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 18th September 2017

WMIC Ground Floor Seminar Room.

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
Kerenza Graves	CNS, Bolton
Kate Garcez	Oncologist, Christie FT
Karen McEwan	Macmillan GP, Stockport
Debbie Elliot	Lead CNS, Christie
Helen Rust	SLT, Christie FT
David Thomson	Oncologist, Christie.
Rachel Hall	Consultant Histopathology, PAT
Frances Ascott	SLT, CMFT.
Suzi Bonington	Consultant radiologist
David Shelton	Cytopathology, CMFT
Rohit Kumar	ENT consultant, CMFT
Cath Cameron	Head and neck specialist nurse, WWL
Natasha Smith	Macmillan user involvement manager, GM Cancer
Angela Wright	Head and neck CNS, Wigan

1. The minutes of the last meeting were not available, resent and all apologies were noted.
2. **Matters arising:**
3. **62 day discussion:** update from SP

Discussion summary 62 day cancer standard	SP wanted to focus some of meetings discussion on the **62 day cancer standard and review the performance across GM not just head and neck.** SP discussed that many Tumour specific pathways that are across Trusts, are not working effectively and therefore many patients are not receiving treatment in a timely fashion. GM has done very well so far at Cancer performance, however there are a few issues

regarding sustainability and we often only just meet the standards.

There is a review of time to diagnosis; by April 2018 patients should be told they have cancer by day 28. This will have significant implication across organisation and there need to be a system wide review of processes as a result, in which we are reviewing pathway across the region and where we can give help/ support to providers we must, this has been led by GM cancer and SP.

Q1 data was discussed, info below.

Q2 - 17/18

TRUST NAME	Brain CNS		Breast		Gynae		Haematology		Head & Neck		HPB		Lower GI		Lung		Other		Sarcoma		Skin		Upper GI		Urology		Excluded From TOTAL: Breast Symptomatic		Rare - childrens		Rare - Leukaemia		Rare - Testicular		TOTAL	
Numerator / Denominator	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches	Compliances	Adjusted Breaches
Bolton			23.5	5.0	6.0	1.0	16.5	1.0	6.0	0.0	2.0	0.0	21.5	1.0	11.5	1.0	2.0	0.0	0.5	0.0	24.5	0.0	5.5	3.0	26.0	0.0	5.0	0.0							145.5	12.0
			82.46%		85.71%		94.29%		100.00%		100.00%		95.56%		92.00%		100.00%		100.00%		100.00%		64.71%		100.00%		100.00%								92.38%	
Pennine			56.0	2.0	15.0	9.5	14.5	6.0	22.0	2.0	5.5	4.0	29.0	16.0	39.5	13.0	3.0	1.0	1.0	0.0	3.0	2.5	7.0	14.5	65.0	8.5	16.5	1.0					3.0	1.0	260.5	79.0
			96.55%		61.22%		70.73%		91.67%		57.89%		64.44%		75.24%		75.00%		100.00%		54.55%		32.56%		88.44%		94.29%						75.00%		76.73%	
East Cheshire			28.0	0.0	5.5	0.0	6.0	0.5	1.0	3.0	5.0	0.0	8.0	1.0	5.5	2.5	1.5	0.0			1.5	0.0	5.0	0.0	20.0	1.0							0.0	0.0	87.0	8.0
			100.00%		100.00%		92.31%		25.00%		100.00%		88.89%		68.75%		100.00%				100.00%		100.00%		95.24%										91.58%	
WWL			30.0	0.0	6.0	1.0	4.5	2.0	7.5	0.0	10.5	0.0	21.0	0.0	13.0	1.0	0.0	1.0	0.5	0.0	22.5	0.0	4.5	5.0	31.0	1.5	9.0	0.0	2.0	0.0			0.0	0.0	151.0	11.5
			100.00%		85.71%		69.23%		100.00%		100.00%		100.00%		92.86%		0.00%		100.00%		100.00%		47.37%		95.38%		100.00%		100.00%						92.92%	
Stockport			33.5	0.0	9.0	1.0	9.5	1.0	3.0	0.0	1.5	3.0	14.5	2.0	4.5	3.0	1.5	0.0			0.0	1.0	15.0	5.0	35.5	2.0	4.0	0.5					1.5	0.0	127.5	18.0
			100.00%		90.00%		90.48%		100.00%		33.33%		87.88%		60.00%		100.00%				0.00%		75.00%		94.67%		88.89%						100.00%		87.63%	
MCHFT			25.0	1.0	10.5	0.0	6.5	1.0	3.5	0.0			18.5	2.0	15.0	3.0					32.5	0.0	4.5	1.5	44.5	2.0	6.0	0.0					6.0	0.0	160.5	10.5
			96.15%		100.00%		86.67%		100.00%				90.24%		83.33%						100.00%		75.00%		95.70%		100.00%						100.00%		93.86%	
Salford	1.0	0.0			7.5	2.0	4.0	4.0	6.5	2.0	2.0	0.0	10.0	2.5	12.0	4.0	0.0	0.0	2.0	0.0	####	1.0	5.5	3.0	30.0	6.5							2.0	0.0	195.0	25.0
	100.00%				78.95%		50.00%		76.47%		100.00%		80.00%		75.00%				100.00%		99.13%		64.71%		82.19%								100.00%		88.64%	
Tameside			24.0	0.0	13.0	3.0	4.0	2.0	7.0	0.0	7.0	1.0	14.0	3.0	7.0	1.0	0.0	0.0	0.0	0.0	32.0	2.0	7.0	1.0	20.0	0.0	5.0	0.0					1.0	0.0	135.0	13.0
			100.00%		81.25%		66.67%		100.00%		87.50%		82.35%		87.50%						94.12%		87.50%		100.00%		100.00%						100.00%		91.22%	
CMFT			0.0	0.0	13.0	3.0	4.5	2.0	12.0	1.0	9.5	1.0	3.5	7.0	11.0	2.0	4.0	0.0	3.0	1.0	21.5	3.0	4.5	3.5	27.5	6.5	0.0	0.0	0.5	0.0			3.0	1.0	114.0	30.0
					81.25%		69.23%		92.31%		90.48%		33.33%		84.62%		100.00%		75.00%		87.76%		56.25%		80.88%				100.00%				75.00%		79.17%	
The Christie			31.0	1.0	23.5	7.0	4.5	1.0	19.5	0.0			17.5	3.0	37.0	3.0	2.5	0.0	1.5	2.0	12.5	3.0	16.0	3.0	4.0	4.5	3.0	0.0							169.5	27.5
			96.88%		77.05%		81.82%		100.00%				85.37%		92.50%		100.00%		42.86%		80.65%		84.21%		47.06%		100.00%								86.04%	
UHSM			67.0	3.0	6.5	0.0	5.0	4.0	6.5	4.5			16.0	3.0	27.0	1.5	1.0	0.0	0.5	0.0	35.5	5.0	8.5	2.0	25.5	3.0	11.0	0.0					1.0	0.0	199.0	26.0
			95.71%		100.00%		55.56%		59.09%				84.21%		94.74%		100.00%		100.00%		87.65%		80.95%		89.47%		100.00%						100.00%		88.44%	
GM Q2 Total	1.0	0.0	####	12.0	####	27.5	79.5	24.5	94.5	12.5	43.0	9.0	####	40.5	####	35.0	15.5	2.0	9.0	3.0	####	17.5	83.0	41.5	####	35.5	59.5	1.5	20.0		2.0				######	260.5
	100.00%		96.36%		80.77%		76.44%		88.32%		82.69%		81.07%		83.94%		88.57%		75.00%		94.49%		66.67%		90.26%		97.54%		100.00%						87.01%	

The data above was discussed, particularly head and neck.

Many Trusts are struggling with diagnostics, radiology and Turnaround times.

There is considerable work required to be done.

SP has been out to all sites across GM and several teams have discussed that the issue seems to be one stop diagnosis/ clinics and adherence to the H&N standard as agreed. Wigan has experience issues as pathology is off site and there is no cover leave, effecting service delivery and turnaround times.

The pathway Board needs to review, and engage the support of haematology services as this is closely linked to H&N and from pathology.

SP stipulated in H&N the importance of getting the front end of the pathway right and particularly neck lung clinics being vital to this.

Laxmi pathway discussed at previous boards, should be attached the front end of the pathway and this is what we should be aiming for as gold standard.

The issue of FNA Turnaround times were discussed which should be 7 days, but in some Trusts 10 days is the current standard.

SP discussed on the day adequacy in which has identified at peer review and deemed

	as best practice. The GM cancer board review have assessed plans for treatment within 7 days i.e. Bolton, currently are achieving. The importance of the front end of the pathway was stipulated to the board and although it is an internal standard, it is not currently monitored and there is significant variation between 10%-80% in seen less than 7 days. This is a clear indication of 62 day compliance. FNA, review of rotas, and cover for holidays and a workforce demand-this is part of an national review on this. In pathology there are very clear deficits. In summary SP and board discussed that one stop clinics were best practice. And the front end of the pathway into Trusts is critical. But also key to this is radiology capacity and demand issues. Pressures on services and number of referrals have increased and demand is too great on the services Key to this would be 2 neck lump clinics a week and diagnostic hub, which is a proposed GM standard. DM expressed concerns on 62 day and sustaining this, which the board agreed was a concern. Discussion suggested that a lot of breaches are identified as lymphomas and there is significant variation across Trusts. There is a review of HMDS (haematological Malignancy Diagnostic) services in GM led by GM cancer-results of which will be shared to the teams this affects across GM. David work on data to be reviewed at the next meeting at dashboard.
Conclusion	Summary report to be circulated to the board Links with HMDS review to be established-COR leading GM review.
Actions and responsibility	**COR/ SP to circulate once completed.**

4. Recovery Package Update:

Discussion summary	SP & COR gave an over view of Recovery package (RP) and treatment summaries. There has been established a Living with and beyond implementation group and an exec lead steering group, will all Trusts involved. All Trusts have put in a bid for transformation funding from Macmillan, to have a support team in place to delivery all elements of the RP. Full roll out of the RP will be a significant piece of work. It must be ensured that CNS's are not expected to do everything and clinician engagement is key. Health and wellbeing events (HWBE) are well established, in H&N but attendance can be variable. DM discussed it could be a success if viewed as a clinic, to ensure they will get commissioned and told the patients is valuable.

	SP discussed that those who needs to access do not often attend, it is often the worried well. Cc discussed the living with and beyond cancer catch up clinic at UHSM. Patients are invited to come on discharge, CNS teams do the assessment and then catch up on anything else, they can take clips out and saves time when they attend the consultant review, but was unsure of coding of this clinic. SP discussed end of Treatment summaries. In many organisations the pathway has changed, but some board members discussed they are not always getting the summaries as hospitals which surgery has been done. DT said they could work on a form at the Christie, in which they will are generating this end of treatment summaries. It is variable, there is a significant piece of work being done at the Christie on ETS at 12 weeks, across all tumour types. It is acknowledged that it is often 3 way pathway, which adds complexity to producing an ETS. SP acknowledged they were also awaiting the transformation team MFT/ Pennine and Christie-to review. eHNA: update limited information and may of the CNS members felt it would be difficult to achieve. Data is being collated on how many being done by each CNS in the Trusts- more updates will be provided for the next board.
Conclusion	SP requested the team to review ETS at each Trust. COR to circulate recovery package updated information when produced in Jan 2018
Actions and responsibility	**As above**

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

Discussion summary	MP discussed the HPV update: MP discussed the work plan & the development of a working group including public health, nurses and clinicians to review the vaccination schedules in GM. The aim to review the rational for plans to not vaccinating boys in GM. SP discussed she would be meeting with the Gynaecology pathway Director to discuss a plan for a Focus group on this, particularly looking at information to school children and how we can get this message out, as it is important to target this younger group. MP was explicit about the need to increase awareness as there is a lack of understanding of this. MP is happy to sit on this working group. Board members discussed the need for HPV to be discussed through the sex education in schools and other prevention campaign. There is a clear schools vaccinations programme in other countries, but not here in the UK. SP discussed a proposal of a study day in 2018 to be organised and information will be forwarded to the group. MP went on to discuss Suzanne Durant's study, which is waiting results, but

	there is a need to get the information endorsed. DM discussed that the community group is working well and there was no additional feedback and he will provide an update at the next board.. Natasha introduced herself as the new User involvement manager at GM Cancer.
Conclusion	Need to establish and focus group/ education event for HPV
Actions and responsibility	**COR and SP meeting with gynaecology pathway director to agree next steps and a date for education event on HPV.**

6. MDT reform in GM:

Discussion summary	MDT reform: Paper circulated about reform in GM on this. It is acknowledged that MDT's have become too big, CRUK commissioned a piece of work, attached and circulated for board members to review and approve. Most patients are treated in 3 centres which deal with these patients, in H&N and it is clear that consolidating services improves outcomes. This review will allow us time to re-define MDTs and ensure patients get better treatment and decision making. For example in head and neck patients who are T1 N0 can go to protocol led services. It is vital MDTs are reviewed to ensure consolidate of expertise and best use of time. SP discussed that the review allows services to assess the way we run the MDTs and find a better way of working. Many clinical teams have commented that they can't contribute due to numbers in the MDT. It is essential therefore that we review staffing in areas such as radiology, to assess the workforce implication of any reform. We need to get the basics right: Right scan, right reporting radiologist, who is present at the radiology/ MDT meeting. There has been considerable work done to survey of teams in MDTs and this reform process is under discussion in GM across all cancers. The new proposals have suggested we can change compliance and those who attends, as the external peer review is being removed. This may allow for greater flexibility for MDT attendance.
Conclusion	Head and neck services will support the GM cancer review of MDTs
Actions and responsibility	**SP will keep the board updated on plans for the GM roll out of MDT reform.**

7. GM Cancer plan

Discussion summary	Greater Manchester cancer update: changes to pathway Directors post. SP discussed the paper circulated there will be more support for pathway directors and the board. 62 day and living with beyond and best timed pathways will be the focus of the Plan, there will be an annual report circulated in Jan 2017
Conclusion	GM cancer team to provide update to the H&N board
Actions and responsibility	**COR to circulate annual report and any GM cancer update relevant to the board.**

8. Laxmi Ramamurthy: Audit update

Discussion summary	Laxmi presentation: On Late cancers presentationT3T4, number 23 patients (presentation circulated to board). • 22 patients met the inclusion criteria, staging of patients, 10 T3 & 11 T4, staging symptoms. • Some patients had symptoms for 13 week or more. 7 had 13 weeks plus symptoms. • No clear details how many times they have been to the GP, this will need reviewing. • It was evident that late presentation was based on tumour factors and patient factors. Laxmi needs to review the results further, • Reason for delay identified in some as life system choice/ Poor self-care and may patients are afraid. • Some are awaiting review from other services. • Prospective audit required and asked KmC if she can check GP data and send information from these. RK asked if Laxmi could look at which tumour sites were most commonly presented late. Further analysis and data will be presented at board. SP also discussed FNA audit: adequacy rates across the region. Awaiting Pennine results, only one outstanding. Information was split between head and neck and thyroid. Most centres do well above 70%, however none have reached the national standard yet and there is considerable variation across the region. Data discussed to all board members. 1 in 4 patients are not getting a diagnostic off an FNA, so this is a significant problem. This information must be circulated to lead H&N pathology lead, need to be reviewed through Cancer services at the providers. Board members identified that this is often dependant on experience of the pathology team and CT guided biopsy skills.

	Aspects to review: • How the sample is taken: i.e. under ultra-sound guidance- and training from the pathology department • How it is prepared in the lab. • Experience of the reporting pathologist and we could share opinions. HPB group have agreed a standard way as part of the royal college guidance. To review this as required. So important to get the first FNA right at the start.
Conclusion	Data requested from Pennine More data and audits required All centres to review FNA adequacy levels
Actions and responsibility	**All board members to review data and report back updates to SP**

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

AOB: MDT asked about staging this should change on the 1st Jan 2018