Kent and Medway Cancer Collaborative

Gynaecology Tumour Site Specific Group meeting
Wednesday 13th May 2026
Conference Room, Postgraduate Centre, WHH
09:00 – 12:30

Final Meeting Notes

Present	Initials	Title	Organisation
Hany Habeeb **(Chair)**	**HH**	Consultant Gynaecologist	MFT
Louisa Bird (Guest Speaker)	**LB**	**Oncology KAM**	**GSK**
Joanna Abiola	**JA**	Consultant Obstetrician & Gynaecologist	MFT
Sharon Griffin	**SG**	Consultant Gynaecologist	MFT
Karen Flannery	**KF**	Macmillan Gynae Oncology CNS	MFT
Jody Taylor	**JT**	Consultant Obstetrician & Gynaecologist	DVH
Rema Iyer	**RI**	Consultant Gynaecological Oncologist	EKHUFT
Ed Inetianbor	**EI**	Consultant Gynaecologist and Obstetrician	EKHUFT
Rhiannon O'Halloran-Jones	**ROHJ**	Gynae Oncology Research Nurse	EKHUFT
Carly Price	**CP**	Family History and Genetics CNS	EKHUFT
Nicola Chalmers	**NC**	Gynae-Oncology Family History / Genetics Associate Practitioner	EKHUFT
Vicky Morgan	**VM**	Macmillan Lead Gynae Oncology CNS & SCP	EKHUFT
Gemma Connaughton	**GC**	Gynae Oncology Support Worker	EKHUFT
Laura Lawrence	**LL**	Gynae Oncology Support Nurse	EKHUFT
Laura Alton	**LA**	Senior Programme Manager	KMCA
David Osborne	**DO**	Data Analyst via Teams	KMCA
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC
Michelle George	**MG**	Gynae Oncology CNS	MTW
Sasha Humphries	**SH**	Consultant Radiologist	MTW
Gary Rushton	**GR**	Consultant Histopathologist	MTW
Amanda Rabone-Young	**AR**	Consultant Radiologist	MTW
Gemma Hegarty	**GH**	Consultant Clinical Oncologist	MTW
Elaine Hales	**EH**	Clinical Oncology Registrar	MTW

Vickie Gadd	**VG**	CNS Lead – Gynae Oncology Genetics & Family History Macmillan Clinical Nurse Specialist, Trust Lynch Champion - Endometrial	MTW
Pollyanna Law	**PL**	Gynae Oncology CNS	MTW
Lorna Kviat	**LK**	Consultant Clinical Oncologist	MTW
Dawn Langdon	**DL**	Advanced Nurse Practitioner	Thanet Health CIC
Apologies			
Charmaine Adeyemi Walker	**CAW**	Cancer Performance Manager	DVH
Faye Fawke	**FF**	Macmillan Deputy Lead Cancer Nurse	DVH
Marie Payne	**MP**	Macmillan Lead Cancer Nurse / Clinical Services Manager	DVH
Justine Elliot	**JE**	Gynae Oncology CNS	EKHUFT
Kannon Nathan	**KN**	Consultant Clinical Oncologist and Clinical Director of Oncology	EKHUFT
Adenike Williams	**AW**	Clinical Oncologist	EKHUFT
Hasib Ahmed	**HA**	Consultant Obstetrician and Gynaecologist	MFT
Stephen Attard-Montalto	**SAM**	Consultant Gynaecologist & Gynae-oncology Surgeon	MTW
Michelle Godfrey	**MG**	Consultant Gynae Oncologist	MTW
Charlotte Wyeth	**CW**	ST6 - Obstetrics & Gynaecology	MTW
Justin Waters	**JW**	Consultant Medical Oncologist	MTW & EKHUFT
Dawn Willis	**DW**	Patient Representative	

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**<u>Apologies</u>** • The formal apologies are listed above. **<u>Introductions</u>** • HH welcomed the members to today's face to face meeting and the group introduced themselves.		

		• If you attended the meeting and have not been captured within the attendance log above please contact karen.glass3@nhs.net directly. **Action log Review** • The action log was reviewed, updated and will be circulated together with the final minutes from today's meeting. **Review previous minutes** • There were no objections from HH's perspective to the accuracy of the previous meeting minutes (12th November 2025). However, HH asked if there were any objections to contact KG by Friday 15th May 2026 otherwise they will be automatically signed off as an accurate record of the previous meeting.		
2.	**Interstitial Brachytherapy Update**	**Brachytherapy for Cervical Cancer – update by Lorna Kviat** • LK mentioned Interstitial Brachytherapy has started with initial funding support from the Cancer Alliance for patients with cervical cancer. • The standard treatment for cervical cancer is Chemoradiotherapy – 6 weeks of radiotherapy and weekly cisplatin chemotherapy. • Interstitial Brachytherapy is a type of internal radiation therapy whereby radioactive sources are placed into or near a tumour using catheters or applicators to deliver targeted radiation. The radioactive substance is sealed inside materials that can be implanted, such as pellets, seeds, ribbons, wires, needles or capsules, and placed inside the body, directly into or near a tumour or within a body cavity. • The implant is placed through a small flexible tube / catheter or through an applicator device. This is kept in place for a few minutes / many days or for the rest of the patient's life. • Standard Radiotherapy will be delivered through normal tissue but this can cause long-term		**Presentation circulated to the group on the 14th May 2026**

		problems to other organs including kidneys, bowel etc. Delivering Brachytherapy provides less long-term issues and a better quality of life for patients. • External beam radiation therapy (EBRT) is a precise cancer treatment that delivers focused radiation beams to target larger tumors while minimizing damage to surrounding healthy tissue. • LV outlined the typical day for a patient receiving Brachytherapy: i) Arrive 8am ii) Spinal Anaesthetic / General Anaesthetic (in some cases) iii) Planning CT Scan iv) Planning MRI Scan v) 4-5 hours – doing volumes, designing plan and confirmatory checks. Ring / Ovoid's are inserted which sit against the cervix. vi) Treatment and applicator removal vii) Plan to go home about 5pm – within the day • Interstitial needles are specialised tools used in brachytherapy to deliver radiation directly into or near tumors, improving dose coverage while sparing surrounding organs. Patients may experience some pain / minor bleeding when the applicator / needle is removed. • Applicators are used to place the radiation inside your body. For some gynecologic cancers, the applicators used are "tandem and ovoid" (T&O) or a "tandem and ring" (T&R). A tandem is a long, thin metal tube that is put through your cervical canal into the uterus. Ovoid's are circular hollow capsules, and a ring is a hollow ring. • LK referred to the EMBRACE trials which are multicenter studies evaluating advanced image-guided radiotherapy and adaptive brachytherapy to improve outcomes in locally advanced cervical cancer. This data is yet to be published. • LK highlighted that 9-10 K&M patients per year have interstitial brachytherapy in London and have to stay overnight. 40% of these patients have PTSD post treatment and they would		

		prefer to treat them closer to home in K&M. There is a bottleneck of patients locally and as such they have set up an extra list on a Thursday. There is a large team in place working closely together to deliver this treatment for their patients including radiation oncologist, medical physicist, dosimetrist, radiation therapist, radiation therapy nurse and sometime a surgeon.		
3.	**Endometrial Cancer Audit – Data findings**	**<u>Endometrial cancer audit pilot – update provided by Rema Iyer</u>** • RI referred to recent 2 x endometrial cancer reports, one published in April 2025 with the second published in January 2026. • The incidence of endometrial cancer has increased largely due to obesity with rates also being higher in deprived areas. There is also a higher incidence for older white women but younger Asian / Black women. • On average 7,828 women are diagnosed with endometrial cancer per year with the largest number of cases amongst women aged 70-74. • There is a higher rate of stage 4 endometrial cancer in K&M compared to the England average plus higher mortality rates. RI mentioned at EKHUFT they operate on 100 endometrial cancers a year – 95% of which are done laparoscopically. • Between 2017 – 2019, 15.9% of women had chemotherapy – most commonly initiated after surgery. The timing of chemotherapy varied depending on tumour characteristics including stage at diagnosis. • The percentage of patients treated with neoadjuvant chemotherapy was greatest among patients diagnosed with stage 4 disease (17.1%) versus just 3.2% for those diagnosed with stage 1 disease. • Among all women diagnosed with endometrial cancer in England from 2017-2019, 31.7%		**Presentation circulated to the group on the 14th May 2026**

		had radiotherapy recorded. The likelihood of receiving radiotherapy varied depending on tumour characteristics at diagnosis, age, Charlson comorbidity score, ethnic group, stage, grade and morphology. • Types of radiotherapy include: i) 28.4% - EBRT ii) 24.4% EBRT + Brachytherapy iii) 46.9% Brachytherapy • Overall, the recording was low for those having endocrine therapy – 13.8% for all women diagnosed with endometrial cancer in England from 2017-2019. • Sentinel Lymph node procedures – MTW carried out for about 5-years and EKHUFT 3-4 years with 90 – 100 cases per year. However, they do not carry out this procedure if the patient is morbidly obese. • Sentinel Lymph Node washings – they do not do washings for low grade cancers but will do washings for high grade endometrial (G3).		
4.	**Data Warehouse Dashboard**	**<u>Update provided by David Osborne (via Teams)</u>** • DO highlighted that the Gynae FDS (28-day) performance target has improved to 71.9%. However, the 62-day performance has deteriorated (81%) in the last 6-months. K&M are still the highest CA nationally in terms of their 62-day performance. • FDS performance is lower at EKHUFT at 69.8% with improvement at the other trusts - DGT – 84.2%, MTW – 81.4% and MFT 0 83.1%. • 62-day performance target – DGT – 100%, EKHUFT – 63%, MTW – 92.6% and MFT – 47.4%. • The Survival Data is new data which has been released nationally and was included during the Covid Pandemic – 2018 - 2022. Endometrial cancer survival data is significantly lower		**Data pack was circulated to the group on the 14th May 2026**

		than England for both 1-year and 5-year survival. DO felt this was worth exploring further. For all other gynae cancers there was no significant difference in the survival data. DO suggested hovering over the data to see the trend over time which provides further detail and what action should be taken. • DO encouraged the group if they do not already have access to sign up to the live dashboard which he proceeded to navigate through – see details below. • Treatment variation indicators for ovarian cancer is lower at EKHUFT compared to the other trusts – which was worth noting. • JT questioned the data in terms of referral numbers in January as being 50 referrals but there were in fact 100 received. AC added that it could be a coding issue. HH suggested they met with their Cancer Team and Co-Ordinator's to ensure the coding process is streamlined and accurate. • LK asked where the survival data had been pulled from and the stage patients present? DO confirmed this data is accurate and comes from the National Death Registrations document. • HH explained they have a small number of referrals - 2-3 per month at MFT and DVH which means they can easily breach the performance target. There have also been ongoing imaging challenges at MFT. There was previously only 1 Gynae Radiologist reporting MRI's but now they have 2 which should improve their 62-day performance. **How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards** • Register for access to Kent and Medway ICB Power BI reports by completing the form at https://forms.office.com/r/svyPSvktHw. • Email David.Osborne11@nhs.net to inform him that you have completed the form for access to the dashboard. It can take up to a week for the ICB to grant access. • Once access has been granted, you can access the dashboard at https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e. Click on the **KM ICB Main** app and you will see Cancer in Primary Care and Cancer Pathways listed on the		

		left-hand menu.		
5.	**GSK ApoiD Support Programme for Patients on Niraparib**	**<u>The Niraparib patient support programme and optional Homecare Medicines Service – update by Louisa Bird</u>** • LB explained the background to the service GSK are providing: i) The Patient Support Programme (PSP – is delivered by Apodi) and the optional Homecare Medicines Service (HMS – is delivered by PHP) which is fully funded by GSK. This is offered as a package deal to support the NHS for advanced ovarian cancer patients prescribed Niraparib path inhibitor. ii) Once agreed by PSP patients will receive dedicated support through phlebotomy, blood pressure monitoring at home and adverse event monitoring, plus optional homecare dispense and delivery. iii) This service is provided by GSK for 3-years at no cost to the NHS or patients. iv) Clinical responsibility for the patient will remain with the NHS trust at all times. • Patients have their bloods taken on a weekly basis for monitoring purposes and then monthly for 11 months. • LB explained the Band 6 Apodi Nurse will ring the patient to introduce themselves. The nurse is proficient in Oncology / Immunotherapy and Chemotherapy and the NHS will have access to their CV and Manager. The nurse will also be covered when on AL. • The patient's weight is checked and other results are delivered to the Hospitals Pathology Lab. It was noted that patients are often living with anxiety and the Apodi nurse visiting their house can alleviate this. • The Royal Marsden have a very busy PARP clinic and are doing an audit to monitor the service both operationally and from a patient's perspective. • LK stated this would make a big difference to K&M patients in terms of avoiding expensive		**Presentation circulated to the group on the 14th May 2026**

		travelling costs. • LB confirmed the Apodi nurse would become part of the Hospital Team by providing a constant link. A clinician from each trust site would need to sign this off. LB highlighted that Kannon Nathan is very interested in this programme. It was noted that MFT patients go to MTW for systemic treatment so they would not need Clinical sign off. • LB concluded they would require an email from members interested in this programme and an Expression of Interest form would be sent via email.		
6.	**Trust Service / Pathway Updates**	**<u>CNS update - DGT</u>** • There is no MDT Co-ordinator in post which is putting additional pressure on the CNS's who are carrying out additional admin roles and is detracting from their clinical duties. **<u>Trust / pathway update – Jody Taylor</u>** • The triaging system continues to work well and JT is supporting the Rapid Access Clinics. • More rapid access clinics are in place and they are able to see a patient within one week of referral. • They have no additional staffing or capacity issues at this time. • They do not receive many referrals without an Ultrasound scan and the referral numbers are lower compared to the other trusts so is manageable. • Referrals are not rejected but "redirected" back to the GP> They may ask the GP to examine the patient before a referral will be accepted. JT highlighted that some GP's may not completed the Obstetrician and Gynae training so will feel less confident when examining a patient. • HH stated in his opinion most patients were not examined before being referred from PC. **<u>CNS update – MFT</u>** • Additional pressure due to sickness within the team. • Gynae CNS in post who will be in a position to support other CNS teams due to having an		

		honorary contract in place. **Trust / pathway update – Sharon Griffin** • They have a new Cancer Lead in post (JA) and HH has now stepped down. Thanks to HH for his support. • Similar challenges to the other trusts in terms of referrals and imaging delays. • Smaller number of patients referred compared to EKHUFT. • Menopause education meetings took place prior to Covid for GP's. • Women's Health Hub – the referral is not coming directly from GP's which is an issue. • Advice and guidance provided for 16 patients takes 4 hours – letter is also provided and patients feel heard and helped. • The quality of USC referrals is not always appropriate. • MFT are currently experiencing challenges regarding referrals and scans from the community - although this is a small number of patients. **CNS update – EKHUFT** • They are ar full capacity in terms of their CNS's and they are also supporting the Family History and Genetics Programme. **Trust / pathway update – Rema Iyer** • Andy Nordin has now retired and they have no replacement due to a recruitment freeze. This has created extra lists and extra pressure on both RI, Fani Kokka and others which is impacting their performance at EKHUFT. • The GP's are not all following the new 2ww proforma and as such they are still receiving referrals without an Ultrasound. However, in general, the referral quality has improved. • There are major issues in terms of diagnostics and CT biopsies which can take 12 weeks to turnaround. • The average first patient appointment is 21-days which means it is impossible to meet the		

		FDS performance target. • They do not have anyone to physically book patient scans. There are 105 MRI's waiting to be vetted and are in-undated. CNS's are having to do more admin work and are chasing patients at the beginning of the pathway. **Action – Ann C and Bana H to provide further education to GP's in terms of referrals – Ultrasound should be in place before a referral to Secondary Care is made. Hany agreed to write to the CEO at EKHUFT to make them aware of the issues in place for both staff and patients due to the lack of resources.** • HH stated they should not be accepting a referral from PC without an Ultrasound and this should not be done in Secondary Care due to their pressured resources. • HH felt it would be helpful to implement a unified Kent & Medway-wide forum focused purely on advice and guidance. • RI suggested conducting an audit looking at endometrial cells – triage vaginal swabs and patients requiring further tests – hysteroscopy. **CNS update – MTW** • CNS are providing further educational events including sixth formers, patient surveys, HNA's, rehabilitation and also the ACCEND programme. **Trust / pathway update – Lorna Kviat** • MTW are unable to maintain a surgical service due to sickness. SAM confirmed after the meeting that Andreas Papadopoulos has officially retired from MTW but is still doing some bank shifts until his replacement. Omer (Devaja) is currently on sick leave. AP will do some bank shifts 2 clinics a month and 2 theatre half day lists a month on average until Sept 2026.		**AC / BH / HH**

		• A Gynae Consultant role has gone out to advert but realistically this will be filled later in the year. **<u>Update from Dawn Langdon – Primary Care</u>** • DL referred to their Women's Health PLT which is taking place in July. This provides advice and guidance to patients so they feel heard and cared for. • More funding is needed in PC as they cannot give consultations in just 7 minutes. DL added the system is broken. • They have qualified Menopause Specialists in PC to advise on Post-Menopausal Bleeding whilst on HRT. They are waiting for a KMCA funding approval bid which will ultimately stop these referrals coming into Secondary Care.		
7.	**AOB**	**<u>Strategic objectives for CRG</u>** • HH confirmed the Gynae CRG meets every 2 months. • The referral proforma has now been updated but it seems it is still not always being followed. • Majority of patients are being seen by day-7. • Robotic surgery is taking place at EKHUFT – RI and FK have completed 20 cases. DVH, MFT and MTW also have access to carry out robotic surgery. • GR confirmed that Digital Pathology is in the process of being rolled out which will improve their TAT's in due course. **<u>Research – EKHUFT</u>** • DETECT-2 – the aim is to recruit 20 patients. • Bluestar Endometrial Study – 4 patients have been screened		

		• Awaiting the PROTECTOR study • TREVI trial is being developed – JW – awaiting site selection. **<u>Research – West Kent</u>** • TroFuse-005 – endometrial trial which is open but not recruited to yet. • 3 ovarian trials are awaiting site selection. • Pharmacy workforce – limited for trials which will impact their research capability.		
8.	**Next Meeting Date**	• **November 2026 – TBC by HH – ideally MTW venue.**		**KG to circulate the meeting invite once the date has been confirmed**