Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

Meeting of the SWAG Network Lung Cancer Clinical Advisory Group (CAG)

Tuesday, 7th November 2023, 10:00-15:30

Engineers House, The Promenade, Clifton Down, Bristol BS8 3NB / MS Teams

Chair: Dr Ashley Cox

REPORT (To be agreed at the next CAG Meeting)	**ACTIONS**

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

2. Review of Last Meeting Report and Actions

As there were no amendments to the report from the previous Lung CAG, held on Tuesday 29th November 2022, the report was agreed as finalised.

3. Service Development

3.1 Genomics and lung cancer update / ctDNA pilot results

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Medical Oncologist Louise Medley

Many advances have been made in the management of lung cancer over the last three years, with genomics allowing the different disease profiles of lung cancers to be identified so more tailored treatments can be provided.

The diagnostic test pathway for lung cancer is complicated, and each Trust has different challenges with coordinating EBUS, CT biopsies, reporting histology etc. It is recognised that there have been some concerns around incorporating the ever increasing armoury of genetic tests.

The technology at the Genomics Laboratory Hub (GLH) has improved over the last few years and a more extensive 150 RNA Next Generation Sequencing (NGS) gene panel is now being undertaken. Turnaround time from when the sample is received to reported is now 12 days.

The GLH team have no control over the time it takes from taking the biopsy to getting the sample to the lab.

In addition, a circulation tumour DNA pilot has been set up, with the initial aim to collect 700 samples, 100 per GLH. Some centres found it challenging to participate, and any feedback to improve the process would be welcomed. The pilot is now in phase 2, which will involve processing an extra 18,00 samples. The South West have processed 160 to date.

At the end of the year, an analysis will be undertaken on the health economics of ctDNA, after which, it is anticipated that 10,000 samples will be sent to a local centre, which is likely to be The Royal Marsden, to roll out as standard of care and routinely offer in clinics from 2025.

There are a number of challenges to the project, the greatest of which is to ensure that the test is provided right at the beginning of the pathway in the two week wait respiratory clinic so that the results are available once the oncologist is planning treatment. The diagnostic pathway is so quick, the ctDNA test can often be missed. A dedicated person responsible for taking the blood and tracking the samples needs to be determined. There is also the challenge of trying to integrate the report into hospital information systems, and then interpret the results in the correct way.

The benefits will be identifying actionable variants as early on as possible and providing targeted treatments where available.

The pilot outcomes will hopefully inform the additional resources required before it can become standard care.

At present, the majority of clinical trials for lung cancer are Phase II looking at different gene variants.

Turnaround time from taking the blood for ctDNA to receiving the result back from Germany is currently around 15 days, so will be comparable with the return of NGS results, which do include how to interpret the findings.

ROCHE reports don't contain any interpretation of the identified variants, but when The Royal Marsden starts processing the samples, the interpretation will be included, which will increase turnaround time. The report will also state if actionable gene variants have not been identified so it is clear that standard treatment can commence.

The ctDNA samples will pick up additional co-mutations that wouldn't be included in NGS. There are clinical trials looking at co-mutations and adapting treatment options.

In Torbay, ctDNA has been shown to improve time to treatment as it is not necessary to wait for the biopsy for those with a positive result.

From NGS, variants have been identified in 54 patients to date, which is 37% of the tests sent; 3 patients have subsequently had early access to clinical trials.

One case demonstrated the need to consider re-sending samples for patients that relapse due to the rapid improvement of gene analysis technology. One particular patient had a Next Generation Sequencing (NGS) sample sent to the GLH in 2020 and 2021 where no variant was identified. However, an additional sample sent following a recent relapse identified the EGFR exon 20 insertion mutation.

All lung cancer patients have been reflex tested at Torbay since April 2022.

Sample failure rate would be interesting to investigate to ensure that they are being processed in the correct way in each centre.

Potential Future Agenda Item

It tends to be older samples that fail; failure rate is approximately 16% nationally, and falling now that there are fewer older samples being processed.

Another case sent for NGS resulted in two actionable variants: EGFR and a skipping variant. There is no National Lung Genomic Tumour Advisory Board (GTAB) available to discuss how to act on complex results, so the case was flagged to the British Thoracic Oncology Group (BTOG) committee to consider if there needs to be a more formal process to discuss these patients along with relevant scientists.

It would be ideal if there was a meeting to which people could dial in, but it is a challenge to find time in the job plan to make this feasible.

CAG Recommendation

A National model was recommended as is the arrangement for Ewings Sarcoma cases, due to the small patient numbers. Educational resources should also be gathered.

GTABs have been held for discussion of complex sarcoma cases on an ad hoc basis which has been helpful.

Although GLH scientists are always available to have ad hoc discussions, there is a need to pool the expertise and have an educational element via a formal GTAB.

In Gloucestershire, the HELP ROCHE pilot commenced and has given the team access to 60 tests, which is low in comparison to the number of eligible patients.

As it is not possible to select patients that are the most likely to have a variant, the tests will be distributed on a first come basis until they run out.

It is anticipated that there will be a gap in provision of tests when the pilot ends and before it is available as standard care. NHS E have been made aware of this issue.

The South West centres are the second highest recruiter to the pilot so have proven that integrating the test is possible, and should help predict the resources required prior to making this standard care.

The team are invited to make contact with any queries or concerns: louise.medley@nhs.net

4. Patient experience

4.1 National Cancer Patient Experience Survey Results 2022

Please see the presentation uploaded on to the SWAG website

Presented by Lead Cancer Nurse Chris Levett

The survey is commissioned by NHS England and used to monitor progress in the experience of cancer care and drive local improvement projects.

It is sent to adults over 16 years who have been discharged as an inpatient or day case for a cancer diagnosis between April to June 2022.

Patients treated in 2023 will be receiving their surveys now.

The response rate in SWAG was 58%. The vast majority of people still respond by paper form, and the majority of respondents identify themselves as white British; work is underway with the Cancer Alliance to try and ensure that responses are received from as wide a representation of the population as possible.

SWAG wide results score of the overall patient experience was 8.9 out of 10, which is comparable with the National average but down by 0.1 in comparison with the 2021 survey. Questions above and below the National expected range are documented in the presentation.

The question on access cancer research opportunities was noted to have a low number of positive responses across SWAG; work is underway with the Cancer Alliance to try and improve the score.

The question on if patients were always able to get help from ward staff had dropped below the previous score, and work was underway with ward matrons to address this, which was felt to be due to workload pressures caused by COVID.

There were 179 responses that specifically relate to patients with lung cancer. The questions that scored greater than 90% and less than 60% have been picked out to identify themes.

Many of the high scoring results relate to the provision of a named Clinical Nurse Specialist contact and Personalised Care and Support (PCS) activity. It is vital for this support to continue.

The lower results mainly relate to pressures on the ward and the need for further support in the community.

The question on having the opportunity to ask for a second opinion is considered a challenging one to answer as this is not always possible in cancer treatment timeframes.

Communication between providers about information on long term side effects is in the action plan for the coming year in the hoped that this can be improved.

NCPES results will be communicated to all relevant stakeholders and a dashboard of actions created so that analysis can inform local and regional service improvement plans.

The results are available online: About the survey - National Cancer Patient Experience Survey (ncpes.co.uk)

Free text comments are not published and made available to individual provider Trusts.

Discussion:

Lung CAG ask for the main take home message that the group can focus upon.

The priority was considered to be improving communication of patient information on side effects where care is shared across providers.

The percentage of patients that are made aware of research trials is considered to correctly reflect the number of patients who would be eligible for trials. Discussing trials with patients who are not eligible risks overloading the patient with information.

Long term side effects of particular concern is neuropathy caused by cisplatin, which is now being used less frequently.

Long term radiotherapy side effects are discussed as part of long term follow up as they arise.

It is difficult to see how improvements can be made in the community at present due to the national shortage of General Practitioners.

Overall, the results were a positive reflection of the service.

There is a need to bolster the number of lung specific responses in Gloucestershire Hospitals, as these have been too low for the results to be reported. A bespoke survey is being designed to overcome this.

Posters could be displayed locally to try and improve responses.

Information on expected side effects could be produced for patients on follow up.

NCPES doesn't capture the experience of the rapid straight to test pathway which, although this suits some patients, can be difficult for others.

Development of a regional SWAG lung cancer service patient experience survey is recommended as NCPES does not enable the lung cancer services to target specific problems, but rather allows comparison with services across the nation.

Action: To share existing patient experience surveys and establish if there is any funding and administrative support for this to be achieved. **Lung CAG**

One of the problems with NCPES is felt to be the number of questions (58). Responder fatigue happens after approximately 20 questions.

Interviewing a smaller sample of patients is another method that could be useful.

When exploring development of SWAG wide surveys in the past, it has been confirmed that the survey needs to go through the individual approvals processes in each provider Trust.

4.2 Clinical Nurse Specialist update

The team in UHBW are now able to provide a service in Weston again since October, which has been very well received.

The two week wait service is still being delivered in UHBW as there are insufficient resources to restart this in Weston; an additional Consultant or Advanced Fellow would need to be appointed. It is recognised that this is not ideal for patients due to the burden of travel time.

The model in Bristol works well, with the CNS team delivering the diagnostic clinic. For surgical patients, there is a weekly follow up phone call clinic for newly diagnosed patients and Personalised Care and Support provided by Allied Health Professionals 6 weeks post diagnosis.

Funding has been provided to appoint an Advanced Nurse Practitioner to help manage the non-cancer clinic workload, and an extra Thoracic Clinical Nurse Specialist. It is hoped to get support from the Trust to appoint a lung cancer tracker to help with neo-adjuvant treatment pathway.

The Treatment Summaries provided by the RUH team have been found to be helpful for surgical patients as they make patients aware of any symptoms of concern to report. Further work needs to be undertaken to ensure these are

provided at the appropriate time for patients undergoing oncological treatments.

A flow chart has been produced for oncologists to demonstrate when patients on oncological treatment in BHOC can be referred to the CNS led Advanced Cancer Support Days. As many more patients are on long term treatments with immunotherapy, the time that it is appropriate to refer patients to these days is being reviewed.

A nurse-led rather that Cancer Support Worker-led end of treatment Holistic Needs Assessment is also being explored for these patients.

Action: to arrange a CNS break-out meeting to share practice — **CNS team: To be allocated**

5. Quality indicators, audits and data collection

Cancer Alliance update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician / Cancer Alliance (CA) Lung Cancer Lead Henry Steer, and Programme Manager Nicola Gowen

Cancer Alliances were established approximately 6 years ago as a second iteration of the previous Cancer Networks, from which the Cancer Clinical Advisory Groups (previously known as Network Site Specific Groups) originated.

The CAs are a sub-set of NHS England, and are used to funnel national initiatives, targets, performance metrics and funding to the providers.

The key challenge for Cancer Alliances is to convert top level targets into ground level initiatives that benefit the services and patients.

H Steer undertook the role of clinical lead approximately 3 years ago, at which time there was managerial support from Programme Manager N Gowen. The support was then halted for 1 year due to a secondment but has now been reinstated. N Gowen also leads on the Improving Cancer Waiting Time Performance and Early Diagnosis projects.

A set of deliverables is defined by the National Cancer Improvement Work Programme and the SWAG Cancer Alliance work to ensure activity takes place that aligns with these and make them work locally.

Everyone who works for SWAG Cancer Services is considered members of the Cancer Alliance.

The Targeted Lung Health Check programme has been set up via the Cancer Alliances.

The National Team have now set up a Treatment Variation Group to look at the downstream implementation of recommendations from Getting it Right First-Time (GIRFT) and results from national audits.

It was decided to focus on three priority workstreams:

- All trusts should have an overall radical treatment rate of 85% or more in those patients with NSCLC stages I-II and of performance status 0-2. This includes all treatment modalities (surgery, radiotherapy including SABR, multimodality treatment and thermos-ablative techniques)

- Trusts should record and monitor multimodality treatment in stage IIIA disease and offer radical intent treatment as standard in fit patients
- Radical intent treatment should commence by day 49 of the overall NOLCP pathway. Furthermore, for surgery, thermos-ablation or radiotherapy, treatment should commence by day 16 after the decision to treat in line with NOLCP.

These were felt to be broad enough to encompass any service improvement that each centre could propose.

Funding is available to facilitate relevant projects.

The consequences of not achieving the targets is not known.

Data needs to be provided back to the national team to demonstrate progress. Cancer Managers are being asked to provide this on a quarterly basis.

A previous attempt to set up a pathway analyser tool has been unsuccessful due to the workload that this created and variation in the interpretation of data fields.

Data from the National Lung Cancer Audit provides the percentage of patients treated with curative intent and the number of patients treated with surgery, chemotherapy and radiotherapy which, as discussed previously, is thought to be lower than other centres. However, it gives no information on the patient pathway or gives any feedback on how to improve outcomes. It is also out of date by the time the results are published.

An excel spreadsheet tool has now been developed by the national team in partnership with ROCHE which has been given free to Trusts. This can pull data from Trust systems and create a series of dashboards to analyse why performance targets have been missed and where the pathway can be improved.

Four out of six providers are in the process of implementing the tool. GRH and RUH are pending. It is expected that the first iterations will identify problems with the data that need to be resolved before it can be made useful.

Partial data from quarter 1 was received just prior to the meeting but this needed to be checked for accuracy.

The BI team can enter search criteria into the spreadsheet so that the data can be automatically pulled from hospital systems, such as the Somerset Cancer Register.

It could be that the ROCHE tool is being underused at present. It is hoped that this will be valuable once set up correctly.

Given the TLHC project and current pressures on the surgical service, it is logical for the regional funding to be provided to the surgical service in the hope that waiting times can be improved.

Action: A potential service improvement would be to implement nurse-led surgical follow up across the region. A proposal will be drafted for this purpose, as detailed in the presentation. **N Gowen**

It needs to be considered that a surgical follow up appointment can take around

5 minutes, whereas a CNS led follow may take between 30-45 minutes. The Yeovil CNS has started to run some of these clinics, which have received positive patient feedback.

The resulting reduction in workload will be matched with new patient activity.

Additional theatre time for thoracic cases is required to manage the impact of TLHC.

Action: An Expression of Interest in the role of Clinical Project Manager will be circulated. **N Gowen**

There is scope for additional bids should CAG members have any service development ideas.

6. Research

6.1 Lung cancer clinical trials update

Presented by Consultant Oncologist Gareth Ayre and Research Delivery Manager Claire Matthews

National clinical trial recruitment from April 2023-November 2024 shows that 6,443 patients have been recruited to lung cancer trials across the 18 research networks. This is on track to be comparable with 2022/23 where 13,921 patients were recruited. There was an even split between commercial and non-commercial trials and about two thirds interventional and one third observational.

The NIHR 6-month Associate Principal Investigator (PI) scheme is still open to any interested clinician who doesn't have research in their current role. It allows associates to work alongside current PIs on studies (as documented in the presentation) signed up to the scheme.

Any PI interested in getting help from an associate while helping their personal development is to get in touch.

The Clinical Research Networks are going through a period of transition. In October 2024 they will be renamed as Research Delivery Networks (RDNs) and reduce from 18 to 12 networks that will operate as one organisation across England. The changes reflect that the NIHR also manages research in local authorities and other out of hospital settings.

The West of England RDN will be renamed South West Central and include Salisbury and Swindon, Bournemouth and Dorset. It will still not include the Somerset Hospitals in SWAG, which will remain under the remit of the Peninsula RDN. The organisational structure is also expected to change but the definitive model is not known at present.

C Matthews will continue to work closely with Peninsula colleagues to report on the trials available in Somerset.

The list of trials open and in set-up across the region is documented in the presentation.

A website is now available where patients can proactively register their interest in participating in research: I want to take part in a research study | NIHR and there is also e-learning for staff to help facilitate research conversations:

https://learn.nihr.ac.uk/.

NIHR website links and team contact details are available within the presentation. Dr Gareth Ayre is the Research Sub-Specialty Lead for the CAG.

7. Service developments

7.1 Targeted Lung Health Checks

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Anna Bibby

National TLHC activity shows that 2,396 patients have been diagnosed with cancer to date, with 74% found at Stage 1 or Stage 2, which is a complete inversion from previous data, where the majority of cases are diagnosed at Stage 3 or 4.

The SWAG pilot commenced in July 2022 and is a community-based roving model held in accessible, non-clinical locations in areas of the highest need, targeting underserved communities. It is hoped that this will equally distribute of the downstream workload and to share learning and future planning.

Sites were chosen according to smoking prevalence, rates of cancer diagnoses and areas of deprivation.

The pilot commenced in BSW, moved to Bridgewater, and is now finishing in North Bristol before moving to inner city Bristol and Gloucestershire.

Details of the experience in Bath and Bridgewater are documented in the presentation.

Many incidental findings have been identified and guidance has been drafted to give advice to GPs and patients about ongoing management. A national taskforce has been formed to standardise the information provided.

Based on a review of the pilot by the UK National Screening Committee, it is recommended that lung cancer screening is added to the adult screening programme as routine practice.

This expansion will mean that approximately 350,000 people will be eligible for the screening across SWAG, which translates to between 20,000-30,000 TLCH per year. The national team expect full coverage by 2028/29. This should result in around 3500 lung cancer diagnoses.

Expansion modelling has been undertaken to show the predicted additional scans, pathology, and treatments each year. This is being shared with all relevant managers; all sites will need additional staffing across the multi-disciplinary team. It will also be necessary to expand the TLHC team.

At present the service is outsourced and whether this should come back under the ownership of the NHS will also be considered.

SWAG TLHC has been flagged as a positive exemplar due to the considerations put in place to enable the roving model set-up and resulting screening review meeting / management of outputs to ensure that relevant tests have been arranged in parallel with arranging the 2WW referral. Results have been disseminated to national conferences including the British Thoracic Society and the British Thoracic Oncology Group.

It is hoped that access to Artificial Intelligence for reporting scans may improve over the next two to three years and help meet the increased demand.

The number of surgical procedures are expected to double.

8. Clinical guidelines

8.1 Electromagnetic Navigational Bronchoscopy (ENB or nav bronch)

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Andrew Low

The ENB Service has now been running for a year.

Case studies were presented to demonstrate where ENB can improve outcomes.

Case 1 had an incidental finding which was difficult to biopsy due to emphysema, and also not accessible via bronchoscopy so was treated with SABR without histological evidence.

Case 2 presented with a cough and an avid lesion, who had a failed biopsy which resulted in a chest drain. The patient then had a wedge resection which resulted in a benign diagnosis.

Case 3 presented with a persistent cough and short of breath although otherwise fit and well but high risk for surgery and not possible to biopsy, who is now on the watch and wait pathway.

Case 4 presented with an abnormal chest x-ray. A biopsy wasn't possible as the patient was unable to breath hold. This resulted in a pneumothorax and the patient is also on the watch and wait pathway.

These lesions could all have been biopsied using ENB to get an accurate diagnosis earlier in the pathway to make appropriate treatment decisions. Electromagnetic technology enables a 3-D map to be created that guides the fibreoptic bronchoscope to the lesion so a sample can be taken.

The imaging is transposed onto the patient and updates in real time as the probe navigates through the airways.

Thirty two cases have been completed to date. The average age is late 60s and the majority have been female. Lesion size has varied between 9-59 mm. The majority have been solid, although some ground glass lesions have also been biopsied.

Sensitivity was 60.7% with 13 cases diagnosed with cancer, 5 infection or inflammation, and 11 were non-diagnostic. Results are getting better as experience in the procedure increases. The team will work towards matching the national data that shows sensitivity of 82% and specificity of 100%.

Other teams are using additional complementary imaging to improve success rate, such as radial EBUS, rapid on-site evaluation and other tools.

UHBW team are also only using ENB for patients who are not possible to biopsy via other routes, whereas it is used more routinely in other centres.

It is hoped to get access to radial-EBUS and thoracoscopy to further improve sensitivity.

It can also be used for localisation, which has been done on three occasions so far, and potentially for therapeutics such as microwave ablation, although it is uncertain how this compared to SABR at present.

Patients need to be able to tolerate a general anaesthetic. The procedure takes approximately 30 minutes. It will take time before there is sufficient confidence to consider undertaking the procedure using only local anaesthetic.

Ideally, lesions referred will be over 2 cm.

Referrals have been received from all centres in the region.

Complications are rare, and the procedure is considered safe.

8.2 Peri-operative Systemic Therapy in Early-Stage NSCLC

Please see the presentation uploaded to the SWAG website

Presented by Consultant Oncologist Ashley Cox

Historically, patients with NSCLC have surgery followed by adjuvant treatment, but there is now a group of patients who are eligible for peri-operative treatment, which requires oncology and surgical services to align so this can be incorporated in the pathway.

Data from multiple previous clinical trials has shown a 5% benefit from adjuvant therapy and that approximately 30% of patients don't progress to treatment following surgery due to ill health. However, introduction of Osimertinib has improved survival outcomes, possibly by another 10%.

The CheckMate-816 trial compared neoadjuvant therapy for resectable Stage III patients, with a randomisation of nivolumab plus chemotherapy for three cycles compared with 3 cycles of chemotherapy. Inclusion criteria included no known EGFR or ALK gene alterations.

Restaging is required with a PET-CT 1 week prior to surgery.

Follow up data shows a significant improvement in event free survival.

Overall survival data has not shown improved survival data as of yet, although it is expected when the data matures.

The next stage is to look at neoadjuvant immunotherapy and chemotherapy, followed by surgery and adjuvant therapy.

In summary, those with an EGFR mutation have surgery followed by adjuvant chemotherapy and 3 years of adjuvant Osimertinib. Those who are EGFR/ALK/(ROS-1.RET) negative should have neoadjuvant chemotherapy plus nivolumab followed by surgery. Those with PD-L1 > 50% with no pre-operative SACT should have surgery followed by adjuvant chemotherapy and atezolizumab.

It is therefore now essential to get the results of molecular tests as early on as possible to inform these treatment decisions.

The team in UHBW are discussing relevant patients and making a provisional plan for chemotherapy which may then change according to NGS results.

Action: Experience operating on patients following adjuvant treatment will be sought from the surgical team.	**Surgical Team**
Action: To explore the possibility of arranging joint oncological and surgical clinics.	**Oncologist Team**

Consultant Oncologist L Toy recommends a rota for regional Oncologist to routinely join the Bristol Surgical Team.

Action: Production of a NSCLC neo-adjuvant treatment Standard Operational Procedure	**Sara Gomez**

9. Clinical opinion on network issues

Managing staff fatigue

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Psychologist Mike Osborn

Lung CAG are invited to contact Dr Osborn with any questions that may arise following the presentation.

CAG members are encouraged to think about how to manage the potential risk of psychological fatigue caused by workload pressures, which has always been high risk, but is currently a much higher risk than usual due to the exponential increase in treatment load. Provision of intensive treatment and support to ill and distressed patients has increased 8 fold over the last decade, as demonstrated in a recent presentation by Prof Mark Beresford.

Attention should be drawn to the accumulative every day small behaviours and brief experiences that can have a critical impact on our health and immune system, rather than focusing on more profound critical incidences.

Culturally, complaining about small everyday stresses, such as car parking or problems with IT systems, can be perceived as trivial. However, recognising the impact of these issues can have the biggest return on improving your quality of life, as it is prolonged duress that makes threat defence responses dominate which, in turn, can cause fatigue. Threat defence responses also do not automatically stand down once work has finished, and it can be helpful to arrange a quiet reunion with those that you live with when you return home.

Fatigue and exhaustion differs from tiredness, as it is an indication that the brain has depleted resources to the primitive brain, which interrupts the ability to regulate your mood and find things interesting, pleasurable or amusing, which can undermine your confidence.

Because hospital staff are high functioning and used to high performance work in stressful environments, the response to fatigue is likely to be more fight than flight, and result in irritation, annoyance and reduced tolerance for being critiqued.

This cognitive disruption, which is as real as the brain fog caused by chemotherapy, causes moral injury to NHS staff, as you are all working very hard, but also feel the need to apologise for the things that have not been

possible to achieve, leading to misplaced guilt.

The talk is not presuming that everyone is feeling these pressures in the same way or at any given time but is simply to raise consciousness of the risk of cognitive fatigue.

To help mitigate or manage this risk, staff are encouraged to make deliberate and active steps to review what it is that you personally need, and to regularly incorporate these needs into your daily routine with benign self-compassion and complete moral authority.

Composure and civility should be prioritised and incivility called out. It is advised to 'strike when the iron is cold' to try to maintain your balance of composure below 4 to 5 out of 10 as once the adrenaline becomes higher than this, it can take significantly more time to dissipate. Even if anger and aggression is righteous, it is never helpful.

Fatigue management cannot be reduced to a test of will power, control or strength, but rather it is a test of flexibility and adaptability.

There is a psychological paradox of fatigue management, in that the virtues of a person working in the hospital environment exactly match fatigue risk factors.

Maintaining a health team culture is the most protective factor to ensure social safety.

In summary, CAG members are asked to prescribe for themselves the advice that a feisty compassionate colleague would recommend.

Date of next meeting: Tuesday 14th May 2024

-END-