Upper GI/HPB Tumour Site Specific Group meeting
Thursday 6th November 2025
Microsoft Teams
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/STT Nurse	MTW
Sarah Eastwood	**SE**	Macmillan Personalised Care Project Manager	MTW
Vivienne Eze	**VE**	Consultant Radiologist	MTW
David Bridger	**DB**	Upper GI CNS	MTW
Roy Wheeler	**RW**	Consultant Interventional Radiologist	MTW
Bushra Ansari	**BA**	STT (Upper GI/Lower GI) CNS	MTW
Ruby Einosas	**RE**	FDS NSS Nurse Specialist	MTW
Justin Waters	**JW**	Consultant Medical Oncologist	MTW
Lauren Menezes	**LM**	Endoscopy Nurse	MTW
Samantha Forner	**SF**	Consultant Clinical Oncologist - Neuro-Oncology and Upper GI	MTW
Wendy Brown	**WB**	Upper GI CNS	MTW
Mathilda Cominos	**MC**	Consultant Clinical Oncologist	MTW
Ryan Johnson	**RJ**	Pathway Navigator	MTW
Dodi Hanumantharaya	**DHa**	Consultant Gastroenterologist	MTW
Monika Verma	**MV**	Consultant Histopathologist	MTW
Adrian Barnardo	**ABar**	Consultant Gastroenterologist	MTW
Tessa Howting	**TH**	Upper GI CSW	MTW
Chirag Kothari	**CK**	Consultant Physician & Gastroenterologist / Clinical Lead - Gastroenterology, Hepatology and Endoscopy	DGT
Ben Warner	**BW**	Consultant Gastroenterologist	DGT
Jennifer Keys	**JK**	MDT Coordinator	DGT
Ella Milan	**EM**	Early Diagnosis Coordinator	DGT
Geoff Dickson	**GD**	Senior Oncology Dietitian	DGT
Raveena Ravikumar	**RR**	Consultant Radiologist	DGT

Sithu Khin-Maung	**SKM**	Consultant Gastroenterologist	DGT
Julie Compton	**JC**	Upper GI STT Nurse	DGT
Sarah Barney	**SBa**	Macmillan UGI/HPB CNS	DGT
Marie Payne	**MP**	Macmillan Lead Cancer Nurse	DGT
Charmaine Walker	**CW**	Service Manager for Gastroenterology and Hepatology	DGT
David Austin	**DA**	Consultant Gastroenterologist	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager - CCHH Care Group	EKHUFT
Pradeep Basnyat	**PB**	Consultant General & Colorectal Surgeon	EKHUFT
Emma Lloyd	**EL1**	HPB CNS	EKHUFT
Katherine Hills	**KH**	Consultant Gastroenterologist	EKHUFT
Stella Grey	**SGr**	General Manager - General Surgery, Colorectal, Gastroenterology and Endoscopy	EKHUFT
Hannah Bradshaw	**HB**	Macmillan Upper GI CNS	EKHUFT
Jacqui Hodge	**JH**	Operations Manager – Hepatology Service	EKHUFT
Natalie Sturgess	**NS**	HCC Surveillance Pathway Navigator	EKHUFT
James Spinner	**JS**	HCC Surveillance Pathway Navigator	EKHUFT
Mohd Wani	**MW**	Consultant Gastroenterologist	EKHUFT
Anna Lamb	**AL**	Cancer Performance Manager	EKHUFT
Georgia Mundle	**GM**	OG & ERP CNS	GSTT
Joanna Taylor	**JT**	OG CNS	GSTT
Lydia Capon	**LC**	Lead Oncology Dietitian	KCHFT
Alara Bailey	**ABai**	Service Manager for Liver	King’s College Hospital
Sarah Selemani	**SS**	HCC CNS	King’s College Hospital
Mohamed Elmasry	**ME**	Consultant Surgeon - Hepatobiliary & Pancreatic Surgery	King’s College Hospital
Tricia Allum	**TA**	Service Manager - HPB, HCC & NET inpatients	King’s College Hospital
Suresh Menon	**SM1**	Consultant Liver Transplant and Hepatobilary Surgeon	King’s College Hospital
Jo Bailey	**JBa**	Early Diagnosis Programme Manager	KMCA
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Jo Jackson	**JJ**	Early Diagnosis Project Manager	KMCA
Jonathan Bryant	**JBr**	Primary Care Cancer Clinical Lead	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Emma Lloyd	**EL2**	Cancer Pathways Improvement Manager	KMCA

Bana Haddad	**BH**	Clinical Lead	KMCA
David Osborne	**DO**	Data Analyst	KMCA
Karen Glass	**KG**	PA/Business Support Manager	KMCA/KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC
Sue Jenner	**SJ**	Macmillan Upper GI CNS	MFT
Deborah Horley	**DHor**	Upper GI Cancer Nurse	MFT
Alison Mannering	**AM**	Oncology Specialist & Team Lead Dietitian	MFT
Irfan Khan	**IK**	Consultant Gastroenterologist	MFT
Hayley Martin	**HM**	PCS Facilitator	MFT
Gabor Sipos	**GS**	Consultant Gastroenterologist	MFT
Suzanne Bodkin	**SBo**	Cancer Service Manager	MFT
Mihaela Zdrinca	**MZ**	Upper GI STT CNS	MFT
Rakiatu King	**RK**	STT CNS	MFT
Adnan Adnan Arif	**AAA**	Specialty Doctor	MFT
Syed Naqvi	**SN**	Consultant Gastroenterologist	MFT
Norman Zhang	**NZ**	Consultant Gastroenterologist	MFT
Sarah-Jane Taylor-Seres	**SJTS**	Associate Director of Endoscopy Programme	NHS Kent & Medway ICB
David Howell	**DHow**	Deputy Director of Information	Surrey Heartlands Integrated Care System
Zaed Hamady	**ZH**	Consultant HPB Surgeon	University Hospital Southampton NHS Foundation Trust
Apologies			
Jane Abrehart	**JA**	Nurse Endoscopist	DGT
Philip Mairs	**PMai**	Consultant Gastroenterologist	DGT
Jennifer Queminet	**JQ**	Upper GI STT Nurse	DGT
Suraj Menon	**SM2**	Consultant Radiologist	DGT
Ruth DeBerry	**RDB**	Consultant Gastroenterologist	EKHUFT
Sue Travis	**ST**	Head of Operations - General Surgery/Colorectal/Gastroenterology/Stoma Services	EKHUFT
Phillip Mayhead	**PMay**	Consultant Gastroenterologist	EKHUFT

James Gossage	**JG**	Consultant Oesophagogastric and General Surgeon	GSTT
Simon Atkinson	**SA**	Consultant Pancreaticobiliary and General Surgeon	GSTT
Jennifer Rowntree	**JR**	Lead Nurse for HPB Oncology	King's College Hospital
Ritchie Chalmers	**RC**	Medical Director	KMCA
Hannah Fotheringham	**HF**	Upper GI CNS	MTW
Bronwyn Tetley	**BT**	Lead Pathway Nurse Coordinator	MTW
Tim Sevitt	**TS**	Consultant Clinical Oncologist	MTW
Nikki Jagger	**NJ**	Endoscopy Programme Manager	NHS Kent & Medway ICB

Item		**Discussion**	**Action**
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • JL welcomed the members to the meeting and asked them to introduce themselves. **Action log Review** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **Review previous minutes** • The previous minutes were not reviewed but had been previously agreed as a true and accurate record.	
2	**CRG update**	**CRG update – update provided by Jeff Lordan** • A new streamlined, integrated Upper GI cancer pathway is being developed in line with NHSE's FDS recommendations. • NHSE divides upper GI pathways into three areas: OG, intrahepatic cancers, and extrahepatic cancers. • The Kent & Medway proposal is to combine these three areas in to a single Upper GI all-encompassing pathway. • Triaging will take place up front to decide whether patients need: a CT only, an OGD only, or both a CT and OGD. • Oversight from a consultant is needed prior to patients being removed from the pathway.	

	Pathway updates	• Results will feed into the PTL cancer box for action (off-pathway, MDT, etc.). • JW highlighted that timelines and action steps (clinic, diagnostics, MDT) require clearer integration. • KH highlighted safety concerns about patients being moved to benign pathways with long waits. There is a clear need for rapid review of histology and re-entry mechanism for cancers. • JL outlined that patients will not be taken off the pathway until they have been fully reviewed and acknowledged the need for a robust benign pathway in order to relieve pressure on the cancer pathway. • **<u>Action</u>: JL to circulate the draft Upper GI (OG and HPB) pathway to the group for feedback.** **<u>Benign pathway reform – update provided by Adrian Barnardo</u>** • Benign gastroenterology referrals are overwhelming cancer pathways due to long outpatient waits (around 48 weeks at MTW). • ABar cited the Northumbria model as best practice because: - There is a single point of access for all gastroenterology referrals. - Consultant vetting of every referral occurs. - Rapid decision-making is actioned e.g. advice, diagnosis, test result or clinic booking. - Urgent cases are seen in 48 hours and routine cases are seen within 14 days. - Only one in five patients are now seen face-to-face after the pathway redesign. • Kent & Medway have now secured: - KPMG support (for five weeks) starting with hepatology referrals. This will come in to effect on 10.11.2025. - £20k and mentorship from Northumbria (one of 10 UK sites selected). • The aims include: - Decompressing cancer pathways. - Reducing low-value histopathology and endoscopy. - Enabling qFIT threshold reduction (from 120 to 80). - Improving outcomes. - Building IT dashboards in order to track pathway compliance and delays. • ABar stressed the importance of GP buy-in and network-wide adoption, otherwise the workload will flood individual Trusts.	**JL**

	Anaemia Pathway	• Integration challenges have been identified vs. the Northumbria model (Kent & Medway has several Trusts, an older GP workforce, and separate IT systems). • From a primary care perspective: - JBr confirmed that he is fully supportive of the model. - Northumbria's model benefits from vertical integration (a significant number of GPs are salaried within the Trust). - Kent & Medway's GP landscape is fragmented and experiencing workforce strain — implementation will necessitate a cultural change, not just process redesign. **<u>Anaemia Pathway – update provided by Pradeep Basnyat</u>** • PB presented a draft IDA pathway, linked to the benign pathway transformation piece. • The pathway is structured as such: - Left-side (primary care): tests, ruling out renal/gynae/ coeliac causes, qFIT, deciding lower GI vs. upper GI route. - Right side (secondary care): straight-to-test (OGD, CT, VC, colonoscopy) depending on symptoms and qFIT/age. • Key aims include: - Avoiding repeat investigations within 12 months. - Aligning upper GI and lower GI pathways and the NSS pathway. • ABar highlighted that a Kent & Medway-wide IDA pathway had already been agreed across specialties (gastroenterology, gynaecology, urology, primary care) and built into EROS, though IT issues have halted deployment. • SJTS agreed to organise a demonstration of EROS for clinical colleagues. • It was felt there should be one unified IDA pathway for the entire network, spanning both primary and secondary care. • BSG and NICE guidance will be utilised as core references.	
3	**Dashboard**	• JL presented the latest performance dashboard figures, outlining improvements in 62d and FDS, ongoing challenges in pathology turnaround times, and disparities in early-stage cancer diagnosis and outcomes across the region. • JL reported that the region is no longer at the bottom of the table in England for 62d and FDS performance, with all Trusts showing overall improvement, though some areas still need further progress.	

		• The dashboard revealed that while 10-day pathology turnaround times have improved, seven-day rates remain low, particularly at DVH, and there are ongoing gaps in data collection for certain metrics. • Analysis showed that the proportion of early-stage OG cancer diagnoses remains below the England average, with urgent and emergency presentations associated with poorer long-term survival compared to incidental findings. • The data indicated higher incidence and mortality rates for upper GI cancers in more deprived areas, with Thanet in particular displaying a statistically significant difference compared to other regions. • ABar noted that DO's dashboard is being shared across the southeast of England and may be adopted nationally, with regular agenda reviews planned to identify and address bottlenecks.	
4	**Oncology update**	**<u>Update provided by Justin Waters & Samantha Forner</u>** • JW and SF provided the group with updates on ongoing and upcoming clinical trials for upper GI and HPB cancers, including neoadjuvant immunotherapy, follow-up pathway studies, and diagnostic and radiotherapy trials, with an emphasis on the importance of timely molecular testing. • JW outlined a neoadjuvant immunotherapy trial for MMR-deficient OG cancers at EKHUFT, emphasising the importance of reflex MMR testing at diagnosis in order to facilitate the recruitment of patients. • JW outlined participation in the SARONG trial for post-curative treatment follow-up and the imminent opening of the ABC10 trial for first-line palliative chemotherapy in HPB cancers, as well as interest in an upcoming adjuvant trial. • SF updated the group on the VISION diagnostic trial for SCCs and her involvement in the SCOPE-3 radiotherapy trial, which is currently in the design phase for 2026. • Following discussion, it was clarified that MMR testing is currently requested at MDT but there is a move towards reflex testing in order to improve trial eligibility and recruitment.	
5	**Histopathology – sampling**	**<u>Update provided by Adrian Barnardo</u>** • ABar provided the group with a comprehensive review of upper GI histopathology sampling, audit findings, and biopsy protocols, leading to the group agreeing to adopt a standardised poster for biopsy guidance across Trusts. • ABar summarised national audit data which showed high rates of missed lesions and inadequate endoscopy quality, with substantial variation between Trusts and a need for	

		improved training and equipment. • ABar advocated for the network-wide adoption of standard biopsy protocols, referencing a North London poster which details indications and numbers of biopsies, and summarised the impact on histopathology costs and workload. • The group agreed to distribute the upper GI section of the poster immediately, with plans to audit pre-implementation and post-implementation biopsy numbers using an NHSE-developed bot for rapid analysis. • CK and ABar articulated the importance of equitable access to high-quality endoscopy equipment and the need to work on reducing overbooked lists in order to improve diagnostic accuracy and reduce missed cancers. • ABar advocated for increased use of non-invasive tests (e.g. stool tests for H. pylori) to reduce the number of unnecessary biopsies, save costs, and prioritise histopathology resources for urgent cases. • **<u>Action</u>: ABar to distribute the upper GI section of the North London biopsy protocol poster to all Trusts for use in endoscopy rooms to standardise biopsy practice.** • **<u>Action</u>: ABar to audit the number of biopsies taken pre- and post-implementation of the biopsy protocol poster and report the impact to the group at the next meeting.**	**ABar** **ABar**
6	**EUS update**	**<u>Update provided by Jeff Lordan</u>** • JL provided the group with an update on the EUS service at MTW, outlining service expansion, case mix, operational difficulties, and improvements in both communication and coordination with other Trusts. • JL highlighted that the EUS service has completed over 400 cases since it was launched, with activity doubling every six months, and described the transition to new equipment at Tunbridge Wells Hospital. • The team addressed incidents such as mislabeled biopsy pots and FNA sample handling errors by implementing new protocols for labelling and communication with biochemistry teams in order to prevent recurrence. • KH raised a query in relation to access to the complex stone service, with JL confirming a single referral route via a generic email address and recent improvements in pathway coordination and booking. • JL outlined plans for hot Axios interventions and dedicated support from CNSs, noting that business cases have been prepared but are on hold due to financial constraints until the next	

		financial year.	
7	**King's update**	**<u>Update provided by Mohamed Elmasry</u>** • ME updated the members on staffing changes, MDT streamlining, and communication issues between King's College Hospital and regional Trusts, particularly with regard to IT and access issues. • ME outlined changes in radiology and surgical staffing at King's College Hospital, the impact on MDT discussions, and efforts to streamline benign and pre-malignant case management through clinician-to-clinician conversations. • SS informed the group that HCC and HPB pathway review away days have been arranged in order to strengthen network relationships and improve pathway efficiency, inviting broad participation. • SJ and DB outlined the difficulties they had faced in accessing the London Care Record following King's College Hospital's transition to the EPIC system, with ongoing efforts to secure access for regional CNS teams. • PE and HB outlined the challenges EKHUFT had faced with regard to MDT participation due to incompatible video conferencing platforms. However, there are plans underway to transition to Microsoft Teams in order to improve cross-site collaboration. • **<u>Action</u>: All Trusts to contact their respective digital leads to obtain access to the London Care Record for CNS teams to improve patient information sharing.**	**All Trusts**
8	**An overview of Survivorship**	**<u>Update provided by Joanna Taylor</u>** • JT presented the survivorship clinic model at GSTT, outlining clinic structure, multidisciplinary collaboration, and challenges with both capacity and dietetic support. • JT outlined the survivorship clinic's eligibility criteria, joint CNS and dietitian-led format, appointment scheduling, and transition to CNS-only follow-up, with discharge at five years post-treatment. • A multidisciplinary team, including gastroenterologists, physiologists, surgeons, CNSs and dietitians, meets regularly in order to discuss complex post-surgical cases and optimise patient management. • AM raised a query in relation to nutritional blood monitoring, with JT outlining the clinic's routine tests (B12, iron studies, ferritin, folate, vitamin D, zinc) and noting the lack of formal national guidelines. • JT and WB discussed the loss of dietetic support in some Trusts due to staffing and funding	

		challenges, outlining the impact on service quality and the need for resource review. • JT and AM described differences in survivorship clinic provision across the network, with some areas lacking dedicated CNS-dietitian clinics and others running regular survivorship clinics with varying levels of support. • Members discussed the importance of survivorship clinics for post-treatment cancer patients, outlining inconsistencies in follow-up practices across the patch and the requirement for standardised approaches, with offers of support and benchmarking between teams. • JT explained that managing patients at home through survivorship clinics results in cost savings by reducing the number of hospital admissions, freeing up consultant clinic slots, and reducing unnecessary imaging, while also improving recovery and long-term survival. • WB and JL highlighted concerns around inconsistent access to survivorship clinics for Kent patients, with some areas lacking clear guidelines or structured clinics, and suggested the need for a meeting in order to align practices and make sure all patients receive equitable support. • LC and EL2 summarised their local practices, outlining that EKHUFT does not currently have a dedicated survivorship clinic and relies on oncologists for follow-up, while LC's community-based service endeavours to follow up surgical patients for a minimum of one year, but cannot match the duration offered by JT's team. • JT outlined opportunities for other teams to shadow her clinic or arrange meetings with her senior dietitian for advice. Following on from this, JL encouraged all teams to benchmark their practices, work on identifying a gold standard, and report back for potential implementation of consistent, multidisciplinary survivorship care.	
9	**ERCP update**	**<u>Update provided by Ben Warner</u>** • BW provided the group with an update on the Kent ERCP and EUS network, detailing service growth, training initiatives, audit processes, and future plans for standardisation and improved access, with JL and BW discussing the need for local training programmes and cross-Trust collaboration. • The Kent ERCP and EUS network is the largest in the UK, with increasing ERCP and EUS lists, a shared trainee between Maidstone Hospital, Tunbridge Wells Hospital, and Darent Valley Hospital, and ongoing efforts to expand training opportunities, including a funded ERCP-US lead post and plans for a train the trainer course. • The network has convened five meetings, shared audits between Trusts, and benchmarked	

		sites against BSG quality improvement standards, focusing on written Standard Operating Procedures, booking policies, vetting, MDT decision-making, and post-procedure care, with plans to have each Trust present their compliance with these standards. • Efforts are in train to align processes for vetting, pre-assessment, consent, and data management across Trusts, with the aim of providing five-day access to ERCP lists and implementing a patch-wide outpatient ERCP pathway in order to reduce hospital stays. • JL and BW discussed the need for a local EUS train the trainer course due to the lack of options nationally, and agreed to explore setting up such a programme, while also confirming the sharing of a fellow across hospitals in order to support service delivery and training.	
10	**Radiology update**	**<u>Update provided by Roy Wheeler</u>** • RW, RR, GS, HB, and JL discussed increasing demand on radiology services, challenges with reporting backlogs, resource constraints, and the development of innovative pathways such as the day case gastrostomy service, as well as the potential for a buddying system to support under-resourced sites. • RW highlighted a 25% increase in MDT case numbers without a corresponding rise in allocated time or radiologist numbers, leading to increased pressure on reporting and MDT preparation, with third-party providers supplementing in-house reporting but causing additional workload for second reads. • RR reported a significant backlog of over 3,300 scans awaiting reporting at Darent Valley Hospital, while GS noted increased complexity and duration of MDT meetings at MFT, with more elderly patients and post-treatment cases contributing to workload. • RW described the successful implementation of a day case gastrostomy pathway at MTW, the first of its kind nationally, with dedicated recovery beds and interventional nurses, and noted interest from other centres in replicating the model. • JL and RW discussed the concept of a buddying system with King's College Hospital to provide diagnostic and interventional support to less well-resourced sites, acknowledging current capacity limitations and ongoing efforts to develop functional networks for procedures such as stenting and PTCs. • HB outlined the challenges the PTC service at EKHUFT has on an ongoing basis, relying on a single Interventional Radiologist and support from MTW, with continued collaboration to improve local capacity.	
11	**Pathology**	• CK and JL outlined issues with pathology support during MDTs, including inconsistent	

	update	attendance and engagement from histopathologists, the impact this has on case discussions, and the need for support from the TSSG to ensure full participation and timely reporting. • CK described variability in histopathologist attendance at MDT meetings, with some hospital sites receiving only partial participation and reports being read out rather than actively discussed, thereby limiting the depth of case review and decision-making. • JL highlighted the importance of full pathology participation in MDT meetings to ensure comprehensive treatment planning, noting that at MTW the pathologist is present for the entirety of the meeting and engages in detailed discussions beyond the written report. • CK requested support from the Upper GI TSSG in order to advocate for dedicated pathology slots at MDT meetings, ensuring that all cases receive appropriate attention and that histopathologists are integrated fully into the multidisciplinary process. • **<u>Action</u>: JL to support CK in raising the issue of consistent and full histopathologist participation throughout the entire upper GI MDT.**	**JL/CK**
12	**Pancreatic Cancer Case finding Algorithm Update**	**<u>Update provided by David Howell</u>** • DHow provided the group with an overview of an AI-based pancreatic cancer screening tool developed using Kent's integrated data, with the group agreeing to support a pilot in Kent & Medway and potentially expand to other regions, aiming for earlier detection and improved outcomes. • DHow outlined the use of machine learning on a large retrospective Kent dataset in order to identify high-risk individuals for pancreatic cancer, achieving a 92% accuracy rate in predicting cases up to six months preceding diagnosis, with models tailored to different age groups. • JL discussed the optimal age range for screening, with NHSE suggesting 60+, but local clinicians advocating for the inclusion of younger patients due to earlier onset cases, and agreed that criteria would be refined as pilot data emerges. • The group expressed unanimous support for launching the pilot in Kent & Medway, with ZH stating that he would be happy to facilitate expansion to other regions and emphasising the importance of integrating multiple strategies for early detection.	
13	**SAFE-D Study**	**<u>Update provided by Zaid Hamady</u>** • ZH presented the SAFE-D trial, a national, commercially-funded study using an epigenomic blood test in order to detect pancreatic cancer in patients with new-onset diabetes, with the members supporting recruitment in Kent & Medway. • ZH outlined the single-blinded, randomised controlled trial which targets patients diagnosed	

		with diabetes within the preceding six months, using multiple recruitment pathways and aiming to enrol 15,000 participants nationally, with a current pilot phase underway. • The test analyses plasma samples for demethylation markers using whole genome sequencing, with reported specificity of 96-97% and sensitivity over 80%, and aims to improve early detection and resectability rates for pancreatic cancer. • Positive test results trigger MRI scans and secondary care involvement, with local MDTs reviewing cases. ZH requested support from local clinicians in order to facilitate imaging and follow-up, and outlined the potential for future biobanking and collaborative research. • The members unanimously supported participation in this trial, recognising the need for multiple early detection strategies and agreeing to provide ongoing support and collaboration for recruitment and implementation in Kent & Medway.	
14	**Liver Surveillance Update**	• Due to time constraints, this item was unable to be presented. However, Laura Alton and EL2 confirmed that the slides they had intended to present could be circulated to the group.	
15	**CNS Updates**	**MTW** • MTW successfully recruited a CSW, who is providing valuable team support. • KMCA funding for HB's neuroendocrine (NET) role ends in January 2026. • Current challenges include: - A high number of post-MDM patients needing review (mostly seen by JL or WB). - Limited NET cases, so work is needed on pathway development in order to broaden post-MDM clinician involvement. • The CNSs are now working as one integrated team, not sub-specialised (i.e. WB is no longer solely OG and DB is no longer solely HPB). • The team use a shared diary and shared email address — colleagues should contact them via that channel. **DGT** • The team are covering maternity leave and supporting the STT team. • From a leadership perspective, BW stepped down as Upper GI Lead and has been replaced by SKM.	

		MFT • Following JT's presentation, MFT will focus on streamlining the survivorship clinic and gaining access to the London Care Records. **EKHUFT** • No update provided.	
16	**AOB**	• JL thanked the members for joining today's meeting and highlighted that the intention is for the next meeting to be face-to-face.	
	Next Meeting	• Thursday 14th May 2026 (09:00-12:30) – venue to be confirmed.	