Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance

Meeting of the Head and Neck Cancer Clinical Advisory Group (CAG, formerly SSG)

Tuesday 10th September 2019, 10:00-13:30, Chapter House Lecture Theatre, Bristol Dental Hospital, Bristol Royal Infirmary, BS1 2LY

Chair: Mr Ceri Hughes (CH)

	NOTES	ACTIONS
1. Welcome and apologies		
	Please see the separate list of attendees and apologies uploaded onto the South West Clinical Network website here.	
2. Review of last meeting's notes and actions		
	The notes from the meeting on Tuesday 2nd April 2019, page 3, paragraph 5, will be amended from 'genome dysphasia trial' to 'genome dysplasia trial'.	
	Set up of the RIG service has been delayed due to the need to agree an emergency care protocol. The Emergency Department (ED) team would prefer patients to have direct access to the Maxillofacial / ENT team rather than be admitted via ED; Consultant Radiologist Mandy Williams (MW) will arrange for a protocol to be drafted. It was noted that readmission numbers would be very small.	**MW**
	Following these changes, the notes were accepted.	
3. Clinical opinion on network issues		
3.1 Multi-Disciplinary Team Meeting Reforms and Survey Results		
Please see presentation uploaded to the SWCN website here.		
Presented by Ceri Hughes (CH) and Helen Dunderdale (HD)		
	An MDT Assessment Tool Training Event, held in the Summer and attended by CH, HD and numerous MDT members, trained attendees how to assess MDT effectiveness by looking at the information and contributions made during each patient discussion. HD has assessed 2 MDTMs to date and plans, along with Barry Main (BM), to assess the Head and Neck meeting in the near future after it has been filmed by Medical Illustration on 3 separate occasions. The films are a valuable training aide, and will be played back to the UH Bristol team. The RUH team would need to be filmed / assessed separately.	**HD/Medical Illustration**
	The MDTM Assessment Tool does not provide insight into how MDT members feel about the meetings, therefore a survey has been undertaken to complement the work: https://www.surveymonkey.co.uk/r/S9R5B7J; 11 responses had been returned to date. The survey will remain open for further feedback.	**All MDT Members**

Results:

- Q1: 45% thought the current meeting length was too short; 45% thought it was about right
- Q2: 90% thought meetings needed to be restructured
- Q3: 90% indicated that there is insufficient time to prepare for the meeting
- Q4: 5 responders thought the length of time reviewing and discussing radiology was too short; 4 thought it was about right
- Q5: 72% thought that the length of time reviewing and discussing pathology was about right
- Q6: 81% thought that the time spent discussing patient preferences to adequately contribute to care plans was too short.

Q7: *Are there any cases that could remain on the MDT list for information, but not discussed in the MDT meeting, as they would be appropriate to protocolise to a standardised treatment pathway?* This question had been discussed at the most recent meeting of the SWAG Cancer Clinical Leads. The Colorectal and other MDTs have started to triage certain patients according to clinical features. The key is having timetabled preparation time and to start with a simple, effective process that does not increase bureaucracy, allowing some time for this to become an embedded, audited routine before considering further changes. Suggestions for removals could be benign pathology (for straightforward cases), thyroid nodules, early stage tumours with standard treatment, for example lobectomy for T1a papillary thyroid cancer and mid-cycle complete response PET results. This could be organised by a maxillofacial radiologist and ENT representative. It would be difficult to further protocolise Head and Neck patients due to the complex nature of the disease. From a speech and language / Allied Health Professional perspective, the patient discussions are vital to identify the patients requiring support.

At the Head and Neck MDT meeting members discuss patients that have already been seen by a member of the team, making it easier to bring information on patients' preferences.

- Q8: 80% of attendees felt that their contribution to the MDT is valued
- Q9: 10 responders felt enabled to contribute concerns; 1 did not.

Feedback from trainees attending the MDT was positive and overall it was considered to be a highly functional meeting.

The position of Chair could be rotated to give MDT members insight into how to conduct the role. Consultant Oncologist Matt Beasley (MB) and Clinical Nurse Specialist Rob Buller (RB) volunteered to Chair. RB will Chair on the following Tuesday. **RB**

- Q10: What would help improve your personal contribution to the MDT meeting? Feedback overall was to improve preparation time and restructure the day.

To address restructuring, changes would need to be made to job plans. The SWAG

Cancer Alliance supports such changes and a letter to this effect has been sent to the Medical Directors in each Trust from Consultant Oncologist Stephen Falk on behalf of the Cancer Clinical Leads. The MDT member allocated to filter the MDT list will quantify how much preparation time is required to facilitate job plan changes. **MDT list triage team**

The feasibility of bringing patients back for a second pre-operative appointment was raised, as there was so much information to absorb from the combined clinics. Changing the structure from patients meeting the whole team on the same day may result in missed attendance with some specialty members. It was particularly important to ensure that patients have dental screening on the same day, as rates seem to have fallen recently; Consultant Restorative Dentist Lisa McNally (LM) will re-audit dental screening rates in the near future. **LM**

The main problem was felt to be the timing of the whole day. Starting the clinic at 15:00 impacted on the patient experience, particularly as the Dental Hospital officially shuts at 17:00, often leaving patients waiting in an inappropriate environment.

It was unanimously decided to move the MDT meeting to Tuesday morning at 08:30, and run the clinic from 10:30 to 12:30. **AGREED**

- Room availability will be investigated **MW**
- Consultant Oncologist Hoda Booz will be contacted to see if it is possible to rearrange the Tuesday morning theatre list **MB**
- A six week run-in will be planned prior to implementing the change
- The change will be evaluated by using the MDT-Mode Assessment Tool before and after and repeating the MDT survey. **HD**

4. Coordination of patient care pathways

4.1 Cancer Alliance Funding: Rapid Diagnostic Clinic

Please see the presentation uploaded on to the SWCN website here.

Presented by Mandy Williams (MW) with input from Hannah Marder (HM)

The National Cancer Board has provided the Cancer Alliance with funding to improve compliance with the 28 day faster diagnostic target. It has been decided to allocate £25,000 to the Head and Neck service, and a rapid diagnostic neck lump clinic has been proposed as a pilot to streamline the patient pathway. Metrics to measure effectiveness of the pilot service need to be agreed. Details of the current service and proposed changes are documented within the presentation.

The new service will ensure that referrals from ENT/MaxFac get a biopsy in the same week, reduce the number of hospital visits by ensuring that ultrasound, biopsy and pathology reviews can be done immediately, resulting in a preliminary cytology report on the same day/within 24 hours, aiding staging scans and reducing the time to diagnosis.

There will be 18 slots available in the Bristol Dental Hospital, manned by 2 radiologists and 1 pathologist. Requests can be sent by ICE (not via Medway), and

booked by calling the dental hospital receptionist.

A suitable second room, hardware and software, dental nurse cover and a patient information sheet are being acquired. A laptop is being reconditioned, and will be checked to see if the quality is sufficient. If not, funding will be used to hire equipment (£1000 per month).

The aim is to start the clinic on the 30th September 2019. The team will not be breaking bad news to patients. All patients will be referred for a clinic appointment to discuss results.

Funding could be used to provide technical support to Consultant Pathologist Miranda Pring.

Although the service does not meet the service specification for a one-stop clinic recommended by Quality Surveillance, it is thought to provide a better model that the Trust supports.

5. Quality indicators, audits and data collection

5.1 Head and Neck Data Review

Please see the presentation uploaded to the SWCN website here.

Presented by Hannah Marder (HM) and Steve Thomas (ST)

No communications or outputs have been received from the Head and Neck (HANA) audit, and the BAHNO council has now withdrawn funding; CAG has not had the opportunity to review MDT data for some time now, and therefore a dataset for audit/research purposes was decided and extracted from local systems to see what is currently available, initially from UH Bristol systems. A separate data extraction would be required from RUH Bath; data on RUH patients referred to UH Bristol may have been collected in RUH, but will not be available via the UH Bristol access to the Somerset Cancer Register.

Details of the data extract for the period 1st June 2018 to 31st May 2019 are within the presentation. It had not been possible to automatically extract into suitable tables, and had been manually sorted by Cancer Manager Hannah Marder.

Data completeness was driven by reporting the mandatory dataset for Cancer Waiting Times, which did not include certain procedures, for example, 'debulking of tumour' was excluded. It did however show a range of different treatments, including if more than 1 surgical intervention had occurred.

Data on 30 day mortality showed all cases as either expected, (confirming best supportive care as the correct treatment plan) or unrelated to the cancer diagnoses.

Table 5 shows all UH Bristol CNS contacts with patients recorded on Medway. A patient with a particularly high number of contacts had been verified as someone with specific needs requiring additional contacts.

Table 6 showed gaps in TNM staging data, and some of the other data fields requested such as comorbidities and performance status, which were particularly important to know about due to the influence of these factors on patient outcomes. These were not routinely collected due to lack of time, although it would be possible for the data to be entered into specific data entry boxes on the SCR; it is not possible to run reports from free text fields.

The Cancer Manager in RUH could be asked to nominate someone to undertake a similar analysis for the team to present at a future meeting.

The next step will be to select one or two audit questions and collect data over the next 6 months to present at a future meeting. **To be allocated**

It was noted that much of this data is already collected and stored electronically during pre-operative and pre-chemo assessments. Outcome data would also be included in the Enhanced Recovery post-operative dataset, which will store death records for up to one year or beyond.

There is no plan to replace the Somerset Cancer Register; it is hoped that there will be more time to complete and ratify data collection within the MDT meeting if it is streamlined. A Consultant sits with the Haematology MDT Coordinator for this purpose.

Data on eligible patients for the PATHOS audit identified a significant number of patients that may have been eligible, but were not recruited. The reasons for this will be investigated, and actions to improve future recruitment will be identified. Algorithms detailing eligibility criteria could be produced to support clinical decision making.

6. Research

6.1 Clinical Trials Update

Please see the presentation uploaded on to the SWCN website

Presented by Steve Thomas (ST) and David Rea (DR)

The National Institute for Health Research (NIHR) has revised the high level objectives from 2019/20 to allow increased focus on smaller recruiting trials. The 30 day and 40 day set up targets have been replaced with a new median study set-up time. The former 30 objectives have now been replaced with 5 harmonised objectives.

New Chief and Principal Investigators will be sought for areas of research that are currently under-represented.

Two West of England Clinical Research Specialty Leads have been appointed: Consultant Oncologist Helen Winters and Consultant Gynae-Oncologist Claire Newton.

Recruitment figures (sourced from EDGE), open trials and trials in set up are documented within the presentation. CAG members are invited to contact the

research team for further information on trials that they might wish to open.

The recruitment per 100,000 population for Head and Neck Cancer was slightly below target in 2018/19. The recruitment of expected numbers within the estimated time frame will need to be improved in the coming year, and the importance of promoting trials, especially those that are open long term, at MDT and CAG meetings was highlighted.

A spectrum of new trials is required to continue to expand the SWAG Head and Neck research portfolio. Grants from the EU's programme for science and innovation - Horizon 2020 - are in question due to the current political situation, but it is hoped that a grant for survivorship related trials will be made available. Given the strength of the research team and capacity to link data from previous trials, hundreds of SWAG patients could be recruited.

Further research activity will be generated from the PATHOS follow up study, which will compare conventional follow up with a reduced follow up schedule for low-risk patients confirmed as disease free following a PET scan.

It would be a good idea to participate in HEADSpAcE, another multicentre project funded by Horizon 2020. The aim is to investigate the determinants of late stage presentation of head and neck cancer, and assess the impact on prognosis and survival in Europe and South America.

The up to date spreadsheet of research trials will be circulated. **HD**

7. Patient experience

7.1 Clinical Nurse Specialist Update

Presented by the CNS Team

The Bristol CNS team are in the process of working through the recently published National Cancer Patient Experience Survey (2018) results to identify priorities and actions. The RUH survey had not had any responses. This may improve next year as the survey is now going to be sent to outpatients; the survey will be managed by a different organisation.

The UH Bristol survey had 36 responses with really positive results, being among the top 2 or 3 teams in the Trust. All responses are above 90% positive, with a few of the questions on ward support and information getting 100% positive feedback. A low score across the board is recorded for being asked about research.

The team in Blackpool Teaching Hospital have undertaken a patient experience project that is due to be presented at a national conference and can be shared at a future CAG.

The Thyroid Cancer Service is running successful now that sufficient resources are I place. A project looking at long term follow up of patients with low risk thyroid cancer with thyroglobulin surveillance is underway.

7.2 User representative input

User representative Ralph Openshaw was asked for his opinion on today's meeting; the lack of robust data was noted to be an ongoing concern. This was an issue that the team as a whole needed to take ownership to ensure improvements can be made.

It would be useful for the MDT survey results to include the role of participating MDT members. This will be included in future surveys. **HD**

8. Living With and Beyond Cancer

8.1 End of Treatment Summary Templates

Presented by Ruth Hendy (RH)

Comments from the team have now been incorporated in the 5 draft End of Treatment Summary Templates, which are now available to the medical secretaries. These will replace the end of treatment clinic letters, and will be resent for final ratification within 1 week of the meeting. The templates are routinely completed for all patients by CNS Melanie Speakman. Consultants will continue to complete palliative and day case patient summaries. **HD**

9. Any Other Business

The next CAG meeting will include more information specific to the RUH Bath service and topics where learning can be shared. **HD**

A guest speaker from the Psychology Department will be invited to provide a presentation at the next meeting. **HD**

Recruitment of additional Head and Neck pathologists remains an ongoing issue.

NICE guidelines on surveillance scans during treatment will be reviewed at a future meeting; patients generally find the number of MRI scans required quite a burden.

Living With and Beyond Cancer activity, including completion of Holistic Needs Assessments, provision of Health & Wellbeing events earlier on in the pathway, and a new event for patients with a poor prognosis, is going well. Cancer Support Workers are supporting the CNS teams to provide this, and Lead Cancer Nurses are exploring how the role might evolve. Discussion is underway with the Clinical Commissioning Groups to agree a sustainable way to continue providing the service, which also includes additional access for patients with cancer to physiotherapy and dietetic services; many of the posts are fixed term until the end of the financial year.

Head and Neck dieticians are now recording all dietetic input on Medway in the clinical notes section.

Date of next meeting: Tuesday 10th March 2020. Conference Room, Trust Head Quarters.

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