Kent & Medway Cancer Collaborative

Head & Neck Tumour Site Specific Group meeting Thursday 26th March 2026 Lecture Theatre (Education Centre) – William Harvey Hospital 13:30-16:30			
Final Meeting Notes			
Present	**Initials**	**Title**	**Organisation**
Nic Goodger (Chair)	**NG**	Consultant Oral and Maxillofacial Surgeon	EKHUFT
Chris Theokli	**CT**	Consultant ENT/Head & Neck Surgeon	EKHUFT
Alistair Balfour (Webex)	**AB**	Consultant ENT, Head & Neck and Thyroid Surgeon	EKHUFT
Eranga Nissanka-Jayasuriya	**ENJ**	Consultant Head and Neck Histopathologist	EKHUFT
Lakshmi Rasaratnam	**LR**	Consultant in Restorative Dentistry	EKHUFT
Omar Ahmed (Webex)	**OA**	Consultant ENT/Head & Neck/Robotic Surgeon	EKHUFT
Sue Honour	**SHo**	Macmillan Lead Head & Neck and Thyroid CNS	EKHUFT
Sarah Stevens	**SS**	Macmillan Speech & Language Therapist	EKHUFT
Jesuloba Abiola	**JA**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Ali Al-Lami	**AAL**	Consultant ENT/Head & Neck Surgeon	EKHUFT
David Tighe (Webex)	**DT**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Khari Lewis	**KL**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Vikram Dhar	**VD**	Consultant ENT and Head & Neck Surgeon	EKHUFT
Annapoorna Pai	**AP**	Oral and Maxillofacial Consultant	EKHUFT
Alexandra Langlands	**AL**	Speech and Language Therapist	EKHUFT
Sanjeev Madaan (Webex)	**SM**	Consultant Urological Surgeon	DGT
Debra Josephs (Webex)	**DJ**	Consultant Medical Oncologist	GSTT
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Business Support Manager/PA	KMCC
Samantha Williams	**SW**	Administration & Support Officer	KMCC
Claire Newbury	**CN**	Faster Diagnosis Head & Neck CNS	MFT
Debbie Hannant	**DH**	Macmillan Lead Head & Neck CNS (MFT & DVH)	MFT
Kannon Nathan	**KN**	Consultant Clinical Oncologist	MTW
Sally Fouda	**SF**	Consultant Clinical Oncologist	MTW

Kate Hulley	**KHu**	Consultant Radiologist	MTW
Bindu George	**BG**	Head & Neck CNS	MTW
Brian Bisase	**BB**	Consultant Maxillofacial Surgeon	QVH
Lynn Monterola (Webex)	**LM**	Macmillan Head & Neck CNS	QVH
Nav Upile	**NU**	Consultant Otolaryngologist Head & Neck Surgeon	QVH
Kevin Harrington (Webex)	**KHa**	Consultant Clinical Oncologist	The Royal Marsden NHS Foundation Trust
Apologies			
Sarah Haslam	**SHa**	Mouth Care Nurse	DGT
Danielle Mackenzie	**DM**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager - CCHH Care Group	EKHUFT
Elizabeth Diamond	**ED**	Highly Specialist Oncology Dietitian	KCHFT
Lydia Capon	**LC**	Oncology Specialist Dietitian	KCHFT
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	KMCA
Ritchie Chalmers	**RC**	Medical Director	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Jeremy Davis	**JD**	Consultant ENT Surgeon	MFT
Basim Wahba	**BW**	ENT/Head & Neck Consultant	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Benjamin Hunter	**BH**	Consultant Oncologist	MTW
Ann Fleming	**AF**	Consultant Histopathologist	MTW
Anthi Zeniou	**AZ**	Consultant Clinical Oncologist	MTW
Helen Graham	**HG**	Research Delivery Manager (Cancer)	NIHR
Stergios Doumas	**SD**	Consultant in Oral & Maxillofacial Surgery	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. **<u>Action log review</u>**	

		• The action log was reviewed, updated 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	**CORBUS Trial**	**Presentation provided by Debra Josephs** • CRB-701, a phase 1/2 clinical trial, is an investigational antibody-drug conjugate (ADC) targeting Nectin-4. It is designed to deliver chemotherapy directly to tumour cells while limiting exposure to the rest of the body. • CRB-701 is delivered intravenously every three weeks and is indicated for advanced solid tumours, including HNSCC. • CRB-701 aims to improve on existing ADCs by reducing systemic toxicity, maintaining anti-tumour effectiveness and lowering the risk of peripheral neuropathy. • Responses were seen across HPV-positive and HPV-negative patients as well as in PD-L1 positive and negative tumours. • Activity was observed in pre-treated patients. • With regard to interpretation, there was a strong early efficacy signal in a difficult-to-treat population and it is competitive with existing treatment options. • In terms of the safety profile, there were no dose-limiting toxicities reported and no Grade 4–5 treatment-related adverse events. It was well tolerated in early studies, although the most common adverse events (>15%) included keratitis, alopecia, fatigue, anaemia and dysgeusia. • In peripheral neuropathy there was ~8% incidence (mild only) and this was lower than expected for this drug class. • DJ highlighted the importance of ophthalmologic monitoring and prophylaxis. • A combination strategy of CRB-701 + pembrolizumab is in development. • The target setting is for those requiring first line treatment for locally advanced or metastatic oropharyngeal HNSCC. • Eligibility highlights include: - No prior systemic therapy (advanced setting). - Prior peri-operative immunotherapy allowed (with restrictions). - Patients with a performance status up to 2.	

		• Key risks and considerations include: - Early-phase data highlights that there was small patient numbers. - Ocular toxicity requires proactive management. - There is a need for validation in larger, randomised trials. - The competitive landscape includes established immunotherapies and ADCs. • In conclusion, CRB-701 demonstrates encouraging anti-tumour activity (ORR up to ~48%), a favourable early safety profile, particularly low neuropathy and a strong rationale for first-line combination strategies. • CRB-701 is a promising emerging therapy in HNSCC with potential to improve outcomes, pending further clinical validation.	
3	**Research Update**	**<u>Presentation provided by Sally Fouda</u>** **NHS Cancer Vaccine Launch Pad (CVLP) – BNT113-01** • This was mentioned as part of ongoing research activity and focuses on cancer vaccine development. **PETNECK2 trial** • This trial is a phase 3 randomised trial. • Eligible patients include pharyngeal, laryngeal or oral cavity SCC and must have completed curative treatment ≥6 months ago. Recruitment for this trial ends on 31.03.2026. **RAPTOR trial** • Treatment for the RAPTOR trial comprises of pentoxifylline, tocopherol and clodronate. • The trial has been open since April 2023 and only one patient has been recruited so far. **HoT trial (thyroid cancer)** • This phase 3 randomised trial focuses on patients who have low-risk differentiated thyroid cancer. • A comparison was outlined - surveillance vs total thyroidectomy (two-stage) and single-stage total thyroidectomy vs hemithyroidectomy.	

		• 30 participants have been recruited to date. **Overall takeaways** • There are multiple active phase 3 trials across head and neck and thyroid cancers. • Recruitment varies significantly (strong in HoT, very low in RAPTOR). • PETNECK2 is nearing the recruitment deadline. • There is a continued focus on expanding clinical research participation.	
4	**Exploring prevalence of Head and Neck Cancer and Skin Cancer in Kent and Medway to identify health inequity**	**<u>Presentation provided by David Tighe</u>** • The project investigates the prevalence and distribution of head and neck cancer and skin cancer across Kent & Medway, aiming to identify any health inequalities or environmental/social determinants linked to these cancers. **Data sources and population** • There is a total population of around 1.8 million people in Kent & Medway. • The time period studied was 2014–2019. • Cancers studied included head and neck cancer and non-melanoma skin cancer. • There were 1,249 head and neck cancers and 11,152 skin cancer patients. • Data came mainly from primary care records plus some acute care data. Secondary metastases were excluded. • Large-scale data engineering was required due to missingness, especially for ethnicity, which was too sparse for reliable modelling. **Geographical patterns** • Heatmaps revealed where each cancer type is most prevalent. • Urban centres consistently showed higher prevalence for both cancer groups. • Age-standardised prevalence mapping at LSOA level highlighted clear clustering of cases. **Deprivation**	

- Both cancers showed no strong correlation with socioeconomic deprivation.

Correlation analysis

- There was detailed mining of all available patient data, including symptoms, medications, diagnostics, tests, demographics and wider determinants.
- Case vs control cohorts were created.
- Numerous correlations were identified, but these require clinical interpretation.
- Not all symptoms are predictive - some occur before and some occur after diagnosis.

Model development

- Synthetic Minority Oversampling (SMOTE) was applied due to low baseline prevalence (~0.2%).
- Multiple classifier types were tested, including logistic regression and greedy feed-forward algorithms.
- Models were tuned using various population-testing sensitivity thresholds (1%, 5%, 10%, 25%).
- Relative Risk Ratios and SHAP values were used to identify the strongest contributing features. Predicted cases were mapped geographically to produce predicted-risk heatmaps for both cancer types.

Key findings

- 870,000 patient records were analysed.
- Urban areas appear to have the highest risk and case density for both cancer types.
- No significant correlations were found with ethnicity, socioeconomic deprivation, coastal location, air pollution and radon exposure.
- UV exposure datasets were not granular enough for LSOA-level use.
- The modelling produced weak but usable predictions due to low baseline prevalence.
- Both observed and predicted maps show clear service need concentrated in urban conurbations.
- No conclusions can be drawn for West Sussex, due to the lack of data availability.

Conclusion

- The study demonstrates:

		- Strong geographic clustering of both cancer types in urban areas. - Weak predictability due to very low baseline prevalence, but enough for generating indicative heatmaps. - No evidence of inequality were linked to deprivation, ethnicity, pollution or coastal proximity. - There was a significant opportunity to improve ethnicity recording and environmental exposure datasets. - There was a clear indication that service planning should focus on urban population centres in Kent & Medway.	
5	**CRG update and discussion of outputs**	**<u>Update provided by Nic Goodger</u>** • The CRG team comprises of Nic Goodger, Ali Al-Lami, Lakshmi Rasaratnam, Debbie Hannant, Elizabeth Diamond, Eranga Nissanka-Jayasuriya and Sally Fouda. • Main focus areas include MDT streamlining, pathology workload (including low-yield biopsies) and FNA practice being performed by designated specialists only. **Key points** • It was noted that there is variation in practice amongst clinicians. • Debate has taken place from a pathology perspective over sending tonsils and nasal polyps. • There is a risk of malignancy (e.g. asymmetrical tonsils: ~2–5%). • Agreement was reached to maintain current standard practice and consider audit before changing practice.	
6	**Guest Speaker - The FORTIFI-HN01 trial**	**<u>Presentation provided by Kevin Harrington</u>** **Ficerafusp Alfa** • Ficerafusp Alfa, a new investigational drug, is a dual-action antibody which targets EGFR and TGF-β. • The goal is to improve immune system access to tumours and overcome resistance, especially in difficult head and neck cancers. **HPV-negative Head & Neck Cancer (HNSCC)**	

		• HPV-negative head and neck cancer has worse outcomes than HPV-positive disease. • There are high resistance rates, with 30–50% recurrence after standard treatment. • There is poor survival associated with current therapies - ~9–12 months median overall survival with pembrolizumab-based approaches. • These patients are the unmet need this drug is targeting. **Why TGF-β matters** • TGF-β plays a major role in blocking immune cells from entering tumours and promoting fibrosis, EMT and immune suppression. **Mechanism of Ficerafusp Alfa** • Ficerafusp Alfa blocks EGFR which reduces tumour growth signals. It also traps TGF-β, removing immune barriers. • The combined effect improves tumour penetration, increases CD8+ T-cell infiltration and enhances the response to pembrolizumab. **Clinical data (Phase 1b)** • Treatment comprised of Ficerafusp Alfa + pembrolizumab (1st line) in HPV-negative, CPS ≥1 patients. **Efficacy results** • With regard to tumour response, the ORR was 54%, complete response was 21% and the disease control rate was 89%. **Speed and durability** • The median time to response was 1.4 months, the median duration of response was 21.7 months and many responses are ongoing. **Survival** • Median overall survival was ~21 months and two-year survival was ~46%. This is roughly double historical benchmarks (~9–12 months).	

		Real patient examples • The slides showed rapid tumour shrinkage (up to 80%+ within weeks), durable responses lasting years and some patients achieving complete remission. **Safety profile** • There were no unexpected safety signals. • Common side effects included skin rash, itching, anaemia and fatigue. • Some immune-related events were noted (e.g. hepatitis, mucositis). **FORTIFI-HN01 (Phase 2/3)** • KHa outlined the comparison between Ficerafusp + pembrolizumab vs pembrolizumab alone and highlighted that the study comprised of 650 patients. • Endpoints discussed included overall survival and response rate and this will determine if the drug becomes a new standard of care. **Key takeaways** • HPV-negative HNSCC is hard to treat and resistant and TGF-β is a major barrier to effective immunotherapy. • Ficerafusp Alfa tackles both tumour growth and immune suppression. • Early data shows high response rates, durable responses and promising survival improvement. • This is a very promising early-stage therapy, but it is still experimental and needs confirmation in phase 3 trials.	
7	**MDT Streamlining**	**<u>Presentation provided by Professor Sanjeev Madaan</u>** • MDT workloads in UK cancer care have become unsustainable due to rising demand and complexity, limiting meaningful case discussion. • MDT streamlining - removing straightforward, protocol-driven cases from full discussion - helps preserve time for complex cases while maintaining care quality through predefined Standards of Care. • A structured pre-MDT review team assesses cases using standardised data, with all streamlined cases still visible to the MDT.	

		• A 2024 pilot at DGT showed improved efficiency (shorter meetings, faster case discussions) with 37% of cases safely streamlined. • Safety was maintained with no adverse events and staff reported time savings and better-quality discussions. • Despite initial concerns and implementation challenges, streamlining proved safe, effective and scalable, with future potential for AI-supported decision-making.	
8	**Oncology Update**	**<u>Presentation provided by Kannon Nathan</u>** • KN provided the group with an overview of current activity and future direction in head and neck oncology across three main domains: radiotherapy, systemic treatments and horizon scanning for emerging technologies. **Radiotherapy updates** • Precision radiotherapy techniques are being showcased through planning screenshots and treatment workflow visuals. • There are continued efforts to optimise radiotherapy delivery and accuracy, illustrating the department's emphasis on improving contouring, planning consistency and patient-specific adaptations. **CVLP trial (Vaccine + Pembrolizumab)** • A significant part of the systemic therapy update is the CVLP trial, which is now open in collaboration with The Royal Marsden Hospital NHS Foundation Trust and GSTT. • The key details include: - The trial being for recurrent/metastatic p16-positive disease. - It requiring PD-L1 CPS >1 for eligibility. - It being a randomised design comparing CVLP vaccine + pembrolizumab versus pembrolizumab alone. - Screening is active across Kent, indicating regional participation and referrals. • This reflects growing interest in therapeutic vaccines in virally-driven cancers, aiming to enhance immune priming and improving checkpoint inhibitor responses.	

		Neoadjuvant Pembrolizumab • Another key systemic development is the adoption of neoadjuvant pembrolizumab in operable head and neck cancer. The pathway involves two doses of pembrolizumab (200 mg IV or SC), surgery following the neoadjuvant window, adjuvant radiotherapy ± chemotherapy and additional adjuvant pembrolizumab thereafter. • Operational considerations include theatre scheduling and coordination with surgical teams, increased pressure on oncology workflows and infusion/SC capacity and the possibility of rare but important immune-related toxicity delaying surgery — a risk that demands careful monitoring and multidisciplinary communication. This reflects a growing global trend toward neoadjuvant immunotherapy to improve pathological response and long-term outcomes. **Horizon scanning** • KN outlined emerging technologies likely to reshape head and neck cancer care. • Surface-Guided Radiotherapy (SGRT) is being explored as a move toward mask-less radiotherapy setups, improving patient comfort and potentially reducing treatment setup time. • Charity funding has enabled preparations to be made at Canterbury, with test cases planned. This represents a significant cultural shift away from traditional head and neck immobilisation (thermoplastic masks), which can cause anxiety and discomfort. **Photobiomodulation (PBM)** • This NICE-approved therapy uses red-light PBM to reduce inflammation and promote tissue healing. It was highlighted as an important upcoming supportive care intervention. • It has been shown to reduce the incidence of severe oral mucositis by ~70%, a major toxicity for patients undergoing radiotherapy and chemoradiotherapy. • This therapy could meaningfully improve patient experience, reduce treatment breaks and lower hospital resource utilisation.	
9	**Updates from CNSs and AHPs**	**<u>EKHUFT – update provided by Sarah Stevens</u>** • The SALT team are under considerable pressure and a funding shortfall has resulted in some patients being sent to London.	

		• Following discussion it was identified that this is a pan-Kent issue. • **<u>Action</u>: NG to review the EKHUFT SALT funding issue raised by SS.** **<u>MFT – update provided by Debbie Hannant</u>** • DH highlighted how CN (Faster Diagnosis Head & Neck CNS - MFT) has had a positive impact on service delivery. • **<u>Action</u>: CC to invite Claire Newbury to the next meeting so she can provide an update on her role and the impact she has made to the head and neck service at MFT.**	**NG** **CC**
10	**AOB**	• NG will liaise with CT to agree a date for the next meeting. • The attendees were asked to sign the attendance sheet. Should anyone identify that they are not listed on the attendees section, they are encouraged to contact c.chamberlain3@nhs.net so this can be rectified. • It was acknowledged that severe technical issues had affected the flow of the meeting, particularly with those joining the meeting virtually via Webex. The KMCC team will liaise with both KMCA colleagues and the relevant individual(s) at the Education Centre to try and ensure that such issues do not occur in the future.	
	Next Meeting	• To be confirmed.	