GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Head and Neck Pathway board

Meeting Head and Neck pathway board

Minutes of the meeting 13th February 2017

Holt Major, Patterson Research Institute.

Attendance	**Representation**
Miss Susi Penney	Consultant ENT Surgeon, Tameside FT, Pathway Director
David Makin	Patient representative
Mark Price	Patient representative
Claire O'Rourke	Pathway Manager, Greater Manchester Cancer
Philip Bryce	CNS, CMFT
Laxmi Ramamurthy	Consultant ENT Surgeon, Stockport FT
Helen Doran	Consultant Thyroid Surgeon, Salford FT
Debbie Elliott	CNS, Christie FT
Kate Garcez	Oncologist, Christie FT
Karen McEwan	Macmillan GP, Stockport
Frances Ascott	SLT, CMFT
Kate Hindley	CNS, SRFT
Helen Rust	SLT, Christie FT
David Shelton	Specialist Biomedical Scientist, CMFT
David Thomson	Oncologist, Christie.
Rodit Kumar	ENT consultant from UHSM
Apologies	
Maria Round	Macmillan Head & Neck CNS, PAT
Rachel Hall	Consultant Histopathology, Pennine
Catherine Cameron	Head and Neck CNS, WWL
Kerenza Graves	CNS, Bolton FT
Suzi Bonington	Consultant radiologist
Lucie Francis	Macmillan User Involvement Manager, Manchester Cancer
Mr V Pothula	Consultant Head and Neck Surgeon, WWL
Hannah Kelly	Specialist Senior Dietician MRI
Chetan Katre	Consultant, PAT
Simon Hargreaves	ENT Consultant Royal Bolton
Mazhar Iqbal	Maxillo- Facial Surgeon, UHSM
In attendance	
Bethan Harland	Specialist nurse, at the Christie

1. The minutes of the last meeting were reviewed and approved with some minor changes. Helen Rust will provide data once this is reviewed, this will be returned as planned

2. **Matters arising:**

3. **Standards:** review of document:

Discussion summary	The board discussed and reviewed the standards document (attached today). SP thanked all the team for comments back and all of the comments how been taken into consideration. Request for the board to approved the updated version of the standards. SP requested final review of the standards to be completed and SP will need to present this document to the GM cancer senior team. SP discussed changes to pathway board structures in GM cancer and the advertisement of the pathway Director job and more accountability of the pathway boards. SP discussed the advert of the standards has now raised other issues of other standards within key services such as in radiology (for example time to scan time to report). David and Kate have put in a section on post-operative guidelines and primary XRT and chemotherapy. Further review will be required on additional services such as access to speak and language therapy and timelines on this in both hospital an in the community. SP recognised that there needs to be some 'mini' standards within the main body of the standards to reflect this and this will need to be expanded a bit further. SP identified that work streams will come off this and the board members will be required to work in smaller working parties, then embed within the final documents. Still evident in areas such as tube feeding as an example, that depending on where you live it will depend on what services you can access. DT discussed the non-surgical treatment for XRT and the standards stipulate about a dental assessment required, as this is correct. ST discussed the need for all patients to be seen by a CNS, dietician and SALT prior to treatment. DT discussed at present that there is only funding for dieticians pre-chemotherapy key issues were: • There should be a move towards providing this for all patients, which would add weight to discussions and to a business case for the Christie. SP said if the board felt we should agree this then this should be added into the document. • Smoking cessation services and health promotion adviser should be available for all patients and this should be written in the standards. DT discussed that currently being funded by the charity and other pathway boards such as lung cancer (under prevention part of the GM cancer plan). There was clear evidence that smoking during XRT halves the chance of cure. This is a key part of the cancer plan/ part of the GM tobacco plan. All discussed that we should also consider the support for relatives to stop smoking and having teachable moments. • DMakin discussed post op treatment; dental support is still a big problem. SP suggested that we should have post XRT and community dental support. SP recognised that we will need work streams on this. PT discussed that he has discussed with Craig and it is essential that we strengthen the pathway, as it is inadequate, restorative dentist, keen to set up a service and support. • Appendix 3, in follow up: most oncologist returns patients to pre

	surgery diagnostic teams, comments of post op radiology and who has responsibility for FU scans and follow up pathways. LR and SP discussed this, as patients are getting lost in the system. Discharge from the Christie is an important issue. SP said we as a board must pay special attention to the follow up arrangements for patients and can it be something that can either be brought in under treatment summaries/ end of definitive treatment, or whether this is built into the treatment summary. Some cases might need hanging onto. SP discussed that patients at Bolton/ stepping hill might experience some problems. MPrice discussed what the patient user group have said is most important is patient's care having central control and patients are not lost in the system. DMakin discussed the importance of CNS numbers, as a constant concern for patients and has escalated this to the cancer board. SP agreed that patients can go into a black hole, not a lot of structure in this area. LR and SP discussed treatment plan post treatment and this needs to be more robust. There is no consistent approach for copy letter for patients and treatment summaries. SP discussed that Pennine are well on way with this as they have a team implementing this. However other trusts are doing things differently, as Central will wait to see what a pathway board agreed they will continue with this. At Tameside they have taken their own individual stance on this came up with own approach, with for example surgeon's oncologists and specialist nurses meeting to discuss this. It is vital all agree who should be including the treatment summary, GP need to get copies and info in the right place. MR was going to come to board but was unable to attend. It's important to use Pennine info. SP to get info from project lead and this will need to be discussed at the next board. SP said that agreement should get this issued post-surgery, and then if they go onto post-operative XRT, after discharge from this, need a template to come up with. Surgical and non-surgical treatment summary to be discussed at the next board. This does not need to be complex. PB discussed at health and well-being events and providing this with a summary of toxicity and health related issues. SP discussed that health and well-being events should be part of the follow up process and given to the patients. PB discussed the difficulties with treatment summaries, as they are time consuming to do have concerns, as it's important to set expectations to patients so they need to know this. HD discussed that treatment summaries can be used under Sumerset cancer system. Live data set can be used at MDT's. HR discussed that post treatment patients swallowing and nutritional needs are only just beginning, and its essential that SALT is required and for rehabilitation. Need to have a Christie consultant in order to be referred. There are issues with 12 months follow up, LR, cannot refer back to SALT. So this pathway needs to be reviewed. DT informed the board if a patient is referred back he is happy to see them under his care. The service will need strengthening to support this additional work and the proposals within the standards.
Conclusion	Standards need to be signed off by all board members and final comments to SP/COR. All member have recognised that the same standards of care should be attained across the patch, this is why we need standards, don't want patients

	lost in the system. We need to ensure a process is in place for treatment summaries, which needs to be straight forward and what patients and GPs want, this will be a key project of the board. IT support required and this is essential and needs to be consistent.
Actions and responsibility	**SP to chase up treatment summary information from Pennine, group to review implementation of this.** **All board members to agree final set of standards**

4. 2WW and review of process and the forms:

Discussion summary	2 WW referral process communicated back to SP from all board members and to Sarah Taylor and the Macmillan group. Agreement that nothing ever written in all the boxes on the form and information is often missing. It is also effected by the PDF files and the formatting and the pulling through of information and KMcK will be reviewing this over the next few months with the team and will feedback accordingly. SP said some of the information is not pulling through including EGRF. SP requested an audit of patients referred as a 2WW at Tameside to see if patients were told they were on a suspected cancer referral result to be presented, but results looks ok and GP had informed them. LR to review an audit and Stockport need to be done to compare suspected cancer referral. LR also discussed that at the 2WW clinic the team hand out leaflets on stop smoking and stop before your op, all Clinical Directors were involved, this was an excellent idea. Review extending this to all pre-op patients.
Conclusion	2ww referral process all comments have been collected and will be reviewed in the next few months, GP team will feedback in the Summer with an update
Actions and responsibility	SP to present Tameside audit if available. LR to see if similar audit can be done at Stockport. Share good practice in teaching moments/ learning opportunities.

5. Patient experience: GM Cancer User Involvement: Mark Price update

Discussion summary	Patient user involvement update by MP and DM. PM discussed the draft standards with the patient user group, additional contributions added by SP to the standards document. MP reiterated that the report was presented in June last year and finding and MP feels we now need to find solutions to what was discussed, to get some outcomes. MP discussed SP to go to steering group, dates will be given. LF has spoken to Susi Lowe from speak therapy regarding the patient leaflet to be designed and bring through the board. Patient leaflets are key, if mark or David will help.
Conclusion	SP discussed that this information is essential mark and David are happy to review and support patient information. SP and board acknowledged the work they both have done and they are vital to the board.
Actions and	**Patient information leaflet will be reviewed by both MP and DM and**

responsibility	**report back to the board.**

6. metastatic melanoma & H&N:

Discussion summary	SP Met with John Lear, skin pathway Director, to discuss the issue of melanoma not going through melanoma MDT, or are going through head and neck MDT after they have had head and neck surgery, plastic surgeons worries about the surgery that these patients are having, too much or too little. SP discussed this was for any melanoma. SP discussed that patient's with Head and neck mets, worried treatment is not standardised as they are not put through the melanoma MDT as well as head and neck MDT. SP had circulated the document on Friday. John and SP discussed a way forward. SP discussed Head and neck MDT first, must go through specialist MDT held at SRFT on Thursday's pm 2-3. Video link in/ john or plastic surgeon. This is happening to some patients, but not all. SP to send the document round. It is a small numbers of patients, important the process is made clear.
Conclusion	Sp to send round document
Actions and responsibility	**SP will discuss with JL and provide the board with further guidance.**

7. GM Cancer plan

Discussion summary	COR discussed the cancer plan, the new plan has been signed off and sent to all members. The board will be asked to deliver on 6 key objectives which will be discussed at the next board and COR will provide a vanguard update. SP discussed the key issues within the cancer plan for head and neck are radiology, pathology, CNS, SALT and come up with implementation plans for these. SP discussed key objectives about late presentation. for example most patients arrive at late diagnosis, late stages and this is no longer acceptable. SP discussed the issue at Tameside in which over 40% of patients are admitted through A&E. how we can measure number of GP contacts. GP how many times, is A&E the first time patients present? Did the patients have a string of GP appointments or A&E visits? This is being audited at Tameside (for all cancers) and as a pathway board we need to look at this across GM. SP asked for other board members to do. To find which areas are the worse and discussed running road shows (similar to lung Cancer), visiting shopping centres with nas-endoscopes. Other board members discussed what are the Education programme of the dentist and why don't patients seek health care advice? David talked about head and neck charities, in Leeds and Newcastle and lots of literature on prevention and 'get ahead', copy what they did. Top 5 symptoms for head and neck cancer.

	GP education: KG discussed that H&N cancer is not always a cancer that is well known. SP felt that we should have an online education platform, KG discussed this is already set up for lung and colorectal. SP discussed that should would like to split the disease up and the members to do this piece of work. Additionally SP discussed that HPV vaccination for all is now documented in the GM cancer plan as supported by our Patient user group.
Conclusion	We need to do better to get patients diagnosed earlier. Can other Trusts do the audit similar to Tameside?
Actions and responsibility	**SP to present audit information on A&E presentation if completed.** **Board members to work up a plan on road show-engage our patient user group with this.**

8. <u>Any other business:</u>

- Date and time of next meeting:
- 28th April 10-12pm CMFT
- 5th July 2-4pm Tameside.
- 9th October 10-12pm Christie.