

GYNAECOLOGY PATHWAY BOARD

CONSTITUTION

JULY 2014

Date for Review: July 2015

Peer Review Measures

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1. INTRODUCTION

2013/14 was a transitional year for cancer services in Greater Manchester and East Cheshire. The Greater Manchester and Cheshire Cancer Network ceased to exist in March 2013 when cancer networks nationally were amalgamated into strategic clinical networks as part of the NHS reorganisation. In Greater Manchester this coincided with the creation of Manchester Cancer, an integrated cancer system for Greater Manchester and East Cheshire.

Twenty Manchester Cancer Pathway Clinical Directors were appointed in late 2013 and took up their roles on 1st January 2014. They spent the first months in post forming their Pathway Boards, multi-professional clinical groups from across the region. These Pathway Boards are now formed and most had their first meeting in April/May of 2014.

As such, this is a transitional constitution document based on the legacy document. In July 2015 every Manchester Cancer Pathway Board will publish a full constitution alongside its annual report and work plan for the year ahead.

2. CONFIGURATION OF SERVICES (14-1C-101e)

2.1 Manchester Cancer

Manchester Cancer covers a population just over 3.3 million.

North West Sector:

Wrightington Wigan and Leigh NHS Trust
Royal Bolton Hospital NHS Foundation Trust
Salford Royal NHS Foundation Trust

North East Sector:

Pennine Acute Hospitals NHS Trust (Bury, North Manchester, Oldham, Rochdale)
Central Manchester University Hospitals NHS Foundation Trust (incorporating Trafford Hospital)

South Sector:

Tameside Acute NHS Trust
Stockport Foundation NHS Trust
University Hospital of South Manchester NHS Foundation Trust
The Christie NHS Foundation Trust
East Cheshire NHS Trust

Brain and CNS patients from Mid Cheshire NHS Trust are referred to North Staffs Cancer Network; they do not fall within the jurisdiction of Manchester Cancer for this diagnostic group.

Some chemotherapy and clinical trials will continue to be delivered from Christie Hospital, although local chemotherapy is currently available at:

- Wigan
- Bolton
- Oldham
- East Cheshire
- Mid Cheshire

2.2 Network PCT Agreed Gynaecology Cancer Referral Policy & Referral Guidelines

Primary care practitioners will refer all patients defined by the “urgent, suspicious of cancer” guidelines for gynaecology cancer to the contact point of a single stand alone diagnostic service or a gynaecology MDT as named in table 3.

Circulated via email to Primary Care Cancer Managers on Monday 18 June 2012

Nice Referral Guidelines for Suspected Cancer – Gynaecological cancer June 2005

Refer urgently patients:

- With clinical features suggestive of cervical cancer on examination. A smear test is not required before referral, and a previous negative result should not delay referral
- Not on hormone replacement therapy with postmenopausal bleeding
- On hormone replacement therapy with persistent or unexplained postmenopausal bleeding after cessation of hormone replacement therapy for 6 weeks
- Taking Tamoxifen with postmenopausal bleeding
- With an unexplained vulval lump
- With vulval bleeding due to ulceration

Consider urgent referral for patients with persistent inter-menstrual bleeding and negative pelvic examination

Refer urgently for an ultrasound scan patients:

- With a palpable abdominal or pelvic mass on examination that is not obviously uterine fibroids or not of gastrointestinal or urological origin. If the scan is suggestive of cancer, an urgent referral should be made. If urgent ultrasound is not available, an urgent referral should be made.

Investigations

- A full pelvic examination, including speculum examination of the cervix is recommended for patients presenting with any of the following:
 - Alterations in menstrual cycle
 - Intermenstrual bleeding
 - Postcoital bleeding
 - Postmenopausal bleeding
 - Vaginal discharge
- Ovarian cancer is difficult to diagnose. In patients with vague, non-specific, unexplained abdominal symptoms such as:
 - Bloating
 - Constipation
 - Abdominal pain
 - Back pain
 - Urinary symptoms

Carry out an abdominal palpation. Also consider a pelvic examination (see NICE Ovarian Cancer Guidelines 122, extract below)

- In patients with vulval pruritus or pain, a period of “treat, watch and wait” is reasonable. Active follow-up is recommended until symptoms resolve or a diagnosis is confirmed. If symptoms persist, the referral may be urgent or non-urgent, depending on the symptoms and the degree of concern about cancer.

Ovarian cancer: The recognition and initial management of ovarian cancer
NICE clinical guideline 122, Issue date: April 2011

Page 5: Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Awareness of symptoms and signs

Carry out tests in primary care (see section 1.1.2) if a woman (especially if 50 or over) reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times per month:

- persistent abdominal distension (women often refer to this as ‘bloating’)
- feeling full (early satiety) and/or loss of appetite
- pelvic or abdominal pain
- increased urinary urgency and/or frequency.
- Carry out appropriate tests for ovarian cancer (see section 1.1.2) in any woman of 50 or over who has experienced symptoms within the last 12 months that suggest irritable bowel syndrome (IBS)³, because IBS rarely presents for the first time in women of this age.

Asking the right question – first tests

- Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer (see section 1.1.1).
- If serum CA125 is 35 IU/ml or greater, arrange an ultrasound scan of the abdomen and pelvis.
- For any woman who has normal serum CA125 (less than 35 IU/ml), or CA125 of 35 IU/ml or greater but a normal ultrasound:
 - assess her carefully for other clinical causes of her symptoms and investigate if appropriate
- If no other clinical cause is apparent, advise her to return to her GP if her symptoms become more frequent and/or persistent.

Page 7-8:

1.1 Detection in primary care

Recommendations in this section update and replace recommendation 1.7.4 in ‘Referral guidelines for suspected cancer’ (NICE clinical guideline 27).

1.1.1 Awareness of symptoms and signs

1.1.1.1 Refer the woman urgently if physical examination identifies ascites and/or a pelvic or abdominal mass (which is not obviously uterine fibroids).

1.1.1.2 Carry out tests in primary care (see section 1.1.2) if a woman (especially if 50 or over) reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times per month:

- persistent abdominal distension (women often refer to this as ‘bloating’)
- feeling full (early satiety) and/or loss of appetite
- pelvic or abdominal pain

- increased urinary urgency and/or frequency.

1.1.1.3 Consider carrying out tests in primary care (see section 1.1.2) if a woman reports unexplained weight loss, fatigue or changes in bowel habit.

1.1.1.4 Advise any woman who is not suspected of having ovarian cancer to return to her GP if her symptoms become more frequent and/or persistent.

1.1.1.5 Carry out appropriate tests for ovarian cancer (see section 1.1.2) in any woman of 50 or over who has experienced symptoms within the last 12 months that suggest irritable bowel syndrome (IBS), because IBS rarely presents for the first time in women of this age.

1.1.2 Asking the right question – first tests

1.1.2.1 Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer (see section 1.1.1).

1.1.2.2 If serum CA125 is 35 IU/ml or greater, arrange an ultrasound scan of the abdomen and pelvis.

1.1.2.3 If the ultrasound suggests ovarian cancer, refer the woman urgently for further investigation.

1.1.2.4 For any woman who has normal serum CA125 (less than 35 IU/ml), or CA125 of 35 IU/ml or greater but a normal ultrasound:

- assess her carefully for other clinical causes of her symptoms and investigate if appropriate
- if no other clinical cause is apparent, advise her to return to her GP if her symptoms become more frequent and/or persistent.

2.3 Network Configuration of Teams and Diagnostic Services (14-1C-102e)

The named local diagnostic gynaecology teams will carry out the diagnostic process for patients from their own catchment, referring patients to the specialist gynaecology cancer teams for specialist care. Low risk endometrial cancer may be managed by individual surgeons from the diagnostic teams provided that they are named as a member of the diagnostic service, and they attend the specialist MDT as a core member.

The three specialist gynaecology multi-disciplinary teams (SMDT) will also provide diagnostic and Unit lead services for their local population (eg. Surgical treatment of low grade endometrial cancer). There is an additional specialist team based at Christie Hospital undertaking exenterative surgery.

Primary care practitioners will refer all patients defined by the “urgent, suspicious of cancer” guidelines for gynaecological cancers to the contact point of a single named local gynaecology team as listed.

Table 1: Local Diagnostic Gynaecology Cancer Teams.

Local Gynaecology Cancer Teams	CCG Population	CCGs in Catchment	Diagnostic Lead Clinician / Contact Point	Diagnostic services within host hospital
Diagnostic Teams				
Bolton Hospitals NHS Trust	294,600	NHS Bolton	Mr Kehinde Abidogun	Hysteroscopy – in & out patient Colposcopy Radiology guided biopsy General biopsy (eg vulval)
East Cheshire NHS Trust	201,000	NHS Eastern Cheshire	Dr Vince Hall	Colposcopy, PMB Clinic, Hysteroscopy (inpatient & outpatient) Imaging (MR, CT, US image guided biopsy) laparoscopy & paracentesis Blood tests.
Mid Cheshire NHS Trust	102,100 173,200	NHS Vale Royal NHS South Cheshire	Mr Murray Luckas	Colposcopy Direct access PMB clinic 2ww dedicated Gynae clinic Inpatient and outpatient hysteroscopy Radiology biopsy
Pennine Acute Hospitals NHS Trust				
- Bury	195,000	NHS Bury	Dr Alan Russell	Colposcopy, Hysteroscopy, biopsy (eg pipelle), (all Pathology inc CA125 Radiology (CT MRI)
- NMGH	183,200	NHS North Manchester	Mr Saad Ali	
- Oldham	239,600	NHS Oldham	Mr H Abouzeid	
- Rochdale	223,300	NHS HMR		
Stockport Foundation NHS Trust	299,000	NHS Stockport	Mr Suku George	Hysteroscopy, Colposcopy, MR, CT, USS, CT Guides Scans, Laparoscopy and Paracentesis.
Tameside Acute NHS Trust	240,300	NHS Tameside and Glossop	Dr Kyle Gilmour	Colposcopy Vulval disorder clinic Postmenopausal bleeding clinic In/out patient hysteroscopy Ultrasound/CT/MR imaging of pelvic /ovarian masses
Wrightington, Wigan and Leigh NHS Trust	320,300	NHS Wigan Borough	Mr Sean Burns	Colposcopy In/out patient hysteroscopy CT guided biopsy

Specialist Gynaecology Cancer Teams	CCG Population	CCGs in Catchment	Lead Clinician / Contact Point	Diagnostic services within host hospital
<i>(also acting as diagnostic team and local MDT)</i>				
Central Manchester University Hospitals NHS Foundation Trust	211,800 233,100	NHS Central Manchester NHS Trafford	Miss Cath Holland,	Colposcopy, hysteroscopy and dedicated clinics for neoplastic and non-neoplastic vulva disorders. Specialist pathology and radiology.
Salford Royal Foundation Trust	247,600	NHS Salford	Mr Jim Wolfe	Colposcopy, PMB clinic, endometrial biopsy, hysteroscopy. USS, CT & MR
University Hospital of South Manchester NHS Trust	165,100	NHS South Manchester	Mr Mike Smith	<ul style="list-style-type: none"> - One Stop Rapid Access and PMB Clinic. - Colposcopy and Vulvoscopy Diagnostic Services for preinvasive cervical and vulval conditions. - Outpatient Hysteroscopy and Endometrial biopsy Service. - Diagnostic Imaging modalities (US, CT, MR) and Specialist Histopathology services.
Total	3,329,200			

The named diagnostic gynaecology teams will carry out the diagnostic process and surgical treatment for low risk endometrial and early stage cervical patients from their own catchment. All other patients should be referred onto to the Specialist MDT for discussion and treatment

2.4 Network Agreed Authorised Surgeons for Diagnostic Services (14-1C-102e)

Table 2: Local Management of Low Risk Endometrial Cancer

Diagnostic Team	Host Trust (hospital site)	Authorised surgeons	Specialist MDT link
Bolton	Royal Bolton NHS Trust	Mr K Abidogun,	Salford
Central Manchester (Specialist MDT)	Central Manchester University Hospital NHS Foundation Trust (St Mary's Hospital)	Prof H Kitchener Mr R Clayton Miss C Holland Mr S Ali Mr A Nysenbaum	Central Manchester
East Cheshire	East Cheshire NHS Trust	Dr V Lether Mr V Hall	South Manchester

Mid Cheshire	Mid Cheshire NHS Trust	Mr G Scott Mr M Luckas	South Manchester
Bury	Pennine Acute NHS Trust (Fairfield General Hospital)	Dr A Russell	Central Manchester
North Manchester	Pennine Acute NHS Trust (North Manchester General Hospital)	Miss B Schaefer,	Central Manchester
Oldham	Pennine Acute NHS Trust (Royal Oldham Hospital)	Mr S Ali	Central Manchester
Rochdale	Pennine Acute NHS Trust (Rochdale Infirmary)	Mr H Abouzeid	Central Manchester
Salford (Specialist MDT)	Salford Royal Foundation Trust	Mr R Slade, Mr B Winter-Roach,	Salford
South Manchester (Specialist MDT)	University Hospitals NHS Trust (Wythenshawe Hospital)	Mr M Smith	South Manchester
Stockport	Stockport Foundation NHS Trust	Mr S George,	South Manchester
Tameside	Tameside Acute NHS Trust	Dr K Gilmour,	Central Manchester
Wigan	Wrightington Wigan & Leigh NHS Trust	Mr S Burns,	Salford

2.5 Specialist Gynaecology Teams (also acting as local MDTs)

Criteria for onward referral from Diagnostic Team to Specialist Gynae MDT:

- High-risk endometrial cancer
 - Serous clear cell or GIII endometrioid endometrial cancer with or without radiological evidence of myometrial invasion
 - GI and GII endometrioid endometrial cancer with >50% myometrial invasion on MR (FIGO stage 1b on pre-operative assessment)
- Carcinoma of cervix of more than 1a1
- Suspected ovarian cancer
- Vaginal or vulval cancer
- Cyto-reductive treatment of recurrent cancer

Table 3:

Specialist Gynaecology Cancer Teams	Lead Clinician	Referring Local Teams	Total Catchment Population	CCGs in Catchment
Central Manchester University Hospital NHS Trust	Miss Cath Holland Consultant Gynaecologist	Pennine, Tameside, Trafford, Central Manchester	1,526,300	Central Manchester; Bury; HMR; North Manchester ; Oldham, Tameside & Glossop; Trafford
Salford Royal Foundation Trust	Mr Jim Wolfe, Consultant Gynaecologist	Wigan, Bolton, Salford	862,500	Salford Wigan Borough, Bolton
University Hospital of	Mr Mike Smith, Consultant	Stockport, South Manchester, East		Trafford; South Manchester;

South Manchester NHS Trust	Gynaecologist	Cheshire, Mid Cheshire	940,400	Stockport, South Cheshire; Vale Royal; Eastern Cheshire
Total			3,329,200	

Criteria for referral from Specialist Gynae MDT to Pelvic Team:

- Selected cases for exenterative or multidisciplinary pelvic surgery

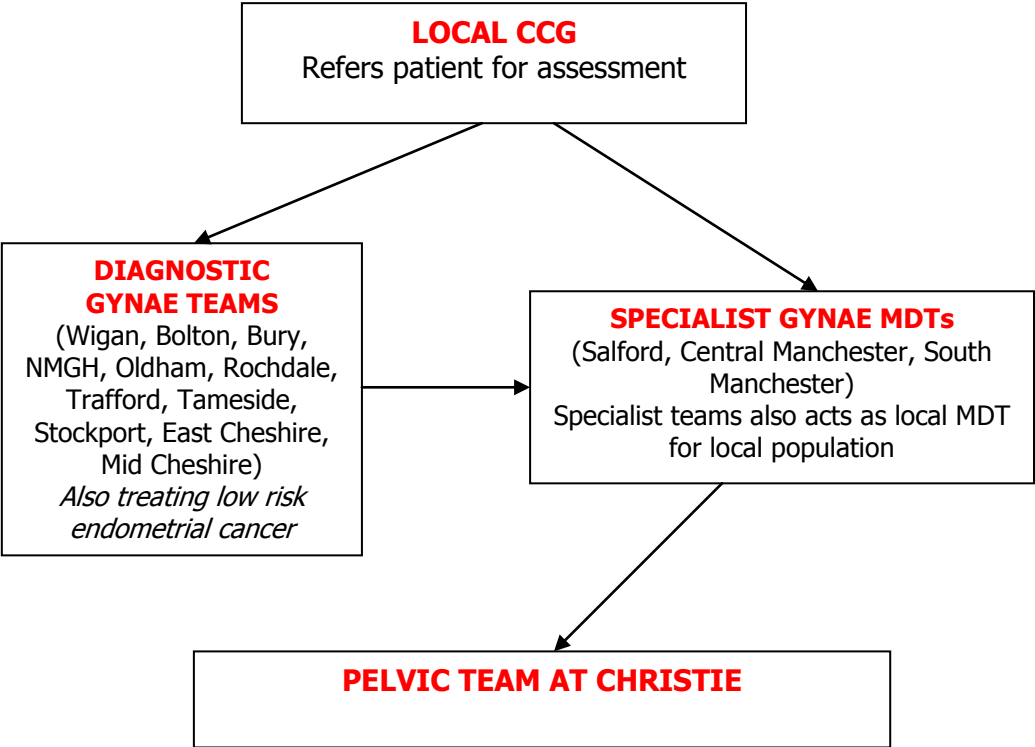
The Cancer Centre.

Radiotherapy and chemotherapy will continue to be delivered from The Christie Hospital. Exenterative surgery may be managed in conjunction with The Christie inter-disciplinary pelvic surgical team in selected cases.

A new satellite radiotherapy unit opened in Oldham in March 2010 and at Salford in September 2011; however, radiotherapy for Gynae cancer will continue to be delivered at Christie Hospital

Patients under the care of clinical or medical oncology at Christie Hospital are discussed at a weekly Christie SMDT. This meeting is attended by surgeons from the associate cancer centres. Discussions are also held about patients who are under other (non-gynae) oncology teams.

Team Relationships in the Network



3. TERMS OF REFERENCE (14-1C-104e)

These terms of reference were agreed on 2014 by ,Dr Lisa Barraclough, Pathway Clinical Director for Gynaecology Cancer, and Mr David Shackley, Medical Director of Greater Manchester Cancer Services, on behalf of the Greater Manchester Cancer Services Provider Board. The terms of reference will be subject to future review.

3.1 The Pathway Board

The Gynaecology Cancer Pathway Board is a cancer care specific board with responsibility to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire (a catchment population of 3.2 million). This area is synonymous with the old Greater Manchester and Cheshire Cancer Network area.

The Pathway Board is led by a Pathway Clinical Director and is formed of a multidisciplinary team of clinicians and other staff from all of hospital trusts that are involved in the delivery of Gynaecology cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients representatives.

The Gynaecology Cancer Pathway Board reports into and is ultimately governed and held to account by the Greater Manchester Cancer Services Provider Board.

3.2 Greater Manchester Cancer Services Provider Board

The Greater Manchester Cancer Services Provider Board is responsible for the service and clinical delivery arm of Manchester Cancer, Greater Manchester's integrated cancer system. Manchester Cancer has two other arms: research and education (see appendix for the structure of Manchester Cancer).

The Provider Board is independently chaired and consists of the Chief Executive Officers of the ten acute hospital trusts in the Greater Manchester area:

- Bolton NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute NHS Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- The Christie NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust;
- Wrightington, Wigan and Leigh NHS Foundation Trust;

The Provider Board regularly invites representatives of commissioners, the Strategic Clinical Network, and Manchester Cancer to its meetings.

3.3 Purpose of the Pathway Board

The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester Gynaecology cancer pathway. Specifically, the Pathway Board aims to save more lives, put patients at the centre of care, and improve patient experience. The Board will

represent the interests of local people with cancer, respecting their wider needs and concerns. It is the primary source of clinical opinion on this pathway for the Greater Manchester Cancer Services Provider Board and Greater Manchester's cancer commissioners.

The Pathway Board will gain a robust understanding of the key opportunities to improve outcomes and experience by gathering and reviewing intelligence about the Gynaecology cancer pathway. It will ensure that objectives are set, with a supporting work programme that drives improvements in clinical care and patient experience.

The Pathway Board will also promote equality of access, choice and quality of care for all patients within Greater Manchester, irrespective of their individual circumstances. The Board will also work with cancer commissioners to provide expert opinion on the design of any commissioning pathways, metrics and specifications.

3.4 Role of the Pathway Board

The role of the Gynaecology Cancer Pathway Board is to:

Represent the Greater Manchester Cancer Services professional and patient community for Gynaecology cancer.

Identify specific opportunities for improving outcomes and patient experience and convert these into agreed objectives and a prioritised programme of work.

Gain approval from Greater Manchester's cancer commissioners and the Greater Manchester Cancer Services Provider Board for the programme of work and provide regular reporting on progress.

Design and implement new services for patients where these progress the objectives of commissioners and Greater Manchester Cancer Services, can be resourced, and have been shown to provide improvements in outcomes that matter to patients.

Ensure that diagnosis and treatment guidelines are agreed and followed by all teams in provider trusts, and are annually reviewed.

Ensure that all providers working within the pathway collect the pathway dataset measures to a high standard of data quality and that this data is shared transparently amongst the Pathway Board and beyond.

Promote and develop research and innovation in the pathway, and have agreed objectives in this area.

Monitor performance and improvements in outcomes and patient experience via a pathway scorecard, understanding variation to identify areas for action.

Escalate any clinical concerns through provider trusts.

Highlight any key issues that cannot be resolved within the Pathway Board itself to the Medical Director of Greater Manchester Cancer Services for assistance.

Ensure that decisions, work programmes, and scorecards involve clearly demonstrable patient participation.

Share best practices with other Pathway Boards within Greater Manchester Cancer Services.

Contribute to cross-cutting initiatives (e.g. work streams in living with and beyond cancer and early diagnosis).

Discuss opportunities for improved education and training related to the pathway and implement new educational initiatives.

Develop an annual report of outcomes and patient experience, including an overview of progress, difficulties, peer review data and all relevant key documentation. This report will be published in July of each year and will be the key document for circulation to the Provider Board. A template for this report is available so that all Pathway Boards complete the report in a similar manner.

3.5 Membership principles

All member organisations of Greater Manchester Cancer Services will have at least one representative on the Pathway Board unless they do not wish to be represented.

Provider trusts not part of Greater Manchester Cancer Services can be represented on the Pathway Board if they have links to the Greater Manchester Gynaecology cancer pathway.

All specialties and professions involved in the delivery of the pathway will be represented.

The Board will have at least one patient or carer representative within its membership

One professional member of the Pathway Board will act as a Patient Advocate, offering support to the patient and carer representative(s).

The Board will have named leads for:

- Early diagnosis
- Pathology
- Radiology
- Surgery
- Oncology
- Specialist nursing
- Living with and beyond cancer ('survivorship')
- Research
- Data collection (clinical outcomes/experience and research input).

It is possible for an individual to hold more than one of these posts. The Pathway Clinical Director is responsible for their fair appointment and holding them to account.

These named leads will link with wider Greater Manchester Cancer Services Boards for these areas where they exist.

All members will be expected to attend regular meetings of the Pathway Board to ensure consistency of discussions and decision-making (meeting dates for the whole year will be set annually to allow members to make arrangements for their attendance).

A register of attendance will be kept: members should aim to attend at least 5 of the 6 meetings annually and an individual's membership of the Pathway Board will be reviewed in the event of frequent non-attendance.

Each member will have a named deputy who will attend on the rare occasions that the member of the Board cannot.

3.6 Frequency of meetings

The Gynaecology Cancer Pathway Board will meet every two months.

3.7 Quorum

Quorum will be the Pathway Clinical Director plus five members of the Pathway Board or their named deputies.

3.8 Communication and engagement

Accurate representative minutes will be taken at all meetings and these will be circulated and then validated at the next meeting of the Board.

All minutes, circulated papers and associated data outputs will be archived and stored by the Pathway Clinical Director and relevant Pathway Manager.

The Pathway Board will design, organise and host at least one open meeting per year for the wider clinical community and local people. This meeting or meetings will include:

- An annual engagement event to account for its progress against its work programme objectives and to obtain input and feedback from the local professional community
- An annual educational event for wider pathway professionals and interested others to allow new developments and learning to be disseminated across the system

Representatives from all sections of the Greater Manchester Cancer Services professional body will be invited to these events, as well as patient and public representatives and voluntary sector partners.

An annual report will be created and circulated to the Medical Director of the Greater Manchester Cancer Services Provider Board by 31st July of each calendar year.

The agendas, minutes and work programmes of the Pathway Board, as well as copies of papers from educational and engagement events, will be made available to all in an open and transparent manner through the Greater Manchester Cancer Services website once this has been developed.

3.9 Administrative support

Administrative support will be provided by the relevant Pathway Manager with the support of the Greater Manchester Cancer Services core team. Over the course of a year, an average of one day per week administrative support will be provided.

4. MEMBERSHIP (14-1C-103e)

Table4: Named Gynaecology Pathway Board Members and agreed roles

Name	Profession/Speciality	Trust
Dr Lisa Barraclough	Pathway Clinical Director	The Christie
Mr James Leighton	Pathway Manager	Manchester Cancer
Mr Kehinde Abidogun	Consultant Gynaecologist	Bolton
Dr Ann mills	Consultant Radiologist	Bolton
Dr Susan Davidson	Clinical Oncologist	Christie
Dr Andrew Clamp	Honorary Consultant	Christie
Dr Mike Smith	Consultant Oncologist	Christie
Karen Johnson	Nurse Clinician	Christie
Mr Richard Slade	Consultant Surgeon	Christie
Catherine Holland	Consultant Gynaecological Oncologist	CMFT
Rick Clayton	Consultant Gynaecological Oncologist	CMFT
Ann Lowry	Gynae Macmillan CNS	CMFT
Mr Vincent Hall	Consultant Obstetrician & Gynaecological Surgeon	East Cheshire
Mrs Vanessa Hilton-Watts	CNS	East Cheshire
Mr S Ali	Consultant	Pennine
Julie Dale	Macmillan CNS	Pennine
Mr Murray Luckas	Consultant Gynaecologist	Mid Cheshire
Mrs Sally Petith	Gynae Oncology CNS	Mid Cheshire
Dr Suku George	Consultant Gynaecologist	Stockport
Jo Dzyra	CNS	Stockport
Dr Richard Hale	Consultant Pathologist	Stockport
Mr Kyle Gilmour	Consultant Gynaecologist	Tameside
Debbie Beadle	Gynaecology Cancer Nurse	Tameside
Karen Blackburn	Lead Manager Cancer Services	UHSM
Dr Manisha Kumar	GP Representative	Central Manchester CCG
Mr S Burns	Consultant Gynaecologist	WWL
Karen Blackwood	Gynaecology Cancer Nurse Specialist	WWL

5. NETWORK GYNAECOLOGY GUIDELINES & PATHWAYS (14-1C-106e-14-1C-109e & 14-1C-111e – 14-1C-114e)

The Pathway Board has only been in place since spring 2014 and has not yet had the opportunity to review its clinical guidelines and patient pathways. As such, the guidelines created by the previous cancer network group have been adopted until such time as they can be reviewed and updated in the coming year.

All of the relevant documentation remains on the legacy website of the old cancer network www.gmccn.nhs.uk and will be migrated to the Manchester Cancer website over the coming months www.manchestercancer.org.

A full list of active current guidelines and their renewal dates will be produced for the updated constitution of July 2015.



GMCCNGuidelinesfor
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5.1 PATIENT PATHWAYS

PATIENT PATHWAYS FOR ENDOMETRIAL CANCER (14-1C-111e)



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PATIENT PATHWAYS FOR CERVICAL CANCER (14-1C-113e)



CervicalCancerRefer
ralPathway[1].pdf

PATIENT PATHWAYS FOR OVARIAN/VAGINAL/VULVAL CANCER (14-1C-112e & 14-1C-114e)



OtherGynaecological
CancersReferralPath

6. CHEMOTHERAPY TREATMENT ALGORITHMS (14-1C-110e)

The Network Chemotherapy Group have developed chemotherapy treatment algorithms for all tumour groups which can be found using the following link. These algorithms are updated regularly with the most recent version being available on the Christie Hospital intranet site.

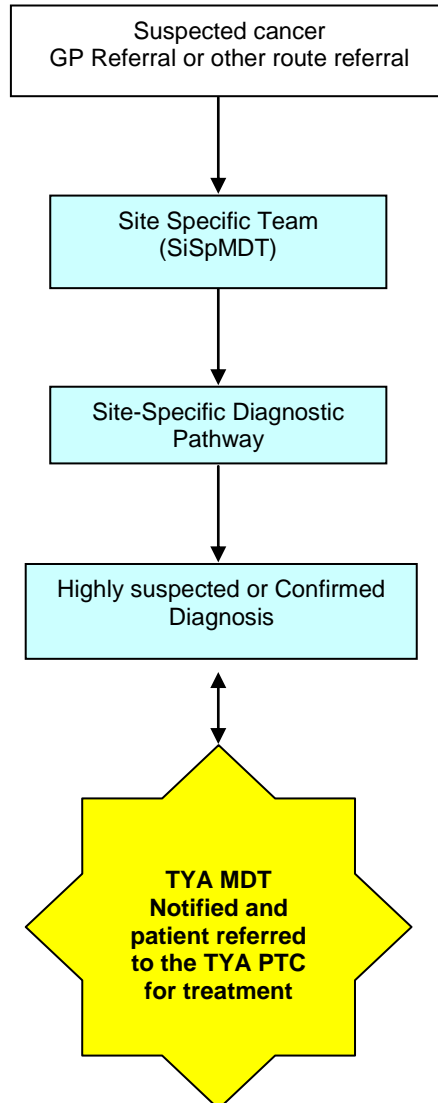
<http://nww.christie.nhs.uk/documents/default.aspx?Category=Y&Category1=1>

7. TYA PATHWAYS

7.1 The TYACN Pathway for initial management (11-1C-110e)

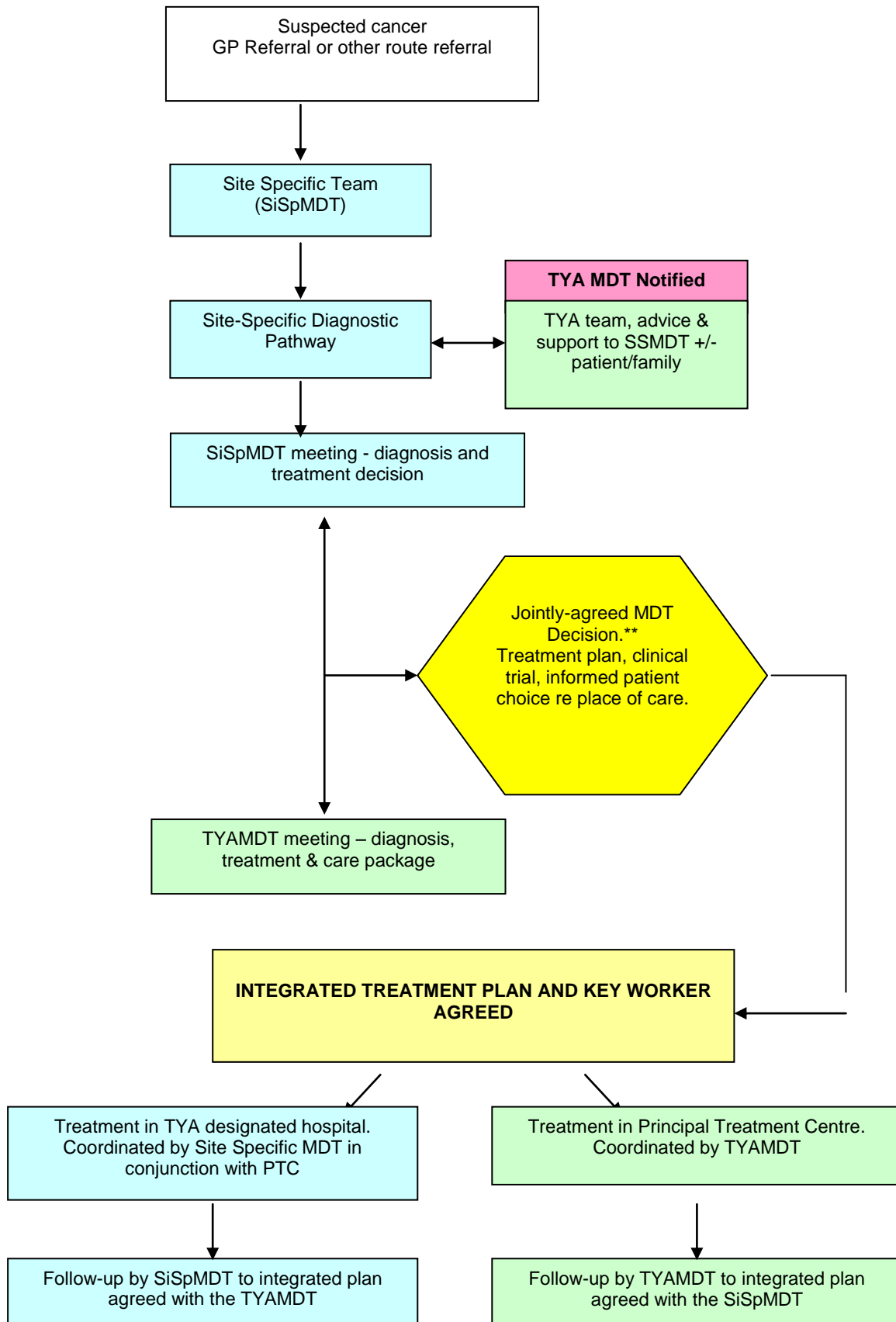
TEENAGE AND YOUNG ADULT PATHWAY 16-18 YEARS INCLUSIVE

(Designated and Non Designated TYA Hospitals)



TEENAGE AND YOUNG ADULT PATHWAY 19-24 YEARS

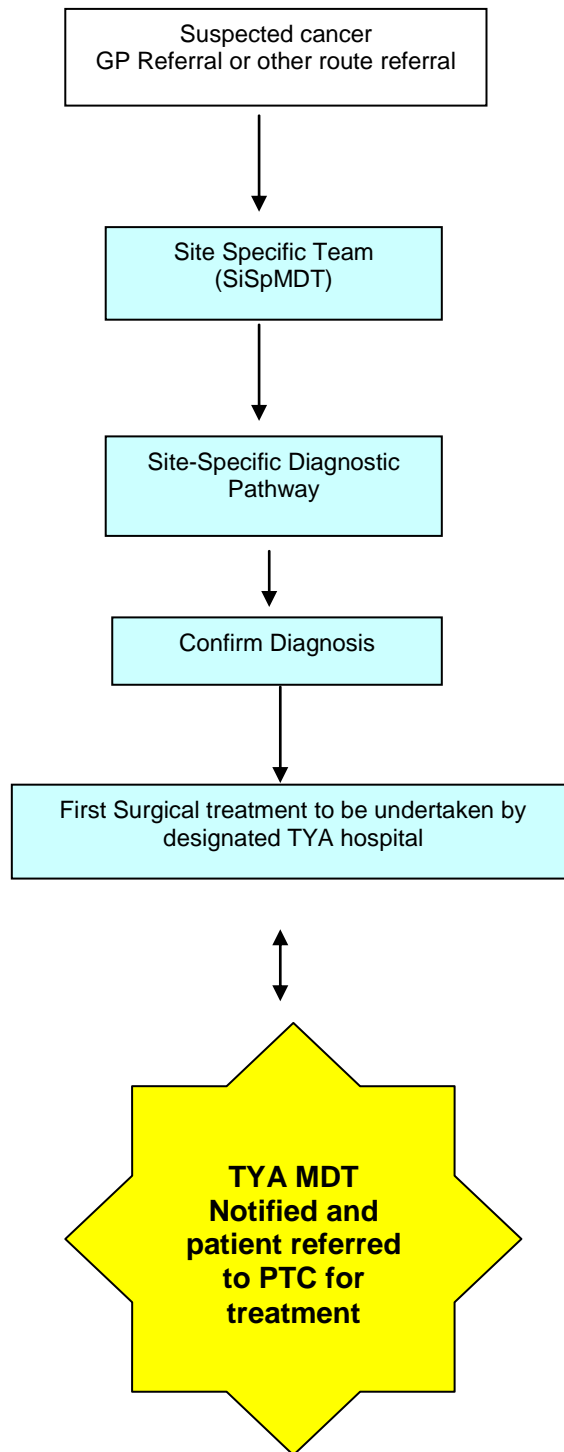
Designated TYA Hospitals



** Jointly agreed MDT decision should not delay the start of urgent treatment

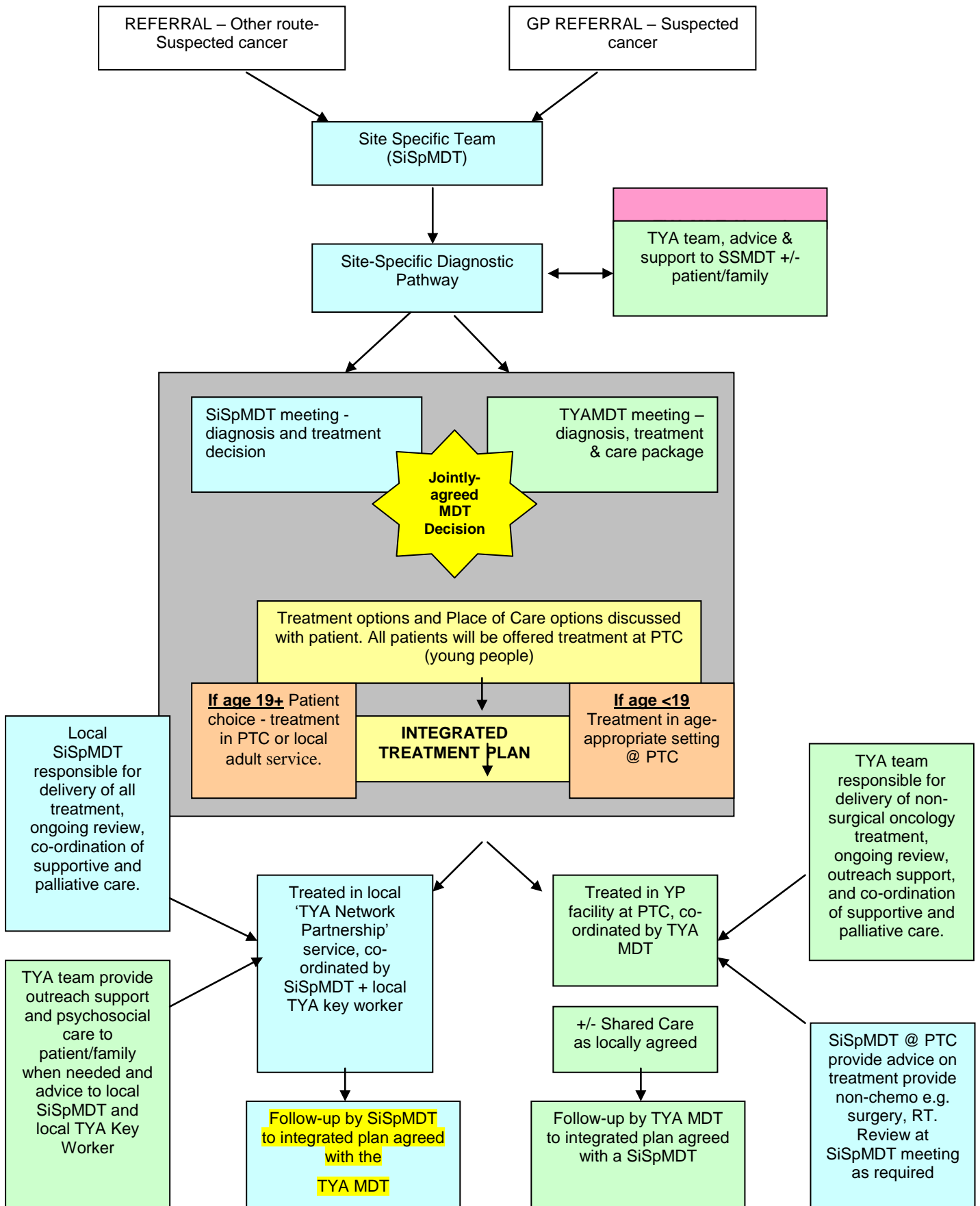
TEENAGE AND YOUNG ADULT PATHWAY 19-24 YEARS.

Non Designated TYA Hospitals



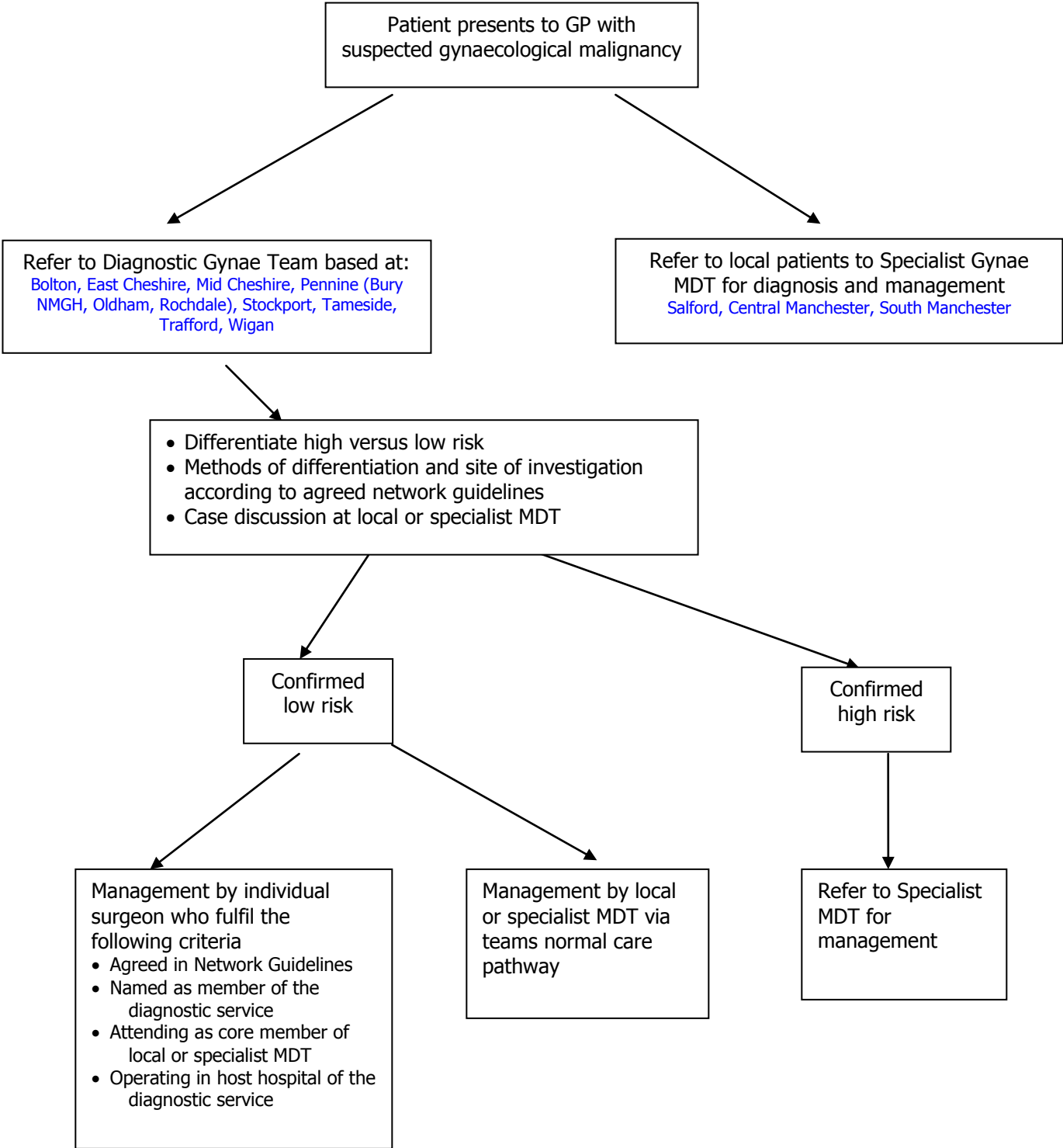
7.2 The TYA Pathway for follow up on completion of first line treatment

Patient aged 16-24yrs Referred to a Site-specific MDT that is NOT based at a Principal Treatment Centre (Young People)

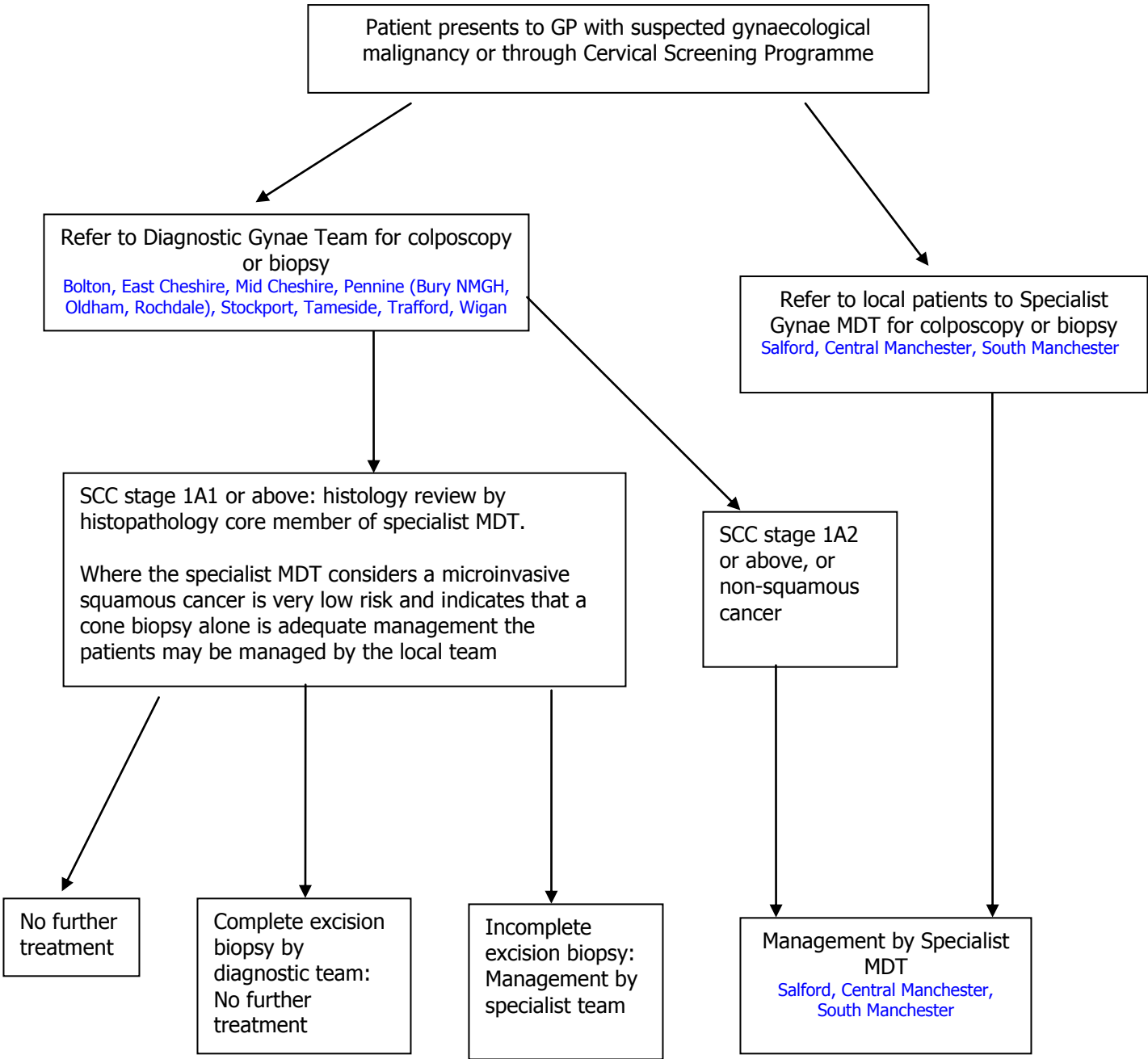


Appendix 1: Network Pathways

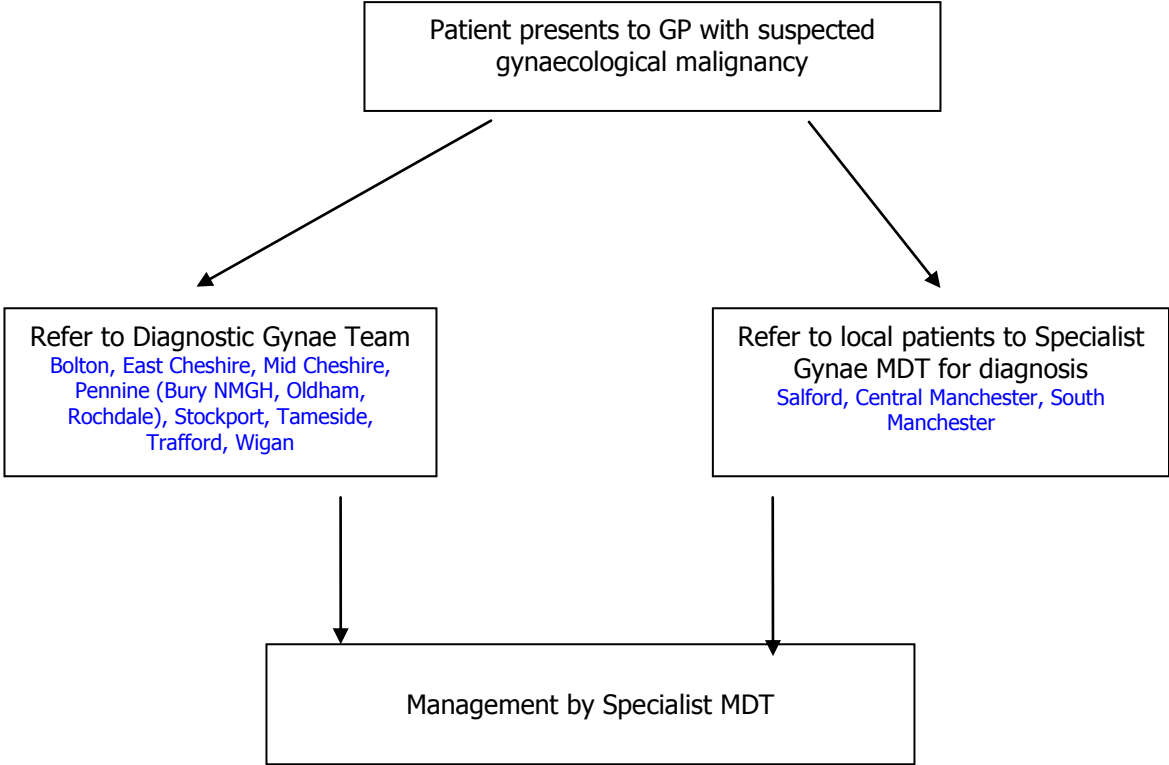
Patient Care Pathways – Endometrial Cancer (14-1C-111e)



Patient Care Pathways – Cervical Cancer (14-1C-113e)



**Patient Care Pathways – Other Gynaecological Cancer
(Including ovary, vagina, vulva)
(14-1C-112e & 14-1C-114e)**



Network Agreed Management Pathway for Gynaecological Cancer

Possible cervical cancer

Possible ovarian, endometrial, vaginal or vulval cancer

