Improving Services for Head and Neck Cancer

Application to London Cancer
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<th>University College London Hospitals NHS Foundation Trust</th>
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<td>Clinical lead</td>
<td>Dr Geoff Bellingan</td>
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<td>Managerial lead</td>
<td>Jo Hunter</td>
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<td>Date completed</td>
<td>17th June 2013</td>
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**Applying to provide:**

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**Proposed sites**

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Following the letter of the 24 April 2013 inviting UCLH to submit an application to *London Cancer* to host specialist services for the diagnosis and treatment of Head and Neck cancer, we are delighted to provide our response as detailed in this application.

The UCLH Board of Directors has endorsed the UCL Partners and *London Cancer* vision for improving outcomes, survival, functional recovery and patient experience of cancer patients across North and East London. We want the whole population to benefit from the national and international excellence in diagnosis, treatment, and care that we deliver here at the UCLH. To achieve this, our Board of Directors has designated cancer as one of our key organisational priorities, and supported this with significant investment to create the organisational capacity to deliver this vision for UCLH and for *London Cancer*. And we have established a ground-breaking partnership with Macmillan Cancer Support to deliver better patient experience alongside excellent treatments and outcomes offered at UCLH.

This document sets out how we will use these strengths to deliver the vision for specialist Head and Neck Cancer Services for *London Cancer*. This would build on existing strengths, for example our one-stop diagnostic services, and the excellent support to this patient group provided by our specialist Head and Neck dieticians and Speech and Language Therapists, and also benefit from the excellent surgical infrastructure including the largest ITU in London. We propose to make further investments to achieve the best possible specialist treatment from all of the relevant disciplines: ENT Surgery, Maxillofacial Surgery, Radiotherapy, and Chemotherapy including clinical trials. We have secured funding from the Department of Health to build one of the UK’s two Proton Beam Therapy centres at UCLH, which will improve outcomes and reduce complications in the treatment of head and neck cancer. We will strengthen each of these services and build them together into a world class multi-disciplinary Head and Neck Cancer Service benefiting the population of North and East London.

Our approach is based on importance of outstanding clinical and academic leadership, and we have valued the input provided by the *London Cancer* Pathway Director, Mr Simon Whitley, to help us develop the proposals in this document. We recognise that achievement of this vision will require further investment in clinical leadership and we will discuss with Mr Whitley and others how best to achieve this at the earliest stages of the implementation process.

The document provides initial thoughts on the implementation timetable. We will continue to work in partnership with *London Cancer* and NHS partner organisations at all stages of the implementation. This emphasis on partnership working will ensure that patients are seen locally wherever this is possible in the integrated pathway. The implementation plan will be modified in the light of these continuing discussions and also, where appropriate, the outcome of public consultation. We look forward to working with *London Cancer* on the implementation of these exciting proposals.

Sir Robert Naylor
Chief Executive
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1. **Introduction**

1.1 This document supports UCLH’s application to host specialist and local Head and Neck Cancer Services by outlining the Trust’s overall strategy and strengths, along with details of the current and proposed future service provision.

1.2 It is acknowledged that combining existing specialist centres and establishing robust and efficient patient pathways for patients with Head and Neck cancer is a complex task and will involve much collaboration between the organisations within North and East London. Our proposal focuses on the aspiration of providing a centre of excellence for surgery and oncology at UCLH, with the support from our partner organisations to deliver high quality care closer to home for patients, including diagnostics, treatment (where appropriate) and rehabilitation.

1.3 We have given careful consideration to the service specification produced and approved by the Head and Neck Cancer Pathway Board and have developed proposals that will enable UCLH to achieve the aims and aspirations of *London Cancer* and to meet the specific requirements for Head and Neck Cancer Services. This document provides an overview of the strengths of UCLH’s clinical services and research capability, with particular reference to cancer services, and demonstrates how we propose to achieve excellence against the criteria laid out in the service specification for head and neck cancer. We have evidenced how we will deliver in the domains considered essential to a high quality patient pathway.

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2. Cancer Services at UCLH

2.1 The UCLH Board of Directors has endorsed the London Cancer vision: saving lives, improving patient experience, and optimising the quality of life of people living with cancer. By supporting the implementation of this vision, we will help the population of North and East London to benefit from cancer services which compete nationally and internationally on excellence in diagnosis, treatment, and care.

UCLH Vision and Values

2.2 Implementation of the vision will be underpinned by the UCLH values which outline the behaviours and standards as to how we serve our patients.

We put your **safety** > and wellbeing above everything

- Deliver the best outcomes
- Keep people safe
- Reassuringly professional
- Take personal responsibility

We offer you the **kindness** > we would want for a loved one

- Respect individuals
- Friendly and courteous
- Attentive and helpful
- Protect your dignity

We achieve through **teamwork** >

- Listen and hear
- Explain and involve
- Work in partnership
- Respect everyone's time

We strive to keep **improving** >

- Courage to give and receive feedback
- Efficient and simplified
- Develop through learning
- Innovate and research
2.3 Our partnership with Macmillan Cancer Support further shapes our services for cancer patients and our innovation in care and support to people affected by cancer. Both UCLH and Macmillan Cancer Support are fully committed to sharing these innovations and improvements across the whole of London Cancer.

Strategy for Cancer Services

2.4 The UCLH Board of Directors has designated cancer as one of the key organisational priorities and supported significant investment to create the organisational capacity to deliver our vision for UCLH and London Cancer. The leadership role which UCLH proposes to play in cancer services across London Cancer will build on existing strengths and expertise from many parts of UCLH working in collaboration with University College London (UCL), to improve cancer care across all parts of the patient pathway. The key components of our strategy for cancer services are articulated below.

Prevention and Early Diagnosis

2.5 As one of the first wave of National Bowel Cancer Screening Centres, we have identified and provided early and effective treatment for over 200 patients with colorectal cancer across North London over the last six years. The success of this programme has resulted in its expansion to include patients up to age 74 and further expansion of the service is planned. In lung cancer, over 100 patients have benefited from pioneering work at UCLH in the early detection of lung cancer, which showed that in many patients with bronchial dysplasia their cancer could be detected when curative treatment is still possible. We are now undertaking a study to develop a Computed Tomography (CT) screening programme for lung cancer in collaboration with London Cancer. In upper GI cancer, nearly 500 patients with early neoplasia of the oesophagus have been identified and treated early, avoiding the need for major surgery, and we have shown that this treatment prevents progression to invasive cancer.

Accurate Diagnosis

2.6 UCLH holds an undisputed global leadership position in novel diagnostic methods for men at risk of prostate cancer. We hold the most comprehensive trial portfolio globally and serve as a national referral centre. Both the diagnostic and therapy techniques developed at UCLH are now being adopted in many of the world's leading centres of excellence. On the 30th May 2013, Professor Mark Emberton was awarded the William Farr Medal for his services to men with prostate cancer. Accepting this award from the Worshipful Society of Apothecaries, Professor Emberton cited the culture of innovation at UCLH that permitted such work to advance at a rate faster than any other institution anywhere.
2.7 The Department of Nuclear medicine was the first in UK to introduce Positron Emission Tomography (PET)/CT and PET/Magnetic Resonance Imaging (MRI) in clinical practice for cancer patients. The department works closely with all of the cancer teams at UCLH and has developed many important innovations to improve the diagnosis and staging of cancer.

**Developing High Quality Specialised Services That Can Be Delivered Locally**

2.8 UCLH has demonstrated excellence in radiotherapy services by the high proportion of radiotherapy treatments which we deliver through Intensity-Modulated Radiation Therapy (IMRT). We have offered to take the lead on behalf of London Cancer to develop a single radiotherapy service model which will ensure these highest technical standards are delivered locally on a consistent basis. The importance of high quality technical radiotherapy has been acknowledged by Professor Sir Mike Richards as supporting improved outcomes, increasing cure rates and improving patient experience by minimising the long-term side effects of treatment.

**Excellent Highly Specialised Treatment Hosted at UCLH**

2.9 UCLH already provides several nationally and internationally renowned specialist cancer services serving the population of London Cancer and beyond. Our established and successful robotic surgery programme is the cornerstone of the specialist bladder and prostate cancer service which UCLH has agreed to provide for London Cancer. This programme started by providing robotic techniques in place of traditional surgical techniques, reducing length of stay and complication rates and improved cancer clearance margins. The programme expanded into more innovative areas offering an alternative to open surgery for bladder cancer patients undergoing cystectomy or lymph node dissection following penile cancer.

2.10 The robotic programme has been greatly enhanced by the creation of a minimal access surgical training facility within the education centre at UCLH, with robotic surgical systems permanently installed within the centre, dedicated solely to training. This centre is the first of its kind in the UK and has enabled specialist training for healthcare professionals both at UCLH and for the European community. This centre also enables junior doctors to start their surgical robotic training and become proficient in minimal access surgical techniques at a much earlier stage in their careers, ultimately improving safety and quality of care for patients. This technology and training facility will offer a platform for innovation in many other specialities with expected developments in robotic surgery in Head and Neck, Gynaecology and Upper GI cancer surgery. Complex surgery at UCLH is supported by our world class ICU, which has outstanding clinical outcomes, including a Standardised Mortality Rate of 0.77 and short lengths of stay for high dependency patients, and participates in many multicentre clinical trials consistently resulting in high impact publications.
2.11 UCLH has one of the largest and best equipped Haematology departments in the UK. For example, we treat the largest number of Lymphoma patients of any UK centre and we provide the largest dedicated apheresis service in the country, undertaking planned and emergency procedures 24 hours a day, staffed by a team of highly experienced nurse specialists, in conjunction with senior haematology clinicians.

2.12 We have secured £125 million central government funding to develop one of the UK’s first two Proton Beam Therapy (PBT) centres to apply the highest possible technical radiotherapy service to specific specialist patient groups who will benefit from this intervention, particularly children.

2.13 The teenage and young adult cancer service at UCLH has developed from the first teenage cancer service which opened in 1990 at the Middlesex Hospital and is now the largest in the world, hosting 30 in-patient beds and a dedicated, state-of-the-art out-patient, day-care and ambulatory care facility. These patients benefit from access to world class cancer treatments, our ambulatory care model which allows people to stay in comfortable surroundings with their families, and a large, expert multidisciplinary team, dedicated to enabling every patient to achieve the psychosocial potential they have despite having experienced the challenges of cancer and cancer treatment.

2.14 The Interventional Oncology Service at UCLH provides world-class image-guided cancer therapy for direct tumour treatment and cancer-related symptom control. Treatments include percutaneous tumour ablation (tumours are targeted in real time and destroyed using either heat (radiofrequency, microwave or laser ablation) or cold (cryotherapy)); Vascular Oncology (tumours targeted through their blood supply to deliver chemotherapy or radiotherapy direct to the tumour) and pain control (using a variety of new techniques that involve the targeted delivery of analgesics to peripheral nerves, plexuses or more centrally).

2.15 The Sarcoma Service (London Sarcoma Service – LSS) is run jointly by UCLH and the Royal National Orthopaedic Hospital, Stanmore (RNOH) and covers a referring population estimated varyingly between 14 and 18 million. The surgical management of head & neck sarcoma patients is centralised at the UCLH site, constituting thus the largest single unit of Head & neck Sarcoma Surgery Services in the country. A recent external peer review assessment confirmed evidence of strong and committed leadership and a sense of team cohesion and collective identity. No gaps in the membership of the team were identified and the report was extremely complimentary of the overall service.
Driving Research and Improvements in Treatment in Partnership with University College London

2.16 Clinical research underpins all aspects of the high quality services at UCLH, the cornerstone being a highly developed clinical trials programme with a total of 1,050 patients entered into National Institute for Health Research (NIHR), academic, commercial and early phase clinical trials last year. A key feature of the commitment to cancer research at UCL and UCLH is the close proximity of translational and clinical laboratories (in the UCL Cancer Institute in Huntley Street) to the innovative treatment facility (the University College Hospital Macmillan Cancer Centre) directly opposite. From 2018, the new PBT serviced will be housed in the basement of our new Phase 4 development in the same street as the Cancer Institute and Cancer Centre. This concentration of clinical and academic excellence in cancer will help to promote further innovations and improvements.

2.17 While researchers develop therapeutic advances in cancer, our Clinical Research Facility (CRF) in Phase 2 of University College Hospital provides a safe environment to trial these therapies and improve current and future treatments and outcomes. This early phase clinical trials facility is now the second largest of its kind in London (after the Royal Marsden Hospital).

2.18 UCLH is a key partner with the UCL Cancer Institute and Great Ormond St Hospital in the Cancer Research UK Centre at UCL. Research grant income to the Centre has increased from £19 million in 2009 to over £41 million this year, making it the second largest such Institute in the UK (the largest being the Institute of Cancer Research linked with the Royal Marsden Hospital). This Centre exemplifies the seamless integration of basic, translational and clinical cancer research with the outstanding treatment and care offered at UCLH.
2.19 Major research grants include the UCL/Kings College London (KCL) Comprehensive Cancer Imaging Centre from Cancer Research UK and the Engineering and Physical Sciences Research Council which supports imaging and biomarker studies; the UCL Cancer Research (UK) Health Behaviour Research Centre which conducts population-based health research studies, especially studies related to diet, obesity and smoking, directly relevant to predisposition for developing Upper GI, Head & Neck and Lung Cancer Services; and the UCL Biobank for Health and Disease, which archives histopathological material from all cancer types. This provides approved access to this material for groups across the UCL Cancer Institute and is rolling out a consent process for all hospitals in University College London Partners (UCLP).

2.20 UCL Cancer Institute researchers have led a number of studies since 2010 which have had a global impact on cancer research and clinical care. Significant advances include; identifying the best chemotherapy combination for advanced gall bladder and bile duct cancer; demonstrating that a single dose of intraoperative radiation therapy may be as effective as a course of external beam radiotherapy in breast cancer in the TARGIT trial; discovering the genetic architecture of acute leukaemia; developing highly successful bone marrow transplant protocols for patients with advanced Hodgkin’s disease, aggressive non-Hodgkin’s lymphoma follicular lymphoma and leukaemia; conducting the first genome-wide analysis of the genetic variation between different regions of the same tumour using samples of kidney cancer; discovering that an experimental drug, olaparib, might have a role to play in ovarian cancer; and publishing the new gold standard treatment for thyroid cancer.
Innovative Models of Care and Patient Experience

2.21 Our new Cancer Centre opened in April 2012 and has won four awards for its design and contribution to improving cancer patient experience. We were delighted to have an inaugural visit to these fantastic facilities by Their Royal Highnesses the Prince of Wales and The Duchess of Cornwall. One of the most exciting features of the cancer centre is the innovative use of art work, which has been shown to have many positive therapeutic and medical outcomes for cancer patients. Coupled with the opening of a new patient hotel, which offers free accommodation to our patients and close relatives when they need it, we believe we are offering some of the most advanced cancer services in the UK.

2.22 Jeremy Hunt, Secretary of State for Health, recently acknowledged the quality of our cancer services and facilities on the NHS documentary Keeping Britain Alive:

“Just been on inspirational visit to UCLH Macmillan Cancer Centre. Courage and optimism of cancer patients truly inspirational.”

2.23 UCLH offers a personal service to each cancer patient. Each patient will receive a personal treatment plan, a key worker to support them and their families throughout the pathway and full Clinical Nurse Specialist (CNS) support at all stages of their journey. In addition, the Macmillan Support and Information Service, based in the Cancer Centre, offers the benefit of a listening ear, a wide programme of activities to help cancer patients and to help them help themselves, and comprehensive patient information and advice. A variety of volunteer roles in the Cancer Centre further enhance the patient experience at all stages of their pathway.
Our Commitment to Working with Patients

2.24 UCLH is committed to involving patients in helping us design and develop services. With the help of Macmillan Cancer Support, we have established a Cancer Patient Experience Board which is actively involved in all of our decisions about developing and designing services. Juliet Bouverie, Chair of this group and a member of our Cancer Clinical Steering Group has commented:

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\text{The Patient Experience Board at UCLH provides a real opportunity for patients to help UCLH improve services to cancer patients. We have been impressed by the openness of the senior management team at UCLH to listen to views of patients and carers. I attend the Cancer Clinical Steering Group with one other patient member of the group and participate in all of the key strategic decisions, while members of the group are involved in a wide range of projects, co-design, and improvement work across the Trust.}
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2.25 We have also worked with London Cancer to ensure that patients are involved in designing wider pathways of care. Ben Wilson, a student from Watford, was diagnosed with Acute Lymphoblastic Leukaemia (ALL) when he was 17. He understands how it feels to be a teenager having regular treatment for cancer;

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\text{“I was asked to join the Teenager and Young Adults Cancer Network Coordinating Group by Dr Rachael Hough, who was my consultant at University College Hospital in London and chair of the group, in 2012. I thought it sounded like a great idea and wanted to get involved. I’m able to discuss issues that really affect teenagers. I’ve raised things that haven’t been talked about before such as sexual health advice and information for teenagers with cancer. Other things like hospital food, exercise and getting back to school are really important to us as patients. Having the right information and support can help us continue to lead normal lives. At first, it was slightly intimidating to be in a room full of people who are leaders in their field. But they all take time to listen and my confidence has grown. I do believe our views will make a difference. It’s fascinating being behind the scenes. Knowing my contribution will help improve the situation for patients following behind me is really reassuring.”}
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Our Commitment to Partnership Working

2.26 Our commitment to the vision of *London Cancer* is matched by our commitment to work in partnership with the other organisations across UCL partners to achieve this vision. We believe that joint consultant appointments between Trusts are an important driver of effective joint working, as these consultants can operate as full members of the specialist cancer services at UCLH and the cancer services at local units, ensuring that innovations in improvements in treatment are delivered locally wherever possible. We have pioneered joint appointments in medical oncology (with Barnet & Chase Farm Hospitals), in haematology (with North Middlesex University Hospital and Barnet & Chase Farm Hospitals, and Whittington Hospital) and in urology (with Barnet & Chase Farm Hospitals, the Royal Free Hospital, and the Barts Health group of hospitals) and we would introduce more joint consultant appointments in other specialties as the plans for Head and Neck Cancer Services are developed.

Our Capacity to Deliver

2.27 As an established Foundation Trust, with a successful financial track record, we have a reputation for delivering major projects and improvements within the NHS. We opened the award-winning Cancer Centre on time and on budget in April 2012. We successfully took on management of the Royal National Nose Throat and Ear Hospital (RNTNEH) from Royal Free London NHS Foundation Trust at the same time. We opened one of the first Hyper-Acute Stroke Units at University College Hospital in 2010 as part of the major reform of stroke services in London, which is estimated to have saved 400 lives per year. We completed the transfer of brain cancer services from Royal Free Hospital to UCLH in 2011 and 2012. We also co-operated fully with the transfer of specialist hepato-biliary cancer surgery to the Royal Free Hospital, when it was agreed that this provided the best model for improving these patient services.

2.28 The development of Cancer Services at UCLH is co-ordinated by our Cancer Clinical Steering Group, chaired by Dr Geoff Bellingan, Medical Director for Surgery and Cancer. Three Executive Directors attend this group together with the senior cancer clinical leadership of UCLH. The membership of the group includes two clinicians who chair National Clinical Reference Groups on specialist cancers for NHS England, and further five clinicians whose expertise and leadership skills have been acknowledged by their appointment as Pathway Directors for *London Cancer*. All parts of UCLH are represented on this important group, together with representatives from our Patient Experience Board. This group ensures a co-ordinated approach to the delivery of improvements in cancer services across UCLH, including the proposals put forward in this document for Head and Neck Cancer.

2.29 This overall commitment by UCLH to the provision of excellent specialist cancer services is matched by the specific strengths of UCLH which make us best placed to deliver the highly specialised cancer services for Head and Neck Cancer; this is described further in the following chapter.
3. Head and Neck Cancer Services at UCLH

3.1 The Head and Neck Centre at University College Hospital was established in July 2005, following centralisation of Head and Neck services from the Royal Free Hospital, The Royal National Throat, Nose and Ear Hospital, and the Middlesex Hospital. Over the last eight years great efforts have been made to ensure that the Centre develops, amalgamating ENT and Maxillofacial Oncology for the Head & Neck including all aspects of Reconstructive Surgery for the region. The surgeons of the Head and Neck Centre are also working very closely with Oral and Maxillofacial Surgery colleagues at the Eastman Dental Hospital and the Great Ormond Street Hospital for Children, respectively sharing dedicated junior staff and thus providing the basis for one of the most comprehensive Head and Neck teams in the UK. This unique centralisation of clinicians from different specialties has led to an ethos of multidisciplinary, patient centred care, while maintaining clinical excellence and contributing towards education and research in the field.

3.2 The Head and Neck department treats more than 200 cancer patients annually, and represents the main heart of the North London Cancer Network, and further afield. The department also includes the Sarcoma Head and Neck Service, being one of two centres for Head and Neck Sarcomas in the South East of England. There is also a very close collaboration with the Royal National Hospital for Neurology and Neurosurgery and the colleagues forming the Skull Base Unit and MDT locally. Joint services are provided for patients with skull base malignancies and the Head and Neck Team at UCLH regularly undertakes the reconstruction for patients with advanced malignancies in the base of skull and neuro-cranial sites.

3.3 The Head and Neck Cancer Service at UCLH comprises six Head and Neck surgeons (OMFS and ENT), two medical and two clinical oncologists, three radiologists, two pathologists and four cytopathologists, all with a special interest in Head and Neck Cancer. The Head and Neck Cancer Service screens and submits to clinical trials and is assisted by a dedicated Clinical Research Nurse.

3.4 The Service is complemented by specialist nursing, speech and language, dietetics, physiotherapy, occupational therapy, psychology, anaesthesia, research, dentistry and palliative care services. Dedicated Dental Services for the Head and Neck patients are also located at the Macmillan Cancer Centre while specialised dental rehabilitation services are provided by the Restorative Department of the Eastman Dental Hospital.
3.5 The Oral and Maxillofacial Surgeons (OMFS) in the Head and Neck department, Eastman Dental Hospital and Great Ormond Street Hospital for Children are responsible for the management of oral and maxillofacial trauma admitted to the Trust via Accident and Emergency Department. The joint team also provides clinical input for maxillofacial emergencies at the Royal Free Hospital and the Whittington Hospital. Paediatric maxillofacial emergencies are covered jointly with the UCLH paediatric team while the OMFS Team provides on-call cover for the paediatric maxillofacial service of the Great Ormond Street Hospital. The ENT surgeons within the Head and Neck department work closely with colleagues from the RNTNEH and are included on a joint on-call rota, providing on-call ENT cover across the sector.

3.6 New patients suspected of a Head and Neck cancer are seen within a rapid access setting. The team deals with all Head and Neck cancers including oral cavity, oropharynx, nasopharynx, larynx, hypopharynx, salivary gland and maxillary malignancies.

3.7 The service includes a weekly multi-disciplinary meeting on Wednesday morning where all new and suspected cancer cases are discussed to formulate a management plan. There are two weekly multidisciplinary clinics each week on Tuesday am (Maxillofacial, Plastics & Oncology) and on Wednesday pm (ENT, Oncology, Maxillofacial & Photodynamic Therapy). There is also close collaboration with the palliative care team, who see selected patients. The UCLH Head and Neck Cancer Oncology Service have full facilities for Head and Neck surgery, chemotherapy, radiotherapy and clinical trials. In addition, on a case by case basis, patients may have joint care with or input from neurosurgery and/or upper gastrointestinal surgery teams, where appropriate.

3.8 UCLH Head and Neck oncology has developed its routine conventional radiotherapy delivery and now routinely treats appropriate Head and Neck targets with more focused and state of the art Intensity Modulated radiotherapy (SIB IMRT). This is also planned for in difficult cases together with the dedicated Head and Neck radiology service.
4. Delivering a New Pathway for Patients with Head and Neck Cancer

4.1 This section of our application outlines the new pathway we propose to implement for patients with Head and Neck Cancer, should we be the designated host for local and specialist services and demonstrates how we would meet the specified requirements of London Cancer. We also set out our plans for an identified clinical leader for the local and specialist services. The parameters from the service specification have been used in order to structure the response.

4.2 The proposed patient pathway for Head and Neck Cancer Services is shown below (Figure 4-1) along with a summary of how UCLH complies with the requirements of levels 1 to 4b (further details can be seen in Appendices A to E) and highlights the key stages in a patient’s pathway through the Local Units, the Level 3 MDT Hub and the Level 4a&b Treatment Centre. Further discussion will be undertaken with partner NHS Trusts and the Pathway Board to finalise the agreed version of this pathway which will then define the areas of responsibility for the different NHS organisations within the London Cancer service model for Head and Neck Cancer.

Patient Pathway

Referral & Diagnostics

Referral and Clinic Management

4.3 The management of the referrals into the Head & Neck Service is the responsibility of a dedicated team, led by an Administrative Manager. The team includes dedicated support for allied health professionals as well as the consultant teams. In order to support the aspiration to reduce waiting times across the cancer pathway and improve communication with patients and their GPs, we plan to invest further in the team and are working with colleagues at Macmillan Cancer to appoint a Cancer Support Worker – a post trialled and shown to be successful in other Cancer Services at UCLH. This post combines administrative and clinical support to patients and their CNS; offering patients a dedicated contact to assist access to the CNSs and freeing up the time of specialist staff so that they can spend more of their time in a clinical role. We would also seek to provide a similar model to that in uro-oncology, to ensure that robust mechanisms are in place for the transfer of patient information both in and out of the organisation.
Figure 4-1 Patient Pathway

1. GP 2WW referral
2. Clinical Assessment and diagnostics
   - If positive for suspicious malignancy — refer to Level 3 unit for discussion (Hub MDT)
3. MDT review at Level 3 hub — histology, radiology, pathology, cytology; initial treatment options identified.
   - Possible consultation at MDT hub clinic — and further investigations as necessary
4. Treatment options agreed with patient; key worker allocation.
   - Surgery
   - Radiotherapy and/or Chemotherapy
      - Adjuvant radiotherapy and/or chemotherapy (at L4A or L4B)
      - Initial follow-up and specialist rehabilitation (SALT/Dietetics/Restorative Dentistry)
   - Palliative treatment — review with palliative care team
5. Local rehabilitation (if appropriate)
6. Local follow-up — local unit and community for 5 years

Consider clinical trial eligibility at all points along patient pathway.
4.4 At present UCLH meets the standard cancer waiting time target to ensure patients referred on a two week wait are seen within 14 days of receipt of their referral. UCLH fully supports the aspiration to reduce this wait to a maximum of five working days. This would be achievable through internal expansion (including holding two week wait clinics at RNTNEH) and joint working arrangements with partnership organisations, to ensure sufficient two week wait capacity within our clinic (in terms of both personnel and space). Although challenging, this will provide an opportunity to work with our specialist colleagues from partner organisations, in offering a number of programmed activities associated with the delivery of additional clinic capacity.

4.5 Imaging and pathology diagnostics tests will be performed on the same day as the clinic, to assist in the overall reduction of waiting times and to improve the experience for patients. These results will be made available within five working days and presented at the following hub MDT meeting. The patient will be brought back to the multidisciplinary clinic on the same day as the hub MDT meeting or within five working days if there is a more appropriate clinic another day, to receive the results and be informed of the discussion regarding their treatment options. The MDT clinics include specialist colleagues from a wide variety of disciplines including surgery, oncology, radiology, nursing, speech and language, dietetics and psychology. Any patient with a confirmed cancer diagnosis would have a CNS present at the time of diagnosis, be allocated a CNS key worker and be given patient information relevant to their condition and treatment options. UCLH recognises that some local centres may need support to deliver the MDT aspect of these clinics. We would welcome the opportunity to include outreach clinics in our clinical staffs’ job plans (including nurses and allied health professionals).

4.6 Psychological support at the point of diagnosis is paramount. Currently UCLH’s Head & Neck Clinical Nurse Specialists offers psychological support to patients. Where patients are found to have extremely complex psychological needs, there is a mechanism to refer patients to a clinical psychologist, although we recognise that capacity would need to be increased in order to offer a satisfactory level of service to a larger cohort of patients. Any patients being given a cancer diagnosis would continue to receive this level of support and those who are advised to undergo major surgery to treat their cancer would be offered an enhanced service.
4.7 Working relationships with charitable organisations such as Changing Faces and Macmillan Cancer Support are already established and we would look to develop these further to ensure patients are as well supported as possible. We plan to implement a specialist pre-operative psychological assessment as standard, along with dental, nutritional, speech and nursing assessments. These assessments would score patients according to the level of input and expertise they require and ensure the support they receive is appropriate. This would complement the holistic needs assessment and will lead to appropriate advice and/or treatments; for example, nutritional work-up, smoking cessation, alcohol detoxification and pre-operative dentistry. This holistic approach to pre-operative care will ensure that patients are well informed and should assist in improving patients' outcomes.

Imaging

4.8 The Head & Neck Department at UCLH is supported by state-of-the-art imaging facilities. The modalities predominantly used in the diagnosis and management of head and neck cancer patients are MRI and ultrasound; although x-ray and CT are also used where required. There are 4 dedicated ultrasound lists for Head and Neck patients every week. Many of these patients are seen in a one-stop service and have ultrasound, fine needle aspiration (FNA) or biopsy and either MR or CT scans during the attendance. The radiologists participate in the MDT’s for Head and Neck patients, offering radiological opinion and advice to their surgery and oncology colleagues. Standard MR imaging now includes diffusion as well as anatomical MR.

4.9 The Radiology Department has some capacity to grow services in certain areas, with well-established pathways to external Imaging contractors for who are able to perform general imaging for the less specialist services within the Trust. These can be used at times of high pressure due to increased referrals or equipment malfunction and can help to create space internally for the complex specialist work. The business continuity plan allows patients to continue along their pathway in a timely and efficient manner.

4.10 Currently there are three specialist Head and Neck Consultant Radiologists, with varying Programmed Activity (PA) allocations (one based solely at the RNTNEH site). All UCH Imaging requests are triaged daily by a mixture of Consultant Radiologists and expert radiographers according a set of agreed departmental protocols. We also offer a one-stop-shop, where patients undergo triple imaging (US, CT and MR as appropriate) and FNA if required and can leave the clinic with a diagnosis.
4.11 The centralisation of specialist surgery at UCLH will increase the demands on the Radiology Department and is likely to require additional workforce and equipment to meet the demand and keep within recommended referral to treatment timescales. We plan to work closely with our partner organisations within North and East London and be able to offer PAs to radiology colleagues currently working at other organisations. We would foresee a model of shared protocols for investigations at partner organisations, in order to minimise the occasions that patients require re-imaging. We support the model of joint working and hope to establish joint appointments in the future.

4.12 The Nuclear Medicine department also provides a service to this patient group, undertaking both PET/CT and PET/MR scans for staging and monitoring patients, and EDTA GFR scans both before and after Chemotherapy. Due to the specialist nature of this imaging, it is accepted that not every referral source will have local access to a department; therefore some of the activity will inevitably be brought into the department. At present, it is not envisaged that there would be a problem with capacity for this patient group.

4.13 Through better joint working, we hope to reduce the number of ultrasound scans that have to be repeated. However, it is acknowledged that in order to provide the level of service required, UCLH’s ultrasound capacity would need to be increased which would require additional consultant resource. This could be provided through joint-working with the local centres if it is identified that capacity may be eased in those locations. Again, this would support our desire to work closely with our partner organisations. Alternatively, investment would need to be made locally at UCLH to address this issue. Robust patient pathways would need to be developed in order to ensure that patients from local centres could access specialist imaging services if they are not available locally.

**Pathology**

4.14 The Pathology Department at UCLH offers world class laboratory testing and excellent turn-around times. Currently the Head & Neck Service is delivered by two dedicated, specialist and experienced histopathology consultants and supported by four histocytopathology consultants. The pathologists participate in the MDT meetings. The department welcomes the centralisation of specialist Head and Neck Surgery at UCLH but acknowledges the increased demand that this will represent. Wherever possible, we will work with our partner organisations to ensure that initial diagnostic pathology is undertaken at the local centres and that pathologists with a specialist interest in cancer diagnostics are invited to supplement the workforce at UCLH. We would wish to ensure that the diagnostic services at local Trusts are conducted within a quality assured framework using agreed protocols, national guidelines and quality control audits are in place. This way of working will reduce the need for duplicate reporting at the hub MDT meetings and thereby increase efficiency. We will ensure that the pathology department has appropriate laboratory resources.
Delivering the Diagnosis

4.15 It is important that patients who are about to receive a cancer diagnosis have access to support at such an emotionally difficult time and we aspire to ensure that a Clinical Nurse Specialist is present at all consultations where a patient is being told about their diagnosis of head and neck cancer. Currently a CNS is present at circa 50% of consultations which compares favourably with North East London (43% of patients had a CNS present at the time of diagnosis) and England (37%).

4.16 The agreed patient pathway ensures that a key worker is assigned at the local Trust when a patient receives a cancer diagnosis. This key worker remains with the patient throughout their cancer journey. If a patient is referred to the centre for specialist surgical treatment, a second key worker is assigned for the duration of their treatment up to discharge. The UCLH Clinical Nurse Specialists will liaise closely with the local CNS to ensure there is good communication and that the patient’s pathway is as seamless as possible, via the network that has already been set up. This network is already working on the creation of a pro forma to assist the safe transfer of patient care between organisations.

4.17 We envisage structuring new CNS posts in a way that improves the whole patient pathway. We will work with local centres to help ensure their staffing arrangements are appropriate for their patient population area. Where new CNS appointments are required and we will work with local centres to ensure that these jobs are designed in a way that will attract good candidates and offer the opportunity for joint working.

Summary

- Investment planned to increase capacity in the administrative team (including a Cancer Support Worker), specialist nursing team and clinical psychology.
- Plan to implement psychological assessment process.
- Review investment required to offer a CNS/AHP out-reach service to local centres.
- UCLH will continue to provide world class imaging and pathology services for patients with suspected and confirmed cancer diagnoses.
- Further capacity required in both imaging and pathology services.
- Capacity for managing additional frozen sections as a result of centralising more major reconstructive surgery would need to be addressed.
Multidisciplinary Team

Team

4.18 The current specialist multidisciplinary team includes colleagues from surgery, medical oncology, clinical oncology, radiology, pathology, cytopathology, nursing, speech and language, dietetics, physiotherapy, occupational therapy, psychology, anaesthesia, research, dentistry and palliative care.

4.19 Joint working arrangements would need to be confirmed to allow colleagues from local centres to participate in hub MDT meetings, especially when they are to be involved in the patients’ treatment. Robust governance arrangements would also need to be established to ensure that colleagues who are jointly appointed work as part of the team and not as an isolated in-reach practitioner. On-call cover for micro-vascular emergencies would need to be reviewed and expanded in order to manage an increase in patients undergoing this type of surgery.

Hub MDT Meeting

4.20 The vast majority of patients referred via a cancer two week wait pro forma into Head & Neck Services are not found to have malignant disease following clinical review and/or diagnostics. All organisations within the sector will therefore continue to receive these referrals, which will enable local centres (L1&2) to continue to see, diagnose and treat patients with benign disease where appropriate.

4.21 This pathway proposes that all L1&2 units refer their patients into one of two hub MDT meeting, hosted each week at UCLH and Barts Health NHS Trusts. As the volume of patients with malignancies is relatively small (although likely to increase over time), it is therefore envisaged that local centres (L1&2) will work no longer hold their own MDT meetings, but will have the opportunity to link into the hub MDT sites at UCLH and Barts Health either in person or via video-link. By reducing the number of forums where diagnoses are presented and treatment options discussed, we hope to ensure a robust and consistent approach for all patients with cancer diagnoses in the sector.

4.22 Detailed procedures will be agreed with each Trust for the management of the specialist head and neck multidisciplinary meetings and handover of patient responsibility between the local unit and the cancer centre at the time that the patient agrees to be referred for specialist treatment at the centre, and when the patient is discharged back to the care of the local unit. The detailed structure of these MDT meetings and the specialist clinics will be discussed with the Pathway Board and with each local unit.
Summary

- Joint working arrangements need to be agreed and put in place to ensure specialist colleagues at local centres are given an opportunity to be involved in the specialist pathway.
- Need to establish robust governance mechanisms for transferring patient care into and out of the specialist centre (L4a&4b).
- Review and invest in establishing a formal micro-vascular on-call rota.

Treatment

Presentation of Treatment Options

4.23 All patients will undergo a comprehensive health needs assessment as part of their preparation for any treatment. Following discussion at the MDT meeting, patients are seen in a multidisciplinary clinic held in the Macmillan Cancer Centre. Each patient is seen by an oncologist and surgeon in order to discuss treatment options including potential involvement within a clinical trial. An appropriate treatment plan might include surgery, radiotherapy or chemotherapy or a combination of these. The multidisciplinary clinic is also attended by a number of other healthcare professionals including clinical nurse specialists, speech and language therapists and dieticians. Following a review of our current services for patients, we are considering implementing a process of prescribing patient information, to ensure that the information given to patients is as tailored to their needs as possible.

4.24 Patients will be able to choose to have radiotherapy and/or chemotherapy treatments either at UCLH or at one of the other designated L4b centres. The designation of other centres as suitable to deliver radiotherapy, chemotherapy and radio-chemotherapy will allow patients the option of being treated closer to home. This is particularly important as these treatments often require patients to attend daily, which can be time-consuming and tiring. Radiotherapy options will always include SIB IMRT, as appropriate.

4.25 Palliative care is routinely considered as a pathway option for patients referred. MDT discussions identifying palliation care as the most appropriate 'treatment' pathway are shared with the patient at the multidisciplinary clinic and referrals made. Further details of palliative care services can be found on page 31. It is envisaged that patients will be presented with post-treatment rehabilitation options which will include referral back to their local centre.
Surgery

4.26 Dedicated pre-operative pre-assessment clinics currently run for both maxillo-facial and ENT surgery. These clinics include specialist anaesthetic support to ensure that patients with complex airway issues are thoroughly reviewed. Pre-assessment is also used to highlight any other concerns regarding the patients’ physical and/or mental ability to cope with the planned surgery.

4.27 Patients have access to pre-treatment clinics with their CNS Key Worker, and specialist dietetic and speech & language therapy review, to ensure that they are prepared emotionally for their treatment and have been able to discuss their likely rehabilitation needs prior to surgery. Patients are seen during their inpatient stay by the speech and language team within two days of surgery. All patients have access to videofluoroscopy, FEES, videostroboscopy assessments as and when required post-surgery.

4.28 Currently the Head and Neck Department prospectively collates all information involving staging, keyworker details, trial inclusion and management plans. Details of individual patients and their outcomes are entered onto Data for Head and Neck Oncology (DAHNO). Screening for suitability for clinical trials will form part of the shared treatment pathway and will take place prior to surgery as part of the pre-operative planning. Specific surgical outcome measures are collated and reviewed as part of the clinical governance procedures at the hub, and are subject to regular benchmarking at individual clinical level. These include surgical resection margins, flap failure rates, and returns to theatre. Prior to consolidation, joint governance processes will be set up to ensure that surgical outcomes across both specialist centres are considered.

4.29 The surgical team is committed to developing new practices and techniques. It is anticipated that robotic surgical skills will be developed so that robotic surgery can be offered as a treatment option for patients with head and neck cancers.

Current Radiotherapy Service at UCLH

4.30 The radiotherapy service for head and neck cancer patients is run by two Consultant Clinical Oncologists. The pathway for patients requiring non-surgical management of head and neck cancer is complex and multidisciplinary in nature. All patients are discussed in the weekly hub MDT meeting. Patients are seen by surgeons and oncologists to discuss treatment options and the MDT recommendation.
4.31 Simultaneous integrated boost Intensity Modulated Radiotherapy (SIB IMRT) is the precise delivery of radiotherapy to tumours whilst lowering the dose to normal tissues. The radiotherapy department at UCLH has been treating patients with SIB IMRT since 2005. The department is a recognised “grandfather” site for SIB IMRT by the National Cancer Action Team (NCAT) and has a clear structure and governance policies for delivery of this treatment. The radiotherapy department has five Varian Linacs; three of which have volumetric arc therapy, four with on board imaging and all with MLC and portal imaging. Volumetric arc therapy is in routine use and more than 24% of the radical workload for the whole department is planned in this manner; head and neck patient make a substantial proportion of this case load. For further information see mycancertreatment.nhs.uk (for UCLH’s self-assessment report on SIB IMRT).

4.32 New patient consultations are attended by the key worker for the patient and the therapy radiographer. Written information is given to the patient. Consent to proceed with treatment is taken at a second visit when the patient has had time to reflect. Any concerns are addressed at this visit. Dental referral and other test required for treatment (such as EDTA-GFR, audiometry) are requested once consent has been obtained. Relevant clinical trials are also discussed. In addition there is a pre-treatment clinic run by CNS and dieticians. Patients have a further opportunity to discuss treatment, are counselled and the requirement for PEG insertion is assessed and discussed. In addition there is a SALT clinic that reviews patients prior to starting treatment.
4.33 All patients undergoing radiotherapy are seen in a weekly multidisciplinary clinic attended by oncologists, therapy radiographer, dietician and speech and language therapist and the radiotherapy nurse. There is a further weekly dietician review to help patients maintain nutrition needs. In addition patients have access to the radiotherapy nurse in between these clinic times.

4.34 A supplementary prescribing service is provided in our department, meaning patient’s side effects are addressed as soon as possible, easing them through the treatment pathway. The therapy radiographer has rights to prescribe within the established framework. UCLH offers a range of additional services including complimentary therapy such as massage, aromatherapy, and reflexology within the radiotherapy department. There is also a dedicated support radiographer to assist patients accessing sources of funding when required.

Future Radiotherapy Provision for Head and Neck

4.35 The clinical oncology service is currently distributed across several sites namely UCLH, the Barts Health group of hospitals, North Middlesex Hospital, and Queens Hospital, Romford. The delivery of SIB IMRT in head and neck cancer is of extreme importance, not just for local control but for patient quality of life by sparing normal tissue such as the salivary glands. Conventional radiotherapy is more likely to cause xerostomia or dry mouth which may affect patient ability to swallow, dysguesia, speech as well as accelerating dental caries, increasing the risk of osteoradionecrosis. Parotid Sparing SIB IMRT has been found to improve salivary flow both objectively and subjectively when compared to conventional radiotherapy (Lancet Oncol. 2011 Feb;12(2):127-36).

4.36 In addition, given that target volumes are frequently adjacent to important structure such as spinal cord and brainstem, SIB IMRT is capable of shaping dose around the organs and provide prescription dose to the target, (J Clin Oncol. 2007 Mar 10;25(8):924-30).

4.37 Currently all patients requiring SIB IMRT at UCLH are receiving it. This has required an increase in resources; clinician training and voluming time, medical physics input and time on machines. UCLH would welcome the responsibility of ensuring equal access to all head and neck patients to SIB IMRT and support local Trusts to develop technical radiotherapy. This may mean in the short term an influx of patients into Central London cancer centres that are able to support this form of treatment.
### Figure 4-3 Future Radiotherapy Provision

<table>
<thead>
<tr>
<th>Current Position</th>
<th>Projected 2018 Position</th>
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<tbody>
<tr>
<td>SIB IMRT at UCLH and Barts</td>
<td>All radiotherapy departments treating head and neck patients have SIB IMRT capability</td>
</tr>
<tr>
<td>UCH Infomral Training of physicists at other hospitals</td>
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<tr>
<td>Most head and neck cancer should be treated with SIB IMRT</td>
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<tr>
<td>◆ Exceptions:</td>
<td></td>
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<tr>
<td>◆ Parotid bed</td>
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<tr>
<td>◆ Early laryngeal</td>
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<tr>
<td>◆ Small field unilateral oral cavity tumours</td>
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<tr>
<td>Local radiotherapy protocols/ quality assurance</td>
<td>Unified radiotherapy protocols/ quality assurance</td>
</tr>
<tr>
<td>Referral to proton panel; treatment abroad</td>
<td>PBT facility at UCLH</td>
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<tr>
<td>Trial portfolio variable between trusts</td>
<td>Integrated approach to research</td>
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<tr>
<td>Limited referral to sites with active portfolios</td>
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<tr>
<td>Translational work at UCLH</td>
<td>Translational work at UCLH</td>
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<tr>
<td>Multidisciplinary- AHP</td>
<td>Multidisciplinary approach</td>
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<tr>
<td>Outreach in areas where service not available needs funding</td>
<td>Patient fully supported throughout pathway</td>
</tr>
<tr>
<td>Education /Training – local policies</td>
<td>Integrated educational programme for medical staff /AHP/CNS</td>
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<td></td>
<td>Network education meetings</td>
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<tr>
<td></td>
<td>Radiotherapy specific</td>
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<tr>
<td></td>
<td>Professor of radiation oncology / academic unit at UCLH.</td>
</tr>
<tr>
<td></td>
<td>Provision of training and education with regard to technical radiotherapy</td>
</tr>
<tr>
<td>Brachytherapy at UCLH</td>
<td>Brachytherapy at UCLH</td>
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</tbody>
</table>
Currently patients undergoing radiotherapy for head and neck cancer benefit in that:

- Tumour delineation is aided by additional PET-CT planning and MRI based planning where required.
- SIB IMRT/Rapid ARC are delivered as standard mode of treatment for all locally advanced tumours. Small volume disease such as T1 Larynx is treated with conventional radiotherapy fields.
- True Beam with stereotactic capability is available for use where tumour volumes about critical structures i.e. Sinus tumours with intra-cranial extension.
- Treatment position is verified daily by KV imaging for all SIB IMRT/Rapid Arc Plans with weekly CBCT, which is reviewed jointly by a senior radiographer and Clinician
- HDR brachytherapy suite within our Radiotherapy dept, where we have treated lip cancers, recurrent nasopharyngeal tumours, and post-operative neck dissection for recurrent previously irradiated nodal disease. UCLH is one of the few centres that are able to offer this service.

**Proton Beam Therapy for Head and Neck Cancer**

In April 2012, the Department of Health announced that UCLH would host one of the first two high-energy Proton Beam Therapy centres in the UK and with central government funding of £125 million for each centre. Along with the Christie Hospital in Manchester, the UCLH PBT centre will apply the highest possible technical radiotherapy service to specific specialist patient groups who will benefit from this intervention.
4.40 The two main advantages of proton beam therapy, compared to photon beams used in radiotherapy, are high precision targeting of the tumour and improved dose distribution, reducing the risks of serious toxicity to critical structures. Both are directly relevant to the treatment of head and neck cancer and result in improved survival for patients receiving treatment and reduced chronic side effects associated with photon radiotherapy. These advantages have been evaluated by the Proton Panel of the National Radiotherapy Action Group and the Department of Health, and their conclusions showed that the benefits to patients will justify the £250 million of public investment in the two proposed centres. Approximately 300 of the patients expected to be treated nationally with proton beam therapy will be head and neck cancer patients.

4.41 The UCLH Proton Beam Therapy Centre will be developed in close proximity to the Cancer Institute and UCH Macmillan Cancer Centre and will consist of an accelerator and up to four treatment rooms. The exact specification of technology and vendor will be finalised over the next 12 months and the new service will open in 2018. At UCLH, the proton and photon radiotherapy services will be a single integrated department at UCLH. All patients treated with proton beam therapy will be defined within clear protocols and enrolled into a prospective programme of evaluation and outcome tracking to provide further evidence of the effectiveness of proton therapy. The Proton Beam Therapy Centre will increase significantly our research and clinical care capabilities for head and neck cancer, in collaboration with existing research in imaging, nuclear medicine, physics and head and neck cancer.

Chemotherapy

4.42 The safe delivery of chemotherapy is a multi-disciplinary service requiring expert medical, nursing and pharmacy input as well as administrative support. Chemotherapy has a role to play in the radical multi-modality management of head and neck malignancies, both as combination chemotherapy regimens as induction therapy and as concurrent chemo-radiotherapy, as detailed below.

4.43 Combination chemotherapy and bio-chemotherapy regimens also improve symptom control, quality of life and life expectancy as an integral part of palliative therapy for patients with many inoperable recurrent or metastatic head and neck cancers. These therapies are delivered with close support from hospital and community specialist nursing and palliative care teams.
Currently chemotherapy for the Head and Neck Service at UCLH is prescribed by two medical and two clinical oncologists. It is a consultant-led service using an electronic prescribing system to reduce prescription errors and improve chemotherapy governance. Peer reviewed chemotherapy algorithms have been agreed in UCLH, with detailed protocols in place, to guide high quality evidence-based chemotherapy use and to ensure patient centred care. The Macmillan Cancer Centre hosts the UCLH chemotherapy day unit where the majority of head and neck chemotherapy regimens are delivered. A specialist in-patient chemotherapy nursing team support the delivery of chemotherapy to in-patients when required.

It is proposed that individual patient cases would be discussed within the hub MDTs, where oncology input and guidance about eligibility to clinical trials running within London Cancer centres would be available. Gold standard chemotherapy would be delivered close to home by local centres. Complex early phase or molecular-focused trials running at UCLH (and possibly other level 4b units where appropriate) would be offered to eligible patients from throughout London Cancer and increased research support will be made available for NIHR Cancer Research Network (NCRN) adopted late phase studies to be run in smaller centres.

**Chemo radiotherapy**

Currently at UCLH, there is a patient pathway for chemoradiation protocols. Patients requiring the addition of chemotherapy are counselled with regard to the benefits and the additional side effects associated with this treatment. Chemoradiation for head and neck cancer is with platinum compounds (Cisplatinum). Renal function, audiometry and fertility implications are assessed prior to treatment. Cetuximab in combination with radiotherapy can be offered to patients of good performance status who are unable to have platinum therapy.

Chemotherapy is usually delivered as an outpatient in the cancer centre, but can be administered on the oncology wards if the patient is required to be admitted. The therapy radiographer plays a crucial role in liaising appointments between the radiotherapy department and the day-care chemotherapy unit. There are updated protocols for indications and delivery of chemotherapy which falls under the remit of chemotherapy governance of UCLH. The prescription of chemotherapy is done electronically through the CHEMOCARE program software. Drug modifications decisions during treatment are made at consultant level. Patients undergoing this treatment are reviewed weekly and chemotherapy prescribed prior to every course of chemotherapy. Toxicity sheets are filled at this visit, which forms an electronic patient documentation trail, allowing for retrospective audit.
Follow-up & Reconstruction

Specialist Follow-up

4.48 The chance of recurrent disease is at its highest in the first two years following major surgery, radiotherapy or chemo-radiotherapy. Specialist clinical observation through regular follow-up is essential. We envisage that this would be done by the treating team, who would be best placed to identify any changes to the patient’s condition. Radiotherapy patients are seen in the weekly ‘on-treatment' multidisciplinary clinic, until their side effects have settled, at which point their care is transferred general multidisciplinary outpatient clinic. All patients are offered the option for follow-up speech and language rehabilitation at the centre. A comprehensive service including ongoing assessments and therapy for voice, speech and swallowing disorders is provided. This includes specialist services for laryngectomy patients for whom we are one of the largest service providers in the UK.

Specialist Reconstruction

4.49 UCLH currently provides specialist reconstructive services, which include post-operative dental reconstruction and facial prosthetics. These services would continue, subject to ongoing commissioner agreement. Patients receive dedicated dental rehabilitation at both level 4 centres and these services will continue, as patients require specialist restorative dental input following surgery and radiotherapy treatments.

4.50 Suitable patients, following a detailed assessment and confirmation of disease-free status, will be offered dental implant placement at UCLH and possibly other level 4 centres. Maintenance of implants will be undertaken through specialist restorative dentistry clinics. Patients who have undergone radically appearance-altering surgery will be offered custom-made facial prosthetics, subject to an assessment for suitability and confirmation of disease-free status. This service will be provided at UCLH with support from a specialist prosthodontist.

Local Follow-up

4.51 Local follow-up of patients who are two or more years’ post-treatment is acceptable and sensible. Pathways would need to be established to safely transfer patients’ care from the specialist centre(s) to the local centres for longer term follow-up. Specialist nursing and therapy support at the local centres will need to be reviewed and it may be necessary to arrange service level agreements to enable UCLH’s specialist MDT to offer support to the local centres. It is essential that clinical advice given to patients at local centres meets a minimum standard.
Acute Oncology

4.52 UCLH has a full acute oncology service which meets peer review standards. The UCLH Oncology Department, of over 30 Consultant Cncologists, provides a comprehensive acute oncology service for emergency patients. Guidelines agreed with A&E are in place, for admission and treatment of these patients, including specific guidelines for the treatment of patients with neutropenic sepsis, and to fast-track referral for suspected lung cancer patients to a clinic appointment within seven days to avoid unnecessary admissions. The consultants undertake a rota to provide this service a week at a time, to supervise investigations and decisions on patient care and communication with the families in line with agreed guidelines. All emergency admissions are seen by their own consultant or by the on call consultant within 24 hours of their admission.

4.53 Our acute oncology consultant lead, Dr Farah Raja, is working with the A&E department, the acute medical unit, and with diagnostic departments to agree improved pathways for these patients, improved arrangements for fast-tracking patients from A&E to urgent outpatient appointments, and other measures to improve the outcomes and patient experience for this group of patients. We propose to appoint an acute oncology CNS. We have agreed a flagging system to ensure that existing cancer patients who are receiving treatment are flagged to emergency department staff at the earliest opportunity, and this is being implemented in partnership with our IT department and our IT services provider.

4.54 We expect that this work, led by Dr Raja, will enable us to submit plans and policies which make us fully compliant with the peer review standards early in 2014. We note that the peer review standards measure primarily the inputs and processes, and do not provide any direct measure of patient outcomes or patient experience for this patient group. We therefore wish to work further with London Cancer to develop measures of patient outcome and patient experience for this patient group. The radiotherapy department provides patients with emergency contact details as standard, should they require guidance or advice at any time. This is available 24 hours a day, 365 days of the year.

Acute Surgery

4.55 All patients will receive information about managing complications following their surgery. Patients should always attend their own local hospital for initial stabilisation should they require emergency care. Provision will be made to ensure that patients can be transferred from local hospitals to the L4a specialist surgery centre at UCLH if further surgery is required. UCLH will run a dedicated micro-vascular on-call rota, to ensure that complications following major reconstructive surgery can be dealt with urgently.
4.56 Patients will be given an enhanced information leaflet including frequently asked questions such as what to do if post-operative complications arise. Instructions will be given on how to contact a member of the surgical team should problems occur, particularly out of hours. In addition, there will be a phone call to each patient post-discharge to answer any queries or concerns and ensure that the discharge was managed appropriately with correct information provided and contact points for follow up.

4.57 We hope to offer a Surgical Clinical Nurse Practitioner hotline available seven days a week, 8am – 10pm, specifically for post-operative patients and a weekly drop in clinics for any post operation concerns. We will need to ensure effective communication with nursing teams at local hospitals relating to care of patients post discharge.

**Palliative Care**

4.58 Specialist Palliative Care services at UCLH are part of a wider service employed by Camden Provider Services, part of Central North West London NHS Foundation Trust (CNWL). The UCLH Inpatient Palliative Care team is part of the Camden, Islington ELiPSe and UCLH & HCA Palliative Care Service. The Service is a member of PallE8, the North Central and North East London Palliative Care Provider Network. UCLH team compromises of 1.6wte consultants and 6wte clinical nurse specialists who provide care to 1,224 new referrals per annum (2011/12 figures). Between 65% and 70% of referrals relate to patients with a cancer diagnosis.

4.59 The service provides symptom control, advice on management of psychosocial and spiritual distress, advance care planning, complex discharge planning with a particular focus on patients who require rapid discharge to allow them to die in their preferred place, and referrals to community services such as hospices as well as local palliative and continuing care teams. The service is provided through direct contact with patients and families in ward and clinic settings, participation in MDTs, weekly ward rounds and case conferences. The team provide under graduate and postgraduate teaching and is actively involved in research and development. These Specialist Palliative Care services support the general palliative care and end of life care provided by all clinical staff at UCLH.
4.60 The Speech and Language Therapy team provide a service to patients with long term and late effects following treatment some of whom may be referred from other centres for specialist and second opinions. They work closely with the palliative care team to support patients during the end of life.

4.61 Any patient, with any life threatening illness and a high symptom burden, can be referred to the SPC team by any member of a clinical team within UCLH, after seeking agreement from the primary medical team. A team member is available via the SPC bleep within working hours to respond to referrals, and via switchboard out of hours. Patients are referred for:

- Symptom control – pain / nausea & vomiting etc.
- Advice on management of psychosocial / spiritual distress
- Advance Care Planning – planning for the future. This involves complex discharge planning, referral for hospice care etc.

4.62 The SPC team holds:

- Three ward rounds/week (adult SPC, paediatric SPC, neuro-oncology SPC)
- One SPC MDT/week
- Two outpatients clinics (neuro-oncology SPC OPD weekly, adult SPC OPD fortnightly)

An Integrated Approach to UCLH Cancer Delivery: Head and Neck, Upper GI, Thoracic

4.63 There are compelling reasons for co-locating the expertise and infrastructure in the management of oesophago-gastric (OG), head and neck and lung cancer. Pharyngo-laryngeal cancers can encroach and extend into the cervical oesophagus, requiring the skills of head and neck and oesophago-gastric teams, and a gastric pull-up is the preferred method of oesophageal reconstruction after a laryngo-pharyngectomy. Although OG surgeons are trained and experienced with thoracic dissections necessary for oesophagectomy, complex situations, particularly involving fistulae between the oesophagus and the airways require the combined skills of OG and thoracic surgeons to ensure the best outcomes. Close working of these three specialties is even more important in complex benign disease and in dealing with complications of thoracic and OG surgery. Such a co-location is also essential for innovative procedures, best exemplified by a tracheal transplant carried out last year at UCLH, involving these three teams and several others.
Leadership

4.64 The Head and Neck pathway is complex and involves multiple organisations and professional groups. UCLH recognises that the real benefit of an integrated cancer system is harnessing the expertise across all of the trusts and is therefore not proposing a named leader at this stage of the process. In order to provide strong clinical leadership across the pathway, UCLH propose the appointment of a senior lead for Head and Neck Cancer Services responsible for the delivery of the clinical service.

4.65 Whilst not exhaustive, the following list gives an indication of the expected core functions of the leadership role:

- Clinical leadership within the head and neck cancer specialist centre;
- Providing clinical leadership and direction for the head and neck cancer pathway across all site levels and locations;
- Oncologist and research CNS from the specialist centre;
- Responsible for the harmonisation of referral pathways and protocols across the local centres;
- Responsible for the implementation of the MDT at the UCLH site and supporting the anticipated MDT level 3 unit provided by Barts Health.;
- Delivering system-wide collaborative working for clinical service matters;

4.66 Should UCLH’s proposal be successful, the process to recruit a senior leader for the Head and Neck Cancer Service would begin immediately. In the interim period, pathway leadership would remain with Mr Simon Whitley, and UCLH clinical leadership would continue to be provided by Mr Kalavrezos, OMFS Surgeon and Clinical Lead for Head & Neck at UCLH, supported by colleagues including Professor Shak Saeed, Consultant ENT & Skullbase Surgeon and Divisional Clinical Director for RNTNEH. Appropriate management resources would be in place to ensure that both the clinical and the academic leadership was adequately supported.
4.67 Academic leadership within Head and Neck Services is also key to the successful delivery of this proposal. Professor Chris Boshoff, Professor Shak Saeed and Professor Martin Birchall are just a few of the existing senior academics within this field at UCLH. Due to the multidisciplinary nature of the clinical work, academic developments are often collaborations between many difference departments and specialties, both in and out of UCLH. It is envisaged that the existing academic expertise would be further enhanced through joint working with other trusts within the sector.

4.68 Whilst not exhaustive, the following list gives an indication of the expected core functions of those appointed to academic leadership positions with Head and Neck Cancer Services:

- Supporting newly appointed Head and Neck Cancer Service Director to create solid relationships with the academic partners at UCL, the Royal Free Hospital, Barts Health, UCLH and the surrounding networks.
- Delivering system-wide collaborative working for academic matters;
- Responsible for ensuring research participation at local centres through the identification and implementation of suitable trials to be delivered in local units with support from the medical

4.69 The UCLH Board and Executive have committed to both the investment required to create the head and neck specialist centre and to deliver a transitional plan. This commitment includes continual assessment and analysis of progress against plan to ensure that services are delivered as agreed, in collaboration with our partner organisations. The UCL Partners Pathway Director, Mr Simon Whitley, has given us much helpful advice in formulating this UCLH proposal, and we have asked him to continue to remain closely involved in the implementation and leadership of this service at UCLH. He will therefore be directly involved in designing the future roles and making the appointments to lead Head and Neck Cancer Service at UCLH.

Research & Innovation

4.70 UCLH has many examples of pioneering research in the field of head and neck. Delivery of the London Cancer Head and Neck Cancer Service through a centralised specialist multi-disciplinary approach, based at UCLH, will significantly enhance the opportunities to build an internationally-respected clinical and translational research program. There is also recognition, highlighted in recent patient satisfaction surveys, that as well as investigator, institution and national drive to recruit into clinical studies, patients themselves would like clearer communication of research opportunities available for them.
Research and Clinical Trials at UCLH

4.71 UCLH is already established as a world-class leader in clinical research and has one of the largest portfolios of studies. At any one time we can have over 1,000 research projects taking place in our hospitals. Our clinicians work closely with scientists at UCL (University College London) and together we continue to make advances in preclinical and translational medical research that will directly benefit patients and save many lives. Our work ranges from basic and translational science, exploring the causes of disease; through experimental medicine, which looks at how certain treatments work and they’re safety and tolerability; to pivotal large scale clinical trials which test the effectiveness of new drugs. As an international centre for research, our patients have access to some of the most cutting edge treatments. Each year thousands of our patients volunteer to take part in these studies. Our research is delivered through:

◆ the National Institute for Health Research University College London Hospitals Biomedical Research Centre which focuses on experimental medicine, with cancer as a core theme

◆ our Joint Research Office which provides research management and support with biostatistics, governance and professional development

◆ the UCLH/UCL NIHR Clinical Research Facility in the Elizabeth Garrett Anderson wing of UCLH which provides a dedicated clinical environment and specialist trained staff for the delivery of early phase clinical research

◆ the Cancer Research UK & UCL Clinical Trials Centre which is a specialist unit with a specific remit to design, conduct, analyse and publish clinical trials and other well-designed studies

Head and Neck Translational Research

4.72 A centralised London Cancer surgical service will increase recruitment into the UCLH Head and Neck tissue bank. This has been established over the last four years and has several hundred samples stored, with associated demographic data. Work to date has included exploration of the drivers of HPV+ve and HPV-ve Head and Neck Squamous Cell Cancers (Lechner et al Genome Med 2013;5(2):15. Lechner et al Genome Med 2013; 5(5):49). A larger sample size will allow more extensive validation studies.
4.73 UCLH has significant clinical expertise in a number of rarer head and neck malignancies including head and neck sarcomas and sino-nasal tumours and tissues stored from these malignancies offer a unique opportunity for translational research. Expanding tumour tissues collected will also allow expansion of the translational program currently underway at UCL Cancer Institute including the interrogation of the molecular landscapes of Head and Neck malignancies through the development of well characterised cell line panels and in vivo models. This translational work will increase the understanding of the cell biology underlying head and neck malignancies, with the potential to discover novel drug targets and generate data to assist the evaluation of rationale drug combination studies with parallel development of predictive and pharmacodynamic biomarkers.

**Head and Neck Clinical Research**

4.74 UCLH has the infrastructure and expertise to run complex commercial and academic early phase head and neck studies, a number of which are currently open, with others in development. These include studies investigating novel therapies in the metastatic setting (for example the Shiniogi phase I and Eisai-7050-702 phase II studies currently recruiting) and studies exploring drugs as radio-sensitising agents in both the radical (for example the ORCA study is a UCL-sponsored UCL-led phase I/II study currently in development) and palliative (for example the PATRIOT study, also currently in development, is co-led by a UCL chief investigator) settings. An increasing number of these studies have UCL-based chief investigators and are UCL sponsored. Centralised MDM discussions of patient care will highlight potentially eligible patients from across London Cancer who can be offered the opportunity to be involved in such studies, increasing patient choice and enhancing recruitment.

4.75 Improved communication across London Cancer will also increase clinician and patient awareness of late-phase studies. Support will be generated to run these studies across multiple London Cancer sites beyond UCLH. The UCLP harmonisation program expedites the set-up process, making London Cancer sites particularly attractive for commercial studies. Future studies will also include UCL-driven academic trials (for example the UCL-sponsored UCL-led randomised phase II ANEMONE trial which is currently in development), academic studies from other centres (for example the HN5000 and TITAN studies currently recruiting) and also commercial studies, strengthening London Cancer as a leading UK centre for Head and Neck clinical research.

**Radiotherapy Research and Innovation**

4.76 The UCLH radiotherapy department is committed to participating in radiotherapy research, with aspirations to increase studies driven by UCL/UCLH investigators as well as to continue recruiting into other national / international academic and commercial studies.
The current trial portfolio includes national trials such as:

- Costar (Recruiting)
- Descalate HPV (Opening imminently)
- Art Deco (Opening imminently)
- Bohemian (In set up) - Two site collaboration to examine the correlation between tumour hypoxia genetic signatures and hypoxic phenotype on Cu-ATSM PET/CT scanning

There are several radiotherapy linked studies with UCLH chief investigators:

- Multi-parametric MR imaging and planning study (grant awarded by RCR, recruiting) is a UCLH pilot study that has been recruiting for a couple of years and is already generating novel data, with 2 manuscripts submitted for publication.
- LEONIDAS – Post Radiotherapy Salivary Pacemaker study (NIHR grant funded, recruiting) is a UCL-led two-centre study and currently recruiting very well
- PANDORA – Non-invasive oral cancer diagnostic study (NIHR funded, opening imminently) is a UCL-led multi-centre study following on from a recently completed UCL based pilot study
- PATRIOT – Phase I investigation of a first-in-class ATR inhibitor as a radiosensitiser for palliative radiotherapy (currently in development)
- HPV study – UCL Health Behaviour Centre study investigating doctor-patient communication regarding HPV as a cause of head and neck cancer

The use of PET MR radiotherapy planning is being examined as an innovation to further enhance accuracy of radiotherapy delivery.
Current UCLH Head and Neck Clinical Trials Portfolio

The NCRN national trials form part of the trials portfolio agreed and approved within the NSSG and 2012/2013 recruitment is detailed below. There has been a gradual increase in the number of studies open to recruitment at UCLH with an associated improvement in accrual across the portfolio. UCLH is becoming recognised as a Head and Neck clinical trials centre with patients being referred from centres around the region and beyond specifically for consideration of entry into a clinical studies. UCLH contributes significantly towards the trials recruitment across the NLCRN, which in 2012 ranked 10th nationally for recruitment into randomised studies and 20th overall.

<table>
<thead>
<tr>
<th>NCRN Trial Title</th>
<th>Trial Status</th>
<th>Trial Type</th>
<th>Screened</th>
<th>Recruited</th>
</tr>
</thead>
<tbody>
<tr>
<td>PET-NECK</td>
<td>Open</td>
<td>Phase III</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>CoSTAR</td>
<td>Open</td>
<td>Phase III</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TITAN</td>
<td>Open</td>
<td>Pilot Randomised Study</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>LEONAI DAS</td>
<td>Open</td>
<td>Pilot</td>
<td>35</td>
<td>25</td>
</tr>
<tr>
<td>HN 5000</td>
<td>Open</td>
<td>Epidemiological</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>SMA</td>
<td>Open</td>
<td>Diagnostic</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>De-Escalate</td>
<td>In set up</td>
<td>Phase III</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ART DECO</td>
<td>In set up</td>
<td>Phase III</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commercial Trial Title</th>
<th>Trial Status</th>
<th>Trial Type</th>
<th>Screened</th>
<th>Recruited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eisai - 702</td>
<td>Open</td>
<td>Phase II</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PCI Biotech (phase II)</td>
<td>Open</td>
<td>Phase II</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Shiniogi</td>
<td>Open</td>
<td>Phase I</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>PCI Biotech 101/06</td>
<td>Closed</td>
<td>Phase I</td>
<td>19</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UCLH in-house studies</th>
<th>Trial Status</th>
<th>Trial Type</th>
<th>Screened</th>
<th>Recruited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiparametric MR study</td>
<td>Open</td>
<td>Pilot</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Tissue Bank</td>
<td>Open</td>
<td>Biobank</td>
<td>-</td>
<td>43</td>
</tr>
</tbody>
</table>

Figure 4-4 Head and Neck Clinical Trials
The current UCLH palliative care team is actively involved in Palliative Care research projects as shown below and it is our vision that these would continue.

**Figure 4-5 Palliative Care Research Projects**

<table>
<thead>
<tr>
<th>Palliative Care Research Project</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CanTalk study</td>
<td>Awaiting R&amp;D Approval</td>
</tr>
<tr>
<td>COMPASS:ion study</td>
<td>Recruiting</td>
</tr>
<tr>
<td>ACP in parents of teenagers</td>
<td>Pilot study. Recruiting</td>
</tr>
<tr>
<td>Use of e-technology</td>
<td>Proposal in development</td>
</tr>
<tr>
<td>EOLC within Brightlight study</td>
<td>Funding awarded</td>
</tr>
<tr>
<td>ACP in brain tumours</td>
<td>Funding awarded. Data collection started</td>
</tr>
<tr>
<td>Decision making in teenagers with haematological malignancies</td>
<td>PhD student in post. Research in development</td>
</tr>
</tbody>
</table>
Joint Working with Other Hospitals

4.82 Our experience of centralisation and collaborative working has taught us that good communication is key to a successful partnership and is required at all levels across the MDT team. To ensure effective communication we will develop a number of systems and forums in partnership with referring Trusts.

4.83 Our partnership with other network trusts will encourage best practice to be shared and adopted across organisations within the sector. Information sharing is important to help optimise systems and processes; for example, we hope to create a pro forma for referral and implement a tracking database that has already been developed in urology services. There are several forums in existence that will facilitate this process; examples include the Network CNS Group, Operational Action Group, London Cancer Pathway Board, London Cancer Research Meeting, North Thames Audit Meeting.

4.84 We envisage that these forums will work together to help standardise patient pathways, reinforce clinical network guidelines and provide consistency in care provision across all organisations. We will establish an Operational Action Group (OAG), which will be the conduit for driving forward improvement across the North and East London. Moving forward we would like to ensure that membership of the OAG includes representation at each organisation involved in the hub MDT. We acknowledge the time commitment which can draw members away from clinical service and will test a video conference system with agenda and outcomes circulated around meetings. As with urology, we would like to formalise the Head and Neck OAG as a structure reporting to the London Cancer Board.

4.85 The proposed changes offer a huge opportunity to collaborate locally in the delivery of training and education to our junior doctor workforce. Such collaboration would ensure that rotas remain compliant with European Working Time Directive (EWTD) requirements. The changes to the delivery of services across all organisations within N&E London will require us to review the content of each trainee’s timetable and will offer the opportunity to work together with our partner organisations to deliver the right training in the right location, tailored to each trainee’s requirements.

4.86 Figure 4-6 illustrates how UCLH and Barts Health will work together as hub MDT sites, incorporating all potential cancer patients from the North and East of London. The specifics of the relationships between UCLH, Barts Health and the other organisations within the sector will need to worked through following the decisions that London Cancer makes having reviewed all of the bids submitted.
Information Management and Sharing

4.87 Good communication is essential to a successful partnership and is required at all levels across the MDT team. To ensure effective communication we plan to develop a number of systems and forums in partnership with referring Trusts.

4.88 The first step will be to adopt the patient-tracking database recently implemented by the Urology Department that has proved successful in the centralisation of pelvic surgery at UCLH. This system logs the patients onto a database from initial referral and tracks the important milestones on their pathway until discharge. The administrative staff use this as a tool to ensure that delays are minimised and any missing data is chased up with referring organisations and also to ensure that communication of key pieces of documentation such as the discharge summary is promptly sent to the referring Trust and primary care. The database will also be used to generate a weekly report updating the referring Trust on the status of each patient within the pathway. We will maintain and update our staff directory to ensure that Clinical Nurse Specialists and MDT co-ordinators are aware of their counterparts within referring organisations and are easily able to make contact.
5. Maintaining Local Access and Enabling Patient Transport

5.1 If UCLH is successful in its application to host local and specialist Head and Neck Cancer Services, we will ensure that patients will receive as much care as possible locally. The services provided in local hospitals will be of the same quality as those delivered from the UCLH site. For those patients who do have to travel to UCLH we will do our best to support the provision of efficient and convenient transport arrangements.

Local Services

5.2 All hospitals within the North and East sector will work together to ensure that the standard of care offered is consistent across all organisations. The pathway diagram on page 14 shows how each patient will move between local and central services. We recognise how important it is to ensure that existing pathways and expertise are maintained for the benefit of both patients and staff.

5.3 In chapter 4 we have explained how UCLH will work with local centres to deliver excellent Head and Neck Services across the sector. Whilst it is proposed that all surgery is centralised at UCLH, chemotherapy and radiotherapy is likely to be available at four sites within the sector (subject to the outcomes of this application process). This will enable patients to receive these treatments, which are often administered daily over a long period, closer to their home and therefore minimise travel time.

5.4 Specific details of our approach to information sharing, a key component of local service delivery, can be found in section 4 (under Patient Pathway). UCLH is committed to ensuring that appropriate information is shared with patients, their GPs and other health care providers in a timely fashion.

Transport

5.5 Our aim is that patients will only come to the specialist centre when they need to; we have opted for a model which minimises patient travel, whilst also recognising the importance for the patient of obtaining access to the best possible diagnostic and treatment options for them. Whilst this section demonstrates the accessibility of the UCLH sites, we recognise the genuine concerns that patients have expressed about the need to improve transport services for patients attending the Cancer Centre at UCLH. We will work with London Cancer and the Cancer Partnership Boards to identify innovative solutions to these problems.
5.6 UCLH is building on the UCLP’s patient transport services specification in the current review of our transport strategy in consultation with Camden Council. As part of these discussions, we will be asking Camden Council to make available space for an increased number of disabled car parking bays in the immediate vicinity of UCLH. However, in line with the transport policies of the Mayor for London and Camden Council, UCLH will not be encouraging patients to attend outpatient appointments using their own private transport that would require local car parking. Public transport links to UCLH are excellent; eligible patients and families will of course continue to receive reimbursement of their travel costs in line with national eligibility rules.

5.7 Patients receiving specialist surgery at UCLH will also be offered the option of hotel accommodation overnight prior to surgery, when travel on the day of surgery is impractical. This will be at the UCLH Charity Patient Hotel (see http://www.cottonrooms.com/) or other suitable hotel near UCLH.

5.8 We acknowledge the need to improve the booking arrangements for cancer patients using NHS transport for journeys to the UCLH campus and back home in order to ensure that the timing is convenient and suitable for patients and their families. This is one specific area where we will work with the Cancer Partnership Broads on the best ways to achieve the necessary improvements.

5.9 UCLH is currently producing an overarching travel plan policy which will govern Trust-wide measures, initiatives and monitoring over the next five years. This travel plan is designed to enable the staff, patients and visitors of UCLH to make more informed decisions about their travel. We are also in the process of assessing the quality of the existing hospital patient transport service and will ensure that patients are transported in suitable vehicles, with appropriate standards of timeliness and comfort, equipped where required to provide appropriate levels of care.

Public Transport

5.10 The site has extensive public transport options due to its central London location.

Buses

5.11 UCLH is very well served by buses, with a number of routes being accessible from within a 600m walking distance of the campus. Between them, these routes provide bus services across Greater London.
Underground

5.12 UCLH is located within walking distance from three London Underground stations: approximately one minute walk to both Warren Street to the west (100m), and to Euston Square to the east (200m) and approximately five minutes’ walk to Euston (600m) also to the east. Between them, these stations provide easy access to the Victoria, Northern, Circle, Hammersmith & City and Metropolitan lines.

Mainline Rail Services

5.13 Euston mainline station is approximately 600m away from the site. The station offers frequent services on the West Coast Mainline and London Midland to Manchester, Birmingham and Liverpool as well as long distance commuter destinations such as Tring, Milton Keynes and Northampton. In addition, King’s Cross and St. Pancras Stations are approximately 1.2km away from the site. These stations offer frequent services on the Midland and East Coast main lines to destinations to the north and south of London, including Luton and Gatwick Airports. Euston, King’s Cross and St. Pancras Stations all offer cycle parking and step-free access for mobility impaired travellers.

Private Transport

5.14 The area surrounding the UCLH sites encompasses major arterial routes, including Euston Road (A501) to the north, Gower Street (A400) to the east and Tottenham Court Road (A400) to the west.

5.15 Car parking provision at UCLH sites is very limited but UCLH is pledging as part of the bid to support as much clinical care as possible is delivered at local hospitals to prevent the need to drive to the hub and when travel to the hub is necessary to ensure that the number of visits is limited as far as possible.
Travel Times

5.16 The maps demonstrate the approximate travel times by car (black text) and by public transport (green text) to UCLH from the other London Cancer hospitals.
6. Improving Patients’ Outcomes and Experience

6.1 We recognise the importance of measuring the impact on patients of the proposed changes to the delivery of Head and Neck Cancer Services within the London Cancer catchment and are committed to making this information widely available.

Audit and Outcomes

6.2 Auditing the head and neck pathway is an important aspect of service delivery and is an evolving process. Included below are the summaries of the previous Network Site Specific Group audits in which UCLH has participated.

6.3 With a dedicated Surgical Head and Neck Ward (T14 South) a provision for Head and Neck Specialist Nursing is available. Ward based audits are regularly carried out to assess the quality of service delivered at a critical point in the patient pathway.

Laryngeal Cancer Audit

6.4 This retrospective audit of laryngeal cancers managed over a one year period, demonstrated the variety of treatment modalities undertaken for laryngeal cancer as well as appropriate CNS and dietetic input being offered to patients with this diagnosis. The audit was presented at the Network Tumour Board.

Figure 6-1 Laryngeal Cancer Audit

<table>
<thead>
<tr>
<th>Treatment Provided for Laryngeal Patients</th>
<th>Number Carried Out on Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial laryngeal surgery (external)</td>
<td>0</td>
</tr>
<tr>
<td>Laser</td>
<td>4</td>
</tr>
<tr>
<td>Total laryngectomy</td>
<td>10</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>24</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>2</td>
</tr>
</tbody>
</table>
6.5 Within the total of ten laryngectomies, the following interventions were carried out:

<table>
<thead>
<tr>
<th>Voice Rehabilitation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary voice restoration with valve</td>
<td>6</td>
</tr>
<tr>
<td>Secondary puncture</td>
<td>1</td>
</tr>
<tr>
<td>Oesophageal speech</td>
<td>1</td>
</tr>
<tr>
<td>Servox/electrolarynx</td>
<td>2</td>
</tr>
<tr>
<td>Post-op swallowing assessment/video swallow</td>
<td>10</td>
</tr>
</tbody>
</table>

Figure 6.2 Laryngectomy Interventions

Fine Needle Aspiration Services – Multiple Sites

6.6 This retrospective audit of Fine Needle Aspiration Cytology (FNAC) was undertaken to assess adequacy rates across three different sites with our Senior Radiologists’ practice. It was evident in two of the hospitals where a named cytopathologist looks at the FNAC the adequacy of results was excellent. In one hospital where more than one or two named cytologists practice, the adequacy of sampling was significantly decreased urging us to streamline our samples towards a named cytopathologist. This cytology now is therefore only sent to the UCLH Cytopathology Department where the combination of excellent radiological sampling and the expertise of a dedicated Cytology Department to interpret these samples offers our patients an accurate and world class service. The audit was presented at the Network Tumour Board.
Data for Head and Neck Oncology (DAHNO) National Audit – UCLH Performance

6.7 UCLH participates in the DAHNO national audit of head and neck cancer. The most recent published DAHNO audit report dates from 2011, where key measures are broken down by provider Trust.

Interval between obtaining biopsy and reporting

6.8 This indicator measures the time between a biopsy being taken, and the results being available to the MDT. UCLH performs well above the national average.

<table>
<thead>
<tr>
<th>Interval between biopsy and reporting</th>
<th>% &lt;= 10 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCLH</td>
<td>94.6</td>
</tr>
<tr>
<td>England and Wales</td>
<td>86.9</td>
</tr>
</tbody>
</table>
Analysis of Resective Pathology at MDT

6.9 Following surgery as a first definitive treatment for head and neck cancer, it is expected that the results of the resection are taken to the MDT in order for margins to be reviewed, and an informed decision on further treatment to be taken. This discussion was recorded for 90 per cent of UCLH patients, which is greater than the national position of 82.5%.

<table>
<thead>
<tr>
<th>Analysis of resective pathology discussion at MDT (patients with surgery as first definitive treatment)</th>
<th>% Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCLH</td>
<td>89.8</td>
</tr>
<tr>
<td>England</td>
<td>82.5</td>
</tr>
</tbody>
</table>

Figure 6-5 Audit of Resective Pathology at MDT

Patients’ Experience

6.10 UCLH recognises the importance of both measuring and publishing information on the outcomes and experience of diagnosis, treatment and supportive care for OG cancer patients.

6.11 UCLH has introduced real-time surveys in cancer day case, outpatients and inpatients to allow on-going feedback about the services with the data (and responses) reviewed regularly by the staff of each service, as well as monthly through a Cancer Patient Experience Programme. UCLH Chief Executive Sir Robert Naylor has commented:

“In the wake of the Francis Report, we support the expectation of greater openness about how we are performing. This new section on our website is just a start: over the next few months we plan to publish more detailed information about the care we provide in a way that patients can easily understand. We want our patients to come to UCLH knowing that they are in the best possible hands”.

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6.12 The National Cancer Patient Experience Survey (NCPES) 2011/2012 published in August 2012, included a number of very positive comments about this service (see Figure 6-6).

6.13 The cross-division Cancer Patient Experience Programme, that includes both staff and patients, was established in December 2012, supported and agreed by the Executive Board. The programme coordinates action plans across four themes, identified from analysis of the survey results and to improve cancer patient experience:

- Explanation and involvement of patients in decisions – to include a greater understanding of patients understanding
- Written information – to improve the quality and availability across the organisation
- Emotional support – improved access to clinical nurse specialists and the roll out of SAGE & THYME training for staff
- Always – some basic dos and don’ts for everyone dealing with cancer patients

6.14 The Head and Neck Department has been working with Macmillan Cancer Support on a patient experience project.

In 2012 we appointed a Macmillan Patient Experience Project Manager to work with the Head and Neck Team on establishing the Macmillan Values Standard. We have concentrated specifically on the dignity of patients, both in outpatient and inpatient settings.
6.15 This post-holder has collective considerable qualitative data, through patient interviews, observations and questionnaires. The Head and Neck Team is using this to identify where there are opportunities to improve practice. The feedback from patients on being involved in this workstream has been extremely positive.

6.16 The numbers of referrals to UCLH for two-week wait (2WW) head and neck suspected cancer patients has risen steadily on an annual basis. In 2012/13 1,276 patients attended the 2WW diagnostic head and neck multi-disciplinary clinic in the Cancer Centre.
6.17 UCLH is committed to providing a high quality patient experience for all of our patients, whether they attend for one diagnostic clinical appointment or continue with life-long cancer treatment with us. We always engage our patients, as members of the general public, and through our network of regular patient representatives, service users, carers as well as seeking the views others through our wealth of user groups. At every stage of the patient journey we constantly review our performance and identify ways we can make improvements. Four pertinent examples (details below) show assessment of patient anxiety levels during the outpatient phase of the pathway; reduction in time from referral to decision due to improved diagnostic pathways; a review of overall satisfaction levels within the treatment modality of radiotherapy; and analysis of preferred place of care for end of life patients. All four examples demonstrate our commitment to ensuring patients have a positive experience throughout their entire cancer journey. We would anticipate sharing knowledge and best practice around head and neck cancer patient experience with our partner organisations and fellow patient groups, to provide an exemplary service for patients.

Outpatients

6.18 The head and neck cancer outpatient service transferred to the new UCH Macmillan Cancer Centre in April 2012. The new building presented opportunities for new ways of working for both patients and staff so the team were keen to understand the impact on their patients who were attending repeatedly.

6.19 Questionnaires were handed to willing participants who attended head & neck cancer clinics (both new and follow-up patients, both ENT and OMFS clinics) in the former outpatient department in the Rosenheim Wing, UCH (RW), and then at the UCH Macmillan Cancer Centre (MCC).

6.20 Participants were asked how many times they had attended clinic before (maximum five times previously), and were asked to rate their anxiety on a 0–100 visual analogue scale (100 being worst anxiety). They were then asked to identify the source of their anxiety (five tick-boxes and free text), and to give general feedback on the service (free text). In the first cycle, they were also given written information on the new building.

6.21 Overall mean anxiety of patients in the MCC was lower (18.76 v 25.56). The mean anxiety levels were highest during the first visit to both buildings, and were very similar (30.19 in the RW, and 29.91 in the MCC) but whilst the anxiety levels dropped and then continually rose in the RW, the patients seen at the MCC experienced increasingly reduced levels of anxiety.
Diagnostics

6.22 The Head and Neck Department introduced a new one-stop service involving Triple Scanning (MRI, CT and US radiology) on the day imaging. The team then audited the benefit achieved to patients under the new diagnostic pathway compared with the previous, more standard process.

6.23 The average time to obtain a biopsy (18.3 v 11.2 days) and to make a diagnosis and treatment plan at the multi-disciplinary team meeting also subsequently improved (25.4 v 16.5 days). As a consequence of quicker diagnosis, treatment was also commenced much more rapidly from a previous 53.6 to 33.6 days.

6.24 It has also been shown that a delay in diagnosis and hence treatment leads to worse survival outcomes. The NHS Cancer Reform, NHS Cancer Plan and NICE address these issues with guidelines regarding timeframes in which patients should obtain definitive treatment. Therefore at UCLH we have found that by introducing the one-stop ‘triple scanning’ radiology service this process is significantly expedited. We feel this is something all Cancer Units should consider adopting.
Treatment

6.25 UCLH is proud to offer an exemplary radiotherapy service to all of our patients, including those head and neck cancer patients we treat. 100% of our radiotherapy patients rated the care and support they received from the radiotherapy department as good or excellent. A recent patient experience survey within the department of radiotherapy demonstrated excellent results:

- 96% found the reception staff welcoming
- 92% felt they were given the information and explanations they needed by the nurses and radiographers
- 96% felt that their pain and treatment side effects were adequately controlled.
- 96% of all patients were seen within 30 minutes of their appointment time including 52% of people who were seen on time and a further 32% who were seen 15 minutes after their scheduled time

End of Life Care

6.26 Between September and December 2011 the palliative care team examined the preferred and actual place of death of patients. The results showed that 40 out of 51 patients (84%), died in their preferred place, of which 57% was outside hospital. The two Community Palliative Care Teams reported preference and actual place of death for all patients covered by the Camden Palliative Care Service to be >88% patients achieving their preferred place. Our Community Palliative Care Teams are commissioned on achieving death in the preferred place of care in over 80% cases and ensuring that out of hospital deaths are >79%.

Figure 6-9 Impact of Triple Scanning

<table>
<thead>
<tr>
<th>Pathway check-point</th>
<th>Pre-Triple Scanning</th>
<th>Post-Triple Scanning</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Days (mean)</td>
<td>Range</td>
<td>SD ±</td>
</tr>
<tr>
<td>Imaging</td>
<td>7.9</td>
<td>0-21</td>
<td>6.3</td>
</tr>
<tr>
<td>Biopsy</td>
<td>18.3</td>
<td>1-34</td>
<td>9.4</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>25.4</td>
<td>7-46</td>
<td>8.6</td>
</tr>
<tr>
<td>Treatment commenced</td>
<td>53.6</td>
<td>18-81</td>
<td>32.8</td>
</tr>
</tbody>
</table>

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6.27 In 2010, 114 UCLH inpatients were surveyed on care provided by the inpatient Palliative Care Team:

- 98% felt they were treated with dignity/respect
- 96% had confidence in the staff
- 93% rated the care provided by the Palliative Care Team as excellent/very good

6.28 UCLH is committed to going further for our patients and whilst pleased with our preferred place of care results, we believe that we can do better. We are proud to have recently obtained charity funding to employ clinical nurse specialists to roll out the AMBER care bundle in selected inpatient settings. The AMBER Care Bundle is a tool, developed at Guys and St Thomas NHS Foundation Trust (GSTT), which facilitates decision making about patients whose condition is deteriorating, are clinically unstable, with an uncertain outcome.

6.29 Once a patient has been identified as fitting the AMBER bundle criteria, the medical team is asked, within four hours, to document the medical plan and a treatment escalation plan (ward based care or critical care) within the medical records, and to discuss and agree the plan with the nursing staff. The nursing staff are then responsible for ensuring that a meeting with the patient and/or carer is held within 12 hours to establish their understanding and preferences about future care, including, where appropriate, preferred place of care, and to communicate the decisions made. Each day thereafter, the patients' clinical condition is reviewed, decisions made are reviewed and amended as appropriate, and there is communication with the patient / carers to keep them updated.

6.30 Data from GSTT has revealed that implementation of AMBER has resulted in a halving of the 30 day emergency readmission rates for AMBER patients from 35% to 14% when compared with patients who died within 100 days of discharge from the same wards. In addition, over 70% patients died in their preferred place, the cardiac arrest call our rate fell from 7-8/month to 1-2/month, and patient/carer satisfaction was very high.
7. Providing the Capacity to Transform Services

7.1 The Board of Directors of UCLH have consistently reaffirmed their support to the strategic development of specialist cancer services at UCLH, and to working in partnership with London Cancer to ensure that these improvements benefit the whole population served by London Cancer. The Board’s commitment to the development of cancer services at UCLH has been demonstrated by the opening of the £100 million University College Hospital Macmillan Cancer Centre in April 2012. The Board have made a further commitment to the development of specialist cancer services by agreeing the Outline Business Case for our Phase 4 development, which will include the proton beam therapy service, due to open in 2018. We will apply the same combination of clinical leadership and disciplined project management to delivering the improvements in Head and Neck Cancer Services outlined in this document.

Organisational Capacity

7.2 In line with UCL Partners’ strategic vision, UCLH is working closely with Barts Health and UCL Partners towards the transfer of specialist cardiac services from UCLH to Barts Health early in 2015, subject to the outcome of public consultation. This change will make 90 inpatient beds and 4 inpatient theatres available at UCLH. Our preliminary calculations confirm that this is more than sufficient capacity necessary to enable us to take on the specialist Cancer Services in Upper GI, Head and Neck, Thoracic, and Haematology. We are currently working on the best configuration of services within the UCLH campus; given the close working between specialist cancer services for upper GI, head and neck, and thoracic (please see paragraph 4.65) and the importance of the clinical synergies, we think it is likely that these specialties will be co-located in the main University College Hospital tower from the middle of 2015.
7.3 These changes will allow us to deliver the full range of specialist Head and Neck Cancer Services at UCLH from 2015. We are also working on longer term plans to consolidate services when our Phase 4 development, including proton beam therapy, opens in 2018. Among the options currently under consideration, we are evaluating the impact of providing up to 150 additional inpatient beds in our Phase 4 development, which will allow us to consolidate all of the inpatient services within UCLH onto two sites in 2018, University College Hospital and the National Hospital for Neurology and Neurosurgery. We expect to have developed this plan in further detail in advance of the public consultation process that is planned to start in September 2013.

7.4 We will work in close partnership with the Pathway Board and other hospitals in London Cancer throughout the implementation period, agreeing all important milestones and decisions with them. We will provide regular progress reports to the Pathway Board to ensure that the benefits from patient outcomes, patient pathways, patient experience, and research and innovation in further advances in Head and Neck cancer treatment are delivered. If the proposals in this document are not accepted by London Cancer, because alternative proposals offer greater benefits to patient outcomes, patient pathways, patient experience, and research and innovation, then UCLH will of course co-operate fully with other Trusts to ensure successful implementation.

Impact of Change

7.5 The argument for the centralisation of specialist surgery and for delivery of complex chemotherapy and radiotherapy (along with other nominated units) at UCLH is compelling and would provide impact within and outside of London Cancer.

7.6 We have considered how we will manage the changes to Head and Neck cancer services that result from the proposals set out in this document. We have addressed two different scenarios according to whether or not our application to host the local and specialist services is successful.
Impact if Successful

Research, academic and clinical centre of excellence

7.7 There is huge potential within Head and Neck Services to provide a comprehensive junior doctor training programme which would feature the full spectrum of clinical opportunities including access to one-stop outpatient diagnostic services, complex surgery at the centre, delivery of oncology services at level 3 and 4b units; work outside the hub in level 1 and 2 units and access to trauma. No fixed plans are agreed at this stage, as any redesign would need to be the subject of detailed discussions between the key organisations, however there is scope to ensure education and training rotas are supported across the network to the benefit of all.

Co-dependencies

7.8 There are compelling reasons for co-locating the expertise and infrastructure in the management of oesophago-gastric, head and neck and lung cancer. Pharyngo-laryngeal cancers can encroach and extend into the cervical oesophagus, requiring the skills of Head & Neck and OG teams, and a gastric pull-up is the preferred method of oesophageal reconstruction after a laryngo-pharyngectomy. Although OG surgeons are trained and experienced with thoracic dissections necessary for oesophagectomy, complex situations, particularly involving fistulae between the oesophagus and the airways require the combined skills of OG and thoracic surgeons to ensure the best outcomes. Close working of these three specialities is even more important in complex benign disease and in dealing with complications of thoracic and OG surgery. Such a co-location is also essential for innovative procedures, best exemplified by a tracheal transplant carried out last year at UCLH, involving these three teams and several others.

Impact if Unsuccessful

7.9 UCLH is committed to the development of specialist cancer services and confident in our ability to deliver both the short and the long term aspirations for head and neck cancer laid out by London Cancer. At all times UCLH is committed to securing the best possible solutions for patients. If we are unsuccessful this would weaken the comprehensive approach UCLH is adopting to cancer care and so would compromise our ability to match the best cancer providers in the world. The population of North and East London would not benefit from a fully joined up head and neck specialist centre including PBT and the ENT expertise at the Royal National Throat Nose and Ear Hospital (RNTNEH), planned to be relocated to the University College Hospital campus from Grays Inn Road.
7.10 If this bid is unsuccessful, we would therefore need to re-evaluate our current plans to relocate the RNTNEH, as this case was based on the clinical synergies created by co-locating RNTNEH with head and neck cancer and other head and neck services within the University College Hospital campus. We would also want to discuss with the Department of Health and other partners how such a decision would affect our plans to develop Proton Beam Therapy at UCLH.

7.11 If UCLH is not supported to deliver our comprehensive vision for cancer services, there will also be an impact on our ability to withstand financially the transfer of cardiac services to Barts Health, as has been proposed to achieve the UCL Partners vision for both cancer and cardiac services. Any detrimental impact on the financial health of UCLH as a whole would impact on the quality of care we are able to provide overall for our patients.

### Implementation Plan

7.12 Due to the complexity of these patient pathways, we propose that the developments outlined in this document are made gradually and in collaboration with our partner organisations within the sector (see Figure 7-1). Ideally, full integration would be made within 24 months, but due to the complexity of the changes and co-dependency on other projects, it would seem reasonable to set an upper limit of 36 months for full implementation. It is recognised that due to the scales of this reconfiguration, some of the changes will need to made incrementally. It is therefore likely that parts of the proposed pathway are implemented much sooner.

7.13 Due to specific changes being made to the delivery of surgery at the Chase Farm Hospital site, it will be necessary to make some pathway changes much sooner. To maintain patient safety, patients requiring major surgery that is likely to involve a post-operative ITU stay will be care for jointly by Barnet and Chase Farm and UCLH. It has been agreed that colleagues from Barnet and Chase Farm Hospitals will participate in the MDT meeting, both via video-link and in person. It is expected the Head and Neck surgeons at Barnet and Chase Farm will be involved with and integrated into the surgical team at UCLH.

7.14 Barnet and Chase Farm Hospitals and UCLH will work together to clarify and agree the local work up each patient should have at the point of entry into the joint MDT. We do not anticipate making other significant changes to the existing pathways established between Barnet and Chase Farm Hospitals and North Middlesex Hospital. These pathways are already well established and enable patients to undergo local radiotherapy and/or chemotherapy, and access local nursing and therapy expertise.
Initially, we expect the inclusion of major surgery to amount to approximately one patient per week. We would hope that within a year we would be able to agree the transfer of the remaining surgical oncology, although it is recognised that this would require a more significant investment in capacity. Establishing the desired pathways and joint working arrangements with Barnet and Chase Farm Hospitals within a short timeframe will provide a platform on which to build further change.

Figure 7-1 Indicative Programme
(subject to review and potential change)
7.16 Project leadership for implementation of the new service model will be provided by Dr Geoff Bellingan, Medical Director Surgery and Cancer Board. Clinical leadership for the project will need to be addressed, but in the first instance we are grateful for the support that Mr Simon Whitley, Pathway Director, is providing. We will involve Mr Whitley in any developments regarding the leadership role(s). The implementation team will be further supported by the senior management team within Head and Neck services to deliver all stages of the improvements outlined in this document. The Director of Strategic Development, David Probert, and his department will support this project and ensure that progress is tracked against agreed milestones and reported to our Strategic Programme Board and Executive Board. This will ensure that the implementation of these improvements is closely co-ordinated with improvements in other specialist cancer services and strategic changes which we are making to our available capacity.

7.17 As soon as the decision is taken that UCLH should host these specialist cancer services, we will set up an implementation group, and work with the Pathway Board and local units to make immediate improvements in diagnostic services, to establish joint appointments between UCLH and local units, to improve the referral pathway and to develop patient information so that patients who need to be referred to UCLH for specialist services get accurate information to help them understand the services that are offered and the support available to them, including information about transport. We expect this phase to lead to immediate improvements in the diagnosis, information, and treatment options for patients across London Cancer, even before any move of specialised services to UCLH.

**Investment Requirements**

7.18 UCLH has a strong track record of investing in service developments. This document details some of the areas where investment is likely to be required; further investment required to deliver the proposals for Head and Neck Cancer Services will be identified during the implementation planning phase that would follow the outcomes of the public consultation exercise.

**Trust Board Commitment to Implementation**

7.19 The Board of Directors of UCLH NHS Foundation Trust has recently reaffirmed their commitment to supporting the development of world class cancer services at UCLH working within London Cancer. This strategic commitment underlines our operational commitment to make available the skilled medical, nursing, and other staff, and the beds, theatre sessions, outpatient space, and other resources needed to deliver the Head and Neck Cancer Service as outlined in the specification prepared by London Cancer.
8. Conclusion: A High Quality Service for Patients and Carers

8.1 We are delighted to have the opportunity to submit this tender to support *London Cancer* in the delivery of high quality, outcome focused Head and Neck Cancer Services. We believe that the pathway model presented incorporating our equally important partners across the whole of North and East London demonstrates that UCLH is particularly well placed to deliver the local and specialist surgery and oncology services.

**Proven Capability and Strong Local Relationships**

8.2 We can offer a highly experienced team familiar with the challenges of delivering Head and Neck Cancer Services. Our existing relationship with the Royal National Ear Nose and Throat Hospital and the Eastman Dental Hospital provides us with local specialisms. In addition, our envisaged joint working arrangements with partner Trusts means that we can offer strong local relationships; regular and appropriate communications between organisations; and an accessible service for all patients.

8.3 Our team provides all the skills necessary for the safe and effective delivery of the full range of specialist cancer services for levels 4a and 4b which is underpinned by an excellent depth of academic, clinical and commercial research.

**Capacity and Commitment**

8.4 ULCH is a successful and financially strong Trust with a proven Board level commitment to Cancer Services. We have a history of implementing significant pathway changes to the benefit of patients and have an estates strategy which supports the development of specialist cancer work at the UCLH site. We have a proven experience of joint working and can bring to bear the resources and depth of expertise necessary to cope with the demands on the services, both now and in the future.

**Acknowledgements**

8.5 In creating this application we would like to express our thanks for contributions from UCL academics, UCLH clinicians, managers and allied health professionals, representatives from our partner organisations and patient representatives, who have helped to shape our proposal. We trust that our proposals meet with the requirements of *London Cancer*. 
### Appendix A: Part I: Outline of Proposed Level 1 Local Unit

#### Part of pathway

<table>
<thead>
<tr>
<th>High-level summary of specification</th>
<th>Proposal</th>
<th>Developments necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis of cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>◆ Fast-track referrals for patients with suspected head and neck cancer</td>
<td>UCLH offers a range of high quality diagnostic tests for all Head &amp; Neck cancers, including the following imaging modalities: CT, MRI, PET-CT and Ultrasound. In addition, ultrasound guided biopsies and biopsies under general anaesthetic are routinely carried out. There are three dedicated Clinical Nurse Specialists with cross cover arrangements to ensure there is a Clinical Nurse Specialist attending each clinic where a cancer diagnosis may be given and ensuring that all patients have a CNS present to give support during consultation.</td>
<td>All core MDT team members will be attending ACS training in 2013/14</td>
</tr>
<tr>
<td>◆ Clinical nurse specialist present at all cancer diagnoses</td>
<td></td>
<td></td>
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<tr>
<td>◆ Diagnostic facilities on-site (CT and MRI)</td>
<td></td>
<td></td>
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<tr>
<td>◆ Robust coordination with other centres in situations in which facilities or resources are not available in-house (e.g. rapid access, PET-CT)</td>
<td></td>
<td></td>
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<tr>
<td>◆ Clinical workforce trained in advanced communication skills</td>
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<tr>
<td><strong>MDT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>◆ MDT conferencing capability with MDT hub</td>
<td>See Part IV (a)</td>
<td></td>
</tr>
<tr>
<td>◆ Access provided to a key worker for all patients (usually a clinical nurse specialist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>◆ Carries out holistic assessment, including palliative care and travel needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part of pathway</td>
<td>High-level summary of specification</td>
<td>Proposal</td>
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<tr>
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</tr>
<tr>
<td>Treatment decision</td>
<td>Patients are offered all appropriate treatment options and all appropriate types of reconstruction whether or not these are available at that particular provider site.</td>
<td>Following discussion at SMDT, patients are offered all treatment modalities that have been identified as suitable for their clinical case. Carefully consideration is given to patients who are borderline with regards to their suitability or eligibility for certain treatments. This is carefully documented and explained to patients at the MDT clinic.</td>
</tr>
<tr>
<td>Surgery</td>
<td>Diagnostic and pre-operative assessment (including access to dental assessment) procedures are available</td>
<td>See Part IV (a).</td>
</tr>
<tr>
<td>Acute oncology</td>
<td>Full acute oncology service that meets Peer Review standards</td>
<td>Full compliance with Peer Review standards.</td>
</tr>
<tr>
<td>Part of pathway</td>
<td>High-level summary of specification</td>
<td>Proposal</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
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</tbody>
</table>
| Post treatment       | ◆ Clear procedures governing the receipt of patients who have been discharged from care of the specialist treatment centres  
◆ Follow-up clinics for post-treatment patients (involving surgeon, oncologist, CNS, rehabilitation services)  
◆ Process in place to enable a patient’s rapid readmission, if necessary | Comprehensive follow-up for local patients with integrated dietetic and SLT services to support rehabilitation, plus access to specialist restorative dentistry clinic. | Further investment needs to be made in administrative (including MDT co-ordination) support. This will include improving the liaison with other trusts.  
Development of clear pathways and handover so that patients can access appropriate post-treatment care at their local provider, or in the community. |
| Palliative care      | ◆ Clear referral pathways for patients with palliative and specialist palliative care needs          | A comprehensive palliative care service is available at UCLH.  
An Oncology CNS acts as lead for palliative care and provides input into MDT. | Plans to create clearer pathways for patients who are deemed to be palliative at SMDT. |
<p>| Research and innovation | ◆ Access to multidisciplinary oncology service including clinical trial research and research nursing | UCLH will offer patients the opportunity to participate in clinical research trials as appropriate. All patients will be considered for research trials at every point along their pathway. Clinical trials will be supported by a variety of research personnel, including research nurses and registrars. |  |</p>
<table>
<thead>
<tr>
<th>Part of pathway</th>
<th>High-level summary of specification</th>
<th>Proposal</th>
<th>Developments necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient travel</td>
<td>◆ Informs patients of support available for travel to specialist centre and radiotherapy units</td>
<td>UCLH will provide clear information about travel and transport to staff in referring hospitals with details about travel options available. Immuno-compromised patients will continue to be eligible for the provision of NHS funded transport, and this will always be provided in personal use vehicles, not shared with other patients.</td>
<td>UCLH is in the process of assessing the suitability and quality of the existing hospital patient transport service and will ensure that the transport service offered meets (as a minimum) the requirements of the UCL Partners specification for patient transport services. This includes ensuring patients are transported in suitable vehicles, with appropriate standards of timeliness, comfort, and equipped where required to provide appropriate levels of care. Work closely with others to identify innovative solutions to travel issues and concerns. If, together with our partners we conclude that additional transport should be provided, we will prepare a feasibility study for a dedicated patient transport service. UCLH will work with Camden Council to make available space for an increased number of disabled car parking bays in the immediate vicinity of University College Hospital.</td>
</tr>
</tbody>
</table>
### Appendix B: Part II: Outline of Proposed Level 2 Extended Local Unit

<table>
<thead>
<tr>
<th>Part of pathway</th>
<th>High-level summary of specification</th>
<th>Proposal</th>
<th>Developments necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis of cancer</strong></td>
<td>◆ Rapid access clinics with ultrasound and same-day cytology services</td>
<td>Daily rapid access clinics, one-stop diagnostics available.</td>
<td>All core MDT team members will be attending in 2013/14.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All UCH Imaging requests are triaged daily by a mixture of Consultant Radiologists and expert radiographers according a set of agreed Departmental protocols.</td>
<td>Improvements to integrated ICT systems at UCLH to ensure smooth administrative pathway for patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RNTNEH is connected via PACS to UCH campus. IEP provides intra UCLP connectivity. Occasionally there are issues with the readability of external reports poorly scanned and sent to UCH, images however are received without issue.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>UCH provides three video fluoroscopy clinics per week SaLT delivered video fluoroscopy service. There is easy access for H&amp;N patients</td>
<td></td>
</tr>
<tr>
<td><strong>MDT</strong></td>
<td>◆ MDT conferencing capability with MDT hub</td>
<td>Video-conferencing equipment is available at UCLH and is already being used to good effect to join with Barnet and Chase Farm Hospital.</td>
<td></td>
</tr>
<tr>
<td><strong>Post treatment</strong></td>
<td>◆ Comprehensive rehabilitation and supportive care services</td>
<td>Comprehensive follow-up for local patients with integrated dietetic and SLT services to support rehabilitation, plus access to specialist restorative dentistry clinic.</td>
<td>Pathways between the L4 and L1&amp;2 centres need to be developed and agreed. Some already exist.</td>
</tr>
</tbody>
</table>
### Appendix C: Part III: Outline of Proposed Level 3 MDT Hub Centre

<table>
<thead>
<tr>
<th>Part of pathway</th>
<th>High-level summary of specification</th>
<th>Proposal</th>
<th>Developments necessary</th>
</tr>
</thead>
</table>
| MDT             | ◆ Hosts and co-ordinates the weekly head and neck specialist MDT  
◆ Coordinates data collection for the system  
◆ Hosts multidisciplinary clinics attended by surgeons and oncologists undertaking treatment for patient | UCLH will form one of two MDT hub centres.  
UCLH local MDT meets Peer Review measures and has appropriate representation in attendance from histopathology, radiology, oncology, surgery and nursing.  
All patients with a positive cancer diagnosis are assigned a key worker.  
The clinical nurse specialist assigned carries out a holistic assessment for each patient.  
UCLH has invested in new videoconferencing technology and the new Cancer Centre has been fitted with a Cisco videoconferencing system with technical V/C support from 'First Connections'.  
Currently the MDT decisions and discussions are captured using MDT proforma and are scanned into CDR (clinical data repository) to form part of the patient’s electronic records.  
It is proposed that UCLH adopts a standardised electronic database system across all cancer types | Links need to be made with L1&2 centres as necessary.  
Additional administrative support required to support advancements in communication and data collection.  
Development of standardised database at UCLH to support information sharing across partner sites and with primary care. |
### Appendix D: Part IV: Outline of Proposed Level 4a Specialist Treatment Centre for Surgery

<table>
<thead>
<tr>
<th>Part of pathway</th>
<th>Summary of specification</th>
<th>Proposal</th>
<th>Developments necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT</td>
<td>Participates in weekly MDT hosted by MDT hub centre</td>
<td>UCLH will form one of two MDT hub centres. UCLH local MDT meets Peer Review measures and has appropriate representation in attendance from histopathology, radiology, oncology, surgery and nursing. All patients with a positive cancer diagnosis are assigned a key worker. The clinical nurse specialist assigned carries out a holistic assessment for each patient. UCLH has invested in new videoconferencing technology and the new Cancer Centre has been fitted with a Cisco videoconferencing system with technical V/C support from 'First Connections'. Currently the MDT decisions and discussions are captured using MDT proforma and are scanned into CDR (clinical data repository) to form part of the patient’s electronic records. It is proposed that UCLH adopts a standardised electronic database system across all cancer types.</td>
<td>Desire to regularly include: CNSs, dieticians, speech and language therapists and psychologist. Further work needs to be done to increase CNS capacity at UCLH. This is underway following a review of cancer CNSs at UCLH. Work required to increase restorative dental input into the MDT and streamline pathways to pre-treatment dental assessments.</td>
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<td>Treatment decision</td>
<td>Patients are offered all appropriate treatment options and all appropriate types of reconstruction whether or not these are available at that particular provider site</td>
<td>Suitable treatment options will be agreed at the hub MDT, involving all disciplines. Patients will be presented with all suitable treatment options, regardless of the whether these are locally available. CNS present at the time of diagnosis, with pre-treatment clinics involving specialist dieticians and SLTs. All patients are seen in dedicated pre-treatment speech and language clinic for baseline assessments (including instrumental examinations), informational counselling and prophylactic therapy. We work closely with the MDT to support the patients choice of treatment.</td>
<td>Pathways will need to be developed to ensure that patients are seen in clinic after hub MDT discussion. Treatment options will be presented, but this must be documented in the patient records. Develop tools for shared decision making in order that patients can make a clear, informed choice.</td>
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<td>Surgery</td>
<td>Close working relationship between both specialist surgical centres (prior to consolidation into a single surgical centre), with unified treatment protocols and sharing of skills, data, etc.</td>
<td>Comprehensive pre-treatment pathway including specialist assessments with dietetics, SLT prior to surgery. CNS key worker support to patients from diagnosis through the surgical pathway. Access to dedicated psychological support prior to surgery for patients undergoing interventions that will alter appearance and function. Currently the Head &amp; Neck department has dedicated bespoke pre-assessment clinics, with specialist anaesthetic support for complex airway patients. Pre-operative and post-operative dentistry support is currently available. Pre-operative dental assessment and surgery is available to all patients. Outcome data captured and submitted to DAHNO.</td>
<td>Further integration of national audit data collection into Trust core business, with investment in administrative support. As above, additional administrative support required to support advancements in communication and data collection. Improved liaison and integration with local units to maximise the pre-operative assessments that can be undertaken locally.</td>
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| **Post treatment** | ◆ Provision for timely discharge and liaison with local units, primary care and local rehabilitation services  
◆ Prompt provision of comprehensive discharge information following completion of treatment in line with national standards  
◆ Process in place to enable a patient’s rapid readmission, if necessary | Post-operative restorative dentistry is offered for patients requiring this, including the provision of custom-made devices to support cosmetic and functional rehabilitation.  
Patients have clear key-worker contacts and access to out-of-hours support, with rapid review and/or admission as necessary.  
Communications with local centres, patients and their GPs will all be made in a timely fashion.  
Acute oncology and surgery support will be available. | Further capacity required prior to full integration.  
Provision & commissioning of community services for H&N patients varies across north and east London – some areas will require commissioning of additional specialist community services in order that patients can be discharged to community rehabilitation.  
Ongoing development of UCLH GP portal to allow for electronic exchange of information. |
| **Acute oncology** | ◆ Full acute oncology service that meets Peer Review standards | Full compliance with Peer Review standards. | |
| **Palliative care** | ◆ Clear referral pathways for patients with palliative and specialist palliative care needs | Palliative care colleagues are included in the hub MDT. A comprehensive palliative care service is available at UCLH.  
A comprehensive palliative care service is available at UCLH.  
An Oncology CNS acts as lead for palliative care and provides input into MDT. | Plans to create clearer pathways for patients who are deemed to be palliative at SMDT. |
### Part of pathway

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<tr>
<td>Access to multidisciplinary oncology service including: tissue banking, clinical trial research, and research nursing</td>
<td>The NCRN national trials form part of the trials portfolio agreed and approved within the NSSG and 2012-2013 recruitment is detailed below. There has been a gradual increase in the number of studies open to recruitment at UCLH with an associated improvement in accrual across the portfolio. UCLH is becoming recognised as a Head and Neck clinical trials centre with patients being referred from centres around the region and beyond specifically for consideration of entry into a clinical study. UCLH continues to contribute significantly towards the trials recruitment across the NLCRN, which in 2012 was ranked 10th nationally for recruitment into randomised studies and 20th overall.</td>
<td>Action to strengthen academic leadership at UCLH, and to put in place processes across the sector to ensure that all patients have equity of access to participation in appropriate trials.</td>
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<td>Patient travel</td>
<td>◆ Informs patients of support available for travel to specialist centre and radiotherapy units</td>
<td>UCLH will provide clear information about travel and transport to staff in referring hospitals with details about travel options available. Immuno-compromised patients will continue to be eligible for the provision of NHS funded transport, and this will always be provided in personal use vehicles, not shared with other patients.</td>
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Appendix E: Part V: Outline of Proposed Level 4b Specialist Treatment Centre for Clinical Oncology

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<td>MDT</td>
<td>Participates in weekly MDT hosted by MDT hub centre</td>
<td>See Part IV (a)</td>
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| Treatment decision | Patients are offered SIB IMRT wherever possible.  
|                  | The decision-making process involves rehabilitation and supportive care professionals to enable a richer, more holistic understanding of the patient’s broader circumstances  
|                  | Palliative care expertise is included, as required | All patients will be offered SIB IMRT as appropriate. Suitable treatment options will be agreed at the hub MDT, involving all disciplines. This will include palliative care. Patients will be presented with all suitable treatment options, regardless of the whether this are locally available. | Develop tools for shared decision making in order that patients can make a clear, informed choice.  
<p>|                  |                                                   | Develop clearer pathways and improved access to specialist psychological support, and continue to work with voluntary sector organisations to provide appropriate support to patients. |</p>
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| **Radiotherapy** | ◆ Provides world class radiotherapy with optimal delivery techniques (SIB IMRT, wherever possible), in a safe timeframe within a quality assured system  
◆ Rigorous approach to surgical clinical trial participation  
◆ Systematic data collection, including capture of outcomes  
◆ Rigorous planning to support integration with local services and oncology services to provide a seamless experience for patients  
◆ Up-to-date, centre-specific information for head and neck patients detailing the processes and side effects of treatment | UCLH will continue to provide SIB IMRT.  
All patients will be considered for inclusion in clinical research trials as appropriate.  
Patients undergoing radiotherapy will be seen in a weekly multidisciplinary clinic attend by oncologists, therapy radiographer, dietician and speech and language therapist and radiotherapy nurse. There is a further weekly dietician review to help patients maintain nutrition needs. In addition patients have access to the radiotherapy nurse in between these clinic times | Pathways need establishing to ensure that patients requiring radiotherapy are successfully moved between local centres, hub MDTs and L4b centres. |
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| Post treatment | ◆ Adequate provision for prompt discharge and liaison with local units, primary care and local rehabilitation services  
◆ Prompt provision of comprehensive discharge information following completion of treatment in line with national standards. | Post-operative restorative dentistry is offered for patients requiring this, including the provision of custom-made devices to support cosmetic and functional rehabilitation.  
Patients have clear key-worked contacts and access to out-of-hours support, with rapid review and/or admission as necessary.  
Communications with local centres, patients and their GPs will all be made in a timely fashion.  
Acute oncology and surgery support will be available. | Further capacity required prior to full integration.  
Provision & commissioning of community services for H&N patients varies across north and east London – some areas will require commissioning of additional specialist community services in order that patients can be discharged to community rehabilitation. |
| Acute oncology | ◆ Full acute oncology service that meets Peer Review standards | Acute oncology service meets peer review standards.  
Mechanisms in place to manage patients presenting as an emergency.  
Emergency support numbers available for patient undergoing radiotherapy and chemotherapy treatments. |  |
| Palliative care | ◆ Clear referral pathways for patients with palliative and specialist palliative care needs | Palliative care colleagues are included in the hub MDT.  
A comprehensive palliative care service is available at UCLH.  
An Oncology CNS acts as lead for palliative care and provides input into MDT. | Plans to create clearer pathways for patients who are deemed to be palliative at SMDT. |
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<tr>
<td>Research and innovation</td>
<td>Access to multidisciplinary oncology service including: tissue banking, clinical trial research, and research nursing</td>
<td>The NCRN national trials form part of the trials portfolio agreed and approved within the NSSG and 2012-2013 recruitment is detailed below. There has been a gradual increase in the number of studies open to recruitment at UCLH with an associated improvement in accrual across the portfolio. UCLH is becoming recognised as a Head and Neck clinical trials centre with patients being referred from centres around the region and beyond specifically for consideration of entry into a clinical study. UCLH continues to contribute significantly towards the trials recruitment across the NLCRN, which in 2012 was ranked 10th nationally for recruitment into randomised studies and 20th overall.</td>
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<td>Patient travel</td>
<td>◆ Informs patients of support available for travel to specialist centre and radiotherapy units</td>
<td>UCLH will provide clear information about travel and transport to staff in referring hospitals with details about travel options available. Immuno-compromised patients will continue to be eligible for the provision of NHS funded transport, and this will always be provided in personal use vehicles, not shared with other patients.</td>
<td>UCLH is in the process of assessing the suitability and quality of the existing hospital patient transport service and will ensure that the transport service offered meets (as a minimum) the requirements of the UCL Partners specification for patient transport services. This includes ensuring patients are transported in suitable vehicles, with appropriate standards of timeliness, comfort, and equipped where required to provide appropriate levels of care. Work closely with others to identify innovative solutions to travel issues and concerns. If, together with our partners we conclude that additional transport should be provided, we will prepare a feasibility study for a dedicated patient transport service. UCLH will work with Camden Council to make available space for an increased number of disabled car parking bays in the immediate vicinity of University College Hospital.</td>
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