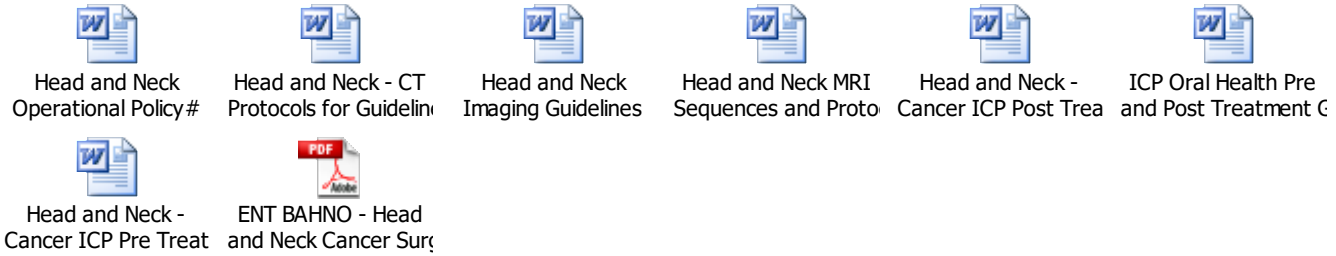
Head & Neck Information Section

Head & Neck Cancer Executive Structure		
1.	Health Board Lead Clinician	Professor Matt Makin, Medical Director
2.	Executive Lead	Mr Tim Lynch, Interim Chief Operating Officer
3.	Lead Manager	Mr Damian Heron, Associate Chief of Staff, Cancer & Director of North Wales Cancer Network
4.	Lead Nurse	None
5.	Lead Allied Health Professional	None
6.	Lead Co-ordinator	Mrs Katie Morris, Team Leader, Cancer Services

	Objectives, Leadership and Membership	
7.	Aims and objectives of MDT	To provide high quality clinical services ensuring early diagnosis, effective treatment and improving survival. Also, ensuring patients well being is at the forefront of all patient discussions.
8.	Head & Neck Cancer Lead	Dr Simon Gollins, Consultant Clinical Oncologist
9.	MDT Hospital Base	Ysbyty Glan Clwyd
10.	Frequency of MDT meetings	Weekly
11.	Number of MDT meetings that took place in previous 12 months	51
12.	The MDT follows locally agreed clinical policy that describes the full diagnostic and treatment pathway. Policies and guidelines should be available that describe; • referral to the service from primary care • achieving a diagnosis and staging	MDT Operational Policy.  As MDT we follow the ENT BAHNO Head and Neck Cancer Surgery Guidelines.

	• referral to the MDT ▪ Treatment; and ▪ Follow up All treatment regimens should be included.	Royal College Pathologist Minimum Dataset Head and Neck Cancer (accessible online).
13.	Details of audits conducted by or participated in by the MDT.	WCISU – survival audit (available on WCISU website). Direct Pharyngoesopagoscopy Audit.  Direct Pharyngoeesopagosc DCIA Free-Flap Audit  DCIA Audit Maxillo Facial Free-Flap audit  Head and Neck - Maxillo Facial Flap Au Head and Neck Cancer Palliative Care Audit.  Head and Neck Cancer Palliative Care

		Patient satisfaction surveys completed across many sites.  YG Radiology - Patient Satisfaction S  YGC Radiology - Patient Satisfactory S  WMH Radiology - Patient Satisfactory S Swallowing study (documentation to be provided for Peer Review Meeting). TOLR audit (documentation to be provided for Peer Review Meeting). Metastatic Cutaneous Squamous Cell Carcinoma Surgical Management Audit (documentation to be provided for Peer Review Meeting). Chemo-Radiotherapy in Oropharyngeal Cancers Audit (documentation to be provided for Peer Review Meeting). Cituximab in Oropharyngeal Cancers Audit (documentation to be provided for Peer Review Meeting). Osteo-Radionecrosis audit (documentation to be provided for Peer Review Meeting).

Names of MDT members and number of meetings not attended						
	Local MDT					
14.	MDT Chair	n/a	Cover:	n/a	No. of meetings speciality was not represented	n/a
15.	Surgeon/s	n/a	Cover:	n/a	No. of meetings speciality was not represented	n/a
16.	Radiologist/s	n/a	Cover:	n/a	No. of meetings speciality was not represented	n/a
17.	pathologist/s	n/a	Cover:	n/a	No. of meetings speciality was not represented	n/a
18.	Clinical Oncologist/s	n/a	Cover:	n/a	No. of meetings speciality was not represented	n/a
19.	Restorative Dentist	n/a	Cover:	n/a	No. of meetings speciality was not represented	n/a
20.	Speech and Language	n/a		n/a		n/a

	therapist/s					
21.	Dental Hygenist	n/a		n/a		n/a
22.	Dietician/s	n/a		n/a		n/a
23.	Specialist Nurse/s	n/a	Cover:	n/a	No. of meetings speciality was not represented	n/a
24.	Co-ordinator/s	n/a	Cover:	n/a	No. of meetings speciality was not represented	n/a
25.	Specialist Palliative Care	n/a	Cover:	n/a	No. of meetings specialist could not be accessed	n/a
	Network MDT					
26.	MDT Chair	Dr Simon Gollins	Cover:	Mr Huw Jones	No. of meetings specialist could not be accessed	0
27.	Surgeon/s	Mr Chris Lloyd (MF) Mr Huw Jones (MF) Mr Zeitoun (ENT C) Mr Hammad (ENT C) Mr Arya (ENT E) Mr Mohan (ENT E) Mr Williams (ENT W)	Cover:	Cross-cover within surgical teams	No. of meetings specialist could not be accessed	0
28.	Radiologist/s	Dr Archard Dr Widdowson Dr Muthu Dr Govind Dr Kraus Dr Nair	Cover:	Cross-cover with radiology team	No. of meetings specialist could not be accessed	0

29.	Pathologist/s	Dr Atkinson Dr Lord Dr Owen-Casey	Cover:	Cross-cover within pathology team	No. of meetings specialist could not be accessed	0
30.	Clinical Oncologist/s	Dr S Gollins Dr W Soe Dr R Neupane	Cover:	Cross-cover	No. of meetings specialist could not be accessed	0
31.	Restorative Dentist	Mr T Nisbet	Cover:	No Restorative Dentist cover.	No. of meetings specialist could not be accessed	5
32.	Speech and Language therapist/s	Dawn Leoni	Cover:	Sue Kirk, Elaine Beavan, Liz Thomas, Dawn Leoni (cross-cover).	No. of meetings specialist could not be accessed	0
33.	Dental Hygenist	None	Cover:	None	No. of meetings specialist could not be accessed	51
34.	Dietician/s	Marion Gash	Cover:	None	No. of meetings specialist could not be accessed	19
35.	Specialist Nurse/s	Gwen Roberts Stephanie Konieczny Mark Cooke	Cover:	Cross-cover within nursing team	No. of meetings specialist could not be accessed	0
36.	Co-ordinator/s	Katie Jones Andrew Owen Sian Baldock	Cover:	Katie Morris	No. of meetings specialist could not be accessed	0
37.	Specialist Palliative Care	Irene Roberts	Cover:	Sue Hughes	No. of meetings specialist could not be accessed	16

38.	New patients diagnosed:	1 year survival – BCU 79.77%; all Wales 77.77% (patients diagnosed 2006-2010)
39.	Number of patients still alive:	
40.	New patients diagnosed in:	5 year survival – BCU 58.98%; all Wales 53.75% (patients diagnosed 2002-2006)
41.	Number of patients still alive:	
42.	New patients diagnosed between 1.11.12 and	

	31.10.13 • Oral Cavity (ICD 10 C00 – C06) • Oropharynx (ICD 10 C09 - C10) • Nasopharynx (ICD 10 C11) • Hypopharynx (ICD 10 C12 – C13) • Larynx-Supraglottis (ICD 10 C32 &C10.1) • Larynx – Glottis (ICD 10 C32) • Larynx – Subglottis (ICD 10 C32) • Major Salivary Gland (ICD 10 C07 – C08) • Nasal Cavity (ICD 10 C 30.0) • Sinuses (ICD 10 C31) • Middle Ear and External auditory canal (ICD 10 C30.1) **TOTAL:**	 27 41 2 7 9 29 0 7 3 2 0 **127**
43.	% new cancer cases discussed at MDT:	98%
44.	Number of USC referrals treated within 62 days.	60/85 = 71%
45.	Number of non-USC referrals treated within 31 days.	59/65 = 91%
46.	Average (median) days until diagnosis.	26
47.	% of patient with pre-treatment stage recorded.	90%
48.	% with pre treatment performance status (WHO 0 – 4) recorded	75%
49.	% of patients waiting 42 days or less from surgery to post operative radiotherapy	0% (range = 49-103)
50.	Average (median) days to first treatment.	47
51.	% of cases where reporting of biopsy specimens is less than 10 days	76%
52.	% completion of co-morbidity	0%

53.	% of patients with post operative staging recorded.	80%
54.	% number of New patients seen by specialist nurse.	61%
55.	% of patients having a pre-op/ pre-treatment dental assessment	50% of patients having radiotherapy.
56.	Number of patients entered into clinical trials.	2010/11 = 3; 2011/12 = 2
57.	Number of patients donating tissue to the Wales Cancer Bank.	0
58.	MDT's have a clear understanding of how well we are performing overall, what services are doing well, and what services need improving (including those services that are carried out by others on our behalf).	CAG meeting every 6 months.  Clincal Advisory Group Meeting 07.03.
59.	Percentage of patients with 30 day post treatment mortality for: a) Chemotherapy; b) Surgery. c) Radiotherapy	Chemotherapy = 1 patient out of 32 patients having chemotherapy (3%) Surgery = 0 patients (0%) Radiotherapy = 2 patients out of 29 having radiotherapy (7%)
60.	Has a patient experience survey been completed by the MDT	Yes – file attached above (see question 13). All Wales Macmillan Patient survey.
61.	Proportion of cases per MDT Radical Palliative	Radical = 100/127 (78.7%) Palliative = 19/127 (15%) Not known = 8/127 (6%)
62.	Proportion of Radical cases treated with primary surgery* (+/- post operative RT/CRT) for	Oropharynx = 1 patient out of 38 total radical surgeries (13oropharynx surgeries) Larynx = 2 patients out of 38 total radical surgeries (8 larynx surgeries)

	Oropharynx Larynx *excluding neck dissection	This data is based on Canisc Data and prior to the Peer Review date statistics will be interrogated.
63.	Hospital Site of surgery	YGC and WMH
64.	% of patients starting definitive RT within 28 days of Decision to Treat Date	17/29 = 59% (NB decision to treat date definition as per Cancer Waiting Times guidance)
65.	% of radical patients being treated with IMRT	97% - All radical radiotherapy patients given IMRT treatment apart from a small number of early stage larynx cancers.
66.	% of patients receiving post op RT	18/45 = 40%
67.	% of patients starting post op RT within 42 Days of surgery	See Qu 49

PART 3
THE SELF ASSESSMENT

PART I: THE SELF-ASSESSMENT

Note: In establishing your level of agreement in relation to each of the statements made, you must be able to demonstrate through your supporting narrative not only <u>what</u> your service is doing, but <u>how well</u> it is working and the resulting <u>impact</u> on organisational performance.

Theme 1 - Setting the Direction

Desired outcomes:

- we place the people who use our services at the heart of our work;
- we make sure our purpose is clear;
- we make it clear to those accessing our services what we can and cannot provide; and
- we are a value based service and carry out our work openly, honestly, ethically and with integrity.

We can **demonstrate** that:

	Strongly disagree----------Strongly agree						
		Strongly disagree	Disagree	Agree in part	Agree	Strongly agree	Supporting Narrative
1.1	The Health Board can demonstrate that it makes an effective contribution to the achievement of the strategic vision for cancer services in Wales as set out in 'Together For Health – Cancer Delivery Plan'.				yes		MDT is set up according to the strategy.
1.2	The Health Board can demonstrate that it has a clear purpose, vision and overall strategic direction that effectively align our local needs with the national strategy for cancer services in Wales.		Yes				Surgical waiting lists seem to be more important. Struggling to keep pace with the rapidly rising workload in terms of oncology resources. 3 sites in North Wales struggling to implement centralisation.
1.3	The Health Board can demonstrate that staff and other stakeholders inform and influence the purpose, strategic vision and direction of our cancer services.			Yes			This does occur through the clinical program groups.
1.4	The Health Board can demonstrate that those working in cancer services carry out our work instilled with a strong sense of values, supported by clear standards of ethical behaviour.				Yes		MDT governs this. All cancer patients are discussed at MDT. Management of patients is multi-disciplinary which helps achieve these aims.

	Strongly disagree----------Strongly agree						
		Strongly disagree	Disagree	Agree in part	Agree	Strongly agree	**Supporting Narrative**
1.5	The Health Board can demonstrate that it promotes equality and recognise diversity across all our cancer services and activities.					Yes	No discrimination to social or ethnicity status.
1.6	The Health Board can demonstrate that it applies and embeds professional standards and quality requirements in a way that meets the needs and expectations of patients, service users, citizens and other stakeholders.					Yes	MDT governs this process. MDT charter.

Theme 1- Setting the Direction:
Your Overall Assessment

In relation to this particular theme, what is your overall assessment of where and how you:

- **are governing well;**
- **need to strengthen your arrangements; and**
- **have noteworthy practice which you may wish to share.**

What maturity level have you demonstrated you have reached for this theme overall:

In relation to this particular theme,

- **what are the priorities for improvement?**
- **what action is being taken, and when?**
- **how will success be measured?**

Theme 2 – Enabling Delivery

Desired outcomes:

- we make sure that everyone involved in delivering cancer care and services understands each others contribution, and how together we can deliver a better service;
- we work constructively in partnership with others to improve the quality and safety of cancer services for our patients, service users and the wider community; and
- we foster innovation and make the best use of all the resources available to us, including our people, facilities and finances.

We can **demonstrate** that:

	Strongly disagree----------Strongly agree						
		Strongly disagree	Disagree	Agreed in part	Agree	Strongly agree	Supporting narrative
2.1	The Head & Neck MDT(s) can demonstrate that it has: ▪ right people; ▪ with the right skills; ▪ doing the right things; ▪ in the right place; and ▪ at the right time. to meet its responsibilities for the provision of safe, high quality cancer care				Yes		ENT centralisation in progress. Multi-disciplines attend (provide evidence here of attendance). Centralised regional MDT – video conferencing occurs across three sites. Overall survival rates – data to be obtained.
2.2	The Health Board and the Head & Neck Cancer Multidisciplinary Team can demonstrate that cancer services provide support to patients and their carers who are given all the information they require regarding diagnosis, treatment options and treatment care plans by a named individual.				Yes		Patients have specifically assigned key worker. Information packs provided. Support patients and carers during their treatment – CNS works closely and communicates with those in the community regarding patient and carers care. HN CNS currently part time in Wrexham and needs more support which then has impact on CNS at YGC.. In YG CNS stretched with workload which then has impact on CNS at YGC. Tracheostomy care, voice restoration, swallowing rehabilitation requires more support.
2.3	The Head & Neck MDT(s) can demonstrate that it has the right facilities (equipment and environment) to enable us to consistently deliver safe, high quality cancer services across all the communities we serve.			Yes			Investment in more imaging to keep up with demand. Radiotherapy and chemotherapy facilities currently being stretched – require investment.

	Strongly disagree----------Strongly agree						
		Strongly disagree	Disagree	Agreed in part	Agree	Strongly agree	**Supporting narrative**
2.4	The Health Board in collaboration with the Head & Neck MDT(s) support the development and delivery of high quality, safe and accessible cancer services through strong, effective financial planning and management.	Yes					Links to management but no influence on financial planning. No established link with regards to strategic financial planning. Multi-disciplinary membership of Head and Neck MDT means that it's difficult to carry out effective financial planning with regards to personnel or equipment that may be necessary to expand our service in the future.
2.5	The MDT can demonstrate that its workforce at all levels of services is equipped with the information they need to help them carry out their work effectively, and this information is shared appropriately and securely held.			Yes			Minutes including management plans widely circulated with password protection. Information entered directly onto the MDM module directly at MDT meetings. However, Clinical Portal not yet available at Wrexham.
2.6	We properly safeguard all those who work in or access our cancer services (including those who may accompany patients), paying particular attention to the needs of children and vulnerable adults.					Yes	Refer to TYA MDT when necessary. All staff undertake mandatory training.

Theme 2 – Enabling delivery:
Your Overall Assessment

In relation to this particular theme, what is your overall assessment of where and how you:

- **are governing well;**
- **need to strengthen your arrangements; and**
- **have noteworthy practice which you may wish to share.**

What maturity level have you demonstrated you have reached for this theme overall:

In relation to this particular theme,

- **what are the priorities for improvement?**
- **what action is being taken, and when?**
- **how will success be measured?**

Theme 3 – Delivering Results, Achieving Excellence

Desired outcomes:

- we provide high quality and accessible lung cancer care services in a manner that ensures equity of access and ensures that all possible steps are taken to support an individual and his/her carers;
- we are committed to continual improvement in lung cancer survival to that achieved in similar high income countries;
- we learn from our own and others experiences to continuously improve the provision of lung cancer care; and
- we contribute to the overall improvement of lung cancer services in Wales by sharing our learning with others.

We can **demonstrate** that:

	Strongly disagree----------Strongly agree						
		Strongly disagree	Disagree	Agreed in part	Agree	Strongly agree	**Supporting narrative**
3.1	The Head & Neck MDT(s) can demonstrate that it has a clear understanding of how well we are performing overall, what services are doing well, and what services need improving (including those services that are carried out by others on our behalf).					Yes	***All audits attached above (see question 13).*** WCISU – survival audit. Ravi's Audit. Oesteo-radionecrosis audit. TPF Max Facs Flap audit Swallowing study. HZ audit. TOLR audit. 2 recent datex forms submitted regarding lack of support services. CNS support lacking across North Wales (CJL – letters about lack of CNS support). Histopathology turn around time slow – not enough resources. PET scanner required in North Wales. Dedicated multi-disciplinary clinics required – SALT services lacking. No cover for Restorative Dentist. ENT centralisation not yet fully implemented although the planning was suggested some time ago. Patient satisfactory surveys completed across many sites.

	Strongly disagree----------Strongly agree						
		Strongly disagree	Disagree	Agreed in part	Agree	Strongly agree	**Supporting narrative**
3.2	The Head & Neck MDT(s) can demonstrate that it responds quickly and effectively to address areas of concern, including those relating to individuals' performance.					Yes	The MDT has dealt with issues which have occurred during the time period in a robust and collective manner.
3.3	The Head & Neck MDT(s) can demonstrate that complies with national cancer standards and NICE guidelines.					Yes	Yearly Cancer Standards completed. Guidelines that the MDT adhere to: RCR guidelines, ENT UK, BTA, BAHNO, Trials Recruitment.
3.4	The Head & Neck MDT(s) can demonstrate that patients are referred, diagnosed and treated promptly.					Yes	All patients tracked and recorded on canisc.
3.5	The Head & Neck MDT(s) can demonstrate that it works closely with primary care to ensure that referral protocols and pathways are in place and followed and that any problems identified in relation to late or inappropriate referrals are addressed.				Yes		Head and Neck MDT policy (see attached file above – question 12).
3.6	The Head & Neck MDT(s) can demonstrate that it has access to high quality imaging services					Yes	Locally modified Royal College of Radiologists Guidelines adhered to across North Wales uniformly. Radiology to email Katie.

	Strongly disagree----------Strongly agree						
		Strongly disagree	Disagree	Agreed in part	Agree	Strongly agree	**Supporting narrative**
3.7	The Head & Neck MDT(s) can demonstrate that care plans are developed in consultation with the individual and his/her family/carers and ensure they are regularly updated.			Yes			CNS feedback required. We do not have care plans as yet. However they are under construction as part of an ongoing Macmillan project. Patient satisfaction surveys completed across many sites.
3.8	The Head & Neck MDT(s) can demonstrate that it has care plans are shared with all those involved in the care and treatment of the patient.			Yes			YG don't currently use care plans as such. If visiting a patient who has community support, community support nursing notes are documented in records which are held in site based offices. YGC document input onto Canisc.
3.9	The Head & Neck MDT(s) can demonstrate that it provides support to patients and their carers who are given all the information they require regarding diagnosis, treatment options and treatment care plan.					Yes	Notes annotated.
3.10	The MDT can demonstrate that patients with Head & Neck cancer receive radiotherapy which is planned, prescribed, delivered and supervised in a safe and effective manner.					Yes	Daily checks of the beam geometry and the beam output and KV imaging done by radiographers. Weekly QA by Physics. Fortnightly machinery and engineering checks. Yearly checks carried out by Varian (manufacturers). All regular checks comply with BS9001. Physics checks performed on Rapid Arc prior to each use. 3 clinical oncologists involved who routinely and regularly Peer Review one another.

	Strongly disagree----------Strongly agree						
		Strongly disagree	Disagree	Agreed in part	Agree	Strongly agree	Supporting narrative
3.11	The MDT can demonstrate that patients with Head & Neck cancer receive chemotherapy which is planned, prescribed, delivered and supervised in a safe and effective manner.					Yes	Chemotherapy policy. Printed protocols. Clinically effectiveness MDT fortnightly.
3.12	The Head & Neck MDT(s) can demonstrate that it has access to high quality pathology services			Yes			Histopathology turn around time slow – not enough resources. Don't have pathologists in 3 sites participating.
3.13	The Head & Neck MDT(s) can demonstrate that it measures its performance against 'best practice' and other standards set for the Cancer Services we provide and we use the results to drive improvement in the provision of high quality, safe and accessible services.					Yes	Cancer Standards. Peer Review process. Survival figures on the Cancer website. DAHNO.
3.14	The Head & Neck MDT(s) can demonstrate that the key worker is recorded at all stages of patient pathway including follow up.					Yes	Recorded on Canisc.

Theme 3 – Delivering results, achieving excellence: Your Overall Assessment

In relation to this particular theme, what is your overall assessment of where and how you:

- **are governing well;**
- **need to strengthen your arrangements; and**
- **have noteworthy practice which you may wish to share.**

What maturity level have you demonstrated you have reached for this theme overall:

In relation to this particular theme,

- **what are the priorities for improvement?**
- **what action is being taken, and when?**
- **how will success be measured?**