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

Friday 3rd November 2023, 13:00-16:00 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 7th October 2022, the report was accepted as finalised.

2. Somerset Self-Referral Post-Menopausal Bleeding (PMB) Service Presented by Consultant Gynae-Oncologist David Milliken

Gynae services have been under excessive amounts of pressure since the COVID-19 pandemic which, when paired with the rapid increase of referrals for Hormone Replacement Therapy (HRT) in response to the Davina McCall campaign, and the national critical shortage of General Practitioners, has severely disrupted the triage process that would normally occur in Primary Care.

In SFT, the effect on Cancer Waiting Times has fallen from regularly meeting the national targets, to regularly breaching them. This was the same across much of SWAG and the Peninsula.

The pathway for women who experience post-menopausal bleeding from making an appointment with their GP to reviewing the results in a clinical appointment has become far too long, especially when the one stop clinic became no longer feasible as swamped with referrals.

To address this, the SFT team decided to adopt a strategy to enable patients to refer themselves directly to cut down the waiting times, make the service more accessible to hard to reach demographics, help address health inequalities, identify endometrial cancer at an earlier stage, and improve patient outcomes.

Community sites are being used, as well as YDH, for the clinics, as it became apparent that there are many resources in the community that are under-utilised; the model could be repeated for other referral pathways.

The next step was to engage with radiology colleagues to determine when sonographers could be made available to provide ultrasound at each site. This informed the structure of the clinics which are staffed by two GPs, one practice nurse, and occasionally covered with staff from the hospital.

SFT Team then sent communications to all GP Practices and Pharmacists and underwent a poster, TV, and radio campaign to ensure that the message was widely disseminated. This included a QR code and text number so if women text BLEED they are sent a link to the website which will take them through a triage process. If unable to access this technology, they can be talked through the referral process by the staff who man the cancer referral hub, although they are still encouraged to fill out the website form, which also provides patient education.

The self-referral form takes approximately 20 minutes to complete. The order of questions will screen out women who do not meet the referral criteria for the high risk clinic early on in the process; they are recommended to seek a GP referral instead.

It is possible to see when people have completed the form on several occasions and tried to change the answers to the screening out questions to access the service.

The service will be continually monitored and refined as necessary. Protocols will not be shared until there is confidence that any flaws have been corrected, which should be in approximately 6 months time.

The referral criteria reflect NICE suspected cancer guidance and guidance on post-menopausal bleeding updated in 2021.

When a patient meets the criteria, the information is reviewed by the Cancer Referral Hub, and an appointment is made by phone in the clinic closest to their home.

At the appointment, they first have an ultrasound and the report is handed directly to the clinician running the clinic. If a pipelle biopsy is required, this is done in the clinic, but not if they are to be sent straight to an outpatient or General Anaesthetic hysteroscopy.

It may be that an examination and reassurance is all that is required.

Biopsy results are reviewed in a specific results clinic session.

Standardised letters have been drafted to explain findings and if they are being referred back to the care of their GP or onwards for further treatment in Secondary Care.

There hasn't been a huge influx of patients to date, with many still being referred via the two week wait pathway. Ideally, GP receptionists and GPs will redirect relevant patients to the website.

To date, the triaging system is working, and appropriate patients are being seen in the clinic within 3 working days. The 28 day CWT target had been 39% in April; this has now increased to 58% and should improve significantly more when patients stop coming through the traditional route and access this new service, enabling better use of the hospital facilities for the patients at risk of malignancy.

Discussion:

Sessions are job planned to turn around results in time to meet the 28 day target. There is a generic results spreadsheet that all of the clinicians can access.

A challenge for the GPs has been screening the patients for the sole reason of assessment for the suspected gynae cancer pathway, as there is a tendency to try and treat unrelated symptoms, but they are definitely adjusting to this now.

In the future, trained nurses could run the clinic with a consultant available in a supervisory role. Eventually it could be completely handed over with minimal input from the Secondary Care Team.

The service improvement has been made possible due to the hard work of the Clinical Nurse Specialists and a dynamic project manager who micromanaged every step; anyone considering rolling out the model at another centre will need a dedicated person to implement the change.

In order to get the assistance required from radiology, the number of scans for PMB across the departments was counted, which was calculated as between 40-50 per week. This was used to justify moving the sonographers into the community, as it was scans that they would be doing anyway, but now in an easier to access setting where other work could also be undertaken.

The new service was of great interest to SWAGGER as all are struggling to manage the number of PMB referrals.

3. The impact of Patient Initiated Follow Up (PIFU) on outpatients in a Gynae-Oncology centre

Please see the presentation uploaded on to the SWAG website

Senior Registrar Srividya Sundararajan

A retrospective observational analysis was undertaken to understand the impact of PIFU on the outpatient department.

Patients are encouraged to make direct contact with the Clinical Nurse Specialists should they have any queries or concerns after being discharged to PIFU.

If concerns are not directly linked to Gynae-Oncology, they may be redirected to contact their GP or other healthcare professionals.

The PIFU study aim was to evaluate the reasons why patients make contact and gather details of any recurrences and how these were managed.

The cohort included patients diagnosed with uterine, cervical, ovarian, vulval and vaginal cancers. Patients discharged to palliative PIFU were excluded.

Data was collected from the Somerset Cancer Register and other electronic hospital systems from 1st January 2017 to 30th October 2022.

Results showed that of the 573 patients discharged to PIFU, 160 (27%) contacted the service, meaning 73% didn't require further input during that time period.

Age ranges, ethnicity and disease distribution are documented in the presentation. The majority of patients were Stage 1 Grade 1 endometrial cancer.

Reasons of contact include anything from headache, PV or PR bleeding, side effects of chemotherapy or radiotherapy, post-menopausal symptoms, or questions about smear tests. Some patients were re-directed by their GP or other health care professionals.

Ethnicity variation in contact was also analysed to see if there were any barriers for those who contact the services. The majority of contacts were from white British women, as this was the majority of patients. However, for the rest of the ethnic breakdown it was shown that patients were confident to contact the service from any ethnic background.

Where translation services were required, this was found to have been appropriately documented.

A word cloud has been created that includes all the reasons for contact. This emphasises the importance of the Clinical Nurse Specialist role, who are mentioned in all of the contacts.

Of the 160 patients that made contact, 74 contacted the CNS team directly, 6 of which were found to have a recurrence. 21 patients contacted the team about side effects following treatment, 1 of which was found to have a recurrence. Another 46 patients contacted other health care professionals, 18 of which were found to have a recurrence.

Further details of the recurrences, all of which were symptomatic and how these were managed, are documented in the presentation. Symptoms included PV or PR bleeding, bilateral leg swelling, supraclavicular and other lymph nodes, pain, abdominal distension, shortness of breath and cough.

There is some evidence that patients from a lower socio-economic background may be more hesitant to contact services and have worse outcomes. Unusual sites of recurrence are also more difficult to manage.

Future areas of research would be to compare patients on PIFU with those who remain on scheduled follow up.

Discussion:

The data will be further analysed with the aim to publish in the near future.

Some patients contact their GP rather than Gynae services, despite the PIFU education and information cards, as symptoms are not felt to be related to a gynae recurrence. No other barriers to accessing the service were identified.

4. Royal Devon and Exeter Post-Menopausal Bleeding (PMB) Audit

Please see the presentation uploaded on to the SWAG website

Presented by Clinical Nurse Specialist Hysteroscopist Alice Biesta

For patients with PMB, North Devon Formulary Guidance advises GPs to stop Hormone Replacement Therapy (HRT) for 6 weeks and refer to Gynae services if the bleeding persists after this time. However, NICE and other guidance does not differentiate between those on or not on HRT.

A review of recent research has shown some evidence that those on HRT may have a reduced risk of cancer.

The PMB audit looked at patients seen in clinic between January to March 2023. Of the 345 women seen, 156 were on HRT and 189 were not. Referral numbers were noted to be lower than normal at this time of year.

The number of patients that required endometrial sampling was 51%. Histology showed that the majority of patients on HRT had an atrophic endometrium and a very low number of significant histology, aside from 2 patients who had other high risk factors.

In the non HRT group, there was much more histological variation, with 11.1% having significant histology in comparison to the 1.28% in the HRT group.

The audit was noted to have limitations as it only includes 3 months of data. It is hoped to repeat it and encompass the whole population of referrals.

Given the number of patients referred on the cancer two week wait pathway, it may be possible to consider triaging patients on HRT to a lower risk referral pathway once further evidence has been gathered.

Discussion:

It should be considered that HRT is not prescribed in a uniform way, with patients being given different levels of progesterone and oestrogen which may decrease or increase the risk of cancers. New guidelines are due to be published in the near future that may help streamline the pathway.

5. PINCS

Please see the presentation uploaded on to the SWAG website

Presented by ST6 Rebecca Newhouse

The PINCS study is investigating the acceptability and accuracy of cervical screening tests at 6 weeks post-natal. It is hoped that SWAGGER will become involved.

It is broken up into 3 sub-studies: Pre-PINCS, which is already underway and involves anonymous questionnaires and in-depth qualitative analysis of semi-structured interviews. Results will be fed into the PINCS 1 and PINCS 2 sub-studies.

Study background:

The peak incidence of cervical cancer is in women aged between 25-30 years old, which coincides with the average age of a first time mother (29 years) in the UK. Cervical screening rates are very low, at around 50-70%, and especially for women with young children.

Local work undertaken as part of the invasive cancer audit identified that 15% of patients diagnosed with cervical cancer were either pregnant at the time of diagnosis or had recently been pregnant. This was a window of opportunity where, at a time when multiple obstetrics appointments were being attended, screening may also be arranged.

This prompted another Quality Improvement project with the aim to improve uptake of cervical screening in pregnant or recently postnatal women. Local data showed that 50% of women were out of date with their smear test by the end of pregnancy, and 75% of these women were still out of date 6 months postnatal.

Qualitative work with pregnant and postnatal women, GPs, and women with cervical cancer concluded that more consistent information from healthcare professionals around the appropriateness of having cervical screening during pregnancy was required, and screening should be made more accessible due to the difficulties with arranging childcare.

Offering cervical screening at the routine GP 6 week postnatal check or for women to self-administer the test were raised as potential solutions.

At present, NHS Cervical Screening Programme guidelines state that screening should not be done until 12 weeks postnatal, but there is scant evidence to support this recommendation.

A literature search found a Randomised Controlled Trial of PAP smears at 4,6 and 8 weeks postnatal. This showed a high rate of abnormal cytology / inflammatory changes at 4 and 6 weeks. A larger observational study was also found which compared inadequate liquid cytology rates 6 weeks post-natal with the non-pregnant population; findings were very similar.

Further evidence is required, especially in the HPB triage and liquid based cytology setting.

It is known that urine HPV self-testing increases the uptake in an under-screened population but, at present, there are no diagnostic test accuracy studies that have targeted women who are postnatal who may be keen to self-test after a recent birth.

PINCS 1 is a feasibility study to investigate the acceptability of screening at 6 and 12 weeks postnatal. Women will be recruited during pregnancy or within 6 weeks of delivery. They will be invited at 6 and 12 weeks postnatal to appointments for a smear and a urine HPV sample on both occasions. Recruitment rate will be tracked, as will the number of patients who attend for the tests. Patient Reported Outcome Measures (PROMs) will be recorded at the same time.

PINCS 2 will also recruit women while they are pregnant or within 6 weeks of delivery and randomised to either 6 week or 12 week testing to investigate if this will be an acceptable approach for larger studies.

Action: SWAGGER centres to display Pre-PINCS poster in clinic spaces / online or on social media: no ethics / Patient Identifying Centre research governance sign off is required. **SWAGGER centres**

PINCS 1 and 2 are going to be multi-site projects; SWAGGER centres are encouraged to apply to open them.

Discussion:

The poster is already being displayed in St. Michaels and patients are being encouraged to complete the questionnaire.

The study team have had over 300 responses to date.

There are some technical problems with the QR code which are currently being resolved. The link to the form still works.

6. ENDO-CARE Study

Please see the presentation uploaded on to the SWAG website

Presented by Clinical Fellow Kathryn Smallwood and Gynae-Oncologist Jo Morrison

ENDO-CARE is a feasibility randomised controlled trial of pre-operative intentional weight loss to support post-operative recovery in patients with obesity and endometrial cancer.

Complications from surgery are known to be higher in women who are overweight or obese and have longer hospital stays.

Improving physical fitness can improve outcomes and with an 800 calorie diet, different studies have shown that people can lose 5% of their weight within 20 days.

The 1:1 randomised intervention involves replacing food with 4 formula products totalling 800 calories and advice to drink 2.5 litres of energy free liquid to off-set the risk of constipation, versus standard care.

Inclusion and exclusion criteria are documented within the presentation.

There needs to be at least 20 days between the decision to operate and the operation date.

To establish if it would be possible to open the trial, data was gathered from SFT between June 2022 and May 2023. This included 70 endometrial cancers; 75% of women fitted into the category for being overweight or obese.

Patient pathways were then evaluated to see how quickly they progressed at each stage, with the longest wait being from referral to diagnosis. The service is not meeting the 28 day diagnosis target at present.

Diagnosis to treatment occurs in a timely manner as the gynae-oncologists are able to plan the next stages via the MDT and waiting times to first appointment are generally very good.

The time from the decision to treat to actual treatment will cause a problem with the study, as this is normally around 12 days due to the delayed diagnosis, rather than the 20 days needed for the weight loss management programme.

It was concluded that improvements need to be made to the diagnostic pathway, which may occur with the introduction of the self-referral service and one-stop PMB scan, and biopsy clinics. It is hoped that this will take pressure off the gynae-oncology team and allow time to participate in the study.

Discussion:

The study is being undertaken in Manchester where it has been agreed that the date when a participant starts on the study counts as the first treatment date for the Cancer Waiting Time targets.

7. NIHR Clinical Research Network update

Please see the presentation uploaded on to the SWAG website

Presented by Research Delivery Manager Claire Matthews

National clinical trial recruitment from 2022/23 shows that 10,690 patient had been recruited to gynaecological cancer trials across the 18 research networks.

The first 6 months of 2023/24 have recruited 5,295 which is looking comparable to last year.

The majority were non-commercial trials and about one third commercial with an even split between observational and interventional.

There are heat maps available which show where the majority of trials have recruited and recruitment numbers across the UK. This shows hot spots for Bristol, Exeter, Torbay and Cornwall.

Eleven trials have opened since 2022. The full list of trials open and in set-up will be circulated. The presentation also includes the trials due to close in the next few months and those in set up.

The NIHR 6-month Associate Principal Investigator (PI) scheme is still open to any interested clinician who doesn't have research in their current role. It allows associates to work alongside current PIs on studies (as documented in the presentation) signed up to the scheme.

Any PI interested in getting help from an associate while helping their personal development is to get in touch.

An NIHR virtual education event will be held on Thursday 30th November 2023.

The Clinical Research Network is in the process of transition which will come into effect in October 2024. CRNs will be renamed as Research Delivery Networks to reflect inclusion of non-clinical research activity and reduced to 12 networks which will work as one organisation with a coordinating centre. The aims to support successful delivery of high quality research remain the same. The boundaries of the West of England CRN will expand to include Dorset and Salisbury and will be renamed South West Central. The service being provided to cancer should remain the same.

NIHR website links and team contact details are available within the presentation. Dr Rebecca Bowen is the Research Sub-Specialty Lead for the CAG.

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

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Colorectal Surgeon Frank McDermott and Lynch Syndrome / Colorectal Cancer / Lynch Clinical Nurse Specialist Siobhan John

Funding for the GMSA projects is currently projected to end in March 2024, when there is an expectation that management of Lynch Syndrome and mainstreaming of genomics will be embedded as business as usual.

The South West has been very successful at increasing testing for lynch syndrome from the audits returned to date. Once a patient has been identified as having lynch, they are entered onto a national database. Colonoscopy surveillance is then arranged by the Bowel Screening Programme every 2 years.

Patients also need appropriate referral to gynaecology to discuss prophylactic hysterectomy, aspirin and helicobacter testing to reduce the risk of cancers in the future.

In mid-September, a GMSA engagement day was held for Colorectal and Gynae Clinical Nurse Specialists to which 50 nurses attended.

Following the event, a CNS in Bristol has been signed off as competent to mainstream testing for lynch and BRCA and there are CNSs in several other hospitals across the region who are in the process of completing the competencies.

Genetic counsellors are in post in both SWAG and Peninsula to support S John with providing the training.

Anyone interested in the training is invited to get in touch: siobhan.john@nhs.net

The competencies developed in the South West have undergone a stringent review process by National Nursing Leads, Health Education England and Clinical Genetics, and are due to be adopted nationally.

They are going to be adapted to also cover ovarian and breast.

An additional mainstreaming event is going to be held on 21st November 2023, and a second meeting will be held later on in December.

Mainstreaming consent forms, patient information leaflets and template letters have been drafted to simplify the process as much as possible and will be distributed soon.

Different members of the MDT can also be trained as the lynch experts; it does not have to be confined to the CNS role. The scope of clinical genetic testing is expected to continue to grow and roll out to other cancer sites so ideally numerous members of the MDTs can be involved to relieve pressure on clinical genetic services where waiting times are currently around 12 to 18 months. All these roles need to be properly funded and job planned.

Discussion:

The GMSA have started by training one Colorectal CNS and one Gynae CNS in each Trust, but more may be required.

Training requires observation of at least one clinical genetics counselling session and to be observed providing a genetic counselling session prior to sign off.

Gloucestershire had identified 5 patients that required referral for genetic counselling over the last year, prompting the need to assess the number of cases that would be required to maintain competencies in genetic counselling.

A centralised service was suggested as an alternative to individuals providing the counselling infrequently.

While concern was raised about adding mainstreaming to the CNS workload, it would only be for a small number of patients each year.

The competency framework contains links to training so this can be revisited at any time.

Some Trusts have talked about having a combined service model to offset the risk of small patient numbers.

Patients on the Clinical Genetics waiting list are also being recalled for counselling by the trained CNS team.

Upfront counselling is required prior to receiving the test result due to the implications of the test. This is not at the same level as the counselling provided once a genetic variation has been identified.

Testing for somatic variants will eventually become routine for all cancers to ensure access to tailored treatments. **Potential workforce development**

Eventually, the model may evolve into having Genomic Practitioners based within each Trust who work across all cancer sites.

A lynch module has been added to the My Sunrise Application which is available in the Peninsula and is a really useful resource for patients.

Patient videos have also been produced and are ready to be piloted.

An MSI plus assay has been produced for endometrial cancer as a potential alternative to immunohistochemistry in the future. This includes Micro-instability, BRAF, and NRAF all in one test. This will be rolled out to the Genomic Laboratory Hub in December 2024 and could significantly improve turnaround times.

Action: To provide SWAGGER with an MSI plus assay update at a future meeting. **F McDermott**

The National Transformation Project tasked the GMSA to set up expert network groups. There is now a regional South West expert group that meets on the first Monday of the month at 12:30 for 1 hour to discuss lynch and polyposis cases. There are usually 3-4 patient discussions and an educational component is included. Please email to be added to the distribution list: rduh.lynch-polyposis@nhs.net

Health Education England have produced some educational resources which are available here:
https://www.genomicseducation.hee.nhs.uk/genotes/

Sustainability meetings are going to be held in each Trust with Lynch Champions and Cancer Managers to establish the additional resources required.

An annual cancer event will be held in January.

Contact details for the team are documented in the presentation.

Discussion:

The DETECT-2 study is looking to randomise patients into genetic testing at cancer diagnosis compared with standard mainstreaming genetic testing for patients diagnosed with colorectal, endometrial, and ovarian cancer.

The ability to support this research trial and the GMSA with mainstreaming was raised, due to the small number of patients.

Web-based consenting may help in the future.

There is a telephone helpline in the study design so that patients can ask the team any questions.

The Chief Investigator ideally wants to identify the 90% of BRCA patients who are currently unknown.

9. National Cancer Patient Experience Survey Results (2022)

Please see the presentations uploaded on to the SWAG website

Presented by Lead Cancer Nurse Ros Helps and Project Manager Andrew Filby

Although the annual survey has been undertaken for 12 years, some of the questions changed in 2020, so it is only possible to directly compare the 2021 and 2022 surveys.

SWAG response rate was slightly higher than the national average. The majority of respondents still prefer to respond on paper.

Response rates from patients who identify as other than white British are low. This is being investigated by Trusts to compare responses with the ethnicity of the patients who were sent the survey.

There are a number of patients who decline to give their ethnicity, which it is thought may be due to mistrust on how the data might be used. The survey provider, Picker, have been asked to include a more comprehensive explanation on how the data can be used.

SWAG Cancer Alliance are going to be employing a data analyst who will be able to investigate trends from the survey in more depth.

SWAG results overall showed 8 questions scored above the expected range and no questions scoring below the expected range. A few questions scored slightly lower than last year.

Gynaecology specific responses totalled 172. Overall rating of care was 8.8/10. There were 12 questions which rated over 90% and 8 questions rated below 60%. Of those highly rated, it was clear that the main theme was having access to key contacts in the team to discuss the plan of care, and that the whole team worked very well together, which should be celebrated.

One of the lower scores was that patients felt unable to discuss fears and anxieties with ward staff. This was being investigated in RUH further to see if it is due to the staff looking too busy to approach, or to establish if staff are not asking the right questions at the point of contact and need to build more confidence to do so.

Other low scores relate to the care provided in the community, with the question ‘patient had a cancer care review from their GP’ scoring 29%.

This had improved from the previous year.

GPs in the Bath district evaluated provision of cancer care reviews and found that this had been provided to 60% of patients. However, it is thought that patients may not have been made aware that their appointment was for this purpose; work is underway to facilitate improvements.

In some areas, Primary Care Nurse Facilitators have been appointed to provide education and support on the importance of providing the care reviews. Feedback from Primary Care is that the Treatment Summaries provided by Secondary Care are vital to help complete the reviews, as they provide all the relevant information on one page rather than scanning through multiple letters.

The question 'cancer research opportunities were discussed with the patient' scored 40%. Although not all patients are eligible for clinical trials, it may be possible to improve this if patients are made aware that they will be contacted about research should an eligible trial become available. Trusts are working on putting some general information together for this purpose and encouraging patients to ask if they have been considered for a research trial.

Overall, the results should be celebrated as they are overwhelmingly positive, with the vital role of the Clinical Nurse Specialists and other team members being evident.

Action: SWAG Gynae Services could collaborate to improve the question on cancer research opportunities and communication on the management of treatment side effects. **R Helps/CNS Team**

Results from NCPES are shared with all stake holders and a SWAG result dashboard will be provided to facilitate further analysis and identify further areas for improvement. Results will also be cross-referenced with the National Quality of Life survey.

Peninsula results:

Highlights from the Peninsula NCPES results are very similar.

SWAGGER is asked to consider how patients are given information, with consideration of methodology, language and technology barriers.

Peninsula results overall rating of care was 1% above the national average and positive overall.

Gynaecology specific responses totalled 156, with 19% better, 79% within, and 2% worse than the expected national range.

The lowest scoring question was 'patients had enough understandable information about progress with immunotherapy' which may be about data quality due to the low number of responses to the question skewing the result.

The highest scoring question (8.8% above the National average) was 'patients had confidence and trust in all of the team looking after them during their stay in hospital', which should be celebrated, as should the other highlights documented in the presentation.

As with SWAG results, patient information from the Primary Care perspective could be optimised.

Further information could also be made available at the point when patients are sent for diagnostic tests.

Action: To explore the information given to patients by their GP and how this is transferred into Secondary Care.

To explore if breaking bad news training should be provided on a more regular basis. **A Filby**

Further work will be undertaken to understand the reasons why some patients did not score the question 'treatment options were explained in a way the patient could completely understand' in a more positive way and the same with the question on getting a second opinion.

The question 'patients were definitely able to have a discussion about their needs or concerns prior to treatment' could potentially be improved by encouraging patients to use the My Sunrise App, where cancer specific information including contact details of the team are uploaded.

My Sunrise is not available to patients in the SWAG region.

Only 60% of patients said they were able to discuss their worries and fears with hospital staff, which reflects how busy it is in the ward environment at present.

Further information is documented within the presentation.

Action: To undertake a regional patient experience survey that captures more of the gynae cancer population. **To be allocated**

It is hoped that information on long term side effects will improve when this is available on the My Sunrise App.

Discussion:

To encourage discussions of research with patients.

10. Centralisation of Rare Surgical Procedures

The SHAPE trial, which compared radical versus simple hysterectomy for early-stage cervical cancer has shown overall survival as equivalent. It is therefore likely that there will be a move to simple hysterectomy in this patient cohort. Although the paper has yet to be published, SWAGGER envisages that there may be training implications as the number of radical hysterectomies will be lower in this rare cancer type which has multiple treatment options.

It is expected that a position statement on centralisation of services will be drafted by the British Gynaecological Cancer Society (BGCS), ready for when the paper is published; it would be ideal to have a plan for where cervical cancer surgery is offered in the region and how surgical training should be remodelled based on predicted prevalence of disease.

Action: SWAGGER to collect data on surgical resection numbers for each gynaecological cancer site — **Surgical Teams**

11. Any other business

The introduction of 6-week Carbo/Taxol as per the INTERLACE trial for high-risk cervical cancer will be discussed further from a network point of view. In the opinions of the oncologists present, the toxicities have been manageable and, due to the overall survival benefits, they are keen to implement this treatment option as soon as possible.

Date and agenda of next meeting: To be determined via Doodle Poll.

-END-