GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Head and Neck Pathway Board

Head and Neck Pathway Board

Minutes and Actions

Friday 14th December 2018

10:00-12:30

Worsley Park Marriott Hotel & Country Club, Worsley Park, M28 2QT

Attendance

Name	Role	Board Representation
David Thomson (DT)	**Clinical Pathway Director**	
Rachel Allen (RA)	Pathway Manager, Greater Manchester Cancer	
Natasha Smith (NS)	User Involvement Manager, Greater Manchester Cancer	
Alison Armstrong (AA)	Programme Lead, Greater Manchester Cancer	
Carly Taylor (CT)	Restorative Dentist	MFT
Charlotte Finchett (CF)	Lead Health Promotion Advisor	The Christie
Debbie Elliott (DEl)	Head and Neck Clinical Nurse Specialist	The Christie
Dympna Edwards (DE)	Consultant in Dental Public Health	Greater Manchester Health & Social Care Partnership
Frances Ascott (FA)	Speech & Language Therapist	MFT - Central
Helen Rust (HR)	Speech & Language Therapist	The Christie
Jarrod Homer (JH)	Consultant Head and Neck / Thyroid Surgeon and Otolaryngologist	MFT (MRI/Central)
Karen McEwan (KM)		GP
Kate Garcez (KG)	Oncologist	The Christie
Kate Hindley (KH) / Dawn Hulmes (DH)	Clinical Nurse Specialist	SRFT
Kathleen Mais (KM)	Nurse Clinician	The Christie
Kerenza Graves (KG)	Clinical Nurse Specialist	Bolton
Laxmi Ramamurthy (LR)	Consultant ENT Surgeon, Stockport FT	Stockport
Marie Hosey (MH) (deputising for Nicola Remmington)	Assistant Chief Operating Officer – Performance and Operational Standards	Cancer Manager representative (GM)

Marie Round (MR)	Macmillan Head & Neck Clinical Nurse Specialist	Pennine
Michael Clinton (MC) (Deputising)	Macmillan Transformation Manager: Recovery package	Macmillan
Morris Tomlinson (MT)	Data Analyst, Greater Manchester Cancer	
Panos Kyzas (PK)	Consultant OMFS Head & Neck Surgeon	Pennine
Philip Bryce (PB)	Clinical Nurse Specialist	CMFT - MRI
Rachel Clare Hall (RH)	Pathologist	Pennine
Rebecca Pearce (RP)	Dietician	Dietetics Representative
Richard Delleman (RD)		Patient Representative
Rohit Kumar (RK)	Consultant Otolaryngologist & Head and Neck Surgeon (ENT)	MFT (Wythenshawe/ South)
Simon Hargreaves (SH)	ENT Consultant	Bolton
Stephen Sweeney (SS)		Patient Representative
Steve Jones (SJ)	CRUK Facilitator (Greater Manchester)	CRUK
Tony Bishop (TB)		Patient Representative
Yatin Jain (YJ)	Consultant Radiologist, the Christie	The Christie
Zoe Merchant (ZM)	Prehab4Cancer Lead, Greater Manchester Cancer	

Apologies

Catherine Cameron (CC)	Head and Neck Clinical Nurse Specialist	WWL
David Shelton (DS)	Consultant Non-Gynaecological Cytopathologist	MFT
Fiona Brennan (FB)	Nutrition Nurse Specialist	The Christie
Helen Doran (HD)	Consultant Thyroid Surgeon, Salford FT	SRFT
Jen Riley (JR)	Senior Commissioning Manager for Planned Care, Bolton Clinical Commissioning Group	Cancer Commissioning Manager Representative – GM
Jonathan Hobson (JH)	ENT Consultant	MFT (Central)
Mazhar Iqbal (MI)	Maxillo Facial Surgeon	MFT (Wythenshawe/ South)
Richard Tipney (RT)	Directorate Manager – Specialist Surgery (Breast and Oral and Maxillofacial Surgery)	NMGH
Robert Metcalf (RM)	Medical Oncologist and Clinician Scientist	The Christie
Susi Penney (SP)	Consultant ENT Surgeon	Tameside
Vijay Pothula (VP)	Consultant Head and Neck Surgeon, WWL	Wigan

1. Welcome and introductions

DT opened the Board and welcomed attendees. DT introduced RA as the new Pathway Manager for the Head and Neck board, taking over Claire O'Rourke who has been promoted to Associate Director for Greater Manchester Cancer.

2. Board minutes

Discussion summary	It was noted that RA will be capturing Board minutes going forward.
Actions and responsibility	**NA**

3. Pathway board standards

Discussion summary	DT noted the huge amount of work to develop Pathway Board standards led by SP. DT highlighted that the Pathway Board standards describe what a great service would look like in GM and Eastern Cheshire including quality standards related to prevention, diagnostics, treatment and living well with cancer. DT described how the Board will be configured into sub-committees going forward which map onto the developed standards.
Actions and responsibility	**a) RA to share the Pathway Board standards developed under the leadership of SP with all members.**

4. Board review

Discussion summary	**a) Draft terms of reference** New Terms of Reference will be drafted for all Greater Manchester Cancer Clinical Pathway Boards which AA is leading. The GM Cancer Board Terms of Reference are currently being reviewed and these will filter down to the individual Pathway Boards. A draft document will be presented to the Board in March where membership quoracy can be agreed. **b) GM Cancer Team Structure** AA presented the Greater Manchester Cancer team structure which has been updated with new roles including SP as Associate Medical Director. AA highlighted new roles to the team which have been funded through Transformation Fund investment to mobilise the GM Cancer Plan including three best-timed pathway leads for lung, colorectal and prostate. The core team will facilitate and enable change in cancer care across the region for the next few years. GM Cancer has a new commissioning lead who will be taking up post in February. AA spoke of staffing changes to the Macmillan User Involvement service. AA highlighted that the first point of contact for the GM Cancer Head and Neck Clinical Pathway Board is RA and DT. DT noted that GM is growing with some major high profile programmes and drew out some of the large-scale projects including Prehabilitation to optimise patient's clinical, psychological, nutritional and physical health before treatment to improve patient treatment outcomes. This will be a major workstream for the Head and Neck Pathway Board. DT highlighted the CURE programme being led by the Lung Pathway Board

	and partners which will be focused initially on inpatients. The Head and Neck Pathway Board will support this work through CF, supporting patients to quit smoking before and during treatment to improve survival outcomes. There will be work to follow up patients to ensure that they do not restart smoking after treatment. AA spoke of the SACT project, offering chemotherapy closer to home led by Andrew Wardley and Claire Goldrick in the new year. **c) Configuration of sub-committees** DT described the draft board structure of four sub-committees including: **1. Prevention** • *Adoption of HPV vaccination for boys being led by Siobhan Farmer, GM Screening and Immunisation Lead and the GMHSCP/PHE. The Pathway Board will have oversight of this and ensure it is delivered successfully* • *Tobacco addiction led by Charlotte Finchett (CF). This may be through the Prehab work or living well with cancer in terms of secondary prevention* • *Oral health led by Dympna Edwards (DE). DT noted that DE brings a dental and public health focus to the Board* 2. **Early diagnosis & best timed pathway led by Rohit Kumar (RK).** This will be core business for the Pathway Board about how people are identified early for diagnostics to begin and then into treatment in a timely manner. Prehabilitation will also feature in this subgroup as head and neck is one of the four areas of focus for the GM Prehabilitation team. 3. **MDT working led by Jarrod Homer (JH).** JH spoke of the two providers of secondary care MDT services in GM (MRI and Wythenshawe – MFT and North Manchester). The main premise of this work is to look at how different professionals involved in a patient's care interact at the end of the diagnostics stage and beginning of treatment stage. It is recognised both in GM and England that there is a need to think a fresh about how clinicians interact, thinking beyond traditional limits. 4. **Living well with cancer led by Philip Bryce (PB) and Fiona Brennan (FB).** This will include ensuring full implementation of the mandated Macmillan Recovery Package in the head and neck pathway and thyroid pathway in a standardised manner across GM. It will also include ePROMS which DT is happy to co-lead with Board members. The ePROMS workstream will look at adapting what is out there already which can be validated with patients to have shorter and useful patient reported outcomes that can be completed electronically remotely online, or with support for the completion of paper-based versions. This would support the follow-up of patients depending on the symptoms or concerns that patients have and will include physical symptoms, psychological screening and quality of life measures. A model will be piloted in the head and neck pathway at The Christie from

	January 2019. DT highlighted that this needs to be a GM model and so whilst it is being started at The Christie, it will become a GM model over time. DT highlighted that as the work progresses, a group will need to be established that can look at changing models of follow-up based on the findings. Secondary prevention will form a further component of this sub-committee. In summary, the living well with cancer group will focus on implementation of the recovery package. Additional workstreams such as ePROMS will remain within the group but will be led separately in parallel. DT described two cross-cutting themes including education led by Kathleen Mais (KM). DT spoke of initial plans for a GM Head and Neck Symposium in 2019. The second cross-cutting theme is research and innovation which will be led by Rob Metcalfe (RM). Board members were invited to consider which sub-committee they would like to contribute to and also to comment on the proposed Board structure.
Actions and responsibility	**a) AA to present draft TORs to Head and Neck Pathway Board in March.** **b) RA to share the updated GM Cancer Team Structure with Board members.** **c) Board members to submit expressions of interest to lead ePROMS component with DT. Submissions made via RA.** **d) AA to discuss GM ePROMS model with GM Cancer SMT.** **e) RA to share draft plan of Board milestones for 2018/19.**

5. Pathway performance

Discussion summary	Marie Hosey (MH), Assistant Chief Operating Officer at The Christie, was invited to present on behalf of the GM Cancer Managers forum. A named Cancer Manager will attend all pathway boards going forward to help with the interpretation and understanding of head and neck pathway performance. MH spoke of the reallocation policy which shows where the breaches / patient delays on 62 days are. A new national allocation policy was brought out in April 2018. It was noted that this has no impact on the patient journey; it is about where the performance of compliance and breaches sit in each organisation. A first organisation that sees a two week wait patient on a 62 day pathway has to get the patient out for treatment by day 38. The treating trust, be that the Christie or another trust for surgery, has to treat the patient in 24 days. If this does not happen, the breach will fall to wherever/whoever has breached that part of the pathway. GM has achieved 62 day compliance since 2011 until Q1 of this year (2018). There are lots of reasons as to why GM is not achieving 62 days as a conurbation across all tumour sites. GM has witnessed an increase in all referrals by 20% with only 2% increase in diagnostics. Commissioners are

	now looking at the fact that we should have had about a 7% increase. Q2 data was presented. The majority of the 27 breaches are sitting in internal diagnostic delays. MH highlighted the categories of patient breaches captured, including: • Patient Choice • Patient Disengagement • Patient Failed to Follow Instruction • Internal Diagnostic Delay • External Diagnostic Delay • Multiple MDT's • Complex/Multi TS's/Co Morbidities • Other • Treatment Delay/Capacity The breach reasons are populated every quarter across all Trusts and tumour sites. Find Out Faster / Faster Diagnosis is being implemented from April 1st 2019. It is mandated. Performance will be measured from 1st April 2020. Patients are referred on a two week wait 62 day pathway. They have to have their diagnosis of cancer or non-cancer by day 28. This should lead to an improvement in 62 day compliance if diagnosis occurs by day 28. MH was unable to confirm thresholds and penalties in relation to this. The issues for investigating organisations are the recording of patients who who do not turn out to have cancer. The close down of day 28 is when the patient is actually told. There is work to look at how the timing and recording of patients who do not have cancer is recorded e.g. via letter, email, phone call. 7+7+7 is something being worked through at The Christie – a 7 day outpatient appointment, 7 day radiotherapy planning (RTP) scan, 7 day to treatment as The Christie only have 24 day. NHS England is undertaking a national review of all cancer standards looking to condense them to 3 or 4 sets of standards. SS queried how this was being explained to patients so that it is clear to them. MH agreed that patient information is a core part of this. CCGs are working with primary care organisations to improve communication. Dr Sarah Taylor, Lead GM Cancer GP is working closely with GM Cancer and primary care to improve this. New cancer waiting times guidance, version 10 will be released in April. MH and Laura Elliott from MFT have been part of the national steering group for these national guidelines. All patients will be upgraded to fast track pathways in the new year. Morris Tomlinson (MT) was welcomed to the Board. MT spoke of some of the work of the data intelligence team. MT highlighted the interactive dashboard available for Board members to access. MT highlighted the small bespoke reporting dashboards that have been developed for other pathway boards and offered the same support to the Head and Neck Pathway Board.

Actions and responsibility	**a) RA to ensure GM Cancer Manager identified to attend future Head and Neck Cancer Boards.** **b) RA to organise board member access to interactive dashboard as appropriate – Board members to inform RA if they would like access.** **c) Board members to contact MT/RA with any requests for data intelligence support around express data/findings of discrete Board related projects.**

6. Speech and language therapy (SLT) service evaluation for Head and Neck Cancer patients undergoing (chemo)radiotherapy in GM

Discussion summary	Helen Rust (HR) HR was invited to present the findings of a Macmillan funded SLT pilot for head and neck cancer patients undergoing (chemo)radiotherapy in GM. It was noted that a paper was shared with Board members ahead of the meeting to support the presentation. HR spoke of an audit undertaken which revealed that 87% of patients had had a significant swallowing problem during course of chemotherapy. HR spoke of funding received for a preventative form of SLT for the first time with 40 patients. It was addressed at patients who they considered were not receiving SLT support at all. HR described the pre-2014 SLT head and neck radiotherapy patient pathway. Outpatients were commonly referred to Christie SALT 6 months to 2 years+ post- radiotherapy for dysphagia and trismus rehabilitation. HR shared the new preventative SLT radiotherapy patient pathway which connects to JH work around MDT reform. Patients are now targeted before treatment starts. Patients are giving a swallowing exercise programme so that the individual is empowered to do as much exercising of their swallowing muscles as they can during radiotherapy. As numbers have increased over the last few years, the speeding up of the pathway has meant that patients are being referred back out to the community (from The Christie), and so whilst patients are being seen at the front end of the pathway, there is a reliance on SLT colleagues outside to refer patients on. HR discussed some of the recommended exercises and supporting evidence base. Giving prophylactic exercises, the group with the exercising during treatment are eating better by mouth at three months which presents positive patient outcomes such as patients returning to work after treatment. HR highlighted that patients who had not had surgery were targeted. There are capacity issues that remain in GM. This project has projected SLT into terrific change and so at the moment the team are reorganising how they work. Taking the lead from patients, HR's team are offering a much better service however there are gaps in service for those who have had surgery. 60% of patients require chemo/radiotherapy and so there is still 40% requiring surgery that need an SLT approach so that it is equitable. Some patients may be lower risk so there is a need to look at a stratified approach. HR requested comments from the Board as to how a more equitable service

	can be offered. HR highlighted that the Pennine pathway is not as equitable as it could be. HR requested feedback from the project. DT thanked HR for her efforts on this project to date. SS highlighted the cost-benefit analysis argument that helping people up front in a prevention model is sensible. SS commented that he did not experience aspects of SLT in his personal patient journey which may have led to a faster recovery so welcomes further roll out of this project to help other patients going forward. SS also queried how this can be communicated to patients. JH commented that SLT can transform patient outcomes for those who have had chemo/radiotherapy and congratulated HR on progressing this work with limited support. DT spoke of the work that will take place through the Pathway Board to look at how this can become a universal, standardised offer for patients. HR highlighted that this project uncovered that there is no national precedent for how many SLTs / dieticians should be assigned to an average clinical oncology caseload. It began with support for surgery but GM has moved to addressing the radiotherapy pathway, it is apparent that there is no national guidance/definition of SLT provision / caseload resource ratio. Workforce modelling of allied healthcare professionals in GM will be important to transform cancer care.
Actions and responsibility	**a) RA to share HR's presentation with Board members.** **b) Board members to feedback any comments on the SLT project to HR directly.**

7. Dental toolkit for Head and Neck Cancer in GM

Discussion summary	DT introduced Dympna Edwards (DE), Public Health Consultant and dentist by background working for Public Health England (PHE) and the GMHSCP. DE highlighted that from a dental perspective there are issues with prevention and early detection; a lot of dentists struggle to have a cancer related conversation with patients. Traditionally, issues with referrals between dentistry and secondary care have not been as streamlined as they could be. DE spoke of the healthy living dentistry team in GM focusing on prevention of disease. The CRUK & C&M toolkit developed with Cheshire and Merseyside was discussed as a resource around early detection of cancer. There is potential for training related to this to be rolled out across GM. DE highlighted that training to improve confidence in having discussion and making cancer referrals would be beneficial. It was noted that referral systems were updated and an electronic referral and new referral form has been in place from April 2018 connected to the two week wait pathway process. DE highlighted that she would be interested in any feedback around this from Board members in terms of its implementation.

	DE highlighted that there are issues around treatment and care cancer in head and neck cancer patients which can be addressed. Rapid access to dental care when needed is required. DE spoke of restorative care in MDT, exemplary cancer champions work in Wigan although this does not exist across GM. Priority access to routine dentistry is currently a gap. DE highlighted the training need to support people on their longer cancer journey (linked to the living well with cancer agenda). It was noted that a local dental network exists around the professional network for dentistry which has developed a number of toolkits over the years. DE spoke of the existing guidance which can be pulled together to form GM guidance including: the CRUK/BDA toolkit; the Cheshire and Merseyside toolkit; restorative dentistry and UKMI guidance. DE summarised the suggested approach to the oral health workstream of the Head and Neck Pathway Board. DE proposed to establish and lead a task & finish group to work on the dental contribution to the Head and Neck Pathway Board. It would be useful look at what dentists need to know to ensure that the care they provide is as good as it can be throughout the patient pathway. DE suggested beginning with the Cheshire and Merseyside toolkit which is very robust picking up the front end of the patient pathway which could be amended for GM. DE proposed to build on it to include dental treatment of people with cancer and the living well with cancer agenda. DE suggested developing guidance over the next few months (Jan-April 2019), and then look at training for dental teams (April-July 2019) with Health Education England (HEE). DE requested input to the task and finish group and suggested potential contributions from CRUK, OMFS, Macmillan and patient representatives. DE invited suggestions of other significant issues to address as part of this work.
Actions and responsibility	**a) Pathway Board members are encouraged to participate in the Oral Health Task & Finish Group looking at developing a GM toolkit for dental practitioners to ultimately drive increased confidence and input of dental teams in head and neck cancer pathways.**

8. Macmillan User Involvement Team update

Discussion summary	NS welcomed the three new patient representatives. NS highlighted the GM Cancer / Macmillan User Involvement programme plan that was endorsed by the GM Cancer Board earlier this year. NS commented that the Head and Neck Pathway Boards plans are reflected in the User Involvement programme plan which is extremely positive. NS spoke of the three main priorities of all GM Cancer patient representatives which are prevention and earlier diagnosis; best timed pathways and psychological support which are mirrored in the subgroups of the Head and Neck Pathway Board. NS spoke of the drive to embed user involvement in every aspect of GM Cancer work, including al Pathway Board work programmes with professionals as equals.
Actions and responsibility	**a) RA to share Macmillan User involvement work plan with all Board members.**

9. Sub-committee feedback

Discussion summary	Sub-committee leads were invited to feedback on their subgroups discussions. **Prevention** DE summarised the actions that will be taken forward: • Dental work • Linking in with secondary care smoking cessation services with services that are commissioned locally within the community to ensure that the pathway is seamless • Ensuring patient information is tooth friendly **Early diagnosis and best timed pathway** RK summarised the main discussion points from the various trust representatives in the subgroup as follows: • Improvement and shortening of the patient journey • Giving patients information before they leave • Cross trust working to make the most of diagnostic imaging. This would tackle the internal diagnostic delays • Considering pooling resources for scanners in the region • Ensuring / considering adequacy tests at all FNAs (outside of neck lump clinic) • Consider reserved MRI/CT slots • Early diagnosis – a review of all presentations of stage 3 and 4 cancers to look at missed opportunities in primary care and secondary care at all points in patient history across all trusts **MDT working** JH outlined that the group's discussion centred on the MDT meeting. JH informed the Board of GM plans for one MDT meeting for MFT (merger of south and central teams); and one at NMGH. The group agreed that it is vital that uniformed, mirrored and standardised processes are followed. Adherence to protocols across both sites to maximise efficiencies of MDT meetings is essential. JH highlighted the group's discussions on how arrangements can be made to maximise MDT meetings so that for difficult cases requiring more complex clinical dialogue, the expertise going in to those discussions can be maximised without compromising the treatment of other patients for whom the management of radiology etc. is deemed more straight forward. The subgroup agreed that every new patient should be discussed and every new patient after histology. The group expressed a view to be strict about adherence to radiology protocols so that every patient has the right scan – it was noted that this impacts on RK's best timed pathway subgroup's work in terms of making sure that patients have timely scans so that all the information is available to the clinicians at the MDT meeting. Regarding putting patients as centre of care, there is a common practice that is not quite uniform in GM currently that the patient comes to the clinic that follows the MDT meeting and therefore the discussions and staging information and engagement of all relevant professionals is current in clinician's minds. This allows the expertise from the discussion to be relayed to the patient, putting the patient at the centre of the decision making process. It was noted that it is not the MDT that decides the treatment of the

	patient; it is the patient who decides. In making this happen, there needs to be discussion between the two Trusts and with GM Cancer to see if there can be improved IMT solutions / software kit. In contrast to the head and neck MDT, it was felt that new thyroid cancer patients do not need a discussion at MDT. Adherence to evidence based protocols which are in place locally and through the British Thyroid Association exist so there is a need to ensure compliance with these protocols. JH summarised that there will be work on protocoloisation of new thyroid patients. **Living well with cancer** PB summarised the subgroup discussion. The focus was on implementation of the Macmillan Recovery Package. There is a need to scope out current practice across head and neck patients and thyroid patients. It is important that patient communication is paramount; including consideration around what information is given, when and in what format. The group spoke about a patient summary booklet that the patient can take with them on their journey. There is a need to look at what is being used around treatment summaries – there is a need for standardisation. Improvements in primary care and secondary care communication is required e.g. sharing HNA info and treatment summary information. IMT solutions were discussed.
Actions and responsibility	**a) RA to extend time allocated to subgroup working at future boards.**

10. Education

Discussion summary	KM summarised planning of a two day Head and Neck symposium in 2019. The proposed dates are Tuesday 5th and Wednesday 6th November. The venue is yet to be confirmed but is likely to be Central Manchester and near to transport links. The organising committee so far is KM, Nurse Clinician Head & Neck Oncology; DT, Consultant Head & Neck Clinical Oncologist; RA, Pathway Manager; FB, Nutrition Nurse Specialist; Dr Kate Garcez (KG), Consultant Clinical Oncologist, Head & Neck & Thyroid. KM highlighted the desire to identify further representatives for the planning committee including a surgical representative, a patient representative and a SALT representative. The next planned committee meeting is Tuesday 18th December. All Board members are invited to attend.
Actions and responsibility	**a) Call for all Board members to consider and suggest:** • **After dinner speakers** • **Event sponsors particularly from surgical side** • **Exciting work** • **Speakers** **b) Board members encouraged to join the Symposium planning committee and to express interest via RA/KM.**

11. Research

Discussion summary	This item was deferred to March 2019 meeting.
Actions and responsibility	**NA**

12. AOB

Discussion summary	**Prehab4Cancer** ZM (Prehab Programme Lead) provided an overview of the Prehab programme which is being funded through TF for the next 2 years and is closely aligned with ERAS+. It was noted that ZM is a Specialist Occupational Therapist with a neurological rehabilitation speciality background. ZM explained that Prehab will involve working with GM Active to deliver an exercise referral scheme in gyms and leisure centres for specific patients. There is capacity to reach 2,000 patients over the 2 years programme. ZM and clinical lead, Dr John Moore are building on existing research undertaken by Prof Sandy Jack. The Prehab programme aligns with the Macmillan Recovery Package which is being implemented across GM. Current evidence indicates that high risk patients benefit from a 2-4 week intensive exercise programme prior to treatment. Lower risk patients are being shown from deriving less benefit from intensive Prehab prior to treatment. The programme team intend to offer something for all patients working with leading GM physiotherapists around home exercise packs at point of diagnosis and surgery schools specific to tumour condition as contraindications. The immediate Prehab focus will be the lung, colorectal, upper GI and head and neck pathways based on the current evidence base. Research indicated that head and neck patients would benefit particularly around compliance and the overwhelming psychological benefits, nutrition and exercise as well as the integration of smoking cessation. ZM described how the team are looking to have parity for chemotherapy and radiotherapy patients in GM by having an equivalent chemo/radiotherapy school (to surgery school) which is likely to be call Care4Cancer. This could be similar to a health and wellbeing event that patients can access earlier on when they are first diagnosed. This could be for anyone rather than a discrete patient group. ZM will return to the Pathway Board throughout the year to update the Board on developments and begin to embed the work across the Head and Neck Pathway.
Actions and responsibility	**NA**

13. Date and time of next meeting:

Wednesday 6th March 2019; 10:00-12:30; venue to be confirmed.