Agenda Item No 7

Central South Coast Cancer Network

Head and Neck Cancer Services

Cancer Target: PSA 03b (formerly T11)

Implementation Plan

'Improving Outcomes Guidance for Head and Neck Cancers'

Document Version 4.0
24th October 2005

Sept 2005

Key dates	
Draft plans	**In for the July NWG meeting**
External view	**Received from CAT Oct 2005**
NWG agree plans	**Ongoing**
Standards issued	**Draft available**
Gap analysis and costings	**August**
Policy Board	**29th Sept**
SHA	**Oct**
Submission to DOH	**Oct 31st 2005**

Contents

Executive Summary

Key recommendations from the IOG and key plans from the network.

The IOG makes the following key recommendations

- Services for patients should be commissioned at the cancer network level. Over the next few years, assessment and treatment services should be increasingly concentrated in cancer centres serving populations of over a million patients
- Multi-disciplinary Teams (MDTs) with a wide range of specialists will be central to the service, each managing at least 100 new cases of upper aero-digestive tract (UAT) per annum. Specialist teams will deal with patients with thyroid cancer and those with rare conditions such as skull base tumours
- Arrangements for referral at each stage of the patient journey should be streamlined. Diagnostic clinics should be established for neck lumps
- A wide range of support service should be provided with a variety of therapists from pre treatment assessment until rehabilitation is complete
- Coordinated local support teams should be established to provide long term support and rehab
- MDTs should take responsibility for recording accurate and complete data
- Research required development and expansion. Multi centre clinical trials should be encouraged and supported.

The Central South Coast Cancer Network makes the following key recommendations for implementation

- Local diagnostic services should be available in all hospitals
- Specialist thyroid clinics should be available in most hospitals
- Rapid access neck lump clinics should be available in all hospitals initially
- Pre treatment assessment clinics should be run by those hosting the MDTs
- Weekly MDTs for head and neck, one in the east (hosted by PHT) and one in the west (hosted by SUHT), and the same for thyroid
- Head and Neck Surgery*
- Skull surgery to continue to be carried out in SUHT for the network (and Dorset) (as currently)
- Thyroid surgery (non complex)to be carried out in hospitals if agreed with the MDT and complex surgery to be carried out only in SUHT SHC PHT
- Local after care and rehab teams in all network localities
- Key service costs and surgical transfers associated with the above
- NHH to MDT with SWSH (Surrey) network (and therefore part of their plans) except for thyroid which will MDT with SUHT.

*The original network proposals for Head and Neck Surgery haven't been accepted by the Cancer Action Team. These proposals placed a surgical centre for the East at PHT, and a single combined surgical centre for the West with surgery carried out at both SUHT and SHC. This latter element was not accepted and consolidation in the West was required to one site (ie SUHT).
This requirement for consolidation has not been accepted by the network in time for submission of this action plan and so is the main issue outstanding to be resolved, probably through a meeting with Cancer Action Team and SHAs.
It is clear that both SUHT and PHT can support centre status for this surgery and the options for SHC are either to

- Press for the single surgical centre two site model
- Move work to SUHT with surgical consultancy if possible (and with infrastructure requirements)
- Move work elsewhere (but then break up the very good clinical relationships that currently exist with SUHT)

SECTION 1

1.10 Structure of network and current services

The Central South Coast Cancer Network has been established for 5 years and covers a population of 2,249,719, including the Channel Islands. The population covers three Strategic Health Authorities, nine Primary Care Trusts and seven Acute Trusts as listed below.

Strategic Health Authorities:

- Hampshire and Isle of Wight
- Surrey, West Sussex and Hampshire
- Avon, Gloucestershire and Wiltshire

Primary Care Trusts	Population
▪ Blackwater Valley and North Hants	383,868
▪ Mid Hampshire	170,574
▪ Southampton City	217,445
▪ New Forest and Eastleigh and Test Valley	330,777
▪ South Wiltshire	116,595
▪ Isle of Wight	132,731
▪ Portsmouth City	186,701
▪ Fareham & Gosport and East Hampshire	354,762
▪ Western Sussex	205,144
▪ Jersey	88,000
▪ Guernsey & Remaining Channel Islands	62,000
Total:	**2,249,719**

Acute Trusts
▪ Portsmouth Hospitals Trust ▪ St Mary's Hospital, Isle of Wight NHS Trust ▪ Salisbury Health Care NHS Trust ▪ Southampton University Hospitals Trust ▪ North Hampshire Hospital Trust ▪ St Richard's Hospital, The Royal West Sussex Acute Trust ▪ Royal Hampshire County Hospital, Winchester & Eastleigh Acute Trust ▪ Associated providers KE7, Guernsey and Jersey

Boundary Issues:

There are a number of boundary issues as follows:

- Blackwater Valley PCT is within the Central South Coast Cancer Network, but only approximately 13% of patients are referred within this Network.
- Salisbury Health Care NHS Trust also has a number of specialities who refer to Poole/Bournemouth within the Dorset Cancer Network for specialist care. Salisbury also has populations from Nth Dorset and Kennett/ W Wilts as well as regional referrals for plastics.
- North Hampshire Hospital refer into SWSH Network for some specialist services, has referred Head and Neck cancers to SWSH for many years and will continue to do so
- Western Sussex have a small percentage of patients referred into the SWSH Network for local care. This is approximately 5%.
- SUHT and WEHT are combined for this servie

I.11 Incidence

The mean incidence (1998- 2002) of Head and Neck Cancers in each PCT in CSCCN is shown below, together with the crude rate/ 100,000 persons and the Mortality/ incidence ratio (the number of deaths due to head and neck cancer compared to the number of new cases).

	Cases per Year	Crude Rate	Mortality to incidence Ratio
5A1 New Forest	30.8	18.2	0.36
5DF North Hampshire	24	11.7	0.29
5DG Isle of Wight	29.2	22.3	0.23
5E9 Mid-Hampshire	25.4	14.6	0.20
5FD East Hampshire	28.6	16.8	0.27
5FE Portsmouth City Teaching	34.4	18.4	0.32
5G6 Blackwater Valley and Hart	20.6	11.9	0.33
5L1 Southampton City	42.6	19.7	0.26
5LX Fareham and Gosport	32.6	17.8	0.31
5LY Eastleigh and Test Valley South	25.6	16.1	0.23
5L9 Western Sussex	24	11.6	0.55
5DJ South Wiltshire	17	14.3	0.20

Head and neck cancers includes the following list of cancers.

C00	Malignant neoplasm of lip
C01	Malignant neoplasm of base of tongue
C02	Malignant neoplasm of other part tongue
C03	Malignant neoplasm of gum
C04	Malignant neoplasm of floor of mouth
C05	Malignant neoplasm of palate
C06	Malignant neoplasm of other part mouth
C07	Malignant neoplasm of parotid gland
C08	Malignant neoplasm of other salivary gland

C09	Malignant neoplasm of tonsil
C10	Malignant neoplasm of oropharynx
C11	Malignant neoplasm of nasopharynx
C12	Malignant neoplasm of pyriform sinus
C13	Malignant neoplasm of hypopharynx
C14	Malignant neoplasm of other sites in lip oral cavity and oropharynx
C30	Malignant neoplasm of nasal cavity and middle ear
C31	Malignant neoplasm of accessory sinuses
C32	Malignant neoplasm of larynx
C73	Malignant neoplasm of thyroid gland
C77	Secondary and unspecified malignant neoplasm lymph nodes

1.12 Overview of process

The I.O.G was published in November 2004 and subsequent discussions have been held at the Network Policy Board and Executive Board, and the Action Plan has been developed in conjunction with the Network Site Specific Group for Head and Neck Cancers.

The Network Site Specific Group comprises membership from 7 Acute Trusts in the Network and includes

Tim Mellor	Maxillofacial Surgeon, PHT and IOW (Chair)
Andrew Webb	Consultant in OMF Surgery, SUHT
Anne Davis	Consultant Surgeon, PHT
Clive Pratt	Consultant in OMF Surgery PHT RWST
Anne Goggin	Consultant in Palliative Medicine, SUHT
Barrie Evans	Cons Oral & Maxillofacial Surgeon, SUHT
Caroline Hampton	Macmillan Clinical Nurse Specialist, SUHT
Chris Baughan	Consultant Oncologist, SUHT
Elizabeth Tilley	Cons Radiologist, PHT
Bruce Addis	Consultant in Cellular Pathology SUHT
Ian Downie	Consultant OMF Surgeon, SHCT
Mr Nimesh Patel	H&N Surgeon, SUHT
Diana Bailey	Audit Project Manager, Highcroft
Mr Nigel Horlock	Consultant Plastic Surgeon, SHCT
Olivia Waller	SIF, PHT
Sue Best	CNS, RWST
Wendy White	Lead Cancer Nurse, PHT
Ron Eskdale	Patient Representative

1.13 User Carer representation

There has been involvement by service users in making recommendations for the implementation of the Head and Neck Cancers primarily through the user representative on the group. That individual considers that they have been made very welcome in the group and have been included in all levels of discussion and decision making. The chair has regularly sought the opinion of the user representative and has included subsequent recommendations in the implementation plan.

The user representative on the Head and Neck Group is part of the Network Partnership Group and also the Isle of Wight locality group and so has the opportunity to be able to offer a representational opinion as well as a personal one.

1.14 Structure of <u>current</u> services

(To include sub-specialisation, MDT meetings, level of care)

Trust	Summary
Portsmouth Hospitals Trust	HN All services provided from diagnostics to fast track. Rapid access assessment for neck lumps, hoarse voice, ulcerated mucosa, oral swellings, red patches of oral mucosa, dysphagia, unlilateral nasal obstruction, unexplained tooth mobility, orbital masses Not yet a fast track neck lump clinic 3 max fax cancer consultants (including one from Chichester), 3 ENT cancer consultants, 2 spec head and neck oncologists Weekly MDT for max fax (covering West Sussex, Ports and East Hants, IOW) and ENT (covering West Sussex and Portsmouth/ East Hants) Offer all radiotherapy and chemotherapy and surgery except skull base surgery which is referred to SUHT Thyroid A thyroid MDT meets monthly and is attended by the West Sussex Team. The trust provides diagnostic and treatment facilities for thyroid cancer including radioactive iodine treatment. There is a monthly thyroid lump clinic
St Richard's Hospital, Chichester	Feed into Portsmouth MDT. 1 Consultant attends PHT MDT and oncology lists. All diagnostics for two week rules available locally. No one stop lump clinic. Chemo and Radiotherapy at QA
St Mary's Hospital, Isle of Wight	Provides diagnostic services. Head & Neck surgeon takes MF cases to PHT for MDT and treatment and takes ENT cases to SUHT for MDT and treatment. Currently does not attend Southampton MDT. IOW patients attend Southampton for ongoing support, advice and changes for Laryngectomy valves Maxillo-facial surgeon visit 1 day a week form Portsmouth. IOW patients discussed at Portsmouth MDT and surgery carried out in Portsmouth No lump clinic or local support team.
Southampton University Hospitals Trust	All services provided. Rapid access assessment for neck lumps, hoarse voice, ulcerated mucosa, oral swellings, red patches of oral mucosa, dysphagia, unilateral nasal obstruction, unexplained tooth mobility, orbital masses. Dedicated Monday p.m. fast track ENT clinic for suspected head & neck malignancy, daily max-fax clinics. Offer all radiotherapy, chemotherapy and surgery including skull base surgery for Wessex region. Joint weekly MDT for ENT, Max Fax and Oncology, followed by combined clinic. Rapid access fortnightly clinic for thyroid lumps (Derek Sandeman and Keith Dewbury). Weekly rapid access surgical clinic for suspected thyroid malignancy (Gavin Royle and David Rew). Monthly thyroid MDT (separate to H&N).

	Four combined skull base clinics monthly (MF, ENT and Neuro). Two, weekly in-patient lists. Discussions regarding supra-network service on-going.
Salisbury Health Care NHS Trust	Services Provided All services provided from diagnostics to fast track. Rapid access assessment for neck lumps, hoarse voice, ulcerated mucosa, oral swellings, red patches of oral mucosa, dysphagia, unlilateral nasal obstruction, unexplained tooth mobility, orbital masses, thyroid. No fast track neck lump clinic in place currently. Some ENT surgery undertaken by SDH ENT Lead at SUHT (e.g. laryngectomy) and then patients transferred back to SDH. Thyroid surgery undertaken. Reconstruction is carried out jointly with the regional Plastic Surgery Service based at SDH. Free tissue transfer routinely carried out. Dedicated Plastics and Max Fax Ward for Head and Neck patients. Max Fax Laboratory and prosthetic rehabilitation service. Oral and cranio facial implantology. Consultants 2 max fax cancer consultants (one oncology lead); 2 ENT cancer consultants (one oncology lead); 9 Plastic Surgery consultants to cover 24 hour emergency and out of hours care (one lead) - routinely carry out microvascular surgery; 1 General Surgeon Thyroid Lead Clinical Sessions Daily general max fax clinics for rapid referrals. General Surgery (for thyroid), Haematology and ENT general sessions for rapid referrals. Local Head and Neck MDT once per month (moving to fortnightly). Followed by monthly max fax oncology follow-up clinic running concurrently with Plastics and ENT clinics. (Peripheral clinics held). ENT Lead consultant operates at SUHT. Max fax lead attends SUHT MDT twice per month and a plastic surgeon attends 3 times per month. Followed by max fax clinic with SDH max fax lead in attendance. CNS - no dedicated Head and Neck CNS currently but have Max Fax Senior Nurses who support the service.
North Hampshire Hospital	Refer to SWSH network
Royal Hampshire County Hospital	Part of SUHT for this cancer

1.2 The new structure; general overview

The CSCCN has a population in excess of 2 million and two cancer centres. SUHT and PHT currently provide head and neck cancer care with on-site surgery, radiotherapy and regular MDT meetings. There is a single service between Southampton and Winchester (based in Southampton cancer centre) and the Chichester head and neck service is undergoing a similar process with Portsmouth. The Isle of Wight head and neck cancer patients are managed through the Portsmouth unit and Basingstoke head and neck cases, who have for some years been managed by the Guildford cancer centre will continue to be exported to that network (SWSH). Salisbury head and neck cancer unit currently serves predominantly South Wiltshire and part of the New Forest area but also host the regional plastic surgery service and burns unit. They also have prosthetic and restorative dentistry. Their plastic surgeons perform reconstructive head and neck surgery on site and are available to join teams within the CSCCN. The cancer centres of Southampton and Portsmouth have head and neck surgeons trained in reconstructive surgery and free flaps. Several of the Salisbury plastic surgeons and the Lead Head and Neck surgeon do attend the Southampton Head and Neck MDT and joint clinics with the oncologists. Their relationship has been good at all levels.

The current population that would feed into the proposed 2 MDTs would be 800,000 + for the east and 1 million+ for the west and major surgical activity for upper aerodigestive cancer exceeds the 100 cases/year in each MDT. Southampton University Hospitals Trust also hosts the neurosurgical regional centre and has a team that specialise in skull bone surgery for the whole of CSCCN and Dorset network with patients also from parts of other cancer networks.

The Network Head and Neck cancer site specific group have agreed that:

1. Head and Neck MDTs meet weekly in Southampton and Portsmouth with leads attending (or videoconferencing) from allied cancer units. IOW splits with head and neck in PHT and ENT in SUHT.

2. Head and Neck cancer surgery will continue in Southampton and Portsmouth (as already configured). The original network proposals for Head and Neck Surgery haven't been accepted by the Cancer Action Team. These proposals placed a surgical centre for the East at PHT, and a single combined surgical centre for the West with surgery carried out at both SUHT and SHC. This latter element was not accepted and consolidation in the West was required to one site (ie SUHT).
   This requirement for consolidation has not been accepted by the network in time for submission of this action plan and so is the main issue outstanding to be resolved, probably through a meeting with Cancer Action Team and SHAs.

   It is clear that both SUHT and PHT can support centre status for this surgery and the options for SHC are either to
   - Press for the single surgical centre two site model
   - Move work to SUHT with surgical consultancy if possible (and with infrastructure requirements)
   - Move work elsewhere (but then break up the very good clinical relationships that currently exist with SUHT)

3. Southampton as an already established cancer centre for skull base surgery for CSCCN and Dorset et al would wish to continue this as the nominated supra-network service for skull bone surgery. (In action now, see appendix 2). A member of the neurosurgery team is already an extended member of the core team.

The CSCCN thyroid cancer group have met and agreed the following:

1. MDT meetings will take place in Portsmouth and Southampton cancer centres providing each with a minimum population between 800,000 and 1.2 million. The geographical relationship is the same as for

head and neck except the thyroid cancer from Basingstoke (North Hampshire) will be MDT'd in Southampton.

2. It has been agreed that thyroid cancer surgery will be undertaken either in the centre or locally if agreed by the MDT which is in accord with IOG guidance. All complex surgery (lymph node dissections) will be performed by head and neck cancer surgeons in the cancer centres. The definition of complex surgery is needed.

In summary, Head and Neck services will be organised into the following levels

- Local diagnostic services
- Rapid access lump clinics
- 2 MDTs one for the east and one for the west of the network, each for thyroid and head and neck
- Pre treatment assessment clinics
- Surgical centres currently 3 are proposed
- Local after care/ rehab teams

Primary Care Trusts										
WS	**Ports**	**FG/EH**	**IOW**	**C Islands**	**SC**	**MH**	**NF/ETVS**	**SW**	**NH**	**Levels of service**
RWST	**PHT**		**IOW**	**CI**	**SUHT**		**SUHT** **SHC**	**SHC**	**SWSH network**	**Local Diagnostic Services**
RWST	**PHT**		**? IOW**	**?**	**SUHT**		**SUHT** **SHC**	**SHC**	**?**	**Specialist Thyroid Clinics**
RWST	**PHT**		**? in IOW interim**	**?**	**SUHT**		**SUHT** **SHC**	**SHC**	**?**	**Rapid access lump clinics**
PHT				**SUHT**			**SHC/SUHT**		**?**	**Pre treatment assessment clinics**
Eastern MDT hosted by PHT *Nb Head and neck for IOW MDTs with PHT*				**Western MDT hosted by SUHT** **Nb IOW MDTs for ENT with SUHT** **CI MDTs here**					**SWSH**	**Head and Neck MDTs**
Eastern hosted by PHT				**Western hosted by SUHT**						**Thyroid MDT**
PHT				**SUHT**			**SHC; TBA**		**SWSH**	**Inpatient services; Head and Neck cancers**
SUHT (also take from Dorset)										**Skull base inpatient work**
RWST	**PHT**		**? IOW**	**?**	**SUHT**		**SUHT** **SHC**	**SHC**	**?**	**Thyroid non complex**
PHT				**SUHT**			**SUHT** **SHC**	**SHC**	**SUHT**	**Thyroid complex**
RWST	**PHT**		**IOW**	**CI**	**SUHT**		**SUHT** **SHC**	**SHC**	**SWSH**	**Aftercare and rehab**

1.21 Proposals for streamlining local referral services for head and neck cancers.

Overview
Local referrals services consist of 3 elements which can be converged

- Diagnosis and assessment in designated hospitals
- Neck Lump Clinics
- Specialist Thyroid Clinics

Diagnosis and assessment in designated hospitals
Designated hospitals have to fulfil the following criteria;

- Specialist facilities for investigation of head and neck patients.
- At least 2 designated clinicians with contracted DPCS (at least 2 for UAT, at least 2 for thyroid or at least 2 overall if consultant does both)
- The designated clinicians should meet criteria set out (measure 1D115)
- They are the only hospitals for which there are contact points for referral

Designated hospitals for the network are PHT/IOW, RWST, SUHT, ?CI, SHC, SUHT/WEHT, (NHH).

Neck Lump Clinics
Patients with non thyroid lumps should be referred to rapid access lump clinics for investigation. These clinics should be established at selected hospitals.
The clinics must be hosted by a designated hospital
They should meet the following criteria

- Dedicated weekly clinic time
- Direct Fax access by GPs
- Senior member of staff assess each patient
- Have one or more consultant designated clinicians for UAT and/or one or more consultant haematol-oncologists with DPCS timetable for the clinic
- UAT clinicians and haem onc clinicians either sharing an integrated clinic or working parallel clinics (measure 1D 112)
- Cytopathologist based in the clinic to perform and interpret FNAC (fine needle aspiration cytology) specimens
- FNAC accuracy of cytopathologists known before clinic starts

Neck lump clinics probably not be in all hospitals in the long term (as the criteria above needs to be met) but are so far confirmed by trusts in PHT, ?RWST, SUHT, SHC., ? IOW in the interim, ? CI, ? NH

Specialist Thyroid Clinics

Patients with thyroid lumps may be assessed either in specialist thyroid clinics or as part of general head and neck lump clinics

These specialist clinics should be hosted by a designated hospital and for the network are as above. Trusts need to confirm referral pathways for thyroid lumps.
IOW need to confirm if thyroid clinics on island, who to MDT with and whether to take all surgery off island

Table 1

Location of local referral services
Trusts need to confirm when they will meet the designated hospital criteria
Max Fax Cancers

Name of Designated Hospital(s)/Trust(s) that provide diagnostic services	**Referring PCTs**	**Population Referred**	**Date when meets criteria for designated hospital Head and Neck**	**Date when meets criteria for designated hospital Thyroid**	**Date by when rapid access neck lump clinic in place and meets criteria**
PHT provide local referrals services for the following PCTs	a) Portsmouth	a) 186701	Now	Assume now	April 2007
	b) East Hants FG	b) 354762			April 2007
	c) IOW (PHT consultant visits island)	c) 132731			IOW provide lump clinic in interim
		Total: 674,194			
Royal West Sussex (As part of PHT MDT)	a)Western Sussex	a) 205,144	Now?		Will this be part of PHT lump clinic or on own
	b) Arun Adur and Worthing	b) ?			
IOW Healthcare Trust	IOW	132731	Now?	? any thyroid on island	?PHT
SUHT provide local referrals services for the following PCTs	a) SCPCT	a) 217445	Now	End 2005	Now
	b) NFPCT & ETVSPCT	b) 304483 (26294 to SHC)			
	c) Jersey	c) 88000			
	d) Guernsey & others	d) 62000			
	e) Mid-Hants	e) 170574			
	f) S Wilts	f) In SHC catchment			
		Total: 842502			
Salisbury provide local referrals services for the following populations	a) South Wiltshire	a) 116,595	Mostly met review 2006		Phase 1 - April 06 Phase 2 - April 07 *(see costed action plan at*

					end of document)
	b) New Forest	b) 26,294 (SDH population out of full population)			
	c) North Dorset	c) 51,057 (SDH population out of full population)			
	d) Kennet	d) 25,566 (SDH population out of full population)			
	e) West Wilts	e) 28,880 (SDH population out of full population)			
		TOTAL: 248,392			
Salisbury Regional Plastics and Prosthetic Rehab general; not head and neck	All HIOW PCTs (excl Western Sussex - small no.)	1,893,453 (main referring population)			
	Guernsey & Remaining Channel Islands	62,000			
	Jersey - under discussion	88,000			
	Dorset & Somerset	682,638 (main referring population)			

1.22 Formation of multi disciplinary teams

Overview

Head and Neck MDT

The network will host 2 MDTs, one for the east and one for the west of the network . The eastern MDT will cover the population of the host hospital (Portsmouth) and those from Western Sussex and the Isle of Wight, a total population of over 800,000. The Western MDT will cover the population of the host hospital (SUHT) and in addition Mid Hants, New Forest and ETVS and South Wiltshire PCTs, a total population of at least 1m

Head and Neck MDTs already meet weekly in Southampton and Portsmouth with leads attending (or videoconferencing) from allied cancer units.

There is no role for a local MDT. The current role of the MDT in SHC needs to be considered as part of the overall proposals for services and VC.

Thyroid MDT

The network will host 2 MDT meetings which will take place in Portsmouth and Southampton cancer centres providing each with a minimum population of 800k to 1.2 million. The geographical relationship is the same as for head and neck except the thyroid cancer from Basingstoke (North Hampshire) will be MDT'd in Southampton.

Table 2.1

Formation of Max Fax and ENT MDT

Name of Specialist MDT 1 (Western Network)	**Host Trust(s) for H&N MDT**	**Confirmed minimum 100 cases (uat)**	**Referring PCTs**	**Population Referred**	**Date for MDT to be established**
Southampton-WEHT IOW for ENT Salisbury *to discuss at NSSG - currently SUHT MDT with Salisbury H&N Lead and Plastic Surgeon in attendance plus there is a Salisbury local MDT*	SUHT	122 surgical cases (2004) Registry figures for all PCTs 170 (table 1.11)	a) SCPCT	a) 217445	2006
			b) NFPCT & ETVSPCT	b) 330777	
			c) Jersey	c) 88000	
			d) Guernsey & others	d) 62000	
			e) Mid-Hants	e) 170574	
			f) S Wilts	f) 116595	
			Total (plus IOW)	1 million +	
Name of Specialist MDT 2 (Eastern Network)	**Host Trust(s) for H&N MDT**	**Confirmed minimum 100 cases (uat)**	**Referring PCTs**	**Population Referred**	
PHT, RWST, IOW for Head and Neck	Portsmouth NHS Trust	Figures from 1st August 2004-31st July 2005 84 cases of UAT cancer excluding lymphomas and ca lip ? 75 for RWST and ? 5 for IOW	a)Portsmouth City	a) 186701	2006
			b) East Hants/ FG	b) 354762	
			c)West Sussex	c)205144	
			d) IOW	d)132731	

		Registry figures from table 1.11 =135	Total	800,000+	

Table 2.2
Formation of the thyroid MDT

Name of Specialist MDT 1 (Western Network)	**Host Trust(s) for H&N MDT**	**Confirmed minimum 100 cases (uat)**	**Referring PCTs**	**Population Referred**
SUHT, SHC, NHH, ? IOW	SUHT	Approximately 30 new per annum, incl 10 from IOW	a) SCPCT	a) 217445
			b) NFPCT & ETVSPCT	b) 330777
			c) South Wilts	c) 116595
			d) IOW PCT	d) 132731
			e) Mid Hants	e) 170574
			f) Jersey & Guernsey? to be agreed	f) 150000?
			g) North Hants	g)383868
			Total	Depends on IOW. 1m +
Name of Specialist MDT 2 (Eastern Network)	**Host Trust(s) for H&N MDT**	**Confirmed minimum 100 cases (uat)**	**Referring PCTs**	**Population Referred**
PHT, RWST, ? IOW	PHT	Figures from 1/8/04 – 31.7.05 18 new cases IOW 12 incl benign and 4-6 RWS	a)Portsmouth City	a) 186701
			b) East Hants/ FG	b) 354762
			c)West Sussex	c)205144
			d)IOW	d)132731
			Total	Depends on IOW; 6-800,000

Table 3 MDT core members

This next section requires all those trusts contributing to the MDT to complete an assessment of which of the core members are in place and where the gaps and costs of gaps are

Max Fax and ENT

MDT Core Members	Name	Gap/Cost
Western MDT SUHT		
Surgeons	Barrie Evans, M-F (Chair) Andrew Webb, M-F Chris Randall, ENT Nimesh Patel, ENT No neurosurgeon at MDT	 0.5 session
Oncologists	Chris Baughan, Clin Onc Virginia Hall, Clin Onc	
Restorative Dentist	No – have to refer to Salisbury plastics service	Two sessions weekly plus funding for treatment required. Facilities at SGH already.
Histopathologist	Not at meeting – Jeff Theaker & Bruce Addis	1 session BMS2 0.5 session
Cytopathologist (may be same as above)	Not at meeting – Neeta Singh & Rachel Howitt	
Radiologist	Not at meeting – Vince Batty, Ken Tung, James Smart	1 session
Clinical Nurse Specialist	Caroline Hampton	1wte
SALT	Vanessa Richards & Janice Tucker	1wte
Senior Ward Nurse	Not at meeting – Lorraine Bunting (ENT), Kay Townsend (RT)	1 session
Palliative Care	Anne Goggin - not at meeting	1 session
MDT Co-ordinator	Linda Vince	0.5 wte (to include DAHNO data capture)
Therapy Radiographer	Jenny Noyce	
Senior Clinic Nurse	Yvonne Lewis	
Dietician	Catherine Richardson	1.0 wte

Extended Members		
Neuro surgeons	Kaure Furgelholm, Dorothy Laing, Anne Davies	
Other specialist surgeons	Salisbury teams - Ian Downie, Mike Brockbank, Nigel Horlock	
Anaesthetist with special interest in H&N cancer	David Laycock, Paul Sutherland, David Rutter, Mick Nielson	
Gastroenterologists etc with expertise in gastrostomy creation	Nutritional team, Mike Stroud, Dr O'Durny, Jim Smallwood	
Ophthalmologist	Ruth Manners, Peter Hodgkins,	
Pain management specialist	Jane Hazelgrove, Cathy Price	
Nuclear Med specialist	Vince Batty	
Max Fax/dental technician	Salisbury service used	
Dental hygienist	Liz Prescott	1 session/week 3.3k
Social worker	No	0.2 wte
Benefits advisor	No	To be provided at Macmillan Centre from end 2005 – Macmillan funding for 3 yr project.
Liaison psychiatrist	Yes	
Clinical psychologist	No	0.1 wte
Counsellor	Ros Beckett. Wessex Cancer Trust Counselling Service - via Macmillan Centre	
Physiotherapist	Ad-hoc provision only	0.2 wte
Occupational therapist	Ad-hoc provision only	0.1 wte
Western MDT - Salisbury (local MDT) – to include thyroid. ? role if SUHT SHC MDT togther		
Surgeons	Max fax: Ian Downie (lead); Tim Flood ENT: Mike Brockbank (lead); Melanie Collins Plastics: Nigel Horlock; Richard Cole Thyroid: Anna Aertsen	MDT already in place monthly but moving to fortnightly as from April 06 - *see costed action plan and options for joint MDT*
Radiologist	Jonathan Annis	
Pathologist	Ian Cooke Angela Scott	
Palliative Care	Consultant: Christine Wood Lead Nurse: Helena Bridgman	

Lead Nurses Max Fax/Plastics	Laura Manders (Outpatients) Heidi Lewis (Ward)	Gap for CNS - *see costed action plan at end of document*
Oncology	*Not available - requires funding/joint MDT*	*see costed action plan at end of document*
Speech & Language	*Not available - requires funding*	*see costed action plan at end of document*
Dietician	Anna Cable	Gap for move to fortnightly MDTs - *see costed action plan at end of document*
Admin Support	Sue Smorfitt (medial secretary)	Gap for MDT Coordinator - *see costed action plan at end of document*
Trust 2 – Eastern PHT		
Surgeons	Max Fac : Tim Mellor (Lead) Prof Peter Brennan Clive Pratt ENT: Adel Resouly Anne Davis Saliya Caldera	
Oncologists	David Boote Danny Dubois	
Restorative Dentist	Heather Beckett	
Pathologists	Anne Spedding Clare Way	
Radiologist	Liz Tilley Simon Ward Janine Domjan	
Clinical Nurse Specialist	Wendy White and Wendy Keating	Temp cover in place
Dietician	Eleanor Keam	Cover
SALT	Fiona Buck	Cover
Senior Ward Nurse	Anne Marie Brogan	Backfill for attendance at MDT
Palliative Care	Dr PJ Morey (withdrawn lack of funding) Jackie Simpson (not able to attend)	Palliative care doctor/ CNS
Data Manager	Gill Penton (9hrs/week)	0.5 WTE AC grade 3 required
MDT Co-ordinator	Vacant	Ditto
Team Secretary	None	Ditto

Extended team None at present (social worker/ psc		
Eastern MDT; RWST		
Surgeon	Mr David Allen	Attends weekly MDT meeting at PHT Cost to RWST to be agreed
Eastern MDT; IOW	Sue Best	

Thyroid Cancer MDT (please indicate if any gaps are duplicates referred to in previous table)

MDT Core Members	Name	Gap/Cost
Western MDT– SUHT		
Endocrinologists	Derek Sandeman, Brian Leatherdale, David Phillips & Andrew Krentz	
Endocrine Surgeons	Gavin Royle, David Rew	
Clinical Oncologist	Andrew Last	
Radiologist	Ken Tung, Keith Dewbury	
Nuclear Medicine Specialist	Dr Nagaraj, Vince Batty. Not at meetings. ? Vince Batty Peter Kemp	1 session
Histopathologist	Jeff Theaker, Bruce Addis	
Cytopathologist	Neeta Singh, Jeff Theaker, Bruce Addis, Rachel Howitt	
Clinical Nurse Specialist	 No	0.5 wte Based on existing referrals only
MDT Co-ordinator	No	0.5 wte
Endocrine Surgeons	Gavin Royle, David Rew	
Western MDT – NHH		
	Kevin Harris	No other gaps?
Western MDT– Salisbury		
Salisbury - ? incl within H&N MDT	Anna Aertssen	
Eastern MDT PHT		
Surgeons	Contantinos Yiangou (lead) Martin Wise	
	Adel Resouly –ENT Ann Davis -ENT Saliya Caldera – ENT	
Endocrinologist	Mike Cummings	
Clinical Oncologist	David Boote	

Radiologists	Alan Jackson Fiona Witham Liz Tilley	
Pathologist	David Poller	
Nuclear medicine specialist	Qasar Siraj	
Clinical Nurse specialist(Diabetes/Endocrinology)	Jean Mundy	Unfunded 0.3 needed
Data collection manager		
Secretary/coord	Carole Barnes	Unfunded
Eastern MDT RWST		
Surgeon	David Allen	
Eastern MDT IOW	?	

1.23 Proposals for the provision of pre treatment assessment and management services (section 4 in the IO guidance)

Networks are advised to have multi-disciplinary pre-treatment assessment and management clinics to ensure a holistic, integrated approach to assessment, involving specialists from a range of disciplines (including consultant surgeons, anaesthetists, and oncologists; head and neck clinical nurse specialists; speech and language therapist, dietician, dentist, psychologist, etc). These would typically be run by the treating hospital ie PHT/SUHT/SHC.
The measures state that the MDT should have at its disposal in the work programmes of the timetables of its relevant staff (see below), sessions identified for head and neck cancer patients to be seen and assessed in a multidisciplinary way prior to delivery of their initial definitive treatment.
The sessions should be identified as pre assessment sessions and should all be timetablesd on the same half days or days for the specialists below

- At least one surgical core member of the MDT
- At least one oncology core member of the MDT
- An SLT core member of the MDT
- A dentist core member of the MDT
- A dietician core member of the MDT
- A CNS core member of the MDT
- A core or extended member of the MDT who is the agreed person responsible for the psychological support of patients

The sessions should be regular and at an agreed frequency
Detail see table 4

1.24 Establishment of coordinated local support teams (after care and rehab please refer to action 6 in the IOG)

Networks are required to have

- A clinical nurse specialist is available in each locality (a defined geographical area in line with the network structure identified earlier for referral/rapid access services) to coordinate access to the full range of expertise from professionals to provide the long term aftercare, support and rehabilitation needs of all patients in the community
- Each patient has an agreed written rehabilitation plan on discharge from hospital and nominated key worker.

Detail see table 4

Table 4 covers both the above items 1.22 and 1.23

Pre-treatment Services and Local Support Teams

Establishment of services	**Name of Hospital / Trust**	**Service changes needed**	**Milestone dates in place/expected**
Multi-disciplinary pre-treatment assessment and management clinics	PHT	MD pre treatment assessment in place as required at MDT clinic	Complete
Clinical nurse specialists available in locality to co-ordinate access to full range of expertise in the community and written rehabilitation plan established	PHT	In place; patient held record of care provided by CNS	Complete
Multi-disciplinary pre-treatment assessment and management clinics	RWST consider needed Worthing	Electronic pathology results facility between Trusts Local clinical MDT would require further development within following areas: • 0.5 wte MDT coordinator, Increased Secretarial support, • Increased pathology, radiology staff if required to attend PHT MDT • Dental laboratory and restorative services based at RWST input. Service improvement work required looking at the provision of dedicated	Within IT programme TBA TBA

		clinics with increased MDT input. Agree role of Nurse Specialist in Worthing	
Clinical nurse specialists available in locality to co-ordinate access to full range of expertise in the community and written rehabilitation plan established	Worthing	Service Improvement work required to match service currently provided at RWST	TBA
Multi-disciplinary pre-treatment assessment and management clinics	IOW Healthcare Trust – this currently happens within Southampton and Portsmouth	None	In place in Southampton & Portsmouth
Clinical nurse specialists available in locality to co-ordinate access to full range of expertise in the community and written rehabilitation plan established	IOW Healthcare Trust	Appointment of locality CNS	2007/8
Multi-disciplinary pre-treatment assessment and management clinics	SUHT	No changes anticipated – see above for details.	
Clinical nurse specialists available in locality to co-ordinate access to full range of expertise in the community and written rehabilitation plan established	SUHT	Need additional CNS and AHP resource for specialist service and SUHT locality patients. Need additional CNS and AHP resource in Cancer Units/PCTs to provide local rehab/support care as per IOG	Subject to funding arrangements.
Multi-disciplinary pre-treatment assessment and management clinics	Salisbury	Clinics already in place at SUHT after MDT which SDH leads attend. Local clinics also held before and after local MDTs currently	Funding required for MDT members as in append 1
Clinical nurse specialists available in locality to co-ordinate access to full range of expertise in the	Salisbury -	Dedicated CNS to be identified - backfill required	April 06 - *subject to funding* *see costed action plan at*

community and written rehabilitation plan established			*end of document*

1.25 Plans for inpatient treatment services (please refer to section 5 of the IOG)

Overview

The IOG requires a consolidation of treatment services resulting in an MDT for UAT and an MDT for thyroid cancer which should deal with 100 new cases per year. A further degree of consolidation is required for the treatment UAT tumours involving the skull base.

The IOG also recommends that over the next few years assessment and treatment services should become increasingly concentrated in Cancer Centres serving populations of over 1 million patients.

The measures require that the network designates operating hospitals where all curative surgical procedures are undertaken with a specialist head and neck ward.

- The designated hospital should have an HDU or ITU on site
- A policy that patients when not on HDU/ ITU are on a named ward to which patients are admitted in preference to other wards.
- This is referred to as the specialist head and neck ward and there should be only one such ward per hospital
- The ward should have a nursing establishment which allows when up to establishment, one grade E registered nurse training in the care of tracheostomies at all times and training available to staff on all wards where such patients are nursed.
- The designated operating hospitals ward should have time specifically allowed to the care of its patients in the list of duties or timetable of at least one Speech and Language Therapist, and at least one dietician, both core members of the MDT
- Surgical voice restoration should be available with specialist SLT support, rehab and equipment.
- All surgical modalities including laser excision and partial laryngeal excision, should be available. A range of surgeons who specialise in different aspects of the procedure should be involved in complex operations. Microvascular expertise is essential in reconstructive surgery. The MDT should agreed agree policies on admission to ITU and adequate facilities need to be available to meet need
- 24 hour access to emergency surgery to reverse flap failure is required

The network proposes that Head and Neck cancer surgery will continue in Southampton and Portsmouth (as already configured) and will service the MDT populations as set out previously. The SHC position is set out as previously.

Southampton has an already established cancer centre for skull bone surgery for CSCCN and Dorset et al would wish to continue this as the nominated supra-network service for skull base surgery. (append 2)

Thyroid surgery (complex) would be carried out in the same surgical centres as above, unless of a non complex nature when surgery can be carried out locally after discussion with the MDT.

Table 5

Inpatient services
Head and Neck / Thyroid Cancer / Skull base tumour surgery

Surgical Inpatient Centre	Type	Milestone date of workload transfer and name of hospital/Trust	Milestone dates for when compliant with requirements on Page 77 of IOG
PHT	Head & Neck	*Portsmouth G4 Head & neck Ward*	Portsmouth already compliant. MF work already moved from IOW and RWST (in summer 2005). ENT had already moved. Transfer of monies not yet sorted.
PHT	Thyroid	*Inpatient surgical beds for thryoidectomies C3/D3 at RHH and facilities for radioactive iodine on C3 at SMH*	Not planned
SUHT	Head and neck	SUHT – *ENT pts on F5, rest on D neuro or neuro ICU*	a) SUHT -Laser excision - ✓ b) Micro-vascular expertise -✓ c) Intensive Care criteria/facilities -✓ d) Ward staff training in tracheostomy care -✓ e) 24 hr access to emergency surgery to reverse flap failure - ✓ f) Surgical voice restoration (after laryngectomy) to include specialist SALT support on wards -✓ g) Salivary gland tumour surgery carried out by appropriate surgeons with specific expertise -✓ h) Dietetic support on wards -✓ i) Histopathology using RCPath Dataset ✓ and photograph specimens for MDT discussion if possible × **ENT Work already moved from IOW**
	Thyroid	SUHT – F level SGH, often located on E level, which is general surgery, not H&N (not desirable)	a) End 2005 – ensure robust booking of thyroid patients. (Surgical CSM, Cancer Centre). b) if a) not resolved - ward staff training in tracheostomy care (E level issue) c) Histopathology using RCPath Dataset and photograph specimens for MDT discussion if possible – x ? work to move from NHH ? when

	Skull base tumour surgery	SUHT -	a) Skull base tumour surgery carried out by appropriate surgeons with specific expertise -✓ b) Histopathology using RCPath Dataset and photograph specimens for MDT discussion if possible – x
Salisbury	Head and Neck	Salisbury - Laverstock Ward (Plastics and Max Fax)	Compliant except: • Tracheostomy training - in TNA for 06/07 • ENT only tracheostomy Ca patients may be on Downton Ward - need to review • Minimal SALT/dietetics support currently - see costed action plan to allow full compliance • Some ENT surgery (e.g. laryngectomy done at SUHT • Review ITU/HDU policy (adequate facilities already in place)
	Thyroid	Britford unless Plastics/Max Fax input then to Laverstock Ward	• Need to review whether possible/appropriate to cohort on Laverstock

Section 2 Costed Action Plans

This section includes a summary of the investment required (gap analysis) for implementation of the Head and Neck IOG with milestone dates covering services:

- for each locality and relevant MDT
- for the network wide services and issues
- for supra network skull base services (co-ordinated by the agreed host network together with the relevant level 2 specialised commissioning group for the service, unless other arrangements have been agreed locally).

These costings assume that the National Tariff does not include NICE implementation. Commissioner discussions are required across the network to determine priorities and pace of implementation. Clearly video conferencing which is already planned, will be of assistance, but establishing the core MDT will be challenging as it has been for the other IOGs..

Data set/ monitoring systems

To be completed regarding thyroid and head and neck data sets

Table 6 Gap Analysis and Provisional Costs

TRUST	DETAILS	COST
Portsmouth Hospitals Trust Items in bold are required to achieve fully funded compliance for current MDTs	**Workforce** **Data Clerk / MDT Co-ordinator/ Team secretary for H& N + Thyroid -Total 1.7 Wte A & C grade 3 or equivalent** **Cover for H & N CNS Band 6** **Funding of current CNS support to Thyroid MDT – 0.2 Wte Band 7** **Palliative Care input to MDT based on 0.5 consultant PA** **Psychologist – 0.2 wte** 2x sessions **Cross reference with Supportive & Palliative Care IOG submission* **Dental Hygienist** 12x sessions annually x £100 per session **Establishment of RANL clinic with Pathology & Radiology and Haematology input** (cost estimated to be £20k per clinic in IOG Guidance p37 likely to be a conservative estimate) **Cost of diagnostic kit** **ICT** **Upgrade of IT system to enable collection of DAHNO database** (£30K quoted to achieve compatibility with Graphnet but likely to be significantly less if linked to local H & IOW Repository project)) **Additional resource for full transfer of H&N from RWST including:** H&N Ward: Nursing H&N Ward: Humidifiers Theatre Sessions H&N Ward: Additional Equipment ENT OPD Medical Equipment Radiotherapy Sessions Chemotherapy Sessions ITU Capacity Acute Pain Services Dietetics – Additional Sessions Nutrition – Additional Sessions	(Includes on costs) **£ 27,500 per annum** **£ 30,500 per annum** **£ 7,000 per annum** **£ 4,000 per annum** **£12,000 per annum** **£1,200 per annum** **£ 31,000 per annum** (3 consultant PAs + admin cost) **To be determined** To be determined £14,000 per annum £1,400 £75,000 per annum £1,700 per annum £5,000 £175,000 per annum £30,000 per annum £9,120 per annum £750 per annum £11,000 per annum £14,000 per annum

	Anaesthesia Transfer of W Sussex work will also incur additional work for radiology and pathology	£41,500 per annum £17,400 per annum (2 consultant PAs)
Royal West Sussex	One stop neck lump clinic (weekly) Requires cytologist and ultrasound input Dedicated operating list for diagnostics so to fast track patients (minimum fortnightly) Requires 0.1 wte consultant plus theatre, anaesthetic and administration (secretarial/ MDT coordinator) costs. Implementation of PACs across Trust. Implementation of Video conferencing 0.5 wte MDT co-ordination ? increase Pathology and Radiology staff if required to attend MDT or increased activity Dental and restorative dentistry service at RWS Increased secretarial support Ensure Data completeness DAHNO Review SALT, Dietician, Physio requirements **<u>Worthing</u>** Service Improvement work required at referral/outpatient stage to fit in with above proposed service. Review nurse Specialist Role in Worthing. Link patient Tracking between Worthing / Chichester / Portsmouth. Review patient information and pathway between all three organisations and agree.	Approx £22000 pa TBA TBA Full costs to be established. No funding agreement at present and requires review of service improvement and modernisation.
Isle of Wight NHS Healthcare Trust	1 – 2 days a week CNS 1 day a week Senior staff nurse 1 day a week Speech & Language Therapist Equipment – valves, information and PC	30k pro rata 20K

Southampton University Hospitals Trust **These costs do not include the cost of transferring work from SHC.** **This would require surgical, theatre, Critical care imaging and path time**	**HEAD AND NECK MDT** **MDT core membership** Histopathologist 1 session Radiologist 1 session Palliative Care 1 session Ward sister band 7 (x2) – clinical oncology and ENT ward – core MDT members to attend MDT meetings – 0.1 wte Neurosurgeon 0.5 session **Services** Restorative Dentist 3-4 sessions weekly plus funding for treatment required Dental Hygienist 1 session MDT co-ordinator/data capture 0.5 wte Path/Rad MDT support 0.2wte BMS2 0.5 session **Additional infrastructure required to deliver IOG - specialist MDT and local care team for locality patients only.** 1.0 wte band 6 Specialist Nurse (Max-Fax +/- skull base tumours) 1.0 wte band 7 speech therapist 1.0 wte band 7 dietician 0.2 wte band 6 physio 0.1 wte band 6 OT 0.2 wte band 6 nutrition support nurse. 0.1 wte band 6 to critical care outreach (re. trache care) 0.1wte psychology 0.2 wte social work 1.0 wte A&C 2 clerical/secretarial support to nursing/rehab team. **NB provides for specialist CNS/AHP telephone advice and support to referring local care teams, but not outreach clinics/visits.** **THYROID MDT** Nuclear Medicine specialist 1 session MDT co-ordinator 0.5 wte	 £10k £10k £10k Assume total requirement is 0.1 wte - £4k £5k £16-32k **3.3k** Assume band 4 post - £22k “ “ £8.8k 0.5 session/week 3k £33k £39k £39k £6.6k £3.3k £6.6k £3.3k £5k £8k £16.5k £10k £11k £16.5k

	0.5 wte band 6 specialist nurse (based on local service needs)	
Salisbury Health Care NHS Trust	**MDT CORE MEMBERSHIP** **See costed action plan appendix 1** SDH plan to be part of a joint MDT with SUHT. This may be achieved in two ways **Option 1 - videoconferencing** Core SUHT/SDH MDT members who are based at SDH will have a videoconference link to be part of the joint MDT. **Option 2 - meeting to be held at SUHT or SDH** Core SUHT/SDH MDT members to meet at SUHT or SDH - require agreement on key members from SDH that would need to attend (?continue as for interim). **Interim** - SDH local MDT to meet (*accepting gaps as indicated in costed action plan*) with 4 SDH core members attending SUHT MDT. **NECK LUMP CLINICS (incl FNAC)** **See costed action plan on separate pages attached.** • Phase 1 - weekly clinic but with max. 2 day FNA reporting - *April 06* • Phase 2 - weekly clinic with one-stop FNAC - *April 07*	
North Hampshire Hospital NHS Trust	None submitted ? correct	
Winchester & Eastleigh Healthcare Trust	NA	

Section 3

Table 7 Assessing and Managing Risk Associated with Action Plans

Trust	Key Risk	Management Strategy
PHT	Provision of RA NL clinic impeded by lack of radiological and pathology resource	Weekly US list attended by H & N surgeon
	Funding for A & C posts to support MDTs inadequate to sustain data collection and tracking of patients leading to breaches in CWTs	Review of MDT Co-ordinator structure & provision by CMT. Improve use of current tracking using IT
	Trust failing to submit DAHNO data (2/3 of trusts nationally now submit this)	Reconsider options
	Transfer of patients from W Sussex	Progress to a Cost per Case model of care
Royal West Sussex NHS Trust		Continue close working between PHT,RWS,WHT, Western Sussex PCT.
		Agree key target dates and establish clear project plan.
	Breaching the 31/62 day wait for fast track patients	See above plan
	Cross cover arrangements for clinical staff.	To be fully agreed
	Insufficient patient support locally if developed as part of reconfiguration.	Completed full costings, consider service improvement and possible modernisation options to support developments.
	Poor Communication between organisations and hence patient could get lost during their journey.	
Isle of Wight NHS Healthcare Trust	1. Attendance at Specialist MDT Southampton	Access through Video Conferencing
	2. Specialist CNS Support	Continued close working with Southampton & Portsmouth
Southampton University Hospitals Trust	Failure to comply with IOG if funding not forthcoming for:	No possibility of going at risk for funding in current financial climate.
	HEAD AND NECK MDT	Explore potential for easement of pressure

	MDT core membership Histopathologist 1 session Radiologist 1 session Palliative Care 1 session Ward sister band 7 (x2) – clinical oncology and ENT ward – core MDT members to attend MDT meetings – 0.1 wte Neurosurgeon 0.5 session **Services** Restorative Dentist Two sessions weekly plus funding for treatment required Dental Hygienist MDT co-ordinator/data capture 0.5 wte Path/Rad MDT support 0.2wte BMS2 0.5 session 1.0 wte band 6 Specialist Nurse (Max-Fax +/- skull base tumours) 1.0 wte band 7 speech therapist 1.0 wte band 7 dietician 0.2 wte band 6 physio 0.1 wte band 6 OT 0.2 wte band 6 nutrition support nurse. 0.1 wte band 6 to critical care outreach (re. trache care) 0.1wte psychology 0.2 wte social work 1.0 wte A&C 2 clerical/secretarial support to nursing/rehab team. Insufficient funding for local care /rehab teams. **THYROID MDT** Nuclear Medicine specialist 1 session	by video conferencing links As above As above As above Explore job plan with newly appointed oncology Neuro surgeon. Withdraw non essential data capture, e.g. DAHNO audit Do not photograph specimens Short-term project funding (three years) from Macmillan for 0.5 wte support nurse

	MDT co-ordinator 0.5 wte 0.5 wte band 6 specialist nurse (based on local service needs).	
Salisbury Health Care NHS Trust	1) Risk of CAT not supporting split-site centre model - loss of casemix 2) Availability of funding for MDT core members 3) MDT - Option 1 - Still awaiting videoconferencing facilities at SUHT 4) Neck lump clinics - funding for one-stop FNAC	1) Case currently being put together by the network. Case supported by SDH being the Regional Plastic Surgery Unit. Currently proceeding with model of services/MDT associated with split-site centre model. 2) Ensuring proposals limit costs (e.g. backfill (sometimes with lower band staff/ part time or sessional input). Include in LDPs whilst also seeking out other potential sources of funds. Also, seek out solutions (e.g. clinical oncology) through videoconferencing with Southampton. 3) Interim model developed with local MDT and key members attending SUHT MDT. 4) Interim model being developed with max. 2 day reporting.
North Hampshire Hospitals NHS Trust	None submitted	
Central South Coast Cancer Network	Approvals for three centre service MDT numbers accepted Achieving core MDT membership	

Section 3

Table 8 Outstanding issues

Action	By	Timescale
SUHT:		
1) Funding issues previously noted	Cancer Network / LIT /SUHT	See below
2) Development of ENT IOW clinic	Surgical CSM	October 05
3) Confirm working practices for split site SUHT/SHT H&N Centre	SUHT/SHC, CSCCN	Dec 05
4) Develop and agree full business case for funding and expansion of SUHT H&N centre if split site model is rejected	SUHT	April 06
5) Infrastructure/staffing costs for either model to be included in LDPs – both for Thyroid and H&N services.	SUHT, PCTs, SHA	April 06
6) H&N and thyroid MDTs held at SUHT to have representation from all referring units (or videoconferencing)	Referring units	Jan 06/as funds permit
7) All complex thyroid surgery for 'Western' MDT to be performed in SUHT	MDT, SUHT, referring units	Jan 06
8) Design and delivery of model of care for local supportive care/rehab teams	CSCCN – acute trusts and PCTs.	Jan 07/as funding permits
PHT None		
IOW • Confirm MDTs splits ENT (SUHT), thyroid (?), Head and Neck (PHT) • Confirm if lump clinic stays in interim and where thyroid lumps will go • ? any further surgical transfer		
RWST • Confirm pre treatment assessment clinic to be done at PHT or maintained at RWST? Take advise • Timing of any surgical transfers ? 12	Pre assessment to be done at PHT	

per year		
SHC • ? role of local MDT if joint MDT with SUHT • Awaiting external view of surgical configuration		
NHH • Thyroid MDT with SUHT and surgery also there (complex). ? timing of any transfers ? any gap analysis • ? local support team gap analysis will this be in SWSH action plan		
Channel Islands • Need to complete their sections		
<u>Central South Coast Cancer Network</u> • Clarify referral criteria and clinics for head and neck/ ENT/ Thyroid / skull base across network • Check any surgical movements of work; sort out commissioning arrangements • Check data set current position • Ensure action plan fully complete with all milestones agreed	JS SS HS SS	

Section 4 Key Dates and Milestones
Table 9 Key Dates

PHT			
Key Milestone	Target Date	Action for	Comments
Designated hospitals meet criteria	PHT compliant		
Clear referral criteria into which clinics	PHT April 2006	NWG	
Head and neck lump clinics established and meet criteria	PHT April 2007		
Pre treatment assessment clinics in place and meet criteria	PHT Compliant		
MDTs for Head and neck operational	PHT Compliant		
HN MDT core membership in place	PHT 2006		Palliative care service withdrawn due to funding issues, uncertainty over re-instatement
MDTs for thyroid operational	PHT Compliant		
Thyroid MDT core membership in place	PHT In Place		Funding gaps for core members
Surgical transfers into compliant hospitals	PHT to accommodate RWST transfer by Dec 2006		
Rehab support teams in place	PHT Compliant		

SUHT/WEHT			
Key Milestone	Target Date	Action for	Comments
Designated hospitals meet criteria	Compliant for H&N End of 2005 for Thyroid	SUHT – surgical Division	Thyroid patients to be Admitted to H&N ward for surgery
Clear referral criteria into which clinics	2006		
Head and neck lump clinics established and meet criteria	Compliant	ENT and lymphoma MDTs	Clinics in place – need to Refine processes
Pre treatment assessment clinics in place and meet criteria	2007	SUHT/MDT	Requires additional AHP Funding
MDTs for Head and neck operational	2006		
HN MDT core membership in place	2006		

MDTs for thyroid operational	2006		
Thyroid MDT core membership in place	2006	SUHT	Additional funding Required
Surgical transfers into compliant hospitals	2006	SUHT, referring hospitals	
Rehab support teams in place	2007		Additional funding Required to meet full IOG
Confirm working practices for split site SUHT/SHT H&N Centre.	Dec 2005	SUHT/SHC, CSCCN	Awaiting response from DoH regardng CSCCN 2-centre model (PHT plus SUHT/SCT split site)
Develop and agree full business case for funding and expansion of SUHT H&N centre if split site model is rejected	April 06	SUHT - surgical /neuro/non-surgical oncology directorates.	As above
Infratructure/staffing costs for either model to be included in LDPs - forThyroid and H&N	April 06	SUHT	As part of of LDP process
H&N and thyroid MDTs held at SUHT to have representation from all referring units (or videoconferencing)	January 06	Referring units	Delivery of video-conferencing for SCCCN being lead by PHT (? Target date)
All complex thyroid surgery for 'Western' MDT to be performed in SUHT	January 06	MDT, SUHT, referring units	MDT to monitor 100% compliance
Design and delivery of model of care for local supportive care/rehab teams	January 07	All CSCCN Centres, Units and PCTs.	Depends upon funding for additional posts, and requires redesign of services/working practices.

IOW			
Key Milestone	Target Date	Action for	Comments
Designated hospitals meet criteria	TBA		
Clear referral criteria into which clinics	TBA		
Head and neck lump clinics established and meet criteria	TBA		
Pre treatment assessment clinics in place and meet criteria			
MDTs for Head and neck operational	2006		
HN MDT core membership in place			
MDTs for thyroid operational	2006		
Thyroid MDT core membership in place			
Surgical transfers into compliant hospitals	TBA		
Rehab support teams in place	TBA		

SHC			
Key Milestone	Target Date	Action for	Comments
Designated hospitals meet criteria	TBA		
Clear referral criteria into which clinics	TBA		
Head and neck lump clinics established and meet criteria	TBA		
Pre treatment assessment clinics in place and meet criteria			
MDTs for Head and neck operational	2006		
HN MDT core membership in place			
MDTs for thyroid operational	2006		
Thyroid MDT core membership in place			
Surgical transfers into compliant hospitals	TBA		
Rehab support teams in place	TBA		

RWST			
Key Milestone	Target Date	Action for	Comments
Designated hospitals meet criteria	TBA		
Clear referral criteria into which clinics	TBA		
Head and neck lump clinics established and meet criteria	TBA		
Pre treatment assessment clinics in place and meet criteria			
MDTs for Head and neck operational	2006		
HN MDT core membership in place			
MDTs for thyroid operational	2006		
Thyroid MDT core membership in place			
Surgical transfers into compliant hospitals	TBA		
Rehab support teams in place	TBA		

NHH			
Key Milestone	Target Date	Action for	Comments
Designated hospitals meet criteria	TBA		
Clear referral criteria into which clinics	TBA		
Head and neck lump clinics established and meet criteria	TBA		
Pre treatment assessment clinics in place and meet criteria			
MDTs for Head and neck operational	2006		
HN MDT core membership in place			
MDTs for thyroid operational	2006		
Thyroid MDT core membership in place			
Surgical transfers into compliant hospitals	TBA		
Rehab support teams in place	TBA		

Section 5 Network and Strategic Health Authority Sign-Off
Table 10

Area	Signature/Comment
Strategic Health Authority Hampshire & Isle of Wight - Eileen Spiller	
Surrey West Sussex & Hampshire - Penny Bridger	
Avon, Gloucestershire & Wiltshire - Roger Paynter	
Network Policy Board Chair – Chris Evennett	
Acute Trusts Chief Executive – North Hampshire Mary Edwards	
Chief Executive – Winchester Chris Evennett	
Chief Executive – Salisbury Frank Harsent	
Chief Executive – Isle of Wight Graham Elderfield	
Chief Executive – Southampton Mark Hackett	
Chief Executive – Portsmouth Ursula Ward	
Chief Executive – St Richard's, Chichester – Robert Lapraik	
Primary Care Trusts Chief Executives Blackwater Valley – Debbie Glenn North Hampshire – Debbie Glenn	
Mid Hampshire – Chris Evennett	

Eastleigh & Test Valley – John Richards	
Southampton City – Brian Skinner	
New Forest – John Richards	
South Wiltshire – Jan Stubbings/Sarah Truelove (Acting Chief Executives)	
Isle of Wight – David Crawley	
East Hampshire Fareham & Gosport- John Wilderspin	
Portsmouth City- Sheila Clarke	
Western Sussex – Claire Holloway	
Network Executive Team Nurse Director – Janice Gabriel	
Network Director – Sarah Smart	
Medical Director – Jim Smallwood	
Chair of Head & Neck Network Site-Specific Group – Mr Tim Mellor	

APPENDIX 1 – Salisbury Costed Action Plan

1 MDT CORE MEMBERSHIP/STAFF REQUIRED FOR SERVICES

note: a local SDH MDT is already held monthly but with gaps in core members. SDH H&N and
Plastics Leads also attend SUHT MDT

Phase 1 - Interim - *Target Date April 06 (subject to funding)*

Fortnightly SDH local MDT and attendance at SUHT MDT by SDH H&N and Plastics Leads

Gaps		**Cost £ p.a.**
Clinical Oncology	- advice sought through SUHT MDT	No cost
	- explore potential for SUHT Clinical Oncology attendance at SDH MDTS and clinical sessions at SDH (total = 2 sessions/month)	*4,098*
CNS	- 3 days band 6 backfill to develop CNS role	15,358
SALT	- 2 sessions per week band 6	6,340
Dietitian	- 2 sessions per week band 6	6,340
MDT Coordinator	- 0.4wte band 2 typing backfill to free up medical secs to take on MDT Coord role	6,197
Restorative dentist	- 2 sessions/month	5,256
Clinical Psychologist	- 1 session/wk	3,794
Pathologist	- 1 session/month in order to move to fortnightly *(note: this cost will be absorbed within the neck lump clinic pathologist costings in phase 2)*	2,050
Radiologist	- 1 session/month in order to move to fortnightly *(note: this cost will be absorbed within the neck lump clinic radiologist costings in phase 2)*	2,050
TOTAL	**excl Clinical Oncology**	**47,385**
Total	***incl Clinical Oncology***	***51,483***

Phase 2 - Joint MDT with SUHT - *Target Date April 07 (subject to funding)*

Option 1 - Joint MDT with SUHT via Videoconferencing

This option is subject to videoconferencing facilities in SUHT and to ensuring clinicians available for joint MDT.

		Cost £ p.a.
Costs as above.	***excl videoconferencing equipment at SUHT***	**47,385**

Option 2 - Joint MDT with SUHT at SUHT or SDH

This option is subject to travel costs over and above the costs above. Local MDT to continue alongside joint MDT.

Assuming attendance at joint MDT additional costs from current =

		Cost £ p.a.
Travel Costs	**return travel x 2 plus 1 hr travel time for 1 staff**	**4,349**
	plus costs in Phase 1	**47,385**
TOTAL		**51,734**

2 NECK LUMP CLINICS

Phase 1 - neck lump clinics for rapid referral neck lumps with 2 day FNA reporting
Target Date: April 06

		Cost £ p.a.
-	Weekly Thurs am clinic to be held in ENT concurrently with Lead H&N (max fax) consultant and Haematology clinics. Thyroid consultant available during that session.	No cost
-	Clinic to see all rapid referral neck lumps	No cost
-	Scoping and FNAC with reporting within 2 days.	No cost
-	CNS to be available during clinic	See MDT gap costs
	TOTAL *(excl CNS which is incl in the MDT costs)*	**No Cost**

To audit neck lumps seen through this rapid referral clinic and neck lumps seen at ENT general clinics

Phase 2 - neck lump clinics for all neck lumps with one-stop FNAC
Target Date: April 07 (subject to funding)

		Cost £ p.a.
-	Weekly Thurs am clinic to be held in ENT concurrently with Lead H&N (max fax) consultant and Haematology clinics. Thyroid consultant available during that session.	No cost
-	Clinic to see all neck lumps - *requires reorganisation of general ENT referrals but no increase in activity expected as proforma for neck lumps already exists*	No cost
-	One-stop scoping & FNAC - 2 x pathologists available for 1 session/wk	16,400
-	Ultrasound - 1 session/wk Radiologist	8,196
-	CNS to be available during clinic	See MDT gap costs
	TOTAL *(excl CNS which is incl in the MDT costs)*	**24,596**

3 Ensure Data completeness DAHNO (systems under review) **?cost**

Appendix 2

Skull Base Surgery – Supra Regional Service.

History of the Skull Base Service

A Skull Base Surgery Service has been in existence in Southampton since 1988. The Surgical Team together with the support disciplines of Neuroradiology, Neuroanaesthesia, Neuropathology / Head and Neck pathology have been working closely together since that time. The surgeons involved in this surgical team have historically devoted a large proportion of their time to the management of pathology and trauma of the base of the skull and surrounding anatomical regions.

Current Service Provision:

Surgeons:
At present, the skull base surgery service is made up of 5 surgeons who have a regular weekly operating commitment:
2 neurosurgeons: Miss Dorothy Lang and Mr Kaare Fugelholme. (Mr Fugleholm replaced Mr G Neil-Dwyer who was one of the original surgeons who set up the service in 1988).
1 ENT surgeon: Miss Anne Davis.
1 Maxillofacial Surgeon: Mr Barrie Evans.

In addition, Mr Andrew Webb, Consultant Maxillofacial Surgeon has a commitment to 2 operating all day operating lists per month i.e. alternate weeks.

Microvascular reconstructive provision: this is provided on as-required basis by the following surgeons

- Mr AAC Webb – Consultant Maxillofacial Surgeon
- Mr Richard Cole and Mr Nigel Horlock – Consultant Plastic Surgeons.

Craniofacial Prosthetic Service: this is provided by Mr Ian Downie, Consultant Maxillofacial Surgeon, Salisbury. are constructed by the Maxillofacial Technicians at Salisbury District Hospital. This is a well established service providing implant retained facial and oral prostheses when necessary. The prostheses
.

Operating provision:
There are currently 2 all day operating lists per week dedicated to skull base surgery. These list are on Tuesday and Thursday. The Tuesday operating list is mainly devoted to surgery of the lateral skull base, in particular the treatment of acoustic neuromas and other tumours / conditions related to the lateral skull base. The Thursday operating list by contrast is concerned with the treatment of anterior skull base pathology and trauma. This would include the treatment of pathology related to the orbits and the orbital contents.

Outpatient Clinics:
Regular outpatient clinics are held for patients with pathology related to the skull base:
AD – lateral skull base clinics. 2 / month

DAL / BTE – 1 month

KF / AACW – 1 month.

Existing Case Load:
These figures are an approximation, but are based on audited figures that can be provided as necessary.
Tumour:

1) Lateral skull base: approximately 40 cases per year (the majority acoustic neuromas).
2) Anterior skull base: approximately 20 per year.

Trauma: Since 1988 we have treated approximately 180 cases of combined trauma to the skull base and facial skeleton i.e. so-called craniofacial injuries. For the last 10 years on average we treat 15 cases per year.

Regular Clinical Meetings: these are held approximately twice per month and are multidisciplinary.

Neruroradiologists :
Dr Simon Barker, Dr John Miller and Dr Mary Gawn-Cain.

Neuroanaesthetists:
Dr David Laycock and Dr Ian Cone

Neuropathologists :
Professor James Nicoll.
Dr Ingrid Mazanti.

Support facilities:
Dedicated neurosurgical ITU including paediatric neurosurgical ITU.

Surgical Fellows: We have had 1 Skull Base Surgical Fellow and there are plans for a further appointment in the future.

Publications / Research:
Numerous book chapters, publications in peer reviewed journals have been published and in addition there have been many papers, lectures and Key Note addresses at National and International Scientific Surgical Meetings since 1988. Details can be provided if required. The Skull Base Group is committed to teaching and research.

Current referral base:
The referral base is from the old Wessex Region. Paediatric cases are also referred from this same area. In addition we receive paediatric oncology referrals direct from the Regional Paediatric Oncology Service based at Southampton General Hospital.

Future Plans:
The possibility of increasing the referral base of the existing Skull Base Service by applying for Supra Regional status has the unanimous approval of all associated with the existing Skull Base Service. It is recognised that the resulting increase in workload would require additional facilities and personnel – the latter if only to back-fill the increasing demands that would be placed on the current clinicians.

Supra Regional status would provide a unique opportunity to develop the Service and thereby maintain the existing high quality of care to our patients in line with the best Skull Base Surgery Centres in other parts of the world. It would also provide great opportunities for research and training.