Meeting of the SWAG Network Head and Neck Cancer Clinical Advisory Group (CAG)

Tuesday 21st January 2025, 13:15-17:00

The Conference Room, Trust Headquarters, Bristol Royal Infirmary, BS1 3NU

Chair: Mr Ceri Hughes

REPORT (To be agreed at the next CAG Meeting)	**ACTIONS**

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

2. Review of last meeting's report and actions

As there were no amendments or comments following distribution of the report from the meeting on Tuesday 26th March 2024, the report was accepted as finalised.

It had not been possible to arrange a meeting within November 2024 due to a lack of room space.

From the Work Programme:

2.1 Clinical Guidelines: Setting up a sentinel lymph node biopsy (SLNB) service

Consultant Pathologists Miranda Pring and Timothy Bates require further resources prior to undertaking the extra workload associated with SLNB as the service has already exceeded capacity.

A meeting will convene on 23rd January 2025 with the pathology team at Severn Laboratory to see how this can be progressed.

2.2 Coordination of patient care pathways: Management of PET positive thyroids

Mr Ceri Hughes has written to the PET team to request that all PET positive thyroids are referred directly to the Head and Neck MDT and this does appear to be happening.

2.3 Patient experience / patient information

To confirm that clinic letters have been changed back to pre-COVID wording – still to be confirmed.

2.4 Patient experience / patient experience surveys

The Cancer Alliance have confirmed in principle that funding and administrative support will be provided for development of regional patient experience surveys. Lead Cancer Nurse Chris Levett will lead on the project as it has been recognised that some cancer sites need additional feedback to inform service improvements than the feedback provided from the National Cancer Patient Experience Survey.

The CNS team in UHBW have been distributing a questionnaire for feedback on the CNS service provision, but regional feedback on the service as a whole would still be useful.

2.5 Coordination of patient care pathways: To improve access to restorative dentistry in RUH Bath

A restorative dentist has now been appointed who sees the patients on a Thursday, which is the day after the Head and Neck Cancer Clinic. Action closed.

All other items on the Work Programme are either ongoing or on the agenda of the meeting today.

3. Fibreoptic Endoscopic Evaluation of Swallowing (FEES) Pilot

Please see the presentation uploaded on to the SWAG website

Presented by Speech and Language Therapist Danielle Holbrook

The aim of the pilot was to implement and evaluate an outpatient FEES service for patients under the care of Head and Neck cancer (H&N) and Bristol Haematology and Oncology Centre (BHOC) Speech and Language Therapy (SLT) teams.

Many practical obstacles required troubleshooting plus extensive training requirements before the pilot could commence.

Once underway, patients would come for a 90 minute clinic slot, which involves 30 minutes for the FEES procedure, 30 minutes analysis and report writing, and 30 minutes to provide the patient feedback, negating the need for the patient to return for a second appointment.

The vast majority of patients found the procedure acceptable and were happy with the information provided.

Average waiting times were 16 days and waiting times for Videofluoroscopy (VF) from 31 days to 18 days.

The assessment helped answer the patient's questions and provided confidence that management plans were optimised.

Due to the benefits observed during the pilot, the service has now been established, currently with one ring-fenced slot per week.

Any unutilised slots are converted into a general outpatient appointment within 48 hours to ensure optimal use of SLT time.

Moving the slot from St. Michaels to the BRI is being considered so that the resource can be more easily shared.

Should demand increase, a business case will be drafted to support the increase in staffing and ringfenced slots.

Discussion:

Patients seem happy to wait for 30 minutes to receive feedback on the day.

Training involves multiple supervised FEES procedures and will continue until the service has a sufficient number of competent SLTs signed off.

The videos from the procedures are stored on the EVOLVE Hospital Information System. Details on how this was achieved, which involves compressing the file, will be shared, as the UHBW team have had problems storing media on PACS systems.

RUH team are also not able to store videos on the Millenium Hospital Information System and have to store them on a hard drive.

RUH currently have an inpatient FEES service and hope to develop an outpatient service at some point in the future.

Action: To share how to upload videos to EVOLVE. **Danielle Holbrook**

4. Clinical Nurse Specialist Update

Patient Representative Gary Nicolls sends thanks to the team for the support and care that he has received over the past several years.

Permanent funding has now been secured for the role of Head and Neck and Skin Cancer CNS in UHBW.

Last year, the role involved working across the Head and Neck and Skin MDTs for 80 patients; the number of patients is expected to be greater this year. A generic email address has been activated that the dermatologists use to refer directly to the service, and a joint Head and Neck and Skin Cancer Clinic is held once a month for complex cases.

Patient numbers in RUH are not thought to be sufficient for this extra service to be required at present.

RUH appointed CNS Amy Collins in September 2024 and the team are future planning in light of upcoming retirements that are expected in the next few years.

5. Research Delivery Network Update

Please see the presentation uploaded on to the SWAG website

Presented by Claire Matthews, Study Support Service Manager

The Research Delivery Network is a new organisation established in October 2024. It used to be the Clinical Research Network but has transitioned to improve support provided to researchers by making this more consistent across the country, and to reflect the growing portfolio of non-clinical trials.

Instead of monitoring trial performance on an individual basis, the organisation will take a more strategic view of the research provision.

The networks are dropping from 15 to 12. The West of England will expand to include Dorset and Salisbury and will be renamed South West Central.

The RDN has appointed two Research Directors, Dr Helen Winter and Dr Patrick Moore, and Helen Lewis-White has been appointed as the Health and Care Research Director.

National clinical trial recruitment from April 2024 to January 2025 shows that 4,503 patients have been recruited to head and neck cancer trials across 15 research networks. The majority were non-commercial (although 47% were commercial) and interventional.

Open trial and trials in set up across SWAG are documented in the presentation.

Recruitment to PETNECK II is slightly behind at 82% of the recruitment target. An extension to recruitment may be required and additional sites are being opened. Recruitment numbers were low in the first year but have since improved.

Recruitment to HoT is also behind but the number of randomisations has been increasing since September 2024, with the trial team arranging weekly drop-in sessions with research teams to trouble shoot recruitment issues.

RUN have struggled to recruit due to patient choice.

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

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.

Additional free training is available for existing research staff to gain experience of the PI role via the Principal Investigator Pipeline Programme (PIPP), which takes approximately 12-18 months.

NIHR website links and team contact details are available within the presentation. Dr Sarah Hargreaves is the Research Lead for the CAG.

Discussion:

Disappointingly, there are no oncological trials open for Head and Neck Cancer for the first time in 20 years, with the Clinical Trials Unit (CTU) resisting opening any trials that are non-commercial due to funding requirements and trials being more targeted to smaller patient cohorts.

Action: To invite RDN Regional Specialty Lead for ENT Emma King to a future meeting to try and resolve the gap in the portfolio.	**Helen Dunderdale**

The Cancer Vaccine Launch Pad (CVLP) has been set up in every SWAG centre and a Head and Neck arm is due to open in the near future; it is currently in set-up in RUH.

Action: To flag to the CTU that small tumour sites should not be discriminated against when expressing an interest in opening new trials.	**Ceri Hughes/Matt Beasley**

Another issue is that many Head and Neck trials are non-commercial radiotherapy based and don't generate income. Two EoI's have recently been rejected.

An Artificial Intelligence (AI) trial is being proposed at a research meeting in Birmingham on Friday, and details will be shared at a future meeting if relevant.

6. RCR Consensus Statement on Neck Radiotherapy

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Clinical Oncologist Georgina Casswell

Since 2016, the Royal College of Radiotherapy (RCR) has been producing consensus statements to minimise the amount of treatment variation of radiotherapy delivered across the UK.

In 2022, a Head and Neck consensus was published to stimulate discussion among clinical oncologists on what should be targeted in radiotherapy fields.

Section 4.1 is on adjuvant contralateral neck irradiation following surgery for oral tongue cancer for patients planned for postoperative ipsilateral radiotherapy. This is recognised to have a poorer prognosis than other oral cancer sub-types.

The focus for discussion is the clinically radiologically node negative contralateral neck.

Treating the contralateral neck could risk overtreatment in the patient cohort. However, if these patients relapse, their survival outcomes are very poor.

The statement recommends offering the treatment if the disease has risk factors of a larger, T3 or T4 tumour, it is not well lateralised, N2B or more, or any extra-nodal spread.

The question for the MDT is whether patients should be treated with bilateral neck dissection or radiotherapy, both of which have long term toxicities.

The next point is based on results from a retrospective review of contralateral recurrence which showed a recurrence rate of 12% in those with Stage pN1/pN2a disease and 27% in those with Stage pN2b disease.

This raises the question for the MDT to consider contralateral neck radiotherapy if there is a single involved lymph node.

It is not clear if this improves survival, but it is recommended to discuss with patients the balance between treatment related morbidity and risk of relapse.

Well lateralised early T1-2 disease also has a 12% risk of recurrence.

It would be useful to discuss how these patients should be treated with either surgery or radiotherapy by looking at the associated toxicities and come to an agreed approach across the region.

Discussion:

The nuances of treating this patient group are increasingly being raised in the MDT, and it would be good to understand the morbidities associated with each treatment option.

The morbidity associated with a bilateral neck dissection is that you gain a tracheostomy short term, and it adds 2 hours to an operation.

Long term sequela from contralateral neck radiotherapy is harder to measure as they happen later on and may involve swallowing problems that are not always reported.

Both options need to be discussed with the patient; radiotherapy can reduce the risk of recurrence.

In the opinion of Patient Representative Ralph Openshaw, the loss of both main salivary glands with the bilateral neck dissection is a major factor for patients to consider in terms of Quality of Life measures for those 88% of patients who won't get recurrence.

There is less debate about the patients who have the high risk factors identified in section 4.1.

Action: To convene a symposium to discuss in more detail, with the plan to make a recommendation at the next CAG meeting.	**Georgina Casswell**
To add to the next BAHNO programme	**Ceri Hughes**

7. Implementation of the panendoscopy proforma

Presented by Graham Porter, Consultant Ear, Nose, Throat, Head and Neck Surgeon

The purpose of the panendoscopy operation note proforma was to formalise surgical reporting in a format that would help oncology colleagues plan radiotherapy, until they recently became unavailable. The forms are now back in supply and will be used for each procedure and scanned to Evolve so they are readily available.

Oncology colleagues have found the proforma extremely useful.

Action: To share the proforma template with the RUH team **Graham Porter**

Dental screens are not currently uploaded on to Evolve and are currently filed in the patients' notes.

Action: To arrange for Dental Screen reports to be routinely uploaded to Evolve. **Lisa McNally**

8. Rationalising neck dissections in salvage laryngectomies

Please see the presentation uploaded on to the SWAG website

Presented by Consultant ENT Surgeon Hiro Ishii

The purpose of the discussion is to clarify how neck dissections are decided and documented.

Current evidence from three systematic review and meta-analysis showed that the occult nodal rate ranged from between 11-14% across all salvage laryngectomies.

Post operative complications tend to be higher, with fistula formation being the most common, although not statistically relevant.

Regional control was not documented in one of the studies but was not found to be statistically different in those who had or did not have a laryngectomy in the Lin study. The Davis-Husband study showed a decreased risk in those who had elective neck dissections.

No statistical difference was found for disease free survival or 5 year overall survival in those who had or did not have a laryngectomy.

The highest risk of occult metastatic disease is in those patients who had T3/4, supraglottic/transglottic subsites and N+ at primary treatment.

Discussion:

Neck dissections can add another 2-3 hours on to theatre time.

It could be possible to rationalise the surgical approach for those patients who are node negative at initial presentation and node negative at radiological relapse.

The most appropriate time to discuss how extensive a neck dissection should be is at the point that salvage laryngectomy is discussed and involves looking back at the patient's initial presentation. **AGREED**

The high risk features can be used as a guide to facilitate these discussions for review on a case by case basis, taking into account the patient's overall health and preferences.

9. Neck MRI Audit

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Radiologist Tamas Schiszler

The current two week wait diagnostic pathway involves patients with ongoing symptoms such as a persistent sore throat, feeling of something stuck in the throat, tongue pain +/- otalgia etc. being referred to ENT, where they have a physical examination and flexible naso-endoscopy carried out at an ENT clinic.

Depending on the findings, staging scans such as cross-sectional imaging and / or ultrasound+ /- FNA / biopsy are requested, and in cases with clinically suspected malignancy, MRI with gadolinium + CT NCA, +/- ultrasound.

In many cases where suspected malignancy is not observed, a plain non-contrast MRI neck is often still requested; the reason for this audit is to evaluate if this is an appropriate use of MRI resource in this patient cohort.

Further reasons for the relevance of the audit are documented in the presentation.

Between April 2021 to March 2022, 500 non-contrast neck MRI scans were identified and reviewed in Summer 2024 to give time to evaluate if any cases of malignancy were missed by ENT or Radiology.

After excluding cases with clinical suspicion of malignancy, 334 cases were identified and divided into those who looked completely normal (ENT Score 0 – 152 cases) following physical examination and those who had some signs of abnormality (ENT Score 1 – 186 cases).

For those cases with an ENT Score of 0, no malignancies or other significant findings were identified and 37 went on to have additional diagnostic investigations.

For those cases with ENT Score 1, 4 malignancies were identified, 3 of which were tongue based head and neck cancer. 52 patients went on to have additional diagnostic investigations.

Royal College of Radiology Guidelines recommend MRI for patients with clinically detected cancers.

It is therefore recommended that patients with normal findings on both physical examination and flexible naso-endoscopy (FNE) are not referred for an MRI as part of their routine diagnostic evaluation.

Patients with normal physical examination and minor changes such as tonsil or tongue base prominence or asymmetry should also not have a routine MRI, with the exception of those with a high risk history combined with asymmetry / bulkiness at the base of the tongue.

Discussion:

Many of the patients sent via the two week wait pathway are very young with asymmetrical tonsils, which creates a problem with trying to find the cancers among the referral numbers.

Recently, it has not been possible to open any clinical research trials that involve MRI due to the severe constraints on capacity.

It causes patients a lot of anxiety when they have had a clear physical examination but are then referred onwards for an MRI.

Currently, approximately 40% of two week wait referrals are sent for imaging.

Action: To present the audit to the ENT department and submit an abstract to BAHNO (if possible to submit in 5 days).	**Tamas Schiszler**

BAHNO is on the 16th May 2025 with Bristol participating as the MDT panel. Any more volunteers to join would be welcomed, and the CNS team should be supported to attend.

RUH team have found the move to video naso-endoscopy from fibre-optics has improved the number of exclusions for cancer due to the exceptional image quality.

With video naso-endoscopy, it is possible for trainees to record any findings that they are unsure about for the Consultant to review.

Action: To seek support from Trust Managers to provide video naso-endoscopy in UHBW **ENT Team**

The ability to record videos of endoscopies would streamline the patient pathway, reducing the need for repeat procedures.

It is the history of the individual patient that is best used to guide the decision to investigate.

Action: To gather further details on the characteristics of the patients diagnosed with Head and Neck Cancer in the audit. **Tamas Schiszler**

Lateralised symptoms or pain are other indicators where an MRI would be justified.

10. Access to Dental Assessments

This session had to be abandoned as it was added to the agenda by Cancer Programme Lead Teressa Allen who was no longer available to attend.

11. Remodelling the ENT Head and Neck Pathway at UHBW

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Ear, Nose and Throat Surgeon Oliver Dale

The Senior House Officer (SHO) and Advanced Nurse Practitioner (ANP) contributors were acknowledged.

The two-week wait policy, introduced in 2000, was abolished in 2023 in favour of a new 28 day Faster Diagnosis Standard (FDS).

Cancer Waiting Time Targets:

- 28-day Faster Diagnosis Standard (75%)
- 62-day referral to treatment standard (85%)
- 31-day decision to treat to treatment standard (96%).

Delayed diagnosis of approximately 4 weeks hugely reduces median overall survival rates, as demonstrated in a US led study of 51,000 patients treated with curative intent correlated with time to treatment.

In UHBW, approximately 500 Head and Neck fast track referrals are received per month, which equates to 120-150 new ENT referrals per week, for which there are 70 clinic slots available.

From September 2023 to August 2024, 6308 Head and Neck fast track referrals were received, and 164 cancers diagnosed, with the conversion rate to cancer being 2.6%.

A general increase in referral numbers can be seen over time.

A 7 day snapshot of an average week was undertaken to demonstrate how these patients are managed in the week commencing 22nd July 2024. The total number of referrals was 144, with the most common symptom being hoarse voice or sore throat.

Patient symptoms were put through the Head and Neck Cancer risk calculator, used during the COVID-19 pandemic, which showed that greater than 50% were in a low risk category, although the majority of patients had some form of diagnostic imaging arranged.

Of all the patients scanned that week, 5 patients had a malignancy diagnosed, all of which scored as high risk.

In the low risk category, 43% of patients had a follow up appointment.

The mean time to fast track appointment was 24.6 days, with 14% of patients being seen within 14 days.

When looking at an overview of all cancers diagnosed over the course of 1 year, the majority of patients diagnosed present with a neck lump and, when putting each case details through the risk calculator, all of these were identified as high risk.

As a result of these assessments, which clearly demonstrate that demand exceeds capacity, it is proposed that the service is remodelled by implementing ANP led triage on the day following receipt of the referral and Consultant delivered care.

In response, a triage pilot was undertaken using the risk calculator and adhering to the following criteria:

- High risk patients (>7.1) will be referred directly to the Consultant Clinic within 2 weeks
- Moderate risk patients (2.2-7.1) will be referred straight to a fast track clinic
- Low risk patients (1-2.2) will be referred straight to a fast track clinic
- Very low risk patients, which make up a 3rd of patients (0.1.1) will be offered a routine appointment and be removed from the fast track pathway
- Exceptions to triage would be neck lumps, epistaxis with nasal blockage and unilateral glue ear.

This criteria is erring on the side of caution as no cancers were identified in the Low Risk category, but by triaging the Very Low Risk category, it makes a big difference without the risk of missing a cancer.

Alongside the pilot, a new roving clinic model was introduced so that every patient in that clinic is reviewed by a Consultant.

The Consultant led clinics have been reduced to 6 slots with a gap in between each, where the Consultant will go and review the additional patients on the list. For select cases, ring-fenced MRIs are available within 2-3 days.

Pilot results to date have shown that 37% of referrals in the very low risk category could be triaged to a non-urgent pathway and high risk patients were seen within 9.7 days of referral.

Two roving clinics have been held to date, with outcomes compared with the previous model of clinics. This showed an increase in the number of patients discharged or sent for Patient Initiated Follow Up (PIFU), and a decreased number of follow up appointments booked, with the remodelling being better for the organisation and improving the patient experience.

Data has been analysed from the period of time during the pandemic, when the risk calculator was used for all patients with only those assessed as high risk seen, and no cancers were missed.

Due to the impact on workforce, funding is required for an additional Band 8A ANP and ENT middle grade doctor for the pilot to move to business as usual.

However, the new model will be cost saving in terms of reducing follow up appointments, scans, and will help meet Cancer Waiting Time Targets, and will also provide an educational benefit for trainees.

Action: To secure funding for an additional ANP and Middle Grade Doctor. **ENT Team**

Discussion:

ENT PIFU is arranged by providing the patient with instruction to make contact with the ENT surgeons' secretaries should symptoms of concern arise.

Formal permission to change the service model is awaiting ratification.

RUH provide Consultant led triage of all patients (approx. 20 minutes per day) and have seen an increase in patient numbers since GP services have been under significant pressure. Patient may be triaged straight to test or clinic and a proportion may be sent back for further information.

There is no risk calculator available for oral cancer at present.

Action: RUH to present triage data at a future meeting. **Stuart Gillett**

It is hoped that the model will also reduce the number of unnecessary panendoscopies and biopsies.

Cancer Manager Hannah Marder reminded H&N CAG that NHS England states that suspected cancer referrals cannot be rejected prior to agreeing this with the patient's GP.

Action: To explore governance arrangements around rejecting suspected cancer referrals in RUH. **Nicola Gowen**

GPs are encouraged to refer patients with a 3% risk of cancer so the model fits with national standards.

Improving suspected cancer referral quality is on the work programme of the Cancer Alliance for the coming year.

12. National Head and Neck Cancer Priorities: A Cancer Alliance (CA) View

Please see the presentation uploaded on to the SWAG website

Presented by CA Programme Manager Nicola Gowen.

Head and Neck Cancer has been identified as a high priority pathway for service improvements by the National Cancer Programme and is therefore an ideal time for the CA to join in with the discussions on service improvements.

The Head and Neck Best Practice Timed Pathway, first published in 2021 and then re-published in 2024, includes the steps required to meet the 28 day Faster Diagnostic Standard.

In 2022/23, an initial scoping exercise was undertaken across SWAG to understand the implementation status of the pathway. This included the other Trusts in the SWAG footprint that are not involved in H&N CAGs MDT.

Results are in the presentation; it is unclear if the issues identified still require resolving, such as provision of one-stop clinics.

It has been recognised that Cancer Navigator roles are at risk due to the need to secure ongoing funding.

The presentation also lists the work underway or under consideration that is documented in the H&N CAG Work Programme. The CA are exploring how they can assist with any of this work, including formation of the Head and Neck Institute and provision of a Digital Intra-Oral scanner.

It is understood that initial plans are underway to provide a PET scanner within UHBW, but numerous steps need to be undertaken before this can progress.

The National Cancer Programme Priority Pathway Deliverables for 2025/26 sits within the FDS workstream and comes with funding that can be used to deliver additional diagnostic capacity, as it needs to be shown to improve performance.

Trusts where performance falls below 75% are requested to submit an improvement plan.

The majority of deliverables align with the discussion held in the meeting today.	
There is a plan to look into the benefits of a lumps and bumps clinic.	
CA Project Managers are available to help implement the improvement plan.	
Action: CA Project / Programme Managers to make direct contact with key members of Head and Neck CAG to form a working group to help facilitate service improvements.	**Nicola Gowen/CA Team**
It is not possible to gather the relevant data and put forward service improvement plans without Project Management support due to workload demands.	
It could be possible to make an effective one-stop clinic once the triaging process is put in place as all patients identified as high risk could be sent for a scope, ultrasound and biopsy in one sitting; it would not be feasible to provide all Head and Neck suspected cancer referrals with one-stop diagnostics.	**Potential Service Improvement**
Several events have been held for GPs to improve referral quality with no discernible impact. Referrals are received on a weekly basis for lumps and bumps that have been present and unchanged for over 5 years.	
Attempts have been made to update the suspected cancer referral form to include images of ulcerated lesions. It has not been possible to mandate this, but it would be helpful to look into as has been implemented with teledermatology for suspected skin cancer.	
Action: To improve the content of the Head and Neck Cancer Suspected Cancer Referral Form.	**Working Group/BNSSG Glenda Beard**
Action: Consultant Surgeon John Collin will be invited to join the Working Group.	**Nicola Gowen**
Midlands team are working on provision of images along with suspected cancer referrals.	**Potential agenda item**
The Working Group needs to include a Clinical Nurse Specialist.	
Funding could be used to support implementation of the triage system but, at present, it is not clear how much funding will be made available.	

13. Update on Thyroid Cancer Pathway for NBT/UHBW

Presented by Ceri Hughes, Consultant Oral and Maxillofacial Surgeon / Mandy Williams, Consultant Radiologist

Referral guidelines have been adapted on REMEDY to ensure that neck lump diagnostic services are managed by the UHBW team and avoid delays.

Conversations are underway with NBT Consultant Endocrine colleagues on the incidental finding upgrade pathway, with a plan to convene a meeting in the summer to optimise the pathway.

Numbers are quite low and will not put an excessive burden on the service, but the patients need to be tracked on the cancer pathway and access the appropriate CNS support.

The Thyroid Cancer Clinical Guidelines are currently being updated and surgical input is required.

Action: ENT Surgeon Hiro Ishii will proof read the guidelines. **Hiro Ishii**

14. Genomic Medicine Service Alliance update

Presented by Managing Director Jonathan Miller

The Cancer Vaccine Launch Pad (CVLP) has helped facilitate the opening of an mRNA vaccine trial for Head and Neck Cancer, manufactured by BioNTech and called BNT113-01. The trial will look at its effectiveness with or without Pembrolizumab.

All Trusts in SWAG have registered as CVLP sites and opened the colorectal cancer study. For Head and Neck, it is currently open in RUH. Patients recruited will have their tissue sent to the trial team and, should all eligibility criteria be met, an individualised vaccine will be manufactured for delivery at a designated trial delivery site. There is not a delivery site open in SWAG at present, but Torbay plan to open in the near future, and the nearest other site is probably London.

H&N CAG are welcome to contact Jonathan for more information: jonathan.miller@nhs.net

The GMSA are also working with pathology and cancer services to make somatic genomic test results available more rapidly. Turnaround Time (TaT) in the South West Genomic Laboratory Hub (GLH) compares favourably with other GLHs.

Work is underway to ensure that teams are able to request tests in the most efficient way at the right time in the patient's pathway, and that pathology have the right resources to process the samples to send to the GLH as soon as possible.

Transport arrangements are being reviewed for the samples being sent from across each centre.

Discussion:

Eligibility criteria for the vaccine is unresectable, recurrent or metastatic Head and Neck Squamous Cell Carcinoma associated with HPV-16.

Action: The full list of eligibility criteria will be circulated. **Jon Miller/Helen Dunderdale**

15. Any Other Business

The SWAG Cancer Alliance Annual Conference will be held on Wednesday 19th March 2025 in Taunton and has a focus on Early Diagnosis.

The Head and Neck results from the most recent National Cancer Patient Experience Survey (NCPES 2023) are outstanding, with 19 questions rated above 90%, particularly around being involved in treatment decisions and understanding the information given.

Date of next meeting: Tuesday 23rd September 2025, Trust Head Quarters, Bristol Royal Infirmary, Marlborough Street, BS1 3NU

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