Kent & Medway Cancer Collaborative

Head & Neck Tumour Site Specific Group meeting
Wednesday 20th September 2023
Microsoft Teams
13:30-16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Nic Goodger (Chair)	**NG**	Consultant Maxillofacial Surgeon	EKHUFT
Stergios Doumas	**SDo**	Consultant in Oral & Maxillofacial Surgery	EKHUFT
Robert Hone	**RH**	Head & Neck Otolaryngology Consultant	EKHUFT
Ciara Mulcahy	**CM**	ENT Deputy Ops Manager	EKHUFT
Sarah Stevens	**SS**	Macmillan Speech & Language Therapist	EKHUFT
Hannah Washington	**HW**	Cancer Pathway Navigator	EKHUFT
Ali Al-Lami	**AAL**	Consultant ENT / Head & Neck Surgeon	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Karen Glass	**KG**	Administration & Support Officer	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Debbie Hannant	**DH**	Macmillan Lead Head & Neck CNS (MFT & DVH)	MFT
Deborah Owen	**DO**	Macmillan Lead Head & Neck CNS (MFT & DVH)	MFT
Emma Bourke	**EBo**	Macmillan Personalised Care and Support Facilitator	MFT
Nadine Caton	**NCa**	ENT Consultant	MTW
Aleksander Zak	**AZ**	MDT Coordinator	MTW
Milena Truchan	**MT**	Head & Neck CNS	MTW
Chris Singleton	**CSi**	Senior Programme Manager – KMCA Commissioning	NHS Kent & Medway ICB
Jonathan Bryant	**JB**	Primary Care Clinical Director – KMCA	NHS Kent & Medway ICB
Brian Bisase	**BBi**	Consultant Maxillofacial Surgeon	QVH
Bincey Joseph	**BJ**	Macmillan Head & Neck CNS	QVH
Clare Schilling	**CSc**	Consultant Oral and Maxillofacial Surgeon	UCLH
Konstantinos Mantsopoulos	**KM**	Associate Professor – Otolaryngology & Head and Neck Surgery	University Hospital Erlangen, Germany
Apologies			
Tamsin Sharp	**TS**	Macmillan Highly Specialist Speech & Language Therapist	DVH
Sarah Haslam	**SHa**	Registered Dental Nurse and Oral Health Practitioner / Mouth Care Specialist Nurse	DVH
Samantha Mitchell	**SM**	Maxillofacial Unit Operations Manager	EKHUFT
David Tighe	**DT**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Eranga Nissanka-Jayasuria	**ENJ**	Consultant Head and Neck Histopathologist	EKHUFT
Sue Drakeley	**SDr**	Senior Research Nurse	EKHUFT

Ami Archer	**AA**	Macmillan Teenage & Young Adult Clinical Liaison Nurse Specialist	EKHUFT
Claire Forsyth	**CFo**	Macmillan Speech & Language Therapy Support Worker	EKHUFT
Lakshmi Rasaratnam	**LR**	Consultant in Restorative Dentistry	EKHUFT
Sue Honour	**SHo**	Macmillan Lead Head & Neck/Thyroid CNS	EKHUFT
Pippa Enticknap	**PE**	Senior Service Manager – CCHH Care Group	EKHUFT
Karen Robinson	**KR**	Clinical Research Practitioner	EKHUFT
Khari Lewis	**KL**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Nicola Chaston	**NCh**	Consultant Cellular Pathologist	EKHUFT
Alexandra Mcswiney-Baxter	**AMB**	Clinical Research Manager	KCHFT
Lydia Capon	**LC**	Oncology Specialist Dietitian	KCHFT
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
Cathy Finnis	**CFi**	Programme Lead – Early Diagnosis	KMCA
Jeremy Davis	**JD**	Consultant ENT Surgeon	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Evelyn Bateta	**EBa**	Macmillan Head & Neck CNS	MTW
Kannon Nathan	**KN**	Consultant Clinical Oncologist	MTW
Maria Blanco-Criado	**MBC**	Deputy Chief Pharmacist-Cancer & Technical Services	MTW
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway ICB
Bill Barrett	**BBa**	Consultant Oral Pathologist	QVH
Nav Upile	**NU**	Consultant Otolaryngologist Head & Neck Surgeon	QVH
Jill Anderson	**JA**	Interim Access & Performance Manager	QVH
Aakshay Gulati	**AG**	Consultant Oral & Maxillofacial Surgeon	QVH
Clare Lancaster	**CL**	Macmillan Lead Cancer Head & Neck CNS	QVH

Item		**Discussion**	**Action**
1	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • NG welcomed the members to the meeting and asked them to introduce themselves. **<u>Review Action log</u>** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **<u>Review previous Minutes</u>** • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.	

2	**Research**	**<u>Research update – presentation provided by Stergios Doumas</u>** • SDo provided the group with an overview of the PETNECK 2 (PET-CT-guided, symptom-based, patient-initiated surveillance versus clinical follow-up in head neck cancer) trial, particularly with regard to the: - Trial's objective. - RCT trial design. - Primary and secondary outcome measures. - Trial's inclusion and exclusion criteria. - Randomised controlled trial schema. - Contact details for the PETNECK 2 trial office. • Eight patients have been recruited to the trial so far (the second best recruitment rate in the country). SDo thanked colleagues for their help with this, particularly ENT staff. • Trials opened or in the pipeline at EKHUFT include: - **RAPTOR** – Principal Investigator = David Tighe. - **MANTRA** – Principal Investigator = Khari Lewis. - **EVEREST-HN 4** – Principal Investigator = Khari Lewis. • AAL confirmed EKHUFT have recruited 13 patients to the PATHOS trial so far. • West Kent are also working on being able to recruit to the RAPTOR, MANTRA and EVEREST-HN 4 trials.	
3	**Guest Speakers**	**<u>Management of parapharyngeal salivary gland tumours – presentation provided by Professor Konstantinos Mantsopoulos</u>** • Parapharyngeal tumours account for only 0.5% of head and neck tumours, the majority of which are benign (80-90%). • The most common pre-styloid lesion is pleomorphic adenoma. • Common retrostyloidal lesions are paraganglioma (most common vagal) and schwannoma. • The avoidance of complications is based primarily on meticulous preoperative planning including taking a detailed history of the patient, a thorough physical examination (assessment of cranial nerves) and pre-operative imaging (MRI) with aimed questioning. • Prestyloid tumours displace the ICA posteriorly and poststyloid tumours displace the ICA anteromedially. This facilitates differentiation between salivary gland and neurogenic tumours. • It is possible to differentiate between a schwannoma from the vagus nerve or the sympathetic chain. Vagal schwannomas grow between the common carotid artery and the IJV or between the ICA and the IJV, resulting in an increase in the distance between the artery and vein (separation). With regard to schwannomas of the cervical sympathetic chain, no separation between vessels is observed. • Diffusion-weighted MRI seems to be a valuable tool for differentiating benign from malignant tumours.	

		• The choice of surgery is defined through: the position of the tumour relative to the skull base, the extent of contact of the tumour to the outer-remaining inner flap of the parotid gland, the likelihood of malignancy and the tumour size. • The division in prestyloidal–retrostyloidal compartments is significant for two reasons: - It facilitates a first differentiation of origin between salivary gland (prestyloidal) and neurogenic as well as chemoreceptor-related tumours (retrostyloidal). - Retrostylodal tumours have higher surgical morbidity. • 90% of the parapharyngeal lesions can be managed by means of the transcervical (extracapsular dissection) or transparotid approach. • Whenever imaging and/or cytology suggests the benign nature of a PPT, a 'wait and see' policy may also be adopted in asymptomatic or slow-growing lesions, especially in patients with severe comorbidities. • The contemporary trend in surgery of parapharyngeal tumours is to develop minimally invasive approaches which allow tumour resection without the need for mandibulotomy. • KM highlighted the importance of bearing in mind the risks of performing surgery and comparing these against the benefits. Various potential complications can occur, including neural and vascular ones, and these should be carefully discussed with patients. • KM provided the group with an overview of 3 studies pertaining to the management of parapharyngeal tumours, including ones for: - Kuet et al *(Kuet ML et al. Management of tumors arising from the parapharyngeal space: A systematic review of 1,293 cases reported over 25 years. Laryngoscope 2015 Jun;125(6):1372-81. d).* - Horowitz et al *(Horowitz et al. The Transcervical Approach for Parapharyngeal Space Pleomorphic Adenomas: Indications and Technique. PLoS One 2014 Feb 27;9(2):e90210).* - Erlangen data *(Mantsopoulos K et al. Extracapsular dissection in the parapharyngeal space: benefits and potential pitfalls. Br J Oral Maxillofac Surg. 2017 Sep;55(7):709-713).* • With regard to recurrence, KM stated this is around 1-2%. • SD asked whether biopsies are carried out prior to surgery. In response to this, KM stated that in Germany (where he works) reliance is placed on the MRI scan picture. **<u>LOOC trial – presentation provided by Clare Schilling</u>** • Oropharyngeal cancer is increasing in incidence, with nodal metastasis at diagnosis common (~60-80%) and contralateral nodal disease uncommon (~10-25%). • With regard to treatment, bilateral neck treatment (DXT) is common in advance unilateral nodal disease (tumours close to midline). • Lymphatic mapping in the head and neck is reliable in detecting contralateral nodal drainage. • CSc's presentation on the Lymphatic mapping of Oropharyngeal Cancer (LOOC) trial provided the group with an	

		overview of: - The background to the LOOC trial including the disease, its treatment options and the technology used for this purpose. - How to inject radiotracer and OPC. - Images of what failed radiotracer injections look like on an LSG and SPECT-CT. - Conventional Lymphatic Mapping. - The FLEX-NODE and PRIMO studies. - The Freehand SPECT (fhSPECT) device, particularly in relation to the floor of the mouth. - The development of the sentinel lymph node biopsy technique in patients with salivary gland cancer using the IDEAL framework study. - fhSPECT vs. SPECT/CT and LSG (fhSPECT was found to be the superior imaging modality for this treatment). - Pilot data on fhSPECT vs SPECT/CT in oral cancer and the results of this pilot. - The utilisation of the Lymphoseek injection. - The NIHR details pertaining to the: LOOC trial, administrative details, study overview, inclusion and exclusion criteria, study schedule, imaging phase of the trial design as well as their primary and secondary outcomes, sub-study treatment/intervention, Patient Acceptability Questionnaire (which the patient group developed), surgical phase of the trial design as well as the primary outcome and plan, recruiting centres for the trial, and data available so far. • With regard to the rate of contralateral drainage (>20/75 = 27%), CSc believes this will be higher when all of the data (which is currently locked in) becomes available to review. • CSc confirmed all images are anonymised and sent to two radiologists separately for review to ensure there is no bias. • CSc mentioned the fhSPECT is funded by the study. • BBi complimented the team for their hard work and for overcoming the many obstacles they had faced with regard to setting up and evolving this piece of work.	
4	**Performance**	**<u>East Kent & West Kent</u>** • Please refer to the performance slide pack for an overview of East and West Kent's 2ww, 28d, 31d, 62d, conversion rate to cancer and Inter-Provider Transfers data. • Kent & Medway is similar to the England average for FDS and below average for 62d performance. • With regard to the 62d data, RC believes it would be helpful to see how the graphs would compare for expected variability versus unexpected variability. • With regard to 28d FDS performance, NG believes the 73.7% score is very good bearing in mind there is a long diagnostic pathway for head and neck. There are delays in ultrasound-guided biopsies, CT scans, MRI scans and turnaround times for pathology currently sits at 10 days. RC plans to work with colleagues on bringing the reporting times down and highlighted that AI (Artificial Intelligence) implementation is emerging for radiology which could have a positive impact on expediting delays/turnaround times thereby allowing radiologists to concentrate more on reporting. RH suggested ultra-sonographers are utilised better to do the biopsies.	

		• In relation to the 42.1% 62d figure for Kent & Medway, NG believes this is low due to the diagnostic pathway, particularly with regard to operational/diagnostic capacity. There are a high number of 2ww referrals so more patients are going through the diagnostic pathway. • RC added it is important to encourage personnel, for example radiologists, to have additional training in order to specialise in particular tumour groups (for example head and neck). • With regard to 2ww performance, NG believes West Kent have the additional issues associated with the fact that they are comprised of more than one Trust. **EKHUFT – update provided by Ali Al-Lami** • Please refer to the performance slide pack for an overview of the Trust's data. • In relation to FDS performance, patient breaches have been stable over the last few months. Diagnostic pathways are the key delays for both thyroid and head and neck. CNS' are now calling patients and requesting their blood tests in advance which is helping to speed up the process. • 31d performance is an improving picture and additional theatre access would result in further improvements. • With regard to 62d performance, there is a need for additional theatre capacity. **MFT – update provided by Nic Goodger** • Please refer to the performance slide pack for an overview of the Trust's data. • NG mentioned there are relatively few head and neck patients for MFT so if one or two patients breach, this can have a significant impact on the performance figures. • NG stated MFT's FDS performance is very good and both Pathway Coordinators and CNS' are driving this work for improvement. • Patients sent on to a different tumour site pathway can result in big delays which can therefore impact on performance targets. **MTW – update provided by Aleksandra Zak** • Please refer to the performance slide pack for an overview of the Trust's data. • FDS performance has been impacted by industrial action and annual leave over the summer period. • With regard to 28d FDS performance, typing delays in informing patients whether they do or do not have cancer has had an impact on compliance. In view of this, BB recommended utilising a standardised letter for the communication of this information – something which has been of benefit to QVH. **QVH (Kent data) – update provided by Brian Bisase** • Please refer to the performance slide pack for an overview of the Trust's data. • BBi stated QVH have noted a consistent rise in the volume of 2ww referrals since 2019. • With regard to 62d backlogs, QVH tend to find most of these issues are associated with diagnostics. • With regard to 104d backlogs, QVH often find these pertain to patient choice.	

		• Better communication has facilitated the utilisation of additional theatre capacity.	
5	**Suction Units – update**	**<u>Update provided by Chris Singleton</u>** • Further to the update provided at the Head & Neck TSSG on 31.03.2023, the below is a reminder of the processes in place to order suction units and related consumables. None of the processes described here have changed since the last update provided on 31.03.2023. Please continue to contact CSi at chris.singleton@nhs.net if any issues with these processes are experienced. • Since the last TSSG meeting on 31.03.2023, only one issue regarding the prescribing of suction consumables has been raised, meaning CSi hopes these processes are better established. The one issue raised was in the Medway & Swale locality, and CSi understands this was resolved with input from the local ICB prescribing team. However, DH highlighted that the ordering of consumables for these areas continues to be an issue despite CSi's, and formerly Rakesh Koria's, hard work. NG noted there is therefore inequity across the patch in terms of processes which needs to be addressed. DH will follow up the issues Medway & Swale are having with JB, RC and CSi outside of this meeting. • It remains the case that there are different ordering processes in place across the Kent & Medway localities. The hope is still to harmonise these processes into a single approach across the county, but there is reluctance to change some of the established local processes, which go far beyond head and neck cancer patients. • KMCA is continuing to make the case for harmonising processes, and highlight any instances where existing processes are not working. Please continue to highlight to CSi if there are any issues. **Ordering of suction units** • For all Kent patients, these can be ordered via the NRS system. All Trusts have nominated leads able to order these items and managers can request individual staff have access to order equipment from the NRS Integrated Community Equipment Service (ICES) catalogue. • For any queries on how to be set up on the NRS system, please contact Kmicb.ices@nhs.net. **Consumables ordering process** • *Dartford, Gravesham and Swanley patients*. A process is in place between GP practices and DVH procurement to order any non-prescribable consumables. This process is now well-established and GPs only need to complete an order form and the DVH procurement team will then order and deliver the item. A copy of the process shared with GP practices and the order form can be provided on request and has already been shared with head and neck colleagues working on the Dartford site. • *East Kent patients*. For patients on the caseload of the EKHUFT trache team, consumables are supplied via EKHUFT. For those not under the EKHUFT trache team, consumables can be supplied via the Kent Community Health NHS Foundation Trust procurement team. These arrangements should be well-established and community and district nursing teams aware. • *Medway & Swale patients*. The current process is consumables should be ordered via the patient's GP practice.	

		• *West Kent patients*. Again, the current process is for consumables to be ordered via the patient's GP practice.	
6	**Cancer Alliance update**	**<u>Update provided by Chris Singleton</u>** • In Kent & Medway, KMCA are about to embark on their third and final year of the Galleri GRAIL trial. The trial has been held in a mobile unit and has visited a number of areas across the locality based on demographic factors. Patients who have been part of the trial are now in the process of being recalled. • KMCA are aware that the expected number of patients who would trigger a Cancer Signal Origin (CSO) is 1-2%. • KMCA have identified a number of pre-symptomatic cancers, particularly those for thyroid. • Two GRAIL webinars will be taking place next month (a national one on 16.10.2023 and a Kent & Medway-specific one on 05.10.2023). • The Targeted Lung Health Check (TLHC) programme has identified a head and neck cancer. • Nationally, there will be some changes to Cancer Waiting Times standards from October 2023. The national team are aiming to harmonise the multiple standards in to three targets – 28d FDS, 31d and 62d. **<u>Medical Director - update provided by Ritchie Chalmers</u>** • RC complimented all TSSG Chairs for their work on developing their respective meetings. • RC believes strong clinical leadership is imperative for driving the TSSGs forward. • RC highlighted the importance of identifying the specific problems KMCA have compared to the rest of the country and identifying what she described as 'pinch points', areas requiring more input from specialties to expedite issues. • RC stated there is an aim to develop a clinical strategy which dovetails with the ICB clinical strategy and KMCA believe the TSSG is the most appropriate forum to drive this forward for the region. • With regard to TSSG membership, KMCA aim to facilitate and support the various sub-specialties to attend these meetings. • RC is also keen for the TSSGs to introduce lead roles such as a Lead Radiologist, Lead Pathologist and Lead CNS and she welcomes views from others regarding implementing these. • RC believes KMCA are exemplary with regard to working towards implementing the national agenda. **<u>KMCA Primary Care Clinical Lead – update provided by Jonathan Bryant</u>** • JB introduced himself to the group as the Primary Care Clinical Lead for KMCA. • JB will be working with colleagues in order to bridge the gap between primary and secondary care and he looks forward to working on expediting issues which affect both services. • There is ongoing work within primary care to improve the quality of referrals. • AAL emphasised the importance of GPs making patients aware they are on a cancer pathway when referring them in to secondary care on a 2ww.	
7	**CNS Updates**	**<u>EKHUFT</u>** • There were no EKHUFT CNS' at today's meeting so an update was not provided.	

		MFT – update provided by Debbie Hannant • There have been a number of HEADSTART meetings since the pandemic and it is functioning well. • MFT recently delivered a Health & Wellbeing event which attracted a number of patients from various tumour sites, although head and neck patients do not tend to attend the events. **MTW – update provided by Milena Truchan** • MTW are looking to introduce a head and neck STT service. **QVH – update provided by Bincey Joseph** • Funding has been provided by KMCA for a new CNS. • Nurse-led clinics will commence later this year. • A new FDS Navigator is in place for the service.	
8	**Audit update**	• NG stated he would liaise with Vikram Dhar regarding whether an audit could be presented at the next meeting.	
9	**AOB**	• **Action: BB asked if a presentation on prehab could be provided at a future meeting.**	**AW**
	Next Meeting	• It was agreed the next meeting would take place in Maidstone on a Thursday in March 2024. Further details to follow in due course.	