Head & Neck Tumour Site Specific Group meeting
Friday 6th September 2024
Ashford International Hotel
13:30-16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Nic Goodger (Chair)	**NG**	Consultant Oral and Maxillofacial Surgeon	EKHUFT
Sue Honour	**SHo**	Lead Head & Neck and Thyroid CNS	EKHUFT
Abbi Smith	**ASm**	Head & Neck and Thyroid CNS	EKHUFT
Anna Lamb	**AL**	Cancer Performance Manager	EKHUFT
Hannah Washington	**HW**	FDS Manager	EKHUFT
Nicola Chaston	**NC**	Consultant Pathologist/AMD for Diagnostics	EKHUFT
Chris Theokli	**CT**	ENT Consultant	EKHUFT
Vikram Dhar	**VD**	ENT/Head & Neck Consultant Surgeon	EKHUFT
Robert Hone	**RHon**	ENT Consultant	EKHUFT
Eranga Nissanka-Jayasuriya	**ENJ**	Consultant Pathologist	EKHUFT
David Tighe	**DT**	Maxillofacial Consultant	EKHUFT
Raghuram Boyapati	**RB**	Consultant – OMFS	EKHUFT
Annapoorna Rai	**AR**	Consultant – OMFS	EKHUFT
Tamsin Sharp	**TS**	Speech and Language Therapist	DVH
Elizabeth Diamond	**ED**	Oncology Dietitian	KCHFT
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	KMCA
Ritchie Chalmers	**RCh**	Medical Director	KMCA
Emma Forster	**EF**	Head of Service Improvement	KMCA
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Samantha Williams	**SW**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Business Support Manager/PA	KMCC/KMCA
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Debbie Hannant	**DH**	Head & Neck CNS	MFT
Milena Truchan	**MT**	Head & Neck CNS	MTW
Sarah Eastwood	**SE**	Macmillan Personalised Care Project Manager	MTW
Roberto Laza-Cagigas	**RLC**	Senior Exercise Physiologist	Quest Prehab

Stergios Doumas	**SDo**	Consultant Maxillofacial/Head & Neck Surgeon	QVH
Nav Upile	**NU**	ENT Consultant	QVH
Bincey Joseph	**BJ**	Head & Neck CNS	QVH
Adam Gaunt	**AG**	Consultant ENT Head & Neck Surgeon	QVH
Colin Maciver (via MS Teams)	**CM**	Consultant Maxillofacial/Head & Neck Surgeon	Sheikh Shakhbout Medical City – Abu Dhabi
Andrew Schache (via MS Teams)	**ASc**	Professor of Head & Neck Surgery/Consultant Maxillofacial (Head & Neck) Surgeon	University of Liverpool
Apologies			
Ali Al-Lami	**AAL**	Consultant ENT / Head & Neck Surgeon	EKHUFT
Alistair Balfour	**AB**	Consultant ENT, Head & Neck and Thyroid Surgeon	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager - Cancer, Haematology, Haemophilia and TLHC Programme	EKHUFT
Lakshmi Rasaratnam	**LRa**	Consultant in Restorative Dentistry	EKHUFT
Rachael Hopson	**RHop**	Macmillan Head & Neck Specialist Radiographer	EKHUFT
Sue Drakeley	**SDr**	Senior Research Nurse	EKHUFT
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Kannon Nathan	**KN**	Consultant Clinical Oncologist	MTW
Carole Drabble	**CD**	Oncology Dietitian	MTW
Lucy Reed	**LRe**	Macmillan Oncology Dietitian	MTW
Natalie Ryan	**NR**	Consultant Radiologist	MTW
Ruth Casey	**RCa**	Macmillan Head & Neck CNS	MTW
Summer Herron	**SHe**	General Manager for Cancer Performance	MTW
Bill Barrett	**BBa**	Consultant Oral Pathologist	QVH
Brian Bisase	**BBi**	Consultant Maxillofacial / Head & Neck Surgeon	QVH
Victoria Worrell	**VW**	Access & Performance Manager and Health Inequalities Lead	QVH

Item		**Discussion**	**Action**
1.	**TSSG Meeting**	**<u>Apologies</u>** • 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**	• There was a review of the Cancer Dashboard on Power BI, the figures of which can be viewed if a user requests access to the platform. • Following a review of the data on the Cancer Dashboard, DT stated it would be helpful for the data for West Kent (MFT, MTW and QVH) to be combined as a comparator to East Kent. • Overall, FDS performance is similar to six months ago, but 62d performance has improved from 57.4% to 61.4%. • FDS performance is lowest at EKHUFT (67.4%) and MFT (70.4%). • In deprived areas, incidence and mortality are higher but head and neck cancer is diagnosed later. • David Osborne is keen to know which parts of the pathway Trusts want to target for improvement and what additional data they need. • NG stated that there is a need to identify where within the pathways more support is required.	**Data pack slides sent to group on 16.09.2024**

		• **<u>Action</u>: GIRFT to be an agenda item for the next meeting.**	**AW**
3.	**Clinical Reference Group Discussion**	**<u>Update provided by Nic Goodger</u>** • RC highlighted that there had been work on bolstering clinical leadership within the TSSGs and described the CRG as a group of experts who work to support the Chair of the TSSG in driving service developments. • NG encouraged the members to get involved in supporting the CRG and to contact AW if they would like to join the group. • The CRG will work on progressing action points as well as on MDT reform and Horizon Scanning. • The CRG will meet monthly and the meeting will be chaired by the TSSG Lead. • The CRG will also review and work towards addressing treatment variation and improving service development. • So far there have been applications to join the CRG from: i) Pathology. ii) Radiology. iii) Surgery (x3). iv) Restorative Dentistry. • Interviews for people who wish to join the CRG will need to be held and renumeration of 0.5 PA will be provided. • There has yet to be any applications from CNSs to join the CRG. • NG highlighted a Work Plan will also need to be put together. • Following a question around whether AHPs can join the CRG, RCh highlighted this could be looked in to. • NG and RCh agreed there needs to be further work on ensuring there is consistent radiology representation at	

		the Head & Neck TSSG meetings. • The CRG will work to define specific audits for all Trusts to carry out.	
4.	**Prehabilitation**	**<u>Presentation provided by Roberto Laza-Cagigas</u>** • Prehabilitation is a process from diagnosis to surgery, consisting of one or more pre-operative interventions of exercise, nutrition, psychological strategies and respiratory training, which aims to enhance functional capacity and physiological reserve to allow patients to withstand surgical stressors, improve post-operative outcomes, and facilitate recovery. • Prehabilitation is part of a continuum in the rehabilitation pathway. It enables people with cancer to make the most of their lives by maximising the outcomes of their treatment whilst minimising the consequences of treatment including symptoms such as fatigue, breathlessness and lymphoedema. • RLC defined prehabilitation as an intervention which aims at optimising an individual's health before facing a major stressor (such as surgery, chemotherapy or radiotherapy). • QuestPrehab is a free mixed-model multimodal prehabilitation programme for patients diagnosed with cancer in Kent & Medway. • QuestPrehab provide tools to improve lifestyle and get healthier before (prehab), during and after (rehab) cancer treatment. • The programme is delivered by telephone calls, video calls or face-to-face and the service can provide support on diet and nutrition, physical activity, psychologic support and signpost when and where appropriate. • The Craetus app helps patients to log their progress and structure their activities during the week. • There are regular live streaming exercise sessions during the week covering different modalities. • With regard to outcomes, a paper on the programme stated more patients reported to have no problems after	**Presentation sent to group on 16.09.2024**

		the programme, implying a better quality of life. Patients also improved their self-rated health and fatigue after prehab. • RLC outlined the ways in which referrals can be made. Both referrals and self-referrals can be made via https://www.questprehab.com/. There is also a form embedded within InfoFlex which can be completed generating a referral.	
5.	**VSP for midface/skull base tumours**	**Guest Speaker – presentation provided by Colin MacIver** • CM provided the group with a presentation on the Use of 3D Planning, Navigation and Mixed Reality in Resective and Reconstructive Head and Neck Cancer Surgery. • Cancer of the head and neck affects vital functional structures in a complex anatomical region. • Obtaining a clear margin is the primary aim in cancer surgery. • Resection often requires reconstruction to restore form and function. • Free flap reconstruction provides optimal reconstruction. • Surgery remains the primary treatment for oral cavity SCC often in combination with post-operative radiotherapy (PORT). • Positive margins increase local recurrence rates by more than two times and it reduces patients' disease-specific survival. • It is not possible to change the adverse tumour features or nodal status, however surgeons have a responsibility to try to achieve an R0 margin.	

		• Within head and neck cancer literature the positive margin rate varies between 6-43%. • Maxillary tumours have a particularly poor rate of R0 margins. • The majority of local recurrences in the mid-face tend to be in the orbital apex, infratemporal fossa, petrous apex or middle cranial fossa. • Cross-sectional imaging allows highly accurate visualisation of tumours. • CT and MRI complement each other in visualisation of head and neck tumours. • Planning software allows image fusion and manipulation prior to surgery. • CM provided the group with an overview of the pathway for custom-made guides and plates. • With regard to surgical navigation, CM described this as a GPS for surgeons. It relates the exact position of the surgical instrument to plan/image. Surgical navigation also provides accuracy around vital structures and allows a predictable translation of surgical plan to procedure. • The technology is used for the planning of head and neck cancer surgery but can also be used for the resection and reconstruction phase. It is also used for complex craniofacial trauma cases in addition to skull base and orbital surgery. • In terms of evidence for the use of 3D planning, there is an increased body of evidence in literature with regard to R0 margins, improved functional outcomes and no increase in free flap failure rates. • In summary, 3D planning can help: i) Improve surgical planning.	

		ii) Improve the transfer of planning to clinical practice. iii) Improve communication with the radiation oncology team. • CM believes this should be the standard of care for complex head and neck surgery.	
6.	**Research**	**<u>Trials updates – update provided by Stergios Doumas</u>** • Recruitment for April 2024 to August 2024 was 24 participants. • Nationally Head & Neck Oncology recruitment sits in 7th position out of 15 LCRNs. • In terms of KSS recruitment for 2024/25: i) EKHUFT had three trials and recruited seven patients to PETNECK, two patients to PATHOS and no patients to RAPTOR. ii) MFT had two trials and recruited five patients to HoT and one patient to INSPIRE. iii) QVH had one trial and recruited one patient to RAPTOR, however there are five more potential recruits. • Forthcoming trials at QVH include: i) PETNECK2. ii) Liquid Biopsy in surgical patients treated for Oral Cancer (collaboration with UCL). iii) Neoadjuvant immunotherapy in locally advanced oral cancer (collaboration with RMH). • EKHUFT have recruited 17 patients in total to PATHOS so far. • EVEREST-HN is in the process of being set up for eventual opening at EKHUFT.	**Document sent to group on 16.09.2024**
7.	**HPV related H&N cancer**	**<u>Guest Speaker – presentation provided by Andrew Schache</u>**	

	epidemiology and vaccination	• Cancers which arise in the oropharynx tend to be a mixture of HPV-positive and HPV-negative cases. AS described this as a very different anatomical site in terms of its immune privilege but also in terms of the lymphoid tissue which sits there. Oral cavity SCCs are all HPV-negative. • In the 1990s there was a change in clinical presentation with younger men presenting with a high burden of disease in their neck with tonsil tumours. • The effects of treatment of oropharynx cancers tend to be profound to the patient. • AS highlighted that there had been a change in NICE guidance in relation to HPV-related disease with an ask to test all squamous cell carcinomas of the oropharynx using p16 immunohistochemistry. The guidance also advised to consider high-risk HPV DNA or RNA in-situ hybridisation in all p16-positive cancers of the oropharynx to confirm HPV status. • AS referred to a Laryngoscope journal entry which postulated that SCC of the head and neck outside the oropharynx is rarely HPV. Using rigorous clinical testing, a colleague of AS' conducted a study which identified HPV present in patients with: i) Oral cavity cancers (4.5%) - all from the floor of the mouth. ii) Larynx (3.2%). iii) Hypopharynx (7.1%). iv) Oropharynx (70%). • The BJC stated TNM8 improves the capability to appropriately stage OPSCC for prognostic stratification but it critically fails to recognise patients who lack HPV aetiology and carry significantly inferior clinical outcomes. • AS outlined the cost of oropharyngeal cancer in England based on hospital data analysis. The cost of treating oropharynx cancer between 2006/07 and 2010/11 went up by approximately half. • AS highlighted that when patients were previously treated with surgery or adjuvant therapy their functional outcomes/feeding tube rates were poor. However, this started to improve with transoral laser surgery (TOLS). • With the introduction of HPV vaccines for adolescent boys in 2019 in England, it is estimated that by 2058 30,000	

		male cancers will have been avoided (equating to about £500 million saving to the NHS). • AS stated he believes with the planned comprehensive vaccination program against HPV in the UK, oropharyngeal cancer will be eradicated at source in the next two to three decades. • The 10th World Congress of the IAOO will be in Liverpool (16th to 19th July 2025). • AS believes it will become mandatory for MDTs to do p16 and HPV DNA testing for all oral cancer cases.	
8.	**Validation of digital pathway across KMPN**	**<u>Presentation provided by Nicola Chaston</u>** • NC has been involved in the early stages of setting up the Kent & Medway Pathology Network (KMPN). • The Laboratory Information Management System (LIMS) will have all relevant pathology data for Kent & Medway in one place and there will be more robust cover for cellular pathology. • There will be much easier information transferred between sites. With increased collaborative working, there will be more back-up for specialties. • The Digital Pathology programme will help with efficiencies in workflow, work allocation, the tracking of cases and the pulling of cases back for review. • From a collaboration perspective, the KMPN digital pathway will allow second opinions almost instantly from anywhere in the world. • In theory, the programme should help with the faster diagnosis of cancers. • Benefits of the digital pathology solution include: i) Reduced case transfer times between the laboratory and the diagnostic pathologist. ii) Improved workload allocation. iii) Rapid case tracking, archival and retrieval.	**Presentation sent to group on 16.09.2024**

		iv) Clearer diagnostic audit trails. v) Increased diagnostic efficiency. vi) Faster diagnosis of urgent cases (in line with 28d faster diagnosis for cancer). vii) Faster access to external second opinions. viii) Faster access to molecular testing. ix) A reduced risk of patient/slide misidentification errors. x) A reduced risk of tissue/slide loss or damage. • The archive of images will be a valuable resource for research purposes, encouraging collaboration between diagnostic departments and higher education establishments, as well as for use in the development of computerised algorithms for Artificial Intelligence. • System training will be provided by the supplier with ongoing support from the Kent & Medway Pathology Network team. • Each pathologist needs to verify their digital reporting against their analogue reporting to ensure clinical care level continuity. • Pathologists will validate in phases so no more than five pathologists at one time will be validating. • The digital pathology project has accessible funding to utilise other resources during validation phases. • Removing patients from cancer pathways alleviates the pressure and allows pathologists to concentrate on cases of significant clinical significance.	
9.	**CNS updates**	**<u>EKHUFT – update provided by Sue Honour</u>** • EKHUFT are in the process of reviewing the NCPES results. • A Support Group has been established and is held every other week in Ashford/Canterbury. • The Pathway Navigator is undertaking some work to identify reasons behind DNA rates.	

		<u>MFT – update provided by Debbie Hannant</u> • A patient satisfaction survey for ENT patients is being worked on. **<u>MTW – update provided by Milena Truchan</u>** • There is a lot of work being invested in to reviewing FDS pathways so they can be made operational. **<u>QVH – update provided by Bincey Joseph</u>** • Nurse-led clinics are set to commence at the end of September 2024. • A new CNS recently joined the team.	
10.	**Clinical Audit updates**	• No clinical audits were presented at today's meeting.	
11.	**AOB**	• No-one had anything to raise under any other business.	
	Next Meeting	• To be confirmed.	