Upper GI/HPB Tumour Site Specific Group meeting
Thursday 1st May 2025
Park View Meeting Room – Mercure Great Danes Hotel
09:00-12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Jeff Lordan (Chair)	**JL**	Consultant Upper GI & General Surgeon	MTW
Tracey Nolan	**TN**	Upper GI FDS Nurse	MTW
Bushra Ansari	**BA**	Upper GI CNS	MTW
Raquel Souto	**RSo**	Practice Educator – Endoscopy	MTW
Debora Primerano	**DP**	Deputy General Manager	MTW
Clare Reeder	**CR**	Macmillan Consultant Clinical Psychologist	MTW
Rebecca Samson	**RSa**	MDT Coordinator	MTW
Mollie Newman	**MN**	Assistant General Manager for Cancer Performance	MTW
Wendy Brown	**WB**	Upper GI CNS	MTW
Leigh Morgan	**LM**	Pathway Navigator	MTW
Adrian Barnardo	**ABa**	Consultant Gastroenterologist	MTW
Marie Payne	**MP**	Lead Cancer Nurse	DVH
Geoff Dickson	**GD**	Senior Oncology Dietitian	DVH
Amanpal Brar	**ABr**	HPB CNS	DVH
Sarah Simpson-Brown	**SSB**	Upper GI CNS	DVH
Chloe Sweetman	**CS**	Upper GI HPB CNS	DVH
Kelsi Widden	**KW**	MDT Coordinator	DVH
Ella Milan	**EM**	Early Diagnosis Coordinator	DVH
Ben Warner	**BW**	Consultant Gastroenterologist	DVH
Chirag Kothari	**CK**	Consultant Physician & Gastroenterologist	DVH
Syed Naqvi	**SN**	Consultant Gastroenterologist	DVH
Diane Muldrew	**DMu**	Upper GI CNS	EKHUFT
Stella Grey	**SG**	General Manager	EKHUFT
Arun Dhiman	**AD**	Consultant Gastroenterologist	EKHUFT
David Austin	**DA**	Consultant Gastroenterologist	EKHUFT
Kate Hills	**KH**	Consultant Gastroenterologist	EKHUFT
Oliviana Rusu (via Teams)	**OR**	Oesophago-gastric Cancer Nurse Specialist	GSTT

James Gossage (via Teams)	**JG**	Consultant Oesophago-gastric & General Surgeon	GSTT
Mohamed Elmasry	**ME**	HPB Consultant	King's College Hospital
Jo Bailey	**JBa**	Programme Lead – Early Diagnosis	KMCA
Jo Jackson	**JJ**	Project Manager – Early Diagnosis	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	**SWi**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Rakiatu King	**RK**	STT CNS	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Sue Jenner	**SJ**	Upper GI CNS	MFT
Alison Mannering	**AM**	Dietitian	MFT
Mihaela Zdrinca	**MZ**	Upper GI STT CNS	MFT
Apologies			
Jane Abrehart	**JA**	Nurse Endoscopist	DVH
Lawrence Ribero-Moreno	**LRM**	Clinical Nurse Endoscopist	DVH
Jennifer Mayow	**JM**		DVH
Yunmei Chen	**YC**	Upper GI STT Nurse	EKHUFT
Ruth DeBerry	**RDB**	Consultant Gastroenterologist	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager - CCHH Care Group	EKHUFT
Claire Bingham	**CB**	Macmillan Personalised Care Facilitator	EKHUFT
Sue Travis	**ST**	Head of Operations - General Surgery/Colorectal/Gastroenterology/Endoscopy (WHH)	EKHUFT
Philip Mayhead	**PM**	Consultant Gastroenterologist	EKHUFT
Danielle Mackenzie	**DMa**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Sara Wells	**SWe**	Service Manager for HPB	King's College Hospital
Ritchie Chalmers	**RC**	Medical Director	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Emma Lloyd	**EL**	Cancer Pathways Improvement Manager	KMCA
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCA/KMCC
Hayley Martin	**HM**	PCS Facilitator	MFT
Monika Verma	**MV**	Consultant Histopathologist	MTW

Hannah Fotheringham	**HF**	Upper GI CNS	MTW
Jelena Pochin	**JP**	Head of Performance & Delivery for Diagnostics and Therapies	MTW
Stephanie McKinley	**SM**	Matron - Faster Diagnosis	MTW
Justin Waters	**JW**	Consultant Medical Oncologist	MTW
Aidan Shaw	**AS**	Consultant Interventional Radiologist	MTW
Tim Sevitt	**TS**	Consultant Clinical Oncologist	MTW
Sarah-Jane Taylor-Seres	**SJTS**	Associate Director of Endoscopy Programme	NHS Kent & Medway ICB
Neil Cripps	**NC**	Consultant Surgeon	NHSE South East

Item		**Discussion**	**Action**
1.	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • JL welcomed the members to the meeting and asked them to introduce themselves. **<u>Action log Review</u>** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **<u>Review previous minutes</u>** • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2.	**CRG update**	**<u>CRG update</u>** • Upper GI CRG meetings have commenced.	

	Pathway updates	• One of the focuses of the CRG will be to establish closer links between primary and secondary care. **<u>Pathway updates</u>** • NHSE have recommended the following three pathways in relation to upper GI cancer: - Jaundice, pancreatic, extra-hepatic cholangio, gall bladder pathway. - Hepatocellular carcinoma and intrahepatic cholangiocarcinoma pathway. - Oesophago-gastric cancer diagnostic pathway. • JL provided an overview of both the *'Hepatocellular carcinoma and Intra-Hepatic Cholangio'* and *'Jaundice, pancreatic, extra-hepatic cholangio, gall bladder'* 21-day best practice timed pathways. The 21-day best practice timed pathway refers to a standard implemented by the NHS in England to ensure patients receive a diagnosis of cancer, or are told that cancer is ruled out, within 21 days of being referred by their GP. This pathway aims to streamline the cancer diagnostic process, reduce wait times, and improve patient outcomes. • The 21-day best practiced timed pathway timeline can be viewed as the below: day 0 (GP referral), day 5 (initial diagnostics), day 8 (clinical assessment), day 10 (MDT review), day 16 (further diagnostics) and day 21 (treatment discussion). • In the context of NICE guidelines on oesophago-gastric cancer, the "28d" refers to a timeframe for patients suspected of having the disease. This means that patients who are urgently referred for investigation of suspected cancer are expected to receive a diagnosis within 28 days. The goal is to ensure timely diagnosis and treatment for these cancers, which affect the oesophagus and stomach. • The 28d best practiced timed pathway timeline can be viewed as: day -3 to 0 (GP referral), day 3 (clinically led triage), day 7 (endoscopy ← → CT scan), day 12 (local meeting and coordination), day 14 (CWT system and referral), day 12 to 21 (further investigations) and day 21 (sMDT review and treatment planning).	

		• In terms of areas to consider, it would be advisable to: - Work with primary care to facilitate appropriate referrals. - Have frailty and performance status at the top of the referral form. - Empower STT nurses to triage patients. - Provide advice and guidance to GPs which could reduce unnecessary referrals. - Establish strategies to reduce low-value endoscopy. - Consider the role of cytosponge/naso-endoscopy where appropriate. - Establish benign pathways where these do not exist. • JL emphasised the need for there to be an efficient front door triage system as endoscopy services are overwhelmed and there are too many low-value endoscopies taking place. By having this process in place, it will decrease waiting times for those patients with a more urgent need. • BW highlighted that it takes around a year for patients to be seen in the gastroenterology clinic at DVH. He feels setting up face-to-face triage would be helpful and for a clinician to lead on this. In view of this, KMCA have been approached for funding to support this.	
3.	**Dashboard**	• In the last six months, FDS performance improved from 59.9% to 67.7%, but is still below the England average of 76.9%. • In the last six months, FDS performance improved at all four Trusts. 62d performance fell at DVH from 90.3% to 79.2%. • Waiting times are longest at EKHUFT, especially at the start of the pathway. • To access the dashboard: - Complete the form: https://forms.office.com/r/svyPSvktHw.	

		- Once access has been granted by the ICB, access the dashboard at: https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e - click on the KM ICB Main app and go to Cancer Pathways on the left-hand menu. • It was highlighted that there appears to be a discrepancy between the 'Straight to test (ICBDW)' and 'Straight to test by day 3 (Infoflex)' data for both the OG and HPB sections of the Dashboard. **Action: JL to contact David Osborne (Data Analyst – KMCA) in order to obtain clarity on this.** • BW feels there needs to be clarity in terms of what is constituted as a treatment. Patients who are prescribed iron for suspected IDA are viewed as having been treated. • EKHUFT are able to get patients a CT scan relatively quickly but the turnaround time for reporting is much slower. • ABa specified that improving how radiology and endoscopy reports are written will improve data collection. • **Action: JL to meet with David Osborne/Ritchie Chalmers to discuss in further detail how the data is collected and reported along the entirety of the pathway.** • ABa stated that he presents data at national meetings and is aware that a lot of hospital Trusts would like to replicate the Kent & Medway Dashboard model.	**JL** **JL**
4.	**EUS update**	**Update provided by Jeff Lordan** • The MTW EUS service commenced in October 2023. • JL (surgeon), Dr Doddaiah Hanumantharaya (gastroenterologist) and Dr Rahel Mahmud (gastroenterologist) in addition to endoscopy nurses have been trained in EUS procedures. • The service has two platforms (one at MGH and one at TWH) and four EUS scopes in place.	

		• MTW are consistently achieving four EUS per list and have two half-day lists per week (eight cases in total weekly). • In terms of the EUS timeline: - On Wednesdays, patients are discussed in the MTW UGI/HPB MDT with HPB surgery representation from King's College Hospital. - On Thursdays, the patient is seen in the MTW UGI/HPB cancer clinic and has a nurse-led outpatient appointment. - On Monday mornings, the patient is discussed in the King's College Hospital HPB MDT to ratify the decision for EUS. - On Monday afternoons, the EUS is performed at MTW. • MTW have developed a one-day assessment and EUS biopsy for patients coming to MTW from elsewhere. MTW are accepting patients from across Kent and Sussex and have close liaison with other Trusts and King's College Hospital. • A questionnaire has been developed to determine patient suitability for EUS. • In terms of current data (October 2023-April 2025): - EUS performed – 182. - Patients seen in the first six months - 25. - Patients seen in the last 12 months – 157. - Percentage of patients who had FNB/FNA - 73.8%. - Percentage of patients who had diagnostic FNB/FNA - 90%. - Complications arose in one patient who developed pancreatitis - this was managed conservatively. Two patients were admitted for observation. - The case mix includes: pancreatic adenocarcinoma, IPMN, P-NET, renal cell metastasis, benign cysts, gastric GIST, pancreatitis, metastatic HCC in the para-aortic lymph nodes, lymphoma – mesenteric lymph nodes, and silicone	

		from a ruptured breast implant (porta hepatis lymph nodes). • The team comprises of endoscopy nurses (EUS and pre-assessment), a pathway coordinator, histopathology, biochemistry, interventional radiology, King's College Hospital support, and the whole MDT. • In terms of future developments: - The service would like to start doing hot axios cyst-gastrostomy stents and establish a complex stone service. - There may be potential to deal with a case load of 200-250 patients per Trust per year (total 800 to 1000 patients). - There is a role for a CNS. - There is a desire to work strategically with other clinicians in Kent more closely and develop links in order to encourage recruitment in all Trusts - e.g. clinicians travelling between Trusts to perform EUS/ERCP. • In concluding, the EUS service at MTW: is a safe, high-quality service; has seen a recent expansion in capacity; and, is ready to receive referrals from Trusts across Kent & Medway.	
5.	**King's update**	**<u>Presentation provided by Mohamed Elmasry</u>** • With regard to an HPB update at King's College Hospital, there is: - A team of seven surgeons. - A team of six HPB radiologists (although one will be leaving in June 2025). - Two HPB MDMs per week (there is also an HCC and NET MDM in place). - A hub and spoke model in place for local MDMs. - A triage MDM. - Not only a CNS team specifically for the HPB service but also ones for HCC and NET.	

		• ME outlined that he deals with complex benign cases including benign tumours, pre-malignant lesions and complete pancreatitis. • Challenges include: - MDM pressures involving large numbers of referrals/triages. There are often 35-40 cases to discuss at MDT. - Unreported local scans. - Incomplete referral information such as performance status, tumour markers and LFTs. - Avoidable referrals e.g. stable IPMN under surveillance. • The updated SELCA guidelines will be circulated next week. • BW feels there is a role for a Benign MDT in the region and he would be happy to support in setting this up. Job planning and radiology support would be needed and JL would be happy to support this. BW also floated the idea of having a network-wide EUS PTL. • There are widespread radiology reporting delays across Kent & Medway and also SELCA.	
6.	**GSTT update**	**<u>Update provided by James Gossage</u>** • NPCA, NBOCA, NOGCA and NLCA have now moved into NATCAN bringing all cancer audits together under one umbrella for the first time. • The cancer audits utilise the nationally mandated flows of data from hospitals to the National Disease Registration Service (NDRS) in NHSE and the Wales Cancer Network in Public Health Wales. Each NATCAN audit has published key data items (Cancer Outcomes Services Dataset – COSD) for each cancer site, which hospitals can check are being completed and submitted to NDRS.	

		• There is increased robotic surgery at GSTT, however the service remains relatively unchanged from the update JG provided at the last meeting. • There will be numerous QI projects taking place within the next two years. • OR highlighted that there are histopathology delays from GSTT affecting DVH, MFT and MTW.	
7.	**ERCP update**	**<u>Presentation provided by Ben Warner</u>** • Reasons for the establishment of the ERCP Network include: - Workforce planning (there is a lack of ERCPists and many of those currently trained are approaching retirement age). - The quality and safety of the ERCP procedure. • With regard to the aspirations of the Network, these include: aligning processes; cross-cover and a shared PTL; research; sharing best practice; better training; and, implementing a hub and spoke model within Kent. • In terms of what the Network has achieved so far, this includes: - Two Network meetings have taken place and have been supported by the ICB. - Shared audits. - Understanding each other's processes. - A plan for improving training. - An ATSM trainee from September being shared between MTW and DVH. • Current barriers include: funding for a Clinical Lead to bring the Network together; local audit data collection; no cross-cover site passports; and, an appetite for everyone to get involved.	

		• There is a plan to improve the ERCP training, which takes place in Stoke. • BW paid thanks to Hemant Sharma (MTW) who has recruited a Hepatobiliary Endoscopy Fellow who will be shared between MTW and DVH and will help with the training of ERCPists. • There is an ambition to sort out the passport issue so ERCPists can work across the Trusts. • BW mentioned that SpyGlass needs to be done under GA and feels there is a role for this in Kent. • BW believes that in order to attract new ERCPists in to the system, Trusts need to have an EUS service in place.	
8.	**'Cancer Psychological service for Kent & Medway – who we are and how to refer'**	**<u>Presentation provided by Clare Reeder</u>** • The Cancer Psychological Service for Kent and Medway (CaPS-KM) covers all four acute Trusts. The CaPS-KM team are separate from, but work closely with, the Oncology Counselling teams. • The service has received two years of funding from KMCA and Macmillan (May 2024-26). CR hopes the service will then be fully commissioned after this. • The aims of the service are: to build on previous scoping to understand local psychosocial services; to demonstrate unmet psychological need; to set up and evaluate a Kent & Medway-wide cancer psychological service; and, to secure permanent NHS funding. • The team comprises of India Barton (Macmillan Assistant Psychologist), Sophie Lansdowne (Honorary Assistant Psychologist), Janet Bates (Macmillan Counsellor), Dr Chris Bonner (Macmillan Clinical Psychologist), Dr Clare Reeder (Macmillan Consultant Clinical Psychologist and Service Lead) and Rachel Maciag (Trainee Clinical Psychologist). • The team have: - Undertaken a widespread listening exercise with MTW, EKHUFT, hospices and other third sector colleagues. - Set up a Steering Group.	

		- Compiled a patient survey. - Established a focus group. - Attended support groups. - Provided video resources for patients. - Established a pilot service which is up and running in MTW (approximately 70 referrals have been received so far). The service can now also receive referrals from DVH, EKHUFT and will soon be able to do the same for MFT. - Focused on developing coherent, safe pathways with existing services. - Worked with other Trusts in Kent & Medway to commence with their service. - Delivered two Level 2 psychological skills training courses for cancer CNSs and AHPs and established five supervision groups. - Provided workshops for CSWs, chemo day unit staff and palliative care colleagues. - Provided induction teaching for haematology and oncology SHOs. • CR outlined: what the service is offering; who to refer to psychological services; who the service will see; and, how to refer to the service and what to expect. • In order to contact the CaPS-KM service, please email mtw-tr.caps-km@nhs.net or clare.reeder@nhs.net. • **<u>Action</u>: CR highlighted that referral forms are available on the Trusts' intranets and also agreed to send these to JL/CC for them to circulate accordingly.**	**CR/JL/CC**
9.	**Radiology update**	**<u>Update provided by Jeff Lordan on behalf of Aidan Shaw</u>** • An EKHUFT Radiologist has been visiting MTW to see their practices and take them back to enhance care. • A case has been submitted for a percutaneous choledochoscope to allow lithotripsy for large CBD stones.	
10.	**Oncology**	**<u>Update provided by Jeff Lordan on behalf of Justin Waters</u>**	

	update	• Maidstone are slowly progressing the opening of the ABC10 trial, which is a first line advanced cholangiocarcinoma trial aiming to match treatment to the molecular profile of the tumour. • EKHUFT are in the advanced stages of opening the Zodiac trial, which is a trial of neoadjuvant immunotherapy in MMR-deficient oesophago-gastric cancers. • Both East and West Kent teams also have the Sarong trial open which is looking at the best modality for follow-up of patients following completion of radical treatment for oesophago-gastric cancer.	
11.	**Pathology update**	• No update provided.	
12.	**The Pancreatic Cancer Case Finding Pilot**	**<u>Presentation provided by Jo Bailey</u>** • KMCA has developed a Pancreatic Cancer programme as part of their strategic objectives for 2025/26. This is to include: Primary Care Case Finding, AI Algorithm, EUROPAC and Family History Case Finding. • JBa explained that KMCA were unsuccessful in receiving NHSE funding for the Pancreatic Cancer Case Finding pilot, however the funding will be provided by the KMCA transformational funding. **<u>Primary Care Case Finding</u>** • The Primary Care Case Finding project seeks to identify patients at risk of pancreatic cancer earlier through case-finding strategies in primary care settings. • The project will test whether a targeted intervention, that supports primary care to case-find people with these key symptoms, improves the early diagnosis of pancreatic cancer.	

- Based on early modelling carried out for this project, it is estimated that 56 patients will be eligible for onward referral (56 patients in total from the five pilot sites). Discussions around the onward referral pathway into secondary care will be held within the working group.

AI Algorithm

- The aim is to develop a clinically-informed, data-driven tool to identify individuals at higher risk earlier. The core principles include: to be proactive (not reactive) with an early intervention focus; for it to be data-led (healthcare and wider determinants of health); and, for it to be clinically grounded (co-designed with clinical leads and patients).

EUROPAC

- EUROPAC referral information is now live on the KMCA website.
- Education events have been planned (including lunch and learns and PLTs) to increase awareness of the programme in primary care.
- The Early Diagnosis team have been linking in with the KMCA Patient Engagement Lead to better understand how to approach conversations around familial risk of pancreatic cancer with patients already diagnosed and how best GPs can have a conversation with their patients once diagnosis is confirmed.
- Discussions have begun with the GP Cancer Clinical Lead regarding the EMIS proactive search of patients diagnosed with pancreatic cancer to increase identification of patients who may have familial history.
- The Early Diagnosis team have been liaising with the EUROPAC regional navigator to progress the local regional surveillance centre, however this may be delayed as currently two further sites in the south-eastern region are currently under development which is impacting on EUROPAC resource.
- MTW are experiencing delays getting EUROPAC set up, however Laura Alton is working to push this through.

		Family History Case Finding • This project aims to identify patients with a family history of pancreatic cancer within a PCN and facilitate appropriate referrals to EUROPAC. This project will launch once the referral centre has been agreed, and referral pathways scoped. • A text message is sent via iPlato to patients aged 40 and over, asking whether they have a family history of pancreatic cancer or any other cancer. Patients who respond 'Yes' to having a family history of any cancer are identified, with a subset specifically indicating a family history of pancreatic cancer. • A second text message is sent to the subset of patients, asking whether the family history of pancreatic cancer involves a first-degree relative (parent or sibling). • Patients are identified as having a first-degree relative affected by pancreatic cancer. Patients who meet the criteria (first-degree relative with pancreatic cancer) receive a further text, explaining that they will be referred to EUROPAC for screening and support. • Patients who do not meet the criteria are provided with EUROPAC's contact details to enable self-referral, ensuring they still have access to support and information. • An additional follow-up text is sent to patients from the original group, who indicate a family history of pancreatic cancer (not first-degree) alongside breast or prostate cancer. • These patients are asked whether they have a known BRCA gene mutation. In line with guidelines, a BRCA mutation combined with a family history of pancreatic cancer qualifies for onward referral to EUROPAC.	
13.	**CNS Updates**	**DVH**	

		• CS has returned from maternity leave. • The part-time STT nurse will be going on maternity leave shortly. The team feel they need to source cover for this role and it will be going to recruitment panel tomorrow. **EKHUFT** • The team feel they would benefit from having a Band 6 Development CNS in place. • The full-time STT CNS is going on maternity leave, however the team are unsure as to whether they will be able to get cover for this role. SG stated she will discuss this further with Alexis Warman. • The team are struggling with PTCs. **Action: JL to contact AS to request he arrange an audit of the number of PTCs MTW do for EKHUFT over a one-year period and present this information at the next meeting.** **MFT** • The team comprises of two CNSs. • The new system for referrals is currently the team's main issue. **MTW** • MTW are experiencing staffing issues. They have lost their admin support; however, the post went out to advert and they are now in the process of shortlisting. • BA is the new Band 7 for the team.	**JL/AS**
14.	**Chemo Top Tips for patients from**	• This document will be circulated to the members following the meeting.	

	patients		
15.	**AOB**	**<u>Endoscopy Network – update provided by Adrian Barnardo</u>** • ABa provided the group with an overview of the roles of the Endoscopy Network, which include: - Developing efficient pathways. - Developing and monitoring of agreed protocols of care. - Patient engagement and coproduction. - Workforce planning. - Equipment and facilities planning. - Facilitation of staff working across NHS boundaries. - Joint training programmes, including CPD programmes. - Centralisation of complex interventions in specific locations. - De-centralisation of care. - Digital connectivity. - Centralised scheduling. - Capacity and demand planning. - Avoidance of duplication of effort. • ABa highlighted that the aspiration for having staff/patient passports has now been shelved. • ABa specified that MTW is a JAG training centre now. As a result, there are two new ERCP fellows coming to Kent & Medway. • There is an intention to establish a single PTL for all referrals which will help the region manage patients and provides a cost-saving. **<u>Other</u>**	

		• JL informed the members that this is AW's last Upper GI TSSG meeting as she will be retiring next month. He thanked her for her support over the last seven years and wished her all the best for the future. • ABa questioned whether it would be possible/advisable to create a joint 'dropbox' for histopathology reports. He feels this would save crucial time for CNSs who often spend a lot of time chasing reports. • **<u>Action</u>: Following discussions around issues pertaining to histopathology turnaround times (particularly delays), JL stated he would meet with Dominic Chambers and Isabel Woodman to discuss the concerns articulated, the impact this is having and the potential reasons for these.**	**JL**
	Next Meeting	• To be confirmed.	