

# **Head and Neck Cancer Pathway Board**

## Annual Report 2014/15

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

## Executive summary

The Head and neck board's vision is 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.

- 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.

## Key Achievements

During June 2015 the Director has met with the Head of Primary Care Operations at NHS England who has identified individuals who can support dental representation at the board for future meetings and explore closer working relationship.

There have been 3 dental road shows raising awareness of Head and Neck cancer and the referral methods.

All referral pathways and guidelines have been reviewed and amended by the board.

The board undertook two audits, salivary gland and chest imaging

## Key Challenges

After much deliberation with regards to how data collection can be improved at multi-disciplinary team (MDT), Central Manchester Foundation Trust (CMFT) MDT have taken the decision to relocate their MDT to the CMFT as they can see no other way of improving data flow between the two centres with the proposal to adopt live data collection. This is effective from Jan 2016.

## The future

The educational program to date has been focused on dentists in primary care and it is important that we are given the opportunity to contribute to educational events aimed at GPs. This has already started with online virtual recordings of Head and Neck cancer key symptoms for GPs. Further sessions planned during the coming year to maximise this platform.

We are very pleased to have been awarded two grants from the living with and beyond Cancer project grants to pilot;

- a health and wellbeing clinic at CMFT
- a project looking at stratification of patients undergoing non-surgical treatment to identify those who would benefit from early intervention from the speech and language therapy team

## 1. Introduction – the Pathway Board and its vision

This is the annual report of the Manchester Cancer Head and Neck 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 its scorecard it is the key document for the Board.
- Provide an overview to the hospital trust Chief Executive Officers (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

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.

- 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.

## 1.2. Membership

<b>NAME</b>	<b>ROLE &amp; TRUST</b>
Gillian Hall	Consultant & Pathway Director
Kerenza Graves	CNS , <b>Bolton</b>
Frances Ascott	SLT, <b>CMFT</b>
Professor Jarrod Homer	Consultant, <b>CMFT</b>
Philip Bryce	CNS, <b>CMFT</b>
David Makin	Patient Lead
Debbie Elliott	Thyroid CNS, <b>Christie FT</b>
Kate Garcez	Oncologist, <b>Christie FT</b>
Suzi Bonington	Consultant Radiologist, <b>Christie FT</b>
Mr Manu Patel	Consultant Oral Maxillo Facial Surgeon, <b>ECFT</b>
Mr Andrew Baldwin	Surgeon, <b>PAT</b>
Maria Round	Macmillan Head & Neck CNS, <b>PAT</b>
Chetan Katre	Consultant, <b>PAT</b>
Kate Hindley	CNS, <b>CMFT</b>
Helen Doran	Surgeon, <b>SRFT</b>
Miss L. Ramamurthy	Thyroid Surgeon, <b>Stockport FT</b>
Mazhar Iqbal	Maxillo Facial Surgeon, <b>UHSM</b>
Miss Susi Penney	Consultant ENT surgeon, <b>Tameside FT</b>
Cath Cameron	Head and Neck Cancer Nurse Specialist, <b>WWL</b>
Mr V Pothula	Consultant Head and neck surgeon, <b>WWL</b>
Katie Foster	Dietician <b>SRFT</b>
Kathleen Mias	Nurse Clinician Head and Neck Oncology <b>Christie</b>
Jonathan Hobson	<b>UHSM</b>

Please refer to appendix 1 for board member attendance register.

The board have discussed the lack of attendance by members, the group have agreed to ensure medical representation from each MDT must attend future meetings, further discussion are underway to explore the barriers for non-attendance from existing members.

The Board has named leads for the following key areas:

<b>Area</b>	<b>Lead name and role</b>
Palliative Care	Shared by CNS members
Early diagnosis and education	Miss L. Ramamurthy, Thyroid Surgeon, <b>Stockport FT</b>
Pathology	Gillian Hall, Consultant & Pathway Director
Radiology	Suzi Bonington, Consultant Radiologist, <b>Christie FT</b>
Surgery	Susi Penney
Oncology	Kate Garcez, Oncologist, <b>Christie FT</b>
Specialist nursing	Shared by CNS's members
Living with and beyond cancer ('survivorship')	Philip Bryce , CNS
Research	Professor Jarrod Homer, Consultant, <b>CMFT</b>
Data collection (clinical outcomes/experience and research input).	Mazhar Iqbal, Maxillo Facial Surgeon, <b>UHSM</b>
Patient representative	Mr David Makin

The board has primary care (GP and General Dental Practitioners) and dietician gap in membership. During June 2015 the Director has met with the Head of Primary Care Operations at NHS England who has identified individuals who can support dental representation at the board for future meetings.

Manchester Cancer has been working with Macmillan Cancer Support to develop its approach to the involvement of people affected by cancer in its work and have funded four user involvement manager (Band 6) post and a user involvement lead at 8a. The team are due to start during May and August of this year.

They will make sure that all pathway boards and groups have at least two people affected by cancer among their membership and that all people affected by cancer have the appropriate induction, support and training to play a full part.

The managers will also support their boards to undertake important work to improve patient experience, such as developing regional patient experience surveys, developing the use of patient-reported outcome measures and standardising patient information across the region.

### **1.3. Meetings**

The Head and neck board have met on five occasions during the period of June 2014 and March 2015 below are the listed dates and the link for a copy of the minutes on the website.

10<sup>th</sup> June 2014 <http://manchestercancer.org/wp-content/uploads/2014/09/Head-and-Neck-Pathway-Board-meeting-10th-June-2014-minutes.pdf>

3<sup>rd</sup> September 2014 <http://manchestercancer.org/wp-content/uploads/2014/09/Head-and-Neck-Pathway-Board-Meeting-Minutes.pdf>

6<sup>th</sup> November 2014 <http://manchestercancer.org/wp-content/uploads/2014/09/Head-and-Neck-Pathway-Board-Meeting-Minutes1.pdf>

13<sup>th</sup> January 2015 <http://manchestercancer.org/wp-content/uploads/2014/09/Head-and-Neck-Pathway-Board-Meeting-Minutes2.pdf>

23<sup>rd</sup> March 2015 <http://manchestercancer.org/wp-content/uploads/2014/09/Head-Neck-Pathway-Board-Meeting-Minutes.pdf>

## 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	Improve all aspects of data recording for Head and Neck patients by 31 <sup>st</sup> March 2016	Improving outcomes, with a focus on survival	To assess the current practice of data flow in MDTs		Red
			Identify measures outside of the national requirements and collect data		Amber
			To extract data from current systems to assess current stage of disease at presentation		Red
2	Ensure patient is able to fully access all aspect of care pre, during and post treatment of Head and Neck.	Improve patient experience	Map current service provision with respect to CNS, dieticians, speech and language and dental care		Green
			To assess organisation and, ease of cross referral and flow of information.		Amber
			To assess availability, quality of patient information and appropriateness		Amber
			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.		Green
3	Improve education for public, patients and referrers to the service.	Improving outcomes with a focus on survival	Liaising with the prevention, early detection and screening Pathway Board		Amber
			Providing primary care (GP, GDP) education on key tips for early detection yearly.		Green
			Ensure referral guidelines and proformas are up to date, accessible and easy to use		Green

### 3. Improving outcomes, with a focus on survival

#### 3.1. Information

##### 3.1.1. Prevalence

	All cancers C00-C97 ( excl C44)	Oral cavity C00-C06	Base of tongue C01	Tonsil C09	Oropharyn x C10
<b>Greater Manchester*</b>	<b>99,303</b>	<b>1,333</b>	<b>215</b>	<b>470</b>	<b>97</b>
NHS Bolton	8,371	105	17	48	5
NHS Bury	6,154	93	13	38	<5
NHS Central Manchester	3,511	73	<5	16	8
NHS Eastern Cheshire Heywood, Middleton & Rochdale	7,924	79	17	27	<5
NHS North Manchester	6,304	97	21	23	6
NHS Oldham	3,685	76	11	21	8
NHS Salford	6,621	93	18	45	8
NHS South Cheshire	6,938	98	16	34	6
NHS South Manchester	6,019	70	11	27	6
NHS Stockport	4,024	71	5	14	5
NHS Tameside and Glossop	10,459	125	23	40	6
NHS Trafford	8,105	112	16	43	16
NHS Vale Royal	7,784	101	11	35	8
NHS Wigan Borough	3,477	21	10	18	<5
	9,927	119	23	41	8

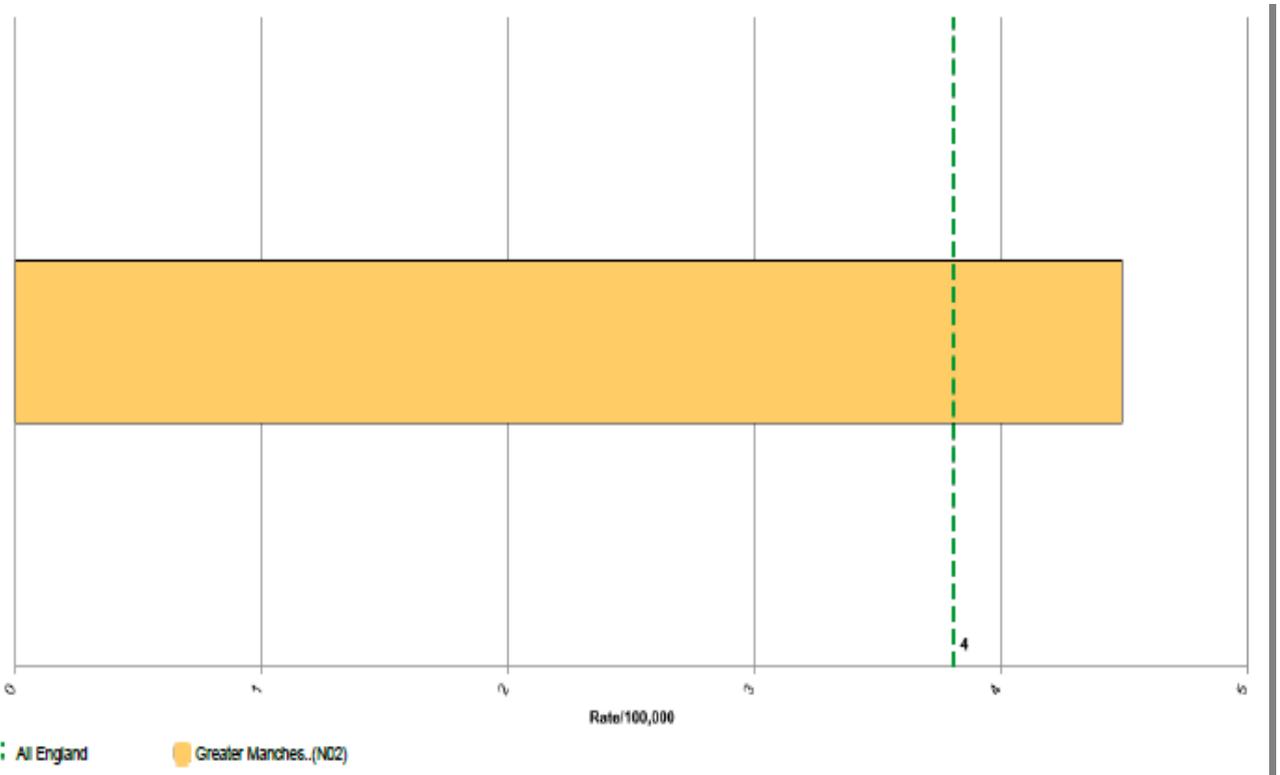
**Table 1: Prevalence of cancer on 31 December 2012 within Greater Manchester\* (incl East Cheshire, South Cheshire and Vale Royal CCGs ) and its constituent CCGs Knowledge and Intelligence Team (North West)**

##### 3.1.2. Survival

Cancer site	One-year survival (2009-2011)	Five-year survival (2005-2007)
	Relative survival (%)	Relative survival (%)
Oral cavity	81.5	58.6
Oropharynx	66.3	42.2
Tonsil	92.8	66.6

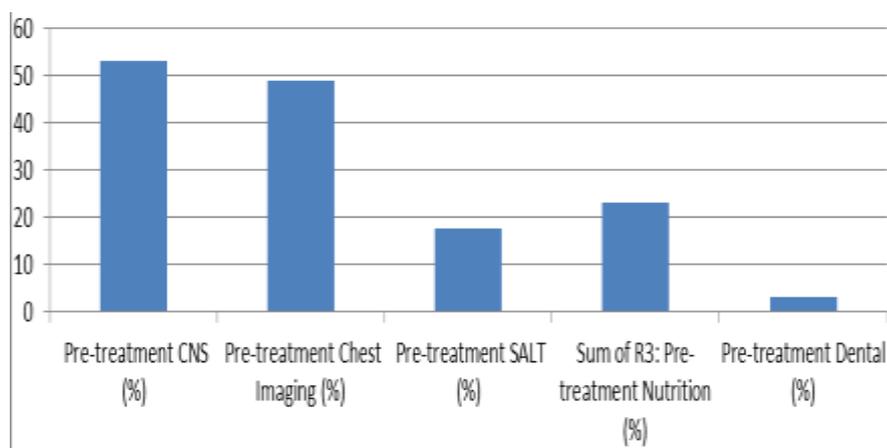
**Table 2: One and five-year relative survival rate (%)for East Cheshire, South Cheshire, Vale Royal and Greater Manchester CCGs, for all ages, Knowledge and Intelligence Team (North West)**

3.1.3. Mortality



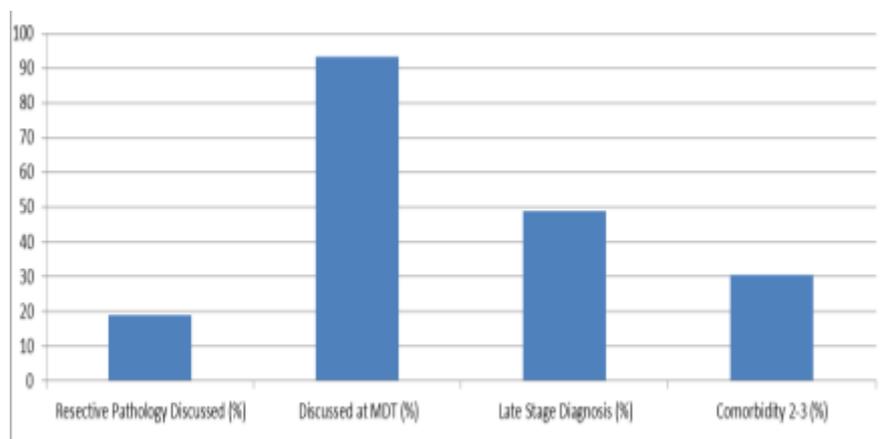
**Table 3: 5 year rolling age-standardised mortality: All age group(s) : 2007-2011 : Head and neck**  
 Data extracted from Cancer Commissioning Toolkit

**3.1.4. National Head and Neck Cancer Audit (DAHNO)**



**Table 4: DAHNO 2013 audit pre-treatment care, the Health and Social Care Information Centre report.**

Values	Greater Manchester & Cheshire	Grand Total
Pre-treatment CNS (%)	53.2	53.2
Pre-treatment Chest Imaging (%)	49.1	49.1
Pre-treatment SALT (%)	17.6	17.6
Sum of R3: Pre-treatment Nutrition (%)	23.3	23.3
Pre-treatment Dental (%)	3.1	3.1



**Table 5: DAHNO 2013 audit MDT discussion, late stage diagnosis and comorbidity data, the Health and Social Care Information Centre report.**

Values	Greater Manchester & Cheshire	Grand Total
Resective Pathology Discussed (%)	18.9	18.9
Discussed at MDT (%)	93.3	93.3
Late Stage Diagnosis (%)	49	49
Comorbidity 2-3 (%)	30.5	30.5

### 3.1.5. Cancer outcomes and services data set (COSD)

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
<b>All diagnosed cancers discussed at MDT</b>												
Diagnosed	113	76	62	98	83	92	68	77	68	83	46	45
Diagnosed with a Treatment Record Submitted	42	46	46	70	48	45	47	48	40	55	39	32
Diagnosed where the First Treatment was Surgery	28	30	28	40	33	27	32	34	27	36	22	17
With a Basis of Diagnosis	66	76	58	88	54	56	55	57	46	70	44	42
With a Histological Basis of Diagnosis	65	67	57	81	54	55	53	55	45	63	43	41
With a CNS indication Code Submitted	20	14	15	24	10	12	16	14	7	18	10	3
Diagnosed who had a CNS Contact	20	14	14	19	9	11	16	14	6	17	10	3
Diagnosed where Age at Diagnosis is under 25	2	0	1	0	1	0	0	0	0	4	0	0
Which are Stageable	113	76	62	98	83	92	68	77	68	83	46	45
Which are Stageable and have a Full Stage at Diagnosis	56	64	43	56	36	55	39	39	38	45	26	20
Discussed at an MDT	103	69	52	79	73	80	51	65	59	67	35	32
Discussed at an MDT with a Performance Status	51	30	32	38	35	41	27	41	34	43	23	22
Discussed at an MDT which are Stageable Cancers	103	69	52	79	73	80	51	65	59	67	35	32
<b>All stageable cancers discussed at MDT</b>												
With a First Treatment of Surgery	24	28	25	32	27	24	23	30	24	28	19	15
With a Full Stage	51	61	41	49	35	52	33	39	36	42	22	17
With a Full Stage and have a Performance Status	30	29	30	33	23	37	22	27	28	29	16	11
With a Full Stage and have a TNM Version supplied	44	61	41	48	32	42	32	37	31	39	21	17
<b>MDT staging</b>												
With a Full Stage Section	51	61	41	49	35	52	33	39	36	42	22	17
With a Partial Stage Section	17	2	6	11	13	7	9	10	5	6	3	3
With a Full Pre-Treatment Stage	49	56	38	44	32	50	29	35	31	42	19	16
With a Partial Pre-Treatment Stage	17	2	6	10	12	7	9	9	5	5	3	2
With a Full Integrated Stage where the First Treatment was Surgery	12	17	18	21	13	15	14	19	20	12	9	3
With Partial Integrated Stage where the First Treatment was Surgery	0	0	0	1	2	0	0	1	0	1	1	1
With a Site Specific Stage	0	0	0	0	0	0	0	0	0	0	0	0

**Table 6: COSD data National Cancer registry service Jan 2014 to December 2014, National Cancer Intelligence Network**

### 3.2. Progress

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.

#### 3.2.1 Data collection

Pennine MDT reported that in response to years of poor data collection, that there had been a change in practice and that now, data was recorded live using Somerset Cancer Register (SCR) during the MDT.

As DAHNO reports are published with a 1-2 year lag period, it will take some time to allow this to show as an improvement.

Pennine MDT is also unique amongst the 3, in that the referring surgeons from the diagnostic centres are in attendance and able to fill in additional information.

The pathway director and manager have visited the University Hospitals of South Manchester (UHSM) and CMFT MDTs hosted by the Christie and looked at data collection for a number of new patients and post surgical patients listed for discussion of post-op pathology.

We extracted the relevant data items which should have been recorded as per minimum dataset requirements and then reviewed the information which was electronically sent back to the Trusts (CMFT and UHSM) from the Christie co-ordinator.

It appeared that whilst all relevant information was discussed, there was transfer of almost none of this back to data collection teams in cancer services.

CMFT MDT have taken the decision to relocate their MDT to the CMFT as can see no other way of improving data flow between the two centres with the proposal to adopt live data collection. This is effective from Jan 2016.

A suggested way of demonstrating a much better service than the DAHNO data suggests we have, was to collect additional data items

A few suggestions from a pathway board meeting were

- Breakdown of Classification of Malignant Tumours (TNM) staging per MDT and no of cases where this was available
- Length of stay
- Cancelled operations, major head and neck cancer resections (suggested by some to be an issue)
- Mortality

Mortality data is published nationally please refer to the link bellows;

<http://www.nhs.uk/choiceintheNHS/Yourchoices/consultantchoice/Documents/Head%20and%20Neck%20Cancer%20Surgeon%20Report.pdf>

And data reported for all 3 surgical centres suggests no issues compared to peers. This data however highlights lack of complete data collection, particularly for the CMFT team, where the number of procedures reported seems extremely low.

Unfortunately for our other requested data collection items, no obvious way of identifying, locating or collecting this data was identified.

The methods of collecting full complete data across all aspects of the patient journey therefore remains a priority and should be considered high on a list of needs for this group. The group would welcome the opportunity to trial the Clinical Web Portal (CWP) system, or any others in development.

### 3.2.2 Education and interactions with referrers (primary care)

The head and neck group await outcomes of ongoing discussions relating to provision of GP educational events, which we would welcome the opportunity to present at.

There have been 3 dental events

July 2014 “Dental Roadshow” – GH presented, introducing Manchester Cancer, talking about the importance of early diagnosis and at this event, and asked the GPs what their educational needs were. It became clear that there were some uncertainties and confusion around the process of referring patients with suspected cancer onto secondary care and also identification of learning needs in relation to signs of early cancers.

As a result, we have developed a tick box referral proforma, to be housed on the Manchester Cancer website. We have identified means of communication the location of this via a newsletter which targets all practices. Alongside this, up to date referral contact details are provided for all diagnostic centres as well as names of the designated clinicians to whom cancer referrals should be directed.

November 2014 “Oral Cancer Study Day”, all day event, 300 delegates, with emphasis on early diagnosis, referral process, rehabilitation. Next event booked for Feb 2016.

In June 2014 “Oral Cancer Awareness” – local educational evening for Stockport GPs, including for the first time, information around the presenting signs of ENT cancers as well as oral cavity cancer.

In addition, to acknowledge the difficulties in ensuring attendance of all GPs and team members at events, two of our surgeons have prepared and recorded short educational presentations which are available on our website.

The focus of these is on early diagnosis, top tips and what not to miss. Again, we intend to publicise these to the dental community via a newsletter article which will be distributed to all practices. However, we have now identified a method of communicating with all dental practices through National Health Service England (NHSE).

### 3.3. Challenges

Data collection remains a huge issue and we have serious concerns about the completeness and accuracy of data which is presented to us. It is apparent that the method of data collection historically at all MDTs made it impossible to provide a complete dataset for each patient.

Improvements at Pennine will almost certainly improve the DAHNO feedback, as will a change in location of the CMFT MDT.

It will however take at least 1-2 years to see if these changes result in improved data and because the data from all 3 MDTs is lumped together, it will remain difficult to identify differences. Without meaningful data, it is impossible to assess our performance and identify where improvements can be made.

The group would welcome a clinician friendly single data collection tool, usable in all centres from diagnostic centres, surgical centres and non surgical treatment centres, the MDT and then in the place of follow up to allow a complete data set for all patients. The ability to extract outcome data is necessary to identify any variations or outliers and to act on these. .

The educational program to date has been focused on dentists in primary care and it is important that we are given the opportunity to contribute to educational events aimed at GPs.

We aim to expand our educational programme for public, patients and referrers 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.

## 4. Improving patient experience

### 4.1. Information

One of the four core objectives for Manchester Cancer is patient experience and the measurement for success is based on the National Cancer Patient Experience Survey (NCPES).

During the June 2014 board meeting, the national patient survey results published in 2013 were shared, with specific questions to address outliers and low scores. With the findings 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 follows:

**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.

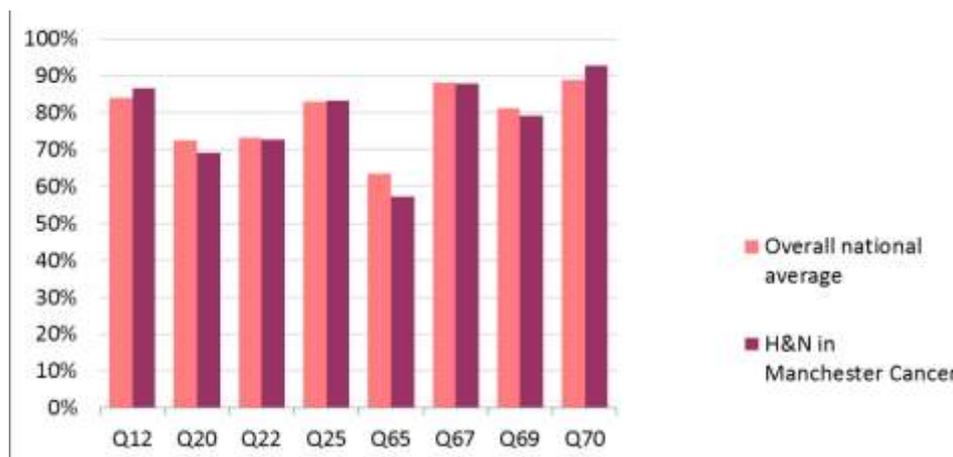
### 4.2. Progress

#### 4.2.1 Patient experience survey

During November 2014 pathway meeting the board review the progress and results of the National Cancer Patient Survey 2014 against Manchester Cancer core questions.

During September a group of stakeholders involved in the delivery and usage of cancer services attended a meeting, to discuss the core priority questions in the NCPES which can be used as indicator of success in the overall delivery of cancer improvements.

Core questions identified were presented at the provider board meeting in October; these questions will be used as indicators to focus improvement efforts in the future for all pathway boards.



**Chart 1: Head and Neck survey benchmarked against Manchester Cancer core questions National Cancer Patient Survey 2014**

Title	Overall national average	H&N in Manchester Cancer
Q12 Patient felt they were told sensitively that they had cancer	84.0%	86.6%
Q20 Patient definitely involved in decisions about care and treatment	72.4%	69.0%
Q22 Patient finds it easy to contact their CNS	73.4%	72.7%
Q25 Hospital staff gave information about support groups	83.1%	83.3%
Q65 Hospital and community staff always worked well together	63.5%	57.3%
Q67 Given the right amount of information about condition and treatment	88.2%	87.8%
Q69 Patient did not feel that they were treated as a 'set of cancer symptoms'	81.3%	79.3%
Q70 Patient's rating of care 'excellent'/'very good'	89.0%	92.7%

A total of 137 patients completed the NCPES for Head and Neck pathway, Christie n=57 and Pennine n=28 are the only findings reported due to the low numbers from the remaining Trusts.

Benchmarking against the overall core questions the Head and Neck findings identifies communication and sign posting are key areas for improvement.

The boards also reviewed areas of concerns to against NCPES findings in its entirety to identify the mitigating circumstances and recommendations to improve. As a result the board engage with Living with and beyond pathway board and have been successful I securing two bids (1) risk stratification for chemo and radiotherapy patients (2) health and wellbeing clinic pilot at CMFT.

Both the above projects are scheduled to begin in April 2015 for a period of one year, the board anticipate the findings of the projects will support in identify patient experience improvement opportunities.

The board seek support from Manchester Cancer User Involvement team to review patient information across the pathway and the method this information is delivered (test results, treatment options, effects of operations and procedures short and long-term).

#### **4.2.2. Mapping of Cancer Nurse Specialist (CNS), dietician, Speech and Language Therapist ( SLT), dental support**

An initial meeting was well attended, the pathway discussed and many areas identified in which there is variation of practice across the region. Whilst many services worked well, and most had adequate and appropriate personnel, it became apparent that the links and communication between these services were not always ideal and that many services rely on single practitioners, with no cross cover for periods of leave.

Further meetings arranged were so poorly attended that no further progress could be made. The pathway director has sent out an email to all those involved with some summaries of the main issues and suggestions of possible solutions and improvements, again with no response.

CNSs have been tasked with identifying 2-3 areas for further consideration or projects as part of next years work plan.

Adoption of national cancer survivorship initiative i.e discharge and treatment summaries, holistic needs assessment, health and well being clinics, recovery packages etc seem like they might help in ensuring that a complete and joined up post treatment support package is available for every patient.

We are very pleased to have been awarded two grants from the living with and beyond cancer project grants to pilot

- a health and well being clinic at CMFT
- a project looking at stratification of patients undergoing non surgical treatment to identify those who would benefit from early intervention from the speech and language therapy team

In terms of post cancer treatment dental support, pathway director visited a team based in Bolton and identified an area of good practice whereby the CNS has direct links with the Oral Health Promotion team who then link into Community dentistry and general dental practices to ensure that all patients have access, advice and support.

The director produced a summary document, with the suggestion that we looked at whether this arrangement existed elsewhere and if not, how could it be implemented.

The post treatment support package as highlighted as the part of the pathway requiring some improvement at a pathway mapping meeting held in Stockport in March 2015, at which many patient representatives were present.

#### **4.2.3. Clinical Guidelines**

We have reviewed and updated all our guidelines and referral protocols which the board are satisfied with, awaiting the findings of individual trust self-assessments to identify the support needed.

There is an opportunity to explore more user friendly method of accessing and using these guidelines i.e. digital or hand book example London Cancer Alliance Head and Neck Guidelines. All documents can be found following the link below on Manchester Cancer website <http://manchestercancer.org/services/head-and-neck/>

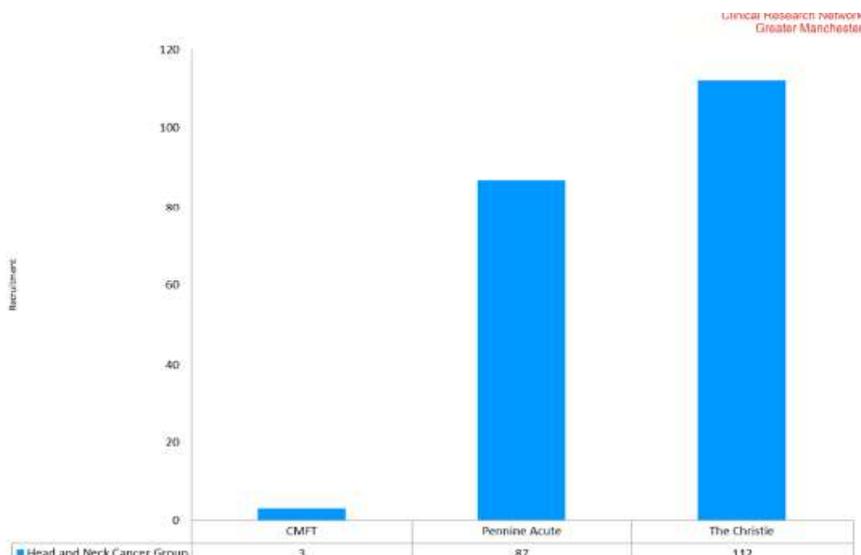
#### **4.3. Challenges**

In terms of mapping of support services for head and neck cancer patients post treatment, the relevant members of the team need to agree some areas to investigate and work on in more depth and they need to be allowed time from their busy schedules to meet to achieve this. Getting members of this team together has proved almost impossible in 2015.

## 5. Increasing research and innovative practice

### 5.1. Information

Comparisons to other centres nationally ranking 3<sup>rd</sup> in 2013 and in 4<sup>th</sup> position 2014 however in 2015 Manchester Cancer is 5<sup>th</sup> Ranking with only 202 patient recruited in clinical trials.



**Chart 2: Head and Neck Clinical Trials by Trust – Cancer Research Network Greater Manchester report May 2015**

Study Design	Acronym	CMFT	Pennine Acute	The Christie	Grand Total
Interventional	A Phase Ib trial of MVAEBNA1/LMP2 vaccine in nasopharyngeal carcinoma			2	2
Interventional	IoN			6	6
Interventional	NCRN - 3173 CheckMate 141: CHECKpoint pathway and nivolumAb clinical Trial Evaluation 141			2	2
Interventional	NCRN583 BKM120 + paclitaxel vs. paclitaxel + placebo			1	1
Interventional	NIMRAD (NIMorazole/placebo plus RADiotherapy in head and neck cancer)			12	12
Interventional	SEND		1		1
Interventional	Trismus RfPB trial			15	15
<b>Interventional Total</b>			<b>1</b>	<b>38</b>	<b>39</b>
Observational	Head and Neck Cancer: molecular, cellular and immunological mechanisms		16		16
Observational	HeadandNeck5000	3	70	74	147
<b>Observational Total</b>		<b>3</b>	<b>86</b>	<b>74</b>	<b>163</b>
<b>Grand Total</b>		<b>3</b>	<b>87</b>	<b>112</b>	<b>202</b>

**Table 7: Breakdown of types of trials recruited to by Trusts – Cancer Research Network Greater Manchester report May 2015**

### 5.2. Progress

Data suggest that performance of recruitment to clinical trials is slipping. The Manchester network has for many years held a top 3 position nationally and we now sit mid table.

Unfortunately, there have been no opportunities to discuss research activity and performance over several pathway board meetings.

This needs to be addressed and discussed in detail at the next available pathway board meeting, and an action plan developed to try to find a way to improve this.

## 6. Delivering compliant and high quality services

### 6.1. Clinical Audits

#### 6.1.2 Salivary Gland Audit

This was undertaken as a response to repeated peer review concerns that we do not have a single centre for salivary gland cancers for the network. Presently all 3 surgical centres treat salivary gland malignancies.

Surgeons think that achieving this is difficult because;

- many low grade malignancies are only retrospectively diagnosed and the excisional biopsy undertaken is both diagnostic and therapeutic
- many are pT1 staged tumours are require simple surgery. Peer review guidance elsewhere states that pT1 tumours do not necessarily have to be treated even in designate surgical centres,
- the surgical treatment of minor salivary gland lesions is identical to that of commoner SCCs, which all centres treat and that of the major gland disease is within the capability of surgeons at all of the centres.

#### a) Central Manchester Foundation Trust

14 cases of salivary gland malignancy, only 3 of which were thought to be malignant ahead of biopsy / removal one a recurrence of a low grade tumour from 2005.

Of these,

- One was a sinonasal tumour, adenoid cystic carcinoma with some areas of de-differentiation which was debulked and then planned for post op non surgical treatment.
- The second, a recurrent PLGA was re-resected, was low volume disease (pT1) and margins were close and observational follow up planned.
- The third case was a high grade malignant adenocarcinoma on pre-op FNA and the patient underwent radical resection and neck dissection by one of the cancer surgeons.

Of the remaining 11,

- 2 had re –excision of the scar after surgery to remove a presumed benign lesion and had either no residual disease or low volume residual disease, all excised and pT1 staged (both mucoepidermoid, low and intermediate grade)
- 5 had no further treatment as the initial surgery was deemed adequate or for other reasons (very elderly, not fit) including PLGA (1), adenoid cystic (1), basal cell

adenocarcinoma (1), low grade mucoepidermoid (1) and low grade adenocarcinoma NOS (1)

- 3 went on to have planned radical surgery carried out by designated cancer surgeons, adenoid cystic carcinoma (2) and carcinoma ex PA (1)
- 1 had non surgical post op treatment, salivary duct carcinoma thought to be PA (multifocal disease in gland)

## **b) Pennine**

9 cases of salivary gland malignancy, 5 referred as urgent suspected cancer, and thought to be either primary salivary, lymphoma or nasopharyngeal.

The final diagnoses on these was salivary duct carcinoma (2), adenoid cystic carcinoma (2), high grade mucoepidermoid (1), i.e. all high grade tumours.

4 unsuspected cancers; One thought to be mucocele and diagnosed as PLGA, one traumatic neuroma in the neck diagnosed as basal cell adenocarcinoma, a further PLGA of palate sent as ? pleomorphic adenoma and the final, thought to be sialadenitis with calculus and was a high grade salivary duct adenocarcinoma. Hence  $\frac{3}{4}$  of the unsuspected cancers were low grade tumours.

## **c) UHSM**

Three malignancies documented, two of which appear to be known or suspected malignant at the time of MDT discussion.

One a superficial parotid elsewhere, initially diagnosed as mucoepidermoid and then on review re designated as acinic cell carcinoma. Subtotal parotidectomy revealed some residual disease.

A second was also acinic cell carcinoma diagnosed on superficial parotidectomy and appears to be 1 stage treatment.

The third was pre-operatively diagnosed as malignancy (uncertain how) and underwent resection for adenocarcinoma NOS.

## **Conclusion**

In total, of 26 cases treatment from around the network from April 2012-13, 10/26 (38%) were suspected cancers.

The information highlights;

- A large number of salivary gland malignancies are unsuspected pre-operatively and that a high proportion of them are adequately treated by the initial excision biopsy or by a relatively simple re-excision procedure. These would largely be low grade tumours and pT1 staged disease. Peer review guidelines state that pT1 tumours do not need to be treated in designated hospitals if treated by simple excision biopsy.

- The unsuspected malignancies are usually the lower grade tumours and usually treated by conservative excision / partial parotidectomy with often, the diagnostic lumpectomy procedure being adequate for treatment.
- This information makes it extremely difficult to designate one of the 3 centres as the centre for salivary gland malignancy
- All 3 centres can demonstrate high volume resection workloads for mucosal cancers and neck dissections and feel that the actual differences in the surgery for salivary gland cancer are minimal
- Parotid cancers with skull base involvement would automatically be discussed and treated by the CMFT / skull base MDT and team.

The 3 UAT MDTs and surgical teams feel that all 3 centres are equipped to diagnose, treat and monitor patients with salivary gland cancers.

I will suggest an agreement for unusual cases or cases where there is non consensus as to appropriate treatment at the initial MDT, that the opinion of one or both of the other UAT MDTs within the network is sought.

### **6.1.3 Chest imaging audit**

The objective of the audit was to identify appropriate chest staging with a standard of 100% patients referred to the Head and Neck MDT should have a pre-MDT CT chest.

Method:

Multicentre retrospective audit

- Christie Regional Head and Neck MDTs
- Central and South Manchester regions
- Pennine Acute Trust Head and Neck MDT
- North Manchester, Bury, Oldham and Rochdale

Period of study

- 31 July 2012 and December 2012

Inclusion criteria

- nasopharynx, oropharynx, hypopharynx, larynx and oral cavity

Exclusions

- unknown primary or a primary site other than above

Data analysis

- Multicentre combined cohort to reflect regional practice.

Findings

Patients identified = 153, 2 patients excluded

Combined audit cohort = 151 patients. Of which 93 from Christie MDTs and 58 from Pennine MDT

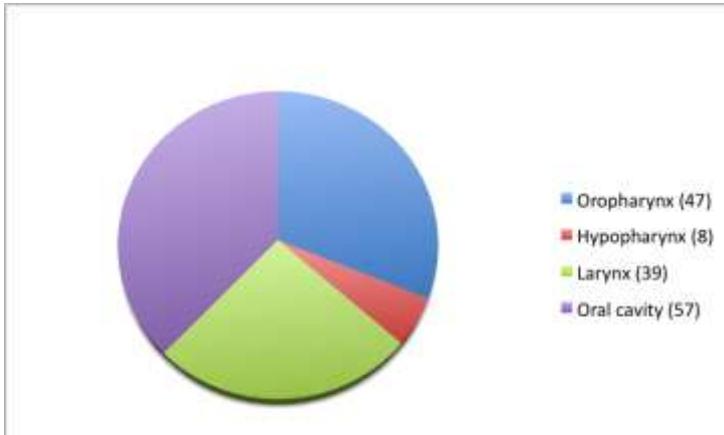


Chart 3: Distribution of pathology

STAGING MODALITY	NUMBER (%)
Pre MDT MR neck and CT thorax	52 (34.4)
Pre MDT CT neck and thorax	54 (35.8)
Pre MDT MRI neck and chest radiograph	22 (14.6)
Post MDT chest radiograph or CT	7 radiographs 10 CTs (11.3)
No imaging	6 (4.0)

Table 8: Modality used for staging

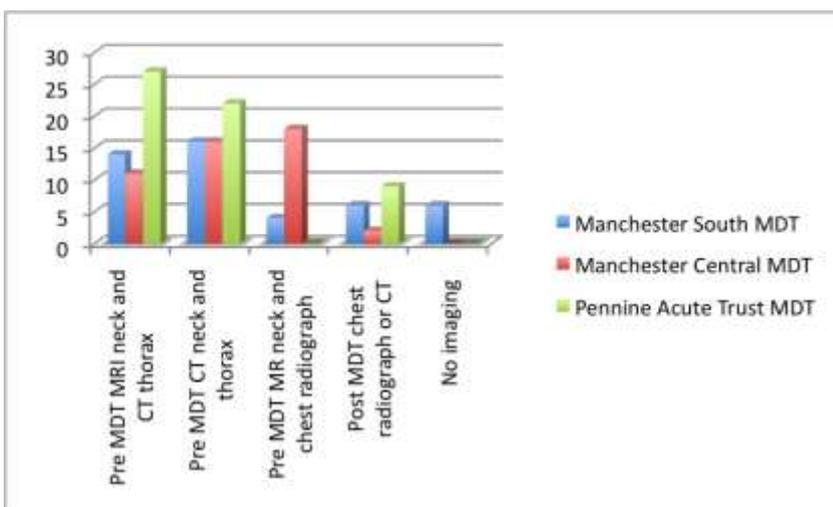


Chart 4: Results by MDT

Cross-sectional imaging is essential for optimal staging, omission of chest staging is unacceptable the target of 100% not achieved only 70.2% had appropriate and timely chest imaging.

**Recommendations:**

- Dissemination of results to individual trusts and clinical sub groups.
- Re-educate referrers about the Regional Imaging guidelines.
- Close the audit loop in one year.

**6.2. Challenges**

Further discussion whether the current 3 MDT and 3 surgical centres is the right model for patient care. Whilst compliant under the national requirements, the head and neck sites consist of relatively small teams and are vulnerable with regards to succession planning and business continuity.

## 7. Objectives for 2015/16

Members identified the future improvement of patient experience and outcome is based on ensuring better pre-treatment care coordination and after care post anti-cancer therapies. There is a real focus in ensuring better recovery and survivorship agenda including the implementation of the recovery package. Below is an over view of the objectives agreed.

### **Patient Experience :**

Audit on patient information regarding treatment, late effects following NCPES findings)

Palliative Care: Head and Neck pathway has understanding of the following;

Where to access pain and symptom control guidelines

Referral guidelines to specialist palliative care teams

Awareness of local palliative care teams

### **Outcome & survival:**

Engage with Manchester Cancer to be part of the CWP project

End of Treatment summaries for patient curative intent

Engage with LW&BC identify all H&N late effects post treatment

Engage with LW&BC late effect patient experience audit

### **Research and Innovation:**

Outcomes and report of two funded Innovation project

## 8. Appendix 1 – 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.

NAME	ROLE & TRUST	10th June	3rd Sept	6th Nov	13th Jan	23rd Mar
Gillian Hall	Consultant & Pathway Director	✓	✓	✓	✓	✓
Kerenza Graves	CNS , <b>Bolton</b>	✗	apologies	✓	Apologies	Apologies
Frances Ascott	SLT, <b>CMFT</b>	✓	✓	Apologies	✓	Apologies
Professor Jarrod Homer	Consultant, <b>CMFT</b>	Apologies	apologies	Apologies	✓	Apologies
Philip Bryce	CNS, <b>CMFT</b>	✓	apologies	Apologies	✓	Apologies
David Makin	Patient Lead	✗	apologies	Apologies	✓	Apologies
Debbie Elliott	Thyroid CNS, <b>Christie FT</b>	✓	apologies	✓	Apologies	Apologies
Kate Garcez	Oncologist, <b>Christie FT</b>	Apologies	apologies	✓	Apologies	✓
Suzi Bonington	Consultant Radiologist, <b>Christie FT</b>	Apologies	✓	✓	Apologies	Apologies
Mr Manu Patel	Consultant Oral Maxillo Facial Surgeon, <b>ECFT</b>	✓	apologies	Apologies	Apologies	Apologies
Mr Andrew Baldwin	Surgeon, <b>PAT</b>	apologies	✓	✓	Apologies	Apologies
Maria Round	Macmillan Head & Neck CNS, <b>PAT</b>	✓	✓	Apologies	✓	✓
Chetan Katre	Consultant, <b>PAT</b>	✓	✓	Apologies	✓	Apologies
Kate Hindley	CNS, <b>CMFT</b>	✓		✓	✓	✓
Helen Doran	Surgeon, <b>SRFT</b>	✓	✓	Apologies	Apologies	Apologies
Miss L. Ramamurthy	Thyroid Surgeon, <b>Stockport FT</b>	Apologies	✓	✓	✓	✓
Mazhar Iqbal	Maxillo Facial Surgeon, <b>UHSM</b>	✗	✓	✓	✓	✓
Miss Susi Penney	Consultant ENT surgeon, <b>Tameside FT</b>	✓	✓	✓	✓	Apologies
Cath Cameron	Head and Neck Cancer Nurse Specialist, <b>WWL</b>	✗	✓	Apologies	Apologies	Apologies
Mr V Pothula*	Consultant Head and neck surgeon, <b>WWL</b>	✓	apologies	Apologies	Apologies	Apologies
Katie Foster	Dietician <b>SRFT</b>	apologies	apologies	Apologies	Apologies	Apologies
Kathleen Mias	Nurse Clinician Head and Neck Oncology <b>Christie</b>		✓	Apologies	Apologies	Apologies
Jonathan Hobson	UHSM					✓

\*Hannah Kulbacki attended on his behalf V.Pothula on the 3<sup>rd</sup> September 2014

## 9. Appendix 2 – Pathway Board Annual Plan 2015/16

<b>Pathway Clinical Director:</b>	Gillian Hall	
<b>Pathway Board Members:</b>	Kerenza Graves	CNS , Bolton
	Frances 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
	Chetan 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	
Kathleen Mias	Nurse Clinician Head and Neck Oncology Christie	
Jonathan Hobson	UHSM	
<b>Pathway Manager:</b>	Hodan Noor	
<b>Date agreed by Pathway Board:</b>	June 2015	
<b>Review date:</b>	June 2016	

### Summary of objectives

No	Objective	Alignment with Provider Board objectives
1	Head and Neck pathway has a good awareness of caring for patients who are palliative	Patient Experience
2	Improve the experience of patient living with and beyond head and neck cancers	Patient Experience
3	HSC referral audit	Delivering high quality, compliant, coordinated and equitable services
4	Increase research recruitment	Increase research and innovation practice

**Objective 1:** Head and Neck pathway has a good awareness of caring for patients who are palliative

<b>Objective:</b>	Awareness and access pain and symptom control guidelines Referral guidelines to specialist palliative care teams Awareness of local palliative care teams
<b>Rationale:</b>	<i>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?</i>  Focus on whole pathway approach to improvements by improving the patient experience in palliative care.
<b>By (date):</b>	<i>What is the target date for completion? If completion is expected beyond 2015/16 what progress is expected in year? If a phased approach is to be taken indicate this here.</i>  June 2016
<b>Board measure(s):</b>	<i>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?</i>  Evidence the above objectives have been communicated at MDT level, board members provider feedback on the progress.
<b>Risks to success:</b>	<i>What factors will hinder or prevent the Board's ability to achieve the objective? How will these risks be mitigated?</i> None
<b>Support required:</b>	<i>What support does the Board need from Manchester Cancer to deliver its objectives and implement its vision?</i> None, the Pathway Manager also supports palliative care board and will be the key information sharer for the board to disseminate and verify the learning is taking place.

<b>Work programme</b>		
<b>Action</b>	<b>Resp.</b>	<b>By (date)</b>
HN to send briefing on the awareness and access pain and symptom control guidelines and each local palliative care team contacts. All board members to disseminate this communication at MDT to be recorded on the MDT minutes and Board.	HN/ALL	November 2015
HN disseminate Referral guidelines of specialist palliative care teams. All board members to disseminate this communication at MDT to be recorded on the MDT minutes and Board.		November 2015

**Objective 2:** Improve the experience of patient living with and beyond head and neck cancers

<b>Objective:</b>	Pilot end of Treatment summaries for patient with curative intent Engage with LW&BC identify all H&N late effects post treatment Engage with LW&BC late effect patient experience audit Innovation fund Health and wellbeing clinic Pathway stratification for therapy patients
<b>Rationale:</b>	<i>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?</i> Improved quality of life for people living with and beyond cancer and ensure national recommendations are tested and supported within the pathway.
<b>By (date):</b>	<i>What is the target date for completion? If completion is expected beyond 2015/16 what progress is expected in year? If a phased approach is to be taken indicate this here.</i> June 2016
<b>Board measure(s):</b>	<i>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?</i> Audit of 30 patients end of treatment summary and pilot to implement change List of late effects post treatment shared with the LW&BC Report from the Health and wellbeing clinic and SLT pathway stratification evaluation for the innovation fund.
<b>Risks to success:</b>	<i>What factors will hinder or prevent the Board's ability to achieve the objective? How will these risks be mitigated?</i>  None
<b>Support required:</b>	<i>What support does the Board need from Manchester Cancer to deliver its objectives and implement its vision?</i> None

<b>Work programme</b>		
<b>Action</b>	<b>Resp.</b>	<b>By (date)</b>
Develop audit methodology for end of treatment summaries		November 2015
Begin audit of 30 patient records		Jan- March 2016
Report on findings for end of treatment summaries		May 2016
Evaluation report on health and wellbeing clinic		May 2016
Evaluation report on pathway stratification for therapy patients		May 2016
List of treatment side effects and late effects for head and neck cancers		May 2016

### Objective 3: HSC audit

<b>Objective:</b>	Explore options to decrease diagnostic delays in Head and Neck Cancers.
<b>Rationale:</b>	<p><i>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?</i></p> <p>A key determinant of prognosis in head and neck cancer is the stage of disease at diagnosis. There are referral criteria for urgent referral for patients with suspected head and neck cancer (HSC-205) so that these patients are seen within 2 weeks of referral.</p> <p>The problem is that the vast majority of these referrals do not have head and neck cancer. The proportion of patients with head and neck cancer has been shown to be around 10% in published data[1-3]</p> <p>There is consequently a considerable usage of resources for the urgent assessment of patients with a relatively low probability of having cancer.</p> <p>Anecdotally, there may be an increase by GP’s to use the HSC-205 pathway for referral, which may increase the burden on the service in seeing these referrals and also decrease the proportion with cancer further still.</p> <p>This project will ascertain the rate of head and neck cancer in patients referred via the HSC-205 pathway. This will allow scrutiny of data to ascertain:</p> <ul style="list-style-type: none"> <li>• Rate of malignant disease in patients referred via HSC-205 pathway</li> <li>• Rate of inappropriate HSC-205 referrals</li> <li>• Predictive value of different referral criteria</li> </ul> <p>In a separate analysis, all patients diagnosed with head and neck cancer and referred to the central manchester head and neck MDT will be analysed to determine:</p> <ul style="list-style-type: none"> <li>• How they were referred to secondary care (HSC-205, routine referral, A&amp;E etc)</li> <li>• With what symptoms according to HSC-205 referral criteria</li> <li>• Delay in referral and reasons why</li> </ul> <ol style="list-style-type: none"> <li>1. Kennedy, A.M., et al., <i>Do GP referral guidelines really work? Audit of an electronic urgent referral system for suspected head and neck cancer.</i> Eur Arch Otorhinolaryngol, 2012. <b>269</b>(5): p. 1509-12.</li> <li>2. Hobson, J.C., et al., <i>Outcomes for patients referred urgently with suspected head and neck cancer.</i> J Laryngol Otol, 2008. <b>122</b>(11): p. 1241-4.</li> <li>3. McKie, C., et al., <i>The 2-week rule for suspected head and neck cancer</i></li> </ol>

	<i>in the United Kingdom: referral patterns, diagnostic efficacy of the guidelines and compliance. Oral Oncol, 2008. 44(9): p. 851-6.</i>
<b>By (date):</b>	<i>What is the target date for completion? If completion is expected beyond 2015/16 what progress is expected in year? If a phased approach is to be taken indicate this here.</i>  June 2016
<b>Board measure(s):</b>	<i>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?</i> This will inform a better strategy for the early diagnosis of patients with head and neck cancer, with optimal use of resources. Recommendations to change the referral criteria. This project will be presented at a National meeting and written up in a peer reviewed journal.
<b>Risks to success:</b>	<i>What factors will hinder or prevent the Board's ability to achieve the objective? How will these risks be mitigated?</i> None
<b>Support required:</b>	<i>What support does the Board need from Manchester Cancer to deliver its objectives and implement its vision?</i> None

*The programme of work through which the Pathway Board will achieve the objective should*

<b>Work programme</b>		
<b>Action</b>	<b>Resp.</b>	<b>By (date)</b>
Initial findings	JH	Jan 2016
Final report and recommendations	JH	June 2016

## Objective 4: Increase research recruitment

<b>Objective:</b>	Identify blockers in the engagement of research Develop tools for engagement in research recruitment at MDT Identify clinical trials specific to secondary care and the criteria to support engagement at MDT
<b>Rationale:</b>	<i>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?</i> The research recruitment has decreased compared to the previous year for the pathway, key focus is to identify the reasons and support engagement to increase the recruitment.
<b>By (date):</b>	<i>What is the target date for completion? If completion is expected beyond 2015/16 what progress is expected in year? If a phased approach is to be taken indicate this here.</i>  June 2016
<b>Board measure(s):</b>	<i>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?</i>  MDT research list including criteria Monthly reports at MDT level
<b>Risks to success:</b>	<i>What factors will hinder or prevent the Board's ability to achieve the objective? How will these risks be mitigated?</i> None
<b>Support required:</b>	<i>What support does the Board need from Manchester Cancer to deliver its objectives and implement its vision?</i> None.

<b>Work programme</b>		
<b>Action</b>	<b>Resp.</b>	<b>By (date)</b>
Identify blockers in the engagement of research	HN/JH	November 2015
Develop tools for engagement in research recruitment at MDT	HN/AJH	November 2015

## **Appendix: Manchester Cancer Provider Board objectives**

---

### **1. Improving outcomes, with a focus on survival**

We aim to:

- have a cancer survival rate for all cancers one year after diagnosis that is consistently higher than the England average for patients diagnosed beyond 2012
- have a one-year survival rate higher than 75% for patients diagnosed in 2018
- narrow the gap with Sweden's one-year survival rate from 12% (now) to 6% for patients diagnosed in 2020
- approach Sweden's one-year survival rate by 2025, and
- have greater than 70% of cancer patients diagnosed in 2020 survive at least five years

### **2. Improving patient experience**

We aim to:

- improve year-on-year the patient experience across the region (as measured by the National Cancer Patient Experience Survey), and
- have the best performance in core patient experience questions of any major city area in England by 2015

### **3. Increasing research and innovative practice**

We aim to:

- increase the proportion of patients involved in clinical trials from 30% to more than 40% by 2019

### **4. Delivering high quality, compliant, coordinated and equitable services**

We aim to:

- support our specialist commissioning colleagues to deliver compliance in the four historically non-compliant specialist cancer surgery services (oesophago-gastric, hepato-pancreato-biliary, gynaecology and urology) by December 2015, and
- maintain regional compliance with the national cancer 62-day waiting time target