Manchester Cancer

Manchester Cancer

Gynaecology Cancer Pathway Board

Annual Report 2014/15

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Pathway Manager: James Leighton

Version 1.2

Executive summary

The Gynaecology pathway board is now a well-established and highly functioning board. It continues to enjoy a representation from all stakeholder organisations s however it remains without patient or primary care representation.

Over the last 12 months the board has been responsive, positive and constructive and will look to build on these behaviours over the next 12 months.

However a number of challenges for the board remain. The most significant one is that it has been meeting during a period of transformative reconfiguration of the central surgical service. Whilst the board has not allowed this to distract them from their work, the board feels that they could achieve much more if the service was unified and supportively governed.

As the planned service reconfiguration continues to resolution and set against a background of a developing Devolution Manchester, the board feel that they are well placed to support the commissioners as an effective clinical body and look forward to undertaking this.

Over the last 12 months the board has largely focussed on standardising the provision of Gynaecology oncology care across the conurbation. This year it has successfully –

- Developed diagnostic Gynaecology cancer guidelines
- Developed standardised clinical and medical oncology guidelines
- Ran a study event on current research in Gynaecological cancer
- Successfully obtained funding to support patients living with and beyond their disease by running education events on pelvic cancer
- Collaborated with Public Health England and the school nurses regarding primary prevention of cervical cancer

The board are proud of this output, as explained previously it was undertaken during a period of uncertainty for all stakeholder organisations.

Looking forward to the next 12 months the focus of the board will be on supporting the new service by acting as a representative expert panel and an effective clinical body for all the patients of Greater Manchester and East Cheshire.

They feel that the work undertaken so far in supporting the service has complemented this aim but feel that they now need to develop a number of service standards that could be used to define any future commissioned service.

The board intends to agree the outcome measures or outputs that will be used to assess and monitor the service effectiveness along the whole pathway. This is a multi-organisation project and particularly challenging as the available data is not easily accessible.

The board will also in the next 12 months undertake a patient experience survey in the absence of the national cancer patient experience survey. This will be done in collaboration with the relevant stakeholder Trusts and if necessary established patient support groups.

It intends to continue to support the agenda of the detection, prevention and awareness cross cutting group in whatever way it can. The board sees this as a key function and one that it looks forward to undertaking.

In summary, in the coming year the board has identified six key objectives, these are –

- Provide the required level of support to the commissioning process to ensure an effective and IOG compliant service is established
- Set service standards that will help define the future commissioned service
- Agree the key clinical outcomes and outputs that will begin to better assess service effectiveness
- Complete the review of the Gynaecology surgical cancer guidelines
- Inform and educate general practice in support of the endometrial awareness week
- Provide direct support to the HPV vaccination programme

The work of the board will not be limited to just these objectives. As the year unfolds new challenges and opportunities will be identified. The board feel that as a high quality, dedicated, functioning group they are adaptable and capable of accepting and addressing all possibilities to deliver the objectives of Manchester Cancer.

Also, currently there is no patient representative on the board. The board are keen that this is resolved in the near future and will work with Manchester Cancer patient involvement team to address this issue and then put in place appropriate supportive measures for the patient representation.

As part of this it is also planning to support patients and carers better in living with and beyond their disease by getting a deeper understanding of the non-surgical elements of the pathway and designing appropriate supportive measures. It will also support the agenda of the detection, prevention and awareness cross cutting group.

The board sees this as a key function and one that it looks forward to undertaking.

The board are rightly proud of their achievements over the past twelve months and thank everyone who played a part in this success for their support and commitment.

1. Introduction – the Pathway Board and its vision

This is the annual report of the Manchester Cancer Gynaecology Pathway Board for 2014/15. This annual report is designed to:

- Provide a summary of the work programme, outcomes and progress of the Board – alongside the minutes of its meetings, its action plan and it scorecard it is the key document for the Board.
- Provide an overview to the hospital trust CEOs and other interested parties about the current situation across Manchester Cancer in this particular cancer area
- Meet the requirements of the National Cancer Peer Review Programme
- Be openly published on the external facing website.

This annual report outlines how the Pathway Board has contributed in 2014/15 to the achievement of Manchester Cancer's four overarching objectives:

- Improving outcomes, with a focus on survival
- Improving patient experience
- Increasing research and clinical innovation
- Delivering compliant and high quality services

1.1. Vision

The vision of the board is in the first instance to support the successful development of single gynaecological service for Greater Manchester and East Cheshire, to take the new service beyond just achieving IOG compliance. It will do this by supporting the commissioning process and clinical teams in any way it can.

Secondly it will also look to standardise the cancer pathways to ensure that all patients have the same route through to treatment.

The board feels that there is a lack of robust data to inform them on their patient population and their outcomes. Over the next 12 months the board will work with the relevant stakeholders to identify and measure the appropriate and meaningful outcome measures.

The board also accepts the challenge of early detection and prevention of the disease. It also sees itself as the body to exploit innovation, provide quality assurance of the pathway and be responsible for enhancing the experience of those living with and beyond their cancer.

The board will deepen its knowledge base and understanding of the whole pathway and put in place actions were the patient outcomes, survival rates and experience can be improved and enhanced.

The pathway board intends to ensure that the Gynaecology cancer service:

- Is in line with all national guidance/standards
- Is compliant with the IOG standards.
- Considers the whole care pathway for patients, both surgical and non-surgical.

- Promotes high quality care and reduces inequalities in access and service delivery.
- Takes account of and acts on the views of patients and carers.
- Exploits any opportunity for service and workforce redesign and innovation.

1.2. Membership

Trust	Nominee	Profession/ specialty
Christie	**Lisa Barraclough**	**CHAIR**
Bolton	Mr Kehinde Abidogun	Consultant Gynaecologist
	Dr Ann Mills	Consultant Radiologist
Christie	Dr Susan Davidson	Clinical Oncology
	Dr Andrew Clamp	Honorary consultant
	Dr Mike Smith	Consultant oncologist
	Karen Johnson Julie Kiernan	Nurse clinician Gynaecology Nurse Specialist
CMFT	Miss Catherine Holland	Consultant Gynaecological Surgeon
	Mr Rick Clayton	Consultant Gynaecological Surgeon
	Ann Lowry	Gynae Macmillan CNS
East Cheshire	Mr Vincent Hall	Consultant Obstetrician & Gynaecological Surgeon
	Mrs Venessa Hilton-Watts	Clinical Nurse Specialist
Pennine	Mr S Ali	Consultant
	Julie Dale	Macmillan CNS
SRFT	Mr Jim Wolfe	Consultant Gynaecologist
Mid Cheshire	Mr Murray Luckas	Consultant Gynaecologist
	Mrs Sally Petith	Gynae Oncology CNS
Stockport	Dr Suku George	Consultant gynaecologist
	Jo Dzyra	CNS
	Dr Richard Hale	Consultant Pathologist
Tameside	Mr Kyle Gilmour	Consultant Gynaecologist
	Amanda Lowe	Gynaecology Cancer Nurse
UHSM	Sabine Fornacon-Wood	Gynaecology Cancer Nurse Specialist
WWL	Mr S Burns	Consultant Gynaecologist
	Karen Blackwood	Gynaecology Cancer Nurse Specialist

1.3. Meetings

The pathway board met five times in 2014 and has three times in 2015. The board have scheduled two subsequent meetings in 2015. Below are the dates of the pathway board meetings and the links to the board minutes.

2nd may 2014
http://manchestercancer.org/wp-content/uploads/2014/09/Gynaecology-Pathway-Board-Meeting-Minutes.pdf

4th July 2014
http://manchestercancer.org/wp-content/uploads/2014/09/Gynaecology-Pathway-Board-Meeting-Minutes-.pdf

12th September 2014
http://manchestercancer.org/wp-content/uploads/2014/09/Gynaecology-Pathway-Board-Meeting-Minutes1.pdf

7th November 2014
http://manchestercancer.org/wp-content/uploads/2014/09/Gynaecology-Pathway-Board-Meeting-Minutes2.pdf

9th January 2015
http://manchestercancer.org/wp-content/uploads/2014/09/Gynaecology-Pathway-Board-Meeting-Minutes-1.pdf
6th March 2015
http://manchestercancer.org/wp-content/uploads/2014/09/Gynaecology-Pathway-Board-Meeting-Minutes3.pdf

1st may 2015
http://manchestercancer.org/wp-content/uploads/2014/09/Gynaecology-Pathway-Board-Meeting-Minutes4.pdf

Holding board meetings within working hours will always be a challenge for clinical staff. However overall attendance has been pretty consistent and where non-attendance has been an issue the Pathway director has addressed it on a personal level.

The record of the attendance at each meeting to-date is in appendix 1.

At this point in time the board has no plans for anymore educational events as it is waiting for the cancer education strategy to be developed by Manchester Cancer. Once this strategy has been agreed the board will support and contribute to all Gynaecological cancer education as required.

2. Summary of delivery against 2014/15 plan

No	Objective	Alignment with Provider Board objectives	Tasks	By	Status Green = achieved Amber = partially achieved Red = not achieved
1	Optimise data collection to generate outcome data	Objective no 1	On-going – will be part of the single service agenda		
2	Develop agreed and standardised follow-up process	Objective no 3	On-going – will be part of the single service agenda		
3	Improved uptake of HPV vaccination programme	Objective no 1	On-going – working with Public Health England to take this forward.		
			Will roll over to 15/16 objectives		

3. Improving outcomes, with a focus on survival

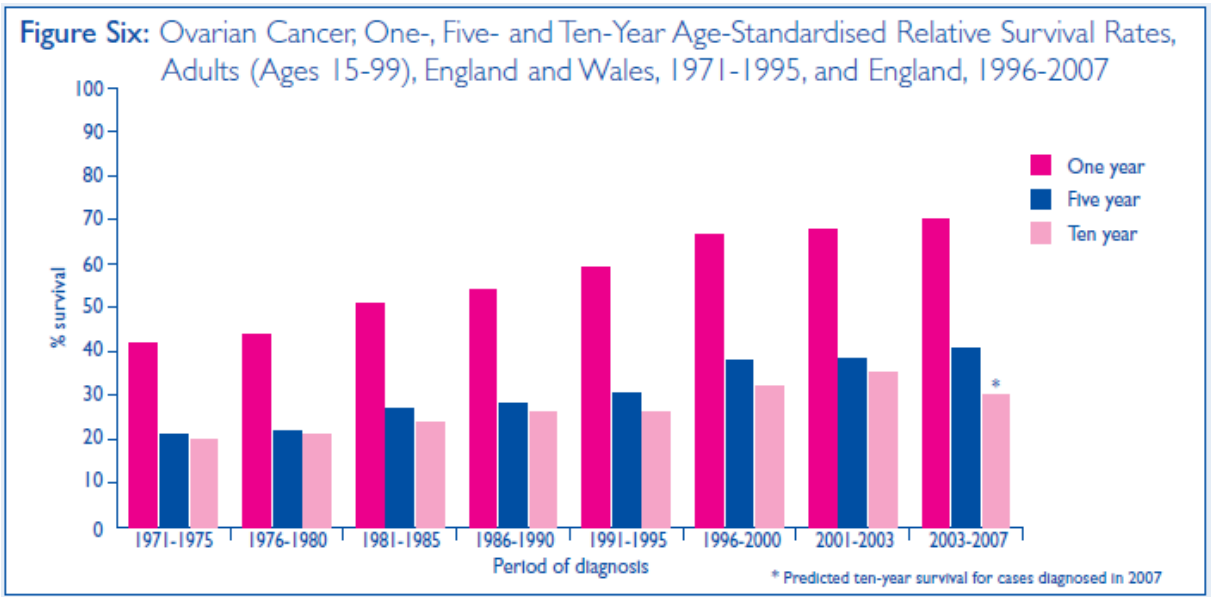
3.1. Information

Endometrial cancer is the fourth most common cancer in women in the UK and is the tenth most common cause of cancer death in women in the UK. In 2011 there were around 8500 new cases diagnosed and almost 75% of all new cases occur in women in the 40 -74 age bracket.

Survival rates are increasing with an almost 25% increase in survival rates in the last 40 years and almost 75% of women diagnosed are likely to survive for at least 10 years. (See appendix 4)

Ovarian cancer is the fifth most common cancer and the fourth most common cause of cancer death in women in the UK. Survival has improved however, around 6,500 cases are diagnosed each year and most of these patients are detected at a late stage. The majority of patients will respond to chemotherapy, but most will relapse, contributing to around 4,400 deaths annually.

Survival for ovarian cancer has improved over the last 35 years, but long-term rates are still low (Figure Six). For women diagnosed in England during 2003-07, the one- and five-year age-standardised relative survival rates were 70% and 41%, respectively, compared to 42% and 21%, respectively, for women diagnosed in England and Wales during 1971-75.



Cervical cancer is the twelfth most common cancer in women with around 3100 new cases diagnosed in 2011. Over three-quarters of all new cases of cervical cancer cases are diagnosed in women aged 25-64. Cervical cancer is the most common cancer in females under 35 in the UK.

Cervical cancer incidence in Great Britain decreased by nearly half between the late 1980's until the early 2000s, but the last decade has seen an increase in rates in younger women.
Two thirds of women with cervical cancer survive their disease for five years or more and death rates have decreased by 71% in the UK since the early 1970s.

Cervical cancer survival is higher in women diagnosed at a younger age. Women under 40 years of age have survival rates of almost 90%.

3.2. Progress

Clinical outcome assessment and review is a fundamental part of clinical care delivered in gynaecology cancer in the Manchester region. All new patients referred to The Christie have a web based form (CWP) generated and completed by the reviewing clinician.

Data regarding demographics, tumour detail, comorbidity and treatment plan are documented prospectively. The web forms are updated when the outcome changes in terms of response to treatment, progressive disease or death.

Clinical web forms are completed for all patients with cancer of the cervix, uterus, vagina and vulva being treated at The Christie with radiotherapy and chemotherapy. Some patients with cancer of the ovary have completed web forms.

The Christie clinical outcome unit has now begun the process of interrogating and reporting on this data. Its first report on outcomes of patients referred with ovarian cancer can be found on http://www.christie.nhs.uk/media/855654/ClinicalOutcomesUnitReport_OvarianCancer_May2015.pdf

The aim is to capture all patients referred for management of gynaecological cancer in the region and complete outcome forms as follow up continues. The aim is to capture these patients as they are referred through the two SMDTs via a web based SMDT referral form.
These forms will be populated sequentially and prospectively as each patient proceeds through their care pathway. All health care professionals involved in the patients' care will be able to edit the outcome form as appropriate when events occur.

3.3. Challenges

The CWP has now been successfully deployed into the Christie SMDT and has received universal acceptance. This work is being supported by another pilot programme that will test the effectiveness of putting CWP into a networked SMDT away from the Christie.

The completion of this second pilot will inform the board of the effectiveness of deployment into the CMFT gynaecology SMDT, which will also be affected by the establishment of the single service. Until these two issues are addressed it will be difficult to proceed with a common database of clinical outcomes.

Improving patient experience

3.4. Information

The 2104 National Cancer Patient Experience Survey for Gynaecology cancer patients had 136 respondents from Greater Manchester and of these 85 came from the two treating Trusts i.e. CMFT and the Christie. It is therefore hard to draw any firm conclusions from such a low response rate.

The report from the 2014 National Cancer Patient Experience Survey for Gynaecology cancer patients can be found in the embedded document below.

survey results_gynae.xlsx

For the 8 questions identified as key indicators the response for Gynaecology is as follows –

Q12	Patient felt they were told sensitively that they had cancer
Q20	Patient definitely involved in decisions about care and treatment
Q22	Patient finds it easy to contact their CNS
Q25	Hospital staff gave information about support groups
Q65	Hospital and community staff always worked well together
Q67	Given the right amount of information about condition and treatment
Q69	Patient did not feel that they were treated as a `set of cancer symptoms`
Q70	Patient`s rating of care `excellent`/ `very good`

	Q12	Q20	Q22	Q25	Q65	Q67	Q69	Q70
National average - total	84%	72%	73%	83%	63%	88%	81%	89%
National average - Gynaecology	80%	72%	71%	83%	61%	88%	81%	89%
Manchester Cancer - Gynaecology	74%	70%	74%	80%	62%	87%	84%	88%

3.5. Progress

This feedback has been reviewed by the board at several meetings and the board are planning to undertake a regional gynaecology specific survey over the next 12 months.

Therefore the board are confident that in the absence of the National patient experience survey that the service continues to draw feedback from their patients. This underlines the commitment of the board and services to improve the patient experience and collect local data as well.

3.6. Challenges

The board feel confident that patient feedback will continue to support service delivery. They feel that by the nature of being an essentially two centre service and the experience of the MDT staff in undertaking such surveys that this challenge will continue to be met.

4. Increasing research and innovative practice

4.1. Information

Over 2014/15 the number of gynaecology patients recruited into trials when compared nationally is as follows –

Design Type	Acronym	East Midlands	Eastern	Greater Manchester	Kent, Surrey & Sussex	NEast & NCumbria	North Thames	North West Coast	North West London	South London	South West Peninsula	TValley & SWilts	Wessex	West Midlands	West of England	Yorkshire & Humber	Grand Total
	CRN Population source ONS (millions)	4.4	3.3	2.9	4.5	3.3	5.4	3.7	2	3.1	2.2	2.7	2.7	5.6	2.4	5.3	
Interventional	A Phase II Clinical Trial in Patients with BRCA defective Tumours (6MP)		3				2	3							1		9
Interventional	Actinomycin-D vs Methotrexate for treatment of low risk GTN															2	2
Interventional	AKTRES study: A Biologic Study in Patients with Ovarian Cancer								4								4
Interventional	CORAL: Cancer of the OvaRy Abiraterone triaL		5							11					6		22
Interventional	DEPICT						2		1								3
Interventional	DESKTOP III	3	1	1			3		3	1			1	2		1	16
Interventional	ENGOT-EN2-DGCG-EORTC-55102	3			1											1	5
Interventional	EPIVIN trial													11			11
Interventional	Gastrointestinal care for patients undergoing pelvic chemoradiotherapy			25													25
Interventional	ICON8: Weekly Chemotherapy in Ovarian Cancer	27	34	26	20	14	34	25	17	17	28	11	7	29	18	16	323
Interventional	INTERLACE	10	1			1	7	1			4			2		4	30
Interventional	MAPPING							11	14	11				2			38
Interventional	Metformin for endometrial cancer RCT			7													7
Interventional	METRO-BIBF		6	4	2		7	3		12		2			2	2	40
Interventional	MIRENA study			16													16
Interventional	NCRN - 2371 / SOLO1 - olaparib maintenance therapy in BRCA ovarian ca		2				1			5				1			9
Interventional	NCRN - 2427 / SOLO2 olaparib in relapsed BRCA ovarian ca following response to platinum-based chemo		4	6			4			7				4			25
Interventional	NCRN - 2434 / ARIEL 2: Rucaparib in Pt-sensitive, relapsed, high-grade gynaelogical ca		8	1		1	9			4							23
Interventional	NCRN - 2489 - Maintenance Study of Niraparib/Placebo in Patients with Ovarian Cancer	1			5		4	4		9	2			2			27
Interventional	NCRN - 2597 AEZS-108 vs doxorubicin in 2nd line advanced endometrial ca	4						1	6	5				4		1	21
Interventional	NCRN - 2643 DNIB0600A in patients with Platinum-Resistant Ovarian Cancer			4				2		10							16
Interventional	NCRN - 2746 / ARIEL 3 - Rucaparib in platinum-sensitive high-grade gynaecological cancer			2			3		2	5						2	14
Interventional	NCRN - 3244 - Masitinib + Gemcitabine VS Gemcitabine in Ovarian Cancer												3	1			4
Interventional	NCRN446: MK-1775+Paclitaxel+Carboplatin vs Paclitaxel+Carboplatin in Pt sensitive ovarian ca		2														2
Interventional	NCRN458 AKTRES - GSK2110183 + Carboplatin & Paclitaxel in platinum-resistant ovarian ca		3		3				4								10
Interventional	NCRN514: INCB024360 vs Tamoxifen in epithelial ovarian ca after complete remission w/ 1st line chemo						1										1
Interventional	NCRN629 SGI-110 and carboplatin in platinum-resistant ovarian ca															1	1
Interventional	PARAGON							1		5							6
Interventional	PAZOFOS		3	2						4							9
Interventional	PAZ-PET								6								6
Interventional	PETROC/OV21		2	1			1	3		1	1					2	11
Interventional	ProGem2 - Acelarin(NUC1031) plus Carboplatin for recurrent ovarian cancer								14								14
Interventional	The role of obesity and diabetes in endometrial cancer								16								16
Interventional	TRIOC: TroVax® in Relapsed Ovarian Cancer			2	2			2				1			3		10
Interventional	Uterine LMS study						1										1
Interventional Total		48	74	97	33	16	79	56	87	107	35	14	11	58	30	32	777
Observational	ADC as a Prognostic Biomarker in Cervical Cancer									62							62
Observational	BriTROC1 - Sample collection study in recurrent HGSOC		15	8		1	10		8	2				2	1	3	50
Observational	CECs/CEP's in Patients with Advanced Ovarian Cancer			2													2
Observational	Chemotherapy-induced procoagulant changes in ovarian cancer															18	18
Observational	CTCR-OV04		98														98
Observational	Diffusion weighted Imaging Study in Cancer of the Ovary (DISCOVAR)		6						6	10							22
Observational	DNA Methylation Study	3	2			37	2				61				18	16	139
Observational	EORTC Quality of Life Module for patients with vulva cancer				1												1
Observational	GI symptoms in OC						23										23
Observational	GROINSS-V II	18	9	8	8	2	7									9	61
Observational	GTEOC - Genetic Testing in Epithelial Ovarian Cancer		126														126
Observational	NCRN509 OSCAR-1: BEVACIZUMAB AS FIRST LINE THERAPY IN PATIENTS WITH ADVANCED OVARIAN CANCER	7	16	4	10	11		3		5	10		12	12	4	20	114
Observational	Symptom Benefit	1	1	3	3		6	15	18	6		5		11	2	5	76
Observational Total		29	273	25	22	51	48	18	32	85	71	5	12	25	25	71	792
Grand Total		77	347	122	55	67	127	74	119	192	106	19	23	83	55	103	1569

The recruitment by Trust over this period is below –

Study Design	Acronym	CMFT	Tameside	The Christie	Grand Total
Interventional	DESKTOP III	1			1
Interventional	Gastrointestinal care for patients undergoing pelvic chemoradiotherapy			25	25
Interventional	ICON8: Weekly Chemotherapy in Ovarian Cancer			26	26
Interventional	Metformin for endometrial cancer RCT	6	1		7
Interventional	METRO-BIBF			4	4
Interventional	MIRENA study	16			16
Interventional	NCRN - 2427 / SOLO2 olaparib in relapsed BRCA ovarian ca following response to platinum-based chemo			6	6
Interventional	NCRN - 2434 / ARIEL 2: Rucaparib in Pt-sensitive, relapsed, high-grade gynaelogical ca			1	1
Interventional	NCRN - 2643 DNIB0600A in patients with Platinum-Resistant Ovarian Cancer			4	4
Interventional	NCRN - 2746 / ARIEL 3 - Rucaparib in platinum-sensitive high-grade gynaecological cancer			2	2
Interventional	PAZOFOS			2	2
Interventional	PETROC/OV21			1	1
Interventional	TRIOC: TroVax® in Relapsed Ovarian Cancer			2	2
Interventional Total		**23**	**1**	**73**	**97**
Observational	BriTROC1 - Sample collection study in recurrent HGSOC			8	8
Observational	CECs/CEP's in Patients with Advanced Ovarian Cancer			2	2
Observational	GROINSS-V II	8			8
Observational	NCRN509 OSCAR-1: BEVACIZUMAB AS FIRST LINE THERAPY IN PATIENTS WITH ADVANCED OVARIAN CANCER			4	4
Observational	Symptom Benefit			3	3
Observational Total		**8**		**17**	**25**
Grand Total		**31**	**1**	**90**	**122**

4.2. Progress

This is a standing item on all board agendas and the research lead, Dr Andrew Clamp, updates the board on progress and any issues that are raised.

4.3. Challenges

The two SMDTs are very active in clinical research at a local level and regularly present and publish research. Some studies require very challenging streamlining of patient pathways to meet tight study timelines, and the entire MDT functions cohesively to deliver this.

Recruitment relies not just on offering and conducting trials, but on having trials to offer. The MDTs and the board will do all they can to engage with Sponsors to ensure that all possible industry-sponsored and NCRN portfolio studies are available to the patients of Greater Manchester and East Cheshire and that all patients are considered for trial entry.

5. Delivering compliant and high quality services

5.1. Information

Previously three specialist gynaecology multi-disciplinary teams (SMDT) were in existence (UHSM, SRFT and CMFT), however due to the on-going reconfiguration of services there are now two SMDTs to cover Greater Manchester and East Cheshire. These SMDTs are at CMFT and The Christie NHS FT, the latter being formed from specialist gynaecology surgical reams form SRFT and UHSM when they moved to The Christie in April and December 2015 respectively.

The named local diagnostic gynaecology teams 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.

For gynaecology cancer the population has been geographically organised into the following organisational sectors.

North-West/South Sector:
Wrightington Wigan and Leigh NHS Trust
Royal Bolton Hospital NHS Foundation Trust
Salford Royal NHS Foundation Trust
East Cheshire NHS Trust
Mid Cheshire NHS Trust
Stockport Foundation NHS Trust
University Hospital of South Manchester NHS Foundation Trust
Christie Hospital NHS Foundation Trust

North-East Sector:
Pennine Acute Hospitals NHS Trust (Bury, North Manchester, Oldham, Rochdale)
Central Manchester University Hospitals NHS Foundation Trust
Tameside Acute NHS Foundation Trust

The Christie Hospital is the Tertiary Referral Centre for treatment with Radiotherapy delivered at The Christie Hospital and the satellite radiotherapy units based at Royal Oldham Hospital and Salford Royal.

Chemotherapy and clinical trials for gynaecology are predominantly delivered at The Christie Hospital, although local chemotherapy is currently available at a number of local trusts across the area. Increased access to chemotherapy and clinical trials closer to home for gynaecology cancer patients will be an aim for the board, working in conjunction with the Systemic Anti-Cancer Therapy pathway.

5.2. Progress

The two SMDTs are now well established and the referral pathways are assured. The Christie SMDT has also this successfully piloted the use of the Christie Web Portal to manage electronic referrals and data management. This is now used by all referring Trusts into this SMDT to manage the output from the SMDT and subsequent treatment.

The work of the Board was disrupted in this first year by the constraints of working within a transforming organisational structure. As a consequence of this the work on –

The board will complete the revision of all of the guidelines in the next few months. Until this point the previous GMCCN guidelines will remain in force. The guideline, pathway and supporting documents are now located on the Manchester Cancer website and can be found on the links below.

Guidelines & Referral pathways –
http://manchestercancer.org/wp-content/uploads/2014/09/Constitution-Gynaecology-2014.pdf

At this point in time the board has no plans for educational events as it is waiting for the cancer education strategy to be developed by Manchester Cancer. Once this strategy has been agreed the board will support and contribute to all Gynaecology cancer education as required.

5.3. Challenges

The biggest challenge will be to unify the service and have a single governance process for both SMDTs. Work on this remains on-going and will depend on the commitment and perseverance of the clinical staff.

The board remain optimistic that this challenge can be overcome and that the patients are managed within a standardised clinical structure.

6. Objectives for 2015/16

The board have set 6 objectives for this year and these are –

1. Optimise data collection to generate outcome data
2. Review and where possible standardise the OP process
3. Improved uptake of HPV vaccination
4. Develop service standards the help define the service
5. Work with provider Trusts to co-ordinate a response to the “suspected cancer : recognition and referral” NICE guidelines
6. Engage with primary care in education events and tools to improve early diagnosis

The work of the board will not be limited to just these objectives. As the year unfolds new challenges and opportunities will be identified. The board feel that as a high quality, dedicated, functioning group they are adaptable and capable of accepting and addressing all possibilities to deliver the objectives of Manchester Cancer.

Appendix 1 – Pathway Board meeting attendance

ATTENDANCE - PATHWAY BOARD MEETING

GYNAE

NAME	ROLE	TRUST	02/05/2014	04/07/2014	12/09/2014	07/11/2014	09/01/2015	06/03/2015	01/05/2015
Lisa Barraclough	Chair		✓	✓	✓	✓	✓	✓	✓
Mr Kehinde Abidogun	Consultant Gynaecologist	Bolton	✓	Miss Ali Ross✓	✓	✓	✓	Apologies	✓
Dr Ann Mills	Consultant Radiologist		✓	✓	Apologies	✓	✓	✓	✓
Dr Susan Davidson	Clinical Oncology	Christie	✓	✓	✓	Apologies	✓	Apologies	✓
Mr Richard Slade	Consultant		Apologies	Apologies	Apologies	Apologies		Apologies	Apologies
Dr Mike Smith	Consultant		Apologies	Apologies	Apologies	Apologies	✓	✓	Apologies
Dr Andrew Clamp	Honorary consultant		Apologies	✓	Apologies	✓	✓	✓	✓
Karen Johnson	Nurse clinician		✓	✓	✓	✓	✓	✓	Apologies
Cathrine Holland	Consultant Gynaecological Oncologist	CMFT	Apologies	✓	Apologies	Apologies	Apologies	✓	✓
Rick Clayton	Consultant Gynaecological Oncologist		✓	Apologies	Apologies	Apologies	✓	Apologies	Apologies
Ann Lowry	Gynae Macmillan CNS		✓	✓	✓	✓	✓	Apologies	✓
Mr Vincent Hall	Consultant Obstetrician & Gynaecological Surgeon	East Cheshire	✓	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies
Mrs Venessa Hilton-Watts	Clinical Nurse Specialist		✓	✓		✓	Apologies	✓	Apologies
Dr Manisha Kumar	GP representattive		Apologies	✓	✓	Apologies	Apologies		
Mr S Ali	Consultant	Pennine	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies
Nil		SRFT							
Mr Murray Luckas	Consultant Gynaecologist	Mid Cheshire	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies
Mrs Sally Petith	Gynae Oncology CNS		Apologies	✓	✓	✓	Apologies	Apologies	Apologies
Dr Suku George	Consultant gynaecologist	Stockport	Apologies	✓	✓	Apologies	✓	✓	Apologies
Ms Jo Dzyra	CNS		Apologies	✓	✓	✓	Apologies	Apologies	Apologies
Dr Richard Hale	Consultant Pathologist		Apologies	✓	✓	✓	Apologies	✓	Apologies
Mr Kyle Gilmour	Consultant Gynaecologist	Tameside	Apologies	✓	Apologies	✓	✓	✓	Apologies
Debbie Beadle	Gynaecology Cancer Nurse		Apologies	Apologies	Apologies	Apologies	Apologies		
Amanada lowe	Gynaecology Cancer Nurse		From Feb 2015				Apologies	Apologies	Apologies
Karen Blackburn	Lead Manager Cancer Services	UHSM	✓	Julie Orford✓	Julie Orford✓	Apologies	Apologies		
Mr S Burns	Consultant Gynaecologist	WWL	✓	✓	✓	Apologies	✓	✓	Apologies
Karen Blackwood	Gynaecology Cancer Nurse Specialist		✓	✓	Apologies	Apologies	Apologies	Apologies	Apologies

7. Appendix 2 – Pathway Board Annual Plan 2015/16

Gynaecology Pathway Board Annual Plan 2014-15

Pathway Clinical Director:	Dr Lisa Barraclough
Pathway Board Members:	
Pathway Manager:	James Leighton
Date agreed by Pathway Board:	To be ratified at September board
Date agreed by Medical Director:	
Review date:	Dec 2016

Summary of objectives

No	Objective	Alignment with Provider Board objectives
1	Optimise data collection to generate outcome data	Objective no 1 and no 4
2	Review and where possible standardise the OP process	Objective no 3 and no 4
3	Improved uptake of HPV vaccination programme	Objective no 1
4	Develop service standards the help define the service	Objective no 4
5	Work with provider Trusts to co-ordinate a response to the “suspected cancer : recognition and referral” NICE guidelines	Objective no 1
6	Engage with primary care in education events and tools to improve early diagnosis	Objective no 1

Objective 1: Optimise data collection to generate outcome data

Objective:	To optimise data collection to allow the generation of meaningful outcome measures. We will scrutinise our data collection to enable the sustainable generation of outcome measures.
Rationale:	The Board wishes to be able to reliably generate meaningful annual outcome data, to facilitate national and international comparison, and year on year comparison of our own outcomes. This will ensure that the patient care delivered compares favourably with other centres and identify areas where care might be improved.
By (date):	31/3/16
Board measure(s):	The ability to generate outcome figures for 1 and 2 year survivals without additional task-specific audit
Risks to success:	Time and other commitments of involved personnel eg MDT lead clinicians, MDT co-ordinators, data managers, doctors, clinical nurse specialists. Mitigation: Aim for an efficient, unified, sustainable approach
Support required:	Recognition and protection of the vital role of existing data managers. Reflection in job-planning and appraisal of the effort and commitment of MDT clinicians in generating this data

Work programme

Action	**Resp.**	**By (date)**
Draft list of outcome measures tabled at board meeting	LB	12/9/15
Final list of outcome measures agreed		7/11/15
Understand the processes of routine data collection		31/1/15
Begin the collection of data		31/3/15

Objective 2: Review and where possible standardise the OP process

Objective:	Review and where possible standardise the OP process
Rationale:	The board is aware that there is significant variance on how and which patients are followed up across Greater Manchester and Cheshire. By standardising this there will be a common agreed approach to the follow-up process.
By (date):	31 march 2016
Board measure(s):	Review of current follow up processes and recommendations on optimum follow-up arrangements for clinically appropriate patients. Increased patient satisfaction, more new appointment slots as follow-up slots are converted
Risks to success:	Time and other commitments of involved personnel. The single service is not established.
Support required:	Support at executive level for organisational change process

Work programme

Action	**Resp.**	**By (date)**
Audit providers on current follow-up processes	Board	Dec 15
Review FU processes nationally to inform processes	Board	Dec 15
Draft possible follow-up protocols	Board	Jan 16
Agree follow-up processes	Board	Mar 16

Objective 3: Improved uptake of HPV vaccination programme

Objective:	Improved uptake of HPV vaccination programme
Rationale:	Vaccination with Human Papilloma Virus (HPV) has a predicted 63% reduction in development of invasive cancer however in recent years there has been a decrease in uptake amongst the target population.
By (date):	31/3/16
Board measure(s):	Development of a social media campaign and an increase in HPV vaccination uptake.
Risks to success:	Resources for campaign roll out. Will be mitigated by use of accessible social media channels
Support required:	Support at executive level for cross organisational working.

Work programme

Action	**Resp.**	**By (date)**
Engage with Jo's Trust for ownership of media campaign	LB	Aug 15
Meet with HPV coordinators at Public Health England	LB	Aug/Sept 15
Engage with LA and Schools	LB/Board rep	Oct/Nov 15
Education events	Board	March 2015

Objective 4: Develop service standards the help define the service

Objective:	Develop service standards the help define the service
Rationale:	As part of the reconfiguration of Gynaecology oncology surgery in Greater Manchester it is intended that the provision is governed by a single service located in two provider organisations. Having set standards for this service will drive the service forward and prevent variance between sites.
By (date):	December 2015
Board measure(s):	To have an agreed number of standards that will be used to govern the single service
Risks to success:	Time and other commitments of involved personnel Resources Mitigation: Aim for an efficient, unified, sustainable approach.
Support required:	Support at executive level for the organisational change process

Work programme

Action	**Resp.**	**By (date)**
Table the discussion at September board meeting	PD	Sep 15
Agree a working party tasked to draw up the standards	Board	Sep 15
Draft service standards	Working group	Jan 15
Agreed by the board	Board	Mar 15

Objective 5: Respond to the "suspected cancer: recognition and referral" NICE guidelines

Objective:	Work with provider Trusts to co-ordinate a response to the "suspected cancer : recognition and referral" NICE guidelines
Rationale:	This guidance has asked for better more direct access for primary care in referring patients suspected of cancer. The full implication of this guidance for providers, service users and commissioners needs to be better understood.
By (date):	Dec 2015
Board measure(s):	Review of guidance and a protocol written to support delivery of the guidance
Risks to success:	Time and other commitments of involved personnel Resources Mitigation: Aim for an efficient, unified, sustainable approach.
Support required:	Support at executive level for organisational change process

Work programme

Action	**Resp.**	**By (date)**
Audit the scanning departments on primary care access	PM	Q2
Liaise with commissioners to understand possible volumes	PD	Q2
Review at board	Board	Nov 15
Develop protocol to ensure correct patients access scanning	Board	Jan 16

Objective 6: Engage with primary care in education events and tools to improve early diagnosis

Objective:	Engage with primary care in education events and tools to improve early diagnosis
Rationale:	With the publication of the NICE guidance "Suspected cancer: recognition and referral" and with current referral practice the board wish to support primary care colleagues in making appropriate and timely referrals into the correct point of access on the pathway.
By (date):	March 2016
Board measure(s):	Development and delivery of a training programme targeted at primary care clinical teams managing suspected or diagnosed gynaecology cancer patients
Risks to success:	Time and other commitments of involved personnel Resources Supporting infrastructure is not put in place
Support required:	Development of city wide training infrastructure Logistical support and resources

Work programme

Action	**Resp.**	**By (date)**
Engage with Primary care to identify training / education wanted	PM	Q3
Agree programme, content, venue and delivery methods	Board	Q3
Advertise the event	PM	31 3 16
Deliver the Training	Board	31 3 16