Meeting of the South West Academic Gynae-oncology Group for Education and Research

(SWAGGER)

Friday 13th December 2024, 13:00-15:00 via MS Teams

REPORT **ACTIONS**

Chair: Claire Newton

1. Introductions and review of previous report

Please see the list of attendees and apologies uploaded on to the SWAG website here.

As there were no amendments or comments following distribution of the report from the meeting on Friday 3rd November 2023, the report was accepted as finalised.

The SHAPE trial, which compared radical versus simple hysterectomy for early-stage cervical cancer, and showed overall survival as equivalent, was discussed in the last meeting prior to final publication. Results have now been published, and SWAGGER are asked if this has resulted in a change of practice across the region.

Royal Cornwall Hospital have changed practice and offer patients who are 'SHAPEable' (<2cm, no lympho-vascular space invasion (LVSI), and not high grade adenocarcinoma) a discussion about the SHAPE results and have performed a small number of simple hysterectomies.

The approach should not be considered for those patients with Grade 3 Adenocarcinoma and patients with positive LVSI as insufficient patient numbers were included in the data.

Somerset FT (SFT) have been involved in a group that are planning a single arm study to look at patients' oncological safety outcomes who are 'SHAPEable' and have a laparoscopic simple hysterectomy as there is some concern over the hazard ratios in SHAPE as, if a LLETZ hasn't been done beforehand, you cannot prove that there is no LVSI. The trial was also not powered to look at open versus laparoscopic, which makes decision making complicated because of the positive oncological outcomes on the open approach reported in the LACC trial results.

It would be useful to have an ongoing national audit of patient outcomes.

SFT team do discuss the results of LACC and SHAPE with patients, but it has not been relevant recently due mainly to encountering referrals with later stage disease who have been going for chemo-radiotherapy. One patient who would have been suitable opted for a radical hysterectomy.

UHBW have changed all radical hysterectomies from laparoscopic to open in light of the LACC study results and have not encountered many patients that are 'SHAPEable'; one patient that was appropriate also opted for a radical hysterectomy.

LACC included the patient cohort that fitted the SHAPE criteria, and the sub-group analysis also showed an increase in oncological risk in the laparoscopic arm for these patients.

The British Gynaecological Cancer Society (BGCS) Guidelines for cervical cancer are expected to be finalised in the summer following several rounds of review.

2. Research

2.1 PINCS

Presented by Consultant Gynae-Oncologist Jo Morrison

PINCS is a four phase feasibility study which has arisen from a quality improvement project undertaken in SFT, to increase uptake of cervical screening in young women.

As a number of young women with young children had been diagnosed with cervical cancer after missing screening opportunities, the post-natal cohort was a particular focus and, after supplying education packages to midwives, screening rates were improved by 8%.

Feedback from new mums and GPs was that it would be easier if screening could be done at the post-natal 6 weeks check, when there is high compliance with attendance. However, current guidelines state that screening should not be done until 12 weeks post-natal. This is based on data from 50 patients comparing PAP screening at 4, 6 and 8 weeks; there is no data to support the guidelines with the use of the current screening methods of liquid based cytology or HPV screening.

Funding has since been sourced from the Medical Research Council (MRC) to commence the feasibility study.

Pre-PINCS 1 was the first phase, which is a mixed-method study using a web based questionnaire to assess acceptability of screening at 6 weeks and also urine testing. 454 responses were received which showed that age and education were not related to screening status, but recent pregnancy was related, especially for women with children under 5 years of age.

Two thirds of responders said that they would be happy to be involved in the study and 80% happy if it just involved urine testing at 6 weeks, and there was a 50/50 split about whether this should be done at 6 or 12 weeks. Overall, feedback indicated that more women would be likely to comply if screening was offered at the 6 week check.

There was some concern raised over the accuracy of the urine test versus the vaginal swab.

Free text comments were very interesting, and qualitative analysis is underway to pull out themes. Those that did not want to take part (146) supplied the most feedback, which was generally negative.

Two main themes that had already been identified were those affected by birth trauma and the burden of testing relating to travel to the GP surgery.

The second phase of PINCS has involved conducting 26 semi-structured interviews which have been transcribed and are in the process of being analysed.

PINCS-1 is now underway which involves inviting women to both 6 and 12 week screening appointments to compare the accuracy of the 6 weeks test and also compare the accuracy of the urine test.

Delays with set up of contracts with R&D had occurred, as had ordering the correct sticky labels for the sample pots, but now the study is open and has recruited 60 patients to date; 40 have attended their 6 week screening schedule and 19 have attended their 12 week screening. The team have been thrilled that there has been so much interest in participating.

The recruitment target is 100 patients attending the 6 week test and the team have recruited 2-3 times faster than expected. Once the results have been compared, the data will be presented to the screening service to see if they would be happy to substitute the 6 week test with the 12 week test as part of a randomised feasibility study, or whether a block step randomised larger trial would be required.

2.2 ENDO-CARE

ENDO-CARE is open in SFT and is run by the Department of Primary Care in Oxford. It is a single arm feasibility study that provides a low calorie replacement diet for 21 days plus prior to surgery for endometrial cancer of any grade. The patient's BMI needs to be >28 with no previous bariatric surgery or recent weight loss. Recruitment is going well, although it has been a bit difficult in SFT as it is not often that there are 21 days between when the patient is seen in clinic and when surgery is scheduled.

The ladies involved seem to like the shake and the soup meal replacements and it is hoped to report some results within the next year looking at fat distribution and complication rates.

Should results be favourable, it is expected to be developed into a larger Randomised Controlled Trial (RCT).

SFT have also undertaken a patient feedback study called GRACEFUL following the suggestion that the service move into the Children's Hospital rather than the new surgical unit; a large proportion of patients do not want to be seen in a Women's and Children setting. The study has been supported by several charity groups, and a research ethics application is underway to develop the protocol and a questionnaire. It is hoped to get ethics approval early in the new year. It will be similar to PINCS, involving online semi-structured interviews.

The team would be grateful if the GRACEFUL study could be advertised by members of SWAGGER once up and running.

The data from the first two parts will generate the questions for part 3, which is the discrete choice experiment, where people will weigh up the costs versus the benefits of having a specialist centre.

Action: To circulate details of the GRACEFUL study — **Jo Morrison/Helen Dunderdale**

Discussion:

NBT and UHBW are looking at long term service reconfiguration now that they are in the same hospital group, and the evidence from the study would be useful to review prior to considering any changes.

It is hoped that funding for the study can be sourced from the Cancer Alliance and Exeter Biomedical Research Centre if it can be married to one of their themes.

There are some simple reconfigurations that can be done to the joint areas, such as ensuring the décor is appropriate and not covered in baby pictures, and that clinics are timed so that they do not coincide with pre and post- natal clinics. It is women of all ages that find it inappropriate to share these areas with cancer-related clinics.

In relation to PINCS, it is understood that an increasing number of women are having a phone call for their 6 week post-partum check rather than a physical examination. This had not been flagged in the study to date but, in general, women had provided feedback that their 6 week check was unsatisfactory as the Primary Care team tend to focus on the baby and not enquire about the health needs of the mother. If the 6 week screening test is successful, it will hopefully have a positive effect on the post-partum check.

3. Clinical Guidelines

3.1 NICE Guideline NG241 update: Genetic Risk in Ovarian Cancer

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Gynae-Oncology Surgeon Claire Newton

Recommendations from the NICE Guidelines have been picked out to establish if everyone is able to meet the requirements.

Offer pre-test counselling and germline testing to anyone diagnosed with:

- invasive epithelial ovarian cancer
- ovarian Sertoli–Leydig cell tumour
- small cell carcinoma of the ovary hypercalcaemic type
- ovarian sex cord tumour with annular tubules
- embryonal rhabdomyosarcoma of the ovary
- ovarian gynandroblastoma.

- Ensure referral pathways to genetics services for people at risk of having a pathogenic variant associated with ovarian cancer. Suggestions include having an online Family History Questionnaire
- Training and information is to be made available for healthcare professionals, specifically for underserved communities e.g. Trans

women, men and non-binary to ensure that the wording used is appropriate
- There should be a familial ovarian cancer multi-disciplinary team (MDT) meeting (with members from Genetics, Gynae Oncology and Gynaecology) with a lead clinician.

In UHBW, there is a separate section to discuss genetic results, but a Clinical Geneticist does not attend, although Consultant Medical Oncologist Axel Walther does attend and has a PhD in genetics. Given the shortage of Clinical Geneticists, teams will need to be creative to ensure genetic results are appropriately acted upon.

The National Genomic Test Directory ovarian cancer gene panels do not match with the NICE guidelines, with the two organisations in disagreement at present.

RCH, North Devon, Exeter and Cheltenham do not have a separate familial ovarian cancer MDT meeting.

Many young patients that fit into the criteria for genetics can access this via the PROTECTOR trial. This is currently on hold to recruitment awaiting some major amendments but will hopefully open again soon.

Recommendations continued:

- The familial ovarian cancer MDT should have referral pathways to psychology, menopause, fertility, colorectal, ovarian cancer, breast cancer risk management services

A menopause service is not commissioned in Cornwall or Devon and is expected to be managed by Primary Care. Women that have become menopausal following treatment are however helped by the Gynae-Oncologists wherever possible when seen in follow up clinics.

UHBW do have a specialist oncology menopause clinic, but it is not commissioned and has required the team to source funding from a variety of different sources; this process is underway at present and it is always very difficult.

- Recognise and raise awareness that at risk populations including Ashkenazi Jewish, Sephardi Jewish, or Greenlander should be offered genetic testing even if there is no personal or family history of ovarian cancer
- When assessing a person's risk of developing ovarian cancer, use a tool with demonstrated accuracy that includes their age,

family history of ovarian and other cancers, and their pathogenic variant (such as CanRisk).

CanRisk can be really helpful with decision making: Welcome to CanRisk

- When discussing risk-reducing bilateral salpingo-oophorectomy surgery with people who are premenopausal: offer specialist menopause counselling before and after surgery
- Consider risk-reducing total hysterectomy alone to prevent endometrial cancer for people (no earlier than 45 years) who have:
    - a heterozygous PMS2 pathogenic variant and
    - no family history of ovarian cancer
- And consider BSO depending on age, menopausal status, and family history of ovarian cancer
- Before carrying out risk-reducing bilateral salpingo-oophorectomy, perform a transvaginal ultrasound and a serum CA125 test to minimise the risk of missing asymptomatic ovarian cancer.Before carrying out a risk-reducing hysterectomy, perform an endometrial biopsy to minimise the risk of missing asymptomatic endometrial cancer.
- If a person is at risk of developing ovarian cancer and chooses to delay or not have risk-reducing surgery, discuss their reasons and explain that:

    - They have an increased risk of developing ovarian cancer and that the only way to reduce their risk is to have risk-reducing surgery
    - Delaying risk-reducing surgery should only be seen as a short-term option
    - Regular surveillance does not reduce their risk of developing ovarian cancer
    - Although regular surveillance means that ovarian cancer may be detected earlier, they should not view surveillance as an alternative to risk-reducing surgery (because there is little evidence on whether this leads to improved outcomes and saves lives)
- Surveillance will involve them having a blood test every 4 months to check their level of the protein CA125 (cancer antigen 125), with an algorithm to analyse results, and a review at least once a year to discuss the recommendation of having risk-reducing surgery
- There is a possibility of getting a false-positive or false-negative test result

- Only consider surveillance for people in the following groups who are at risk of developing ovarian cancer but who choose to delay or not have risk-reducing surgery
    - over 35 and have a BRCA1 pathogenic variant or
    - over 40 and have a BRCA2 pathogenic variant or
    - over 45 and have RAD51C, RAD51D, BRIP1 and PALB2 pathogenic variants.

It was raised in the PROTECTOR study meeting that there was not consensus over the testing schedule as this was based on data from the UKFOCCS trial that was published a long time ago and wasn't powered to detect overall survival due to low patient numbers.

The Risk of Ovarian Cancer (ROCA) algorithm is recommended to check the level of CA125, but it is only possible to process this using a ROCHE machine, which is not available on the NHS at present, and so it is unclear why this is in the NICE guidance.

It is understood that there is a plan to make ROCA available on the NHS at some point.

Local experience is that very few people with the BRCA1 pathogenic variant choose to delay surgery and want to arrange it at the earliest opportunity. The few that do delay have their surveillance organised by the PROTECTOR trial.

Centres will need to consider how they access an algorithm to analyse CA125 results for the patient cohort who choose to delay surgery once the trial has closed to recruitment.

It is difficult to keep track of patients outside a trial and historically they are advised to make contact when they are ready for surgery. There is a very different patient cohort in London, where there are far more women with BRCA1 and 2 at 45 years old who are still hoping to plan a family.

At present, PROTECTOR is still discussed with all relevant patients, with the plan to recruit them as soon as it re-opens.

Action: To raise with the author of the guidelines the need to develop an alternative threshold tool to ROCA that is accessible to all centres. **To be allocated**

Surveillance with CA125 was not previously recommended over risk reducing surgery as it was thought that it could be falsely reassuring. Going forward, it may be monitored manually and patients encouraged to consider surgery should this appear to be rising.

4. Service Developments

4.1 South West Genomic Medicine Service Alliance (GMSA) / Lynch Syndrome update

Please see the presentation uploaded on to the SWAG website

Presented by South West GMSA Lead Genetic Counsellor for Cancer Matilda Bradford

Mainstreaming of the R207 ovarian panel is in place at all sites, which was integrated relatively easily following on from the tumour testing that was done for BRCA. The eligibility criteria has been expanded to include serous tubal intraepithelial carcinoma (STIC).

Mainstreaming of the R210 lynch syndrome panel is a bit more mixed but in place for colorectal and gynae at most sites. A few centres are still trying to integrate the work, which is more complicated as it involves different tumour types and the initial MSI/IHC stage. Another limiting factor is the small numbers for gynae, so it is not something that is often undertaken.

Resources are available on the South West Genomic Medicine Website: SWGLH Inherited Cancer Testing Services | North Bristol NHS Trust

Tool kits have been developed for all the core cancer tests that are available via the National Test Directory. These provide a step by step guide on eligibility criteria, all the forms required and the process for sending the samples, plus tailored Patient Information Leaflets, which are version controlled on the website.

Template letters are being developed for initial clinic discussions and results; these are just in the process of being reviewed by the patient involvement group.

A quick access to genetics referral pathway of within 4 to 12 weeks has been agreed for those patients with a positive result. The majority of patients are currently being seen within 6 weeks and are not put on the main waiting list.

Genetics also want referrals for those patients who have had a negative result but have a significant family history, as additional tests

may need to be arranged. This includes all patients who have had an R210 test for Lynch Syndrome as they have already had an abnormal MSI or IHC test. Although it is possible to get a false positive abnormal MSI/IHC as this is increasingly common as patients get older, these referrals can still be triaged by genetics by obtaining as much family history as possible. A letter of reassurance will be sent to those where the risk is evaluated as low.

Action: To refer all patients who have had an R210 test to Clinical Genetics.	**Patient's Named Consultant**

A regional Lynch Syndrome MDT is held once a month on a Monday from 12:30-13:30.

Please email: rduh.lynch-polyposis@nhs.net for information, invites and case referral forms for discussion, and the team are also welcome to attend just to observe.

Further training and support is available as documented in the presentation, including a competency framework that lays out all the core skills and knowledge to mainstream genomic testing. It is mostly used by the nursing workforce, but any health care professional can make use of the resources.

Training starts on a one to one basis to assess and sign off members of the nursing team following some shared consultations. Once confident, the trained nurse can then cascade the training to the rest of the nursing team.

Video resources have been released, including a mock consultation.

A more generic package of training is going to be produced for the additional tumour sites.

As raised earlier, there is currently a mismatch between NICE guidelines on the genomic tests to offer for ovarian cancer and those listed in the National Genomic Test Directory (NGTD). All providers are asked to adhere to the NGTD as it is not feasible to deliver the NICE extra tests at this time. The plan is to expand the offer of genetic tests in the future to the most appropriate patient cohorts, once additional resources have been secured.

For any case by case queries where you think a patient would benefit from a particular test but they sit outside the eligibility criteria, please contact the genetics team:

matildabradford@nhs.net
ruth.cleaver@nhs.net

Discussion:

When looking at the testing criteria for R207 at point 2, it is useful to use the CanRisk calculator to give a benchmark of the inherited cancer risk, alongside the clinical discussion.

It is rarely but sometimes relevant to test a non-affected person if they have a particularly high Manchester score, and these can also be referred to genetics for assessment.

5. Quality Indicators, Audits and Data Collection

5.1 UK National Survey of Pre-operative Imaging and Lymph node Staging Practice in Early Stage Endometrioid Endometrial Cancer

Please see the presentation uploaded on to the SWAG website

Presented by Gynae-Oncology Research Fellow Hannah Pierce

The survey, which was run via the BGCS, opened online between 26th January to 2nd August 2024, and received 69 responses representing 82% of UK cancer centres; 83% of responses were from cancer centres and 16% from cancer units and 61% of responses were from Consultant Gynae-oncologists. The other responses in the majority came from sub-specialty trainees.

First, the survey looked at pre-operative imaging. Current BGCS guidelines recommend pelvic imaging, chest x-ray or CT depending on the grade of the tumour. For high grade endometrial cancer, CT Chest, Abdomen and Pelvis is recommended.

European Society of Gynaecological Ooncology (ESGO) guidelines are very similar, and recommend trans-vaginal ultrasound or pelvic MRI, and additional imaging modalities such as CT based on pathological risk.

There is significant variation in pre-operative imaging for Grade 1 and 2 endometrioid endometrial cancers, with the results documented within the presentation.

There is a lot less variation in pre-operative imaging for Grade 3 cancers, with 99% of responders arranging CT Chest/Abod/Pelvis in these patients.

Sentinel Lymph Node Staging procedure choices were also investigated to see if molecular classification is being used to guide the choice of procedure. Results showed that 64% were not using molecular classification in this way. 82% confirmed that this was because the results were not available prior to the surgery being scheduled.
A small group do routinely use molecular classification to guide surgical procedures, which is recommended in the new ESGO guidelines as it can help with decision making, in particular for polar mutant who are low risk category and P53 abnormal who are high risk category.

ESCO recommend SLNB in low and intermediate risk to avoid systematic lymphadenectomy. Results of current practice are documented within the presentation along with rates of pelvic lymph node metastases from a study involving 161,960 patients published in 2020, which showed a higher rate of metastases in those with Stage 1B disease.

To align practice with the current guidance, it may be possible to increase the number of chest x-rays in the Grade 1 and 2 patient cohort and reduce the number of CTs, as the risk of pulmonary metastases is very low.

Variation could also be reduced in lymph node staging selection for Grade 1 Stage 1b and Grade 2 stage 1a endometrioid endometrial cancers. It was recognised that this would have service implications.

Discussion:

Further evidence is required on the benefit of SLNB guiding decisions on lymphadenectomy, which is not thought to improve patient outcomes. Lympho-vascular space invasion may be the more accurate indicator of recurrence.

An interesting finding was that fewer centres undertake chest imaging than was expected.

There are discussions underway about Unit Leads performing SLNB and the potential service implications.

The service implications for the pathology department need to be considered as well as the ultra-staging creates extra time and work.

The survey did not include whether molecular classification was available in time to inform adjuvant treatment.

It is hoped to do an additional study to see when node status makes a difference to patient management, which would involve each centre entering some data into a spreadsheet. An ethics application is underway.

Action: To circulate details of the node status study when available Claire Newton

6. Cervical Cancer Elimination / Staff Access to Cervical Screening

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Medical Oncologist and Cancer Alliance Clinical Director Helen Winter

Helen Winter also works for the National Institute for Health and Research (NIHR). The Clinical Research Networks have recently been rebranded and are now called Research Delivery Networks. West of England RDN has been renamed South Central and now includes Dorset. Any ideas for research that could be undertaken in community settings would be welcomed.

The South West Collaborative Commissioning Hub held an event to launch the Cervical Cancer Elimination Strategy in line with the World Health Organisation's (WHO) global strategy, which plans to make cervical cancer a thing of the past through HPV vaccinations, screening and treatment of pre-cancerous conditions, and improving access to diagnostics and treatment of invasive cancers.

SWAGGER members are invited to contact the presenters of the Pillar 1, Cervical Cancer Prevention, Pillar 2, Cervical Screening and Pillar 3, Timely Treatment, should they wish to get involved in the Strategy.

The South West ambition is documented within the presentation.

Working Groups will be organised and initiated following publication of the National Strategy.
A survey had been undertaken by Dr Isabelle Wood in UHBW of cervical screening in NHS staff. 56 staff members responded, 40% of which were doctors, and the rest was a mix of different healthcare professionals. This flagged multiple barriers that health care professionals have to try and find a convenient appointment for cervical screening outside working hours. The survey prompted publication of a poster stating that UHBW staff are encouraged to

arrange their cervical screening appointment within working hours when an alternative was not available and make the time back or take it as annual leave.

Evening drop-in screening clinics have been organised in Exeter and Barnstaple for a number of years, which are well attended and positively evaluated. Many attendees are 5 years overdue with their screening and there is a higher positivity rate than baseline screening levels.

Ideally, cervical screening should be made easily accessible to all NHS and social care staff. **AGREED**

SWAG Business Meeting

Chair: Sarah Platt

7. Cancer Alliance (CA) update

Please see the presentation uploaded on to the SWAG website

Presented by CA Programme Manager Nicola Gowen

Optimisation of Gynae-Oncology pathways remains a priority for the National Cancer Programme 2025/26, with the aim to improve compliance with the 28 day Faster Diagnostic Standard (FDS) as it is the 3rd highest contributor to FDS breaches.

Cancer Alliances have been tasked to deliver the following:

- Improvement plans where FDS performance is below 64%
- Clear triage models with sufficient safety netting by end of Q4
- Understand and reduce the FDS variation between cancer and non-cancer
- Deliver unscheduled bleeding on HRT pathways for 100% of services by Q2
- Complete a targeted project on improving hysteroscopy delivery in the context of patient care and improved FDS performance by Q4
- Define and deliver straight to CT from abnormal ultrasound for Ovarian Cancer by Q4 – there have been discussions about concurrent CA125 and ultrasound as mandated in Scotland
- Key project for Ovarian pathway improvement.

Funding is available to support the projects.

A scoping exercise took place earlier in the year to establish the status of unscheduled bleeding on HRT pathways in each centre. Some delays have been caused by the governance requirements to align with the BMS guidelines and service delivery, in particular with implementing direct access to ultrasound within 6 weeks.

Although Women's Health Hubs do exist in the SWAG region, these are not used to manage the unscheduled bleed pathway; this is a question that the National team often raise.

Variation exists on who undertakes triage, and whether this is undertaken by a nurse, consultant, administrator or sonographer.

The main challenges identified are pathology capacity, workforce and hysteroscopy capacity. The wait for hysteroscopy is currently around 23 days and work is underway across the region to try to get this reduced.

SFT have recently moved from nurse-led triage to admin-led and the experience so far has been poor. Triage requires an experienced individual as it is very complicated, and the change resulted in an incident that has been formally reported.

UHBW triage is Consultant and Specialist Nurse Led which works really well to speed up the patient pathway.

Action: To streamline triage administrative processes in UHBW. **To be allocated**

Gynae CAG require an experienced CNS to triage with supervision from a consultant and help to manage the administrative work; triage processes need to be correct from the outset to avoid delays in the patient's pathway. **AGREED**

The challenge is ensuring that enough people are available to cover the workload and for all those triaging to do so with consistency.

The National team also have a treatment variation workstream where they go through the process of picking out variation in practice from National Audits or Getting it Right First Time (GIRFT) recommendations and then task Cancer Alliances to reduce that variation.

The target identified for Gynae is from the National Ovarian Cancer audit and is for 80% of women with Stage 2-4, or un-Staged ovarian cancer to receive treatment of any type.

It is recognised that there are challenges with accessing timely and accurate data from these audits, and the data around this target is sourced from 2021.

Action: To source more recent data on the treatment variation target. **Nicola Gowen**

SWAG is doing very well in comparison with other organisations.

Funding is also available for the treatment variation work.

8. Personalised Care and Support

8.1 Clinical Nurse Specialist update

An update was provided by the CNS team in RUH Bath prior to the meeting. Holistic Needs Assessments (HNAs) are now all being completed by Cancer Support Workers (CSW). Health and Wellbeing days have been reinstated. The CNS team are completing treatment summaries for endometrial cancer and are currently drafting summaries for all of the other Gynae Cancers. Nurse-Led Genomics Clinics are due to be set up in the new year for patients with BRCA and Lynch Syndrome. An enhanced recovery project is also due to commence.

RDUH CNS Team have a CSW who provides the final HNA as part of the CNS end of treatment clinics for all gynae cancer patients, and this has proved to be invaluable for sign posting patients to the right services. The team won the overall Health Tech award in Exeter recently for their provision of electronic HNAs. Prehab and Rehab have been consolidated into a well-established service. BRCA and Lynch mainstream testing is routinely undertaken; clinics are arranged ad hoc at present. A cancer tracker has been implemented to facilitate PIFU and avoid patients having to come into follow up clinics; this will be audited soon. **Potential future agenda item**

Action: To share a blank End of Treatment (EoT) Summary template with SWAGGER. Gail Webb

Following the End of Treatment clinic, the patient is sent a care plan and invited to have either a telephone or face to face follow up appointment.

The EoT Summary contains all of the alert symptoms that they need to report to the CNS team and all relevant contact details.

Provision of the EoT clinic is stipulated in the CNS Job Plan.

Further updates from the CNS team are not available on this occasion.

Date and agenda of next meeting: Friday 28th November 2025 via MS Teams

-END-