Deborah Horley	**DH**	Upper GI CNS	MFT
Suzanne Bodkin	**SB**	Service Manager	MFT
Emma Bourke	**EB**	Macmillan Personalised Care and Support Facilitator	MFT
Glynis Corry	**GC**	STT (Upper GI) CNS	MFT
Zivile Baniene	**ZB**	STT Lead CNS	MFT
Rakiatu King	**RK**	STT (Upper GI) CNS	MFT
Alison Mannering	**AM**	Oncology Specialist & Team Lead Dietitian	MFT
Sue Jenner	**SJ**	Upper GI CNS	MFT

Bertha Mtika	**BM**	Upper GI CNS	MFT
Gabor Sipos	**GS**	Consultant Gastroenterologist	MFT
Laura Alton	**LA**	Senior Programme Manager – KMCA	NHS Kent & Medway ICB
Apologies			
Philip Mairs	**PM**	Consultant Gastroenterologist	DVH
Marie Payne	**MP**	Lead Cancer Nurse / Clinical Services Manager	DVH
Suraj Menon	**SMe**	Consultant Radiologist	DVH
Ioannis Bollas	**IB**	Consultant Gastroenterologist	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Theresa Woods	**TW**	Macmillan Upper GI CNS	EKHUFT
Sandra Holness	**SHo**	Cancer Pathway Tracker Coordinator	EKHUFT
Yunmei Chen	**YC**	Upper GI STT Nurse	EKHUFT
Pippa Enticknap	**PE**	Senior Service Manager – CCHH Care Group	EKHUFT
Zach Tsiamoulos	**ZT**	Consultant Gastroenterologist & Specialist in GI Endoscopy / Clinical Lead - Endoscopy	EKHUFT
Deepika Balasubramanian	**DB**	Upper GI STT Nurse	EKHUFT
Hasmath Montgomery	**HM**	Clinical Research Practitioner	EKHUFT
Simon Atkinson	**SA**	Consultant Pancreaticobiliary and General Surgeon	GSTT
James Gossage	**JG**	Consultant Oesophagogastric and General Surgeon	GSTT
Harvey Dickinson	**HD**	SELCA Cancer Improvement Manager - Colorectal, OG & HPB	GSTT/SELCA
John Devlin	**JD**	Consultant Gastroenterologist & Hepatologist	King's College Hospital
Ian Vousden	**IV**	Programme Director	KMCA
Kirsty Hearn	**KH**	Service Manager	MFT
James Wood	**JWo**	Consultant in Anaesthesia and Intensive Care Medicine	MTW
Jelena Pochin	**JPo**	Head of Performance & Delivery for Diagnostics and Therapies	MTW
Ravneet Oberai	**RO**	Specialist Oncology Dietitian	MTW
Joanne Patterson	**JPa**	Lead Clinical Trials Pharmacist	MTW
Mark Hill	**MH**	Consultant Medical Oncologist	MTW
Victoria Earl	**VE**	Clinical Trials Coordinator - Colorectal/Upper GI	MTW
Bijay Baburajan	**BB**	Consultant Gastroenterologist	MTW
Stephanie McKinley	**SMc**	Matron – Faster Diagnosis	MTW
Monika Verma	**MV**	Consultant Histopathologist	MTW
Mathilda Cominos	**MC**	Consultant Clinical Oncologist	MTW
Samantha Forner	**SF**	Consultant Clinical Oncologist - Neuro-Oncology and Upper GI	MTW
Timothy Sevitt	**TS**	Consultant Clinical Oncologist	MTW
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway ICB
Hannah Vincent	**HV**	GP	NHS Kent & Medway ICB
Holly Groombridge	**HGro**	Cancer Commissioning Project Manager	NHS Kent & Medway ICB
Helen Graham	**HGra**	Research Delivery Manager (Cancer)	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 to the members along with the final minutes from today's meeting. **Previous minutes - review** • The previous minutes were reviewed and agreed as a true and accurate record.	
2	**Complex GI Stenting**	**Presentation provided by Aidan Shaw** • AS' presentation provided the group with an overview of: - OG stenting. - The types of stent (Nitinol, uncovered vs covered, removable vs unremovable, GOJ and biodegradable stents). - Contraindications (relative ones could include clotting disorder, chemoradiation, severe tracheal compression and high lesions). - The techniques employed (local anaesthetic spray, conscious sedation and oesophageal stent). - Success rates. - Complications (including both early and late ones). - The pyloric/duodenal stenting procedure. - Simultaneous duodenal and biliary stenting. - Afferent loop syndrome, which is an obstruction of the upstream limb of a side-to-side gastrojejunostomy, or the biliopancreatic limb of a Roux-en-Y gastrojejunostomy. Causes of this can include: kinking at the anastomosis, radiation stricture, internal hernia, or recurrent tumour at the anastomosis. • AS stated a swallow is not required if stenting is not performed endoscopically. • There have been discussions regarding putting in place SLAs across the Trusts for patients to come to MTW as part of a network model approach with support from the Radiology Network. • It is advised to cease chemotherapy 4-6 weeks prior to administering a stent, although there is no published evidence supporting this. Stenting on chemotherapy can therefore be considered but is not the preferred method. There are, however, generally no issues with a patient being stented whilst undergoing immunotherapy.	
3	**Total Pancreatectomy/ Islet Auto transplantation**	• Due to an emergency, Evangelos Prassas was unable to attend the meeting and an update was therefore not provided.	

4	**SARONG Study**	**Presentation provided by Mark Kelly** • MK's presentation provided the group with an overview of the SARONG (**S**urveillance **A**fter **R**esection of **O**esophageal a**N**d **G**astric cancer) trial. His slides provided a summary of: - There not being a clear consensus on the optimum strategy for clinical follow-up in patients undergoing surgical resection. - Its possible benefits including: Patient reassurance. HRQLs. Identifying early recurrence and treatment options. Longer OS. - The current NICE guidance regarding follow-up (which MK believes is quite vague), particularly in relation what to offer and not to offer patients who have no symptoms or evidence of residual disease after treatment for oesophago-gastric cancer with curative intent. - The aims of SARONG. The study aims to determine whether intensive surveillance after completing curatively intended treatment improves survival and health-related quality of life in patients with oesophageal or gastric cancer. - The study's design and implementation: The SARONG study is a multi-centre, open-label, two-arm, parallel design, superiority Randomised Controlled Trial. 952 patients (476 in each of the 2 trial arms) will be recruited over a period of 32 months from approximately 24 sites in the UK. - The implementation of the study which would require a Principal Investigator at each site to coordinate imaging/clinical review. Mathilda Cominos has previously expressed an interest in supporting this. - The European Investigation of Surveillance after Resection for Esophageal cancer (ENSURE study) and its results. • MK highlighted the importance of the Trusts considering whether to alter current surveillance for implementation of this approach or to utilise it as an additional practice. • MK is unaware as to whether there will be funding for implementation of this practice at each site. • MK believes the next step is for the sites to agree whether or not to proceed with recruitment to this trial. JWa did, however, highlight there is a lack of research nurses across the patch which could have an impact. • The aim would be to recruit 2-3 patients per month at each site. • MK believes the main costings associated with the study will be for imaging. • MK feels there is a benefit to be had from intensive surveillance with ENSURE, although this can result in increased anxiety for patients.	
	2WR guidelines	**2WR guidelines** • **Action: MK agreed for the document to be shared and encouraged the members to email him if they have any comments/queries.**	**CC**
5	**Endoscopy**	• This item was not discussed.	
6	**EUS update**	**Presentation provided by Jeff Lordan** • The current pathway for the implementation of the EUS service is as follows:	

	Creon audit for Pancreatic cancers	- **Wednesday am:** Patients needing an EUS will be identified at the MTW UGI/HPB MDT. - **Thursday:** Patients will be reviewed in the cancer clinic to inform and determine if further investigation is clinically appropriate. - **Thursday/Friday:** Patients have a nurse-led outpatient appointment. - **Monday am:** Patients are to be ratified at the King's College Hospital HPB MDT. - **Monday pm**: EUS list. • A SOP and patient information leaflet have been completed and a business case has been signed off at the Trust's Board. • An agreement for funding from the ICB and Specialist Commissioning NHSE has been granted. • Support from King's College Hospital for the management of complications has been agreed. • Interventional Radiology support in parallel to the EUS lists is in place as is pathology support for cytology and histology analysis. Biochemistry support for cyst fluid CEA and amylase analysis is also in place. • Both nurses and clinicians have completed the necessary training. • EUS lists performed are to be undertaken at Maidstone Hospital on Monday afternoons, with 2 clinicians operating (JL and Dodi Hanumantharaya). • The scopes are currently at Olympus being serviced and once they have been returned the service will be ready to launch. • When the service launches, it will focus on MTW patients for the first 6 months. Those intended for an EUS at King's College Hospital will be rediverted back to MTW which will therefore open up additional slots for other Trusts in Kent & Medway. • JL believes MTW will have capacity to perform 4 EUS' on Monday afternoons to begin with but this is likely to increase to 8 EUS' after 6 months. **<u>DVH/MFT – update provided by Ben Warner</u>** • BW stated DVH/MFT's EUS list is expected to commence at the end of June 2023 and they will work on benign cases for the first 6 months before moving on to cancer cases from December 2023. • BW stated there is now a patient information leaflet and CNS' have had the relevant training in London. **<u>Update provided by Ben Warner</u>** • Of the 20 recently diagnosed patients with pancreatic cancer contacted to take part in the audit: - 3 had died. - 4 could not be contacted. - 8 were prescribed Creon (with 7 taking it). • The outcome of the audit included: - Having a rep from a PERT company coming to present to them. - Providing education to CNS' regarding the benefits of PERT. • There is a plan to re-audit in the summer to hopefully have a larger number of patients involved. **<u>Action</u>: Update to be provided at the next meeting.** • It was agreed the default position for the TSSG should be for all patients to commence with Creon, prescribed by their GPs, as it can make a significant difference for them prior to commencing with chemotherapy.	**BW**

7	**How can Primary Care Support?**	• LA stated the 2ww standard is out for consultation with a decision due by the end of the year. **<u>Anaemia Pathway</u>** • Following on from discussions at the Colorectal TSSG on 18.04.2023, feedback received there highlighted the need for primary care to improve the quality of referrals. • LA posed the question of what secondary care can do to support primary care with regard to IDA, for example whether providing training to them would be of benefit. • Following a review of the proposed pathway at the Colorectal TSSG, LA agreed to support in developing a GP-friendly version with help from Dr Jonathan Bryant. The group there agreed that to do a wide cross cutting pathway would prove too complicated but instead to focus on supporting GPs to differentiate between anaemia and IDA as it was highlighted that 2ww clinics are flooded with anaemia patients who perhaps should be on alternative pathways if certain tests were carried out in primary care first or indeed could, if appropriate, be managed in primary care. • **<u>Action</u>: JL highlighted the need for standardised practice and requested an agenda item on the anaemia pathway to be added to the next agenda.** • **<u>Action</u>: LA to review other services anaemia pathways to identify whether any can be adopted and adapted by Kent & Medway.** • MM stated a number of patients are not being seen face-to-face by a GP (40% of which are locums in Kent & Medway) and highlighted the importance of primary care being aware of the need to improve the quality of referrals. **<u>Liver Surveillance</u>** • The KMCA hold regular stakeholder groups with all interested parties, including the 4 Trusts, public health, the HepC ODN, and InfoFlex. From these meetings the consensus view is that a robust pathway needs to be built for Liver Surveillance which is equitable across all the Trusts. This is something currently being worked through, with the cancer commissioners in the NHS Kent & Medway ICB, so they can offer a recommended fully costed model pathway. Ultimately, the Alliance hope to write a business case in the longer term for the ICB to commission the funding of this pathway. • The Alliance have now met with each Trust separately and have discussed their problems and concerns as well as solutions. In addition, they have carried out an audit with good responses from all Trusts. Most of the Trusts state they are experiencing rapidly growing lists and need more staff. Currently the service is often left to a single CNS in liver whose main role is not surveillance per se. However, this is a substantial role with much administration. Therefore, there is some consideration to the roles which could be pump primed by the KMCA. • The Alliance have met with the national InfoFlex team to discuss a possible development into the liver surveillance space. They have invited them to their next Liver Surveillance Stakeholder Group to discuss their ideas and plans with the group. The InfoFlex team are going to present their plans based on the group's conversation at their next meeting on 02.05.2023 (12:00-13:00). • 598 people have been invited to surveillance in the last 6 months (this is incomplete). Data from 2 Trusts has been received (MTW and MFT) whereas DVH and EKHUFT were not able to provide data. North Kent currently does not have any liver surveillance set up as they explain that it was previously agreed under a block contract with GPs. EKHUFT do have a liver surveillance service but no updated data - they are collecting this prospectively. The Alliance appreciate the data they are receiving and if they could possibly receive as much data as possible in terms of numbers on the Trusts' surveillance database, and those who attended, this would really help their pathway costings.	**AW** **LA**

		• The Alliance have also had conversations with the HepC ODN and they are jointly working, with all stakeholders, toward being in a position where more high-risk patients can be recruited through the 'van' in 2024/2025. • AB has been asked to lead on the liver surveillance piece on behalf of King's College Hospital for Kent & Medway. MTW have a nurse-led clinic in place which has been running for a number of years. An update on how this workstream has evolved will therefore be provided at the next meeting by AB/Cathy Finnis.	
8	**Performance Questions** **Performance data**	• **<u>Action</u>: KMCA currently have the worst FDS performance nationally. JL highlighted the reason for this is likely to be multi-factorial including issues with CNS capacity as was raised by members during today's meeting. JL stated he would be happy to support the need for additional resource to help expedite this problem across the Trusts and will contact Ian Vousden accordingly.** • KMCA are currently doing very well with regard to 62d performance (2nd nationally). • KMCA currently have a USC backlog of 6.3%. • Data completeness issues are likely to have an impact on the performance figures seen. • Differences in data could also be due to dependencies on other Trusts for treatments such as King's College Hospital. • SG stated she is awaiting access to InfoFlex at which point she can work with David Osborne (Data Analyst – KMCA) to obtain more detailed information pertaining to data. **<u>DVH – presentation provided by Michelle McCann</u>** • Please refer to the performance slide pack circulated on 20.04.2023 for an overview of the Trust's data. • The team are undertaking process mapping for the Best Practice Timed Pathway piece, with support from the quality team. • DVH have applied for Alliance funding for a consultant-led role to prioritise and vet the 2ww pathways. • There has been some long-term STT nurse sickness and MM highlighted how hard the team have had to work in order to mitigate any issues for the FDS piece. • Patient choice issues have also had an impact on performance. **<u>EKHUFT – presentation provided by Diane Muldrew</u>** • Please refer to the performance slide pack circulated on 20.04.2023 for an overview of the Trust's data. • EKHUFT are experiencing some issues with pathology and radiology due to capacity issues. DM believes this needs to be escalated to the Trust with support from the MDT and TSSG. • There have been some pathology delays (2 weeks+) due to capacity issues. • The service has also experienced some delays with getting radiology as well as biopsies (there is a minimum of a 4 week wait for a liver biopsy). JL suggested raising this with the Trust with support from the MDT Lead. He also stated they would have the support of the TSSG and asked DM to let him know the outcome of this. SG agreed to raise this issue with Malcolm Nudd (Head of the Pathology Network). • Diagnostic delays have resulted in breaches. **<u>MFT – presentation provided by Suzanne Bodkin</u>** • Please refer to the performance slide pack circulated on 20.04.2023 for an overview of the Trust's data.	**JL**

		• The service has experienced some issues with endoscopy capacity. They currently have 2 rooms but there are plans for this to be expanded at some point in the future. **<u>MTW – presentation provided by Summer Herron</u>** • Please refer to the performance slide pack circulated on 20.04.2023 for an overview of the Trust's data. • FDS performance has been impacted, amongst other factors, by issues with consultant review and communication processes. • With regard to the >62d backlogs, SH believes the local utilisation of EUS' will help to clear some of these. • There have been capacity delays at King's College Hospital which has had an impact on performance. • An upper GI oncologist is due to step down shortly. TS is leading on the recruitment of a replacement.	
9	**MDT Streamlining update**	• MM stated DVH have sent out to advert a position for a Project Manager to oversee the MDT Streamlining piece. The advert for this closes tomorrow. • JL believes the MDT at MTW operates well and highlighted the importance of vetting cases prior to the meetings. • AS is the Clinical Director for Radiology at MTW and provides valuable input to the MDT. The MDT Coordinators do prep work prior to the meetings. • DM feels there is a misuse of the time at MDT meetings, which can take around 3.5 hours at EKHUFT, with around 50% of cases being inappropriate for discussion there. She believes there is not sufficient time for consultants to prepare for the MDT meetings. • SB stated MFT hold a weekly pre-MDT with the CNS' and Lead Clinician to review all patients prior to the main MDT as part of the streamlining process. • DM highlighted that EKHUFT are struggling to have MDT input from Parthi Srinivasan/the King's College Hospital team. **<u>Action</u>: JL to contact him to see if this can be resolved.**	**JL**
10	**CNS provision for oncology** **Molecular Testing in UGI & HPB** **Role of EUS staging**	**<u>Update provided by Justin Waters</u>** • JWa highlighted the variation in practice across the patch with regard to CNS' following up with oncology patients, particularly face-to-face contacts. The intention is for this to be brought in to line across Kent & Medway. • **<u>Action</u>: DM mentioned there are too few CNS' at EKHUFT in particular (2.2 WTE), which has been an issue for a long time and makes it extremely difficult for them to attend oncology clinics. JL highlighted that a lack of adequate CNS workforce can have an impact on FDS performance and he will highlight this to Ian Vousden.** • MFT are in talks with MTW regarding an honorary contract for their CNS' to attend MTW clinics for MFT's patients. **<u>Update provided by Justin Waters</u>** • JWa highlighted the need to identify the most effective ways of supporting pathology and arranging/reporting testing for these patients as the service expands. It was suggested that it would be worthwhile linking in with Pathology Network colleagues in order to formulate how this could be coordinated. **<u>Update provided by Justin Waters</u>** • JWa stated there is a keenness not to abandon the use of EUS for OG cancer.	**JL**
11	**Research updates**	**<u>Research updates provided by Justin Waters</u>** • JWa highlighted that there have been challenges with regard to relaunching upper GI research trials since the pandemic.	

	Introduce research delivery team	• The SCOPE2 trial is being recruited to whereas the PLATFORM trial is currently on hold. **Introduce research delivery team** • SD and HM were unable to attend today's meeting so an update was not provided.	
12	**Clinical Audit update**	• No update was provided pertaining to this item.	
13	**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 20.04.2023 for a detailed breakdown of what these are): - Faster diagnosis and operational performance. - Early diagnosis. - Treatment and care. - Cross-cutting. • The CNS workforce appreciation day will be taking place on 27.04.2023 at the Mercure Hotel in Maidstone. • A decision has been made not to move forward with a Community Pharmacy Pilot which the Alliance had previously expressed an interest in initiating/supporting. • The Galleri GRAIL trial is currently in its second year and pancreatic cancers have been identified through it. There is currently no published data for the trial.	
14	**CNS Updates**	**DVH** • A Cancer Support Worker is in place for the service 2 days a week. • An advert is due to go out for a part-time CNS position. **EKHUFT** • DM did not have anything to add beyond what she had raised throughout the meeting. **MFT** • There is currently no room space for the planned nurse-led clinic. This has been escalated to the gastroenterology service manager. • The MFT CNS' are looking to attend some of the MTW oncology clinics as they feel this would be of benefit to them and their patients. • The STT service commenced at MFT in June 2022. A Band 7 leads on it and a Matron is also in place to support the service. • There are currently 3 CNS' in place for the service but the team hope to recruit an additional Band 7 to support in due course. **MTW** • BJ, who is a full-time Cancer Support Worker, is now in place for the service and is working on setting up a HNA telephone clinic. • The team will have a Band 6 Development Nurse in place in July 2023. • The CNS team comprises of 4 Band 7s and 1 Band 6. **GSTT** • GM highlighted the importance of adequately completing the referrals when sending patients to GSTT for one-stop investigations.	

		• Jessica Jones is the new STT nurse for GSTT. **KCH** • No update provided.	
15	**AOB**	• No-one wished to raise anything under any other business.	
	Next meeting	• To be confirmed.	