Head & Neck Cancer Pathway Services fo Eastern Cheshire residents

Report for the meeting of the Cheshire East Council Health, Adult Social Care and Communities Overview and Scrutiny Committee

8 October 2020

Purpose of the presentation?

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to provide the committee with an update on the current unsustainable situation with regards the delivery of the Head and Neck Cancer pathway services for Eastern Cheshire residents* ***(and some N. Derbyshire)***

to outline the steps we have taken to develop plans to improve the quality and performance of the service for our residents as quickly as possible

to brief the Committee on the challenges we are facing and solutions in place

outline the steps we need and intend to take to implement the service changes

outline key dates of note and intended process

stern Cheshire geography – Alderley Edge, Bollington, Congleton, Chelford, Disley, Handforth, Holes Chapel, Knutsford, Macclesfield, Poynton, Wilms

Head and Neck Cancer Pathway

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The Head and Neck Cancer pathway service is delivered in partnership between East Cheshi Trust (ECT) and Manchester Foundation Trust (MFT), under a Service Level Agreement betwe the two Trusts. This sub-contracting arrangement has been in place since June 2014. The existing SLA between providers specifies a 42 week consultant led service with the remainin weeks covered by Registrar's

Patients are initially seen at ECT by a weekly visiting oncology Ear, Nose, Throat (ENT) consultant from MFT at Macclesfield Hospital. The Trusts does not offer one-stop appointments at Macclesfield where various diagnostics are completed and reported on the first visit.

If a malignancy is detected the patient is referred onto MFT for surgery, The Christie for Oncology or the ECT Palliative Care Team for best supportive care. At the point of breaking l news to a patient there should be a Clinical Nurse Specialist (CNS) available to support the patient and any family members but there is no CNS service at East Cheshire Trust.

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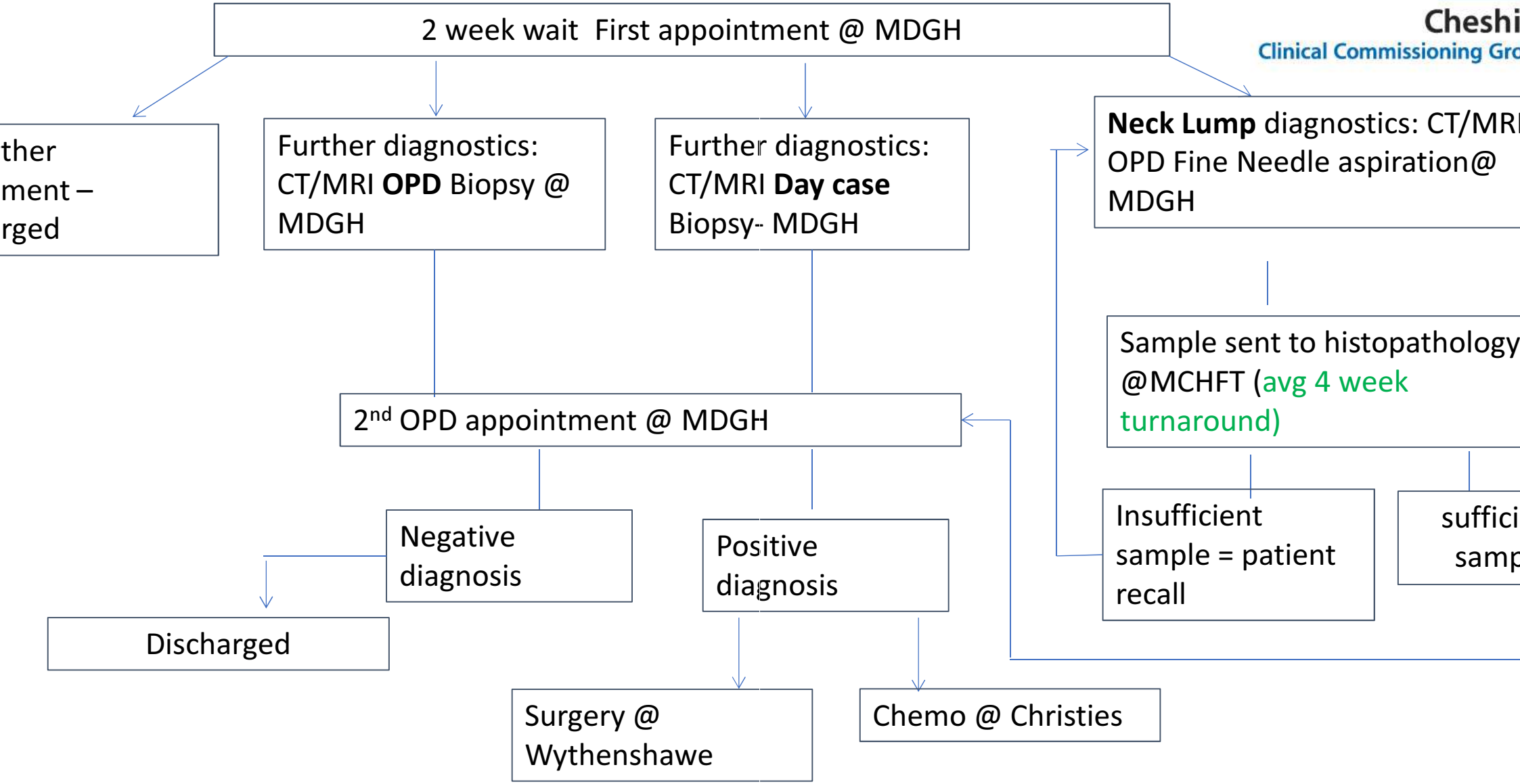
A review of performance on the 62 day waiting time target for ECT shows a deteriorating picture - 22% in Q2 and 10% in Q3 against a target of 85% in 2019/20. This is compounded b insufficient consultant cover and a 4 week average wait for some diagnostics (Fine Needle Aspiration (FNA)). The *lack of on site pathology* services also means that FNA samples canno be checked and reported on within the 24 hour target *with 39% of all patients having to re-attend* for a second FNA where samples have been insufficient

both the CCG and the Trust (ECT) identify the performance on this service as a risk

Head and Neck Cancer Pathway



eps taken to date:

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ollowing a review of the service in June 2019 an action plan was developed and agreed

n January 2020 a 'Situation, Background, Assessment Recommendation (SBAR) was undertaken and submitted to NHS E
Cheshire CCG in March. The recommendation was to *recommission the assessment and diagnostic service directly with M*
ensure improved timely access to assessment and diagnostic services. MFT have signalled their support for these proposa

post COVID clinically led working group has been established with Commissioners and Providers from ECT and MFT

letailed activity modelling completed, new improved pathways agreed and an Quality, Equality Impact Assessment comp
nd reviewed by QEIA panel

benefits identified for patients and system through service improvement of the pathway/delivery model

patient engagement undertaken and report completed

Stage 1 Assurance review meeting undertaken with NHSE/I – very positive meeting, receiving their support for our appro
work undertaken to date and proposed preferred option

pdate given to informal CEC OSC in September and to local MP on issues and plans for resolution

ndings about the pathway:

only patients who have a neck lump (*circa 27 people per year*) or require a biopsy (*circa 69 people per year*) or those receiving bad news (*30 – 50 people per year*) would benefit from additional travel to a specialist centre

patients with lived experience who require specialist cancer services have stated they would prefer to travel if thi means getting a quicker diagnosis and timely access to treatment where required

enefits to be realised through improving the service:

timely diagnosis for neck lumps reduces the average wait from 4 weeks to 1

the provision of one stop services result in less visits to hospital for the patient

continuity of care and specialist support for people with a cancer diagnosis through access to a multidisciplinary t

timely access to treatment pathways for those with a cancer diagnosis through a reduction in delays

local services retained where possible

atient Engagement Undertaken

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he engagement took place over three weeks during late August and early September 2020. We invited and nvolved:

patients referred onto the East Cheshire NHS Trust pathway whether or not they had a cancer diagnosis and those wi
experience of a head and neck cancer pathway at other nearby Hospital Trusts and specialist centres across the UK

gainst a sample size of 300 a total of 64 people engaged, bringing the level of interaction above the base ccepted level of 8% up to just above 21% of the entire sample

keeping with Government guidelines for COVID people were offered online or hard copy questionnaires, 1-2-1 telephon
online video interviews and online video focus group sessions

summary the findings showed:

having services close to home where practical is good but not at the expense of speed of diagnosis. Patients are clear that the issue of travel is outweighed by a quicker diagnosis

access to a specialist nurse and good honest communication and a clear plan is critical

patients are willing to travel for a speedier diagnosis at a specialist centre, this is fine for the vast majority of respondents but travel is a real issue for some people who rely on others to drive them. Fewer appointments would be better for all in that case

Options to be considered by CCG

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Option one: Do Nothing

- Under this option all outpatient appointments and diagnostic tests would be undertaken at MDGH under the existing arrangements.
- The treatment pathways for those with a positive cancer diagnosis would be unchanged with surgery undertaken at MFT at Wythenshaw and chemotherapy at The Christie.

Assessment against benefits	**Yes /No**
• Timely diagnosis reducing the average wait from 4 weeks to 1	**No**
• Less visits to hospital through the provision of one stop service	**No**
• Continuity of care and specialist support for people with a cancer diagnosis through access to a multidisciplinary team	**No**
• Timely access to treatment pathways for those with a cancer diagnosis through reduction in delays	**No**
• Local services retained	**Yes**
• Increased travel requirements for non-specialist care	**no**
Assessment: This is not a viable option, as it would result in continued under performance against CWT standards and significant delays in the diagnostic phase of the pathway with poor patient outcomes and experience and possible harm as a result of delayed treatment.	

ption Two: Recommission all Out Patient activity for Head and Neck ancer Service from MFT

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- Under this option the CCG would recommission all head and neck cancer assessment and diagnostic elements of the pathway for all patients directly from MFT (with treatment remaining the same; i.e. surgery at MFT or Christie for chemotherapy) this would be around 450 patients per year.
- Under this option MDGH would no longer accepts GP referrals for suspected head and neck cancers.
- For patients requiring further investigations this would be undertaken on the same day wherever possible.

Assessment against benefits	**Yes /No**
• Timely diagnosis reducing the average wait from 4 weeks to 1	**Yes**
• Less visits to hospital through the provision of one stop service	**Yes**
• Continuity of care and specialist support for people with a cancer diagnosis through access to a multidisciplinary team	**Yes**
• Timely access to treatment pathways for those with a cancer diagnosis through reduction in delays	**No**
• Local services retained	**No**
• Reduced travel requirements for non-specialist care	**No**
Assessment: This is not a preferred option, as MFT are not able to accommodate this volume of activity and deliver performance standards . In addition it would provide no additional clinical value to patients who do not require specialist support	

tion Three: (*preferred option*) Re provide some specialist diagnostics
d positive diagnosis consultation for Head and Neck Cancer Service from MFT

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- Under this option all patients with a neck lump will be referred directly into the neck lump clinic at MFT at Wythenshaw, providing all investigations and results on the same day. Whilst this would entail additional travel for 27 people per year it would be offset by reducing 3 appointments into one.
- All remaining patients will be seen for their first out-patient appointment at MDGH. For the 69 patients per year requiring a biopsy investigation this would be done at MFT at Wythenshaw.
- CT and MRI scans will be remain at MDGH with results reported remotely to expedite diagnosis
- For 48 people per year who are found to have a confirmed cancer diagnosis, the 'breaking bad news' appointment will be undertaken at MFT at Wythenshaw where the patient will have access to the full specialist team who will be able to conduct a holist assessment and confirm the treatment plan at the appointment
- Where patients are found not to have a cancer diagnosis, a second hospital will be avoided where possible with patients being telephoned at home with the results, and a forward plan agreed with the patients GP

Assessment against benefits	Yes /No
• Timely diagnosis reducing the average wait from 4 weeks to 1	**Yes**
• Less visits to hospital through the provision of one stop service	**Yes**
• Continuity of care and specialist support for people with a cancer diagnosis through access to a multidisciplinary team	**Yes**
• Timely access to treatment pathways for those with a cancer diagnosis through reduction in delays	**Yes**
• Local services retained	**Yes**
• Reduced travel requirements for non-specialist care	**Yes**
Assessment: This is the preferred option, as it delivers on all benefits identified and is the acceptable option for MFT	

Why Option 3 is the preferred option

this new pathway will address the clinical quality and performance concerns

all benefits identified would be realised

this proposal for change is supported by patients who have experienced existing services and addresses what is important to them

additional travel for patients who do not require specialist services would be avoided

local services are retained

Quality & Equality Impact Assessment has been completed on the preferred option and demonstrates significant improvements in proposed changes

hallenges faced

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FT unable at this time to confirm support to transfer activity for those patients who require a biopsy
NA or biopsy under GA or those who are found to have cancer and require the support of a CNS

at did we do?

HSE/I advice/support requested (and given) at Stage 1 assurance meeting

tter was written by Sinead Clarke and John Hunter (ECT MD) to Medical of MFT

eeting was held with Dr David Thompson (Head & Neck Cancer MDT Chair for GM Cancer Alliance)

e CCG and MDGH are working with MFT Consultants, the Greater Manchester and Eastern Cheshire
ancer Alliance to identify a solution which may involve a phased approach to the delivery of our
referred option

tter received from MFT CEO seeking to discuss in further detail and commitment to work to identify a
olution

rovider meeting scheduled to discuss possible solutions

he Cheshire East Council Health, Adult Social Care and ommunities Overview and Scrutiny Committee is asked o:

- ***note*** ***and*** ***support*** ***the work undertaken to address the identified service issues and develop an alternative improved option***

- ***note*** ***and consider the extent of the patient and clinical engagement***

- ***note*** ***the expected benefits to patients that would occur as a result of commissioning a NICE compliant service***