

# Specialist Multidisciplinary Team

## Head & Neck Cancer

### Operational Policy

Designated Host Specialist Centre

The Royal Devon and Exeter NHS Foundation Trust

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#### **Designated Hospitals**

Taunton and Somerset Hospital Trust

North Devon Healthcare Trust

South Devon Healthcare Foundation Trust

Yeovil District Hospital



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## Introduction

This operational policy documents the purpose and organisation of the Head and Neck Specialist Multidisciplinary Team (SMDT) and the scope of services provided in the diagnosis, treatment and aftercare of patients with Head & Neck Cancer in this region. This document has been drawn up in response to NICE Improving Outcomes in Head and Neck Cancers (2004), the Manual for Cancer Services (2014) and the most recent Peer Review recommendations. It draws together agreed standards of best practice in the management of patients with suspected and/or confirmed Head and Neck malignancies and provides a framework for high quality, patient-centred care.

The specific aims of the SMDT are to improve collaborative decision making around treatment options for patients with Head and Neck Cancers, utilising weekly face to face meetings and videoconferencing to aid optimal patient discussions and to capture and report all data as a single centre.

SMDT members will meet at least annually to review, agree and record operational policies and service development. Outcomes from these meetings will be presented in the SMDT annual report.

## Structure and Function

### 1. Catchment population<sup>1</sup>

The SMDT provides a diagnostic and treatment service for a combined population of 1,388,470.

- Exeter, East and Mid Devon (catchment population 401,841)
- North Devon (catchment population 140,563)
- South Devon (catchment population 340,000)
- Taunton and Somerset (catchment population 356,066)
- Yeovil District Hospital<sup>2</sup> (catchment population 150,000 ).

<sup>1</sup> Population figures provided by the Peninsula Cancer Network

<sup>2</sup> Maxillo-facial patient referrals only

## 2. Named Designated Hospitals for Head and Neck Cancer

(14-1C-102i, 2I-111)

The Royal Devon and Exeter NHS Foundation Trust (RDEFT) is the designated host centre to the SMDT. Any patient with Head and Neck Cancer should have equal access to diagnostic services, regardless of their location in the peninsula. The diagnosis and assessment of patients with head and neck cancer symptoms, and some specifically agreed treatments<sup>1</sup> also take place in the following designated hospitals. These are outlined in more detail under the heading “Levels of Care”.

- Taunton and Somerset Hospital Trust<sup>1</sup> (TSHT)
- South Devon Healthcare FoundationTrust<sup>1</sup> (SDHFT)
- North Devon Healthcare Trust (NDHT)
- Yeovil District Hospital<sup>2</sup> (YDH)

<sup>1</sup> Designated hospitals where specifically agreed treatments take place

<sup>2</sup> Assessment and referral of maxillo facial cancer patients only

## 3. Membership arrangements and responsibilities (14-1D-101i, 104i, 2I-101, 104 , 105, 107)

The SMDT has a multidisciplinary / multiprofessional membership which is drawn from each of the acute trusts providing Head & Neck cancer services

Core members		
Role	Name	Cover
Lead Clinician	Andrew Husband	John Bowden
Consultant Otolaryngologist	Andrew Husband <sup>2, 5,</sup> Andrew Brightwell Andrew Drysdale <sup>6</sup> Edward Chisholm <sup>5, 6</sup> Simon Hickey <sup>7</sup> Philip Reece <sup>7</sup>	Andrew Brightwell Andrew Husband Edward Chisholm Andrew Drysdale Philip Reece Simon Hickey

Consultant Maxillofacial Surgeon	John Bowden (deputy lead clinician) Andrew McLennan Graham Merrick <sup>6</sup> David Cunliffe <sup>5, 7</sup>	Andrew McLennan  John Bowden Andrew McLennan John Bowden
Consultant Plastic Surgeon	Chris Wallace Katerina Anesti	Katerina Anesti Chris Wallace
Consultant Clinical Oncologist	David Hwang <sup>3</sup> Chris Hamilton Petra Jankowska <sup>6</sup>  Ruth Carr <sup>7</sup>	Chris Hamilton David Hwang Informal cross cover arrangement with RDEFT
Consultant Radiologist	Simon Harries Richard Thomas John Hunter <sup>6</sup> Paul Burn <sup>6</sup> Lyn Morris <sup>7</sup> Richard Perriss <sup>7</sup>	Richard Thomas Simon Harries Paul Burn John Hunter Richard Perriss Lyn Morris
Consultant Histopathologist	Claire Murray Charles Keen Steve Holwill <sup>6</sup> Andrez Karmolimski <sup>6</sup> Ian Buley <sup>7</sup> Consuela Garrido <sup>7</sup>	Charles Keen Claire Murray Andrez Karmolimski Steve Holwill Consuela Garrido Ian Buley
<b>Core Consultant Members Spend 50% of Time on Care of UAT Cancer</b>		
Clinical Nurse Specialist	Claire Barber <sup>1, 5, 8, 9, 13</sup> Joy Higgs <sup>5, 9</sup> Zoe Copp <sup>5, 9</sup> Joanne Greedy <sup>1, 5, 6, 9</sup> Joanna Dauncey <sup>6, 9</sup> Julie Hewett <sup>1, 5, 7, 9</sup> Fahida Manby <sup>7, 9</sup>	Joy Higgs Zoe Copp Claire Barber Joanna Dauncey Joanne Greedy Fahida Manby Julie Hewett
Head & Neck Ward Manager	Pippa Kassam	Sue Wearing
Speech and Language Therapist	Claire Higgins Stefania Antonucci Karen Dockings <sup>6</sup> Daphne Carpenter <sup>7</sup> Awaiting recruitment <sup>8</sup>	Stefania Antonucci Claire Higgins

Dietitians	Laura Finlay Marie-Claire Oliver Lynsey Clode <sup>6</sup> Deborah Howland <sup>7</sup> Awaiting recruitment <sup>8</sup>	Marie-Claire Oliver Laura Finlay
Consultant Restorative Dentist	Matt Jerreat <sup>6</sup> (with some access for RDEFT patients) Catherine Drysdale <sup>7</sup>	Vasiliki Bilerou
MDT coordinator	Gemma Tedd	Carol Whitton
<b>Extended members</b>		
Specialist Palliative Care Consultant	Becky Baines Charlie Davis <sup>6</sup> Catherine Leask <sup>6</sup> Joanna Sykes <sup>7</sup>	
Designated Clinicians for Diagnosis and Assessments at local (secondary) catchment areas	Mr Andrew Drysdale <sup>6</sup> Ms Lynne Fryer <sup>7</sup> Mr Mike Essen <sup>8</sup> Mr Andrew Baker <sup>12</sup>	
Consultant Anaesthetist & Pain Specialist	Rupert Broomby Douglas Natush <sup>7</sup>	
Consultant Skull Base Surgery	Mr David Baldwin <sup>10</sup> Mr Paul McCardle <sup>11</sup>	
Consultant Ophthalmologist	Ms Fiona Irvine	
Consultant Plastic Surgeon	Mr Chris Stone <sup>4</sup>	
Consultant Oncologist Skin and Thyroid	Dr Andy Goodman	
Gastrostomy & Feeding Tube Service	Georgie Adams Zoe Copp Laura Finlay Claire Barber	
Tracheostomy Tube Service	Claire Barber Joy Higgs Zoe Copp	
Therapeutic Link Radiographer	Sally Bell	
Locality MDT Co-ordinators	Michelle Grant <sup>7</sup>	
Head and Neck CNS Yeovil General	Sarah Levy	

Hospital	
Oral & Maxillofacial Technician	Lindsay McNeal Paul Nash <sup>7</sup>
Benefits advice	FORCE The Lodge <sup>7</sup> Macmillan CAB <sup>6</sup>
Clinical Psychologist	Dr Phil Yates Ellen Young <sup>7</sup> Awaiting Macmillan Appointment <sup>6</sup>
Physiotherapy	Locality Rehabilitation Departments Megan Achieson <sup>6</sup>
Occupational Therapy	Locality Rehabilitation Departments Kelly Willis <sup>6</sup>
Social work	Locality On-Call
Teenage & Young Adult Nurse Specialist	Lorraine Bedford (All sites)
Teenage & Young Adult Social Worker	Richard Nobes via CLIC Sargent
Cancer Audit Facilitator	Gillean Lazelle Abigail Leigh <sup>6</sup> Mike Francis <sup>7</sup>

<sup>1</sup> Nominated as having specific responsibility for patient issues and information for patients and carers

<sup>2</sup> Nominated as having responsibility for the integration of service improvement

<sup>3</sup> Nominated as the person responsible for ensuring that recruitment into clinical trials is integrated into the MDT

<sup>4</sup> Core member of the Sarcoma MDT

<sup>5</sup> Core member of the RDEFT Endocrine & Thyroid MDT

<sup>6</sup> Taunton & Somerset NHS Foundation Trust

<sup>7</sup> South Devon Healthcare NHS Foundation Trust

<sup>8</sup> North Devon Healthcare Trust

<sup>9</sup> Psychological level 2 training

<sup>10</sup> United Bristol Hospital Trust

<sup>11</sup> Plymouth Hospital Trust

<sup>12</sup> Yeovil District Hospital

<sup>13</sup> Lead for Head and Neck Service Improvement



## Key Responsibilities

- Appendix 1 **Core SMDT Member** responsibilities.
- Appendix 2 **Extended SMDT Member** responsibilities
- Appendix 3 **Leadership** arrangements and responsibilities
- Appendix 4 **SMDT Co-ordinator** responsibilities
- Appendix 5 **Local Support Team** responsibilities
- Appendix 6 **Key Worker** responsibilities
- Appendix 7 **Consultant Restorative Dentist** responsibilities

### **4. National Advanced Communication Skills Training Programme**

Members of the Head and Neck Cancer SMDT share a commitment to ensure all those core members of the team who have direct clinical patient contact should have participated in an approved course in advanced communication skills.

### **5. Services for psychiatry or clinical psychology (14-2I-101)**

Psychological support services for head and neck cancer services have been implemented across all four locality sites. Level 2 psychological support is provided by specialist nurses who have attended the National Advanced Communications Skills Training course and who have undergone a network agreed training programme, relevant to cancer patients and their carers. These courses have covered basic psychological screening, assessment and intervention skills. Level 3 psychological support is provided by cancer support services and hospices at each locality site. Level 4 psychological support is provided by

- a consultant psychiatrist;
- a consultant liaison psychiatrist;
- a clinical or counselling psychologist

The key worker has access to the psychiatry team or the psychology department if required. If the patient is already registered under the care of a Psychiatrist or Psychologist, the key worker will discuss the patient's needs with the mental health key worker and agree a plan of care. This will be with the

permission of the patient. For RDEFT, referrals can be emailed to Debbie Clyburn, Health Psychology & Neuropsychology Service Administrator at debbieclyburn@nhs.net or sent in internal post to her at the Department of Clinical & Community Psychology, RD&E (W), Church Lane.

## **6. Treatment and Levels of Care (14-1C-102i)**

Along with the designated host centre, the following hospitals offer specialised facilities for the investigation of head and neck cancers and have contracted direct patient care sessions with designated clinicians for head and neck diagnosis and assessment.

### The diagnostic process

- (i) Northern Devon Healthcare NHS Trust
- (ii) Taunton and Somerset NHS Foundation Trust
- (iii) South Devon Healthcare NHS Foundation Trust
- (iv) Yeovil District Hospital

All patients will be assessed locally by a surgical member of the Head & Neck Specialist SMDT. Certain biopsies, examinations under anaesthesia, imaging and blood work will be carried out locally. Subsequent to a positive histological diagnosis being made, all patients will be duly referred to the Specialist MDT along with any radiological images, pathology reports and other diagnostic information.

Some patients from Yeovil who are referred to the maxillofacial surgeons may have imaging and surgical biopsies carried out at YDH. Such patients will be supported by a local dedicated Head and Neck CNS and timely referrals made to the SMDT members based at the TSHT locality.

### Specialist Care (14-2I-111)

Treatment and procedures categorised under 'Specialist Care' include all curative operations for UAT cancer excluding those listed below under "Local Care". Such specialist care should only be delivered at the designated host centre by core MDT surgeons. Patients will be nursed on a specified Head and Neck ward. Any emergency surgical procedures, where the diagnosis is

unforeseen and / or made at the time of the operation, are not subject to these measures.

### Local care

All patients diagnosed with UAT cancer should be discussed as individual cases at the Head and Neck SMDT to determine any proposed treatment option(s). At this time the agreed list of procedures which may be done at local units and following SMDT discussion and agreement are as follows

- Excision biopsies of T1 tumours.
- Uncomplicated neck dissections\*
- Palliative surgical management of tumours as agreed at the Specialist MDT.\*
- Curative radiotherapy +/- chemotherapy\*
- Adjuvant radiotherapy +/- chemotherapy\*
- Palliative interventions and supportive care including radiotherapy\*, chemotherapy, transoral laser surgery\*, tracheostomy\* and gastrostomy insertion\*
- Tracheoesophageal punctures\*

\*SDHFT AND TSHT Only

## **7. On-call and cover arrangements**

Head and Neck surgeons who have carried out a complex surgical case are available to support non-head and neck consultants who are on call that night.

Oncologists at RDEFT provide informal on-call cover for TSHT. This will require monitoring and annual review

## **8. Distribution of Local Support Teams (14-1D-101i)**

A total of four dedicated Local Support Teams (LST's) have been established covering the following catchment areas:

- Exeter, Mid and east Devon – Delivered by RDEFT
- North Devon – Delivered by NDHT
- South Devon - Delivered by SDHFT
- Taunton and Somerset – Delivered by TSHT
- Yeovil District Hospital – CNS only. Liaises with TSHT LST.

Each team is made up of Clinical Nurse Specialists (CNS), Dietitians, Speech and Language therapists (SLT) and Restorative Dentists. Clinical Psychology, Occupational Therapy, Physiotherapy and Specialist palliative care services are important members of the wider team and are involved as necessary.

**Table of LST Members at each designated hospital sites**

	RDEFT	SDHT	TSHT	NDHT	YDH
<b>CNS</b>	Claire Barber Joy Higgs Zoe Copp	Julie Hewett Fahida Manby	Joanne Greedy	Claire Barber Satellite cover from RDEFT	Sarah Levy
<b>SLT's</b>	Claire Higgins Stefania Antonnuci	Daphne Carpenter	Karen Dockings	Awaiting appointment	
<b>Dietitians</b>	Laura Finlay Marie-Clare Oliver	Deborah Howland	Lynsey Clode	Awaiting appointment	
<b>Tracheostomy &amp; Tracheoesophageal valve Service</b>	Claire Barber Joy Higgs Zoe Copp	Julie Hewett Fahida manby	Ann Dodds	Claire Barber Satellite cover from RDEFT	
<b>Gastrostomy and Feeding</b>	Georgie Adams Zoe Copp Laura Finlay Claire Barber	Jane Gagg Sarah Smith	Suzy Cole Sarah Watkins	Rebecca MacMillan Emily Cruwys Claire Barber	
<b>Dental Hygienist</b>		Rose-Marie Perry	Joseph Chikosi		
<b>Therapeutic Radiographers</b>	Sally Bell	Jeanette Bowes-Cavannagh	Joan Sweeney Kate Cooper	RT treatment given at Host Centre	

## 9. The SMDT (14-2I-102, -103, -104, -109, -116, -118, -119)

### Purpose

The SMDT's core functions are to provide:

- An exemplary and comprehensive service for all referred patients with head and neck cancers that are delivered in line with the Improving Outcome Guidance and Cancer Waiting Times.
- High quality holistic care delivered through a multidisciplinary team with a specialist interest in head and neck
- Clinically appropriate consideration and provision of surgery within the head and neck cancer patient pathway.
- Expert diagnosis of head and neck cancers utilising the most up- to-date validated diagnostic tools and knowledge.
- Radiological, pathological and diagnostic facilities to effectively diagnosis, classify and stage the condition prior to planning treatment
- Assessments and advise on the appropriateness of head and neck cancer treatments
- High quality surgical treatment of patients with Upper Aerodigestive Tract (UAT) cancer (and thyroid cancer)
- Continuous monitoring of risk and governance to ensure that clinical treatment is safe and effective
- Opinions on diagnostically difficult and other complex cases
- Effective monitoring of treatment outcomes to ensure optimal functioning and quality of life for the patient with regards to their head and neck cancers.
- And facilitate clinical governance for primary and secondary care head and neck cancer management
- Support to local healthcare providers to manage patients with head and neck cancer whenever it is clinically appropriate and safe to do so
- Engagement with local and national research initiatives relevant to the field of Head and Neck Cancer.

- A forum for discussion between wider specialist groups with the overall advantage of pooled knowledge and experience in care and treatment planning for patients.

The SMDT is committed to achieving the highest standards of care and patient outcomes through high quality discussion of each individual patient and by:

- Complying with Peer review Measures
- Complying with Care Quality Commission regulations
- Central collection of high quality data
- Analysis of such data in audit cycles
- Involvement in local, national and international research studies
- Incorporation of new research and best practice in to patient care (Implementing NICE guidance and IOGs)
- Providing comprehensive support and information to patients and their relatives
- Providing care with a patient and family centred focus to maximise the patient experience
- Involving patients in assessment and redesign of the services

### SMDT review

SMDT members take responsibility for diagnosing and treating patients with cancer of the upper aerodigestive tract i.e. sinonasal, oral, laryngeal and pharyngeal cancers, as well as patients with salivary gland cancer. Those patients with parotid and neck metastases from primary cutaneous malignancies are also discussed and managed via direct referral from the locality skin multidisciplinary teams. Those patients with skull base carcinomas are referred to Bristol or Plymouth. Patients requiring the input of Thoracic surgeons are referred to Plymouth.

The SMDT will discuss a minimum of 100 new and separate cases of Squamous Cell Carcinoma each year. Cases which sit within the following

criteria will be presented by the patient's principle clinician or nominated representative and discussed at the SMDT meeting

- All patients with a new diagnosis of head & neck cancer, prior to any treatment
- All previously treated patients who present with complex problems such as Osteoradionecrosis.
- Postoperative patients requiring a decision on future treatment following receipt of histology
- All cases referred in to the centre for treatment
- All complex cases
- Patients with newly identified local recurrence of disease
- Patients with newly identified metastatic disease
- Patients with head and neck metastases arising from cutaneous and primary lesions from other anatomical sites

It is the responsibility of the CNS to ensure that patients' Holistic Needs Assessments (HNA's) are taken in to account in decision making.

### Meeting arrangements

The weekly SMDT meeting takes place every Monday between 9am – 12 pm at the designated host centre. Meetings take place via face to face discussions and video-conferencing. Core surgical consultants from each locality site will endeavour to travel to face to face meetings. All other consultants and Local Support Team Members from locality sites will link up via video conferencing for the entirety of the meeting. Each individual core member should personally attend at least two thirds of meetings (either video or face to face). At least one member of each core sub-speciality should be present at every meeting. A programme of meetings is timetabled through the year and attendance is recorded centrally by the SMDT co-ordinator at the host site. An audit of annual attendance is carried out, the results of which are published in the annual report for the Head & Neck SMDT.

Core members will liaise with each other to provide cover for absence, avoiding overlapping leave wherever possible. The SMDT coordinator will liaise with the lead clinician to ensure their attendance. If unavailable the coordinator will ensure that the meeting is chaired by the nominated deputy. If another core member of the SMDT is unable to attend the SMDT coordinator will be informed but the responsibility to ensure cross cover sits with individual SMDT member.

Extended team members need not attend meetings but should be available for referral or consultation if required.

Cut-off dates for adding patients to the next available MDT are

Pathology - Thurs lunchtime

Radiology - Fri lunchtime

Final agenda circulated - The Final SMDT agenda containing a list of all patients to be discussed is circulated in advance and by the Friday afternoon preceding the meeting. It is the responsibility of the SMDT coordinator at the specialist centre to ensure that patient notes and diagnostic reports are available for the meeting to facilitate discussion and informed decision making. It is the responsibility of the presenting clinician to prepare and deliver a summary presentation of each individual patient to support discussion.

### SMDT decisions and outcomes

The SMDT will agree and record individual patient's treatment plans at the SMDT meeting. A record will be made of the treatment plan and will include the following:

- The identity of the patient discussed
- The SMDT treatment / care planning decision
- The patients named principle clinician and key worker
- Details of referral to another team (if appropriate)
- A note of current clinical trials that the patient may be invited to consider



- Confirmation that HNA's have been taken in to account

In addition, for patients in the TYA age group (19-24 years), the following will also be noted:

- The named consultant in charge of each modality of treatment
- Named person with responsibility for organising age appropriate support and care environment (usually the TYA Liaison Nurse)
- Choice of treatment location i.e. adult service, TYA facility or designated centre

The outcomes are recorded in real time by the SMDT coordinator based at the specialist centre using an electronic pro forma. A copy of the SMDT outcome pro forma is filed in the patient's central case notes at both the specialist centre and the referring trust. Copies of the pro forma are sent to the referring clinician.

In the event of a delay or alteration in diagnosis that affects the management of an individual patient's condition, a significant event analysis will be undertaken. Results will be relayed to relevant clinicians and reported to the SMDT. The patient will be informed of the details.

#### Treatment planning decisions outside of the SMDT meeting

Whilst every patient must be discussed in a multidisciplinary way there may still be occasions when treatment planning decisions need to be made in between meetings to enable continued and uninterrupted flow of patient care. (e.g. during Bank Holidays). In such circumstances discussions will be undertaken collaboratively between at least one Surgeon, Oncologist and CNS and any decisions brought to the next available SMDT for ratification.

Management of day to day issues such as local cases which sit outside of the SMDT criteria, for example on-going palliative care patients, will be discussed locally between relevant members of the team and with the agreement to refer directly back to the SMDT should the criteria of care-needs escalate.

#### Pathology and Radiology

Each designated hospital including the specialist centre, will take responsibility for the primary analysis and reporting of imaging and tissue specimens carried

out locally. Imaging will be performed in line with 2 week wait guidelines where indicated. Follow-up imaging will also be carried out at local sites. PET/CT facilities and reporting will be provided by in-health.

## **10. Breaking Bad News consultations**

Test results are often discussed with patients prior to discussion at the Head and Neck SMDT. In such cases, consultants will endeavour to contact their relevant CNS so that support, information and key worker details can be provided at the point of breaking bad news.

Head and Neck CNSs are based 5 days a week at RDE, TSHT and SDHT, 3 days at YDH and weekly at NDHT. On those occasions where the CNS is not immediately available the consultant will request that the CNS makes contact with the patient within 3 working days. The clinic nurses at NDHT have undertaken local relevant training in “supporting patients during bad news” for those occasions when a CNS is not available. Where patients are identified early through the Head and Neck SMDT, the CNS will timetable their attendance at the planned breaking bad news consultation. The CNS teams at each site hold weekly tracking meetings with their respective MDT co-ordinators in order to track patients along their pathway and to identify and plan early for any patients who may have a diagnosis of Head and Neck cancer.

Patients diagnosed with head and neck cancer are counselled in an appropriate environment by the consultant with support from the CNS. All patients are issued with a list of contact numbers which allows for access to a member of the SMDT for on-going advice and support. On occasions the CNS may need to carry out a home visit for those patients with highly complex physical, emotional or social circumstances, particularly those with vulnerable airways who require extra assessment and planning.

## **11. Assessment and Treatment Planning (14-2L-106, -116)**

### Pre-Treatment Assessment Sessions

All *new* patients whose treatment will be at the specialist centre will undergo a multidisciplinary pre-treatment assessment at the Combined Head and Neck

clinic immediately following the SMDT discussion. At least one core member from each key specialty will be timetabled to attend these weekly sessions. LST members at the host site will communicate any key outcomes from this assessment to their relevant colleagues at Locality sites. New patients whose treatment will be at locality sites will be assessed locally by their own relevant team. Consultant restorative dentists at TSHT and SDHFT offer pre-assessments and treatment to patients within their own catchment areas. Patients from RDEFT and NDHT undergo a dental screen by the maxillofacial consultant team at the host centre prior to commencement of radiotherapy treatment.

## **12. Teenagers and Young Adults (14-1C-111i)**

Patients aged 19-24 years with a suspected or confirmed diagnosis of head and neck malignancy will be referred to the Head & Neck SMDT. Once a diagnosis is confirmed, and following discussion at the SMDT meeting, the treatment plan will be discussed with the patient. Part of the discussion includes offering the patient the choice of either having their care locally or being referred and treated at the Children & Young People's Principal Treatment Centre (PTC) in Bristol. All cases should be notified to the Teenage & Young Adult (TYA) Coordinator and the TYA Nurse Specialist.

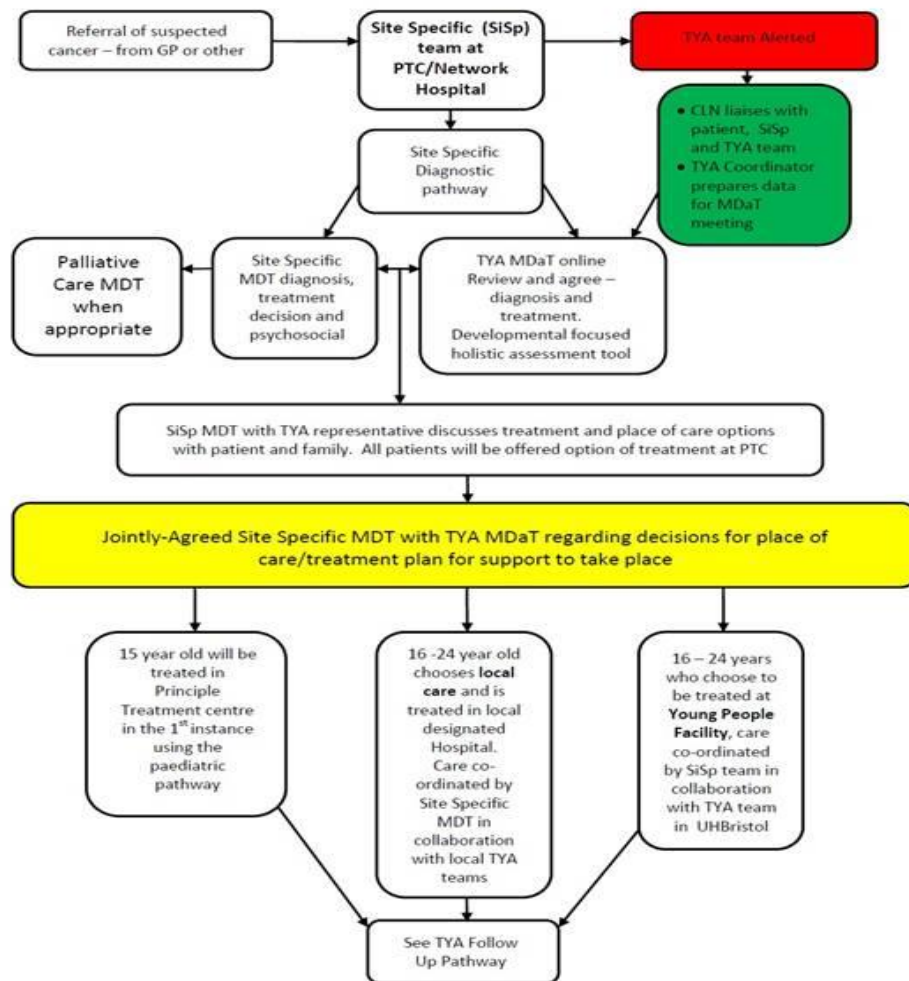
Patients aged 15 years and below are managed by the local Paediatric Oncology MDT in a shared care arrangement with the Paediatric Principal Treatment Centre in Bristol.

Patients aged 16-18 years will usually be managed by the Paediatric Oncology MDT. For some patients aged 16-18 years who are referred directly to adult services, it may be appropriate for them to receive their care locally. All cases should be notified to the TYA Coordinator and the TYA Nurse Specialist. All cases should be referred to the PTC for discussion at the TYA MDT.

In addition all patients aged 15-24 years will be referred to the TYA MDT meeting at the PTC. Referral is for the purposes of registration and advice only. Responsibility for care of the patient remains the duty of the Head & Neck

SMDT. Referral is made with patient consent via completion and email submission of the TYA MDT Registration & Review Form.

**South West TYA Patient Pathway for Initial Management of Cancer for 15 – 24 year old**



Version 1.1

9<sup>th</sup> November 2011

**13. Role of Local Support Teams (14-1c-103i, -1D-101i)**

LST's remain an integral part of Head and Neck Cancer patient care and the SMDT acknowledges the importance of keeping care local where possible yet central where necessary. It is essential that each Local Support Teams is given the opportunity to establish an early relationship with their patients as it is likely that support and rehabilitation will continue in to the medium and long term future. Locality support teams will transfer all relevant early phase assessments and correspondence across to support team members at the designated host centre (for those patients whose treatments are to be carried out there). Support team members at the designated host centre will endeavour to meet patients from locality sites at existing scheduled clinic or mould room

appointments, in order to minimise unnecessary travel. Daily ward rounds for surgical patients and weekly radiotherapy reviews will continue throughout the course of the patients' treatment. A clear summary of the patients treatment, care and rehabilitation needs will then be communicated back to the relevant designated LST, immediately prior to discharge from the treatment centre.

**Appendix 5** outlines the key responsibilities of each LST

**Appendix 8** outlines LST communication pathways for patients undergoing surgery and radiotherapy.

Each locality site has a nurse who is responsible for the management of stomas (tracheostomies and gastrostomies), nasogastric tubes and tracheo-oesophageal valves. At the RDEFT (including NDHT), an expansion of the Head and Neck CNS workforce has meant that these services can be integrated in to one team in order to ensure continuity of care during periods of absence.

#### **14. Rescue of Reconstructive Surgical Flap Failure (14-2I-112)**

If a patient requires reconstructive plastic surgery then the type should be discussed and agreed between the patient's OMFS or ENT surgeon and a plastic surgeon core member. All flap reconstructions will be carried out at the host site. Surgical cover for the rescue of flap failure is available 24 hours a day, seven days a week, 365 days a year by consultant surgeons trained in microvascular surgical techniques. A separate operational policy for flap reconstructions, including free flap escalation protocol, named members on the rota and agreed cover arrangements, is currently in working progress and will be circulated at a later date.

## **Co-ordination of Care / Patient Pathways**

#### **15. Clinical guidelines (14-1C-108i, -2I-113)**

The Network Site Specific Group for Head and Neck Cancers previously adopted two guideline documents to support clinical practice:

- [Diagnosis and Management of Head and Neck Cancer](#) (2006), Scottish Intercollegiate Guidelines Network.
- [Head and Neck Cancer Multidisciplinary Management Guidelines](#) (2011), British Association of Otorhinolaryngology.

The Head and Neck SMDT continues to support these guidelines.

#### Imaging guidelines

The Network Site Specific Group for Head and Neck Cancers previously adopted national guidelines to support cross-sectional imaging:

- [Recommendations for Cross-Sectional Imaging in Cancer Management: 2nd Edition](#) (2014), Royal College of Radiologists

The Head and Neck SMDT continues to support these guidelines.

#### Pathology guidelines

The Network Site Specific Group for Head and Neck Cancers previously adopted network devised pathology reporting guidelines for head and neck cancers.

- [Network Pathology Reporting Guidelines](#)

The Head and Neck SMDT continues to support these guidelines.

### **16. Enhanced Recovery**

Patients with a new Head and Neck Cancer (or clinically thought to have one) and who are to undergo surgery at the host centre will be offered a full comprehensive enhanced recovery assessment at the centre in order to optimise recovery rates and to strengthen clinical governance at the host site. For patients who live some distance away all efforts will be made for this assessment to be carried out on the same day as their MDT assessment at the combined head and neck clinic to help minimise travel. Patients will be admitted for their planned procedure on the day of surgery and will be issued with a diary to log any symptoms and to record their own personal experiences. Once the gold standard benchmark has become established at the host centre, it is anticipated that the same model of enhanced recovery assessments can be replicated and rolled out to locality sites, but still working from one single document that follows the patient.

### **17. Local Support Team Clinics (screening, Information and support)**

Alongside enhanced recovery for surgical patients, Head and Neck Local Support Teams across all designated sites run a series of weekly screening and information clinics where newly diagnosed patients and their carer's are provided with verbal and written information, a base line assessment of their current needs (i.e. swallowing, nutritional, psychological, HNA) and the opportunity to discuss the implications and side effects of any proposed treatments. This will include information on the long term effects on swallowing function and consequent nutritional intake and rehabilitation. HNA's will also be carried out at this consultation.

### **18. Admission arrangements for major surgery (14-1D-105 & 106i)**

All surgery allocated to the designated centre is booked and listed by the ENT and Maxillo-facial surgical secretaries. Patients are admitted in to the care of the RDEFT as agreed in the Enhanced Recovery Care Plan. ITU beds are booked as required. All patients will be nursed on the designated Head and Neck Cancer ward (Otter ward) for the entirety of their acute phase of treatment and will be discharged back home or to designated units as agreed by the SMDT (see surgical discharge criteria).

### **19. Specialist Head and Neck Ward (14-1D-106i)**

Most surgical patients are operated on at the designated specialist centre and are cared for on a named specialist Head, Neck and Plastic Surgical Ward (Otter ward) where there are daily ward rounds by a team of Surgeons, clinical nurse specialists and speech and language therapists. Blake Ward at TSHT and Forrest Ward at SDHFT have the clinical facilities and resources to cater for the care and management of Head and Neck patients undergoing agreed local care.

### **20. Head and Neck Ward Staffing (14-1D-107i)**

The designated Head and neck ward (Otter Ward) has a team of nursing staff and specialist LST members who are highly trained in head, neck and upper airway management. Ward sisters from the designated operating hospital are



integral core members of the MDT and ensure that nursing skill mix on the ward reflect the needs of patients with tracheostomies at all times. SLT's and Dietitians who are core members of the SMDT are specifically allocated time to care for head and neck cancer patients on the wards. A set number of tracheostomy and airway patient workshops are rolled out across the each of the designated hospitals and reflect the standards expected from the NCEPOD recommendations (2014).

## **21. HDU and ITU (14-1D-105i)**

The designated host site has an ITU / HDU department which is situated adjacent to the named designated Head and Neck Ward.

## **22 Chemotherapy (14-1c-110i)**

Specialist chemotherapy nurses based at all four locality sites assist in the co-ordination, care and management of patients undergoing chemotherapy. The care and treatment of North Devon patients who require concomitant or neo-adjuvant chemotherapy will be delivered by the RDEFT. However palliative chemotherapeutic regimes can be delivered locally. **Appendix 8** outlines the chemotherapy algorithm for Head and Neck Cancer

## **23 Patient Referral Pathways (14-1c-111i, 14-1D-102i)**

Network Site Specific Group Meetings have recently been reinstated. Referral pathways require Group ratification

### Primary care referrals

All urgent suspected cancer referrals received via the fast-track fax service are seen in urgent slots in ENT and Maxillofacial clinics or dedicated two-week wait clinics within 14 calendar days of the decision to refer, as per the national two-week wait guidelines. Patients with neck lumps are referred in the same way and assessed by the relevant local neck lump services.

### Neck lump clinic

Weekly Neck Lump Clinics with identified slots for fast track referrals and patients on the Head and Neck cancer pathway run alongside head and neck



clinics at designated hospitals<sup>1</sup> and serve each of the relevant local catchment areas. Core members of the Head and Neck SMDT are available at that time including consultant designated clinicians for UAT and Oncology. Head and Neck patients from both NDHT and YDH are also assessed by named core or extended members of the SMDT. Flexible Endoscopic examinations are also carried out at each designated hospital site.

Table of Information for Neck Lump Clinics

	Identified on OPD clinic List	Named in the Network Guidelines	Has bookable clinic Slots	Designated Clinicians UAT & Oncology	Offers weekly Fast Track appointments	Same Day FNA sample microscopic assessment for adequacy	Runs Weekly	Offers Flexible Endoscopy
<b>RDEFT</b>	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
<b>TSHT</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>SDHFT</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>NDHT</b>	No	Yes	No	No	Yes	No	Yes	Yes
<b>YDH (Max Fax)</b>	No	No (ASWCN)	No	No	Yes	No	Yes	No

<sup>1</sup> RDEFT, TSHT, SDHFT

Only a percentage of head and neck cancers are detected in primary care and some patients are referred as a routine referral to ENT, Max Fax, or other departments. Patients with proven head & neck malignancies who are referred to the Head & Neck SMDT must be subsequently assessed in the combined Head & Neck clinic (Pre-Treatment Assessment Clinic)

Consultant upgrade for suspected cancer and notification of recurrent or secondary cancer

Any patient suspected of having a head and neck cancer but not referred via the urgent referral route, may be upgraded by a consultant member of the SMDT at any time prior to decision to treat.

The upgrade should be undertaken using an internal upgrade referral pro forma and following processes outlined in the relevant Trust policy.

### Tertiary referrals

Some patients are referred to the Head and Neck SMDT from other consultants within the designated Trusts (particularly general surgery, thoracic surgery, neurology, haematology, dermatology and plastic surgery). Such patients must be referred to a SMDT member for biopsy and subsequent MDT discussion.

### Patients with synchronous cancers

Such patients will be discussed at both the Head and Neck and other relevant MDT meeting. Responsibility for the management of the patient will be shared between team members until it becomes clear which is best placed to lead the care for each individual patient. Relevant CNS's and MDT co-ordinators will ensure seamless and timely discussions and investigations are carried out within recommended cancer waiting times.

### LST referrals

Head and Neck Local Support Teams will refer back to the Head and Neck SMDT, any patients with possible recurrence seen in the support team clinics and will ensure patient GP's are made aware of any current concerns.

## **24. Transfer and Discharge criteria (14-21-115)**

Surgical patients who are operated on at the main treatment centre will spend the entirety of their in-patient episode on the dedicated Head and Neck Cancer ward (Otter ward).

Patients referred across hospital sites are co- managed by the designated support teams at each site. The network of specialist nurses, dietitians and speech and language therapists have together, established a robust system of transferring information across sites before patients are admitted to or discharged across sites (**Appendix 9**).

## 25. Adjuvant therapy

The SMDT is relatively unique in that it provides 3 oncology centres based at RDEFT, TSTH and SDHFT. Each site offers full oncology provision with radiotherapy and chemotherapy facilities and specialist staff to plan and deliver treatment for patients in those catchment areas. This level of service provision fulfils the requirements for access to radiotherapy as specified in the National Radiotherapy Advisor Group Report 2007, specifically with regard to minimising travel times for patients. Chemotherapy services are provided at a newly built unit at NDHT, but north Devon patients who require radiotherapy (+/- chemotherapy) are treated at the RDEFT.

Intensity Modulated Radiotherapy (IMRT), Image Guided Radiotherapy (IGRT) and Volumetric Modulated Arc Therapy (VMAT) is offered as appropriate. Mechanisms between regional oncologists are in place to ensure robust clinical governance for review of target volumes and dose distributions (especially where IMRT has recently been introduced). A fortnightly forum between oncologists at RDEFT and SDHT allows for local peer review of planning volumes and dose plans. A weekly treatment planning meeting takes place remotely between the Taunton and Exeter oncologists.

Approximately 70% of patients will require radiotherapy +/- chemotherapy post-operatively. Final decisions regarding this are made via the SMDT, once the histology is known. Patients will receive their oncology treatments at their local hospital RDEFT (also serving the population of North Devon), TSHT and SDHT although some specialist cases are referred on to tertiary centres eg The Royal Marsden for Open Trials. Throughout their oncology treatment, all patients are assessed and reviewed at least weekly by their local head and neck consultant oncologist and LST members to ensure that any symptoms and treatment toxicities are recognised early and comfort and recovery times optimised. Head and Neck therapeutic radiographers based at the RDEFT and TSHT have a principle role in the care of oncology patients treated at these particular centres and link in closely alongside the consultant oncologist in co-ordinating treatment planning, delivery and follow-up arrangements for this site specific patient group.

## 26. Clinical follow-up

Follow up continues for up to five years post treatment. Approximately 90% of recurrences occur in the first two years post-operatively. Post-operative patients are seen every 1-2 months for follow-up for the first year, then every 2-3 months in year two, every 3-4 months in year three and six monthly in years four and five.

Patients will undergo post treatment and palliative care reviews at their local designated hospital by their principle clinician. Surgical patients operated on at the designated centre will undergo their first follow-up at the centre with subsequent reviews at their locality hospital thereafter

### Clinics

- Consultant led combined head and neck clinics (RDEFT, TSHT, SDHT)
- Neck Lump Clinics (RDEFT, TSHT, SDHT)
- Local support team clinics (RDEFT, NDHT, TSHT, SDHT)
- Enhanced Recovery Clinics (RDEFT)

## 27. Aftercare and rehabilitation

A range of support clinics are offered locally at each site by local Head and Neck support teams for the assessment and correction of symptoms and to signpost patients to relevant support agencies/ healthcare professionals. These clinics support patients throughout all key stages of the pathway, specifically before during and after treatments and also offer teaching opportunities for a range of trainee healthcare professionals.

Post radiotherapy clinics support patients who have recently completed a course of radiotherapy +/- chemotherapy. This allows for symptoms to be assessed and managed during the time frame where patients generally experience the peak of their treatment reactions.

Other weekly clinics are geared towards the longer term follow-up and rehabilitation of head and neck cancer patients, including tracheoesophageal valve drop-in clinics and airway, acupuncture and specialist rehabilitation clinics.

Specialist nurses are available to carry out domiciliary visits for those patients who are too frail or unwell to travel.

The local support team at TSHT will liaise with the Yeovil CNS for East Somerset patients.

The Lead CNS at the designated host site has undertaken training in advanced healthcare practice and non-medical prescribing. This allows for a weekly independent satellite clinic to be run at NDHT which caters for local Head and Neck inpatients and outpatients and patients with complex and long term tracheostomies.

## **28. Supportive Care Services**

An impressive range of supportive care and complementary therapies are offered on both an in-patient and outpatient basis across all designated sites. FORCE Cancer Support Centre and Exeter and District Hospice provide for the Exeter locality with similar services at The Lodge and Rowcroft Hospice for Torbay patients, The Beacon Centre and St Margaret's hospice for Taunton patients and North Devon hospice for patients in the North Devon locality. Lymphoedema management services are routinely provided at each locality site. Weekly acupuncture treatments for patients suffering from xerostomia are provided at FORCE Cancer Centre which has access open to all patients who are treated at the RDEFT regardless of where they live. SDHFT offers a similar service for their own local patients.

## **29. Living with and beyond cancer initiatives**

A series of 'living with and beyond cancer', 'health and well-being' and other cancer support groups are run at each locality site and are well supported by local cancer support centres. Many patients become regular visitors at local hospices and at FORCE, The Lodge and The Beacon Cancer Support Centres..

Laryngectomy support groups have been established across all sites. Where possible, patients are encouraged to take ownership of these groups to help foster stronger relations and offer a sense of control. A specialist practitioner is

more often than not, present at these meetings or at a minimum, contactable for support and advice. An annual regional survivorship event to support laryngectomy patients has proved successful

Head and Neck CNS's across all sites meet regularly to identify gaps in service provision and to ensure that the care standards delivered across the region remains consistent and of high quality.

A pilot service is currently being set up at the RDEFT to help reintroduce neck-breathing patients back in to the water using an Aquather snorkelling device.

### **30. Bereavement Services**

A range of bereavement services are available across all locality sites including Community Palliative Care, Cancer Support Centres, CRUISE, voluntary and GP based services.

### **31 Collaboration and networking (14-21-114)**

#### Peninsula Cancer Network

It is expected that at a minimum, the lead clinician or their representative will attend 2/3 of NSSG meetings.

#### South West Head and Neck CNS Forum

The Head and Neck CNS's from each Head and Neck designated Trust within the south west meet as a sub branch of the British Association of Head and neck Oncology Nurses (BAHNON), three times a year. The aims of this forum is to share specialist knowledge, update and educate on latest innovations and practice, provide peer support, shape local and national policy and ensure practice remains both current and streamlined throughout the region. The CNS forums also link in closely with SLT and dietetic groups throughout the southwest.

## Patient Experience

### **32. Patient and carer feedback and involvement (14-1C-114i, -2L-123)**

A patient experience exercise will be undertaken at least every two years to obtain feedback on patients' experiences of the services offered, specifically regarding key workers, holistic needs, information and support. Findings will be presented to the SMDT for consideration and to identify action points to address highlighted issues.

Feedback from patients and carers will be obtained on an on-going basis from numerous sources which may include surveys, focus groups, Patient Advice & Liaison Service (PALS) and complaints. This will be reviewed at the SMDT annual business meeting.

Patient representation at local cancer forums and network meetings has been invaluable in helping shape future service planning.

### **33. Principal clinician (14-2I-118)**

Every patient has a principal clinician at each stage of their journey. This is the clinician to whom the patient primarily relates with regard to decision making for their clinical management and it will be a consultant member of the SMDT. The patient and GP are informed of the name of the principal clinician and it is recorded in correspondence within the notes.

### **34. Key worker (14-2I-119)**

The definition of a key worker is accepted as a "person who with the patient's consent and agreement, takes a key role in coordinating the patient's care and promoting continuity, e.g. ensuring the patient knows who to access for information and advice" (NICE Improving Supportive and Palliative Care for Adults with Cancer. 2004) and is endorsed by the Cancer Reform Strategy (2007).

All patients who are referred to the SMDT for treatment will be allocated a key worker who will take the lead in co-ordinating the care and promoting continuity for the patient throughout their pathway. The key worker is most likely to be a

CNS but can be any member of the SMDT or other health care professional involved in the patient's care.

The key worker will be agreed and identified as early as possible on the patient's care pathway. This is likely to be at the SMDT meeting but may in some cases be when there is a suspicion of cancer when the patient is undergoing investigations. The identification of the key worker will be the responsibility of the designated CNS at the SMDT meeting.

The Key worker's name, contact details and date of first contact will be recorded in the central case notes using relevant sticker' systems. It is important to ensure that the patient and carer understand the role of the key worker as early as possible on the patient's pathway of care. Information about the role of key worker is included in the written information offered to patients. It may be appropriate as the patient continues through their pathway of care that other professionals (e.g. palliative care nurse specialists, chemotherapy nurse specialists, general practitioner) fulfil the key worker role. Any changes will be negotiated with the patient and carer prior to implementation and a clear handover provided to the next key worker.

The impact and effectiveness of the key worker system will be regularly evaluated and audited via patient experiences exercises and the Peer Review process.

### **35. Discussion of treatment options\_(14-2I-120)**

Treatment options are discussed with the patient in a relevant multi-disciplinary setting, with the principle clinician for each modality explaining the implications of the proposed treatment, i.e. surgery, radiotherapy, chemotherapy. The CNS will aim to be present at all of these discussions, in particular when bad news is delivered. Patients will have the opportunity to receive a copy of the permanent record of the consultation, or a summary. Treatment options will also be reiterated at local support team clinics.

### **36. Patient information (14-2I-121)**



Comprehensive information is available to patients throughout their pathway of care and include signposts that are specifically tailored to assist patients in making fully informed choices.

### Local written Information

#### **Pre- diagnosis**

- 2WW Clinics
- Joint Head and Neck clinic
- Information on entitlement to copy of clinic letters
- Smoking cessation services
- Travel Costs

#### **At diagnosis**

- Patient information pack at diagnosis including site specific treatment information
- Cancer Support Centres
- Gastrostomy Feeding
- Costs associated with cancer
  - Head and Neck Support Team
  - Neck Dissection
  - Parotidectomy
  - Cancer Support Services

#### **Post treatment**

- Acupuncture
- Xerostomia
- Moving on group
- Look good feel better
- Skin care post radiotherapy
  - Lymphoedema
  - Neck physiotherapy
  - Healthy eating
  - Benefits advice sessions

National written information

At diagnosis

*Macmillan*

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Larynx</li> <li>• Head and neck cancers</li> <li>• Understanding radiotherapy</li> <li>• Understanding chemotherapy</li> <li>• Diet and cancer</li> </ul> | <ul style="list-style-type: none"> <li>• What to tell the children</li> <li>• Dealing with emotional issues</li> <li>• Work and travel</li> <li>• Managing symptoms of cancer</li> <li>• Malignant melanoma</li> </ul> |
|--|--|

Post treatment – for inclusion in survivorship patient information pack

- Changing Faces - cosmetic camouflage
- Cancer survivors guide
- Macmillan ten top tips
- Post treatment – longer term effects of head and neck cancer management.

In addition to cancer specific information which is offered to patients routinely by the CNS, written information is also displayed on the wards and in the outpatient areas. The Cancer Supports Centres are charity run organisations which also offer further information and psychological support to patients and their families.

**37. Patient permanent record of consultation (14-21-122)**

Patients will be given the opportunity of a permanent record or summary of their consultations about diagnosis, treatment options and follow-up arrangements. Leaflets advertising this are displayed in outpatient areas. This may also be offered to patients during individual consultations and documented in the patient's notes.

The written record can be provided in an alternative language via the Health Information Centre if required. Documents can also be provided in alternative formats such as large print and easy to read.

### **38. Communication with General Practitioners**

GPs are kept informed of their patient's progress throughout the pathway. Specifically they receive:

- New cancer diagnoses. It is aimed to inform the GP by the end of the next working day. Details are sent electronically
- The name of the principal clinician and/or key worker at each stage.
- Feedback on the timeliness of urgent suspected cancer referrals and overall patient waiting times to treatment.
- Feedback on the appropriateness of referrals.
- The team will liaise with a patient's GP at various stages in a patient's diagnostic and treatment pathway as required.

The Directory of Cancer Services which is circulated to all GPs in the catchment area offers the opportunity for informal telephone liaison with members of the SMDT at any stage in the patient's diagnostic and treatment pathway, and in particular for guidance on referrals. The Choose and Book directory of service also offers this facility.

### **39. Patient Advisory Liaison Service (PALS)**

The contact details for the Patient Advisory Liaison Service are provided should the patient or family wish to discuss any aspect of relevant hospital's services

### **40. Information for non-English speaking patients**

Interpreters can be accessed via the Health Information Centre or via Cancer Backup to facilitate communication if English is not the patient's first language. This is provided through a three-way conversation between an interpreter, a healthcare provider and the patient. If the conversation may last longer than thirty minutes the Trust would expect provision of face-to-face interpretation.

The written record can be provided in an alternative language via the Health Information Centre if required by the patient. Written information relating to cancer generally, specific diseases and living with cancer are available in a wide range of languages via the Cancer Equality Directory of Cancer Information available in Ethnic Minority Languages 2005-2006. The CNS will access this information prior to a consultation with a non-English speaking patient.

## Clinical Outcomes Indicators

### **41. Audit and Data Collection (14-1C-115i, -2I-124)**

The SMDT in consultation with the Network Site Specific Group (NSSG) for Head and Neck Cancer will participate in at least one network audit project per annum. Progress in each audit project will be reviewed annually and results presented to the NSSG for review and discussion. There may be a number of local audit projects undertaken at any one time. Audit activity planning and review will be discussed at the annual SMDT business meeting. Results of audit projects will be presented in the annual report for the Head & Neck SMDT. All significant complications and peri-operative deaths are discussed at relevant divisional and speciality audit meetings.

The Peninsula Cancer Network previously agreed a policy setting out the minimum dataset for each site specific group. This previously complied with Cancer Waiting Times monitoring and the cancer registration dataset. From January 2013 the Cancer Outcomes Dataset (COSD) replaced the National Cancer Dataset as the new national standard for reporting cancer across England. All patients with a diagnosis of malignancy and who are discussed at the SMDT will be entered on to Dendrite with copies of any outcomes sent to respective hospital trusts. Data from the Trust Registry is submitted to the South West Public Health Observatory (SWPHO). The Head and Neck SMDT will contribute fully to the wider National Head and Neck Cancer Audit (DAHNO), until future management of the audit has been clarified.

### **42. Clinical Trials (14-2I-125)**

The SMDT will review its trials portfolio at the annual SMDT business planning meeting. A written report will be produced on progress of entry into clinical trials which should include recruitment against stated targets and remedial actions to improve entry into approved clinical trials. The report will also highlight progress on implementation of any prior remedial actions. The report will be presented in the annual report for the Head and Neck SMDT and submitted to the Head and Neck NSSG.

A designated core member of the SMDT is responsible for ensuring recruitment to clinical trials and other studies is integrated into the function of the SMDT.

## Appendices

### Appendix 1

#### Responsibilities of Core SMDT Members

- To ensure consistent and seamless care provision across all sites
- To adhere to SMDT policies
- To ensure a minimum 2/3 individual attendance at MDT meetings (individual disciplines to be represented at 95% of meetings)
- Undertake preparation prior to the SMDT meeting to facilitate effective and timely discussion about patient management
- Provide input into discussions relating to patients, policies and guidance
- Contribute to the development of the SMDT operational policy
- Attend SMDT business meetings
- Participate in the Advanced Communication Skills Training Programme (applicable to those team members with direct clinical contact with patients)

### Appendix 2

#### Responsibilities of Extended SMDT Members

- To adhere to SMDT policies
- Be available for clinical consultation and discussion as necessary
- Attend SMDT meetings when appropriate
- Undertake preparation prior to the SMDT meeting to facilitate effective and timely discussion about patient management
- Provide input into discussions relating to patients, policies and guidance

## Appendix 3

### Leadership arrangements and responsibilities (14-21-101)

The responsibilities of the Lead Clinician for the Head and Neck SMDT have been agreed by the Trust Associate Medical Director for Specialist Services.

### Overall responsibilities

- To ensure that a high quality service is delivered to patients under the care of the Head and Neck Cancer SMDT.
- To ensure pathway development including diagnostics, surgical locations and on-going management are agreed and met
- To be responsible for providing professional advice within and outside the Trust on the tumour site and its services.
- To be responsible to the Associate Medical Director for the overall responsibility for ensuring the SMDT meeting and team meet Peer Review quality measures.
- To establish and maintain appropriate links with colleagues in the region
- The governance arrangements for the SMDT sit with the Royal Devon Hospital. The SMDT will ensure that relevant Trust policies and procedures are reviewed and agreed at the annual business meeting

### Specific duties

- To ensure the multi-disciplinary team meets weekly, with an agreed core membership, records of attendance, and appropriate records and care plans of all cases discussed.
- To confirm the membership and roles of the core and extended SMDT at regular intervals with the team members and the Associate Medical Director.
- Ensure that objectives of SMDT working (as laid out in Manual of Cancer Services) are met:
  - To ensure that designated specialists work effectively together in teams to agree multidisciplinary decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies.

- To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected centrally to inform clinical decision making and to support clinical governance/audit
- To ensure mechanisms are in place to support entry of eligible patients into clinical trials and discuss suitability of each case at the SMDT meeting to optimise recruitment
- Ensure attendance levels of core members are maintained, in line with quality measures
- Ensure that all newly diagnosed, post-surgical and recurrent H&N cancer patients are discussed at the SMDT is met and recorded centrally on Dendrite.
- Provide link to NSSG either by attendance at meetings or by nominating another SMDT member to attend
- Lead on or agree on a nominated lead for service improvement
- Organise and chair annual meeting examining functioning of team and reviewing operational policies and collate any activities that are required to ensure optimal functioning of the team
- Ensure SMDT activities are audited and results documented centrally and presented annually at the business meeting
- Ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported
- Ensure MDT outcomes are communicated to designated units in a timely manner
- Ensure target of communicating SMDT outcomes to primary care is met
- To ensure that clinical services are delivered in accordance with the required standards for accreditation, i.e. the Manual for Cancer Services and NICE Improving Outcomes Guidance and that any exceptions including agreed local surgical procedures are agreed with the Specialist Commissioning Group.
- Co-ordinate preparations for Peer Review visits and ensure the implementation of the resulting action plans for continuous quality improvement.

- To ensure that there are satisfactory systems across all designated sites for the confidential reporting of clinical incidents to the Medical Director in accordance with clinical governance procedures.
- To work with other members of the SMDT to ensure patient and carer views of the service are taken into account when planning and delivering services.
- To ensure the SMDT reviews service improvement opportunities and embeds them within clinical operational practice wherever possible.
- To advise the Associate Medical Director on issues likely to affect the strategic development of head and neck cancer services.
- To support the Trust's strategy for the development of cancer services as required

## **Appendix 4**

### Responsibilities of the SMDT Co-ordinator

- Be responsible for the organisation and timetabling of meetings.
- Support video-conferencing when needed.
- Liaise with the local MDT Coordinators at TSFT, SDHT and NDHT to ensure that one central list of patients to be discussed at meetings is prepared and distributed in advance.
- Ensure one central list of patients to be discussed at meetings is prepared and distributed in advance.
- Be responsible for ensuring all relevant patients are discussed at SMDT meetings, co-ordinating and distributing the list of patients for discussion
- Ensure all patient notes, referral letters, X-rays, CT and MRI scans and histopathology reports/specimens are located in advance of the meeting.
- Attend all multi-disciplinary meetings and maintain central attendance records of core members across all 4 hospital sites.
- Take minutes at SMDT meetings and type notes back in the required format distributing to all concerned.



- Ensure all SMDT decisions and action plans relating to the individual patient's management/ action plans are typed at the time of the SMDT meeting, recorded and distributed to appropriate staff with an agreed review, within one working day.
- Manage systems that inform GPs of each patient's diagnosis, decisions made at outpatient appointments etc.
- Complete SMDT pro forma electronically as part of the SMDT meeting, which are agreed by the SMDT
- Organise and minute SMDT operational business meetings.
- Work with the CNS(s) to ensure that actions are taken to ensure the smooth running of the patient pathway
- The MDT co-ordinator at the specialist centre will liaise with locality MDT co-ordinators to ensure consistent and seamless transfer of relevant data and information

#### Monitoring Cancer Waiting Times

- Monitor all patients' progress against national cancer waiting times targets, providing information to medical secretaries, directorate service managers, and the Cancer Services team in the centre and ensuring any relevant information is passed back to spoke sites.
- To ensure that all patients' treatments are booked within target times and that any potential breaches of waiting standards are clearly highlighted according to the escalation policy.
- Help validate the monthly cancer waiting times submission to the Department of Health, using relevant data sources.
- Liaise regularly with the Cancer team, members of the SMDT and specialties to complete breach analysis forms, identifying delays in treatment and potential remedies, ensuring any issues from referring hospitals are referred back to the appropriate individuals.

#### Coordination of inter-Trust referrals

- Maintain good working relationships with colleagues in other Trusts who refer to or take referrals from RDEFT.

- To ensure that inter-trust referrals are closely monitored, and information fed back to referring Trusts as appropriate.
- Liaise closely with medical secretaries to ensure that inter-Trust referrals are appropriately tracked, and treated as far as possible within target waiting times.
- Ensure that communications regarding patients between Trusts are sent via generic NHS.net accounts

#### Peer Review and service development

- To work with other members of the cancer team and SMDT to collate any necessary information, as requested, in relation to the manual of Cancer Standards for peer review.
- To participate with other members of the cancer team and SMDT in the development of the patient pathway and continual improvement of the service for patients.
- To keep a comprehensive diary of all team meetings including NSSG attendance.

#### Other responsibilities

- To work with other members of the team to ensure the smooth running of the SMDT and to cover other members of the team or other MDT co-ordinators as appropriate.
- Liaise with the local MDT Coordinators at NDHT, TSHT and SDHT to ensure data accuracy and completeness of national audit submissions

## **Appendix 5**

### **Responsibilities of the Local Support Teams (14-1C-103i)**

One of the key responsibilities of all support team members relates specifically to the aftercare and rehabilitation of Head and Neck cancer patients. Such requirements are listed as part of their core responsibilities and are included in relevant job descriptions

Support Team members work cohesively to ensure patient pathways are seamless and clinically consistent across all sites. The CNS will facilitate timely access back to the

SMDT and act as patient advocate to ensure that their informed wishes regarding the management of their cancer are conveyed to the SMDT in a non-judgemental manner.

- Communicate with extended members of the SMDT to ensure timely and appropriate referrals of patients to palliative care services, clinical trials and support services
- Support the lead clinician and other team members in facilitating patient care
- Utilise research in their specialist area of practice
- Attend training relevant to their post

#### Lead CNS's key responsibilities

- Leading on patients' and carers' communication issues
- Taking responsibility for the coordination of the patient pathway for patients referred to the team and be involved in patient mapping exercises
- To lead on the living with and beyond cancer initiative in collaboration with Cancer Services
- Contributing to the management of the head and neck service via close workings with the Specialist Cancer Directorate
- To liaise with other health professionals regarding patient care
- To be actively involved in clinical audit and research.
- The CNS at the designated host site will communicate decisions and outcomes of patient assessments to relevant CNS colleagues at locality sites.

#### **Core Responsibilities of the Specialist Head & Neck Dietitian**

The agreed responsibilities of the Specialist Head & Neck Dietitian are as follows:

- To personally attend at least 2/3 of SMDT meetings and contribute to team discussion and patient assessment / care planning decision at the regular weekly meetings
- To ensure dietetics representation at 95% of Head and Neck SMDT meetings by named agreed cover.

- The dietitian at the designated host centre will attend the full weekly joint head and neck clinic as written in to their job plan and will ensure named agreed cover is available during periods of absence.
- The dietitian at the designated host site will communicate decisions and outcomes of patient assessments to relevant dietetic colleagues at locality sites.
- Dietitians at locality sites will communicate decisions and outcomes of patient assessments to dietetic colleagues at the designated treatment centre
- To act as a key member of a relevant Head and Neck Local Support Team
- To refer long term enterally fed patients to home enteral feeding teams where relevant
- To provide expert nutrition and dietetic advice and support to other healthcare professionals
- To play an important advisory and supportive role throughout the patient's cancer pathway from pre-treatment and through rehabilitation towards recovery or end of life care.
- To be responsible for the nutritional support and co-ordination of patients who require dietary intervention
- To communicate with and support peers and relevant local support teams in ensuring that patients with nutritional needs experience a seamless transition across the healthcare interface.
- To provide nutritional support and advice for those patients requiring artificial nutritional support, liaising with members of the core and extended team and other relevant healthcare professionals.
- Supporting the lead clinician and other team members in facilitating nutritional care
- To attend training relevant to the specialist dietetic post

### **Core Responsibilities of the Specialist Head and Neck Speech and Language therapist**

The agreed responsibilities of the Specialist Head & Neck Speech and Language Therapist (SLT) are as follows:

- To personally attend at least 2/3 of SMDT meetings and contribute to team discussion and patient assessment / care planning decision at the regular weekly meetings
- To ensure SLT representation at 95% of Head and Neck SMDT meetings by named agreed cover.
- To attend the full weekly joint head and neck clinic as written in to the specialist head and neck SLT's weekly job plan and to ensure named agreed cover is available during periods of absence.
- To act as a key member of a relevant Head and Neck Local Support Team
- To provide expert advice and support relating to swallowing and communication to all those patients requiring their help including other healthcare professionals
- To play an important advisory and supportive role throughout the patient's cancer pathway from pre-treatment and through rehabilitation towards recovery or end of life care.
- To be responsible for the support, assessment and intervention of swallowing and communication difficulties of patients using a combination of bedside and specialist instrumental assessment.
- To co-ordinate videofluoroscopic evaluation in relation to swallowing and voice rehabilitation (including insufflation test and assessment of tonicity/stricture)
- To be jointly responsible for Fiberoptic Endoscopic Evaluation of Swallowing
- To be responsible for specialist SLT voice rehabilitation for alaryngeal patients (SVR, Electrolarynx, oesophageal voice)
- Facilitate access to members of the SMDT where requested by patients or their carers. Also acting as patient advocate to ensure that their wishes regarding the management of their cancer and specifically swallowing and communication are conveyed to the SMDT
- To refer to specialist voice clinic for voice therapy where indicated
- To provide psychological support to patients and their carers

- To communicate with and support peers and relevant local support teams in ensuring that patients with swallowing and communication needs experience a seamless transition across the healthcare interface.
- To work closely with specialist dietitian and radiographer to ensure seamless management of swallowing and nutrition in relation to alternative feeding and insertion of RIG
- To liaise with members of the core and extended team and other relevant healthcare professionals
- To be actively involved in clinical audit and research
- To support the lead clinician and other team members in facilitating patient care
- To attend training relevant to the specialist SLT post
- To provide training about communication and swallowing difficulties to other health care professionals

## **Appendix 6**

### **Roles and responsibilities of the key worker**

- Provide care coordination, information and communication with the patient and be an integral member of the patient's multidisciplinary team. The aim should be to provide continuity of care throughout the patient pathway.
- Be accessible to the patient as the main constant point of contact, handing over to colleagues when unavailable and ensuring the patient has clear information about alternative contacts e.g. out-of-hours contacts
- Play a key role in the assessment of the patient and the planning of their care, liaising with multidisciplinary team members and agreeing the care plan with the patient
- To ensure assessments and interventions take place and results subsequently communicated to patients and SMDT members in a timely fashion
- Provide timely and individualised information in the most suitable way for the patient concerned to enable patients and their families to make informed choices about their current and future healthcare needs.

- Be present at and contribute to discussions about the patient's care.
- Provide expert specialist advice and support to other health professionals in the specialist area of practice.
- Act as the patient's advocate and to assist to empower patients as appropriate
- To ensure the patient pathway is coordinated and all relevant information is shared/ transferred to the appropriate professionals as the patient moves across care boundaries when care is transferred between teams.
- To ensure contact details of the key worker are recorded in the patient's notes using the relevant sticker system and to contribute to subsequent audits of this standard

## **Appendix 7**

### **Core responsibilities of the Consultant Restorative Dentist**

All patients with a proven malignancy of the head and neck region are seen by the Restorative Oncology Team. Assessment of oral health is established at an early stage and a decision made as to immediate required treatment so that unwanted complications during and after cancer therapy are avoided.

Patients with a diagnosed cancer of the head and neck region who have planned panendoscopy and who have been assessed as likely to have radiotherapy as part of their cancer treatment, will undergo dental screening and may be advised to have dental extractions at the time of panendoscopy. Proposed treatment prior to commencing cancer treatment such as dental extractions under local anaesthesia are arranged as a matter of priority and protected oral surgery appointment slots are also in place to allow this to happen within 7 days. Review of the healing of extraction sockets ensures patients do not proceed to radiotherapy if socket healing is delayed. A minimum of 10 days socket healing is advised prior to commencing radiotherapy. The intention is to minimize the risk of osteoradionecrosis (ORN) consequent o prophylactic dental extraction prior to radiotherapy of the jaws.

Risks of ORN are determined by dosage, fields of irradiation exposure and sight of primary malignancy. An audit completed by Torbay Restorative Oncology Team

highlighted that 80 % of patients undergoing treatment for a cancer of the head and neck region in SDHT receive Radiotherapy as part of their cancer treatment. The consequence of this is that the majority of patients will have lasting risk factors due to xerostomia. 5 year follow up for all patients is offered to minimize unwanted dental disease. **The results of this audit were published in the British Dental Journal Vol 215 (2) July 2013.**

### **Oral Rehabilitation**

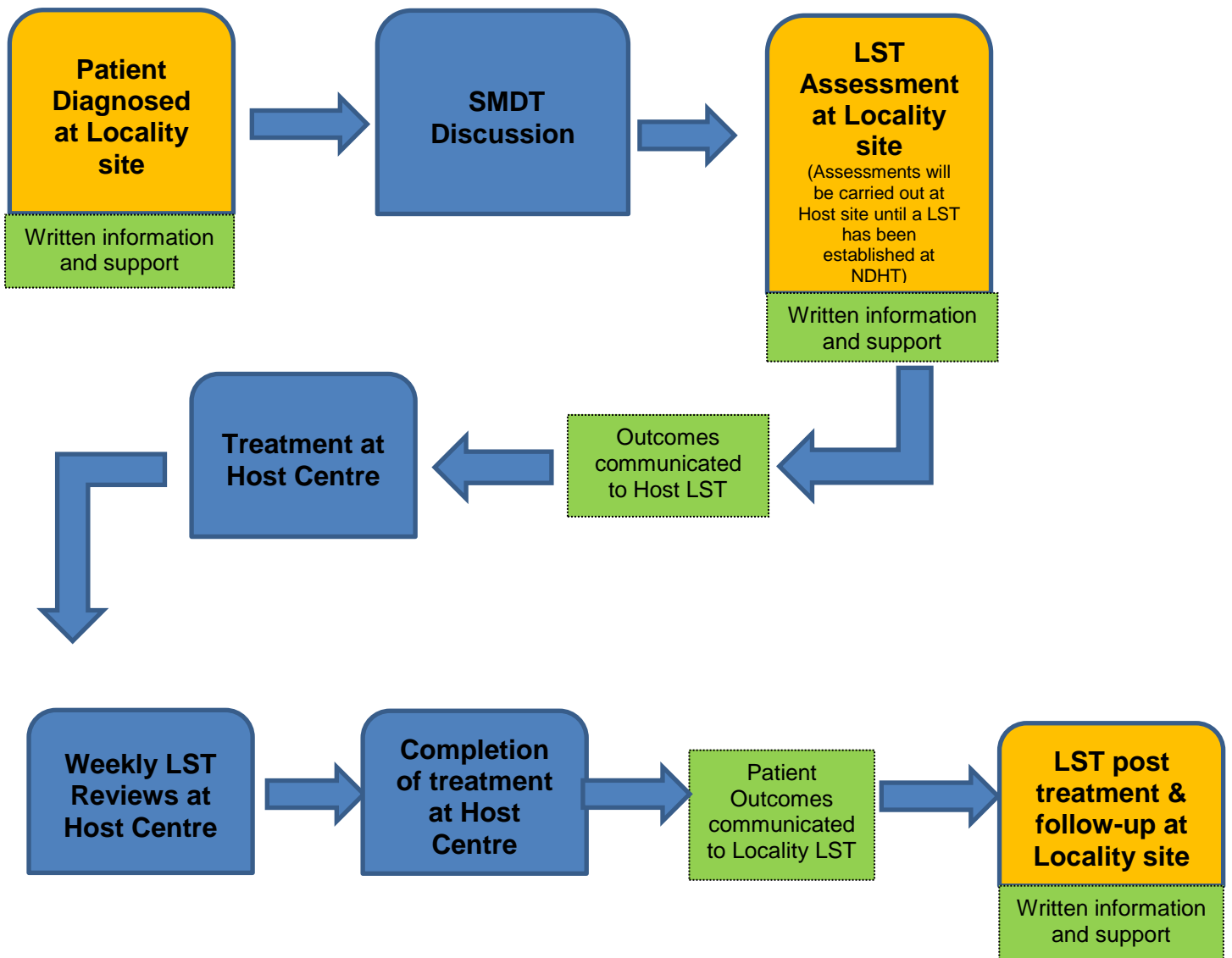
Where intraoral resection is necessary, a joint approach to treatment is in place. Surgical resections are planned between the Maxillofacial team and the Restorative Team so that the perisurgical prosthesis is optimal. In many cases, dental implant placement is appropriate at the time of surgical resection of the tumour and where appropriate, this is delivered. Dental implant rehabilitation is also undertaken in patients with healed free flaps and in patients who have had radiotherapy but cannot adapt to wearing conventional prostheses.

All screened head and neck cancer patients are seen by the **Dental Hygienist** prior to surgical or non-surgical treatment and given advice regarding care of the mouth before, during and after cancer therapy. Dentate and edentulous patients are included. The Hygienist coordinates care of current radiotherapy patients with the radiotherapy team and sees patients prior to and during Radiotherapy. A dedicated website ([www.mouthcareincancer.co.uk](http://www.mouthcareincancer.co.uk)) has been designed to advise head and neck cancer patients on oral health before, during and after surgical or oncological treatments. The website also gives information regarding aetiological factors contributing to head and neck cancer as well as information regarding appropriate protocols to follow to minimize unwanted disease and oral complications. A section has been set up for health care professionals to follow up to date protocols. A hand held patient information document is given to patients at the screening appointment as well as samples of products which will help to reduce unwanted oral complications during and after treatment.

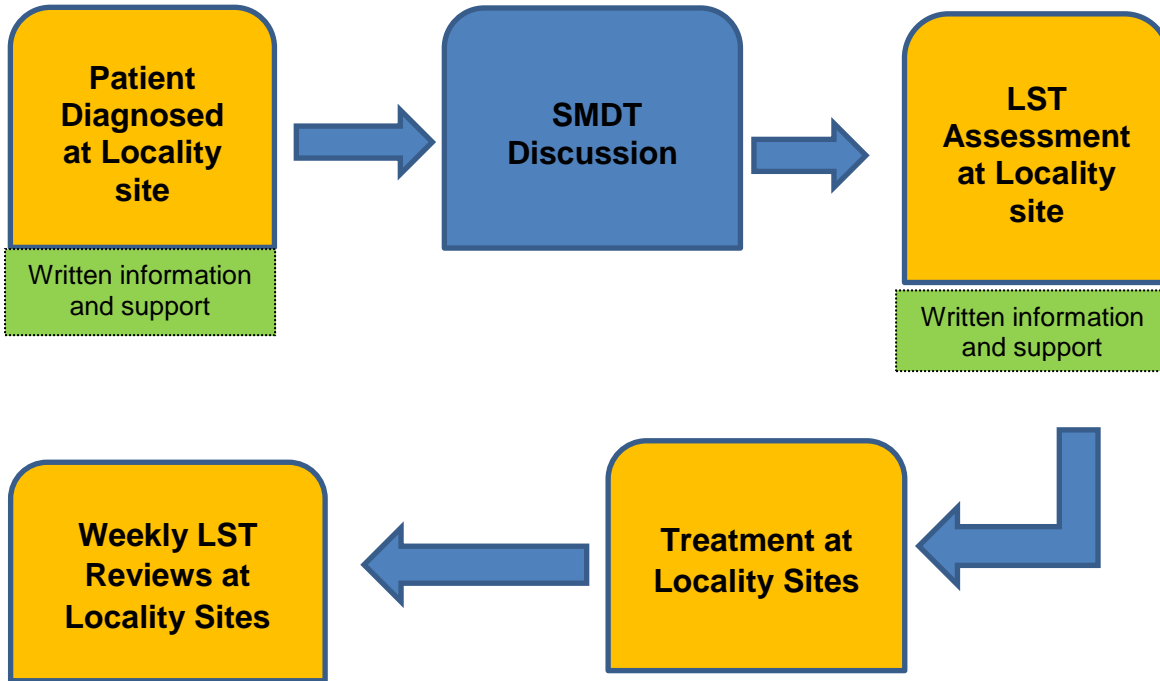


Appendix 8

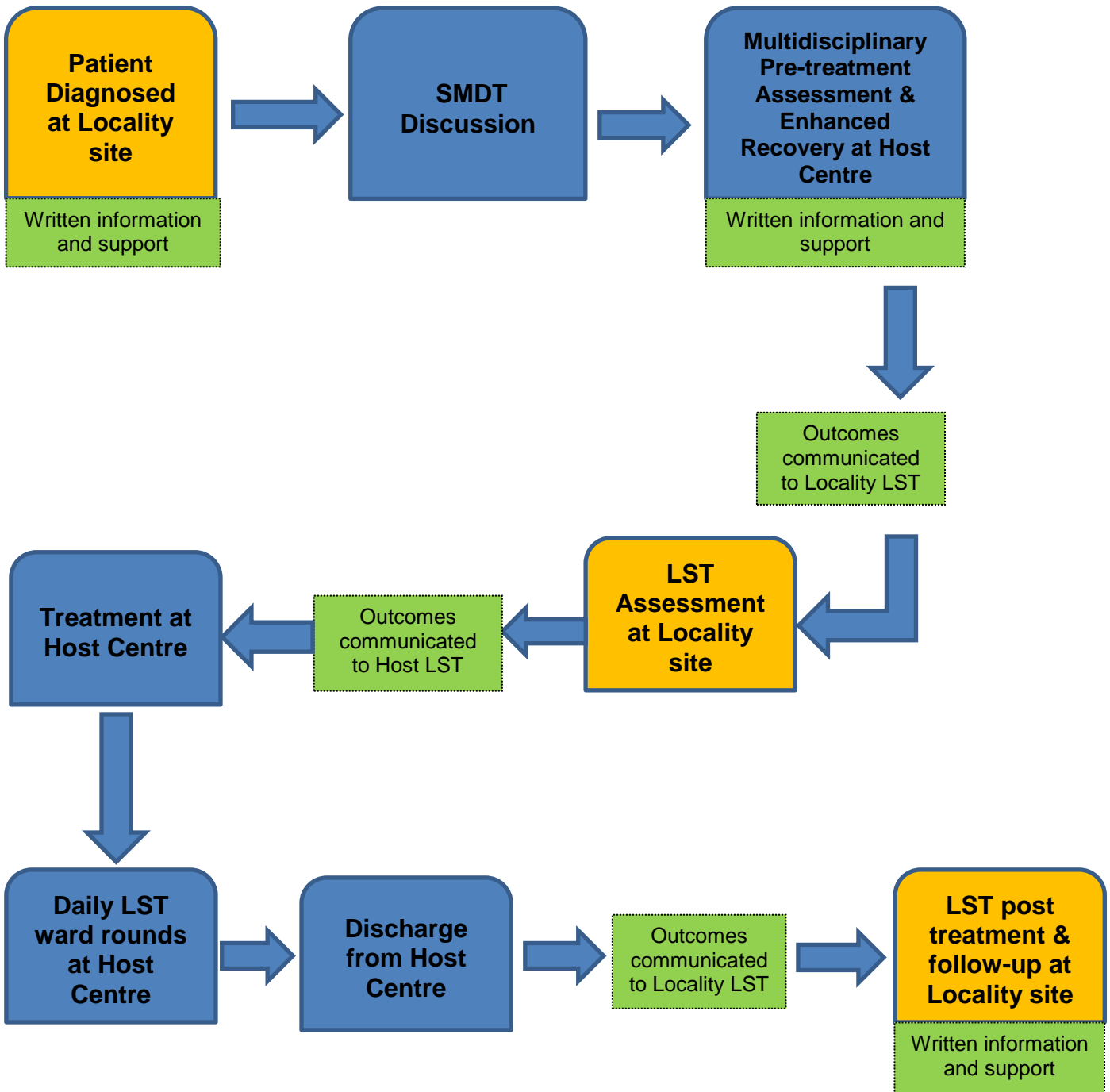
**Local Support Team Pathway**  
Between the Designated Host and North Devon Locality Sites  
**Radiotherapy**



**Local Support Team Pathway**  
Between Designated Host and TSHT & SDHFT Locality Sites  
**Radiotherapy**



**Local Support Team Pathway**  
Between Designated Host and all Locality Sites  
**Surgery**



## Appendix 9

### LST Transfer forms

#### Head and Neck Pre Op Transfer Form

*Date Information Sent:*

<b>Patient Name:</b>		
<b>DOB:</b>		<b>NHS Number</b>
<b>Planned Operation Date:</b>		<b>Planned Surgical Procedure:</b>
<b>GP:</b>		<b>Tel:</b>
<b>N.O.K.</b>	<b>Relationship:</b>	<b>Tel:</b>
<b>Key Worker:</b>		<b>Tel:</b>
<b>Diagnosis:</b>		
<b>Date Diagnosed:</b>		
<b>Consultant:</b>		

Past Medical History:
-----------------------

Current Medication:
---------------------

<b>Social History</b> <i>inc. Smoking status, Alcohol intake, Social support</i>
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**Pre-operative Assessments**

<b>Current Symptoms:</b>	<b>HNA score:</b>
Referrals made: <input type="checkbox"/> Hospice	<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> Patient Information	<input type="checkbox"/> Cancer Support
<input type="checkbox"/> Verbal	<input type="checkbox"/> Other:
<input type="checkbox"/> Written	

**Swallow & Diet**

Dental Screening:

Restorative dental Assessment	<input type="checkbox"/>	Dental Hygienist Assessment	<input type="checkbox"/>
Date:		Date:	

**Any other relevant information**

**Email to:** [clairebarber2@nhs.net](mailto:clairebarber2@nhs.net)  
[joy.higgs@nhs.net](mailto:joy.higgs@nhs.net)  
[zoe.copp@nhs.net](mailto:zoe.copp@nhs.net)

**RD&E NHS Foundation Trust**

**Head and Neck Post Op Transfer Form**  
**Date Information Sent:**

**Patient Name:**

**DOB:** \_\_\_\_\_ **NHS Number:** \_\_\_\_\_

**Surgical Procedure** \_\_\_\_\_ **Operation Date:** \_\_\_\_\_

<b>Tracheostomy tube:</b>	Date inserted	Type	Length	Size
<b>Wounds</b> (Inc. sutures/clips)				
<b>Dressings:</b>				
<b>Referrals made:</b>	<input type="checkbox"/> DN date	<input type="checkbox"/> Hospice date	<input type="checkbox"/> SW date	
	<input type="checkbox"/> OT date	<input type="checkbox"/> Physio date		
<b>Psychological Status:</b>				
<b>Discharge destination &amp; tel.</b>				
<b>Discharge meds:</b>				
<b>Contact required:</b>	Home visit <input type="checkbox"/>	Telephone call	<input type="checkbox"/>	
<b>Support at Home:</b>	Family <input type="checkbox"/>	Agency	<input type="checkbox"/>	None <input type="checkbox"/>

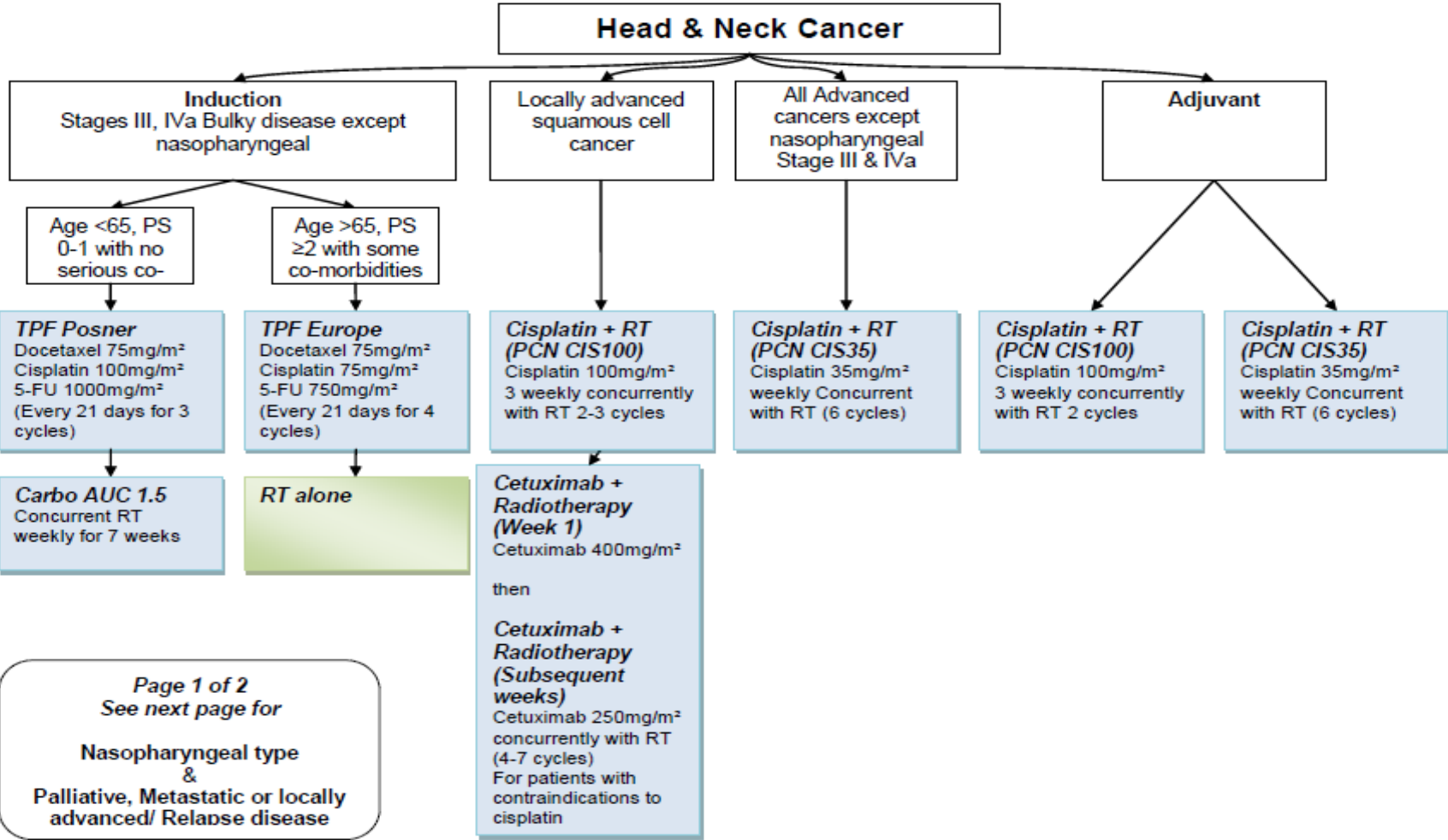
**Swallow & Diet**

**Other relevant information**

**Head & Neck follow-up appointment**  
**South Devon Hospital: Fax 01803 655 506**  
**342**

**Date:      Time:      Hospital:**  
**Musgrove Park Hospital: Fax 01823**  
**463**

**Chemotherapy Algorithm for Head & Neck Cancer**



Page 1 of 2  
 See next page for  
 Nasopharyngeal type  
 &  
 Palliative, Metastatic or locally  
 advanced/ Relapse disease

