Meeting of the Head and Neck Cancer Clinical Advisory Group (CAG)
Tuesday 26th March 2024, 13:00-17:00

Chair: Mr Ceri Hughes (CH)

REPORT **ACTIONS**

1. Introductions and review of last meeting's report

The list of attendees and apologies are available on the SWAG website here.

As no amendments were requested to the previous report from Tuesday 17th January 2023, the report was accepted as finalised.

The November 2023 meeting was postposed due to the Getting It Right First Time (GIRFT) visit, details of which are on the agenda today.

The Work Programme will be reviewed and progress fed back outside the meeting today due to time constraints.

2. Clinical guidelines

2.1 Transoral Robotic Surgery at UHBW: the first 6 months experience

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Ear Nose Throat Surgeon Oli Dale

Robot assisted surgery commenced approximately 20 years ago, with the first operations in the USA performed in 2005.

In 2018/19, surgeons in UHBW formed a working group to promote the service improvement and presented an initial proposal of the relevant specialties and volume of cases for Upper GI, Lower GI, HPB, ENT, Thoracic and Gynae.

A business case was then developed in 2022 and 2 Da Vinci Robots purchased in 2023, costing 5 million GBP; the first robotic case was performed in September 2023.

The robot is not an autonomous device but assists the surgeon to perform minimally invasive operations. The device involves using both your hands and feet to operate the arms. Three of the four arms are used for Head and Neck procedures.

A video was played to demonstrate how the device is used, showing how it allows access to areas of tissue which would otherwise be challenging to view and treat, with high definition images, and how it helps with margin control.

The downside is the expense of the upfront starter costs. Disposables are not overly expensive, being approximately £240 per case.

H&N lists are currently run every other week and include three sessions. There are two consols in the theatre which means that the surgeons can switch controls between the two, which is very helpful for training.

The Da Vinci robot is the fourth iteration of this medical device. Da Vinci have strict licencing criteria for appropriate case selection, as documented in the presentation.

From September 2023 to March 2024, 20 cases have been performed, including 9 lateral oropharyngectomies (3 PATHOS), 9 tonsillectomies, and 2 tongue base mucosectomy & bilateral tonsillectomies in cancers with an unknown primary. Details of outcomes are documented in the presentation.

There is some concern over pain scores with this patient group and a pain protocol has been put in place in collaboration with the Anaesthetic team and after consultation with guidelines from several other centres. Aspirin gargles are particularly effective. A PCA is only prescribed if additional pain management is required. Swallowing outcomes are also being gathered.

2.2 The role of robotics in Head and Neck Squamous Cell Carcinoma (SCC) with a Cancer of Unknown Primary (CUP)

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Ear Nose Throat Surgeon Oli Dale

The definition of a Head and Neck CUP is an SCC diagnosed in the cervical node following a Fine Needle Aspiration, or core biopsy, with no evidence of a primary tumour following clinical examination, nasoendoscopy, MRI or PET-CT; this is approximately 2-4% of Head and Neck SCC diagnoses.

Evidence from a meta-analysis found that the primary site of origin was identified in 78% of 556 cases following a tongue based mucosectomy performed using transoral robotic surgery or transoral laser microsurgery. 64% originated from the ipsilateral tongue base; 31% originated in the ipsilateral tonsil, 2% from the contralateral tongue base and 1% from the contralateral tonsil.

The recently updated UK National Multidisciplinary Head and Neck Cancer Guidelines (April 2024), has a chapter dedicated to management of H&N SCC CUP. This acknowledges the challenges with producing guidance due to variabilities in case definitions and the low incidence of cases.

In order to draft the guidance, a meta-consensus process was undertaken, which involved a national audit, consensus day and Delphi exercise; H&N CAG took part in the process. This resulted in recommendations that were graded as per NICE guidelines, with those ending in (R) meaning that they should be followed, and those ending in (G) meaning it is a good practice point, but not enough evidence to make a definite conclusion.

Recommendations include performing all radiological investigations to try and identify the primary site prior to diagnostic surgery; offer nasopharyngeal biopsies when the cervical node sample reveals Epstein-Barr positive metastases, and not to offer biopsies of clinically and radiologically normal upper aerodigestive tract mucosa. This excludes tonsillectomy or tongue base mucosectomy.

A pathway has been produced to facilitate the MDT decision making process, as documented in the presentation.

Discussion:

One of the patient representative members of the group was in the category of patients for whom a primary site was never identified.

In summary, following the guidance could help to offer the least invasive surgical and oncological interventions to reduce the risk of long term treatment related side-effects, which will be discussed by the MDT on balance with risks associated with undertreatment.

In conclusion, robotic surgery is preferable for the surgeon and the patient.

3. Coordination of patient care pathways

3.1 Head and Neck Cancer Panendoscopy Quality Improvement Project (QIP)

Please see the presentation uploaded on to the SWAG website

Presented by Clinical Oncology Fellow Siona Growcott

A Quality Improvement Project has been undertaken in collaboration with Oncology and ENT to standardise the panendoscopy operation note proforma.

Panendoscopy provides crucial information to facilitate primary tumour diagnosis, enabling assessment of the involvement of midline structures, and helps decision making for bilateral or unilateral neck irradiation and radiotherapy planning.

The current operation note is generic with no prompts to record specific findings in a standardised auditable format.

Two publications outline recommendations for panendoscopy assessments: The UK National Multidisciplinary Guidelines and the Royal College of Radiologists Consensus Statements, which are documented in the presentation and have been used to guide the QIP criteria, along with the Royal College of Surgeons 'Good Surgical Practice'.

First, a baseline assessment of 52 panendoscopy reports was undertaken to assess completeness against the criteria, the majority of which were legible and documented whether the tongue base was involved.

Areas for improvement include palpation findings, recording of review areas, access to photographs, whether disease is lateralised or not, whether there is soft palate involvement or not, diagrams, resectability and whether there was posterior pharyngeal wall involvement or not.

A new panendoscopy proforma has now been drafted with all relevant data fields included, plus example diagrams and white space for free text comments. This will be implemented in ENT theatres in the near future and audited after 6 months to see if further improvements need to be made, including considering making it into a digital form.

It is hoped that is will be a useful guide for trainees.

Action: To add a field to confirm if the patient has undergone dental screening. S Growcott

3.2 Thyroid Cancer Pathway for NBT/UHBW

Presented by Consultant Maxillofacial Surgeon Ceri Hughes

A process is underway with external facilitation to try and encourage development of a single suspected or proven thyroid cancer pathway in Bristol.

One meeting was held with the Acute Care Collaborative who decide how services run across Bristol. UHBW have proposed that all confirmed thyroid cancer and suspected thyroid cancer diagnostics are managed by the Bristol Royal Infirmary.

RUH Bath will continue to manage their referrals in house.

PET positive nodules should also be referred to the Head and Neck Cancer Service for further diagnostic tests (ultrasound and FNA) to streamline the patient pathway; this has been discussed with the nuclear medicine team at NBT who have confirmed that this will be arranged.

3.3 Requesting radiological tests

Presented by Consultant Radiologist Tamas Schiszler

The radiology department has recently appointed an extra Consultant and Fellow. However, the workload is still overwhelming as the backlog of CT and MRI scans to report dates back to the middle of February due to staff shortages and the ever increasing week on week demand.

There are currently 8 ultrasound lists per week, but more are required to manage the quantity of two week wait referrals received.

The majority of CT scans are requested appropriately; work is underway to assess the need for staging scans to include the upper abdomen, which is separate from the topics for discussion today.

In general, radiological tests are divided into two sections: cancer/pathology workup and reassurance. There are issues with false positives, negatives and incidental findings associated with each.

With MRI, work is underway on sequences using dynamic contrast enhancing imaging to optimise categorisation of salivary gland tumours. This should help to give more reassurance for benign parotid lesions or confirmation of malignancy.

Head and Neck CAG are asked to consider that a significant amount of MRI work is devoted to reassurance of the absence of Head and Neck cancers as a secondary test; many patients come for MRI following a normal endoscopic result, when this is the superior detection method. Although it is acknowledged that some cancers are not visible using endoscopy, it is rare that these would be detected on MRI.

Action: An audit of pick up rate of MRI neck has commenced, and an update will be provided at a future meeting. **T Schiszler**

Indications for PET-CT are increasing which is expected to slow down reporting turnaround time.

Although ultrasound is excellent for assessing thyroid disease and salivary tumours and differentiating benign from malignant nodes, it is not as useful for assessing very small nodal disease of 1 cm or 1.5 cm, which is considered in the normal node category. The majority of the ultrasound workload is taken up with scanning benign lesions such as sebaceous cysts, lipomas and 1cm lymph nodes.

Scans that involve a barium swallow are outdated and should no longer be requested to rule out cancer as radiologists of today are not familiar with interpreting the results.

Discussion:

Currently the guidance for Cancer of Unknown Primary mandates an MRI request and cannot be avoided, even in the presence of a clear nasoendoscopy.

This is understood by the radiology department, and it is for patients with non-specific symptoms, such as sore throat, where it is hoped that MRI requests can be avoided.

It is recognised that there is a tendency to over-investigate, however, patients with lateralised pain also need to be scanned as there is the potential for these patients to have tongue base tumours that are otherwise difficult to detect. Cancer conversion rate is around 2%, but the expectation once a patient has been referred via the two-week-wait pathway is to be scanned so that cancer can be ruled out. Patients tend to re-present if that reassurance is not provided.

The MRI audit is expected to provide evidence about the degree of reassurance that it provides.

Cancer Waiting Time Targets require the team to confidently state that a patient has not got cancer prior to the 28 day Faster Diagnostic Standard. When a clinic letter clearly states that the consultant does not think that a patient has cancer, but is referred for a scan for reassurance, Cancer Manager Hannah Marder can stop the 28 day clock at that point.

Action: In light of the increasing demand, Head and Neck CAG are to escalate the need for a PET-CT scanner based in UHBW. To be allocated

The need for a PET-CT had been briefly raised at a recent meeting of the MDT Leads.

The Head and Neck Cancer Patient Tracking List (PTL) is the largest in UHBW and patients are rapidly signed off once reassurance has been given, with a safety net to track when fast track scans have been done.

4. Patient experience

4.1 Complex Head and Neck and Skin Cancer Pathways

Presented by Clinical Nurse Specialist (CNS) John Bostock

A new role has been funded by Macmillan and UHBW for two years to optimise management of the patient cohort that sits between Dermatology and Head and Neck services.

John Bostock was appointed 12 months ago and has facilitated the care of 59 non-melanoma Head and Neck patients to date, predominantly in the radiotherapy clinic setting.

Patients with melanoma and non-melanoma skin cancers in other areas of the body are supported by an additional Skin Cancer Clinical Nurse Specialist.

A fast track pathway has been developed by working closely with the Dermatology department. Previously, patients would be seen by a Dermatologist and be treated for their skin lesion and discussed at the Skin Cancer MDT prior to referral to the Head and Neck Cancer Service, which could result in delays in the assessment of associated neck lumps. Now, a monthly face to face clinic is held to assess their surgical and oncological needs which has streamlined the pathway. In addition, two wound assessment clinics have been set up, which are held every Monday in the Dental Hospital, and Thursday in Dermatology, so that patients that come via the Dermatology route can get additional lesions assessed quickly and have continuity of care. A monthly clinic is also being held in Weston to support the patients that prefer not to travel to Bristol.

Discussion:

The new service has successfully addressed an unmet need for this patient cohort. Before the service was in place, it was not uncommon for patients with skin lesions and metastases in the neck to be on a waiting list with dermatology for longer than appropriate. The monthly clinic has resolved this, and examples also show that networking with other centres outside Bristol have streamlined patient pathways.

Action: Head and Neck CAG to write a letter of recommendation for continued funding of the post.	**C Hughes/H Dunderdale**

4.2 CNS update

The Laryngectomy Support Group has now been reinstated in Bristol and has been very well attended.

The team have been liaising with The Swallow Head and Neck Cancer charity to see if an additional support group can be arranged in the region and are also exploring the possibility of a patient led support group.

Historically, it had been thought that patients could be referred to lymphoedema services once remission had been confirmed on PET-CT. Recent advice from Lymphoedema CNS team is to refer within 6 weeks of lymphoedema occurring.

Action: Head and Neck CAG to refer patients to lymphoedema services within 6 weeks of symptoms occurring.	**Named Consultant**

It has been found that patients on palliative care who are discharged to Hospice Care are rejected by the Hospice if asymptomatic, as they expect the patient's care to remain under the GP until end of life symptoms commence.

Although this has an impact on workload, it is considered more appropriate for these patients to remain under the care of the CNS team.

A business case has been proposed to managers for additional CNS resources for patients with long term terminal conditions, including a home visit service due to the complex acute nature of these patients; any service developments are on hold for this financial year so this will be resubmitted in the next financial year.

A new laryngectomy care plan has been drafted and is currently with clinical governance for ratification before it is disseminated to the ward. It is hoped that this will support new nursing staff with post operative care.

An Enhanced recovery plan has also been developed with input from the specialist enhanced recovery nurse and will be available to look at in time for the next CAG meeting. **Future Agenda Item**

RUH CNS Team are organising funding to replace the CNS post that was lost in the previous year; problems had arisen with agreeing the appropriate banding.

The CNS led clinic has been working really well, and the team have also been working with The Swallows Head and Neck Cancer Charity. The first jointly organised support group will be held in April 2024.

The CNS team were thanked for the invaluable support they provided for their patients.

4.3 QR code for Quality of Life (QoL) Patient Reported Outcome Measures (PROMS)

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Maxillofacial Surgeon Soudeh Chegini

Soudeh Chegini recently joined the team in November 2023.

A QoL survey has been developed in collaboration with SHO Anesah Anwar to meet NICE Improving Outcome Guidance (2004) recommendations, and guide service improvements to meet the needs of our local Head and Neck cancer patient population. It also helps patients reflect on their needs and voice these in clinic.

There is a National Cancer QoL tool already available, but the data is not accessible via cancer sites and has generic questions that do not capture the specific needs related to different cancer treatments and side effects.

It was decided to use the University of Washington QoL Questionnaire as this is the most widely used Head and Neck specific survey that can demonstrate subtle changes. It is a short and simple 10 question user friendly format.

A poster has been created with a QR code where patients can access the survey on their phones, and it has also been made available on paper slips that have been distributed to the clinic space.

Action: H&N CAG are encouraged to ask all patients that have completed treatment to complete the survey. **ALL**

The survey answers automatically download onto an excel spreadsheet stored in accordance with UHBW information governance guidelines, so the data is safe, easy for the Head and Neck team to access with minimal workload, and a paper free solution.

The poster was put up last week and one patient has completed it to date.

There is a sentence to say ask the team for help if they find it difficult to complete; further work needs to be undertaken to find the best way for this to be provided.

Once results have been analysed and needs identified, these will be presented back to the group to prioritise actions.

Action: Soudeh Chegini to present QoL results at future Head and Neck CAG meetings. **S Chegini**

Discussion:

There is a link to the form for patients who are unfamiliar with using QR codes.

There is not a free text box for general comments because the focus is purely on Quality of Life and not on other service improvements. Existing hospital surveys give patients the opportunity to provide feedback on clinics etc.

It may be possible to be sent to the patient at set intervals in their recovery. At present, it is hoped that the patient will complete it at every follow up appointment.

Patient Representative feedback is to add the reason why you are doing the survey to the poster / how the data will be used (to improve the service), and it will encourage patients to complete it if the poster also states approximately how long it will take to complete (10 simple questions).

Action: The poster will be amended to include how the data will be used and how long the survey takes to complete. S Chegini

The Doctor Doctor system could be used to send the survey at the same time as appointments which would also help track who has responded.

Action: The appointments team will be contacted to see if this can be added to appointment letters. S Chegini

5. Quality indicators, audits and data collection

5.1 Cancer Outcomes and Services Dataset (COSD) data collection

Please see the presentation uploaded on to the SWAG website

Presented by Cancer Service Clinical Data Quality Manager India Galdies

The role of Cancer Service Clinical Data Quality Manager has been newly created in response to the need to improve the quality of cancer data in UHBW.

The COSD dataset will be investigated to identify any missing data fields and then the Quality Manager with work with members of the MDT to improve data input.

COSD is a mandatory dataset for all cancer sites and is submitted to support national cancer registrations and associated analysis.

The priority key metrics are staging completeness, performance status and clinical nurse specialty indicators.

The NHS has an ambition to diagnose 75% of cancers at either Stage I or Stage II by 2028 and COSD data on staging is required for this to be measured; this is the immediate priority for improvement.

A monthly report on COSD data completeness is provided. Data completeness of staging across all cancer sites in UHBW is currently 53.5%, with the Trust ranking at 117th in comparison with all of the NHS Trusts in England.

Completeness of staging data for Head and Neck Cancer is 73.91%, which compares favourably with the other cancer sites, being second only to breast cancer staging completeness, which exceeds the National target of 80%.

It is understood that staging methods vary across cancer sites and are more challenging to capture in some areas.

The first task will be to look at staging completeness between April to December 2023 and complete any missing data. The challenge is calculating this if it is not clearly documented and will involve working with radiologists, pathologists and

other MDT members to see how this can be achieved and how to improve prospective data collection in the future.

Head and Neck MDT will be contacted to ask for help with Staging data when required.

Discussion:

Ophthalmic cancers can often be seen in different MDTs, such as Head and Neck, Lymphoma, Skull Base or Skin, and it is unclear how data on these patients is completed and tracked.

Each MDT should complete the COSD dataset for these patients using the Somerset Cancer Register (SCR).

Any patient with a suspected ocular cancer should be registered on to the SCR register by emailing the relevant Skin Cancer MDT Coordinator as soon as they are known about, regardless of the referral route and still discussed by the most appropriate alternative MDT.

COSD data is extracted from the SCR on a monthly basis. It is thought that some of the problems with data completeness is due to the time that the extraction takes place. One of the challenges is finding out how these deadlines work, plus the data extraction also occurs from a number of other hospital information systems and may include patients that have not been registered via an MDT, for instance, if they are entered into the national registration via a death certificate but were not seen in the hospital setting.

6. Clinical opinion on network issues / MDT service

6.1 Output from Getting It Right first Time (GIRFT) visit

The GIRFT report is available on request

Presented by Consultant Maxillofacial Surgeon Ceri Hughes

Thanks were given to the Head and Neck team for the contributions to the GIRFT submission.

GIRFT have assessed Head and Neck Services across the nation and produced feedback reports. Feedback on the SWAG service was very positive, in particular around the cohesive nature of the team and their excellent communication processes. GIRFT plan to use the team as an example of best practice for MDTs that also involve working across different hospital sites.

Areas identified for improvements include ensuring MDT members have protected time of two hours to attend the MDT meeting.

Further input from psychology and palliative care was also recommended, which is a national issue, as is the attendance of Plastic Surgeons at every MDT meeting. This is less relevant for the UHBW/RUH service as the Skin Head and Neck Cancers are discussed in the Skin Cancer MDT which is chaired by a plastic surgeon.

The physical infrastructure at UHBW requires updating.

An increase in the resources for the FEES (fibreoptic endoscopic evaluation of swallowing) service at RUH was recommended as this is only available to inpatients, and there is very little opportunity for Head and Neck patients to be seen.

The ENT clinic capacity at RUH had been raised as having limitations and subsequently progress has been made to reorganise the slots. The team in RUH were previously double booked to conduct ward rounds at the same time as the MDT meeting in the morning but the time table has been rearranged so that at least one of the surgeons can attend every other week in person.

Radiology and Pathology colleagues in RUH would also need to make significant changes to job plans to attend the whole meeting. This will be discussed further in the near future.

Another priority for improvement for the CAG is access to restorative dentistry.

The number of laryngectomies performed in RUH are quite low and a process to move these to UHBW is being considered.

All the equipment and staff required to offer a Sentinel Lymph Node Biopsy (SLNB) service are now in place, but pathology do not have the resources to support this at present as it will result in a significant increase in workload. The option of referring patients to alternative centres is being explored. However, it seems that the majority of this work is being undertaken in the private sector.

Action: SWAG Cancer Alliance will be contacted to see if any help can be provided with offering SLNB to relevant H&N patients. H Dunderdale

The GIRFT report will be used as a lever to prioritise the recommended service enhancements.

Discussion:

Recently, two sessions for a restorative dentist had been arranged in RUH without any Head and Neck work incorporated into the job plan. RUH team are encouraged to ask for extra funding for this to be amended as their patients currently have to commute to Bristol for this service.

Action: Restorative Dentist Lisa McNally will email details of the RUH Restorative Dental Service to Consultant Surgeon Stuart Gillett. L McNally

7. Service Developments

7.1 Head and Neck Institute

Presented by Consultant Surgeon Ceri Hughes

The aspiration for a Bristol and Bath Head and Neck Institute has been pitched to the Business Management Team. Subsequently, Project Manager Peter May has been allocated to produce a scoping paper that will define the virtual, physical, financial and governance requirements to achieve Institute status by looking at local resources including the links with the University, and other Institutes across the UK.

There are strict legal requirements to become an institute. It is necessary to apply to the Secretary of State and satisfy a number of criteria. The existing service already complies with many of these; any additional criteria required needs to be put in place prior to an application being made.

The Liverpool team have been consulted as they went through the process to achieve 'centre' status. This resulted in significant investment from the University to appoint numerous scientists, surgeons and support staff and have a significant dedicated budget to support research programmes.

Existing links with the University of Bristol, the Dental School and RUH Bath are going to be helpful in the process.

All CAG members are invited to get involved.

Discussion:

Consultant Radiologist Chu Yap Lan wishes to get involved, in particular as the SWAG Regional Imaging Network aspires to implement cross-site working, which will only be possible with integrated IT systems and also a desirable aim for an Institute.

Implementation of a shared PACs system is being discussed, but it is not expected that the current plan will be achievable, as each Trust have contracts that are ending at different times and having overlapping contracts would be incredibly expensive.

8. Research

8.1 West of England Clinical Research Network update

Please see the presentation uploaded on to the SWAG website

Presented by Research Delivery Manager Claire Matthews

National clinical trial recruitment from April 2023 to March 2024 shows that 5,274 patients have been recruited to Head and Neck cancer trials across 18 research networks which has exceeded recruitment in 2022/23 where a total of 4,888 patients were recruited.

58.9% of the trials were non-commercial, 63% of the total were interventional, 31.5 % observational and 5.5% both.

There are 16 trials open across the region. The full list of trials open and in set-up will be circulated.

PETNECK 2 reduced the recruitment target this month as it is significantly behind at present. Recruitment is expected to finish in July 2025. It is recruiting both Max Fax and ENT patients. RUH recently opened the trial and then immediately had to suspend recruitment as the CNS, AHP and administrative team do not have the capacity to support commencing the Patient Initiated Follow Up (PIFU) process.

The UHBW team are recruiting via a specific clinic run by Consultant Surgeon Steve Thomas, with patients identified by the Surgical Research Nurses.

Action: UHBW Research Nurses will share how to set up the PIFU process with the RUH Team. **UHBW Research Nurses**

Research nursing support is essential as there are numerous trial related case report forms to complete. Support from the CNS team is also essential as they provide the education sessions.

UHBW CNS team have found, after undergoing the initial training sessions, that providing patients with the education session has formalised the support that the team were already giving and is not that time consuming due to support from the Research Nurses.

HOT trial is also behind with recruitment. A note from the sponsor in January cited factors such as delays in trial activation and have since hosted recruitment webinars and launched patient information videos to try and boost recruitment, which also closes in January 2025.

Further funding needs to be sourced for additional research nurses, which could be included in the priorities of the Head and Neck Institute.

Question 58 in the National Cancer Patient Experience Survey ‘Cancer research opportunities were discussed with the patient’ scored below average across SWAG in comparison with the national average.

Patient Representative feedback is to let the patient know that research trials have been considered, even if the outcome is that there is no eligible trial available.

A website is now available where patients can proactively register their interest in participating in research, and there is also e-learning for staff to help facilitate research conversations: https://learn.nihr.ac.uk/.

Results and actions from the Participant in Research Experience Survey (PRES) are documented within the presentation.

The NIHR 6-month Associate Principal Investigator (PI) scheme is still open to any interested clinician who doesn't have research in their current role. It allows associates to work alongside current PIs on studies (as documented in the presentation) signed up to the scheme.

Any PI interested in getting help from an associate while helping their personal development is to get in touch.

The second cohort of the free Principal Investigator Pipeline Programme (PIPP) to support research nurses, midwives and dentists to become PIs commenced at the beginning of March 2024.

The Clinical Research Networks (CRNs) are transitioning into Research Delivery Networks (RDNs) from the 1st October 2024 to reflect that there are increasing amounts of research in non-clinical settings. The primary purpose of the RDNs remains the same: to support delivery of high quality research and increase the capacity and capability of future research. The networks are dropping from 18 to 12. The West of England will expand to include Dorset and Salisbury and will be renamed South West Central.

NIHR website links and team contact details are available within the presentation.

The BHOC Clinical Trials Unit currently has a number of bottlenecks that are delaying trial set up. A push to prioritise opening commercial trials for the associated income is detrimental for radiotherapy trials as the majority of these are non-commercial.

9. Any other business

The laboratory in UHBW is going to start assessing thyroid samples in-house which will reduce turnaround time from 4 weeks to 3 days. RUH may want to consider sending samples via this route rather than to Severn Laboratory.

Should the MDT review any unreported scans within the meeting, this would need to be flagged on the MDT outcome and sent as a task following the meeting to the appropriate imaging specialist.

BAHNO is currently advertising on the website for accredited short fellowships which involves short courses either at UCL for SLNB for surgical fellows, or Proton therapy for oncology fellows and will provide £2,500 for accommodation, travel and the course.

A FEES outpatient pilot is due to commence after Easter for 1 patient per week to assess the benefit via patient feedback and assessment outcomes. **Potential Future Agenda Item**

RUH Dyson Cancer Centre is opening next month and will vastly improve the patient experience with new waiting areas for radiotherapy and the new chemotherapy day unit.

The patient representative members of the group recommend recruiting additional patient representatives with recent experience of the cancer pathway.

Action: The SWAG Patient Representative Brief will be circulated for CAG members to share with any relevant patients. H Dunderdale

When the presentations are uploaded on to the SWAG website tomorrow, a presentation will also be included from a TYA Haematologist who is trying to coordinate sending samples for Whole Genome Sequencing for patients under the age of 25 with lymphoma.

Date of next meeting: Tuesday 21st January 2025

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