



Welcome to the NHS Oncology Conference



6th October 2026
etc.venues, Prospero House, 241 Borough
High St, London, SE1 1GA





CancerCare

FEATURED ORGANISATIONS

Visit selected stands for your chance to win a £100 voucher!

MSD are not included in this prize draw



My medical record



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NHS

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*“Engaging, thought-provoking and
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providing valuable opportunities to
learn and network with NHS peers”*





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- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.



SCAN ME

Stay Connected Beyond Today

Join the **HES Clinical Diagnostics & Medical Sciences WhatsApp Community** to stay connected with the people, ideas and conversations shaping this space. Receive relevant updates, access focused peer discussion groups, share practical insight and be first to hear about future events, resources and opportunities.



Scan the QR code to join the Community



Slido

Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.



SCAN ME



Chair Morning Address



Chris Sleight MSc BSc FIBMS

Chief Executive Officer of Sleight Insights

Formerly Chief Officer of the Greater Manchester Diagnostic
Networks



Keynote Presentation



Dr Harrison Carter
Director of Screening
NHS England



Skills Clinic



Siwan Owen
Lead Cancer Nurse
Shrewsbury and Telford NHS
Trust



**Marisa Raquel Durao
Portela de Lima**
Lead Cancer Nurse
Barts Health NHS Trust



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Consultant Urological Surgeon
The Christie NHS Foundation Trust



Refreshments & Networking





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Chair Morning Reflection



Chris Sleight MSc BSc FIBMS

Chief Executive Officer of Sleight Insights

Formerly Chief Officer of the Greater Manchester Diagnostic
Networks



Case Study



My medical record



CancerCare

Case Study



Claire Marsh

Personalised Care Lead & Systemic Anti-Cancer Therapy
(SACT) Practitioner
University Hospital Southampton NHS Foundation Trust





Patient Stratified/Initiated Follow Up (PSFU/PIFU) for Cancer Patients

Claire Marsh

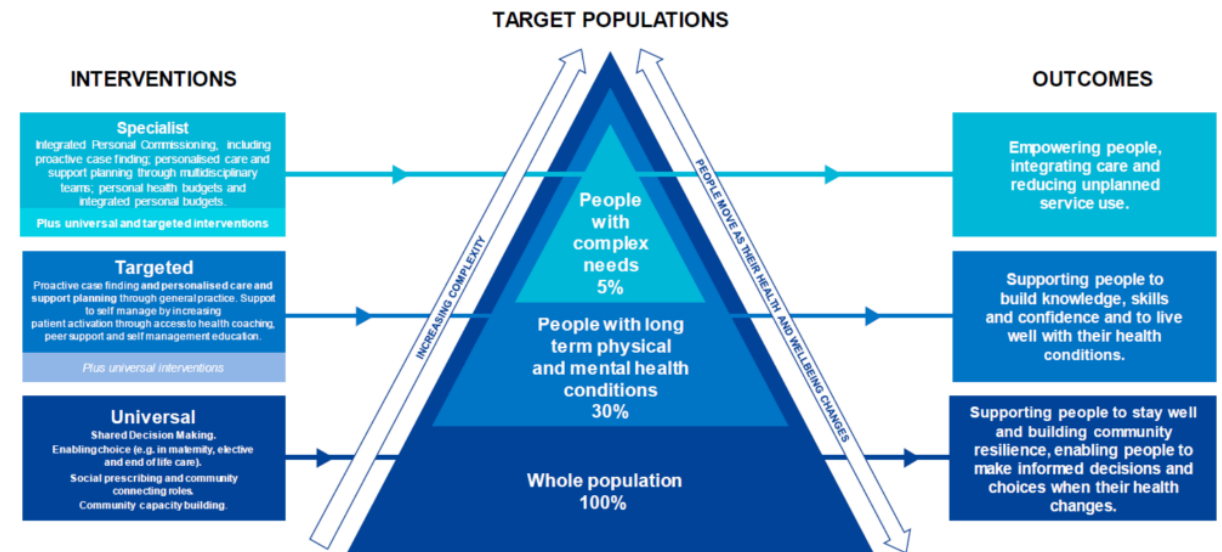
Personalised Care
Lead & Systemic Anti-
Cancer Therapy
(SACT) Practitioner

PSFU/PIFU & Supported Self-Management

- Links to the NHS Long Term Plan¹ (Jan 2019) & NHS Health Plan⁴ (2025) & NHS Cancer Plan⁶ (2026).
- PSFU/PIFU allows patient follow up to be stratified and person centred – Personalised Care².
- Removal of follow-up OP appointments for post treatment cancer patients supported by a digital system – MyMedicalRecord (MyMR).
- During PIFU patients:
 - continue cancer surveillance & monitoring
 - are encouraged & enabled to self-manage
 - are only seen in clinic if new symptoms, disease progresses or late effects (based on recall criteria)
- UHS established Cancer PIFU in 2012, active PIFU pts 7604 (Aug 2026). Overall 12k pts participated.
- 12 Cancer PIFU Pathways Live.
- Prostate PIFU (2014) – part of TrueNth project³.

Comprehensive Personalised Care Model

All age, whole population approach to Personalised Care

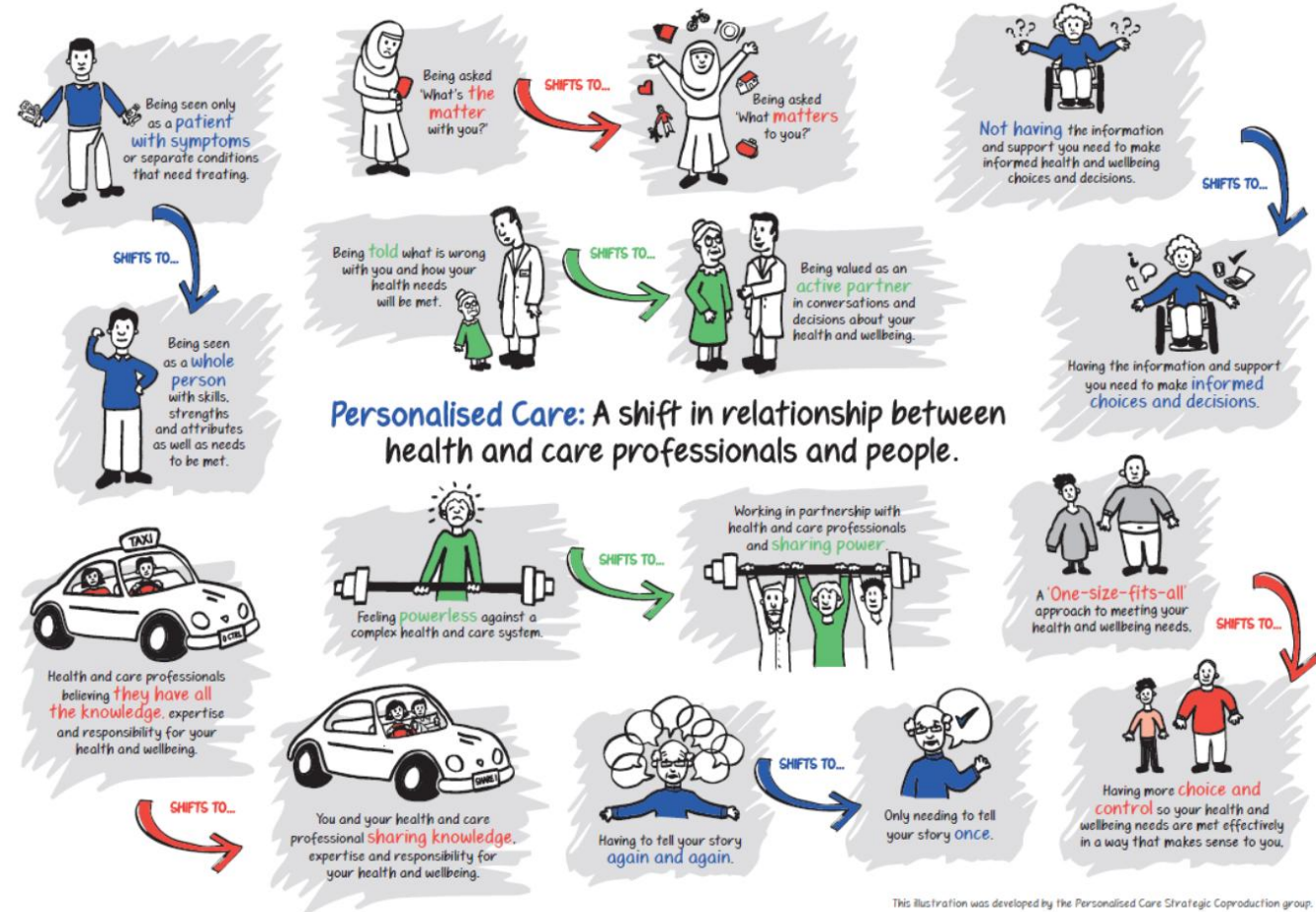
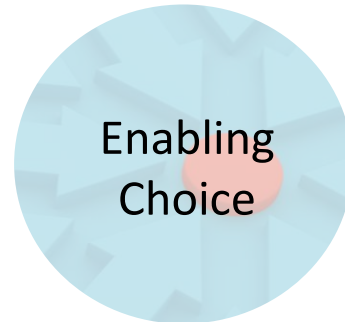
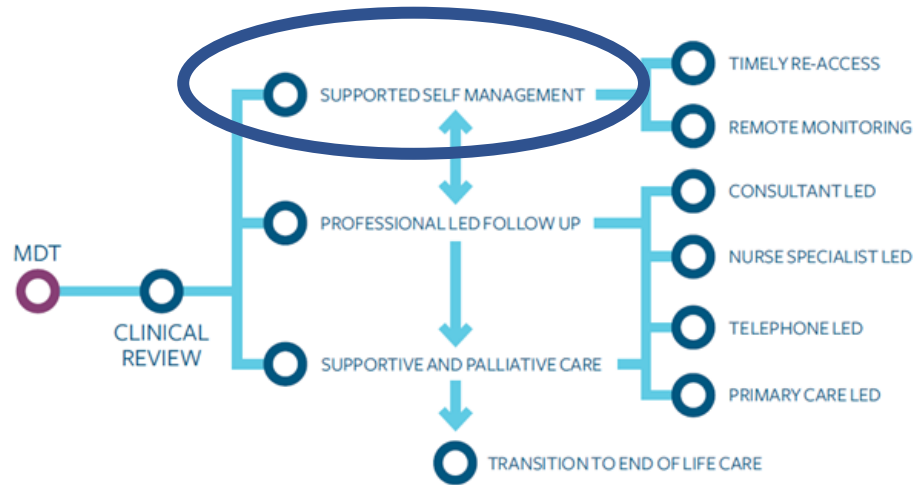


PROSTATE
CANCER UK



University of
Southampton

PIFU & Supported Self-Management



This illustration was developed by the Personalised Care Strategic Coproduction group.

How personalised stratified follow up in cancer (PSFU) aligns with patient initiated follow up (PIFU)

Personalised Stratified Follow Up (PSFU)

- Professional-led follow-up
- Ensures delivery of personalised care within a cancer follow-up pathway
- Allows for some patients to stay on 'traditional' follow up (with scheduled consultations with the cancer team) while other patients that are suitable can go onto a self-managed (PIFU) pathway.

Patient initiated follow-up (PIFU)

- Allows a patient or carer to book follow-up appointments as and when they need them, rather than at routine intervals. It is key to delivering a personalised outpatient model and meeting elective recovery ambitions.
- PIFU is one aspect of PSFU - essentially the 'supported self-managed pathway' within PSFU
- In PIFU, patients do not receive routine follow-up appointments but instead are empowered to call the oncology team directly.

All cancer patients, regardless of pathway type, will have timely access back into their cancer team, ongoing surveillance tests and scans (in line with NICE guidance), and will receive personalised care and appropriate health and wellbeing information and support throughout.

Timeline of Cancer PIFU Development

Pre-2019	2019	2020	2021	2022	2023	2024	2025	2026	In Development
Prostate	NET	Breast	Lymphoma	BMT	GI Late Effects	Lymphoid	Thyroid	Bladder	Neuro Oncology
Colorectal	Gynaecology	Prostate Surveillance	Advance Bowel	Haematology	Upper GI	Lung	Thyroid Routine	My Cancer Treatment	Complex Cancer
Germ Cell			Dermatology	Liver	Skin		Hepatology	Kidney	Advanced Prostate
Endometrial					Ovarian		Renal		Breast Cancer CDKI
							Colorectal Family History		Sarcoma
									Cutaneous SCC
									Glioma

Governance, Safety & Pathway Redesign

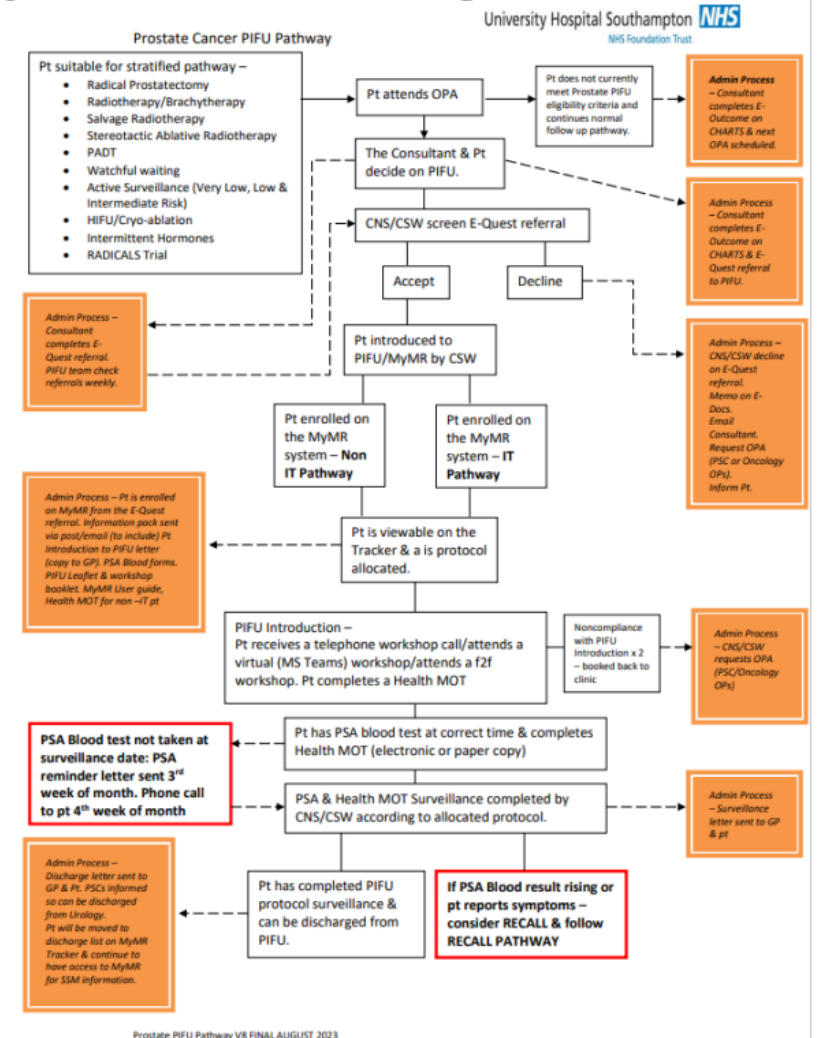
Standard Operating Policy⁵

Clear Process, Pathways and Protocols

STAFFING

Patients enrolled on a cancer PIFU pathway and registered on the My Medical Record Tracker are never lost to follow up. If a patient is recalled to clinic, they are transferred to the recall list on the clinical tracker.

Once further face to face review or treatment is completed, the patient returns to the PIFU pathway and is reinstated on the active clinical tracker list, so that ongoing surveillance continues seamlessly.



Protocols

Prostate Clinical Management Protocol
IT and Non IT patient inclusive

Protocol	Eligibility		Monitoring	Recall
Radical Prostatectomy LEVEL 2 PIFU	Decision by Clinical Team. Consider from 6 weeks post-surgery. PSA <0.05ug/L (or serial stable PSA <1.0ug/L diagnosed benign by Consultant) Completion of Health MOT with no ongoing functional or psychological problems requiring secondary care input identified.	Exclude patients with non-PSA producing tumours, patients who are unable to self-manage or are required to attend clinic to manage functional or psychological	<u>Protocol will commence from surgery date.</u> - Year 1 – PSA every 3 months - Year 2-5 – PSA every 6 months - Year 6- 10 – PSA annually	Post-Operative Biochemical Failure - Two consecutive rises in PSA and final PSA >0.1ug/L - OR - Three consecutive rises in PSA regardless of whether final PSA > than 0.1ug/L - New onset LUTS, visible haematuria, bone pain lasting >6 weeks. If meets the above PSA criteria refer to Clinical Oncology except - - if PSA >0.2ug/L, Urology Consultant to request PSMA PETCT and MDT then referral to Clinical Oncology - If symptomatic or concerns regarding fitness for salvage radiotherapy discuss with Urology Consultant Follow Recall Pathway
			Discharge Criteria Pts recruited from Jan 2020 onwards: At 5yrs if: - PSA <0.01ug/L At 10yrs if: - PSA undetectable - Any other PSA – d/w PIFU Consultant Pts recruited prior to Jan 2020 remain on 10 yrs PIFU	

Protocols

Breast Clinical Management Protocol

Breast PTFU – years 1-5 from diagnosis

Breast Surveillance – years 6-10

Protocol	Eligibility		Monitoring/Surveillance	Recall
Breast Conserving Surgery +/- Endocrine Therapy	Completion of - • Surgery • Chemotherapy • Radiotherapy • Anti Her2 Therapy	Exclude patients who are unable to self manage or are required to attend clinic to manage functional or psychological issues. Those patients participating in clinical trials.	<u>Aged Under 50</u> Years 1 – 5: • Annual surveillance imaging • Year 5 – Pts on Endocrine Therapy: Review original plan. If no plan discuss with Consultant. • Discharged from PTFU Years 6 – 10: • Annual surveillance imaging until 50 years of age or 2 yearly if ≥ 50 years of age. • Discharge from surveillance imaging at 10 years. <u>Aged 50+</u> Year 1 - 5: • Annual surveillance imaging • Year 5 – Pts on Endocrine therapy Review original plan. If no plan discuss with Consultant. • Discharged from PTFU Year 6 - 10: • 2 yearly surveillance imaging until year 10.	• Abnormal surveillance imaging result Appointment for further assessment/investigation sent to patient from the Breast Imaging Unit PTFU (years 1 – 5 post diagnosis) Direct access back to clinic via CNS or GP Persistent symptoms lasting more than 2 weeks warrant investigation: • New lump in or around the breast, mastectomy or WLE scar, axilla or neck • New swelling of the arm • Unexpected weight loss, or loss of appetite • Shortness of breath or persistent cough • Nausea or abdominal pain • Headache or visual disturbances • Loss of balance • Unexplained bone pain in one or more places Discharged back to care of GP 5 years post diagnosis & re-referral required if new symptoms develop



My medical record

Protocols

Bone Marrow Transplant Clinical Management Protocol

Protocol	Eligibility		Monitoring	Recall
Transplant protocol: All protocols used in Lymphoma [Diagnosis: Lymphoma including CLL]	Consultant decision to recruit onto PIFU Disease is in a Complete Remission (CR)/ PET scan negative Has attended PIFU information session Absence of Graft Vs Host Disease (GvHD) Not on active treatment e.g., Tyrosine Kinase Inhibitor/Donor Lymphocyte Infusion From Year 3 post-transplant	Exclude patients who are unable to self-manage or are required to attend clinic to manage functional or psychological issues	Year 1 & 2 – hospital based follow up If a patient has low CD4 counts, perform BMT immune reconstitution profile on each blood test Year 3 – BMT clinic bundle – FBC, UEC, LFT, Gamma GT, LDH, CRP, Retics, Bone Profile, Phosphate, Magnesium – Month 4, 8 & 12. BMT late effects annual screen bundle – Vit D, HBA1c, Cholesterol, Ferritin, Folate, Glucose, TFT, Vit B12, ESR, Immunoglobulins, Hormone Profile (LH, FSH, Testosterone/Estradiol) – Month 12 - Blood pressure – patient led @ month 12 - Weight – patient led @ month 12 Year 4 – BMT clinic bundle – Month 6 & 12 BMT late effects annual screen bundle – Month 12 - Blood pressure – patient led @ month 12 - Weight – patient led @ month 12 Year 5 – BMT clinic bundle – Month 12 BMT late effects annual screen bundle – Month 12 - Pneumococcal IgG, Tetanus IgG, and Haemophilus-b for vaccine response assessment - DEXA bone density scan - Pulmonary function test - Echocardiogram (if pre-transplant ECHO abnormal) - Blood pressure – patient led @ month 12 - Weight – patient led @ month 12 Year 6, Year 7, Year 8 & Year 9 – BMT clinic bundle – Month 12 BMT late effects annual screen bundle – Month 12 - Blood pressure – patient led @ month 12 - Weight – patient led @ month 12 Year 10 – BMT clinic bundle – Month 12 BMT late effects annual screen bundle – Month 12 - Pneumococcal IgG, Tetanus IgG, and Haemophilus-b for vaccine response assessment - DEXA bone density scan - Pulmonary function test - Blood pressure – patient led @ month 12 - Weight – patient led @ month 12	Trend changes/new abnormalities in blood results. Patient reports symptoms lasting more than 2 weeks: - Unexplained bleeding e.g., from mouth, urinary tract, back passage - Skin rash - More than 2 infections in 4 months - Persistent cough for more than 2 weeks - Jaundice- yellowing of the eyes/skin - Unexplained weight loss or loss of appetite - Pain or unexplained discomfort - Shortness of breath at rest or on exertion - Persistent worsening tiredness/fatigue - Enlarged lymph nodes - Night sweats OR A failure for the patient to perform blood tests on 2 separate occasions. [Arrange bloods in preparation for OPA/telephone review: BMT clinic bundle]

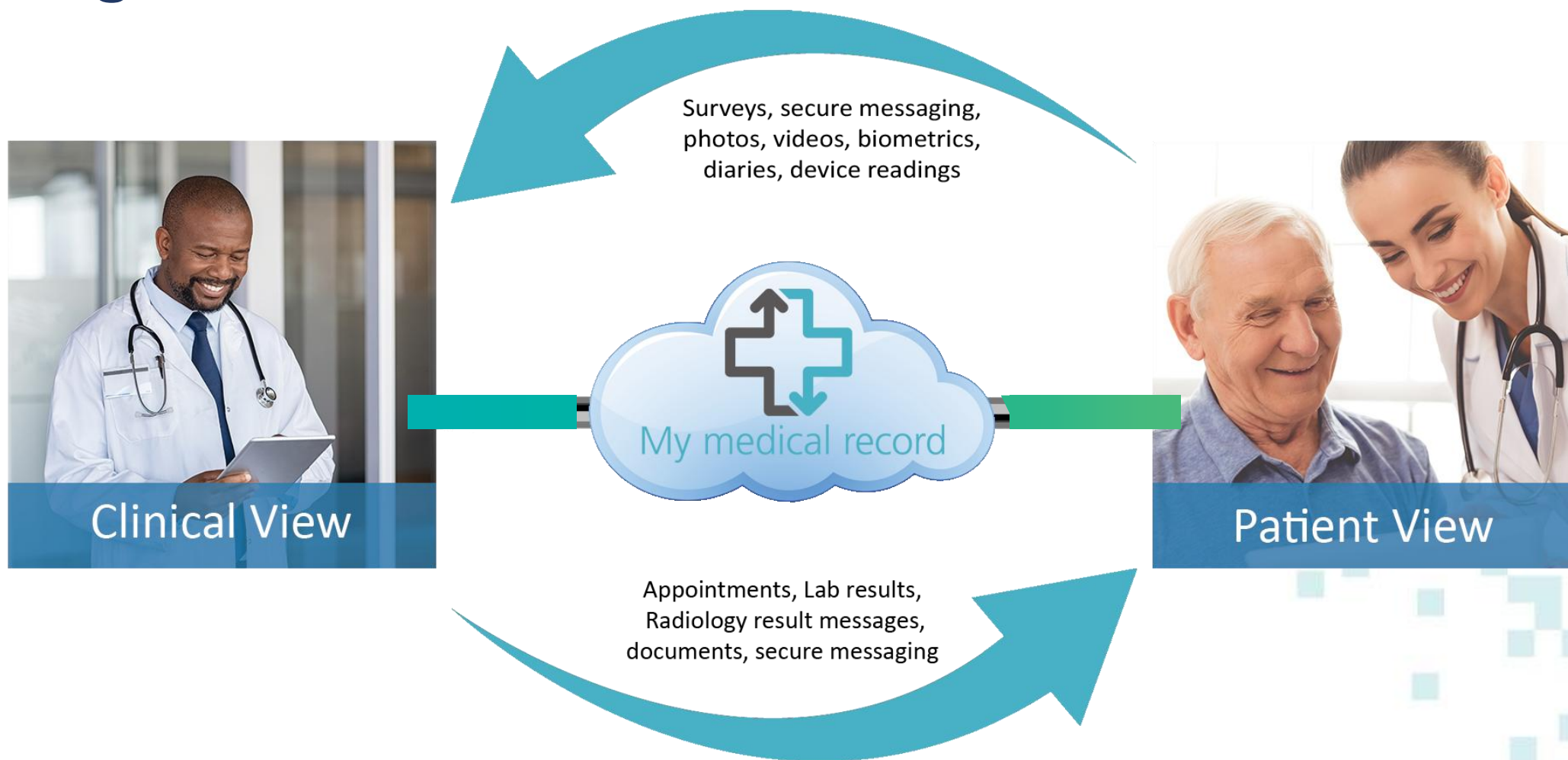
Protocols

Endometrial PIFU Clinical Management Protocol

Protocol	Eligibility		Monitoring	Recall
Endometrial Cancer [Clinical management – 5year] Low Risk & Intermediate Risk (Low Intermediate & High Intermediate) According to the current Risk group classification and treatment algorithm Level 2 PIFU <i>Discharge at 5 years</i>	Consider at 1st OPA post treatment intervention. Completion of treatment +/- adjuvant therapy. No ongoing functional or psychological problems requiring secondary care input identified on symptom checklist. Consultant decision to refer to PIFU	Exclude patients who are unable to self-manage or are required to attend clinic to manage functional or psychological issues	Reminder sent to pt to report any new symptoms: • Year 1 • Year 2 • Year 3 • Year 4 • Year 5	Patient reports symptoms of: • Vaginal bleeding • Persistent abdominal or pelvic pain or bloating • Unexplained weight loss or loss of appetite • Persistent changes in bowel habit • Persistent problems when passing urine Refer to Endometrial PIFU Recall Pathway

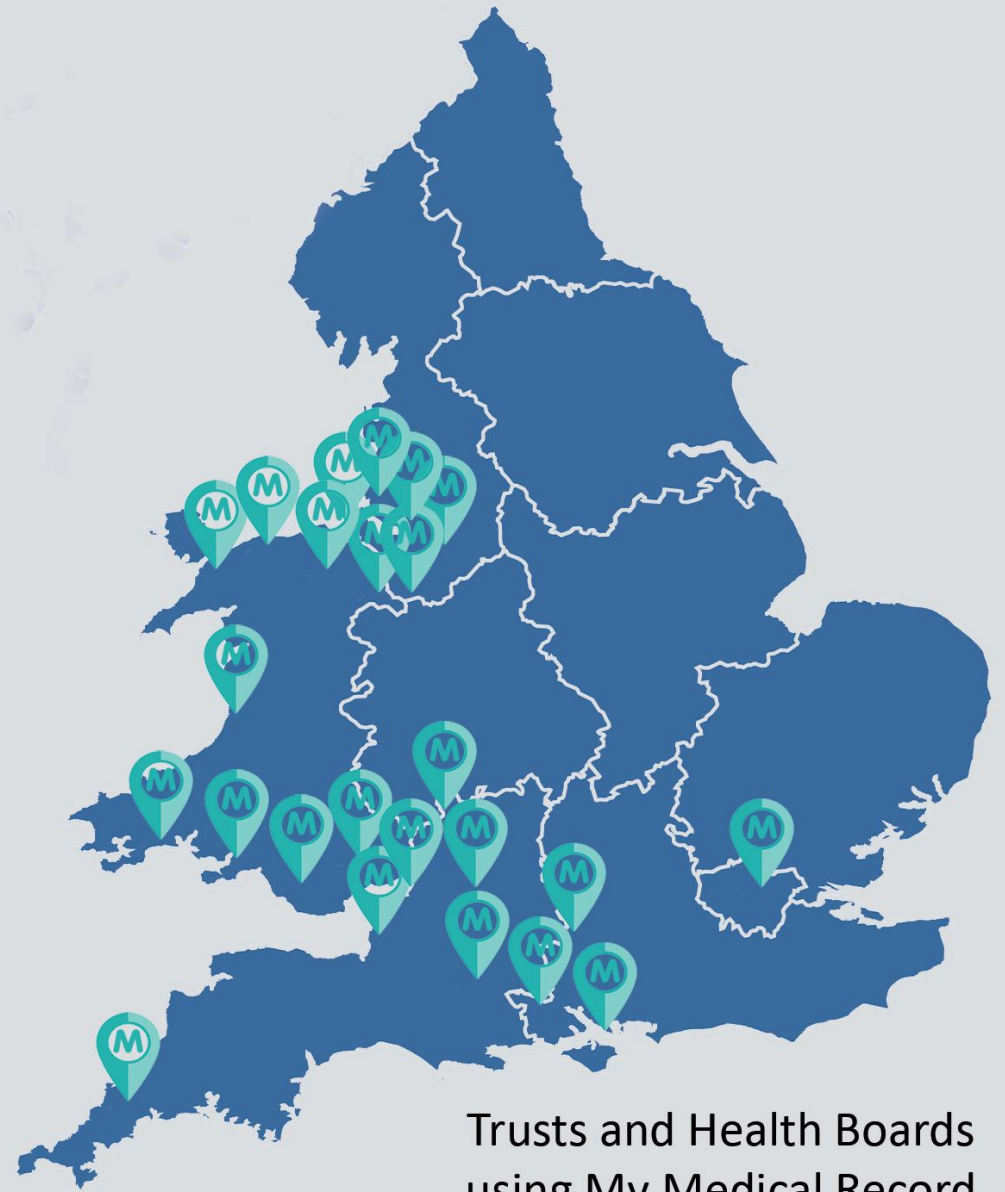


Developing A Digital Relationship With Patients To Manage Their Care



My Medical Record

- UHS started development in 2012
- Live in over 30 hospitals
- Utilised by over 70 different clinical specialties*
- Over 350k registered patients
- Over 1m documents
- Over 2 million laboratory results



Our Patients

Speciality	Patients Using My Medical Record
Prostate	42,617
Breast	20,134
Colorectal	12,915
Skin	5,623
Dermatology	4,016
Hepatology	3,663
Haematology	3,036
Upper GI	1,315
Germ Cell	740
Bladder	720
Gynaecology	644
Lymphoma	577

Speciality	Patients Using My Medical Record
Endometrial	548
Renal	393
Liver	373
Advanced Bowel	106
Thyroid	104
Other Systems	67

**95,035 patients rely on
My Medical Record in the UK**

**includes patients at UHS on these pathways*

My Medical Record - Patient Pages

Patient initiated
follow-up using
My Medical Record



Home

NHS
University Hospital Southampton
NHS Foundation Trust

- Home
- My condition
- My appointments
- My documents
- My lab results
- My record
- Shared decision making
- Adult services
- Children's services
- Help and settings

Your next appointment

No upcoming appointments

Our new site

Learn all about our new site and the changes we've made.

Ask 3 Questions

There may be choices to make about your healthcare. It's about shared decision making.

New data added to your record

The 'Entered On' date is when the item was added to your record – it is **not** the date of your appointment, blood test or when a letter was sent to you. For these dates visit the relevant page from the main menu. The 'Entered On' date for any updated items will be when we received the update, not when we first received the original item.

Entered On	Item	Results	Action
18/11/2021 04:13 pm	File	Headache days over the past three months.pdf	View and Download
15/11/2021 01:29 pm	Allergy	Xy	
15/11/2021 01:29 pm	Height	1.74 Meters	

My condition

Visit the 'My condition' section to access the content and features you have been registered to use.

Help and settings

Covid-19: latest updates

Find the latest coronavirus updates

Find out about our hospitals

Click here for more information about our hospitals.



My Medical Record – Messaging

 My medical record

Home

My condition

My appointments

My documents

My lab results

My record

Shared decision making

Adult services

Children's services

Help and settings

Colorectal

Messages

CEA results

My schedule

Messages

Inbox

Sent

12 new message(s)

From	Subject
Support Portsmouth Prostate - Portsmouth Prostate Team	test message
Support PIFU Knee surgery - Knee Surgery follow up team	Test message, please Ign
Support PIFU Hip surgery - Hip surgery follow up team	RE: Test
Molly Walton - Dermatology Team	RE: Testing - S
Philandra Costello - Genetics rare disease team	RE: Test, please let me k
Support UHS General - UHS General	RE: Test message
Support Parkinsons - Parkinsons team	clin

Send a new message

* Indicates a required field

* To:

* Subject:

* Message:

Attach file(s) from:

Computer/Device

My Medical Record

Cancel

Send

 My medical record

My Medical Record – Clinical Tracker

My medical record

Home

Messages

Clinical tracker

Covid-19 triage

Specialty tools

Preoperative assessment

Clinical tracker

Page size: 10 IT Users: All Patient Status: Active Consultant: All

Name	Birth Date	Hospital Number	NHS Number	Result Due	Reminder Sent	
ELLIOTT, YVONNE	23/07/1962	3578850				View
SMITH, JOAN	06/08/1944	7458965				View
Testptthirty, Vthreeit	22/02/13	v3TestITPatient5				View
Testptthirty, Vthreeit	11/11/2011	v3TestITPatient30				View
Bre003, Uhs	09/09/1988	uhsbre003		12/07/2017		View
MACNAMARA, LUCY	01/01/1970	520000001		09/04/2019		View
Bre004, Uhs	11/09/1981	uhsbre004		05/06/2019		View
Davies, Andrew	12/10/1981	123456c		12/05/2020		View
Bre007, Uhs	30/08/1917	uhsbre007		04/06/2020		View
Bre008, Uhs	31/08/1923	uhsbre008		23/07/2020		View

Page 1 of 3

Patients can be IT or Non -IT

My Medical Record Tracker - Staging

Add Staging

Date:

Ann Arbor Stage:

Please select...

Ann Arbor Sub-Stages:

Please select...

A - Asymptomatic

B - Symptoms present

E - Single, extranodal site contiguous/proximal to a known nodal site involved

S - Splenic involvement

X - Bulky nodal disease

Binet Stage:

Please select...

Rai Stage:

Please select...

Add

Clear

Staging History

Delete	Date	Ann Arbor	Binet	Rai	Source
☐	04/01/2023	I X	A	0	Manual
☐	04/01/2023	I	A	II	Manual

Page 1 of 1

PIFU My Medical Record Tracker - Protocol

Current Protocol: CLL & SLL started on 04/01/2023

Add Event

Choose Protocol

Protocol	Event	Date	Tasks	
CLL & SLL	6-monthly	04/07/2023	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	EditDelete
CLL & SLL	Annual	04/01/2024	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	EditDelete
CLL & SLL	Annual	06/01/2025	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	EditDelete
CLL & SLL	Annual	05/01/2026	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	EditDelete
CLL & SLL	Annual	04/01/2027	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	EditDelete
CLL & SLL	Annual	04/01/2028	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	EditDelete
CLL & SLL	Annual	04/01/2029	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	EditDelete
CLL & SLL	Annual	04/01/2030	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	EditDelete

PIFU My Medical Record Tracker - Surveillance

- Monthly surveillance using My Medical Record clinical tracker – CNS/CSW
- Each patient's results are checked against the protocol – bloods, CT, MRI, Colonoscopy etc
- Symptom questionnaire/HNA is checked for any new reported symptoms & action taken
- Surveillance notification sent to patient and G.P. electronically or by post

Actions & letters

Update type:

☐ Administration

☐ Surveillance

☐ Audit

Action: (Now active)

☐ None

☐ Notification

☐ Recall to clinic

☐ Suspend patient

☐ Discharge patient

☐ Reinstate as active

Document to generate:

☐ None

☐ Introduction

☐ Test Due

☐ Test Overdue

☐ Normal Result

☐ Recall to clinic

☐ Discharge from surveillance

☐ Surveillance Schedule

Cancel

Save

MyMR – Overall Cancer PIFU Benefits

Between April 2025 –
March 2026 there
were **13,402 virtual
surveillance reviews**

Between April 2025 –
March 2026 there
were **4,734 messages**
between Patients &
PIFU Teams

Virtual reviews saved
**3,496 hours of
Consultant time =
£188k saved**



**789 hours of Clinical
Nurse Specialist time**
was saved by using
messaging instead of
telephone calls

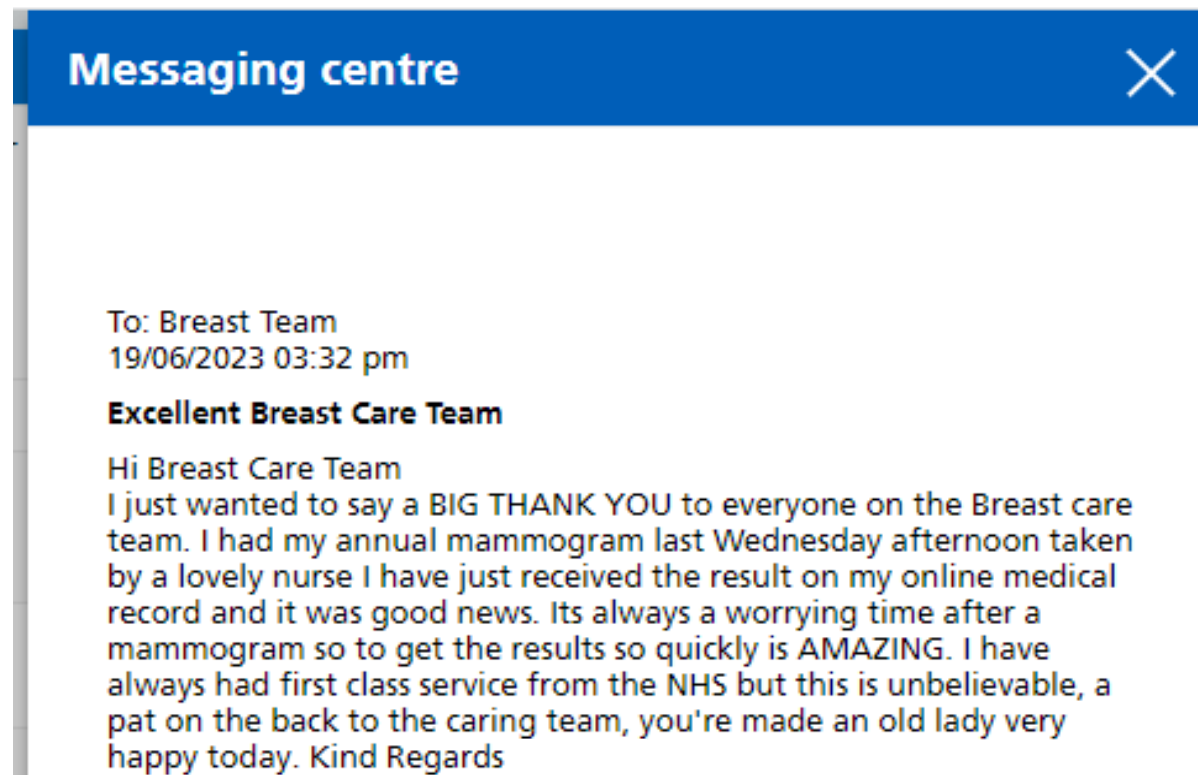
Virtual reviews saved
patients **230,000
miles in travel &
61,000 kilos of carbon**

Virtual reviews saved
patients **£54k in
travel expenses**

Benefits of PIFU

“There is a significant advantage in terms of being able to access both my schedule and results online. I’m safe in the knowledge that if I do have any concerns, I can immediately escalate them”

“Thank you so much for getting back to me so quickly, about 90 minutes by my reckoning. What a fantastic service!”



My Medical Record and cancer PIFU

For patients

Access schedules and results online.

Message the cancer team about concerns.

Continue supported self-management with a route back to clinical review.

For clinical teams

Track surveillance against each patient's protocol.

Review results and symptom questionnaires.

Manage recall and ongoing follow-up, including patients who do not use IT.

Business-case support for deployment

We have produced a paper that can support your business cases for funding that is being made available from the 14th October until the 1st December.

Cancer innovation funding: Open Call 4

Applications: 14 October to 1 December 2026, 1pm

Up to £3m

Real-world implementation and evaluation

100% funding for up to 24 months.

UK/EU lead with an English NHS partner and independent evaluator.

Deployment across multiple NHS sites.

Up to £5m

Innovation Spread Fund

Funding for the first 24 months of a project lasting up to 36 months.

ICB or Cancer Alliance lead.

Proven impact and ongoing ICB funding required.

PIFU Teams – CNS & CSW

**Nursing
Times
Awards
2022**
FINALIST



Thank you, any questions?

Email: claire.marsh@uhs.nhs.uk



My medical record



References

1. NHS Long Term Plan (2019) [NHS Long Term Plan](#)
2. NHS Improvement. Innovation to implementation: Stratified pathways of care for people living with or beyond cancer. A 'how to guide' (2013) <https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf>
3. Follow-up care after treatment for prostate cancer: evaluation of a supported self-management and remote surveillance programme, Frankland et al. BMC Cancer (2019) 19:368, [Follow-up care after treatment for prostate cancer: evaluation of a supported self-management and remote surveillance programme | BMC Cancer | Full Text \(biomedcentral.com\)](#)
4. Fit for the Future: 10 Year Health Plan for England (2025) [NHS England » Fit for the Future: 10 Year Health Plan for England](#)
5. <https://staffnet.uhs.nhs.uk/TrustDocsMedia/DocsForAllStaff/Clinical/Cancer-Patient-Initiated-Follow-Up-PIFU-Policy/Cancer-PIFU-Policy-1.1.pdf>
6. The National Cancer Plan for England: delivering world class cancer care (2026) [The National Cancer Plan for England: delivering world class cancer care \(accessible version\) - GOV.UK](#)

Case Study



MENARINI
— *group*



Case Study



Michal Sladowski

Advanced Pharmacist-Oncology
York and Scarborough Teaching Hospitals
NHS Foundation Trust



Presentation



Dr Jessica Curtis

Clinical Research Fellow for Cancer Trials
Southampton Clinical Trials Unit, University
of Southampton



The Cancer Vaccine Launch Pad (CVLP)

Accelerating Research into Cancer Vaccines and Immunotherapies

Dr Jessica Curtis



Challenges in Cancer Research

Challenges limiting reach, access and delivery



RECRUITMENT

Low uptake and high attrition



BIOLOGICAL SAMPLES

Difficulty accessing biological samples



PATIENT REACH

Limited reach and equity of access



FUTURE ROLLOUT

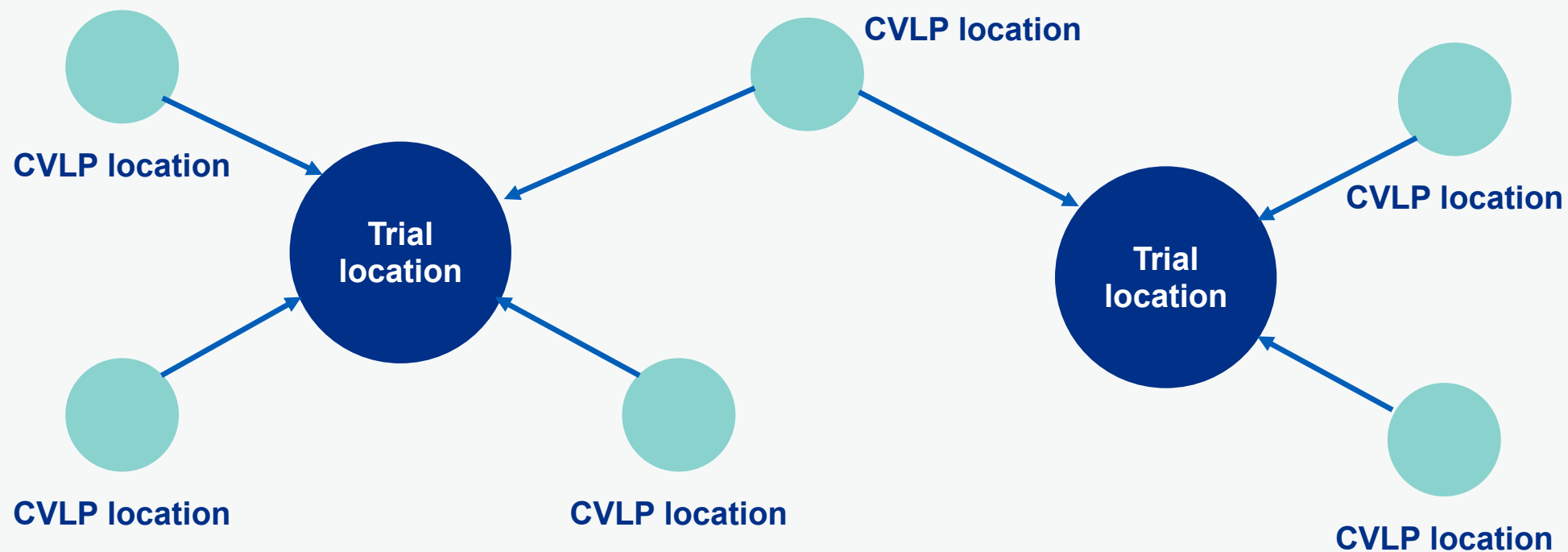
Integrated infrastructure to support national rollout

What is the CVLP?

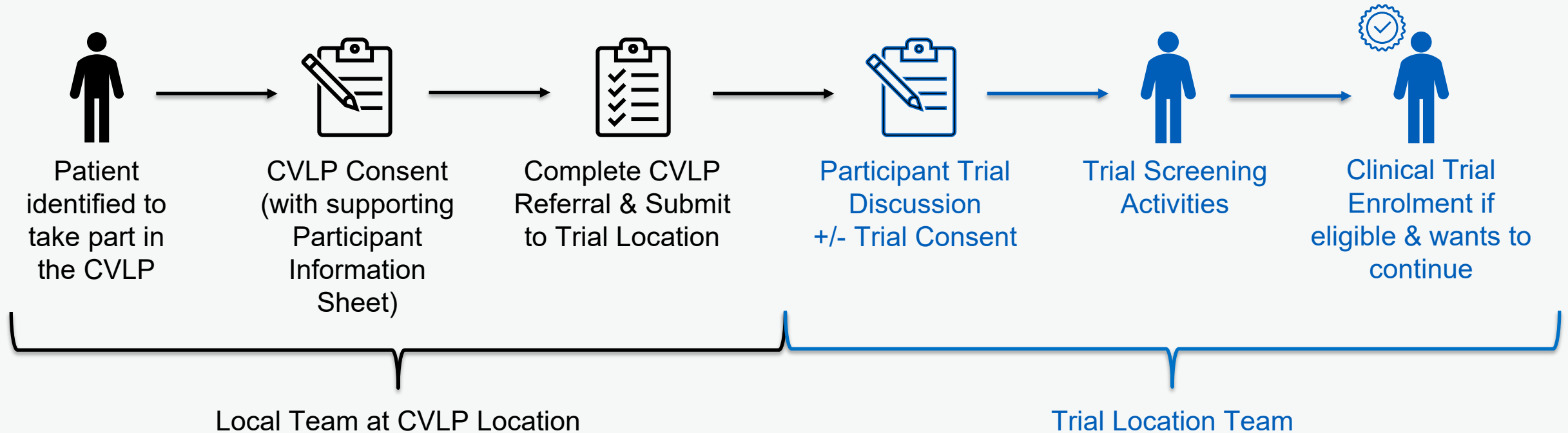


A national platform that supports patient referrals and access to their tissue samples to speed up recruitment to cancer vaccine and immunotherapy clinical trials

The CVLP Network



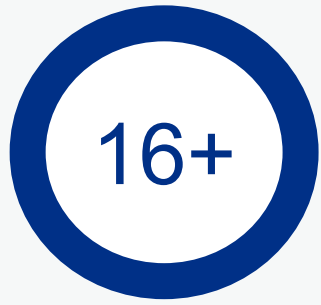
The CVLP Pathway



Cellular Pathology Genomic Centres (CPGCs) – Parallel sample processing

CVLP Eligibility Criteria

Eligibility is confirmed against four trial-specific checks



AGE

16 years and over



TUMOUR SAMPLE

Tissue or procedure
criteria



CONSENT

Participant agreement



GENOMIC ANALYSIS

Trial-specific biomarkers

Trial-Specific Referral Criteria – Developed by streamlining the trial protocol

Clinical Liaison Team



**Trial Management
Staff**

**Clinical Research
Fellows**

WHAT THE CLINICAL LIAISON TEAM DOES

01 **ENABLE TEAMS**

Train healthcare professionals on each trial and build team relationships

02 **COORDINATE REFERRALS**

Support referral completion and track participants through the pathway

03 **ONGOING SUPPORT**

Identify recruitment barriers and support participating locations

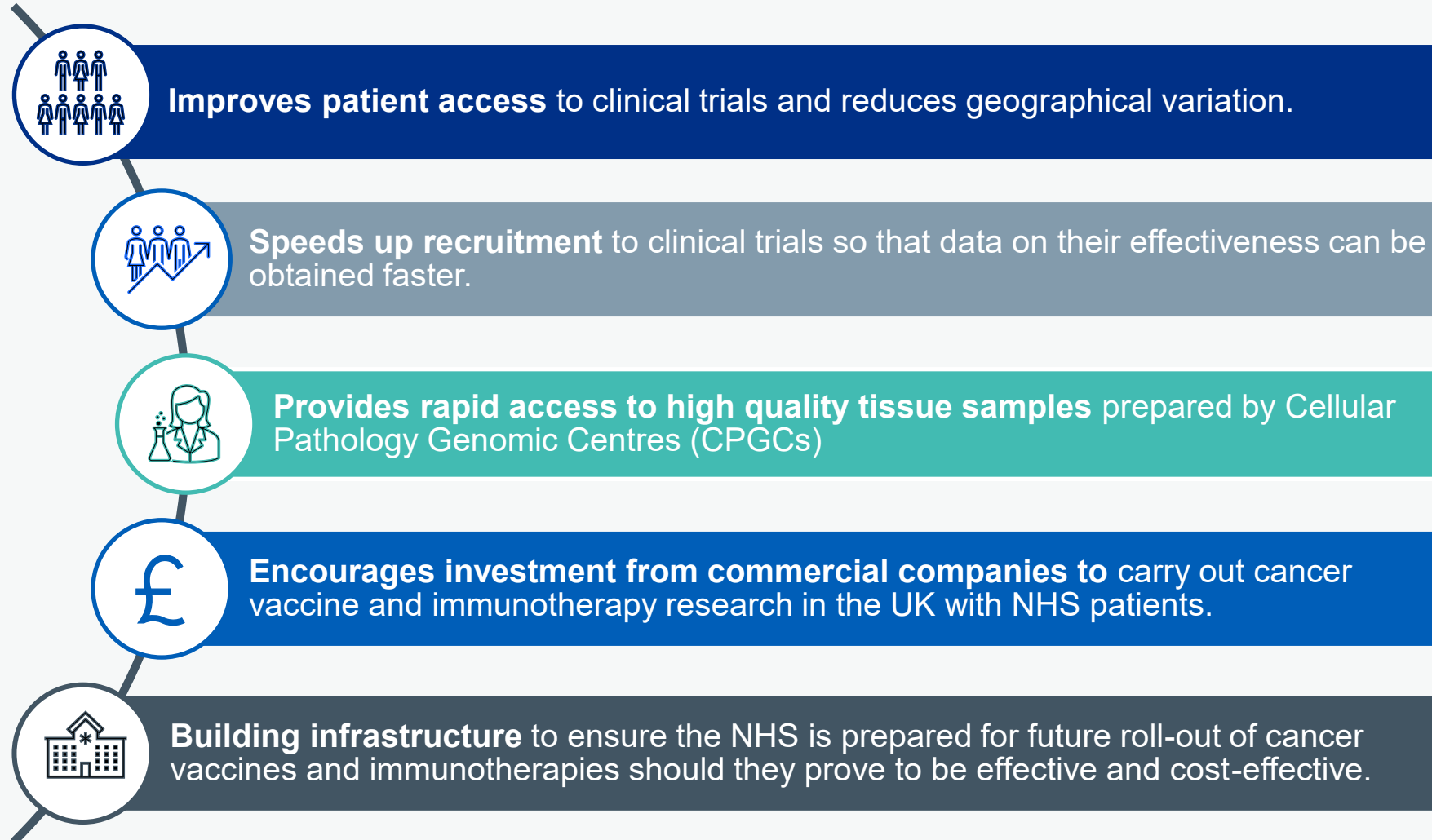


CVLP REFERRAL TOOL



ELECTRONIC CONSENT (ECONSENT)

Benefits of the CVLP



CVLP Involvement - Expectations

Clear responsibilities support a consistent hand-off from local screening to trial delivery.

CVLP locations

- Screen patients and complete screening logs
- Obtain CVLP consent for suitable patients
- Complete and submit the referral
- Send biological samples where required
- Continue standard care for screen failures
- Update the Referral Tool / Clinical Liaison team

Trial locations

- Receive and review referrals
- Hold trial discussion and obtain consent
- Complete screening, enrolment, treatment and related visits
- Notify the network of screen failures
- Update the Referral Tool / Clinical Liaison team

The CVLP Portfolio

CLOSED TO RECRUITMENT

BNT122-01

BioNTech

Colorectal cancer

PERSONALISED CANCER VACCINE

SCOPE

Scancell

Advanced melanoma

NON-PERSONALISED / “OFF THE SHELF” CANCER VACCINES

BNT113-01

BioNTech

Head & Neck SCC

NON-PERSONALISED / “OFF THE SHELF” CANCER VACCINES

OPEN TO RECRUITMENT

ROSETTA Lung-02

BioNTech

NSCLC

BISPECIFIC ANTIBODY

ROSETTA CRC-203

BMS

Colorectal cancer

BISPECIFIC ANTIBODY

ROSETTA Lung-201

BMS

NSCLC

BISPECIFIC ANTIBODY

CVLP Progress to date

NETWORK REACH

80

CVLP locations

26

Trial locations

16

CPGCs

ACTIVITY TO DATE

>3,270

patients screened

>500

patients referred

>400

tissue samples prepared

2.1 days

average turnaround time for
tissue sample preparation



CVLP network footprint across England

BNT122-01: Faster Screening, Broader Access



01

FAST ACTIVATION

50 sites

mobilised within travelling distance of trial sites

A streamlined pathway for adding additional trials.



02

SCREENING ACCELERATION

3×

the global average screening rate

The NHS screened as many patients monthly as the rest of the world combined.



03

RAPID TISSUE ACQUISITION

2.5 days

average tissue preparation turnaround

>350 high-quality samples were prepared rapidly for vaccine manufacturing.



04

DIVERSITY & REACH

16% → ≈60%

estimated patient coverage in England

Reach expanded among resected colorectal cancer patients, including underrepresented groups.

The CVLP has led to the rapid increase in clinical trial activity:

“with the help of 36 CVLP sites, in a short space of time we have scaled up to screen more than 50 patients per month (a number that keeps increasing). The NHS is now screening as many patients each month as the rest of the world combined, with UK sites screening at more than 3x the global average rate and around 2x the rate of the next best country (Spain). This is unheard of in the global commercial trials world”

- BioNTech representative, July 2024

BIONTECH



“CVLP enables us to readily access patient tissue specimens and increases inward referrals for trials. It’s the way forward for the NHS and for patients”

— Dr Danny Ulahannan, consultant medical oncologist at Leeds Teaching Hospital



What's Next?

- 01** Onboarding additional clinical trials in multiple cancer types
- 02** Continuing to collaborate with industry partners
- 03** Expand the CVLP Network, including new sites in Scotland & Wales



Further Information . . .



CVLP Website:

www.southampton.ac.uk/ctu/cancer-vaccine-launch-pad.page

Email:

cvlp@soton.ac.uk

Thank You



@nhsengland



company/nhsengland



england.nhs.uk



Case Study



NORTHWEST
BIOTHERAPEUTICS



Case Study



Dr Matnix. L Bosch
Chief Technical Officer
Northwest Biotherapeutics



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SCAN ME

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Scan the QR code to join the Community



Chair Afternoon Address



Chris Sleight MSc BSc FIBMS

Chief Executive Officer of Sleight Insights

Formerly Chief Officer of the Greater Manchester Diagnostic
Networks



NHS Deep Dive



Dr Majid Kazmi

Director of Research & Innovation for Cancer and Surgery
and Consultant Haematologist
Guy's & St Thomas' NHS Trust



Evaluation and adoption of digital technology to optimise MDT working in cancer care

Dr Majid Kazmi

Director of Research, Innovation, Commercial and Digital for Cancer and Surgery, and Consultant Haematologist, Guy's and St Thomas' NHS Foundation Trust



Why Cancer MDT working has to change

375,000

cancers diagnosed in the UK each year

500,000

projected each year by 2035

2 min

average discussion time per patient in our local prostate MDT — 15 patients in 30 minutes

Calman–Hine set up multidisciplinary teams in 1995 to standardise care and reduce unwarranted variation. Referral volumes have climbed steadily since; the resource around the meeting has not. Cancer Research UK reported in 2017 that there was too little time for complex cases, and NHS England issued streamlining guidance for cancer alliances in 2020.

What technology can do to solve the issue

GSTT uses a rules-based clinical decision support system — a spin-out from Oxford University, UCL and Cancer Research UK, regulated as a UK medical device and in use across several NHS cancer pathways.

Triage to standard of care or in MDT 2nd opinion

Patients who clearly meet a standard of care the MDT has agreed are listed, not discussed. Within MDT can act as a check/2nd opinion

Traceable recommendations

Every recommendation links to the passage of the guideline it came from, on screen, in the meeting.

Reads the record

Structured data pulled from the electronic record, with extraction from letters and reports.

Audit & CTM built in

Automated reporting of MDT decisions, and a teaching resource for trainees and nurses. Can identify patients for trials.

- Deterministic by design: the same inputs always produce the same recommendation, and the reasoning is open to inspection, which is what made it governable in a clinical setting.
Versatile Can use different guidelines- Local/ National/International.

How it works in the meeting



The meeting does not get shorter by discussing patients faster. It gets better by discussing fewer of them and being confident about which ones.



NIHR grant funding: the PROSAIC-DS study

What the award funded

- An executable standard of care for the prostate pathway, signed off by the MDT's clinical governance group
- A two-year retrospective/prospective evaluation across two trusts
- Integration with existing cancer systems, and a patient portal for shared decision-making
- Independent health economics analysis by KiTEC at King's College London

The partnership

- Guy's and St Thomas' - sponsor
- King's College Hospital
- Deontics-Prosaic-DS tool
- Somerset Cancer Register
- KiTEC, King's College London
- Prostate Cancer UK

Funded through the National Institute for Health and Care Research and the NHSX Artificial Intelligence in Health and Care Award. The study completed on 31 July 2023.

What the evaluation showed

33%

of prostate patients could be triaged away from the MDT, with over 96% agreement with the MDT decision

85.6%

concordance with MDT recommendations across 355 evaluable cases

97.8%

concordance in the subgroup identified for streamlined management

- **And what it did not show**

The study was inconclusive on whether the system improved MDT compliance with evidence-based practice, and it flagged real uncertainty about assimilation during the move to a new electronic record, with a clear call for user-centred design.

Breast cancer pathway evaluation

250 women discussed over the preceding 16 months were run through the platform in five cohorts of 50. Each cohort's blinded MDT outcome was compared with the standard of care recommendation, and the gaps that surfaced were used to refine the pathway before the next cohort.

Cohort	Patients	First pass	After refinement
Benign disease	100 (two cohorts)	82%	100%
Malignant disease	150 (three cohorts)	94%	100%

- On the initial, deliberately conservative standard of care, only **31% of benign** and **44% of malignant** patients would have needed formal discussion at the meeting.



Delivery at Guy's and St Thomas'

●	●	●	●	●	●
2021–22	Jun 2022	Jul 2023	Oct 2023	2024–25	Oct/Nov 2026
Standard of care for the prostate pathway developed and signed off by clinical governance	PROSAIC-DS opens at Guy's and King's under the NIHR and NHSX award	Two-year evaluation completes; 416 patients in the prospective phase	Trust-wide Epic go-live across Guy's and St Thomas' and King's	Prostate standard of care in routine use; breast standard of care developed and validated	Epic-integrated pathway goes live in prostate

Five years from first standard of care to routine use, and the evaluation was not the slow part. The pathway work and the EPR transition were.

Conventional MDTM List

Name/Hospital no/Gender/DoB	Pathway	Case summary
Benign Two BR196501 Female 01/01/1972	Benign biopsies & excisions	33 mm FA P3U3M2 B2
Post Op One BR7612301 Female 01/01/1970	Post-op cancers	T2N1 TNBC postNACT PCR WLE + TAD clear margins
Post Op Two BR1198034 Female 01/01/1967	Post-op cancers	LABC HER2 -ve ER +ve treated with Mx & ALND
PostOP WLE HRpos BR430128 Female 01/01/1960	Post-op cancers	22mm IDC ER+ve HER2 -ve WLE SLN pT2N0
Pre Op One BR100231 Female 01/01/1960	Pre-op cancers	T2 N1 TNBC G2 IDC
Pre Op WLE BR531208 Female 01/01/1960	Pre-op cancers	65 yr P4M5U5 18mm ER+ve HER2 -ve
Pre Op Tx Incomplete Data BR320125 Female 01/01/1987	Pre-op cancers	U5M3 ILC G2 HR+ve HER3-ve
Benign One BR122306 Female 01/01/1992	Benign biopsies & excisions	Post TA B3 AIDEP
Pre Op Two BR1212543 Female 01/01/1984	Pre-op cancers	Screen detected T1N0 Multiple synchronous cancers

Smart MDTM list with built in CDS Triage

Home / Patient list

Breast MDTM Pathway ⓘ

List loaded: 20/06/2025

Search / Sort ⓘ

ADD/EDIT PATIENTS

ALL	MDTM						
Name/Hospital no/Gender/DoB	Pathway	Case summary	Triage ↓	Recommendation	Next steps		
Benign Two BR196501 Female 01/01/1972	Benign biopsies & excisions	33 mm FA P3U3M2 B2	Not for MDTM discussion	Discharge, Excision	SoC	Override	📄
Post Op One BR7612301 Female 01/01/1970	Post-op cancers	T2N1 TNBC postNACT PCR WLE + TAD clear margins	Not for MDTM discussion	WBRT, Pembrolizumab, Genetics	SoC	Override	📄
Post Op Two BR1198034 Female 01/01/1967	Post-op cancers	LABC HER2 -ve ER +ve treated with Mx & ALND	Not for MDTM discussion	Chest wall RT, ET, Chemo, CDK4 inhibitors, Zometa, Regiona RT, Staging	SoC	Override	📄
PostOP WLE HRpos BR430128 Female 01/01/1960	Post-op cancers	22mm IDC ER+ve HER2 -ve WLE SLN pT2N0	Not for MDTM discussion	WBRT, ET, Zometa	SoC	Override	📄
Pre Op One BR100231 Female 01/01/1960	Pre-op cancers	T2 N1 TNBC G2 IDC	Not for MDTM discussion	NACT, Pembrolizumab, Staging	SoC	Override	📄
Pre Op WLE BR531208 Female 01/01/1960	Pre-op cancers	65 yr P4M5U5 18mm ER+ve HER2 -ve	Not for MDTM discussion	Surgery, SLNB	SoC	Override	📄
Pre Op Tx Incomplete Data BR320125 Female 01/01/1987	Pre-op cancers	U5M3 ILC G2 HR+ve HER3-ve	Incomplete data	Surgery, SLNB, OncotypeDx, Imaging, Fertility counseling, Genetics	Reschedule	Override	📄
Benign One BR122306 Female 01/01/1992	Benign biopsies & excisions	Post TA B3 AIDEP	For MDTM discussion	Discuss in MDTM, Excision	MDTM		📄
Pre Op Two BR1212543 Female 01/01/1984	Pre-op cancers	Screen detected T1N0 Multiple synchronous cancers	For MDTM discussion	Surgery, SLNB, Discuss in MDTM	MDTM		📄

Rows per page: 200
1-10 of 10

Column 4 classifies patients into three categories: "Not for MDTM discussion," "For MDTM discussion," and "Incomplete data," as determined by CDS Column 5 outlines the evidence-based management plan generated by CDS.

Medical calculators and pathway guidance

Home / Patient list / Assessment

Breast MDTM Triage Pathway

Ms Preop TNegative [RB1211860] - 01/01/1971 (54) Female

Icon Meanings

Pathway: Left - Preop

Clinical: [P5]

Imaging: [U5 R5]

Diagnosis: [Invasive cancer]

Treatment: []

Subtype: [TNBC]

Stage: [IIB (T2 N1 cM0)]

PREDICT output: NA

Medical calculators + Key parameters

Summary	Pathway	Patient	Preop (L)	Preop (R)	Post-op (L)	Post-op (R)
M1 or Rec (L)	M1 or Rec (R)	BBL (R)	BBL (L)			

M Stage: M0 or MX
Menopausal status: Post or post BSOH
Performance status (ECOG): 0

Gene carrier: No

Did patient receive neoadjuvant treatment?: No

Left breast

ER status: Negative
PR status: Negative

Clinical T Stage at diagnosis: cT2
Clinical N Stage at diagnosis: cN1

Disease extent (focality): Localised (Unifocal)
BI-RADS US: 5
BI-RADS mammogram: 5

Core biopsy score: B5b
Malignant core bx histology (including in situ): Ductal carcinoma NST (Infiltrating duct carcinoma IDC)
Invasive cancer grade: G2

Right breast

SoC triage outcome

☐ For discussion at MDTM. Keep on MDTM list under "For-discussion" category

SoC recommendations

☐ Neoadjuvant Chemotherapy (NACT) with appropriate coils and clips to mark primary and nodes.
☐ Genetics referral
☐ Staging with either PET/CT or CT & NMBS

SoC Prompts

Guideline recommendations - locoregional treatment

Guideline recommendations - systemic treatment

☐ Neoadjuvant treatment with four-drug ChT regimen of taxane carboplatin followed by AC or EC, all combined with Pembrolizumab. Other alternatives are neoadjuvant Atezolizumab or Durvalumab (with nab-paclitaxele anthracycline backbone)

Guideline prompts

☐ Pretreatment MRI before starting NACT
☐ Marking of primary site left
☐ Marking of positive ALN left

Clinical decision support in practice



Clinical decision support in practice



Epic integration: going live

Guy's and St Thomas' and King's went live with Epic on 5 October 2023 - the largest single Epic go-live anywhere in the world. The decision support tool was fully integrated with the EPR.

What went live

- Pathways in scope: **[prostate / breast]**
- Go-live date: **October 2026**
- How the data flows: **EPIC-CDS-EPIC (epic final record)**
- Where the team sees it: **Embedded in Epic.**

Where we are now

- **TBC** patients through the integrated pathway
- **Target 30%** listed rather than discussed
- **New KPI** minutes released per meeting, time saved on pathway.
- Next pathways: Lung and skin

Epic integration: what we learned

01

Design with the users, not for them

Our own evaluation showed the technology worked, and the interface was where adoption was won or lost. MDT engagement.

02

Plan for the EPR change, not around it

The biggest adoption risk we identified was assimilation during the move to a single record. Sequencing mattered more than the build. Prioritisation is the major challenge.

03

The standard of care is the hard part

Agreeing and codifying the pathway took longer than the integration, and it has to be owned by clinical governance, not the supplier.

04

[Tenacity and Focus.]

Multiple vested interests and stakeholders. From clinicians to IT departments and stakeholders. Academic publications help but on their own are not enough.

Three things we would tell another trust

01

How to evaluate a medical technology

Define the standard of care first and the product second, and design the evaluation so it is capable of telling you the technology does not work.

02

The pathway to adoption in the NHS

Budget, Clinical governance, information governance and the operational roadmap set the timeline as much as the evidence does. Plan for all four.

03

How to scale and deliver the benefits

Benefits land when the capacity you release is deliberately redesigned into the pathway, not simply measured and reported.

Start slow, gain confidence and then accelerate fast

Thank you — questions welcome

Dr Majid Kazmi · Guy's and St Thomas' NHS Foundation Trust

majid.kazmi@nhs.net

Further reading

Khattak et al., AI-driven streamlining of prostate cancer MDT recommendations in a tertiary NHS centre, BJU International, 2025 · PROSAIC-DS findings, NIHR Biomedical Research Centre at Guy's and St Thomas' ·

Development and evaluation of AI-based clinical decision support system for streamlining breast multi-disciplinary team meetings *Jeffery H1,2, *Sinha A1,2, Shifa B2, Bitsakou G2, Harries M2, Sawyer E1,2, Pinder S1,2, Ng W2, Sever, A2, Hasso S2, Javed M2, Devadas P2, Chougale QA2, Almajali N2, Attia M3, Malik M2, Thorat M2, Patkar V4, Purushotham A1,2 BMJ Health & Care Informatics 2026

Keynote Presentation



Siwan Owen
Lead Cancer Nurse
Shrewsbury and Telford NHS Trust



Providing equitable access to cancer services

Shropshire, Telford and Wrekin,
and North Powys

Siwan Owen

Lead Cancer Nurse
The Shrewsbury and Telford Hospital NHS Trust

What we want to change for patients

Fewer unnecessary journeys

More suitable care closer to home, with specialist support when needed.

Support while waiting

Help with barriers to attendance, and follow-up that responds to individual needs.

Clearer information

Patients understanding the next step in their care and who to contact for advice.

Joined-up care

Better continuity between hospital and community, including for people living in North Powys.

We will judge progress by patients' access to care and their experience of it.

Roadmap to equitable cancer access

01 Understanding barriers

Using EDS review, CPES, and individual patient feedback.

02 Supporting patients

Patient-initiated delay reviews, Waiting Well and the Cancer Ambassador programme.

03 Improving services

Care closer to home, North Powys links and timely specialist access.

04 Measuring progress

Compare access and experience across groups. Use findings to guide further improvement.

Care that people can reach and use

Support matched to individual needs

Our aim: fewer barriers to diagnosis, treatment and ongoing support.

3,705 urgent suspected cancer referrals to SaTH in August 2026.

274 patients informed they had cancer in August 2026.

Shropshire

Rural journeys and repeated visits can make hospital care harder to reach.

Telford and Wrekin

People need accessible information and support to attend and use services.

North Powys

Cross-border care needs clear handovers and access to local support.

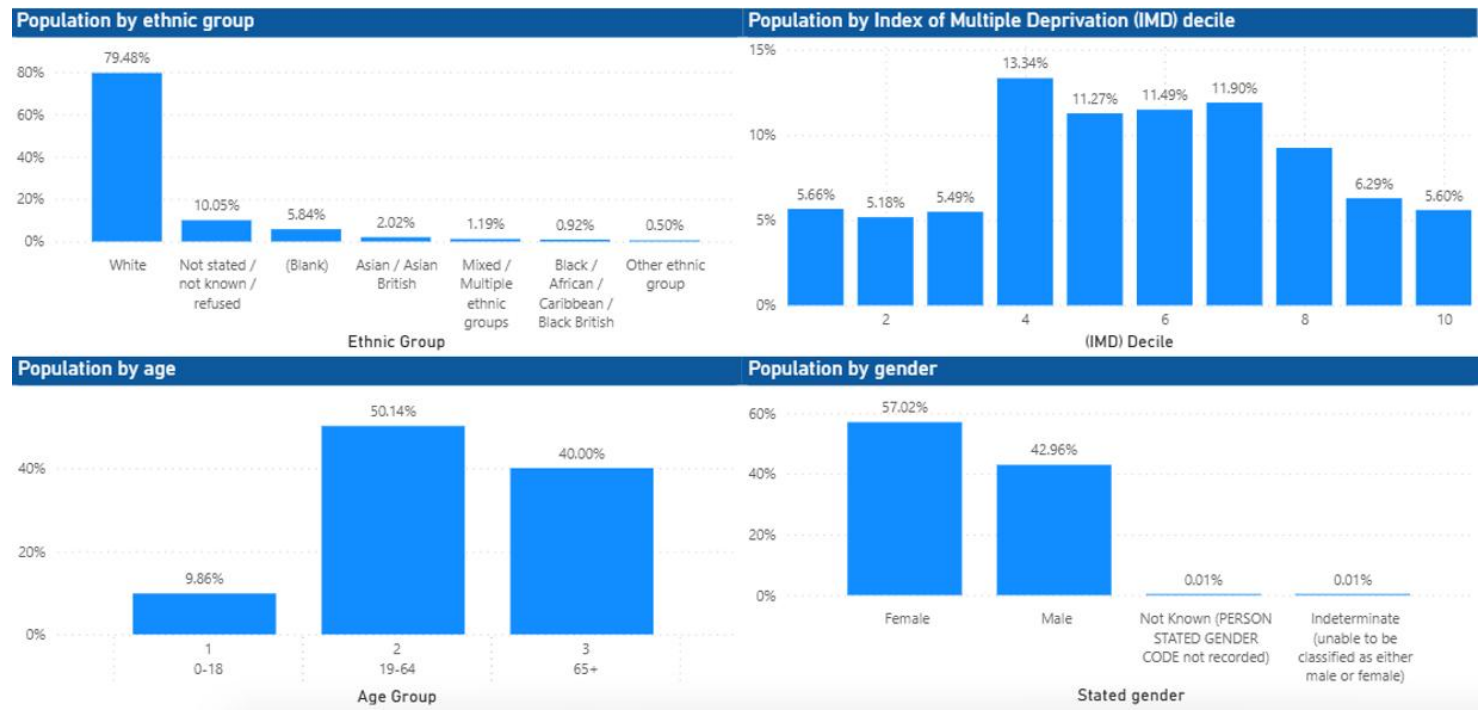
Who is reaching our cancer pathways?

Demographic pattern in EDS	What this means for equitable access
Most patients aged 65 and over	Care planning needs to consider mobility, transport and support from carers.
Predominantly White patients	Check whether people from other ethnic groups can access and navigate care.
More men than women	Understand differences in referral patterns and support needs.
Low referrals from deprived areas	Investigate possible barriers using population and cancer-need data.

EDS 62-day demographic summary. Pathway data, not a regional population profile.

EDS demographic graphs: ethnicity and deprivation

Demographic composition of cohorts waiting over and within 62 days



IMD decile 1 = most deprived. Decile 10 = least deprived.

Cohort composition (not the risk of delay within each demographic group.)

National Cancer Plan 2026: equitable access

England plan priorities	What this means for our approach
Earlier diagnosis and faster treatment	Timely pathways with clear referrals and reliable scheduling
More equitable access	Support matched to transport, language and individual needs
Personalised care and quality of life	Informed staff, support plans and continuity after treatment
More care in the community	Local care where clinically suitable, with specialist oversight

Published 4 February 2026. Applies to England. North Powys requires Welsh policy alignment.

EDS action plan: progress and next steps

Equity priority	Action-plan progress
Access close to home	Ongoing: work with Shropcom and Powys to widen access and monitor inequalities
Individual support needs	Actions: offer Holistic Needs Assessments, monitor needs and review the workforce
Safety while waiting	In place: Patient-Initiated Delay and Waiting Well SOPs, with a new patient tracking list (PTL) process
Patient experience	Steering group in place. Survey improvement and cancer experience action-plan work continue

May 2026 action plan: progress in care processes. Patient outcomes still need evaluation.

Patient-initiated delays and Waiting Well

Patient-initiated delays

Explore what is delaying attendance.
Identify transport, communication or other support needs.
Arrange clinical and supportive review.

Waiting Well

Maintain contact after diagnosis.
Offer a Holistic Needs Assessment and signpost to support.
Arrange clinical assessment if needed.

Equity means understanding unmet needs

Support informed choices and address barriers, with clinical oversight while people wait.

CPES: access includes information and support

8.8

Overall care rating
2025 survey

8.7 in the previous year

Selected themes in 1,269 non-blank comments

Selected free-text themes	Mentions
Speed, access and waiting	365
Communication and information	337
Parking, travel and facilities	142

Theme mentions can overlap. These are not percentages or counts of unique patients.

Patient feedback guides our access priorities

Themes in the SaTH report	How our work responds
Diagnosis and family communication	Ambassador communication training, clear next steps and carer information
Side effects and ongoing concerns	Clinical safety education, consistent advice and specialist contact routes
Emotional and practical support	Personalised Care and community partners that support needs beyond treatment
Research opportunities	Research teams develop routine discussions and clearer information

SaTH CPES 2025 findings, reported in 2026.

Cancer expertise beyond our specialist cancer workforce

A response to variation in care

Launched 13 May 2026 for acute and community colleagues

Foundations

Cancer care education and development aligned with ACCEND.

Clinical safety

Cancer treatments, acute oncology and recognition of emergencies.

Personalised care

Communication, support planning and what matters to each patient.

Aim: informed support wherever patients receive care. Six-month programme with online learning.

Sustaining cancer knowledge across settings

Delivery to date

Launch completed in May.
Online learning and support sessions underway.
Quick-start guidance supports access.

Evidence of benefit

Completion planned for November.
Compare learning before and after.
Review patient feedback and complaints.

Learning time supports consistent care

Ward pressures and complex learning platforms can limit staff participation.

Local treatment with safe specialist support

Evidence by September 2026	Safeguards before wider local delivery
Community nurses began working in the day centre	Competency sign-off and an agreed community care model
PICC care and pump disconnection scope confirmed	Approved protocols, escalation and information sharing
Ludlow site visit completed on 22 September	Site assurance, workforce and pharmacy arrangements

Aim: fewer journeys for suitable care. Wider delivery needs approval and evaluation.

Continuity across the England–Wales border

Specialist nursing team business case approved

Existing community support

SaTH teams connect patients with Powys community support and money advice.

Clinical pathway development

The proposed local bloods route depends on results reaching the SaTH team.

Who benefits, and who still faces barriers?

The equity question	Evidence we need
Who can use the service?	Eligible patients offered care, uptake and reasons for declining
Does care reduce the burden?	Travel time, additional visits and patient-reported experience
Is care safe and timely?	Treatment delays, missing results and unplanned hospital contacts
Who still faces barriers?	Uptake and experience by geography and individual support needs

Proposed measures. Activity and launch dates alone cannot show that inequalities have narrowed.

Our next priorities

Consistent support

Embed Waiting Well and supportive delay reviews.
Complete and evaluate the Cancer Ambassador programme.

Care closer to home

Prepare community oncology for wider delivery.
Plan implementation of the approved Powys nursing team.

Evidence of fairer access

Progress the EDS and CPES actions.
Use patient feedback and equity measures to guide change.

Next phase: delivery, with patients helping us judge the difference.

Skills Clinic



Dr Alona Sosinsky
Scientific Director for Cancer
Genomics England



Dr Angela George
Consultant Medical Oncologist and Consultant in
Oncogenetics, Medical Director of North Thames
Genomic Medicine Services
The Royal Marsden Hospital; The North Thames
Genomic Medicine Service



Ravi Chana
Executive Director, Diagnostics
ABHI

