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

Meeting of the Head and Neck Cancer Clinical Advisory Group (CAG, formerly SSG)
Tuesday 10th March 2020, 13:00-17:00, 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 on to the South West Clinical Network website here.

2. Review of last meeting's notes and actions

As there were no amendments or comments following distribution of the notes from the meeting on Tuesday 10th September 2019, the notes were accepted.

3. Clinical opinion on network issues

3.1 Multi-Disciplinary Team Mode Assessment Results

Please see the presentation uploaded on to the SWCN website

Presented by Helen Dunderdale (HD)

As agreed in the previous meeting, the time and format of the MDT meeting and clinic has been changed; this has been found to benefit both staff and patients.

The MDT meeting was filmed prior to the change so that a baseline assessment, using the validated tool MDT-Mode to measure the quality of decision making, could be undertaken. This will enable the team to collectively identify and agree points for improvements, and how these should be actioned.

Highlights from the presentation:

Purpose:

To support the need to streamline and improve the efficiency of MDT meetings due to the increase in workload since their formation.

Background:

2014: CAG (formerly SSG) Support Service commences and MDT reforms are added to the Template Agenda and Work Programmes of all CAGs.
2015: Initial meetings identified long standing cross-cutting issues with MDT capacity and information, with Peer Review measures restricting the potential for change.
2016: Cancer Research UK MDT effectiveness review takes place with contributions from SWAG members and MDTs.
2017: CRUK Effectiveness Report is reviewed by all 12 CAGs and potential service improvements are identified. The National Cancer Board appoints a Clinical Lead

for MDT reforms (the late Professor Gore) who is contacted by SWAG to express interest in related projects.
2018: Inaugural meeting of the SWAG Cancer Clinical Leads for the purpose of sharing MDT reforms; methods for Assessment of MDT meetings introduced by Behavioural Scientist Researcher Dr Tayana Soukup, King's College London, Centre for Implementation Science
2019: Training on MDT-Mode Assessments provided for 30 MDT Members across the region; assessments commence. This involves scoring the quality of information, the contribution from MDT members, and decision making for each patient discussion.

Results:

A total of 104 cases were discussed across the 3 meetings with 35, 35 and 34 discussed within each meeting respectively.

The average discussion time per patient was approximately 2.10 minutes with a minimum of 20 seconds, and a maximum of 8 minutes per patient.

A total of 14 cases were deferred for discussion at a future meeting.

Details on the types of decisions made, type and quality of information covered, and contribution to case discussion per disciplinary group are within the presentation.

Discussion:

Could some of the benign cases be removed from the list if additional planning time is scheduled (10.6% of cases)?

Additional planning time to hold a pre-MDT meeting and potentially streamline the list is currently not permitted. A formal way to undertake this would need to be added to Job Plans, as it would result in extra work for the individuals involved. This could, for example, involve Consultant Radiologist Mandy Williams (MW) and MDT Chair Ceri Hughes (CH) meeting prior to the MDT to work through the list. Adapting Job Plans for this purpose has been strongly recommended by the Cancer Clinical Leads group and the Cancer Alliance Board to the Medical Directors in each Trust.

MDTM intervention: MDTM Planning time

It was noted that borderline or complex benign cases do benefit from a wider MDT discussion.

Some MDTs remove surveillance scans prior to the meeting if no change has been reported – would this be possible / appropriate if additional planning time was scheduled?

As above regarding planning time, although not all scans will be available to view prior to the meeting, as a percentage are often reported the day before.

Could attendance be reduced by reordering the case discussions to have a specific slot for oncology discussions (64% of cases were not applicable to oncology)?

As above regarding planning time.

Could pathology provide a cut-off date for listing cases to report results from surgical samples (6.7% of cases were deferred due to pathology)?

The turnaround time from the panendoscopy session on Wednesday works well. The key thing to note is that biopsies sent on Thursday afternoon will not be received at the lab until Friday and then won't be cut until Monday; pathology email requests for the Tuesday MDT should ideally be sent before Thursday lunchtime, should indicate on the request form if turnaround time is urgent or not, and include the date of the MDT. The system is generally very efficient.

MDTM intervention: Panendoscopy team

Is it necessary to view pathology slides in the meeting, or would it save pathologist planning time if they didn't have to pull the slides?

Viewing the pathology slides is felt to be of great value to the MDT. This is usually a selection that are of particular interest to share, rather than every case. Long term, it is expected that pathology attendance will go digital.

With the new time, it is helpful that the RUH team are now able to be present for the whole MDT via video link. There are, however, ongoing problems with connectivity, with a need for better microphones and less background interference.

Examples of practice to share with other MDTs have been identified and are detailed in the presentation.

MDTM intervention: Microphones

Extracts from the MDT video were viewed.

The lecture theatre style layout of the room is a barrier to communication and a round table solution is required, with pathology and radiology remaining at the plinths.

MDTM intervention: Room layout

There is significant noise pollution from the room next door; a sound proofing solution is required.

Chairmanship could be rotated on a three monthly basis.

MDTM intervention: Sound proofing

A member of the team could sit with MDT Coordinator Zoe Robinson to ratify the MDT outcome and help challenge / double check the action plan if this is not made clear.

Taking telephone calls within the meeting should be limited if at all possible, and the Trust should support team members to be unobtainable for that hour.

MDTM intervention: Information output

The information given to the MDT Coordinator prior to compiling the list is often incomplete, and currently requires the MDT Coordinator to gather information from different sources that is catered to the MDT question, which can be very time consuming. This could be addressed if completion of the MDT proforma is made mandatory.

MDTM intervention: Information input

4. Patient Experience

4.1 Enhanced Recovery Programme

Please see the presentation uploaded on to the SWCN website.

The presentation was cancelled due to unforeseen circumstances; presentation slides are available on the website.

4.2 Clinical Nurse Specialist Update

A SWAG Patient Experience Survey developed by the CNS teams for use across both Trusts is near to completion and should result in feedback from more participants this year and hopefully in the following years.

The potential for digital pre-operative assessment clinics for patients from RUH to avoid travel to UHBW will be raised again with the relevant anaesthetist teams. **RUH CNS Team**

The volunteers recruited by the RUH CNS team, to provide a buddying system for patients from diagnosis onwards, recently received the South West Macmillan Volunteers Award.

5. Clinical Guidelines

5.1 Cancer Associated Thrombosis (CAT) Service

Tabled for discussion

The CAT service available currently at RUH Bath will be replicated at UHBW. This will streamline the pathway and optimise monitoring and managing anti-coagulation therapy. The teams will collaborate to support this service development. **UHBW/RUH Team**

5.2 Two Week Wait (2WW) Discharge Advice Letters

Presented by Paul Tierney (PT)

There is a risk that patients who have been discharged from the Head and Neck Cancer two week wait pathway after clinical assessment may be falsely reassured and not re-present with alert symptoms. A template discharge advice letter will be drafted to mitigate the risk, for approval by Trust communications teams. This will include the red flag symptoms that should prompt them to return to their GP for onward referral. Many clinicians already do a similar discharge letter, but this will bring uniformity to the process, which will be useful for medicolegal documentation purposes. It would also be an opportunity to provide additional public health advice on smoking, diet, alcohol etc. **P Tierney**

AGREED

6. Work Programme update

Living With and Beyond Cancer (LWBC): The Cancer Treatment Summaries have been ratified and are available on the website; action closed.

Network audit: Data on the network audit of thyroid cancer guidelines has been sent to Matt Beasley by Amy Smith; a further copy will be resent.

Set up of a sentinel lymph node biopsy (SLNB) service in UH Bristol: The new nuclear radiologist has now commenced in post and plans to visit Guys and St Thomas's to undertake SLNB training and lead on providing the service. **A Smith**

Research: Recruitment to LITEFORM has now closed. There has been an upsurge of referrals to PATHOS.

Potential network audits:

- On day cancellations
- Thyroid function and fatigue
- Repeat audit of dental screening rates (undertaken every year by
- Lisa McNally with findings consistently no worse yet no better) **L McNally**
- Osteoradionecrosis, sampling patients after 10 years
- Dental extractions: to be allocated to Sarah Gardiner. The preference is for straightforward extractions to be undertaken a minimum of 10 days prior to oral surgery, but this was often dependent on the surgical slots available **S Gardiner**
- Pathology audit of the adequacy of fine needle aspirate.

Booking of PET-CT: The issues with the electronic booking system with PET-CT have been escalated to the Cancer Alliance, but have yet to be resolved. It is not possible to have a record of what has been submitted, or confirmation that the booking has been received. There are also issues with receiving results, with some centres able to access the reports via the Integrated Health Environment (ICE), and others where this is not accessible by this route. RUH does not have these issues as they have their own scanner.

CAG will alert the NHS England Specialist Commissioners that there is a vote of no confidence in this PET-CT service, and there is a need to send referrals elsewhere until processes have been improved or, if the contract is due for renewal, recommend that this is moved to a different provider. **H Marder / H Dunderdale**

RIG emergency care protocols: The protocol is now in place; action closed.

There was noted to be funding available to the Peninsula for the costs associated with extra imaging in the HORIZON trial. The West of England research network will investigate if this will be made available if the trial is opened in SWAG. **WoE Research Network**

7. Coordination of Patient Care Pathways

7.1 Branchial Cyst Pathways

Please see the presentation uploaded on to the SWCN website

Presented by Salma Mohamed (SM)

Two case studies were presented that demonstrated the diagnostic challenges associated with identifying malignant cystic tumours, which often have a benign appearance on imaging. A literature search was undertaken to look for existing guidelines. Results suggested that particular attention should be paid to cervical

cysts in patients over 40 years of age.

Cases should remain on the cancer pathway as suspected cystic metastases until pathology can confirm that it is appropriate to de-escalate.

7.2 End of Treatment Imaging Protocol

Please see the presentation uploaded on to the SWCN website

Presented by Matt Beasley (MB)

A review of follow up imaging for head and neck cancer was presented at the recent Oncology Conference in Barcelona.

A change in the management of current imaging was proposed for the cases treated primarily with chemo-radiotherapy (CRT), with a PET-CT only proposed at the 3 month post treatment assessment point in the pathway, rather than an MRI and PET-CT.

The review reinforced that no post-treatment imaging is required for cases of T1/T2/N0 disease that are surgically excised without reconstruction or adjuvant radiotherapy; follow up with clinical examination only is sufficient.

An MRI three months after completion of treatment by surgical excision of T3-T4/N+ disease (with or without adjuvant therapy) is recommended as a baseline assessment.

Consultant Radiologist M Williams agreed that this is an important scan, as anatomy can look quite different at this point, and it is useful to compare with future surveillance scans.

Discussion ensued about the proposed change post CRT. An alternative would be to do either PET-CT or MRI, and only do a 2nd scan if the first is equivocal, or to continue doing both. Some PET-CT results pick up activity of uncertain significance, but can be useful to pick up lung and bone metastases.

Node negative disease could have MRI only and not PET-CT.

The RUH Bath Team is arranging PET-CT follow up only for node 2 or above disease; enrolment in the PETNET study has helped with throughput.

The associated dose of radiation is noted to be significant and should always be considered.

British Association of Head and Neck Oncologist (BAHNO) follow up guidance is now over 10 years old, and the standard to scan everyone at three months was felt to be excessive; scanning at 4 months is recommended. For surgical patients where there is concern about a growing node, an ultrasound could be performed.

User Representative feedback indicated that a change in schedule could be of concern to those already expecting the 3 monthly follow up, and patient expectations would need to be managed.

The change to 4 month intervals will be raised at BAHNO, and a draft protocol will be written by Consultant Oncologists Matt Beasley and Emma Winton after consultation with the radiologists in RUH Bath.

8. Research

8.1 Clinical Trials Update

AGREED

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 as detailed in the presentation. There is an 80% patient recruitment target for both commercial and non-commercial trials. Set up targets are now 80 days for commercial studies and 62 days for non-commercial. 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; for example, expressions of interest from radiology / radiographers would be welcomed.

Specific areas of focus for the NIHR are surgical trials, which are inherently difficult to recruit to, radiotherapy, rare cancers and Teenage and Young Adult (TYA) trials. A TYA Research Nurse has recently been appointed; the role will be based in the Bristol Haematology Oncology Centre, but will have a network-wide remit.

Recruitment figures (which are shown to be performing well as a region), open trials, trials in set up, and open to new sites, are documented within the spreadsheet and presentation, which also includes a list of useful links for people to check for trial availability; these will be circulated and uploaded on to the SWCN website.

PATHOS is recruiting well, with 11 out of 18 participants recruited to date.

CAG members are invited to contact the research team for further information on trials that they may wish to open.

At the last meeting, it was found to be a useful exercise to identify where patients who were eligible for trials had been missed, understand why, and repeat this task in the future.

The portfolio of trials was noted to significantly fluctuate, with the group wildly over-performing when Head and Neck 5000 was recruiting, and now falling to a middle ranking level, although all relevant trials available were open.

Potential future agenda item

PEARL: a PET-based adaptive radiotherapy clinical trial is currently in set up. This does have excess treatment costs, but will answer an important question and so should ideally be opened in the region. Two more studies could be considered, but they also come with excess treatment costs.

The European Union Horizon 2020 research fund which is opening a study looking at routine MRI follow up at 1 year will also generate excess treatment costs, but has the potential for high recruitment figures.

The Clinical Oncologists are opening TORPEdO, a trial comparing proton beam versus intensity-modulated radiotherapy, and POPPY, a Phase II trial of Pembrolizumab in recurrent or metastatic Head and Neck SCC.

A protocol is in the process of being finalised for HoT, a trial comparing hemi-thyroidectomy versus total-thyroidectomy in low risk thyroid cancers.

The INNOVATE and NICO trials are high recruiters. There have been obstacles to opening the COMPARE trial, and it may now be too late to persist with this.

In the MDT-Mode Assessment, it was noted that research was discussed in 7 out of the 104 cases reviewed. RUH Bath has members of the trials team within the MDT, whereas UHBW do not, and if the Principal Investigator for a trial is not in the room, there is a risk that it might not be discussed. Research could be listed as an item for routine discussion if it is possible to streamline the MDT, and the Chair could nominate a member of the team to focus on highlighting relevant trials.

Funding is currently being sought for Head and Neck 5000 analysis of 10 year follow up.

MDTM intervention: Recruitment to Clinical Trials

9. Service development

9.1 South West Head and Neck Institute

Presented by Ceri Hughes (CH)

Funding to produce a logo for the South West Head and Neck Institute had been provided some time ago. This is used on documentation sent out by the Head and Neck Team in Bristol.

Definition of an Institute: A permanent cooperative social (formal or informal) structure with a defined purpose and enforceable rules that influences behaviour and implements change, made of a group of experts with a common identity that generate activity related to research, innovation, education, and charitable funding.

A plan to progress formation of the Institute, in collaboration with benign colleagues, will be defined at a breakout meeting this evening, aiming to establish this by the end of the year to enhance the reputation of the service, secure its future resilience, generate additional funding, and provide a greater platform for incorporating patient views into the future development of the service.

10. Any other business:

RUH Bath Consultant ENT Surgeon John Waldron is retiring imminently; Associate Specialist Catherine Ashworth is providing support to the Head and Neck service. A replacement Consultant ENT Surgeon will be appointed in the near future.

CAG will consider the questions to put to the Head and Neck long term follow up trial. One suggestion was to consider evidence of heart disease.

Date of next meeting: Tuesday 15th September 2020 **CAG members**

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