Meeting of the Head and Neck Cancer Clinical Advisory Group (CAG)
Tuesday 17th May 2022, 13:00-17:00
Chapter House Lecture Theatre, Bristol Dental Hospital and MS Teams

Chair: Mr Ceri Hughes (CH)

REPORT	ACTIONS
1. Review of last meeting's notes and actions	
The previous report from Tuesday 23rd November 2021 was amended to clarify that radiology have robust systems in place for reporting unexpected findings. No further amendments were identified, and the report was accepted.	
Highlights from the Work Programme:	
Action 006/16: Setting up a sentinel lymph node biopsy service in UHBW.	
All elements required to run the service are now available; assistance from a Project Manager will be sought to bring everything together and make a start.	**H Dunderdale**
All other actions are on the agenda today or will be progressed outside the meeting.	
2. Coordination of patient care pathways	
2.1 Faster Diagnosis Service: Neck Lump Pathway	
Presented by C Hughes / M Williams	
Head and Neck CAG recommend that all Head and Neck ultrasound in Bristol follow the same pathway, with GP referrals directed straight to the Neck Lump Clinic in UHBW to provide an equitable service across the patch. Early discussions have commenced with relevant stake holders.	**CAG Recommendation**
Centralising the imaging would be comparable to the service provided by the breast lump clinic in NBT.	
The backlog for assessment of neck lumps in NBT currently goes back to September 2021. There are only two members of staff running the service, and it would be more suitable for the team to be managing internal referrals, for example, from endocrine services.	
There will be an impact on resources once the correct pathway is put in place in UHBW, requiring Max Fax and ENT to explore how to organise this in the most efficient way possible. There is a consistently high number of GP referrals requesting ultrasound.	
RUH now triage all two week wait referrals to direct low-risk cases straight to ultrasound. This is only possible if the GP has provided sufficient information in the free-text part of the referral form. Referrals with insufficient information are returned to the GP with feedback.	
The problem in NBT pertains to thyroid lump referrals that are not referred via the two week wait system, and then remain in the care of the radiologists with no support from the Head and Neck team.	

Given the current backlog, it may be advisable to send these referrals back to the GP with the recommendation to re-refer via the neck lump suspected cancer pathway.

UHBW have a Radiology Fellow commencing in post in August and are hoping to recruit additional trainees to generate capacity to effectively manage the pathway.

The current Friday morning clinic works well, with 50-60% of referrals resulting in a biopsy. A business case may be required to get the funding and support to replicate this clinic on an additional day. This would only work if staffing levels and processes were truly replicated.

Some funding was available via the Rapid Diagnostic Service, but this was non-recurrent and could not be used for capital purchases.

The future of thyroid surgery at NBT was currently unclear, with no formal succession plan communicated to date.

UHBW team tried to move all surgery to UHBW 5 years ago, but managers had no wish to relinquish the service due to the tariff generated.

This also has an impact on pathology as cases can be discussed in two different MDTs (NBTs on a Monday and UHBW on a Tuesday) by two different pathologists and tracking the cases between the two hospitals is also a challenge for the Thyroid CNS.

It is considered to be in the best interest of patients with thyroid lumps to officially centralise the service and have all relevant cases discussed at the Thyroid MDT on the Tuesday morning.

Action: A meeting will be held with C Hughes, G Porter and M Beasley to discuss the future of the NBT Service with NBT Consultant J Morgan — **C Hughes et al**

The need to comply with NICE guidance and refer neck lumps via the suspected cancer pathway rather than straight to ultrasound will be disseminated to the regional GP via the Commissioners.

The service needs to be continually monitored to ensure everything runs smoothly.

Consultant Oncologist Waheeda Owadally requested clarification on management of PET positive thyroid patients identified in the Lung MDT.

These patients should be referred directly to the Head and Neck Two Week Wait Service at UHBW as they have a 30% chance of being malignant.

Action: To highlighted guidelines on management of PET positive thyroids to all relevant MDTs. — **MDT Members**

3. Clinical Opinion on Network Issues / MDT Service

3.1 MDT Proforma: Review of New Layout

Presented by I Galdies

Many MDTs are currently updating their referral profomas. MDT Coordinator I Galdies has looked at different samples and updated the Head and Neck proforma to provide clear guidance on the information required for those referring from outside.

The draft is presented to the group for ratification. Contact details and an extra section on thyroid details have been added.

A section needs to be added to clarify management of PET positive cases.

The platform for the referral form used by the Bristol Neuro Oncology Group team was considered very useful and was accessible from any web browser, although it does take some time to complete. An automated email alert is sent via the system to confirm that a patient has been added to the MDT.

UHBW have an intranet repository of MDT referral forms. It would be ideal to have an electronic form with drop down mandatory data fields.

Action: To explore options for electronic forms available to access online / to liaise with UGI Surgeon P Wilkerson who is thought to be leading on this work in UHBW.	**C Hughes / I Galdies**

3.2 MDT Mode Follow Up Assessment Results

Please see the presentation uploaded on to the SWAG website

Presented by H Dunderdale

The Head and Neck MDT meeting has now been reassessed using MDT-Mode and is the first MDTM to have completed an audit cycle.

MDT-Mode measures the information and contributions from each patient discussion.

Developers of the audit tool recommend that the audit cycle may need to be repeated on several occasions before the meeting can be completely optimised.

After review of the baseline assessments in 2020, it was unanimously decided to move the meeting to a different time, and this change has now been embedded.

The follow up assessment shows that the move has increased the average time spent discussing each patient, which in turn has increased the overall quality of the MDT discussions.

The following changes were observed:

- Reduction of discussion of patient focused information and reduction in nurse contributions
- Reduction in discussion of clinical research
- Reduction in availability of information from pathology.

The results for pathology reflect current pressures caused by the COVID pandemic.

Discussion:

It was noted that the baseline assessments were undertaken pre-pandemic before moving to a virtual platform.

The other parameters measured (information available on history, imaging, and contributions from surgery, oncology and radiology were all the same or better than reported in the baseline assessment, which reflected the feeling that the MDT was far more efficient now that the time had been increased.

Nursing contributions are thought to have been affected by moving to the virtual platform during the pandemic, especially as the nursing team did not have a working web-camera.

It was felt that not being able to read the body language of team members could hinder communications, and the drop in patient centred information was most likely to be related to the drop in CNS contribution.

Although the meeting was quicker and slicker than the previous afternoon meeting, the team were discussing an increased number of patients.

A move to a more hybrid system could be a future option to consider. This was the formation of the Gynae MDTM, which had a few core members in the room and others online, with MDT outcomes on one screen and radiology on another.

It works well as long as hybrid etiquette is followed, such as turning on web cameras when speaking, introducing themselves, ensuring that everyone can hear, and asking for any other input at the end of the discussion.

It could be possible to rotate who attends the face to face option and return to the room in BRI radiology department.

MDT attendees

RUH are currently upgrading the MDT meeting equipment in the hope of a return to a hybrid format.

Action: To project the MDT outcome on the screen or in the MS Teams chat to be ratified in real time by someone other than the Chair of the meeting

It is difficult to remove cases that may need to be rolled on to the next meeting due to the availability of imaging or pathology as often this is not know until just before the meeting. However, the patients could be crossed off just before the start of the meeting after the M&M section.

Research conversations may have been impacted by the reduced number of open studies during the pandemic. It could be recorded whether there is or isn't a relevant research trial available.

Recording of staging also needs to be improved.

Action: H Dunderdale to circulate MDT-Mode report to CAG members once completed and plan when to reassess the meeting. **H Dunderdale**

3.3 MDT Reforms: Potential Triage of Low-Risk Thyroid Cases

Presented by G Porter

There may be the potential to protocolise some low-risk thyroid cases straight to a treatment rather than for discussion in the MDT meeting.

The cases would still need to be listed for information with the recorded outcome 'as per protocol' to give MDT members the opportunity to dispute the decision.

Potential protocols could be U3, Thy-3 - for diagnostic lobectomy, or T1 / T2 with no risk factors – not for radioiodine.

A small working group will meet to develop the protocols and present this back to the CAG. Andy will be asked to join the group, as he worked with the Oxford team who may have guidelines to share.

Action: M Beasley and G Porter to arrange working group **M Beasley / G Porter**

Job planned preparation time would be required for the individuals protocolising the cases prior to the MDTM.

There may be other cases that could be protocolised such as the severe dysplasia oral carcinoma in situ that always go for a wide local excision.

4. Research

4.1 West of England Clinical Research Network Update

Please see the presentation uploaded on to the SWAG website.

Presented by C Matthews

National data from March 2021 to April 2022 shows that 2971 participants were recruited to 62 different Head and Neck trials, recovering well after the pause in research activity during the pandemic. There are 306 studies currently on the portfolio which are mainly observational, non-randomised and NIHR badged.

The recovery is also reflected in the recruitment figures from the West of England.

The trials open in both the West of England CRN, including Taunton and Yeovil are documented in the presentation.

Trials which have been particularly successful include:

- CompARE
- POPPY
- INOVATE
- TORPEdO.

Studies in set up:

- NIFTy – NIRF Imaging to prevent PoSH after thyroid surgery is due to open at YDH
- NANORAY-312 Ph III Study of NBTXR3 Activated by Investigator's Choice of RT Alone or RT in Combination with Cetuximab for Platinum-Based Chemo-Ineligible Elderly Patients with LA-HNSCC. This will open at UHBW and Cheltenham.

Research Leads S Thomas and B Main flagged the shortage of workforce in the UHBW surgical research team as the main barrier to undertaking research at present; they are currently exploring options with the oncology research team, although it would be ideal to have a dedicated H&N research nurse.

The aim is to open three more trials:

- PETNECK II feasibility study
- SAVER
- RAPTOR.

Aims for CRN in 22/23 include:

- Increasing research opportunities for underserved communities and those with major health needs by supporting equitable access to research
- Improve the lives of people with Multiple Long-Term Conditions (MLTC) by improving access to research and by cross-specialty working
- Embedding EDI across the NIHR CRN.

The CRN offers opportunities for career development in research:

https://www.nihr.ac.uk/health-and-care-professionals/career-development

S Hargreaves has successfully enrolled in the Research Scholars scheme. There is also an Associate PI scheme.

Action: CRN are looking at ways to improve access of information to the trials open across the region. **C Matthews**

Development of a mobile application to access trial information was recommended.

The NIHR Open Data Platform had been developed as an app but was currently only available to access via a computer.

Action: C Matthews will investigate if ODP app can be developed further. **C Matthews**

At the BAHNO Conference, held on Friday 13th May 2022, the focus was on health inequalities.

The Oracle Trust are inviting people to submit potential research projects as they have access to a £25,000 grant since forming a coalition with around 20 Head and Neck charities to coordinate efforts and combine outputs.

The HOT trial is due to open for low-risk thyroid cancers, comparing hemithyroidectomy versus total thyroidectomy.

For further information on Head and Neck trials, please contact C Matthews, B Main or S Thomas. Contact details are within the presentation.

5. Quality Indicators, Audits and Data Collection Issues

5.1 Two Week Wait Referral Audit

The audit will be revisited at a future meeting.

The team have discussed auditing two week wait referrals to see how many have seen a GP or other health care professional face to face prior to referral. At present, it is considered easier to see Secondary Care specialist teams than it is to get a GP appointment. Teams are to see if any junior medics would be willing to undertake a snapshot audit.

This is not a question included on the current referral form, which may need to be updated.

Often, the questions 'please confirm if a patient has been made aware that this is a suspected cancer referral' and 'please confirm that the patient has received the two week wait referral booklet' are ticked, but the patient has no recollection of cancer being mentioned or receiving the booklet.

An audit of two week wait referrals was undertaken in RUH last year. Approximately 40% of referrals would have been more appropriate to manage via a different route, which prompted implementation of the triage system.

It is not possible to reject two week wait referrals; you can only contact the GP to request that they retract the referral. It is often quite time consuming to contact the referring GP.

It would be preferable to have a two-way referral system where advice and guidance could be given to GPs. One such system is called Synapse.

Head and Neck has the greatest number of two week wait referrals in the Trust.

RUH referrals have increased from 120-130 per month to 170-180 per month.

The audit should provide useful feedback to perhaps encourage face to face appointments in Primary Care.

Triaging two week wait referrals will be considered as a pilot in UHBW.

Action: Feedback will be sought from GP representatives to understand the current pressures in Primary Care. **H Dunderdale**

6. Clinical Guidelines

6.1 Ratification of PEG Insertion Guidelines

Presented by C Hughes

UHBW guidelines have been drafted and will be circulated to all members for ratification after the meeting. It has been updated to reflect the change in practice to same day discharge.

RUH have a protocol in place for RIG instead.

Action: H Dunderdale to circulate PEG Insertion guidelines to the UHBW CNS team **H Dunderdale**

6.2 Systemic Anti-Cancer Therapy Update

Please see the presentation uploaded on to the SWAG website.

Presented on behalf of K Gregory

Out of the list of 11 SACT protocols available on the website, 6 require review and version 1 of pembrolizumab needs to be drafted.

K Gregory asks for volunteers to update them. The oncologists present agreed to share the list out between them.

Three additional protocols are required:

- Gemcitabine and Cisplatin
- Single agent Docetaxel
- Carboplatin and Paclitaxel.

Action: Head and Neck Oncologists will liaise with K Gregory to update highlighted protocols and add three further protocols **Oncologists / K Gregory**

6.3 South West Genomic Laboratory Hub

Please see the presentation uploaded on to the SWAG website.

Presented by F McDermott

Cancer Lead for the South West Genomic Medicine Service Alliance (GMSA), F McDermott, (the GMSA is the clinical arm of the Genomic Laboratory Hub), attends today to update the group on progress made since the 100,000 genome project, including what can be offered for Head and Neck patients, and to the clinical teams in terms of educational needs.

GMSA aims to provide patient centred personalised care, excellent access to the clinical information and optimise access to all relevant research opportunities.

SW GMSA is one of seven genomic hubs across England and is centralised in Severn Laboratory.

The GMSA is tasked with improving pathways for access to tests.

At the moment (Phase 1), Whole Genome Sequencing (WGS) is offered to all patients with sarcoma, paediatric and haematological malignancies.

In Phase 2, GMSA will extend the repertoire to other cancer sites, but this is complex as, in the three billion bases that make up the genome, often variants are identified that are of uncertain significance.

All solid tumours however have access to a 500 gene panel and other tests such as DPYD.

The gene panel is available in the presentation, as is the list of test for head and neck cancer, which is also available in the National Genomic Test Directory here: https://www.england.nhs.uk/publication/national-genomic-test-directories/

DPYD is a very useful pharmacogenomic test that can be used to avoid using or reduce the use of 5FU containing SACT treatment. It can often be turned around within 24 hours.

There is a research trial available for those patients who have a negative DPYD, which involves sending another blood sample. CAG members are to contact Chief Pharmacist Rachel Palmer from the GMSA if interested.

NTRK is also very relevant to this group and there are potential drug targets for this currently available. Further information is available on the GMSA website.

Future developments will include expansion of testing to more cancer sites, including cancer of unknown primary, analysis of circulating tumour DNA and how this can be used to inform decision making, and formation of Genomic Tumour Advisory Boards (GTABs) to facilitate interpretation of results.

There is a genomics event on 4th October 2022 which spans all relevant cancer sites; the clinical team are welcome to request items to add to the agenda.

GMSA has an educational team and is appointing CNSs to support genomic activity. It is acknowledged that each Trust manages specimens in slightly different ways, and that the need for fresh frozen samples can be challenging for pathology. GMSA would like to work with CAGs to iron out any problems in the pathways.

There are 30-40 minute free modules online for those who want to learn more, and further sponsored educational opportunities available.

Any further questions, please contact: f.mcdermott@nhs.net

Discussion:

Given current resource limitations, prioritising certain patients to the 500 gene panel was discussed.
It was considered important to refer all patients with metastatic or locally recurring thyroid cancer.

Action: The MDT will make a list of all indications to automatically refer for the 500 gene panel. MDT members

Although available for all sarcoma patient, WGS is currently offered to the minority of patients due to pathway and resource issues.

7. Patient Experience

7.1 CNS Update

Presented by CNS Teams

The UHBW team are in the process of bidding for Macmillan funding for a new Band 7 Head and Neck and Skin Cancer Clinical Nurse Specialist. Treatment can be very complicated, with patients moving between between Dermatology, Plastics, Max-Fax and ENT, and so it would be ideal if there was a role to help support patients through this pathway.

Lead Cancer Nurse R Hendy has made the application for two years of funding to scope the role, in the hope that this can become permanently funded by the Trust in the future.

The H&N CNS team support many metastatic skin cancer patients, but there are some patients who are currently not sufficiently supported, such as patients receiving unilateral radiotherapy who are often old and frail with complex needs.

R Buller has written the Job Description and sent this to R Hendy to present to the Board.

There are still issues with up-banding one of the existing CNS posts to a Lead Thyroid CNS post and, once achieved, the plan is to then recruit another Thyroid CNS support role given the exponential increase in thyroid cancer incidence.

RUH has a team of three CNSs. A new CNS, S Worthington has been appointed, who comes with many years of experience as a Critical Care Nurse. C Cook has retired but returned on a part time basis to support Stephanie's training. The team also hope to appoint a Pathway Navigator to provide additional administrative support.

It may be useful to explore if the additional CNS roles could provide cover for RUH patients and secure additional funding via that route. RUH patients with thyroid cancer do get the contact details of the UHBW Thyroid CNS and provide them with online information.

7.2 Any Other Business

A network social event will be held for the team on Tuesday 7th June 2022.

CNS T Marsh is due to complete the nurse prescribing course in the near future.

Date of next meeting: Tuesday 8th November 2022, Chapter House Lecture Theatre and via MS Teams

-END-