

**Upper GI/HPB Tumour Site Specific Group meeting**  
**Thursday 17<sup>th</sup> October 2024**  
**Mercure Great Danes Hotel**  
**09:00-12:30**

**Final Meeting Notes**

<b>Present</b>	<b>Initials</b>	<b>Title</b>	<b>Organisation</b>
Jeff Lordan (Chair)	<b>JL</b>	Consultant Upper GI/HPB and General Surgeon	MTW
Adrian Barnardo	<b>AB</b>	Consultant Gastroenterologist & Clinical Lead for Endoscopy	MTW
Janine Ramilo	<b>JRa</b>	UGI FDS Nurse Specialist	MTW
Aidan Shaw	<b>AS</b>	Consultant Interventional Radiologist	MTW
Dominic Chambers	<b>DC</b>	HPB Pathologist	MTW
Alison Watkins	<b>AWa</b>	FDS Team Lead	MTW
Wendy Brown	<b>WB</b>	Upper GI CNS	MTW
Carlos Tomaz George	<b>CTG</b>	Upper GI Development CNS	MTW
Benjamin Bickford	<b>BB</b>	Clinical Management Fellow	MTW
Mathilda Cominos	<b>MC</b>	Consultant Oncologist	MTW
Chirag Kothari	<b>CK</b>	Consultant Physician, Gastroenterologist & Hepatologist	DVH
Fay Fawke	<b>FF</b>	Deputy Lead Cancer Nurse	DVH
Ben Warner	<b>BW</b>	Consultant Gastroenterologist	DVH
Jane Abrehart	<b>JA</b>	Nurse Endoscopist	DVH
Geoff Dickson	<b>GD</b>	Oncology Dietitian	DVH
Vicki Hatcher	<b>VH</b>	Head of Nursing for Faster Diagnosis	EKHUFT
Hannah Bradshaw	<b>HB</b>	Upper GI CNS	EKHUFT
Emma Lloyd	<b>EL</b>	HPB CNS	EKHUFT
Stella Grey	<b>SGr</b>	General Manager	EKHUFT
Kate Hills	<b>KHi</b>	Consultant Gastroenterologist	EKHUFT
James Gossage (Microsoft Teams)	<b>JG</b>	Consultant Upper GI and General Surgeon	GSTT
Mark Kelly (Microsoft Teams)	<b>MK</b>	Consultant Upper GI and General Surgeon	GSTT
Sarah Wells	<b>SWe</b>	Service Manager	King's College Hospital
Jennifer Rowntree	<b>JRo</b>	Lead HPB CNS	King's College Hospital
Serena Gilbert	<b>SGi</b>	Cancer Performance Lead	KMCA
Ann Courtness	<b>AC</b>	Macmillan Primary Care Nurse Facilitator	KMCA
Jo Bailey	<b>JBa</b>	Early Diagnosis Programme Manager	KMCA

Laura Alton	<b>LA</b>	Senior Programme Manager for KMCA Commissioning	KMCA
Karen Glass	<b>KG</b>	PA/Business Support Manager	KMCA/KMCC
Colin Chamberlain (Notes)	<b>CC</b>	Administration & Support Officer	KMCC
Samantha Williams	<b>SWi</b>	Administration & Support Officer	KMCC
Alison Mannering	<b>AM</b>	Dietitian	MFT
Adnan Arif	<b>AA</b>	Consultant Gastroenterologist	MFT
Rakiatu King	<b>RK</b>	Upper GI CNS	MFT
Sue Jenner	<b>SJ</b>	Upper GI CNS	MFT
Louise Black	<b>LB</b>	Deputy Lead Cancer Nurse	MFT
Mihaela Zdrinca	<b>MZ</b>	Upper GI STT CNS	MFT
Maira Rizvi	<b>MR</b>	Student Dietitian	MFT
Deborah Horley	<b>DH</b>	Upper GI CNS	MFT
Nikki Jagger	<b>NJ</b>	Endoscopy Programme Manager	NHS Kent & Medway ICB
Beata Gubacsi (Microsoft Teams)	<b>BG</b>	EUROPAC Surveillance Navigator	University of Liverpool
<b>Apologies</b>			
Suraj Menon	<b>SMe</b>	Consultant Radiologist/Clinical Lead – Radiology	DVH
Jennifer Mayow	<b>JM</b>		DVH
Marie Payne	<b>MP</b>	Lead Cancer Nurse	DVH
Danielle Mackenzie	<b>DMa</b>	Macmillan Lead Nurse for Personalised Care	EKHUFT
Diane Muldrew	<b>DMu</b>	GI Nurse Specialist & Key Worker	EKHUFT
Philip Mayhead	<b>PMay</b>	Consultant Gastroenterologist	EKHUFT
Pippa Enticknap	<b>PE</b>	Deputy General Manager	EKHUFT
Sue Travis	<b>ST</b>	Head of Operations for WHH	EKHUFT
Sue Drakeley	<b>SD</b>	Senior Research Nurse	EKHUFT
Yunmei Chen	<b>YC</b>	Upper GI STT CNS	EKHUFT
Ruth DeBerry	<b>RDB</b>	Consultant Gastroenterologist	EKHUFT
David Austin	<b>DA</b>	Consultant Gastroenterologist	EKHUFT
Deepika Balasubramanian	<b>DB</b>	Upper GI STT Nurse	EKHUFT
Paul Matravers	<b>PMat</b>	Consultant Radiologist	EKHUFT
Ioannis Bolas	<b>IB</b>	Consultant Gastroenterologist	EKHUFT
Oliviana Rusu	<b>OR</b>	Oesophago-gastric Cancer Nurse Specialist	GSTT
Simon Atkinson	<b>SA</b>	Consultant Pancreaticobiliary and General Surgeon	GSTT

Harvey Dickinson	<b>HD</b>	SELCA Cancer Improvement Manager - OG & HPB	GSTT/SELCA
Bana Haddad	<b>BH</b>	Clinical Lead for Living With and Beyond Cancer/Personalised Care & Support	KMCA
Emma Forster	<b>EF</b>	Head of Service Improvement	KMCA
Sharon Middleton	<b>SMi</b>	Workforce Programme Lead	KMCA
Jonathan Bryant	<b>JBr</b>	Primary Care Cancer Clinical Lead	KMCA
Ritchie Chalmers	<b>RC</b>	Medical Director	KMCA
Annette Wiltshire	<b>AWi</b>	Service Improvement Lead	KMCC
Kirsty Hearn	<b>KHe</b>	Service Manager	MFT
Nicola Cooper	<b>NC</b>	Deputy Divisional Director of Operations for Planned Care	MFT
Steph McKinley	<b>SMc</b>	Matron – Faster Diagnosis	MTW
Laurence Maiden	<b>LM</b>	Consultant Physician and Gastroenterologist	MTW
Carlos Tomaz George	<b>CTG</b>	Upper GI Development CNS	MTW
Hannah Fotheringham	<b>HF</b>	Upper GI CNS	MTW
Jelena Pochin	<b>JP</b>	Head of Performance & Delivery for Diagnostics and Therapies	MTW
Summer Herron	<b>SH</b>	General Manager - Cancer Performance	MTW
Sarah-Jane Taylor-Seres	<b>SJTS</b>	Associate Director of Endoscopy Programme	NHS Kent & Medway ICB
Nicola Perry	<b>NP</b>	Clinical Lead / GP - West Kent	NHS Kent & Medway ICB
Helen Graham	<b>HG</b>	Research Delivery Manager (Cancer)	NIHR

Item		Discussion	Action
1.	TSSG Meeting	<p><b><u>Apologies</u></b></p> <ul style="list-style-type: none"> <li>The apologies are listed above.</li> </ul> <p><b><u>Introductions</u></b></p> <ul style="list-style-type: none"> <li>JL welcomed the members to the meeting and asked them to introduce themselves.</li> </ul> <p><b><u>Action log Review</u></b></p> <ul style="list-style-type: none"> <li>The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting.</li> </ul>	

		<p><b><u>Review previous minutes</u></b></p> <ul style="list-style-type: none"> <li>The final minutes from the previous meeting were briefly reviewed and agreed as a true and accurate record.</li> </ul>	
2.	<b>CRG update</b>	<ul style="list-style-type: none"> <li>The CRG has been created to support the TSSG and will meet on a regular basis to review pathways.</li> <li>The CRG representatives for Upper GI are as follows: <ul style="list-style-type: none"> <li>i) Lead – Jeff Lordan.</li> <li>ii) Nursing – Sue Jenner.</li> <li>iii) Surgery/Physician – Ben Warner.</li> <li>iv) Radiology – Aidan Shaw.</li> <li>v) Pathology – Dominic Chambers.</li> <li>vi) Oncology – Sam Enefer.</li> </ul> </li> </ul>	
3.	<b>UGI Pathway – What next to set priorities</b>	<ul style="list-style-type: none"> <li>JL highlighted the need to work on the development of pathways and to understand where the gaps are so work can be undertaken to address shortfalls. This will be discussed in greater detail at the CRG meetings when they commence.</li> <li>AB highlighted the need for ICB-standardised pathways which can be implemented patch-wide.</li> </ul>	
4.	<b>Dashboard</b>	<ul style="list-style-type: none"> <li>FDS performance has improved from 51.3% to 59.9% in the last six months, but Kent and Medway are still the lowest Alliance for FDS. They are, however, the highest Alliance for the 62d standard. This phenomenon may be due in part to data completeness issues. However, work on pathways needed.</li> <li>FDS performance is below the England average at EKHUFT, MTW and MFT.</li> <li>At King’s College Hospital, 31d performance (time from decision to treat to treatment) has deteriorated over</li> </ul>	<b>Presentation sent to group on 18.10.2024</b>

the last 10 months.

- Low FDS performance at MFT is related to longer waiting times for gastroscopy and cancer being ruled out.
- Waiting time to cancer diagnosis is longest at EKHUFT.
- The proportion of patients on a straight to test pathway has fallen over the last year.
- In terms of variation in surgery rates, this is highest at DGT (data is by Trust first seeing patient).
- Low stage data completeness at EKHUFT and MTW means “% diagnosed at stage 1 or 2” is less accurate.
- In terms of resection margin data for GSTT: the percentage of oesophageal patients with positive longitudinal margins is 9.5% (4.9% being the England average); the percentage of oesophageal patients with positive circumferential margins is 27.9% (21.5% being the England average); and the percentage of gastric patients with positive longitudinal margins is 8.1% (9.8% being the England average).
- With regard to data from the National Pancreatic Cancer Audit for King’s College Hospital:
  - i) The percentage of patients with an FDG-PET/CT scan before surgery was 77% (England average being 45%).
  - ii) The percentage of patients with biliary drainage (stent before surgery) was 55% (England average being 53%).
  - iii) The percentage of patients who received CT/RT before surgery was 5% (England average being 9%).
  - iv) The percentage of patients who received CT/RT after a Whipple procedure was 60% (England average being 56%).
- AB highlighted the importance of ensuring capture of comorbidities within the data.
- BW stated the endoscopy and CT services at DVH are very efficient hence why the waiting time from referral to milestone data is very good.
- Performance is often affected by patients who are inappropriately referred through the USC route as there are limited/no other suitable alternative pathways.

		<ul style="list-style-type: none"> <li>• SGI encouraged the group to let her/David Osborne (Data Analyst – KMCA) know if they have any additional data they would like to see.</li> <li>• A number of patients are still not being seen face-to-face by GPs and the first time they are seen for their upper GI issues is in secondary care.</li> <li>• From a streamlined pathway perspective, BW stated DVH are doing well, with an alternative pathway for non-suspicious diagnoses in place. The service has set up Consultant reviews for all patients and their FDS performance has improved. There is also nurse-led triage for endoscopy.</li> <li>• BW stated TNE has also helped at DVH. This is not, however, currently being done at MTW - something which AB will explore further.</li> <li>• KHi highlighted that there is a need for a rejection process to be in place as a number of USC referrals are for IBD patients. She does, however, understand the difficulty in doing this due to the lack of alternative pathways.</li> <li>• MC stated that Oncologists do not attend the Pancreatic MDM at King’s College Hospital as they do not have enough time in their job plan to do this.</li> <li>• The pathology feed, including transport times, has now been incorporated in to the Dashboard.</li> </ul>	
5.	OG Pathway	<p><b><u>Presentation provided by James Gossage</u></b></p> <ul style="list-style-type: none"> <li>• JG provided the group with an overview of the National Oesophago-Gastric Cancer Audit 2022 Annual Report.</li> <li>• Among patients diagnosed over three years (April 2018 - March 2021) who had curative surgery, there were 3632 oesophagectomies and 1770 gastrectomies.</li> <li>• 30 day mortality for oesophagectomy was 1.5% and for gastrectomy it was 1.4%.</li> <li>• 90 day mortality for oesophagectomy was 3.3% and for gastrectomy it was 2.6%.</li> </ul>	

- The local 90 day risk-adjusted mortality rate was 2.0% and the local 30 day risk-adjusted mortality rate was 0.4%.
- In terms of pathology outcomes after surgery (based on 2018-2021 data):
  - i) The proportion of patients with 15 or more lymph nodes examined was 95.4% locally (national average being 89.3%).
  - ii) The proportion of patients with positive longitudinal margins for oesophagectomy (adjusted) was 5.4% (national average being 4.2%).
  - iii) The proportion of patients with positive circumferential margins for oesophagectomy (adjusted) was 27.9% (national average being 27.9%).
  - iv) The proportion of patients with positive longitudinal margins for gastrectomy (adjusted) was 7.1% (national average being 9.8%).
- All NHS organisations achieved similar rates of positive longitudinal margins (risk-adjusted) after surgery for patients diagnosed between 2018 and 2021.
- For patients diagnosed between 2018 and 2021, the one-year survival rate 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.
- The one-year adjusted data for GSTT was 87.9%.
- There is rapidly expanding robotic activity in oesophagogastric surgery nationally, with clear benefits around the hiatus and in the chest.
- With regard to the Upper GI Robotic Programme at St Thomas' Hospital:
  - i) It started in July 2022. However, there is limited access due to competing specialties.
  - ii) Lists are on alternate Mondays (minus leave/Bank Holidays/strikes and so on).

		<ul style="list-style-type: none"> <li>iii) There are four to five Saturday lists per year.</li> <li>iv) There is one trained Consultant Surgeon (JG) and one training Consultant Surgeon. There are also senior trainees.</li> <li>• JG provided the group with an overview of the oncological outcomes for the robotic service between 2022 and 2024.</li> <li>• With regard to complications, there were no mortalities or re-admissions during this time period.</li> <li>• Currently at St Thomas' Hospital only 15% of OG cancer activity is robotic.</li> <li>• Less than 20% of anti-reflux and hiatal hernia surgery is robotic.</li> <li>• Only one out of six OG surgeons are fully trained in robotic surgery.</li> <li>• All upper GI surgery should be robotic in the next five years. There is a plan to have six people who will be fully trained to use the robot in due course at GSTT.</li> </ul>	
<p>6.</p>	<p><b>Interventional Radiology</b></p>	<p><b><u>Presentation provided by Aidan Shaw</u></b></p> <ul style="list-style-type: none"> <li>• AS provided the group with a presentation on Transoral Stenting of the Distal Duodenum and DJ Flexure.</li> <li>• The learning objectives were to demonstrate that using a combination of novel wires and catheters, the distal duodenum and DJ flexure can be safely and effectively stented via the transoral route negating the need for gastrostomy or OGD. Additionally, with a pictorial review, to demonstrate the technique and equipment required to perform the procedure.</li> <li>• The primary goal of duodenal stenting is to alleviate symptoms and improve quality of life, which may also enable patients to proceed with chemotherapy.</li> <li>• Strictures in the distal duodenum or duodenojejunal (DJ) flexure can require stenting through a gastrostomy or with the assistance of endoscopy. However, there is limited literature on effective transoral stenting techniques</li> </ul>	<p><b>Presentation sent to group on 18.10.2024</b></p>



		<p>for the distal duodenum and their impact on symptom relief.</p> <ul style="list-style-type: none"> <li>• In this pictorial review (please see presentation circulated on 18.10.2024 for further information), there is presentation of the technique and key insights gained from extensive experience in long-distance stenting of the duodenum and DJ flexure via the transoral route, eliminating the need for gastrostomy or OGD.</li> <li>• Pre-procedural planning with CT is essential to define disease extent.</li> <li>• If there is significant gastric distension, pre-procedural drainage with a large bore Ryles tube is recommended for 24-48 hours for prevention of aspiration and to decrease the chances of looping in the stomach.</li> <li>• With regard to the procedure:             <ol style="list-style-type: none"> <li>i) A 6Fr BMC catheter is sited into the stomach. A 90cm 6Fr sheath is then placed into the stomach, through which a 5Fr 135cm radial length Berenstein catheter and a standard angle Terumo wire are used to get to and cross the duodenal stricture.</li> <li>ii) If the lesion is D3 or D3/4, the lesion can usually be stented with a fluoroscopic length uncovered duodenal stent delivery system over a 260cm extra stiff Amplatz wire.</li> <li>iii) If the lesion is D4, or there is a large loop in the stomach, then endoscopy length equipment is usually required. Once the lesion is crossed, a 400cm long X wire is inserted. The X wire can be passed deep into jejunal loops and allows an endoscopy length uncovered duodenal stent to be sited. Despite the long delivery system, the stent tracks well over the wire.</li> </ol> </li> <li>• The equipment includes: 6Fr BMC; 5Fr 135cm Berenstein catheter; 90cm 6Fr sheath; 180cm Angled Terumo (sometimes stiff angled Terumo used); 280cm Extra Stiff Amplatz wire; and 400cm X Wire.</li> <li>• The pictorial review demonstrates that the distal duodenum/DJ flexure can be safely and effectively stented via the transoral route without the need for endoscopic support or gastrostomy placement.</li> <li>• Utilising the correct wires, sheaths, catheters and stents, including endoscopic length equipment, enables a high technical success rate.</li> <li>• AS confirmed it is relatively simple to do same day transfer of inpatients from other local Trusts.</li> </ul>	
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<p>7.</p>	<p><b>HPB Pathway update from King’s</b></p>	<p><b><u>Presentation provided by Jennifer Rowntree</u></b></p> <ul style="list-style-type: none"> <li>• With regard to staffing there are: four HPB CNSs, five NET Consultants, seven HPB Surgical Consultants, three NET CNSs, three HCC CNSs, six HCC Consultants and two EUS Endoscopists.</li> <li>• In October 2023, a new IT system called EPIC was implemented with Liverware no longer being used.</li> <li>• The MDM meetings take place on Microsoft Teams and referrers dial in to present cases (08:00-10:00 on Mondays and 14:00-16:00 on Wednesdays). The MDM is recorded and around 35 cases are discussed (down from the previous 50).</li> <li>• On 03.06.2024, there was a cyber attack which resulted in there being no surgery and limited IR and theatre lists for two full weeks amongst other issues.</li> <li>• In terms of referral documents, JRo highlighted the importance of filling in the specified boxes on the proforma.</li> <li>• Consistent MDM attendance is needed.</li> <li>• There is currently no Pathway Coordinator at King’s College Hospital.</li> <li>• JRo highlighted the importance of needing a clear pathway for neoadjuvant/borderline resectable pancreatic cancers.</li> <li>• CK stated that at DVH there is no time allocated within job plans for MDMs.</li> </ul>	<p><b>Presentation sent to group on 18.10.2024</b></p>

		<ul style="list-style-type: none"> <li>• AB highlighted the need for a standardised model for each MDT with allocated time for the MDM meetings. SGI suggested utilising RC's support regarding job planning and confirmed she would be happy to collate and share examples of what other MDTs do in relation to job planning (this can also be driven through the CRG).</li> <li>• <b>Action: CRG to schedule a meeting with Adeyinka Pratt in order to discuss an effective streamlined MDT for upper GI and to bring this back to the next TSSG meeting.</b></li> <li>• SJ stated that the upper GI team at MFT are not in favour of the EPIC system and have to print outcomes off. They also find it is not very user-friendly. <b>Action: JRo to follow up on this.</b></li> </ul>	<p>CRG</p> <p>JRo</p>
<p>8.</p>	<p>EUROPAC</p>	<p><b><u>Presentation provided by Beata Gubacsi</u></b></p> <ul style="list-style-type: none"> <li>• The European Registry of Hereditary Pancreatic Diseases (EUROPAC) is in the first instance a registry for families with histories of Familial Pancreatic Cancer and Hereditary Pancreatitis. They register these individuals and collect their family history as well as samples for research purposes.</li> <li>• The EUROPAC study also runs surveillance programs for individuals who are deemed high-risk. Using the family history individuals provide they can assess their lifetime risk of developing pancreatic cancer. Surveillance is offered on a yearly basis, and they use a combination of CT, EUS, MRI and blood tests.</li> <li>• EUROPAC are an open-ended study with no confirmed end date supported by The University of Liverpool, Pancreatic Cancer UK, NHS England, NIHR, and Cheshire and Merseyside Cancer Alliance.</li> <li>• BG provided an overview of the patient pathway. Staff in secondary care, primary care and genetic services email referrals to their regional coordinator and the Navigator then contacts and enrolls eligible participants to EUROPAC. Individual and family history and calculated risk is discussed at the EUROPAC MDT and Navigators then coordinate annual surveillance at regional surveillance centres. The Navigators advise Trusts on actionable findings and coordinate MDTs and then the NHS Trusts treat patients as needed.</li> <li>• EUROPAC produce progress reports including numbers enrolled and share actionable findings with the NHS Cancer Programme.</li> </ul>	<p><b>Presentation sent to group on 18.10.2024</b></p>

		<ul style="list-style-type: none"> <li>• Patients do not need to have an identified mutation to be eligible for surveillance.</li> <li>• Individuals are referred to GMSA for genetic screening if needed.</li> <li>• There are three main referral routes in to the Navigators: secondary care, primary care and generic services.</li> <li>• BG provided the group with an overview of the Healthcare Professional Information Sheet and the EUROPAC Referral Sheet.</li> <li>• Patients currently go to London for screening if they are on surveillance.</li> <li>• JL raised a query in relation to how MTW within Kent &amp; Medway can become a EUROPAC screening site. In response to this, BG confirmed she could be contacted directly and will facilitate a meeting with the Clinical Lead and the Cancer Alliance. <b>Action: JL to link in with BG directly to commence discussions from an MTW perspective.</b></li> <li>• JL asked BG if she has any data on pick-up rates. In response to this, BG confirmed she did not have this information readily available but would check and get back to him on this.</li> <li>• In terms of the identification process, BG confirmed the majority of participants are from the self-referral route.</li> <li>• LA raised a query in relation to whether there is a way to identify how many patients are Lynch Syndrome-positive. In response to this, BG confirmed she could source this data and let LA know.</li> </ul>	<p>JL</p>
<p>9.</p>	<p>ERCP update</p>	<p><b><u>Update provided by Ben Warner</u></b></p> <ul style="list-style-type: none"> <li>• The aim of the ERCP Network is to bring ERCPists together to discuss workforce, training opportunities, the setting up of hub and spoke models and the sharing of best practice.</li> <li>• The ERCP Network met on 04.06.2024 and shared data. They discussed what the Network should look like and what the minimum and maximum offer should be. The minimum offer should be to train people in the region to do ERCP and meet bi-annually to share best practice. The maximum offer should be for staff to work across</li> </ul>	

		<p>sites. Funding will also be required.</p> <ul style="list-style-type: none"> <li>• BW highlighted the need for leadership with regard to the ERCP workstream.</li> <li>• AB has been informed that 25% of ERCPists plan to retire within the next three years. There is therefore a critical need for a push to train more staff to be ERCPists. <b>Action: This issue to be highlighted to the NHS Kent &amp; Medway ICB by JL/RC.</b></li> <li>• There is a need to think about how the network can move ERCPists around the patch to ensure there is adequate provision in all areas of Kent &amp; Medway.</li> <li>• There are currently no plans for the ERCP Network to meet again. They were due to meet in September 2024 but this did not materialise.</li> <li>• JL highlighted the need for there to be discussion with senior managers who communicate out to clinical staff on a weekly basis about reminding them what to, and what not to, biopsy.</li> <li>• Cancer Alliance support was previously provided but this has since reduced/ceased due to its transition to the ICB.</li> <li>• AB stated that a lot of individuals who train in London on fellowships remain in the region – however, if there were fellowships in Kent &amp; Medway, people may choose to stay in this county.</li> </ul>	<p>JL/RC</p>
<p>10.</p>	<p>EUS update</p>	<p><b><u>MTW EUS update – presentation provided by Jeff Lordan</u></b></p> <ul style="list-style-type: none"> <li>• MTW are following the same model as King’s College Hospital’s EUS service.</li> <li>• EUS is a vital step in the pancreatico-biliary cancer pathway and assists with accurate local staging. FNB/FNA is utilised as an aid for diagnosis.</li> <li>• Planning for the EUS service began in April 2021 and it launched in October 2023.</li> </ul>	<p><b>Presentation sent to group on 18.10.2024</b></p>

- Clinicians trained include JL and Dr D Hanumantharaya. Endoscopy Nurses have also been provided training.
- As stated above, the service started at Maidstone in October 2023. The Trust purchased the latest platform and had two new linear EUS scopes.
- They now have two platforms (one at Maidstone Hospital and one at Tunbridge Wells Hospital) and four EUS scopes.
- A regular EUS list moved to Tunbridge Wells Hospital in April 2024.
- MTW are consistently achieving four EUS' per list. There are two clinicians per EUS list and there is a plan to separate in to two lists per week from December 2024.
- The pathway is as follows:
  - i) Wednesday - patient is discussed in the MTW Upper GI/HPB MDT with HPB surgery representation from King's College Hospital.
  - ii) Thursday - patient is seen in the MTW Upper GI/HPB cancer clinic and has a nurse-led OPA.
  - iii) Monday am – patient is discussed in HPB MDT at King's College Hospital to ratify decision for EUS.
  - iv) Monday pm - EUS performed at MTW.
- 77 EUS' have been performed so far. The number of FNB/FNA is 62 (80.5%) and the diagnostic FNB/FNA rate is 88%.
- MTW have had no complications. Two patients, however, were admitted for observation.
- JL outlined the case mix.
- The team includes: Endoscopy Nurses (EUS and pre-assessment), histopathology, biochemistry, interventional radiology, King's College Hospital support and the whole MDT.
- In terms of future developments:

		<ul style="list-style-type: none"> <li>i) An EUS request form is being developed on Sunrise and for external referrals.</li> <li>ii) There is an aim to have two EUS lists per week from December 2024.</li> <li>iii) Two new Consultants have been recruited – a Radiologist and Gastroenterologist.</li> <li>iv) There are plans to do Hot Axios stents, cyst-gastrostomies and to have a complex pancreatitis service in place.</li> </ul> <ul style="list-style-type: none"> <li>• The EUS service at MTW is a safe, high-quality service. There is imminent expansion in capacity and the Trust are ready to receive referrals from Trusts across Kent &amp; Medway. SLAs do not need to be put in place due to the way the service is funded. JL stated the other Trusts are to email him and their MDT Coordinator in the first instance.</li> <li>• JL confirmed that MTW have very efficient Endoscopy Nurses in place and pre-assessments are based on the SOP from King’s College Hospital.</li> <li>• KHi stated that when the new EUS services are due to go live, it should be communicated across Kent. This is part of AB’s remit and the KMCA newsletter could also be utilised.</li> </ul> <p><b><u>DVH EUS service – update provided by Ben Warner</u></b></p> <ul style="list-style-type: none"> <li>• DVH commenced with their EUS service one year ago.</li> <li>• They have performed 174 EUS’ and done 31 biopsies since April. They have a hit rate of 91%.</li> <li>• BW highlighted an issue the Trust have had in relation to the washing of EUS scopes. JL stated this is not, however, a problem for MTW.</li> </ul>	
<p><b>11.</b></p>	<p><b>Best Practice Timed Pathways</b></p>	<p><b><u>Presentation provided by Serena Gilbert</u></b></p> <ul style="list-style-type: none"> <li>• Best practice timed pathways support the ongoing improvement effort to shorten diagnosis pathways, reduce variation, improve experience of care, and meet the Faster Diagnosis Standard (FDS).</li> </ul>	<p><b>Presentation sent to group on 18.10.2024</b></p>

		<ul style="list-style-type: none"> <li>• SGI provided an overview of the:             <ul style="list-style-type: none"> <li>i) 28d best practice timed pathway.</li> <li>ii) Jaundice, pancreatic, extrahepatic cholangio, gall bladder timed pathway.</li> <li>iii) Liver and intrahepatic cholangio timed pathway.</li> <li>iv) The <i>'Implementing a timed HPB cancer diagnostic pathway. Pancreatic, liver, bile duct and gall bladder'</i> audit tool document. This tool can be used to undertake a baseline audit of services being delivered and whether sufficient capacity is in place to routinely deliver, identify areas for improvement, select measures for improvement, and contact re-audits as part of continuous improvement. Patient experience measures should also be considered as part of auditing and improvement. <b>Action: All Trusts to complete this audit by 08.11.2024.</b></li> </ul> </li> <li>• Whipple's patients are generally all being stented at King's College Hospital.</li> <li>• There will be further discussion around Best Practice Timed Pathways at the CRG meetings.</li> </ul>	<p><b>All Trusts</b></p>
<p><b>12.</b></p>	<p><b>Digital pathway across the KMPN network</b></p>	<p><b><u>Presentation provided by Dominic Chambers</u></b></p> <ul style="list-style-type: none"> <li>• The Laboratory Information Management System (LIMS) will have all relevant pathology data for Kent &amp; Medway in one place and there will be more robust cover for cellular pathology.</li> <li>• There will be much easier information transferred between sites. With increased collaborative working, there will be more back-up for specialties.</li> <li>• The Digital Pathology programme will help with efficiencies in workflow, work allocation, the tracking of cases and the pulling of cases back for review.</li> <li>• From a collaboration perspective, the KMPN digital pathway will allow second opinions almost instantly from anywhere in the world.</li> <li>• In theory, the programme should help with the faster diagnosis of cancers.</li> </ul>	<p><b>Presentation sent to group on 18.10.2024</b></p>



- Benefits of the digital pathology solution include:
  - i) Reduced case transfer times between the laboratory and the diagnostic pathologist.
  - ii) Improved workload allocation.
  - iii) Rapid case tracking, archival and retrieval.
  - iv) Clearer diagnostic audit trails.
  - v) Increased diagnostic efficiency.
  - vi) Faster diagnosis of urgent cases (in line with 28d faster diagnosis for cancer).
  - vii) Faster access to external second opinions.
  - viii) Faster access to molecular testing.
  - ix) A reduced risk of patient/slide misidentification errors.
  - x) A reduced risk of tissue/slide loss or damage.
  
- The archive of images will be a valuable resource for research purposes, encouraging collaboration between diagnostic departments and higher education establishments, as well as for use in the development of computerised algorithms for Artificial Intelligence.
  
- System training will be provided by the supplier with ongoing support from the Kent & Medway Pathology Network team.
  
- Each pathologist needs to verify their digital reporting against their analogue reporting to ensure clinical care level continuity.
  
- Pathologists will validate in phases so no more than five pathologists at one time will be validating.
  
- The digital pathology project has accessible funding to utilise other resources during validation phases.
  
- Removing patients from cancer pathways alleviates the pressure and allows pathologists to concentrate on cases of significant clinical significance.
  
- Support from clinical colleagues across the TSSG to understand and accept limited duration verification impact and to remove patients from cancer pathways when endoscopic findings are normal/benign is needed.

		<ul style="list-style-type: none"> <li>There is a plan to implement AI within 12 months of going live with the digital pathology workstream.</li> </ul>	
13.	GIRFT	<ul style="list-style-type: none"> <li>This item was not discussed.</li> </ul>	
14.	CNS Update	<p><b><u>DVH</u></b></p> <ul style="list-style-type: none"> <li>One CNS is currently on maternity leave.</li> <li>The team are struggling with workload.</li> <li>DVH only have one full-time and one part-time STT CNS. FF stated the intention is to develop a business case for an additional CNS. SGI stated FF could contact her outside of this meeting to discuss further.</li> </ul> <p><b><u>EKHUFT</u></b></p> <ul style="list-style-type: none"> <li>Thanks to KMCA funding, EH is now in post as HPB CNS and there is therefore increased face-to-face capacity.</li> <li>The team are reviewing their breach reports.</li> <li>The FDS Manager has developed an internal FDS Dashboard.</li> <li>Endoscopy capacity has improved as a result of a lot of hard work.</li> <li>Face-to-face nurse-led clinics are in place.</li> </ul> <p><b><u>MFT</u></b></p> <ul style="list-style-type: none"> <li>The nurse-led survivorship service at MFT is evolving well, however the Lead Consultant has left the role. If this person is not replaced, they will have to cut the service. <b>Action: SJ to email JL to highlight this issue for him to then take forward, perhaps through the CRG.</b></li> </ul>	SJ

		<ul style="list-style-type: none"> <li>The team have upgraded a Band 6 CNS to Band 7.</li> <li>King's College Hospital link in to the MFT MDM on a fortnightly basis.</li> </ul> <p><b><u>MTW</u></b></p> <ul style="list-style-type: none"> <li>The team have successfully recruited to a Band 7 post. They are awaiting a start date for this person.</li> <li>The NET service is in the process of being developed.</li> <li>KMCA have also funded a standalone Band 7 CNS post.</li> </ul>	
<b>15.</b>	<b>AOB</b>	<ul style="list-style-type: none"> <li>With regard to the liver surveillance workstream, LA stated teams are in the process of recruiting more Navigators. Kent &amp; Medway are also doing well from a national perspective.</li> <li>The liver surveillance workstream's next objective is to work on primary care outreach.</li> </ul>	
	<b>Next Meeting</b>	<ul style="list-style-type: none"> <li>To be confirmed.</li> </ul>	