Head and Neck Pathway Board
Annual Report 2013/14

Pathway Clinical Director: Dr Gillian Hall
Pathway Manager: Hodan Noor

Version 0.5 25/7/2014
Executive summary

The Head & Neck network Site Specific Group (NSSG) was in existence supported by Greater Manchester and Cheshire Cancer Network. Due to the reconfigurations of Networks’ nationally the former NSSG was dissolved and a Head and Neck Pathway board was formed. The purpose of the board is to ensure that services for patients with suspected or diagnosed Head & Neck or Thyroid cancer are being delivered in accordance with NICE Improving Outcomes Guidance, Peer Review Cancer Quality Measures and create an opportunity to further develop standards of care.

There are three upper aerodigestive tract (UAT) Specialist Multi-Disciplinary Teams (SMDTs) There is also one (separate) Thyroid MDT covering the whole of Manchester Cancer.

Patient information: Based on the results from the national survey 2013, patient information prior to treatment and regarding side effects score lower in some cases than the national average, however generally the scores are predominantly low.

The National Head and Neck Cancer Audit is commissioned and by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), and developed in partnership with the British Association of Head and Neck Oncologists (BAHNO). 468 patients were captured during 2012. Of the registered patients only 20% reported some form of pre-treatment contact.
A report was commissioned by the **National Cancer Intelligence Network** on the Head and Neck incidents and mortality rates in England in 2010. Below are a snap shot summary of the findings:

- **Oral cavity cancer** incidence has risen by more than 30% and the main factors for this are smoking and alcohol, during 2004-06 **5 year survival was at 56%**
- The incidence of **oropharyngeal cancer** have more than doubled in the study period the suggestion for this increase may be altering with a subpopulation when HPV virus is the primary factor. Oropharynx **5 year survival rate is 52% but HPV associated tumours do have a better outcome.**
- **Thyroid incidence** has nearly doubled in the study period. This may in part be due to imaging of goitres and subsequent surgery leading to an increase in the numbers being detected. The 5 year relative survival rate for the most **recently diagnosed cases is 87%**.

**The challenge**

**Patient flow:** With 10 diagnostic centre and three surgical sites for UAT cancer, the patient flow is complex with variations in the systems. This level of variation and activity across three sites does have its constraints in relation to data system and functionality including the process for recording.

**Data systems:** For many years, DAHNO data has shown what appears to be poor performance for the Greater Manchester and Cheshire particularly regarding completeness of TNM staging information and clinical lines of enquiry. The group strongly feel that a unified data collection system would resolve this issue.

**Patient care:** Ensuring that there is equitable and full access to dental care, speech and language therapy, dietician expertise and psychological support through all stages, from diagnosis through treatment to long term follow up.

**Early detection and diagnosis:** With increasing incidence of some forms of head and neck cancers, specifically HPV associated tumours which affect those who might not be perceived to be “at risk”, patient and primary care education is paramount. This board welcomes guidance and will harness a close working relationship with the prevention, awareness and screening pathway board.

**Living with Cancer:** Late staging of oral cavity having a significant impact on survival the board has made links with the Living with and Beyond and Palliative Care boards and will be engaged in the mapping of service provision for patients living with cancer.

**The vision**

Every patient in Greater Manchester and Cheshire has **access to all** pre-treatment assessment and diagnostics, **quality and timely information** on the types of treatments available to them and their side effects, detailed transfer of **care and support in the community by 2018**.

**The objective**

- Improve **all aspects data recording** for Head and Neck patients by 31st March 2016
- Ensure **patient is able to fully access** all aspect of care pre, during and post treatment and is fully informed by 31st of March 2019
- **Improve education** for public, patients and referrers to the service 31st March 2019
- Actively **engage in Research** year on year
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 annual report. It outlines the current configuration of services, the progress in forming the Pathway Board, the data on outcomes and experience that the Board took into account when setting its objectives, and what those objectives are for 2014/15 and beyond. In July 2015 every Manchester Cancer Pathway Board will publish a full annual report, outlining the work of its first full year and its progress against those objectives.

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.

2. General overview


The national peer review measure supports the development of the pathway board and set the standards required for assessment (May 2014 version 1.1). The service delivery follows the National Specifications set out in the document B16/S/a.

The Data for Head and Neck Oncology (DAHNO) is the national data set that captures and reports by annually the position of service providers by region.
2.1 Incidence and Survival rates for Head and Neck Cancer

A report was commissioned by the National Cancer Intelligence Network on the Head and Neck incidents and mortality rates in England, the Oxford Cancer Intelligence Unit (OCIU) which is the lead cancer registry for head and neck cancers in collaboration with the National Cancer Intelligence Network’s Head and Neck Site Specific Clinical Reference Group produce a report in 2010. Below are a snap shot summary of the findings.

Oral cavity cancer has risen by more than 30% and the main factors for this are smoking and alcohol. Further risk awareness for oral cancer is needed including early detections. Nationally there has been a significant improvement of 1 and 5 year survival rate for oral cavity cancers during 2004-06, 5 year survival was at 56%.

There has also been an increased in the incidence of salivary gland by 73% although the reason for this is unclear and it likely relates to better recording of a rare tumour type. The 5 year survival for most recently diagnosed stands at 69%. However, in some tumours, the disease course is long, and a further 10 to 25 years study is required to truly understand the impact in clinical practice.

The incidence of oropharyngeal cancer have more than doubled in the study period and showing a greater rise in incidence than any other head and neck cancer sub site. It is accepted that this is attributed to the so called epidemic of HPV associated tumours at this site. The 1 and 5 year survival improved 13 to 14% during this period. Future data collection must separate HPV + and HPV – tumours as survival rates are drastically different.
The incidence of nasopharyngeal carcinoma has remained static. The one year survival rates have increased by 10% during this period and 5 year has increase by 10%. This is reflective of the improvement in chemo-radiotherapy combined delivery. The 5 year survival rate in the most recently diagnosed cohort is 49%.

The incidence of laryngeal carcinoma has fallen by 20% during the study period but levelled off in the last five years. Age standardised rates are highest in Greater Manchester and Cheshire at 4.21 per 100,000 population. 5 year survival for recently diagnosed cases is 65%. Although the survival has not improved there is evidence of improved quality of life with advances such as surgical voice restorations.

The incidence of hypopharyngeal cancer remains static although some geographical variation identified with Liverpool and Cheshire having the highest incidence rate compared to other areas. One year survival has increased by 10%. Five year survival remains poor at 26% for most recently diagnosed cases.
Thyroid incidence has nearly doubled in the study period. This may in part be due to imaging of goitres and subsequent surgery leading to an increase in the numbers being detected. The trends in one to five years relative survival for thyroid show an increase of 11% the 5 year relative survival rate for the most recently diagnosed cases is 87%.

According to the Cancer Research UK changing Incidence and Mortality Predictions for Oral Cancer (includes oropharyngeal but not hypopharyngeal or laryngeal) incidence has increased from 5 to 9 persons per 100,000 with the highest increase during 1997 to 2009. The lung cancer incidence curve over the same period has seen a slight drop in incidence and the difference could be explained by HPV associated oropharyngeal tumours.

Oral cancer mortality rate is predicted to increase to 22.4% (2010-2030 predictions).
3 year survival by stage data from the National Cancer Intelligence Network (NCIN) demonstrates that early diagnosis doubles the survival rate of oral cavity cancer.

### 3. Background to the pathway

The Head & Neck network Site Specific Group (NSSG) was in existence supported by Greater Manchester and Cheshire Cancer Network. Due to the reconfigurations of Networks’ nationally the former NSSG was dissolved and a Head and Neck Pathway board was formed.

In principal the basis of the old NSSG is the same as the pathway board with members drawn from the MDT Lead Clinicians from each specialist and local team, and clinical support services involved in tumour management along the patient care pathway.

The purpose of the board is to ensure that services for patients with suspected or diagnosed Head & Neck or Thyroid cancer are being delivered in accordance with NICE Improving Outcomes Guidance, Peer Review Cancer Quality Measures and create an opportunity to further develop standards of care.
4. Configuration of services

There are three upper aerodigestive tract (UAT) Specialist Multi-Disciplinary Teams (SMDTs) whose remits are described below. There is also one (separate) Thyroid MDT covering the whole of Manchester Cancer.

4.1 Central SMDT
This SMDT deals with salivary gland tumours, UAT cancer and UAT cancer involving the skull base.
- Designated site of UAT resection and extradural surgery: Manchester Royal Infirmary (CMFT)
- Designated site of intradural surgery: Salford Royal
- Designated site of MDT meetings/clinics: The Christie

Populations served: Central Manchester, Salford, Trafford (ENT and Maxfac cancers), Wigan (MaxFac), Bolton (ENT), Tameside (ENT),

4.2 North SMDT
- This SMDT deals with salivary gland tumours and UAT cancer.
- Designated site of surgery: North Manchester General Hospital
- Designated site of MDT meetings/clinics: North Manchester General Hospital

Populations served: All Pennine PCTs plus Tameside (MaxFac)

4.3 South SMDT
- This SMDT deals with salivary gland tumours and UAT cancer.
- Designated site of UADT resection surgery: Wythenshawe hospital
- Designated site of MDT meetings/clinics: The Christie

Populations served: South Manchester, Stockport, East Cheshire (MaxFac and ENT), Wigan (ENT)

The lack of compliance to a peer review measure that states that all salivary gland cancers should be treated at one centre per network has been discussed in an audit.

4.4 Thyroid cancer MDT
This MDT deals exclusively with thyroid cancers and serves the population of the whole network (3.3 million). All Trusts in the Network refer patients to the Thyroid MDT at Christie Hospital for thyroid cancer.

All hospitals whom have surgeons listed as core members of this MDT perform primary thyroid surgery. If cancer is inadvertently diagnosed by a non-core member, our policy is for completion surgery, if deemed necessary following discussion at the MDT, to be performed by a core member.

When lateral neck dissections are necessary, onward referral to one of the surgeons designated as performing lateral neck dissection, as listed on page 15 is required.

Designated site of MDT meeting/clinics: The Christie
## 4.5 MDT contacts

<table>
<thead>
<tr>
<th>MDT Type</th>
<th>Location</th>
<th>Co-ordinator</th>
<th>Contact</th>
<th>Lead Clinician</th>
</tr>
</thead>
</table>
| 2 - UAT  | Central Manchester / Christie | Sam Barrett       | Tel: 0161 446 3491  
Fax: 0161 918 7273  
E mail: Sam.Barrett@christie.nhs.uk | Mr Jarrod Homer         |
| 2 - UAT  | Pennine Acute             | Kath Nolan         | Tel 0161 720 2799 (42799)  
Fax 0161 720 2251 (42251)  
Kath.Nolan@pat.nhs.uk | Mr Andrew Baldwin      |
| 2 - UAT  | South Manchester / Christie | Sam Barrett       | 0161 918 7272  
Sam.Barrett@christie.nhs.uk | Mr Andrew Birzgalis    |
| 3 - Thyroid | Christie               | Ben Hilldevries   | 0161 918 7272  
0161 918 7273  
Ben.Hilldevries@christie.nhs.uk | Interim Mr S Loughran  |

The host organisations for the specialist teams will also provide access to their local Clinical Commissioning Group populations for diagnosis and assessment of patients with head and neck symptoms.

### Outflows from Manchester Cancer

- Bolton (MaxFac only) to Blackburn
### 4.6 Designated hospital for diagnostics and assessment

<table>
<thead>
<tr>
<th>Designated Hospital for Diagnosis &amp; Assessment</th>
<th>SMDT for UAT cancers</th>
<th>Diagnostic Lead Clinician</th>
<th>Referring Clinical Commissioning Groups</th>
<th>Catchment Population</th>
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<tr>
<td>Bolton Hospitals NHS Trust (BFT)</td>
<td>Central Manchester/Christie (ENT) Blackburn (MaxFac)</td>
<td>Mr Simon Hargreaves</td>
<td>Bolton</td>
<td>294,600</td>
</tr>
<tr>
<td>Central Manchester University Hospital Trust (CMFT)</td>
<td>Central Manchester/Christie</td>
<td>Mr Jarrod Homer</td>
<td>Manchester (Central)</td>
<td>211,800</td>
</tr>
<tr>
<td>East Cheshire NHS Trust</td>
<td>South Manchester/Christie</td>
<td>Mr Manu Patel</td>
<td>East Cheshire Vale Royal South Cheshire</td>
<td>201,200 102,100 173,200</td>
</tr>
<tr>
<td>Pennine Acute NHS Trust</td>
<td>Pennine</td>
<td>Mr Andrew Baldwin</td>
<td>Bury HMR Manchester (North) Oldham</td>
<td>195,000 223,300 183,200 239,600</td>
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<td>Salford Royal Foundation Trust (SRFT)</td>
<td>Central Manchester/Christie</td>
<td>Mr Sean Loughran</td>
<td>Salford</td>
<td>247,600</td>
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<tr>
<td>Stockport Foundation NHS Trust</td>
<td>South Manchester/Christie</td>
<td>Mr Vivek Kaushik</td>
<td>Stockport</td>
<td>299,000</td>
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<tr>
<td>Tameside Acute NHS Trust</td>
<td>Central Manchester/Christie (ENT) Pennine (MaxFac)</td>
<td>Miss S Penney</td>
<td>Tameside and Glossop</td>
<td>240,300</td>
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<td>Trafford Healthcare NHS Trust</td>
<td>Central Manchester/Christie</td>
<td>Mrs Astrid Bieger-Farhan</td>
<td>Trafford</td>
<td>233,100</td>
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<td>University Hospital of South Manchester NHS Trust (UHSM)</td>
<td>South Manchester/Christie</td>
<td>Mr Andrew Birzgalis</td>
<td>Manchester (South)</td>
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<tr>
<td>Wrightington, Wigan and Leigh NHS Trust (WWL)</td>
<td>Central Manchester/Christie (MaxFac) South Manchester/Christie (ENT)</td>
<td>Mr Vijay Pothula</td>
<td>Wigan Borough</td>
<td>320,300</td>
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<td><strong>TOTAL</strong></td>
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<td><strong>3,329,200</strong></td>
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<td>Trust</td>
<td>Designated Hospital</td>
<td>Designated Head &amp; Neck Clinicians</td>
<td>Designated Thyroid Clinicians</td>
<td>Neck Lump Clinic</td>
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<tr>
<td>Bolton Hospitals NHS Trust</td>
<td>Royal Bolton</td>
<td>Mr Simon Hargreaves</td>
<td>Mr Simon Hargreaves</td>
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<td></td>
<td></td>
<td>Mr Christopher Lobo</td>
<td>Mr Neel Umapathy</td>
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<td>Mr Neel Umapathy</td>
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<td>Mr Blackbum</td>
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<td>Mr M Maranzaro</td>
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<tr>
<td>CMFT</td>
<td>Manchester Royal Infirmary</td>
<td>Mr Jarrod Homer</td>
<td>Mr Jarrod Homer</td>
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<td></td>
<td></td>
<td>Mr Sean Loughran</td>
<td>Mr Sean Loughran</td>
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<td></td>
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<td>Miss S Penney</td>
<td>Mr Neil Parrott</td>
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<td>Mr Tim Blackburn</td>
<td>Mr T Augustine</td>
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<td></td>
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<td>Mr M Maranzaro</td>
<td>Mr Forgacs</td>
<td></td>
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<tr>
<td>East Cheshire NHS Trust</td>
<td>Macclesfield</td>
<td>Mr Manu Patel</td>
<td>Mr A Birzgalis</td>
<td>Yes</td>
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<tr>
<td></td>
<td></td>
<td>Mr A Birzgalis</td>
<td>Mr Camilleri</td>
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<td></td>
<td></td>
<td>Mr Camilleri</td>
<td></td>
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<tr>
<td>Pennine Acute NHS Trust</td>
<td>North Manchester General Hospital, Royal Oldham Hospital, Fairfield General Hospital</td>
<td>Mr Andrew Baldwin</td>
<td>Mr Prad Murthy</td>
<td>Yes*</td>
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<tr>
<td></td>
<td></td>
<td>Mr Robert Woodwards</td>
<td>Mr Ian Shepherd</td>
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<td>Mr C Katre</td>
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<td>Mr W. Aleid</td>
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<td></td>
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<td>Mr Prad Murthy</td>
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<td></td>
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<td>Mr Sharma</td>
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<tr>
<td>SRFT</td>
<td>Salford Royal</td>
<td>Mr Sean Loughran</td>
<td>Miss Helen Doran</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Miss R Aggarwal</td>
<td>Mr Iain Anderson</td>
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</tr>
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<td></td>
<td></td>
<td>Mr A Kalantzis</td>
<td>Mr Sean Loughran</td>
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<tr>
<td>Stockport Foundation NHS Trust</td>
<td>Stepping Hill</td>
<td>Miss Laxmi Ramamurthy</td>
<td>Miss Laxmi Ramamurthy</td>
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<tr>
<td></td>
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<td>Mr Vivek Kaushik</td>
<td>Mr Vivek Kaushik</td>
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<td>Mr M Iqbal</td>
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<tr>
<td>Tameside Acute NHS Trust</td>
<td>Tameside General</td>
<td>Mr Yakubu Karagama</td>
<td>Mr Simon Ellenbogen</td>
<td>Yes</td>
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<tr>
<td></td>
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<td>Mr Rajiv Bhalla</td>
<td>Ms S Penney</td>
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<td></td>
<td>Miss S Penney</td>
<td>Mr W. Aleid</td>
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<td>Trafford Healthcare NHS Trust</td>
<td>Trafford General</td>
<td>Mr Atef El-Kholy</td>
<td>Mr Al-Dabbagh</td>
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<td></td>
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<td>Mrs Astrid Bieger-Farhan</td>
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<td>Mr A Kalantzis</td>
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<tr>
<td>UHSM</td>
<td>Wythenshawe</td>
<td>Mr Andrew Birzgalis</td>
<td>Mr A Birzgalis</td>
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<td>Mr Vijay Pothula</td>
<td>Mr Ashu Gandhi</td>
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<td>Mr Manu Patel</td>
<td>Mr Vijay Pothula</td>
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<td>Mr M Iqbal</td>
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<tr>
<td>WWL</td>
<td>Royal Albert Edward</td>
<td>Mr Vijay Pothula</td>
<td>Mr Nirmal Kumar</td>
<td>Yes</td>
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<td></td>
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<td>Mr Steve Izzat</td>
<td>Mr Vijay Pothula</td>
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<td>Mr S Clarke</td>
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<td>Mr M Maranzaro</td>
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</tbody>
</table>

ENT clinicians in green, Maxillofacial clinicians in blue
The Christie Hospital is the Tertiary Referral Centre for the pathway and delivers radiotherapy including satellite units based at Royal Oldham Hospital and Salford Royal.

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

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

### 4.7 Agreed Named Hospital for Surgical Treatment Delivery

The following table lists the hospitals in the Network where the curative surgical treatment for head and neck cancer takes place along with the named MDTs associated with each hospital and the designated head and neck ward. These hospitals provide a full diagnostic and assessment service for head and neck cancer.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Designated Head &amp; Neck Ward</th>
<th>MDT</th>
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</thead>
<tbody>
<tr>
<td>Wythenshawe</td>
<td>F9</td>
<td>South Manchester/Christie</td>
</tr>
<tr>
<td>Manchester Royal Infirmary</td>
<td>Head &amp; Neck Cancer Unit</td>
<td>Central Manchester/Christie</td>
</tr>
<tr>
<td>North Manchester General</td>
<td>B1</td>
<td>Pennine</td>
</tr>
<tr>
<td>Salford Royal</td>
<td>H7</td>
<td>Central Manchester/Christie</td>
</tr>
</tbody>
</table>

(For base of skull surgery - Patients are all discussed at the Central Manchester/Christie MDT and the neurosurgeon attends this discussion. Surgery is then carried out at the Salford neuro-surgical site if intracranial / intra-dural. This is a joint surgical procedure with one of the ENT surgeons from Central Manchester Foundation Trust. Follow up after discharge from hospital is by the Central Manchester/Christie MDT and Central Manchester Foundation Trust)

All 3 UAT surgical sites have a designated head and neck cancer ward and have a Band 5 + nurse, trained in tracheostomy care on duty at all times. All 3 have 24/7 on call facility for flap failure and there is an agreement in place between Central Manchester and Wythenshawe to provide cross cover if needed. All 3 surgical centres have HDU and ITU facilities on site.
4.8 Policy for Surgeons Authorised to Perform Lateral Lymph Node Resections on Thyroid Cancer Patients

The surgeons named in the table below who are linked to the Head & Neck SMDTs are the only surgeons authorised to perform lateral lymph node resections on thyroid cancer patients. This policy excludes simple excision of lymph nodes for diagnosis. All of the named surgeons are designated core members of the UAT SMDTs or Thyroid MDT.

The named surgeons are agreed by the Pathway Boards and the lead clinicians of the SMDTs.

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>Associated SMDT</th>
<th>Hospital Site where Neck Dissection carried out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr S Loughran</td>
<td>Central Manchester UAT and thyroid</td>
<td>Manchester Royal Infirmary and Salford Royal</td>
</tr>
<tr>
<td>Mr J Homer</td>
<td>Central Manchester UAT and thyroid</td>
<td>Manchester Royal Infirmary</td>
</tr>
<tr>
<td>Mr Prad Murthy</td>
<td>Pennine UAT and thyroid</td>
<td>Pennine</td>
</tr>
<tr>
<td>Mr Vijay Pothula</td>
<td>Thyroid</td>
<td>University Hospital South Manchester</td>
</tr>
<tr>
<td>Mr Andrew Birzgalis*</td>
<td>South Manchester UAT*</td>
<td>University Hospital South Manchester</td>
</tr>
<tr>
<td>Ms Susannah Penney</td>
<td>Central Manchester UAT and thyroid</td>
<td>Manchester Royal Infirmary</td>
</tr>
</tbody>
</table>

* Mr Birzgalis is a member of the UAT MDT but not the thyroid MDT and cases requiring thyroidectomy as well as lateral neck dissection are operated on jointly with a core thyroid MDT member performing the thyroid surgery.

5. Clinical guidelines

The Head and Neck 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](http://www.gmccn.nhs.uk) and will be migrated to the Manchester Cancer website over the coming months [www.manchester肿瘤.org](http://www.manchester肿瘤.org).

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

6.1 Data for Head and Neck Oncology (DAHNO) 2012 Audit report (2013)

The National Head and Neck Cancer Audit is commissioned and by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), and developed in partnership with the British Association of Head and Neck Oncologists (BAHNO).

The DAHNO and the National Patient Survey findings was discussed at the board meeting in June 2014 which influenced members’ views on the work programme and the way forward, the data below describes the finding of the eight annual report published in 2013.

468 patients were captured during 2012. Of the registered patients only 20% reported some form of pre-treatment contact.

5.4% reported speech and swallowing assessment 10% reported dietetic services 6% reported dental assessments

0% Reported chest imaging (CXR or CT) prior to MDT 37.5% reported chest imaging (CXR or CT) prior to cancer care plan 84% T NM staging recorded in 2012

6.2 Cancer waiting targets Quarter 4 2013/14

Quarter 4 findings show 2 week wait targets are being achieved with 7 out of the 8 Trust achieving over 96%.

31 day waits are at 100% in quarter 2 and 3

62 day waits at 95.8 quarter 2 and 100% in quarter 3.
7. Patient experience

During the June board meeting, the national patient survey results were shared, with specific questions to address outliers and low scores. With the finding the board identified a list of interventions to be developed as a project to address the concerning areas.

The main themes that need to be addressed are as follow:

**Patient information**: Based on the results patient information prior to treatment and side effects score lower in some cases than the national average, however generally the scores are predominantly low. The board aims to achieve over 90% to improve patient experience by analysis and address the information giving quality and process.

**Patient view and care planning**: The board welcome close working relationship with the Living with and Beyond Cancer pathway board and is part of the mapping of service provision which will address the assessment and care planning including the Psychological support findings. The board will take forward any recommendations from the mapping exercise to ensure improvements are made.

---

**Type of Cancer and Operation**

**Treatment Side Effects**

---

**Patient’s views, written assessment and care plan**

**Emotional support/ Health and social care services**
8. Research and clinical trials

In May / June 2014, Chair of the Board Gillian Hall and Research Lead Jarrod Homer conducted a gap analysis looking at the list of current active trials on the UK Clinical Research network website, the list of trials on a list provided by the previous cancer network group and obtained an update from the Christie clinical research team. This is for discussion at the September meeting with the aim of producing an up to date list of clinical trials that we are actively engaged in along with those in set up. We plan to review this list each year and discuss progress on target biannually. Updated figures will be provided by NIHR Clinical Research Network.

Performance on the projected recruitment targets have improved significantly year upon year achieving above the set RCT and non-RCT in 2013/14. At the next Board meeting, we need to discuss the slight drop in performance in 2013-14 and to ensure that we are fully engaged in and actively recruiting to trials. The most recent information provided to us does include comparisons to other centres nationally ranking 3rd in 2013 and currently in in 4th position. The group are keen to monitor this and not to let our previously excellent performance slip.

Below are the most recent research activity of board members and their publications;


9. Innovation in clinical practice

- Cancer patients in the North West are set to benefit from a revolutionary new treatment that will aim to shorten treatment times, reduce side-effects and improve their chances of beating the disease. It is hoped that **Head and Neck Cancer patients will be amongst those who benefit.** The Christie has been selected to house an MR Linac machine, of which there are just 10 in the world. The state-of-the-art radiotherapy machine uses imaging technology to better and more safely target radiation beams to the site of a tumour. Current radiotherapy is hampered by the fact that cancers move and shrink during treatment, meaning that some radiation doses may not be accurately delivered to the target tumour. The new system, which costs £5 million, will combine a standard linear accelerator machine used for radiotherapy with an MRI scanner, allowing highly detailed images to be taken of a tumour and surrounding tissue during treatment. These images let doctors visualise the cancer in real-time and adapt a patient’s treatment plan, taking shrinkage or movement into account and improving the accuracy and effectiveness of radiotherapy.

- CNS’s for the last 6 months have offered Peer support via a ‘Buddy service’ to pre-op or pre treatment patients. Only a few pre op patients have taken this up but there has been good feedback. Our Laryngectomy patients have had this service for years and this also encourages members to join the support groups that are available.
10. The Pathway Board

a. Formation of the Board

The principle of Manchester Cancer Pathway Boards is that they should be professionally and institutionally representative, yet small and manageable in size. To help Pathway Clinical Directors form institutionally representative Boards the Manchester Cancer central team sought nominations from trusts for their representative(s) on 16 of the 20 Pathway Boards. Nominations were not sought for Children’s, Sarcoma, Palliative Care and Early Diagnosis as alternative arrangements were necessary in these areas.

For each Pathway Board trusts were asked to provide up to three nominations from a range of professions from which the trust representative(s) could be chosen. The team asked that nominations included a brief statement of the individual’s suitability for membership of the relevant Pathway Board.

Nominations were passed to Pathway Clinical Directors who took them into account when forming their Boards. Trusts were informed during this process that Directors would not be obliged to accept all trust nominations but that, if a Pathway Clinical Director wished to appoint a trust representative that had not been nominated by their organisation, then this would be discussed with the Trust Cancer Clinical Lead.

The Head and Neck 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 Head and Neck cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients representatives.

The Head and Neck Cancer Pathway Board reports into and is ultimately governed and held to account by Manchester Cancer Provider Board.
### b. Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Role &amp; Trust</th>
<th>Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gillian Hall</td>
<td>Consultant &amp; Pathway Director <strong>CMFT</strong></td>
<td>Pathology</td>
</tr>
<tr>
<td>Kerenza Graves</td>
<td>CNS, <strong>Bolton FT</strong></td>
<td>CNS and Trust</td>
</tr>
<tr>
<td>Francis Ascott</td>
<td>SLT, <strong>CMFT</strong></td>
<td>SLT and Trust</td>
</tr>
<tr>
<td>Professor Jarrod Homer</td>
<td>Consultant, <strong>CMFT</strong></td>
<td>Research, ENT and Trust</td>
</tr>
<tr>
<td>Philip Bryce</td>
<td>CNS, <strong>CMFT</strong></td>
<td>CNS and Trust</td>
</tr>
<tr>
<td>David Makin</td>
<td>Patient Lead</td>
<td>Patient</td>
</tr>
<tr>
<td>Debbie Elliott</td>
<td>Thyroid CNS, <strong>Christie FT</strong></td>
<td>Thyroid and Trust</td>
</tr>
<tr>
<td>Kate Garcez</td>
<td>Oncologist, <strong>Christie FT</strong></td>
<td>Oncology (clinical / medical and radio-iodine treatment) and Trust</td>
</tr>
<tr>
<td>Suzi Bonington</td>
<td>Consultant Radiologist, <strong>Christie FT</strong></td>
<td>Radiology</td>
</tr>
<tr>
<td>Mr Manu Patel</td>
<td>Consultant Oral Maxillo Facial Surgeon, <strong>ECFT</strong></td>
<td>Maxillofacial surgery</td>
</tr>
<tr>
<td>Mr Andrew Baldwin</td>
<td>Surgeon, <strong>PAT</strong></td>
<td>Maxillofacial Surgery and MDT Lead</td>
</tr>
<tr>
<td>Marie Round</td>
<td>Macmillan Head &amp; Neck CNS, <strong>PAT</strong></td>
<td>CNS and Trust</td>
</tr>
<tr>
<td>Chetan Katre</td>
<td>Consultant, <strong>PAT</strong></td>
<td>Maxillofacial Surgery and Trust</td>
</tr>
<tr>
<td>Kate Hindley</td>
<td>CNS, <strong>SRFT</strong></td>
<td>CNS and Trust</td>
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<td>Helen Doran</td>
<td>Consultant General Surgeon, <strong>SRFT</strong></td>
<td>Thyroid and Trust</td>
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<tr>
<td>Katie Foster</td>
<td>Dietician, <strong>SRFT</strong></td>
<td>Dietetics and Trust</td>
</tr>
<tr>
<td>Miss L. Ramamurthy</td>
<td>Thyroid Surgeon, <strong>Stockport FT</strong></td>
<td>ENT and thyroid and Trust</td>
</tr>
<tr>
<td>Mazhar Iqbal</td>
<td>Maxillo Facial Surgeon, <strong>UHSM</strong></td>
<td>Data, Maxillofacial surgery and Trust</td>
</tr>
<tr>
<td>Miss Susi Penney</td>
<td>Consultant ENT surgeon, <strong>Tameside FT</strong></td>
<td>ENT and Trust</td>
</tr>
<tr>
<td>Cath Cameron</td>
<td>Head and Neck Cancer Nurse Specialist, <strong>WWL</strong></td>
<td>CNS and Trust</td>
</tr>
<tr>
<td>Mr V Pothula</td>
<td>Consultant Head and neck surgeon, <strong>WWL</strong></td>
<td>ENT and thyroid and Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary care and dental primary care vacant</td>
</tr>
</tbody>
</table>
c. Meetings

A meeting took place on the 1 April 2014 at the Christie Hospital with the main focus of addressing the outstanding issues and work program from the former CSSG group.

**Outstanding issues from previous peer review**

- a) data collection
- b) neck lump clinics FNA adequacy check
- c) salivary malignancy
- d) standardised tariff
- e) HPV testing
- f) Thyroid surgery
- g) CNS / dietician / SALT / dentist – adequate staff / cover?
- h) Patient information
- i) Action plans following outcome of national patient survey
- j) primary care referral

Outstanding items of work are to be included in the new work program and are highlighted in blue.

The results of an audit “North West Head and Neck Cancer Regional Audit – Chest Staging in Newly Diagnosed Patients.” By Dr S Bonington was shared at the meeting, the audit across all 3 MDTs showed 70.2% had timely and appropriate chest imaging. These findings are conflicts with the DAHNO data which suggested that 0% of patients had chest imaging highlighting the gaps in recording data on some areas of the patient journey.

There was also a presentation by Ben Lewis, a representative from the Christie IT team who have developed databases for other tumour groups which was generally well received.

A second meeting was held on the 10th of June to scope the work programme activity using patient survey findings and DAHNO data. This influenced the priority of the Head and Neck pathway board as described in the annual plan is to focus on (1) increasing the recording of clinical lines of enquiries to meet the national standard and to ensure that patient access to services is not as the data would suggest (2) achieve 90% score in the national patient survey were identified as areas for improvement (3) targeted engagement with primary care physicians and dental services to support the increase of survival rates by early detections and referral (4) effective engagement and monitoring of clinical trials to support innovation in care.
11. Progress and challenges to date

11.1 Challenges:

**Patient flow**

With 10 diagnostic centre and three surgical sites excluding Thyroid the patient flow is complex with variations in the systems. This level of variation and activity across three sites does have its constraints in relation to data system and functionality including the process for recording of key data items.

**Data systems**

For many years, DAHNO data has shown what appears to be poor performance for Greater Manchester and Cheshire particularly regarding completeness of TNM staging information and clinical lines of enquiry. The data paints a poor picture of the presence of supportive care across ranging disciplines including dieticians, speech and language therapy and dental care and suggests absence of CNS at the time of breaking of bad news. The previous network group always felt that this data did not reflect the true service although gaps had previously been identified (CNS at diagnostic centres Trafford and Stockport, dietician at Christie) and which have since been resolved.

The group strongly feel that until a unified data collection system is in place that tracks all key items of data (as defined by COSD, DAHNO, NWCIS, Trusts for monitoring of pathways etc) in an additive fashion through all stages of the pathway from diagnostic centres, through surgical and non-surgical treatment centres, MDTs and through follow-up clinics, there is little hope of being able to fully collect the minimum dataset and / or collect meaningful outcome data which can be used to monitor our progress against national and international standards. This must be a priority going forward.

At present, independent items collected at time of diagnosis, at the MDTs and in treatment centres are not joined and in many instances are not collected by the same database. Specifically the Central and South MDTs are hosted by the Christie but owned by CMFT and UHSM and the databases used between those sites are not the same.

The 2013-14 chest imaging audit is a good example of how the data does not reflect the true service: DAHNO data suggests 0% of patients have chest imaging pre MDT, our own collected data demonstrates 70% compliance.
Patient care
Ensuring that there is equitable and full access to dental care, speech and language therapy, dietician expertise and psychological support through all stages from diagnosis through treatment to long term follow up.

Early detection and diagnosis
With some Head and Neck Cancer incidents on the up public, patient and primary care education is paramount, this board welcomes guidance and will harness a close working relationship with the prevention, awareness and screening pathway board.

Living with Cancer
Late staging of oral cavity having a significant impact on survival the board has made links with the Living with and Beyond and Palliative Care boards and will be engaged in the mapping of service provision for patients living with cancer.

11.2 Successes:
Since the formation of the Manchester Cancer Head and Neck Pathway Board in April, there has been further successes listed below;

- Formation of the board
- Work plan
- Imaging audit complete and information disseminated
- Salivary gland cancer audit completed
- HPV testing guidelines produced and disseminated to all pathology departments in diagnostic centres
- CNS survey
- Development of 2 WW referral template
- Research clinical trial GAP analysis to redefine current active list of clinical trials
- Delivery of a 1 hour talk to Greater Manchester Dental Team Roadshow (4 July 2014), first step in GDP engagement work early detection and diagnosis.
- Formulation of all key contact list of key worker involved in cancer care to seek opinion and disseminate communication beyond the board representation.

12. Vision and objectives
Outline here the agreed vision of the Pathway Board and introduce its objectives for 2014/15 and beyond. Append the latest version of the Board’s 2014/15 annual plan.

The vision of the pathway board is every patient in Greater Manchester has access to all pre-treatment assessment and diagnostics, quality and timely information on the types of treatments available to them and their side effects, detailed transfer of care and support in the community by 2018.
Appendix 1 – Pathway Board Terms of Reference

Head and Neck Cancer Pathway Board

Terms of Reference

These terms of reference were agreed on 18\textsuperscript{th} June 2014 by Dr Gillian Hall, Pathway Clinical Director for Head and Neck Cancer, and Mr David Shackley, Medical Director of Manchester Cancer, on behalf of Manchester Cancer Services Provider Board. The terms of reference will be subject to future review.

1. The Pathway Board

1.1. The Head and Neck 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.

1.2. 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 Head and Neck cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients representatives.

1.3. The Head and Neck Cancer Pathway Board reports into and is ultimately governed and held to account by Manchester Cancer Provider Board.

2. Manchester Cancer Services Provider Board

2.1. Manchester Cancer 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).

2.2. 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
2.3. The Provider Board regularly invites representatives of commissioners, the Strategic Clinical Network, and Manchester Cancer to its meetings.

3. **Purpose of the Pathway Board**

3.1. The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester Head and Neck 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 Manchester Cancer Provider Board and Greater Manchester’s cancer commissioners.

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

3.3. 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.

4. **Role of the Pathway Board**

The role of the Head and Neck Cancer Pathway Board is to:

4.1. Represent Manchester Cancer professional and patient community for Head and Neck cancer.

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

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

4.4. Design and implement new services for patients where these progress the objectives of commissioners and Manchester Cancer, can be resourced, and have been shown to provide improvements in outcomes that matter to patients.
4.5. Ensure that diagnosis and treatment guidelines are agreed and followed by all teams in provider trusts, and are annually reviewed.

4.6. 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.

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

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

4.9. Escalate any clinical concerns through provider trusts.

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

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


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

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

4.15. 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.

5. Membership principles

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

5.2. Provider trusts not part of Manchester Cancer Services can be represented on the Pathway Board if they have links to the Manchester Head and Neck cancer pathway.

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

5.4. The Board will have at least one patient or carer representative within its membership
5.5. One professional member of the Pathway Board will act as a Patient Advocate, offering support to the patient and carer representative(s).

5.6. 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).

5.7. 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.

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

5.9. 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).

5.10. 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.

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

6. Frequency of meetings

6.1. The Head and Neck Cancer Pathway Board will meet every two months.

7. Quorum

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

8. Communication and engagement

8.1. Accurate representative minutes will be taken at all meetings and these will be circulated and then validated at the next meeting of the Board.
8.2. All minutes, circulated papers and associated data outputs will be archived and stored by the Pathway Clinical Director and relevant Pathway Manager.

8.3. 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

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

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

8.6. 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 Manchester Cancer website once this has been developed.

9. **Administrative support**

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

Overall aim
Achieving world-class outcomes and experience for patients with cancer in Greater Manchester and Cheshire through well led coordinated clinical services, innovation, research and education.

Manchester Cancer

**Services**
- Provider Board
- Independent Chair
- Medical Director
- 20 Pathway Clinical Directors and Pathway Boards
- Trust Leads Board and professional groups
- Associate Director and support team

**Education**
- Independent Chair
- Director

**Research**
- Independent Chair
- Director

Commissioners of cancer services

Strategic Clinical Networks

Manchester Academic Health Science Centre

Greater Manchester Academic Health Science Network
13. Appendix 2 – Pathway Board meeting attendance

Include here a table outlining the attendance at each Board meeting and a summary of each member’s attendance for the whole year.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role &amp; Trust</th>
<th>10th June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gillian Hall</td>
<td>Consultant &amp; Pathway Director</td>
<td>✓</td>
</tr>
<tr>
<td>Kerenza Graves</td>
<td>CNS, Bolton</td>
<td>✓</td>
</tr>
<tr>
<td>Francis Ascott</td>
<td>SLT, CMFT</td>
<td>✓</td>
</tr>
<tr>
<td>Professor Jarrod Homer</td>
<td>Consultant, CMFT</td>
<td>Apologies</td>
</tr>
<tr>
<td>Philip Bryce</td>
<td>CNS, CMFT</td>
<td>✓</td>
</tr>
<tr>
<td>David Bryce</td>
<td>Patient Lead</td>
<td>✓</td>
</tr>
<tr>
<td>Debbie Elliott</td>
<td>Thyroid CNS, Christie FT</td>
<td>✓</td>
</tr>
<tr>
<td>Kate Garcez</td>
<td>Oncologist, Christie FT</td>
<td>Apologies</td>
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<td>Suzi Bonington</td>
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<td>Consultant Oral Maxillo Facial Surgeon, ECFT</td>
<td>✓</td>
</tr>
<tr>
<td>Mr Andrew Baldwin</td>
<td>Surgeon, PAT</td>
<td>Apologies</td>
</tr>
<tr>
<td>Maria Round</td>
<td>Macmillan Head &amp; Neck CNS, PAT</td>
<td>✓</td>
</tr>
<tr>
<td>Chethan Katre</td>
<td>Consultant, PAT</td>
<td>✓</td>
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</tr>
<tr>
<td>Katie Foster</td>
<td>Dietician SRFT</td>
<td>Apologies</td>
</tr>
</tbody>
</table>

14. Appendix 3 – Pathway Board minutes to 31st July 2014

Minutes of the 10th of June will be signed off as accurate at the next pathway board meeting in September.
## Head and Neck Pathway Board Annual Plan 2014-15

**Pathway Clinical Director:** Gillian Hall, Consultant & Pathway Director

**Pathway Board Members:**
- Kerenza Graves, CNS, Bolton
- Francis Ascott SLT, CMFT
- Professor Jarrod Homer, Consultant, CMFT
- Philip Bryce, CNS, CMFT
- David Makin, Patient Lead
- Debbie Elliott, Thyroid CNS, Christie FT
- Kate Garcez, Oncologist, Christie FT
- Suzi Bonington, Consultant Radiologist, Christie FT
- Mr Manu Patel, Consultant Oral Maxillo Facial Surgeon, ECFT
- Mr Andrew Baldwin, Surgeon, PAT
- Maria Round, Macmillan Head & Neck CNS, PAT
- Chethan Katre Consultant, PAT
- Kate Hindley, CNS, CMFT
- Helen Doran, Surgeon, SRFT
- Miss L. Ramamurthy, Thyroid Surgeon, Stockport FT
- Mazhar Iqbal, Maxillo Facial Surgeon, UHSM
- Miss Susi Penney, Consultant ENT Surgeon, Tameside FT
- Cath Cameron, Head and Neck Cancer Nurse Specialist, WWL
- Mr V Pothula, Consultant Head and neck surgeon, WWL
- Katie Foster, Dietician SRFT

**Pathway Manager:** Hodan Noor

**Date agreed by Pathway Board:**

**Date agreed by Medical Director:**

**Review date:**

### Summary of objectives

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Alignment with Provider Board objectives</th>
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<tbody>
<tr>
<td>1</td>
<td>Improve all aspects data recording for Head and Neck patients by 31st March 2016</td>
<td>Improve survival rates and patient experience</td>
</tr>
<tr>
<td>2</td>
<td>Ensure patient is able to fully access all aspects of care pre, during and post treatment and is fully informed by 31st of March 2019</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>3</td>
<td>Improve education for public, patients and referrers to the service 31st March 2019</td>
<td>Improve survival rates and patient experience</td>
</tr>
<tr>
<td>4</td>
<td>Actively engage in Research year on year</td>
<td>Research and innovation</td>
</tr>
</tbody>
</table>
**Objective 1:** Improve all aspects of data recording for Head and Neck patients by 31st March 2016

**Objective:**
- To assess the current practice of data flow in MDTs and identify new models of collection and recording to support Trusts and the Pathway Board, in an attempt to meet national standards and provide evidence of a quality service.
- Identify measures outside of the national requirements to provide more up to date local intelligence to gain additional understanding of the current services.
- To extract data from current systems to assess current stage of disease at presentation and to then collect similar staging data yearly – to allow assessment of impact of educational program with intention that disease is picked up earlier.

**Rationale:**
*What was the Pathway Board’s motivation for choosing this objective? What is the expected impact on the quality and experience of patient care and on the health of the wider population?*

The National Head and Neck Cancer Audit is commissioned and by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), and developed in partnership with the British Association of Head and Neck Oncologists (BAHNO).

The DAHNO and the National Patient Survey findings was discussed at the board meeting in June 2014 which influenced members’ views on the work programme and the way forward, the data below describes the finding of the eight annual report published in 2013.

468 patients were captured during 2012. Of the registered patients only 20% reported some form of pre-treatment contact. 5.4% reported speech and swallowing assessment 10% reported dietetic services 6% reported dental assessments, 0% Reported chest imaging (CXR or CT) prior to MDT 37.5% reported chest imaging (CXR or CT) prior to cancer care plan, 84% T NM staging recorded in 2012.

For many years, DAHNO data has shown what appears to be poor performance for the Greater Manchester and Cheshire particularly regarding completeness of TNM staging information and clinical lines of enquiry. The data paints a poor picture of the presence of supportive care across ranging disciplines including dieticians, speech and language therapy and dental care and suggests absence of CNS at the time of breaking of bad news.

At present, independent items collected at time of diagnosis, at the MDTs and in treatment centres are not joined and in many instances are not
collected by the same database. Specifically the Central and South MDTs are hosted by the Christie but owned by CMFT and UHSM and the databases used between those sites are not the same.

**By (date):** What is the target date for completion?

The assessment and optional appraisals for new models of data collection will be completed by 31<sup>st</sup> of March 2015. The buy-in, implementation and delivery of the suitable option will be undertaken post March 2015.

**Board measure(s):** Which of the Pathway Board’s key measures will show it that the objective has been met?

Optional appraisals produced by the members are the key measure to confirm the objectives has been met.

**Risks to success:** What factors will hinder or prevent the Board’s ability to achieve the objective? How will these risks be mitigated?

No risks identified.

**Support required:** What support does the Board need from Manchester Cancer to deliver its objectives and implement its vision?

The board aims to utilise existing operational support of the Pathway Manager to facilitate the development of the data collection models. Any proposals that require considerable changes to Trust data collection infrastructure will be share with the Provider Board to seek advice.

### Work programme

<table>
<thead>
<tr>
<th>Action</th>
<th>Resp.</th>
<th>By (date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set up virtual sub group</td>
<td></td>
<td>August</td>
</tr>
<tr>
<td>Devise a data review proforma and observe current process Identify key measure above and beyond national requirements</td>
<td></td>
<td>Sept</td>
</tr>
<tr>
<td>Review of 5 randomly selected patients data files per MDT by Pathway Manager</td>
<td></td>
<td>Sept</td>
</tr>
<tr>
<td>Report</td>
<td></td>
<td>Oct</td>
</tr>
<tr>
<td>Solutions and model of approach</td>
<td></td>
<td>Oct</td>
</tr>
<tr>
<td>Present to the pathway board</td>
<td></td>
<td>Nov</td>
</tr>
</tbody>
</table>
**Objective 2**: Ensure patient is able to fully access all aspect of care pre, during and post treatment of Head and Neck.

**Objective:**
- Map current service provision with respect to CNS, dieticians, speech and language and dental care from diagnosis through to follow-up to identify gaps and inequities.
- To assess organisation of the above services, ease of cross referral and flow of information.
- To assess availability, quality of patient information and appropriateness.
- To fully engage with the Living with and Beyond and Palliative Care service mapping to ensure full assessment of Head and Neck delivery of care.

**Rationale:**
*What was the Pathway Board’s motivation for choosing this objective? What is the expected impact on the quality and experience of patient care and on the health of the wider population?*

During the June 2014 board meeting, the national patient survey results were shared, with specific questions to address outliers and low scores. With the finding the board identified a list of interventions to be developed as a project to address the concerning areas.

**Patient information:** Based on the results patient information prior to treatment and side effects score lower in some cases than the national average, however generally the scores are predominantly low. The board aims to achieve over 90% to improve patient experience by analysis and address the information giving quality and process.

**Patient view and care planning:** The board welcome close working relationship with the Palliative Care, Living with and Beyond Cancer pathway boards and will engage in the mapping of service provision which will address the assessment and care planning including the Psychological support findings. The board will take forward any recommendations from the mapping exercise to ensure improvements are made.

Of the registered patients on the **DAHNO audit** only 20% reported some form of pre-treatment contact. 5.4% reported speech and swallowing assessment 10% reported dietetic services 6% reported dental assessment. Processing mapping service provision and identifying variations and good practice will enable the board to identify gaps in service and standardise practice.
**By (date):**

What is the target date for completion? If completion is expected beyond 2014/15 what progress is expected in year? If a phased approach is to be taken indicate this here.

- A gap analysis of service provision prior to treatment report
- A report on service provision post treatment and the level of engagement with the recovery package and palliative care including the last days of life.

**Board measure(s):**

Which of the Pathway Board’s key measures will show it that the objective has been met? What are the performance standards that will be expected?

A gap analysis of service provision and models of new approaches to be completed by 31\(^{st}\) March 2015

The service mapping post treatment will be led by Palliative Care and Living with and Beyond Pathway Board key measure is to fully engage and comply with the timeframe set for completions of information requested.

**Risks to success:**

What factors will hinder or prevent the Board’s ability to achieve the objective? How will these risks be mitigated?

No risks identified

**Support required:**

What support does the Board need from Manchester Cancer to deliver its objectives and implement its vision?

The board aims to utilise existing operational support of the Pathway Manager to facilitate the development of this objective. Any proposals that require considerable changes to Trust infrastructure or require capacity will be share with the Provider Board to seek advice.

## Work programme

<table>
<thead>
<tr>
<th>Action</th>
<th>Resp.</th>
<th>By (date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For a sub group from members and non-members of the pathway board</td>
<td></td>
<td>Sept</td>
</tr>
<tr>
<td>Mapping of service</td>
<td></td>
<td>Sept- January</td>
</tr>
<tr>
<td>Report on gaps and good practice</td>
<td></td>
<td>February</td>
</tr>
<tr>
<td>Proposal for models and new approach</td>
<td></td>
<td>March</td>
</tr>
<tr>
<td>Presentation to the pathway board</td>
<td></td>
<td>March</td>
</tr>
</tbody>
</table>
**Objective 3:** Improve education for public, patients and referrers to the service.

**Objective:** The main driver for improving patient outcome is by improving early detection and diagnosis. This can be achieved by;

- Liaising with the prevention, early detection and screening Pathway Board
- Providing primary care (GP, GDP) education on key tips for early detection yearly.
- Ensure referral guidelines and proformas are up to date, accessible and easy to use.
- Develop visual aids/handbook of early signs to improve confidence and knowledge.

**Rationale:**

*What was the Pathway Board’s motivation for choosing this objective? What is the expected impact on the quality and experience of patient care and on the health of the wider population?*

According to the Cancer Research UK changing Incidence and Mortality Predictions for Oral Cancer (includes oropharyngeal but not laryngeal) has increased from 5 to 9 per 100,000 with the highest increase during 1997 to 2009.

Oral cancer motility rate is predicted to increase by 22.4% by 2030.
3 year survival by stage data from the National Cancer Intelligence Network (NCIN) shows that early diagnosis doubles the survival rate of oral cavity cancer.


Key:
Red line, low T stage and N0 (early stage)
Green line, bulky primary and nodal metastases (high T and N, late stage)
Other lines, intermediate stage at presentation

Providing primary care (GP, GDP) education on key tips for early detection as a yearly programme and linking in with the Manchester Cancer GP education series will begin the on-going journey of raising awareness of early detection.

Review the referral guidelines and pro formas are up to date, accessible and easy to use will also improve the response time and support early diagnosis. Supporting this with interactive visual aids/handbooks will also to improve confidence and knowledge.
By (date): What is the target date for completion? If completion is expected beyond 2014/15 what progress is expected in year? If a phased approach is to be taken indicate this here.

Engaging with the education series has already begun delivery education to Primary Care Dental services and the annual programme will be delivered within this financial year.
The reviewing of referral guidelines will also be completing by 31st March 2015 however, the visual aids/handbook will require some scoping with the support of patients and primary care staff and identify any potential invest in this financial year however the finished products will not be reported until 2016.

Board measure(s): Which of the Pathway Board’s key measures will show it that the objective has been met? What are the performance standards that will be expected?

Below are the key performance indicators to assess the delivery of the board objectives this financial year;

- 3 GP education sessions per year across Greater Manchester and Cheshire areas annually
- 1 Primary Dental practitioner education session annually.
- Proposal for visual aids/handbook
- Reviewed guidelines and promoted the information to primary care services.

Risks to success: What factors will hinder or prevent the Board’s ability to achieve the objective? How will these risks be mitigated?

None identified

Support required: What support does the Board need from Manchester Cancer to deliver its objectives and implement its vision?

The board aims to utilise existing operational support of the Pathway Manager to facilitate the development of this objective. Any proposals that require considerable changes to Trust infrastructure or require capacity will be share with the Provider Board to seek advice.

Work programme

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<thead>
<tr>
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<th>Resp.</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Deliver GP education</td>
<td></td>
<td>Nov/Dec</td>
</tr>
<tr>
<td>Identify needs of GP and GDP</td>
<td></td>
<td>Sept</td>
</tr>
<tr>
<td>Develop visual aids</td>
<td></td>
<td>March</td>
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</table>
Support the findings of the Prevention, early detection and screening pathway board.

**Appendix: Manchester Cancer Provider Board objectives**

The Manchester Cancer Provider Board has identified the themes of its three key objectives. The precise wording of those objectives remains to be confirmed.

1. **1-year SURVIVAL**: Focus on improving 1-year pooled cancer overall survival rate, so that we halve the survival gap with the world’s best (Sweden) for patients diagnosed in 2020, and approach their figures by 2025.

2. **Patient EXPERIENCE**: Achieve year-on-year improvement in patient experience aspiring to be the best performing conurbation in the National Cancer Patient Experience Survey.

3. **RESEARCH and INNOVATION**: Increase patient involvement in research (>40% by 2019) and be an international leader in developing innovation in clinical practice.