Meeting of the SWAG Network Skin Cancer Clinical Advisory Group
Wednesday 6th December 2023, 09:30-15:00
Engineers' House, Clifton, Bristol BS8 3NB / MS Teams

REPORT

Chair: Mr Ewan Wilson

1. Welcome and apologies **ACTIONS**

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

2. Review of last meeting's report and Work Programme

The section on the Sentinel Lymph Node pathway requires clarification. This will be revisited in the meeting today. As there were no further amendments or comments following distribution of the report from the meeting on Wednesday 2nd November 2022, the report was accepted as finalised.

Work Programme:

Personalised Care and Support: Implementation of the Recovery Package.

The UHBW CNS team were holding group sessions prior to COVID, but these stopped, with a plan to restart with Melanoma in the near future once the logistics have been arranged to ensure this is replacing activity, rather than adding to the workload.

Cancer Support Workers (CSWs) are now in post to provide patients with Holistic Needs Assessments (HNAs).

The Somerset Team also have CSWs completing HNAs, and they have restarted a Melanoma Support Group, which is going to be handed over to the patients to run in the near future.

Although RUH Skin Cancer team have not returned to face-to-face skin cancer specific support groups at present, there are generic wellbeing events available. Treatment Summaries are being completed for skin cancer patients.

The NBT Teams also have HNAs completed by CSWs and are restarting Melanoma Group Sessions.

3. Clinical opinion on network issues

3.1 Cancer Alliance Skin Cancer Improvement Project

Please see the presentation uploaded on to the SWAG website

Presented by Regional Cancer Improvement Lead Lisa Brown and Programme Manager Niki Gowen

The three elements that the project is covering are teledermatology (telederm), performance overview, and system transformation plans.

Nationally, there is significant political interest in telederm. Slide 3 shows the percentage of coverage across England, and how this has increased from Quarter 1 to 2 during 2022/23. This shows SWAG provided between 51-75% of dermatology referrals via telederm, which is an estimation that compares favourably with the rest of England.

Each year, approximately one in four people contact their GP about a dermatological condition and, with the increasing incidence of skin cancers and challenges to recruiting the dermatology workforce, it is hoped that telederm will help manage this demand.

Many referrals will be benign, and it is thought that approximately >33% of patients sent with a quality image can be discharged and the patient informed that there is no suspicion of cancer.

An impact report published last year has been shown that telederm pathways can improve waiting times, staff capacity, service efficiency, and patient experience of care, reducing the need to travel.

It is reliant on provision of high-quality images, needs to be appropriately incorporated into Consultant Dermatologist's job plans, and integrated into hospital IT systems.

NHS England published a telederm roadmap in November to accelerate roll out by providing practical steps to implement a safe and effective service: NHS England » A teledermatology roadmap: implementing safe and effective teledermatology triage pathways and processes

Different models are being explored, which may involve images taken by the Secondary Care or Primary Care teams, aiming to ensure that the patient receives a diagnosis by the Faster Diagnostic Standard (FDS) of Day 28.

Discussion 1:

It is not always possible to definitively state if a lesion is cancerous on clinical examination alone, with histological confirmation required before the patient can be informed of the diagnosis. In these cases, Day 28 is often not feasible.

Performance targets should not pressure skin cancer services to prioritise histological diagnosis of indeterminate lesions faster than obvious cancers.

Patients triaged off the suspected cancer pathway require a letter of confirmation from Secondary Care.

MS Teams Chat: RUH are not communicating directly with the patient on telederm, but directly with the GP, as this is the set up on the telederm platform. Therefore, the FDS clock does not stop until the patient is seen in clinic.

An overview of Skin Cancer FDS Performance compared with England shows the seasonal increase over the summer months followed by a dip in performance, which may also relate to recent strike action.

The skin cancer diagnosis conversion rate is significantly higher (11%) in the South West in comparison with the rest of England (7%), although there has recently been a drop in the most recent quarter.

Performance by Provider, backlog, plus the SWAG and Peninsula plans, are documented within the presentation. Projects are underway in each Provider Trust.

Seven CNS/AHPs have undertaken the physical examination training in SWAG; outputs will be measured.

Discussion 2:

The main problem with telederm is poor quality images.

RUH are hoping to set up a medical photography hub, so that standardised images can be taken that facilitate triage of the patient to the right place first time.

The pilot ‘poly’ clinics in NBT are designed to maximise the number of patients that can be seen in one clinic for a decision to treat. This involves multiple clinicians attending in one large room divided with privacy screens.

The morning clinic tomorrow has 70 patients booked and a team of 5 clinicians with one Consultant, who doesn't have a list, but provides oversight for the registrars.

The clinic has a beneficial educational function and builds resilience into the service.

The melanoma clinic model for Mr Wilson comprises bookings at 15-minute intervals, which also allows time for oversight of the registrar clinics.

The Gloucestershire clinic model is multi-disciplinary and includes a see and treat element; funding of these models has changed and is now less financially viable.

UHBW have a similar model with CNSs and Trainees and two people standing by to deliver treatments. There is an electronic system in place which reduces the number of cases that can be processed by approximately 10-20% but produces other efficiencies later down the pathway.

The key to the ideal clinic is to free up the Consultant Dermatologists, who are the ultimate decision makers, to avoid unnecessary listings and process large numbers, with recognition of the risks of decision fatigue.

Patient feedback from the poly clinics has been positive, with rapid processing seeming to be acceptable.

It is better from a CNS perspective to be involved and improves the patient pathway.

The clinic configuration however does not resolve the underlying problem due to the exponential increase in referrals. For example, NBT has 424 scheduled two week wait referral slots per month but routinely receives over 800 referrals per month. Weekend and evening lists are being arranged for this to be managed.

Outsourcing of pathology from the lists has caused some tracking issues.

Surgical capacity needs to be expanded; activity is underway for this to be addressed.

3.2 Regional Melanoma Pathway – round-table discussion

A working group was held last week for the purpose of finding solutions to speed the pathway to oncology, particularly in light of the new eligibility criteria for adjuvant treatment.

Estimated waiting time steps currently mean that the patient is seen in the oncology clinic with all necessary investigations between 23 to 37 weeks.

The decision for adjuvant treatment is supposed to take place 12 weeks into the pathway.

The following potential ways to shorten the pathway were proposed:

- Assessment of appropriateness to proceed to Sentinel Lymph Node Biopsy (SLNB) prior to primary excision
- Bring the SLNB discussion in parallel with waiting for the CT scan to be reported, as there will be very few patients for whom the scan upstages the patient for a referral straight to oncology; patients can be informed that the CT result may change management
- Progress the patient pathway without waiting for the SSMDT discussion by following protocolised guidance
- Immediately book an appointment for results after the first excision which could be via telephone if the patient agrees that this is appropriate; the CT, SSMDT referral and plastic appointment within 3-4 weeks, booked on the same week as the SSMDT, can be booked at the same time. Should the CT upstage the patient, the plastic slot can be cancelled and the patient referred to oncology
- Plastics to inform oncology of the date of surgery and make a parallel appointment with oncology 3 weeks after
- Increase SLNB capacity; this will hopefully be addressed in February 2024 (there is currently a maximum of 24 SLNB slots of nuclear medicine operating time)
- When the SLNB indicates a Stage 3 or 4 diagnosis, the 12 weeks to adjuvant treatment date should begin following the Wide Local Excision, with recognition that the view from oncologists is that oncological treatment should ideally be given within 3 months of a melanoma being removed.

The age cut off for SLNB is dependent on an individual's physical fitness. The general rule would be that the patient has an expected life expectancy of 10 years.

Patients up to 75 should be referred; 75-80, an individual assessment needs to be made; 80-85, some may be eligible if they are particularly fit.

Patients referred for SLNB in SWAG have been found to be correctly screened. The Clinical Nurse Specialists see the patient quickly after they are booked for surgery to take a full history and assessment.

The work undertaken by A Bray to estimate the timelines at each step of the pathway could evolve into a lean project to audit the effect of implementing pathway streamlining initiatives with hard data on the outcomes.

From a pathologist point of view, there is approximately a 1 week delay from the LSMDT notifying the SSMDT of a melanoma, which can be improved upon by sending results to both MDTs in parallel while ensuring that the LSMDT continues the process of assessing if the patient is appropriate to refer and has all the necessary workup. The referral to the SSMDT can always be retracted if found not to be appropriate following the LSMDT.

Action: To streamline the pre SLNB pathway by arranging multiple steps in parallel and audit the impact.	**A Bray/Skin CAG Team**
Action: To circulate guidelines on the cases that would be excluded from progressing to SLNB	**E Wilson/ Plastics Team**
Action: To audit the number of initial Stage 2B/2C where the CT scan report identifies a higher stage disease.	**NBT CNS Team**

4. Artificial Intelligence / Teledermatology

Presentation available on request

Presented by Consultant Dermatologist Adam Bray

There is no conflict of interest related to the presentation and the company who provided the tested product.

A project was undertaken to look at the use of AI in screening patients on the two week wait pathway in UHBW. It commenced in June 22 and completed in April 2023. Images were provided by Secondary Care Medical Illustration Hubs based at 5 different sites: Weston, Bridgewater, Taunton, South Bristol and Bristol City Centre.

Patients had a phone call appointment with a Consultant booked at the same time that the images were taken.

It was possible to book patients straight to surgery from the telephone appointment where applicable.

Several sites across the UK were involved, with funding provided by NHS X, where different models (as documented in the presentation) were deployed so that a cost-benefit analysis can be undertaken in comparison with face-to-face clinic appointment models; results are pending.

The reasons behind the pilot is to mitigate the risk of missed or delayed diagnoses in Primary Care, plus reduce over-referral of benign lesions.

Patients were given a tailored information leaflet describing the process.
A general history and the history of the lesion would be taken at the same time as the photographs.

The photographer would take the usual images including an extra dermascopic image that is analysed using the AI device, which is an online application (app) with a portal to register the patients.

The aim is for benign lesions to be discharged back to their GP using a template letter without any intervention required from Secondary Care.

The app is the only UKCA certified Class IIa Medical Device for identifying skin cancer, and has been trained to classify 11 different types of skin cancer and will state if it is malignant or benign.

There are many other apps without dermascopic images that claim to be able to do the same thing, but they have not been certified.

Exclusion criteria includes all patients with cognitive impairment, genital lesions, under 18 years, or more than two lesions.

It cannot be used to assess the following areas:

- Lesion too large for dermatoscope
- Previous biopsy site
- Ulcerated/open wound
- Hair-bearing
- Tattooed or scarred area.

It is not as accurate with darker skin types, rare or 'ugly duckling' lesions.

The system does err on the side of caution and may make false positive.

Approximately 40% of two week wait referrals were assessed over the time period.

The other 60% went via either face to face or via the traditional Medical Illustration Telederm (MITD) service that had already been established, either due to patient choice, exclusions or patients with multiple lesions.

The MITD service usually has 15-minute slots; it was necessary to increase this to 20 minutes for the pilot due to an extra questionnaire, more technological requirements and an extra photo, resulting in reduced capacity in the pilot clinic. This may have been a driver for the booking team when consenting to the pilot.

1672 patients went through the AI pilot; 14% of referrals were excluded from the AI part of the MITD service and processed as per usual or sent to face-to-face appointments.

65% were flagged as cancerous, who went on to be booked for an appointment with the Dermatologist and on to treatment. 35% were identified as benign and went through the safety net of being re-assessed by a GMC registered Dermatologist appointed by the AI company. This resulted in 20% of patients being discharged without any contact with the UHBW dermatology team.

Of 65% flagged as cancerous, 14% were discharged as benign and the other 51% went for a biopsy or treatment.

There was a percentage of cases where the second read by the dermatologist altered the AI outcome. This was higher for Atypical Naevus.

Advice needs to be provided to patients to ensure they seek further advice, should a lesion continue to change.

Patient acceptance of the use of AI was approximately 60% positive. Patient overall experience of the pathway, which had been very fast, was mainly positive.

It is expected that normal teledermatology will be found to be the most cost-effective option. AI will make some savings in Secondary Care, but would be more expensive if placed in Primary Care.

To date, it is unclear if investing in AI will be as cost effective as having a fully staffed dermatology service. Although there would be some opportunities missed on giving advice and topical treatments, it may be more effective as a cancer exclusion pathway.

The project has helped to expand the medical illustration team and increase their expertise.

It could be of value in areas where there isn't a fully integrated teledermatology service.

Action: The full report is pending and will be revisited at a future meeting. A Bray

5. Patient Experience

5.1 National Cancer Patient Experience Survey (NCPES) (2022)

Lead Cancer Nurse Ros Helps

Although the annual survey has been undertaken for 12 years, some of the questions changed in 2020, so it is only possible to directly compare the 2021 and 2022 surveys.

The survey is sent to adults over the age of 16 who have been discharged from an inpatient or day case attendance for cancer related treatment between April to June each year.

Results are compared with the national average to see if responses are above or below an expected range to inform service improvements.

SWAG response rate was slightly higher than the national average. The majority of respondents still prefer to respond on paper, although there is an online and phone option.

Response rates from patients who identify as other than white British are low. This is being investigated by Trusts to compare responses with the ethnicity of the patients who were sent the survey.

There are a number of patients who decline to give their ethnicity, which it is thought may be due to mistrust on how the data might be used. The survey provider, Picker, have been asked to include a more comprehensive explanation on how the data is being used in cancer care.

SWAG Cancer Alliance are going to be employing a data analyst who will be able to investigate trends from the survey in more depth.

SWAG results overall showed 8 questions scored above the expected range and no questions scoring below the expected range. A few questions scored slightly lower than last year.

Skin cancer specific responses totalled 153. Overall rating of care was 9/10.

Gloucestershire, Somerset and Bath had insufficient numbers of responses for the data to be published.

There were many questions which rated over 90%. Of those highly rated, it was clear that the main theme was having access to key contacts in the team to discuss the plan of care, and that the whole team worked very well together, which should be celebrated.

Some of the lower scores relate to the care provided in the community, such as the question 'patient had a cancer care review from their GP' scoring 17%. Feedback from Primary Care is that the Treatment Summaries provided by Secondary Care are vital to help complete the reviews, as they provide all the relevant information on one page rather than scanning through multiple letters.

Two of the lower scoring questions to consider:

Question 32: 'Patient's family or someone close was definitely able to talk to a member of the care team while looking after them in hospital'.

Question 58: 'Cancer research opportunities were discussed with the patient'. This was low across all cancer sites, and an opportunity to work across SWAG to raise awareness that patients may be invited to take part in clinical research trials if an appropriate trial is identified.

It was recognised that 44% of patients recalling discussing research opportunities was high in comparison to the number of patients who would be eligible for trials.

Results from NCPES are shared with all stake holders and a SWAG result dashboard will be provided to facilitate further analysis and identify further areas for improvement. Results will also be cross-referenced with the National Quality of Life survey.

Overall, the results should be celebrated as they are overwhelmingly positive, with the vital role of the Clinical Nurse Specialists and other team members being evident.

5.2 Clinical Nurse Specialist (CNS) update

UHBW team now has an additional CNS which has allowed the Band 7's to commence two week wait clinics with consultant supervision, and provide more peer to peer support for follow up clinics, reducing the need for consultants required on site.

Competencies have been developed to help gain confidence in lesion assessments.

The capacity to manage the middle and follow up sections of the pathway need to be monitored carefully due to the push to focus on the 28 day pathway so that the workload is appropriately balanced.

Provision of two week wait clinics should be recognised in the CNS Job Descriptions and formally recognised as a developmental element to the role.

Competencies are vital; the teams need to make sure that no one is put in a situation where they are uncomfortable undertaking a clinical assessment.

Action: CNS teams to share competencies prior to the next meeting, ideally for agreement by Skin CAG, with timeframes for training completion.	**CNS Team/ M Savu**
Action: To add CNS competency section to the next meeting agenda	**H Dunderdale**

The CNS team in Musgrove have been through a lot of changes recently due to the repatriation of many patients from UHBW. The use of teledermatology for booking straight to surgery has been increased since November, and nurses are being upskilled in surgical procedures to help manage the backlog. It is hoped to recruit an additional CNS to the team in the near future. It is also hoped to undertake some prevention work.

Action: The navigator and other administrative roles are essential to provide the CNS teams with administrative support and should be incorporated in the recommended service model; to be explored in the next meeting	**Skin CAG recommendation/ future agenda item**

6. Research

6.1 NIHR Clinical Research Network update

Please see the presentation uploaded on to the SWAG website

Presented by Research Delivery Manager Claire Matthews

National clinical trial recruitment from April 2023-November 2023 shows that 3,194 patients have been recruited to skin cancer trials across 18 research networks. This compares well with 2022/23 where 4,749 patients were recruited. There is an even split between commercial and non-commercial trials, with 58% being interventional, 40% observational and 2% both.

Research activity has surpassed pre-pandemic levels this year.

There are 18 trials open across the region; the full list of trials open and in set-up will be circulated.

It was noted that the Fianlimab trial opened in BHOC last week and the V940-001 trial is also due to open soon.

There is a huge push to launch the cancer vaccine trials, a number of which are available for skin cancer. The Christie, Velindre and Churchill are setting up as hub and spoke centres to make the vaccines available.

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.

Although a base hospital may be associated with a trial, such as Southmead for MelMarT-II, recruitment involves a regional collaborative effort which is coordinated and added to the outcomes within the Specialist and Local MDTs.

A website is now available where patients can proactively register their

interest in participating in research and there is also e-learning for staff to help facilitate research conversations: https://learn.nihr.ac.uk/.

Results from the Participant in Research Experience Survey are documented within the presentation.

The second cohort of the Principal Investigator Pipeline Programme (PIPP) to support research nurses, midwives and dentists to become PIs, is due to commence in March 2024.

The Clinical Research Networks (CRNs) are transitioning into Research Delivery Networks (RDNs) to reflect that there are increasing amounts of research in non-clinical settings. The primary purpose of the RDNs remains the same: to support delivery of high quality research and increase the capacity and capability of future research. The networks are dropping from 15 to 12. The West of England will expand to include Dorset and Salisbury and will be renamed South West Central.

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

6.2 MelmarT update

Presented by Consultant Plastic Surgeon Ewan Wison

MelMarT-II is the one versus two centimetre wide local excision margin trial for primary cutaneous melanoma. A lymph node is required as well. Recruitment continues to time and target at North Bristol. Preliminary data suggests that one centimetre may be sufficient. Patient quality data to decrease the burden of local skin flaps etc. is also collected as well as treatment outcomes.

6.3 The UK Keratinocyte Cancer Collaborative (UKKCC) and Skin Research Update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Histopathologist Paul Craig

The UKKCC has been set up as part of the British Association of Dermatologists for the purpose of creating a sustainable, internationally leading, collaborative research network. This will support and build UK expertise, working together across the UK dermatology community to deliver major research initiatives on epidemiology, molecular pathogenesis, treatment and prevention of

keratinocyte cancers (KC), starting with cutaneous SCC (CSCC).

A UKKCC biobank, funded by the British Skin Foundation, is in set up which will be used to collect frozen tissue and also archival paraffin embedded SCCs; ethics approval has recently been granted. This will be used to undertake translational research studies.

The first study, UKKCC-MOLECULAR will require 60 fresh frozen samples. SWAG is not required to be involved in this initial project, but it would be helpful if SWAG centres will hopefully partake in the further validation study.

Eligibility criteria is detailed within the presentation, which will also involve working with the Head and Neck team.

IRAS approval is in place, and the next step is local R&D approval, which should be achieved in the next 6 months.

It is hoped that the study will identify a gene expression profile for predicting the risk of metastases from a Primary SCC.

Action: Skin CAG Research Leads to consider expressing an interest in the study **Research Leads**

7. Coordination of patient care pathways

7.1 Sarcoma Skin Cancer Shared Care Pathway

The sarcoma skin cancer shared care pathway has been updated by the Sarcoma CAG to include details of the follow up guidelines, and updated by the plastics team to include the Skin Cancer Plastic Surgeons or the Sarcoma Surgeons at NBT, depending on how the patient presents.

Action: All patients with a skin sarcoma will be registered with the sarcoma MDT. The updated pathway has now been ratified. **AGREED**

8. Service developments

8.1 Genomic Medicine Service Alliance (GMSA) update

GMSA Managing Director Jonathan Miller and Clinical Geneticists Emma Baple and Ruth Cleaver attend to answer any GMSA related questions.

Turnaround times for samples sent to the South West Genomic Laboratory Hub (SWGLH), based in Bristol, have now reduced to 14 days, which compares favourably with the rest of the UK.

Referral criteria for genomic tests can be found in the National Genomic Test Directory for Rare and Inherited Diseases: NHS England » National genomic test directory

The most relevant test for Skin Cancer CAG will be the familial melanoma panel, which contains a panel of genes that may identify germline mutations associated with cancers other than melanoma and that may not result in an actionable conclusion. This can be a complicated discussion and may lead to the patient declining the test.

Educational support has been provided to the Colorectal, Gynae and Breast Cancer CNS teams across the South West to help with these discussions, which can also be provided to members of Skin CAG.

Action: GMSA to explore the support required for members of the Skin CAG to facilitate consenting for germline testing **GMSA Team**

Once a germline mutation has been identified, the patient can be referred for further genetic counselling to the Clinical Geneticist team.

Discussion:

Clarity was sought on accessing Muir-Torre syndrome screening for patients with sebaceous neoplasms. This was currently not available via the SWGLH but is an agreed test in other regions.

Clinical genetics tend to assess referrals of sebaceous neoplasms using the Muir-Torre scoring system as a guide. A young person with a family history of lynch syndrome would meet the eligibility criteria. Due to the high rate of false positives, this would not be appropriate for elderly patients with no medical history and one lesion.

Sebaceous neoplasms are rare and referrals would be approximately 5-6 cases per year, but 20% are likely to have lynch syndrome.

Action: GMSA to explore the addition of sebaceous neoplasms to the National Test Directory for screening of lynch syndrome due to the risk of colorectal and endometrial lynch related cancers in this patient cohort.

Pathologist Representatives to email relevant data held on sebaceous neoplasms to the GMSA to facilitate this discussion. **GMSA Team/ N Carson/ P Craig**

Funding is planned for pathology service, which will be distributed with equity across the SW region to facilitate the extra workload associated with preparing samples for the GLH.

8.2 Managing Staff Fatigue

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Psychologist Mike Osborn

Skin Cancer 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 healthy 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.

9. Any other business:

In order to support MDT streamlining initiatives and make best use of the Consultant Histopathologists' time, given current workforce shortages, the Histologists will now attend the MDT every fortnight, allowing more time for pathology reporting. Information for the MDT

will continue to be made available every week.

Where relevant, patients can be discussed and plans progressed outside the SSMDT, for ratification when the MDT next convenes.

Date of next meeting: To be confirmed via Doodle Poll

-END-