Head & Neck Tumour Site Specific Group meeting
Tuesday 4th March 2025
Park View Meeting Room - Mercure Great Danes Hotel
13:30-16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Nic Goodger (Chair)	**NG**	Consultant Oral and Maxillofacial Surgeon	EKHUFT
Maria Ploch	**MPl**	Head & Neck Dietitian	EKHUFT
Sue Honour	**SHo**	Macmillan Lead Head & Neck CNS	EKHUFT
Amy Organ	**AO**	MDT Coordinator	EKHUFT
Vik Dhar	**VD**	ENT Consultant	EKHUFT
Hannah Washington	**HW**	Faster Diagnosis Manager	EKHUFT
Anna Lamb	**AL**	Cancer Performance Manager	EKHUFT
Ali Al-Lami	**AAL**	ENT Consultant	EKHUFT
Chris Theokli	**CT**	ENT Consultant	EKHUFT
Stergios Doumas	**SDo**	OMFS Consultant	EKHUFT
David Tighe	**DT**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Sally Fouda	**SF**	Consultant Clinical Oncologist	EKHUFT
Kalyani Nair	**KNai**	F1 Doctor	EKHUFT
Eranga Nissanka-Jayasuriya	**ENJ**	Consultant Head & Neck Histopathologist	EKHUFT
Jesuloba Abiola	**JA**	OMFS Consultant	EKHUFT
Elizabeth Diamond	**ED**	Oncology Dietitian	KCHFT
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	KMCA
Karen Glass	**KG**	PA/Business Support Manager	KMCA/KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Samantha Williams	**SW**	Administration & Support Officer	KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Amy Cass	**ACa**	Cancer Pathway Coordinator	MFT
Debbie Hannant	**DH**	Macmillan Head & Neck CNS	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT

Michael Ho (via Microsoft Teams)	**MH**	Consultant in Oral and Maxillofacial Surgery	Leeds Teaching Hospital
Hayley Martin	**HM**	Personalised Care & Support Facilitator	MFT
Anthi Zeniou	**AZ**	Consultant Clinical Oncologist	MTW
Charlotte Hardy	**CH**	Registrar	MTW
Flora Elwes	**FE**	ST5 Clinical Oncology	MTW
Dennis Baker	**DB**	Consultant Radiologist	MTW
Miles Pope	**MPo**	MDT Coordinator	MTW
Navdeep Upile	**NU**	Head & Neck Consultant	QVH
Adam Gaunt	**AG**	Head & Neck Consultant	QVH
Michelle Dubber	**MD**	Head & Neck CNS	QVH
Nicky Starling	**NS**	Head & Neck CNS	QVH
Bincey Joseph	**BJ**	Head & Neck CNS	QVH
Ben O'Leary	**BOL**	Consultant Clinical Oncologist	The Royal Marsden
Apologies			
Sarah Haslam	**SHas**	Mouth Care Nurse	DVH
Alistair Balfour	**AB**	Consultant ENT, Head & Neck and Thyroid Surgeon	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager - CCHH Care Group	EKHUFT
Rob Hone	**RH**	Head & Neck Otolaryngology Consultant	EKHUFT
Danielle Mackenzie	**DM**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Sue Drakeley	**SDr**	Senior Research Nurse	EKHUFT
Sarah Hale	**SHal**	Speech and Language Therapist	EKHUFT
Jo Jackson	**JJ**	Early Diagnosis Project Manager	KMCA
Ann Courtness	**ACo**	Macmillan Primary Care Nurse Facilitator	KMCA
Annaselvi Nadar	**AN**	Matron – Faster Diagnosis	MFT
Jeremy Davis	**JD**	Consultant ENT Surgeon	MFT
Aleksandra Zak	**AZ**	MDT Team Lead	MTW
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Kannon Nathan	**KNat**	Consultant Clinical Oncologist	MTW
Natalie Ryan	**NR**	Consultant Radiologist	MTW
Nadine Caton	**NC**	ENT Consultant	MTW
Emma Lloyd	**EL**	Cancer Pathways Improvement Project Manager	NHS Kent & Medway ICB
Brian Bisase	**BB**	Consultant Maxillofacial Surgeon	QVH

Item		Discussion	Action
1.	TSSG Meeting	**Apologies** • The apologies are listed above. **Introductions** • NG welcomed the members to the meeting and asked them to introduce themselves. **Action log Review & discuss** • The action log was reviewed, discussed and will be circulated to the members along with the final minutes from today's meeting. **Review previous minutes** • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2.	Dashboard	• FDS performance improved from 69.7% to 76.4% in the last six months, but 62 day performance fell from 61.4% to 53.2%. • 62 day performance is lowest at EKHUFT (43.0%) and QVH (48.2%). • EKHUFT are currently experiencing issues with diagnostics, particularly in relation to radiology. • DT feels it would be helpful for the Dashboard for head and neck to have an East Kent versus West Kent comparator (combining the aggregated data for MFT, MTW and QVH) and for the England average to be included. • NG encouraged the members to sign up to the Dashboard if they have not done so already.	

3.	**Clinical Reference Group Discussion**	**<u>Update provided by Nic Goodger</u>** • The Head & Neck CRG (which meets monthly) is made up of the following members: - Nursing – Debbie Hannant. - Surgery – Ali Al-Lami. - Pathology – Eranga Nissanka-Jayasuriya. - Oncology – Anthi Zeniou. - Dietitian – Elizabeth Diamond. - Speech & Language Therapist – Tamsin Sharp. - Restorative Dentist – Lakshmi Rasaratnam. • There is currently no primary care lead or radiologist for the Head & Neck CRG. • So far there have been two Head & Neck CRG meetings. The first meeting focussed on the pathway and there was a discussion around the need to review this from the point of primary care contact all the way to palliative care. • There have also been discussions around radiology pathways and whether mutual aid could be put in to practice as well as discussions around data and audits. • **<u>Action</u>: AW to circulate the CRG Terms of Reference to the relevant CRG members.**	**AW**
4.	**GIRFT**	**<u>Presentation provided by Sue Honour</u>** • SHo's presentation provided the group with an overview of: - The process involved in the GIRFT review. This includes: questionnaires, data collection, a virtual review and a written report.	

		- What good practice looks like. This includes: the MDT set-up and structure; an excellent MDT altered airway team; a useful pre-MDT meeting being in place; good documentation of TNM, performance status and treatment plans; a single generic head and neck urgent suspected cancer referral form being in place; CNS support and CSWs completing HNAs; dedicated alcohol and addiction team support; and, all patients at MTW having a CNS present at diagnosis. • With regard to Speech Therapy, there is: an excellent research collaboration; good access to fees and VF support; and, frequent use of standardised outcome measures. • In relation to Restorative Dentistry, there is: good engagement between all MDT members and the RD service; a one-stop head and neck restorative clinic running alongside the MDT; an electronic referral to allow early triage; an MDT bi-monthly QoL clinic; specialist trainee exposure to the non-dental hospital setting and dental implant placement; and, joint working with OMFS/RD. • In terms of follow-up, there is an MDT Late Effects clinic in place. • Areas of concern include: the volume of referrals; there being no one-stop neck lump clinic; there being insufficient nasendoscopes; the CNS in East Kent is not present at diagnosis; the SALT is not available five days a week across all sites; and, there is no designated dietetics support. • Areas of concern relating to Restorative Dentistry in particular include: there being a split pathway (lack of development of appropriate support staff and infrastructure in West Kent); a lack of cover for MDT meetings; a lack of job planned time for some important aspects of work; a lack of access to Zygomatic implants as a treatment option; funding for intra-oral optical scanner/digital planning software; and, a lack of access to primary dental care. • Areas of concern in relation to surgery in particular include: a lack of infrastructure (the team has expanded but not the facilities) and there is a need for a new microscope in theatre. • Key actions and recommendations include:	

		- A clarification of patient pathways between MTW and EKHUFT. - Joint head and neck appointments. - Cover arrangements for leave for MTW. • In terms of a post-meeting update: - A dietitian has been appointed in East Kent. - The CNS team in East Kent is working with surgeons to be present for more patients at diagnosis. - There is improved cover for MDT for pathology and radiology. - The new pathology system will allow access to East/West Kent pathology. • SHo stated that the GIRFT review, which took place in September 2024, was an easier process than the previous Peer Review. The written report has been sent back to Alistair Balfour. **<u>Presentation provided by Nav Upile</u>** • This presentation follows the GIRFT review of November 2023. • The MDT network serves a population of 1,009,216 people. • A review of decision-making around the move of ENT patients from MTW to EKHUFT would be beneficial with specific consideration given to whether this is causing delays to patient pathways – a review of the inter-provider transfer policy would be useful. • Diagnostic imaging at Dartford & Gravesham requires standardisation to be in line with the rest of the network. • In terms of strengths, these include but are not limited to: a cohesive group who are happy to have robust discussions and are always happy to help one another; a sentinel node biopsy implanted in the network; an excellent nuclear medicine service; an overall excellent radiology service; all CNSs attend the MDT and see almost all patients at the	

		point of diagnosis; and, there is a good range of free flap reconstructions. • With regard to concerns, these include but are not limited to: there are split pathways and a lack of any clear process highlighted in both reports; the MDT Coordinator is overstretched with a high turnover of staff; there are difficulties in recruiting head and neck oncologists; there is no CNS based at MTW; insufficient SALT capacity leading to shorter follow-up times; Maidstone dietitians have limited time to attend MDT, due to staffing levels and increased numbers of patients on their caseload; QVH have a stretched dietetic service with difficulties recruiting; and, Macmillan radiographers cover a huge amount of the work of supporting radical and palliative patients throughout their radiotherapy appointments. • NU highlighted the need for there to be further discussions around service provision, particularly around the concept of sharing resources. He suggested a single MDT for Kent & Medway would be helpful and also that consideration be given for cross-MDT support for radiology and pathology. • NG highlighted that the national GIRFT report has yet to be published (although it is expected shortly) and the national Service Specification is sat with NHSE currently. The national GIRFT report will set the scene for the future and be the method through which services move forward. • AZ emphasised the importance of ensuring joint clinics do not cease, with patients often needing to see an oncologist and specialist surgeon at the same time. With regard to split pathways, AZ believes it is important these patients are not lost and this is currently taking a lot of work from the MTW Oncologists. • NG suspects the underlying solution may be to have a single MDT in the future across the patch. • **<u>Action</u>: NG to contact Ian Vousden and Ritchie Chalmers regarding the publications of the GIRFT reports and the discussions had at today's meeting pertaining to the findings/concerns raised.**	**NG**
5.	**Guest Speakers**		

		<u>Complications in H&N surgery - presentation provided by Michael Ho (Consultant Maxillofacial Oncology - Leeds Teaching Hospital)</u> • MH's presentation on 'Complications in H&N surgery' provided the group with an overview of: - The cost of surgical complications. - Strategies in the reduction of complications/optimisation of outcomes. - Complications and the MDT treatment pathway. - The association between deprivation and surgical complications. - Future strategies. • Each year, around 135,000 on-the-day surgical cancellations take place, estimated to cost the NHS £400 million annually in lost operating theatre time. • 10-15% of operations have complications – which are often predictable and potentially preventable. • Within hospitals, 45% of costs can be attributed to 3% of patients – typically those experiencing complications. • Patients often spend one or two days longer than necessary in hospital after surgery due to surgical pathway inefficiencies. • MH provided the group with an overview of: - A North American study on around 15,000 patients on the 'Complications Associated with Mortality after Head and Neck Surgery: An Analysis of the NSQIP Database'. - A BMJ Open study on the 'Costs and outcomes in evaluating management of unhealed surgical wounds in the community in clinical practice in the UK: a cohort study'. - An article on 'Designing and integrating a quality management program for patients undergoing head and neck resection with free-flap reconstruction'.	

- A QOMS study on 'TIME FROM SURGERY TO ADJUVANT TREATMENT IN THE MANAGEMENT OF ORAL CANCER – NATIONAL FINDINGS FROM THE BAOMS QOMS INITIATIVE'.
- A study on the 'Evaluation of Deprivation Status on Outcomes of Head and Neck Cancer Treatment with Primary Surgery'.
- An article entitled 'Complication Is Inevitable, but Suffering is Optional—Psychological Aspects of Dealing with Complications in Surgery'.

Deciphering evolution of therapy resistance in head & neck cancer – presentation provided by Ben O'Leary (Consultant in Clinical Oncology - The Royal Marsden)

- BOL provided the group with a presentation on 'Deciphering evolution of therapy resistance in head and neck cancer'.

- BOL posed the following questions to the group:

- What do we know about evolution in HNSCC?
- Why might evolution be important in radiotherapy and immunotherapy resistance?
- How we can explore this further? Introducing immunoREACH.

- BOL's presentation provided the group with an overview of:

- Radiotherapy failure in HNSCC which has a ~40% relapse rate.
- Immunotherapy being effective in recurrent disease as per KEYNOTE-048.
- Concomitant/adjuvant trials to date with radiotherapy/immunotherapy in the curative treatment setting.
- The evolution of HNSCC.
- The origins of RECUT plus RESCUE.
- The postulation that:
  1. Cancers with unstable genomes evolve to evade the immune system.
  2. IMvigor010–ctDNA+ve bladder cancer patients after surgery have better outcomes with adjuvant atezolizumab.
- 3. ctDNA can predict relapse in HNSCC–HPV+.
- Immune microenvironment in radiotherapy recurrence.

		- The detection of ctDNA and clinical recurrence. - immunoREACH. - QX600 ddPCR. - Carbo/5FU/Pembrolizumab/Evorpacept (ASPEN 04 trial) in metastatic disease. - Cemiplimab/ISA101b HPV vaccine (ProCem ISA trial). • In concluding, BOL stated: - There is very little understanding about evolution in HNSCC. - How HNSCC evolves through radiotherapy could help us understand mechanisms of resistance to radiotherapy and the interaction between the immune system and radiotherapy. - There is the potential for collaborative translational work and he introduced the premise of immunoREACH.	
6.	**Service Evaluation of First Line Pembrolizumab For Incurable Head & Neck Cancer at East and West Kent**	**<u>Presentation provided by Flora Elwes & Charlotte Hardy</u>** • FE and CH provided the group with a presentation on the 'Service Evaluation of First Line Pembrolizumab for Incurable Head and Neck Cancer in East and West Kent'. • The service evaluation was a focus on a retrospective audit of patients with untreated recurrent or metastatic head and neck cancers in Kent Oncology Centre. • The KOMS database searched for all patients with a head and neck cancer diagnosis who received Pembrolizumab between 01.01.2019 and 14.11.2024. • The Keynote-048 Study compared Pembrolizumab alone or with chemotherapy versus cetuximab with chemotherapy for recurrent or metastatic SCC of the head and neck. • The presentation provided the group with an overview of: - Demographics.	

		- Tumour subsites. - Disease status. - PDL1 CPS score. - The number of cycles completed. - Response to treatment as evaluated by PET-CT scan after three cycles of Pembrolizumab. - The response to treatment by CPS. - Survival data. - Immunotherapy toxicities. - The reasons for stopping treatment. - The number of deaths on treatment. • In summary: - There were 77 patients as part of the evaluation. - 56% of patients had oropharyngeal cancer. - Patients received an average of 8.5 cycles (+/- 8 cycles) of Pembrolizumab. - Staff saw stable disease or response in 51% of patients after three cycles. - The mean overall survival was 10.32 months. - 20% of patients experienced IO toxicities (leading to discontinuation in 9% of patients). - Most patients discontinued treatment due to disease progression; the second most common reason was patient death. • In conclusion: - Better collection/retrieval of information on immunotherapy toxicities is required. - There are learning points around communication between medicine and oncology. - There needs to be better data/insights into deaths on treatment.	
7.	**BAOMS QOMS**	• Due to time constraints, this item was not discussed.	

		• **<u>Action</u>: BAOMS QOMS to be an agenda item for the next meeting.**	**KMCC team**
8.	**CNS updates**	**<u>EKHUFT</u>** • The head and neck support group is functioning well. • Listening events have been set up and these have received positive patient feedback. **<u>MFT</u>** • The team have employed a STT CNS to support the 2ww pathway. **<u>MTW</u>** • No update provided as there was no MTW CNS representation at today's meeting. **<u>QVH</u>** • The team are running a 12 week 'Surgery Hero' programme to support prehab/rehab patients. • The team are due to commence with PETNECK2 with SDo's support. • Nurse-led clinics commenced around six months ago and they are seeing 2ww and low-risk follow-up patients. • There is a SALT-led clinic in place.	
9.	**Clinical Audit updates**	**<u>Update provided by Ali Al-Lami</u>** • AAL stated that:	

- PETNECK2 has recruited 42 patients and the trial has been extended to June 2026.
- PATHOS recruited 17 patients and AAL is awaiting the results publication.

QIP evaluating the efficacy and outcomes of local anaesthetic biopsy in clinic – presentation provided by Kalyani Nair

- KNai provided a presentation on 'QIP evaluating the efficacy and outcomes of local anaesthetic biopsy in clinic'.

- Local anaesthetic (LA) biopsy outpatient clinics offer significant advantages:

- Faster diagnosis and treatment initiation.
- Shorter waiting time for biopsies.
- Reduced healthcare costs.
- Improved patient safety and comfort.
- It can avoid a general anaesthetic so therefore ideal for patients who have significant medical comorbidities.

- The aim of this project was to assess how effective these LA biopsy outpatient clinics are at providing a definitive diagnosis which can be used to guide treatment.

- NHS England suggest LA biopsy in an ENT one-stop clinic if it will not interfere with imaging for staging.

- Specific equipment required includes a flexible nasendoscope with side channel and a transnasal oesophagoscope. Trained personnel/clinic staff are essential.

- With regard to the methodology:

- There was data collected from 13 clinics over 20 months. The biopsy clinic runs on the first Thursday of every month.
- There was inclusion/exclusion criteria. Clinic letters were reviewed from each patient and patients were excluded if they were booked in the same clinic but not on a LA biopsy slot.

		- Key metrics were evaluated. These included patient demographics, indications for the procedure, the adequacy of the biopsy for diagnosis and the need for further GA and reasons for this. • In terms of the results: - 26 out of 32 patients (81%) had a procedure in clinic. - One patient had two biopsies (nasal and interarytenoid). - Six out of 32 patients (19%) were listed for GA directly from clinic. - The majority were biopsies (22 out of 26 – 85%). - Non-biopsy procedures (four out of 26 – 15%). - In total there were 26 patients who had procedures under LA in clinic (27 procedures in total). - There was a definitive diagnosis in 92% (24 out of 26 patients). - The sensitivity was 88% (7/8) and the specificity 100% (15/15). • In terms of points of discussion: - The majority of patients referred to this clinic had a procedure under LA. - This provided a definitive diagnosis in 92%. - Three patients (11%) had to have a further procedure due to an insufficient sample. • With regard to limitations: - There were issues with equipment. - Training for clinic staff on new equipment/assisting procedure was required. - The data sample was small. - There is the potential to be falsely reassured by benign histology. - LA biopsy should not be used to rule out cancer but more to confirm. If a case is benign and suspicious, it is worth considering a further biopsy under GA.	

		• In relation to recommendations and concluding points: - It is essential equipment is up-to-date and spares are available for clinics. - It is worth continuing to utilise LA biopsy clinics for those who have large/exophytic lesions which are amenable to a biopsy. - It is helpful to create inclusion/exclusion criteria for those who would be suitable for referral to LA biopsy clinic to streamline the process. - It is recommended to complete a further cycle of data collection after changes are implemented. - LA biopsy clinics offer a safe alternative for those patients where GA carries a high risk of morbidity/mortality. - LA biopsy clinics can reduce waiting times for procedures and the initiation of treatment. - If there is any suspicion of malignancy despite negative histology, this should be discussed at MDM and consideration should be given to a further procedure under GA.	
10.	**AOB**	• NG informed the members that AW will be retiring in June 2025 and thanked her for the support she has provided to the Head & Neck TSSG.	
11.	**Next Meeting**	• To be confirmed.	