North Wales Cancer Network
Rhwydwaith Canser Gogledd Cymru

North Wales Regional Head and Neck Multidisciplinary Team (MDT)

Operational Policy

Agreed July 2010 (last updated June 2014)

HEAD AND NECK MDT GUIDELINES

1.0 INTRODUCTION

This operational policy details the scope and organisation of services offered by the North Wales Regional Head and Neck Multidisciplinary Team. It sets out the agreed standards and processes to which all members of the MDT should work in order to ensure the delivery of high quality patient focused care.
The Regional Head and Neck MDT serves the population of North Wales of approximately 670,000.
An effective well functioning MDT will ensure that all relevant disciplines are able to contribute to, and participate in, discussions and decisions made on the clinical management of patients.
Documented are the Integrated care pathways between primary, secondary and tertiary levels.
The policy has been developed in accordance with NICE guidance on Improving Outcomes in Head and Neck Cancer, the National Cancer Standards and the National Guidelines on the delivery of Head and Neck services 2005

The policy should be reviewed annually by the MDT.

2.0 HEAD AND NECK SERVICES IN NORTH WALES.

Consultation, assessment, diagnostics, surgery and follow up management are carried out at each of the three sites.

The maxillofacial department based at YGC offer a reconstructive / microvascular service to all specialities.

Radiotherapy is undertaken at the North Wales Cancer Treatment Centre. All major surgery with the exception of cases needing neuro or cardiothoracic surgery is conducted on the Glan Clwyd site. A joint surgical / oncological clinic takes place on 1st and 3rd Friday of each month.
Wrexham patients receive chemotherapy at the Shooting Star Unit, Wrexham Maelor Hospital, Bangor patients at the Alaw Unit Ysbyty Gwynedd and Glan Clwyd patients at the North Wales Cancer Treatment Centre.

Restorative dentistry provides a service across North Wales for dentate patients whose treatment for cancer will result in xerostomia or trismus.

Cancer nurse specialists are based in each hospital providing support, advice and information for patients and their carers from diagnosis until they discharged back into the care of the GP.

3.0 CLINICAL GUIDELINES AND POLICIES

All patients should be treated according to agreed clinical guidelines or as part of a formal clinical trial
The MDT follow the guidelines of :
The British Association of Otolaryngologists,
The British Association of Oral and Maxillofacial Surgeons
The British Association of Head and Neck Oncologists
NICE service guidance

In addition clinical teams deliver care in line with local policies which available on intranet sites :
North Wales Cancer Network Chemotherapy protocols
Infection prevention and control
Management of side effects
Chemotherapy administration (including intrathecal chemotherapy)
Risk management and incident reporting
Radiotherapy treatment protocols

4.0 MDT STRUCTURE

All members of the MDT specialise in the management of head and neck cancer.

4.1 Core MDT members

Core Team	Site	Designated Member	Cover in absence
MDT Chair	YGC	Dr S Gollins	Mr H Jones
Consultant Clinical Oncologist		Dr Win Soe	
Consultant Clinical Oncologist	YGC	Dr R Neupane	
Consultant ENT Surgeon	YGC	Mr H Zeitoun	Registrar
Consultant ENT Surgeon	YGC	Mr Z Hammad	
Consultant ENT Surgeon	WMH	Mr Arya	Registrar
Consultant ENT Surgeon	WMH	Mr D Snow	Registrar
Consultant ENT Surgeon	WMH	Mr A Mohan	Registrar
Consultant ENT Surgeon	YG	Mr R Williams	
Consultant ENT Surgeon	YG	Mr D Hill	
Consultant ENT Surgeon	YG	Mr A El-Sheikha	
Consultant Maxillofacial Surgeon	YGC	Mr C Lloyd Mr H Jones	Registrar Registrar
Consultant Maxillofacial Surgeon	YGC		
Consultant Histopathologist	YGC	Dr M Atkinson	
Consultant Histopathologist	WMH		Dr K Pradeep
Consultant Histopathologist	YG	Dr M Lord	
Consultant Radiologist	YGC	Dr N Archard	Dr D Widdowson
Consultant Radiologist	YGC	Dr D Widdowson	Dr N Archard
Consultant Radiologist	WMH	Dr Senthil Muthu	Dr P Govind
Consultant Radiologist	YG	Dr U Nair	
Consultant Restorative Dentistry	BASED IN WMH	Mr T Nisbet	No cover; Max Fax available
Head and Neck Nurse Specialist	YGC	Gwen Roberts	
Head and Neck Nurse Specialist	WMH	Stephanie Konieczny	
Head and Neck Nurse Specialist	YG	Mark Cook	
MDT Coordinator (YGC/LC)	YGC	Katie Jones	Covered by Cancer Services
MDT Coordinator (WHM/LC)	WMH	Sian Baldock	
MDT Coordinator (YG/LC)	YG	Andrew Owen	

4.2 Role of Core MDT Lead Clinician/ Chair

To have overall responsibility for team working.
To ensure the MDT holds regular meetings to review head and neck cancer cases
To ensure the MDT meeting commences on time and that all members are able to participate in the discussion
To clearly confirm the patient treatment plan at the end of the discussion including clinical staging also distinguishing the aim of treatment as curative or palliative

To ensure that treatment planning decisions are made in line with the agreed clinical guidelines
To ensure all eligible consenting patients are entered into agreed clinical trials
To ensure the MDT participates in the Network and National audit programmes, minimum requirement being the All Wales Cancer Core Dataset
To ensure participation in ongoing service improvement and modernisation
To raise clinical governance or operational concerns with the relevant CPG governance team
To attend Trust and Network cancer meeting as appropriate
To ensure the operational policy of the MDT is reviewed at least annually and updated as necessary

4.3 Role of Cancer Nurse Specialist
To meet patient and explain role
To be present when patient receives diagnosis, assess patient understanding of disease, treatment offered, potential short and long term side effects and to provide Patient Information Pack
To assess emotional and physical needs and aid planning of individual care referring to other health care professionals as necessary including PEG insertion arrangements if necessary
To ensure ward and community care has been arranged for tracheostomy and RIG patients
To act as patients advocate in MDT discussions
To assist / supply the coordinator with information relating to the data collection for the Canisc core dataset

4.4 Role of the Coordinator
To pursue all malignant path reports/ USC/imaging and highlight to the MDT where appropriate
To collate the list of patients for discussion
To request and provide patient cases notes for the meeting
To ensure the meeting room is prepared making certain the videoconference, microscope and PACS are available.
To record the outcome of discussion and circulate to team members within agreed timeframe.
To collect data to support the cancer waiting times
To liaise with other coordinators to ensure the consistent collection of data.
To aid completion of the Annual Report of Compliance of National Cancer Standards
To gain the consent of the MDT Lead when data requests arise

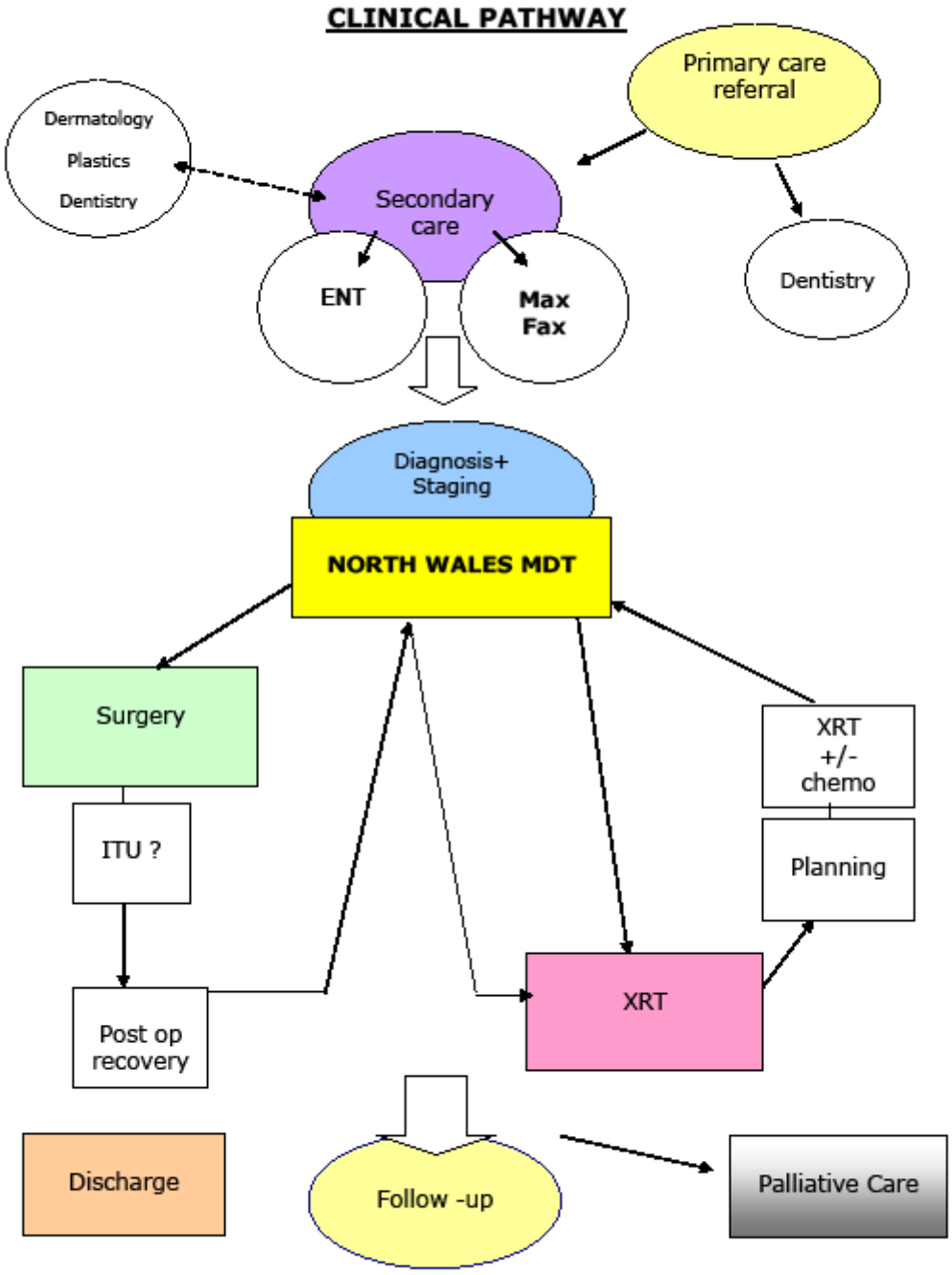
5.0 PATIENT PATHWAYS

The MDT will follow the patient pathway as agreed by the Head and Neck Clinical Advisory Group. The MDT should advise general practitioners on the appropriateness of urgent suspected cancer referrals and should be informed if the consultant downgrades an urgent suspected cancer referral to non-urgent.
A member of the team should inform the GP of the outcome of MDT discussion within 2 working days

Guidelines for urgent GP referral for suspected head and neck cancer
Hoarseness persisting more > 6 weeks
Ulceration of oral mucosa persisting > 3 weeks
Oral swelling persisting > 3 weeks
All red or red and white patches of the oral mucosa
Dysphagia persisting for 3 weeks
Sudden nasal obstruction with blood stained/purulent discharge particularly if accompanied by pain or disturbance of vision
Unexplained tooth mobility not associated with periodontal disease
Unresolving neck masses for > 3 weeks
Cranial masses
The level of suspicion is further increased if the patient is a heavy smoker or an alcohol drinker and is aged over 45 years old and male.

6.0 CLINICAL PATHWAY

Agreement for clinical guidelines will be reviewed and updated as necessary on an annual basis.


CLINICAL PATHWAY
Primary care referral
Dermatology
Plastics
Dentistry
Secondary care
ENT
Max Fax
Dentistry
Diagnosis+ Staging
NORTH WALES MDT
Surgery
ITU ?
Post op recovery
XRT +/- chemo
Planning
XRT
Discharge
Follow -up
Palliative Care

7.0 REFERRAL TO THE MDT

All patients diagnosed with head and neck cancer or where cancer is strongly suspected should be referred to the MDT,
The need to reassess the patient for further treatment or adjuvant treatment will require a further MDT discussion

- In order to list a patient for discussion a formal referral should be faxed / emailed to local coordinator (LC) , this request must include the reason for discussion, which site the diagnostics took place and specifically which reports are to be discussed.
  LC at WMH and YG will forward the list to YGC coordinator (YGC/LC)

- Any member of the core or extended MDT may add patients to the list although this should be discussed with the site-specific surgeon/physician beforehand to ensure responsibility for presentation.

- The MDT coordinators frequently review pathology reports to identify cancer patients, if a patient is identified via this route and not previously listed the coordinator should seek communication with responsible clinician for verification of need for discussion.

- The agreed timeframe for the latest addition to the list is Tuesday 5pm before the Friday meeting this ensures YGC/LC has time to collate the list.

- YGC/LC will email the compiled list to WMH and YG by Wednesday 12pm to be circulated by the LC.

- Radiology and pathology will be informed in advance of the meeting in order to review images/slides, RADIS and Tpath numbers will be provided, communication between coordinators is an essential part of preparation for the meeting.

- LC will supply case notes for their respective patient cases and confirm to YGC/LC that relevant core members are available for the meeting.

Request for patient discussion after the agreed time will be highlighted as an addition, in this case where possible the notes will available at the meeting and images / slides will be reviewed at the discretion of radiologist/pathologist.

If local site pathologist / radiologist is not available to be present for discussion of their patient which would then result in a delay to treatment it may be possible to refer the case to pathology / radiology on a different site– this is dependant upon on all relevant information being sent in the agreed time frame for review.

7.1 The MDT meeting

The meeting is held weekly on Friday from 9am – 11.00am across the three sites via videoconference. On the 2nd and 4th Friday the Thyroid MDT takes place prior to H+N discussions, therefore on 2nd + 4th Friday the H+N MDT meeting will start at 9.15am.

WMH will connect to YGC seminar room at 9.00am and YG at 9.30am using dial in number 1091

At present YGC cases are discussed after WMH and prior / during YG connection, time management within the meeting is paramount

- The attendance register will be completed prior to the start of the meeting to identify the members present and will be source of information for audit.

- Team working and collaboration between teams should support cover for leave and attendance at the meeting

- A list of patients for discussion will be supplied by the coordinator, patient details will include date of referral, referral priority, diagnosis, RADIS no. and histology number if applicable inclusive of information relating to cancer waiting times position for each newly diagnosed patient, who is responsible for reporting and highlighting any potential breach.

- The responsible clinician will present the patient case to the meeting, lead the discussion and summarise the diagnostic and treatment plan to date.

- The chair of the meeting will ensure discussions are focused and that all core members of the MDT are able to contribute, TNM staging (Sixth Edition) and confirmation of plan should be confirmed before discussing the next case.

- If a patient is seen in the joint clinic and following a physical examination the MDT decision is modified the YGC/LC should be informed.

- YGC/LC will type up the minutes during the MDT meeting, live on the MDM module in CaNISC. All members of the MDT will verify the accuracy of the data on the MDM module at this point.

- If a referral to oncology is required theYGC/LC will print a direct referral from the MDM module.

  A referral to the oncologist will be dependant upon patient district

  WMH patients -- Dr Simon Gollins / Dr Win Soe

  YGC patients -- Dr Rekha Neupane / Dr Win Soe/Dr Gollins

  YG patients – Dr Rekha Neupane

A standard referral form should be completed for patients requiring restorative dentistry assessment and given to Mr Nisbet during the meeting or alternatively faxed to his secretary based in Wrexham on 01978 727207.
All patients who require adjuvant radiotherapy or all dentate patients treated with primary radiotherapy, chemotherapy or chemo-radiation for intra-oral, oropharyngeal or salivary gland tumours should be referred after first consultation with the oncologist as soon as possible as any extractions to be carried out will require 10 days to allow the swelling to subside before mask impressions.

Requests for PET scans should be made directly by the referring clinician on The Christie Hospital website, in line with The Christie's policy.

7.2 Accessing the service

Emergency access for patients needing the opinion or treatment of an oncologist or surgeon can be made via phone call or faxed referral letter directly to the department, the urgency will be assessed and the patient either admitted to the ward or seen in the next available clinic.

New patients in need of treatment prior to the scheduled MDT weekly meeting should be listed for the next meeting and outcome of team discussion documented in the case notes. This also applies should the MDT meeting fall on a Bank Holiday.

8.0 SUPPORT SERVICE MEMBERS

Role	Name	Site	Contact details
Speech and Language Therapist Speech and Language Therapist Speech and Language Therapist	Elaine Beavan Sue Kirk Dawn Leoni	YGC WHM YG	01745 534396 01978 725702 01758 701000
Dietician	Marion Gash Jane Power Solah Rasheed	YGC WHM YG	01745 534396 01978 727159 01248 384103
Principal Psychological Therapist North Wales area	Jilly Wilcox-Jones		Sec 01745 443222 Fax 01745 342069
Social Worker	Diane Waters / Ann Simister Covered by the team Covered by the team	YGC WHM YG	01745 445220 01978 725325 01248
Palliative Care	Irene Roberts Teams for each Trust but no designated one member	YGC WHM YG	01745 445169 01978 727177 Fax – 01978 01248 662775
Thoracic Surgeon	Mr Woolley	Liverpool YG	
Anaesthetist and Specialist Pain	Dr A Williams/ Dr B Tehan Dr G Arthur/ Dr S Underhill Dr A Williams/ Dr B Tehan	YGC WMH YG	
Neurosurgeon	Mr A Brodbelt	Walton	
Opthalmologist	Mrs E Morton		
Gastrostomy Service	Dr E Moss Paula Edwards Dr Kakali Mitra	YGC WHM YG	
Surgical Specialist experienced in microvascular and microneural surgery for free tissue transfer	Mr C Lloyd / Mr H Jones Mr H Jones Mr C Lloyd	YGC WHM YG	
Maxillofacial Technicians	Mr J Bright / Mr P Evans	NW cover	

8.1 Access to support service members

Relevant input from the dietician, speech and language, palliative care and assessment of psychological needs are vital, arrangements are in place to access these services.
The patient should also have access to physiotherapy services for assessment of mobility and function of the neck, shoulders and respiratory status as an in-patient. If input is required after discharge this is done via a referral from Consultant or GP to the relevant out patient department. Ideally all patients prior to neck dissection should have physiotherapy input.

8.2 Speech and Language

Indicators for referrals include:

Significant changes in voice quality.
Speech/articulation difficulties and/or reduced intelligibility.
Oral or pharyngeal stage difficulties in swallowing, especially where a risk of aspiration is indicated (e.g. recurrent chest infections, cough whilst eating or drinking, wet voice quality).
High levels of patient distress regarding communication or swallowing difficulties.

Patients with swallowing or communication difficulties should be referred to the SALT service via gp or consultant, referrals for an inpatient needing assessment for therapy needs can be accessed through the internal IT appointment system.
Information required upon referral should include previous medical history, diagnosis and summary of problem to be assessed.
The service includes the contribution of a detailed clinical assessment of swallowing including instrumental techniques such a videofluoroscopy and fibre optic evaluation of swallowing.
Support is provided for the joint head and neck clinic in NWCTC accepting verbal written referrals when in attendance which will be documented in the notes.
As part of the YGC SALT service patients from Wrexham and Bangor receiving surgery or oncology treatment will continue to be supported whilst attending YGC for appointments, after this time a report will be completed which shall act as a transfer back to the SALT service at their local site.

The SALT team for WMH are based in the Deeside Hospital and the YG team Bodfan Erryi Hospital Caernarfon.

8.3 Nutritional Support

Dieticians with specific expertise in dealing with head and neck cancer patients are based at each of the three sites. The dietician will be involved in pre-treatment assessment, taking action to correct patients' pre-existing nutritional deficiencies before treatment begins and to maintain their nutritional status during treatment also devising an individual nutritional care plan. The dietician will provide support and advice for those who require tube feeding also helping patients to cope with the after effects of treatment. Dieticians should also be involved in providing education on nutritional issues.

8.4 Psychological support

A psycho-oncology service is provided for North Wales, referrals for assessment of psychological support needs should be directed to the administration office located in the The Royal Alexandra Hospital or fax to 01745 443222.

8.5 Social worker
The need for assistance from the Social Work department generally occurs whilst during a stay as inpatient and referral usually takes place directly from the ward as deemed appropriate.
The social worker will liaise with voluntary and the private sector when necessary

8.6 Palliative care
The palliative approach may be applicable at any stage of the patients' illness. Referrals can be made via internal IT appointment system whilst as an inpatient or designated fax referral form from all health professionals and the GP. The patient and family are able to speak directly to a member of the palliative care team for assessment of particular physical problems or the need for psychological support. The palliative care nurse will liaise with community Macmillan and district nurse services if necessary.
To access palliative care in WMH all referrals must be faxed and directed to the District nurses who coordinate the service.
The MDT has access to specialist palliative care advice line, which is provided for Health Care Professionals in North Wales out of hours.

Purpose of Service
To deliver out of hours Specialist Palliative Care advice to clinical staff across North Wales requiring additional support regarding ***complex*** symptom control and management issues in adult patients in the palliative phase of their disease by an advice line staffed by senior Specialist Palliative Medicine professionals (Consultant, Associate Specialist or honorary Associate Specialist roles)

Responsibilities of Healthcare professionals using advice line
Patient review
Before contacting the advice line, the healthcare professional must have reviewed the patient, discussed the case with the most senior staff member of their team, and where possible, direct assessment by a senior staff member should have occurred.

- For a patient in the community setting → to have been assessed by the GP/OOH GP service
- For a patient in a community hospital → to have been assessed by the medical practitioner in charge of their care
- For a patient in the acute setting (hospital) → to have been assessed by the Specialist Registrar/Consultant
- For a patient in an independent hospice → to have been assessed by most senior nurse on shift and been seen by GP OOH service

Record keeping
- The primary responsibility for documentation of the advice given / actions agreed in the clinical records of the patient lies with the caller seeking advice
- The caller may be asked to 'read back' what they have recorded in the notes regarding the conversation/advice/actions agreed, to ensure accuracy
- The caller may be requested to liaise with the SPCT in the patient's locality

Access to the service
Access to the service will be via a single number to Nightingale House Hospice (01978 316800). Trained nurses will deal with the call as the first clinical contact and act as triage.

Access from the East
If the healthcare professional is accessing the service from the East, the usual system of dealing with calls will remain unchanged.

Access from Central and West
If the healthcare professional is accessing the service from the Central or West Areas, the trained nurse will triage the call as appropriate and, if necessary, contact the 'on call' senior Specialist Palliative Medicine professional directly.

The staff at Nightingale House Hospice will make it explicit that the medical support to Central and West consists of telephone advice only.

9.0 COMMUNICATION

MDT members will meet weekly at the MDT meeting, see section 7.
Where a treatment plan is required before the next scheduled meeting, relevant members of the MDT will discuss the case by telephone or at an ad hoc meeting.

9.1 Communication between MDT and patient / carers

All members of the MDT should follow the North Wales Cancer Network's 'Policy for Communication of Cancer Multi-Disciplinary Teams with Patients and Carers' which has been developed in partnership with the Network's Patient and Carer Liaison Group. In particular:

Patients and carers should be supported appropriately throughout the course of their treatment.
All treatment options should be explained and adequate time to consider options given.
Key worker details should be given this is usually the cancer nurse specialist who should be present if possible when a patient is informed of their diagnosis in a designated room. MDT members involved in breaking bad news should be encouraged to attend the communication skills training provided, this is a one day course are held periodically throughout the year.

Course tutor contacts:
Carolyn O'Connor - 01745 445259 YGC
No named tutor - 01978 727177 WHM
Lynsey Roberts - 01248 384384 ext 5121 YG

Written patient information should be offered to the patient /carer by the cancer nurse specialist and also be provided and displayed in patient areas with information relating to local self help groups.
In YG this is carried out by the consultant or associate specialist.

9.3 GP notification, documentation of key worker and contact details

For all new patients once they have a confirmed diagnosis and they have been informed of this, the GP should be notified by consultant letter or cancer nurse specialist phone call within 24 hours.
This information must include the name of the key worker and their contact details.
A copy of this should be filed in the patients' notes.

10.0 DATA COLLECTION AND AUDIT

Data collection is vital in order to ensure the improvement of clinical outcomes for cancer patients**.**
National Cancer Standard audits are completed annually to ensure compliance, effectiveness of the service and monitor progress in service improvement.
The MDT should agree clinical data to be collected for 'in house' audit purpose or the participation in national databases.

Canisc is a communication link during the treatment of patients with cancer and improves sharing of information maximising the accuracy of patient information, a standard generic data collection form is available which requires completion prior, during and after the MDT to enable comprehensive recording and timeliness capture of data.
Each LC is responsible for recording all relevant information for a patient with a diagnosis of cancer this covers any referrals to the organisation including patients' who may only receive investigations and/or treatment on site.
Information recorded should cover all activity which occurs within their organisation, exceptions include patients receiving investigations and/or treatments across the border of Wales, this information will then be recorded by the referring organisation.

Requests for data should be directed to the LC who will then liaise with the site lead clinician and respective cancer manager.

Canisc specialists are based in the North Wales Cancer Network at Ty Livingstone HM Stanley Hospital providing training and education for data entry and in the extraction of information also providing monthly reports for the Steering Groups :

Linda Roberts
Linda.Roberts11@ wales.nhs.uk
WHTN: 1815 5123

Anne Hughes
Anne.Hughes5@ wales.nhs.uk
WHTN: 1815 5887

10.1 Waiting times

The focus in setting waiting times targets is to work towards continual improvement.

The SaFF targets relate only to all newly diagnosed cancer patient
A recurrence of the original primary cancer at a secondary site is not included within the reporting

The waiting time for a newly diagnosed patient is measured in calendar days and will start from the day the referral is received.
Maximum of 62 days wait from urgent suspected cancer (USC) referral to treatment
Maximum of 31days wait for all other referrals from date decision to treat (DDT) to first treatment.

The full guide and definitions for the SAFF cancer waiting times target are available from
www.dh.gov.uk/en/Publicationsandstatistics/Publications?PublicationsPolicyandGuidance/DH_063067

The SaFF target requires that each site has a system in place to ensure standardised data collection, all three sites have an implemented strategy and action plan for cancer waiting times reporting to enable the patient to be proactively managed throughout their treatment ensuring the effective transfer and accuracy of cancer waiting times between diagnosing and treating sites.
To avoid breaches the agreed escalation policy should be actioned.
Radiotherapy, chemotherapy and surgical information will be supplied by the patient tracker within cancer services YGC in line with the agreed weekly process

11.0 AGREEMENT TO OPERATIONAL POLICY

Signature……..Date……....

Name and title