STANDARD OPERATIONAL POLICY
FOR THE SPECIALIST MULTIDISCIPLINARY (SMDT) MANAGEMENT OF SKULL BASE TUMOURS

Authors: Skull Base MDT
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## Document information

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<td>Cambridge University Hospitals</td>
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## Approval

This document has been approved for use by:

<table>
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<tr>
<th>Job Title:</th>
<th>Skull Base MDT Lead Clinician</th>
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<tbody>
<tr>
<td>Name:</td>
<td>James Tysome</td>
</tr>
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<td>Date:</td>
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<table>
<thead>
<tr>
<th>Job Title:</th>
<th>Trust Lead Cancer Clinician</th>
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<tr>
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<tr>
<th>Job Title:</th>
<th>Operations Manager</th>
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<td>Name:</td>
<td>Claire Holmes</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
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1 INTRODUCTION

This document defines and describes the role and operational function of the Specialist Skull Base multi-disciplinary team (hereafter referred to as ‘the MDT’) including detail on membership, responsibilities, referral, diagnosis and treatment.

Its purpose is to demonstrate compliance with implementing the Improving Outcomes Guidance (IOG), adhering to clinical guidelines/operational policies and monitoring implementation and impact through participating in network agreed audits.

The policy aims to ensure:

- Optimisation of and continuity of care, based on local, national and network guidelines.
- Reduction of unjustifiable variations in provision of care.
- Ease of follow up.
- Data collection and audit
- Patients are enrolled in appropriate clinical trials.

Cambridge University Hospitals Foundation Trust (CUHFT) is one of two cancer centres in the East of England Cancer Alliance. The East of England Cancer Alliance (EoECA) has one Skull Base MDT (SBMDT), which is hosted at Cambridge University Hospital Foundation Trust and is the designated operating site for benign and malignant skull base tumours. The SBMDT aims to provide first class multidisciplinary treatment and support for all patients with skull base tumours within the catchment population of the Anglia Cancer Network throughout their management pathway. The designated host neurosciences centre for the region is also CUHFT.

The EoECA will cover the geography of the previous Anglia, Essex and Beds & Herts Cancer Networks and will continue to work to improve cancer outcomes across the East of England. The EoECA will provide support to the Network Cancer Groups (formerly known as Site-Specific and Cross-Cutting Groups) via Local Cancer Network Support Team.

The population area of the Anglia region is estimated as 2.6 million. There are an estimated 6.3 million people in the EoE geographical region as a whole.
Section 1 - Structure of the MDT

2 BACKGROUND AND CONTEXT
The majority of skull base referrals are taken from the following Trusts, who may diagnose and assess skull base tumours prior to referral in to the SBMDT. These include urgent 2 week wait referrals. All patients with skull base tumours should be referred to the skull base MDT for discussion and management. For guidance on making referrals, please see Section 12.

Referring Hospitals

3 PURPOSE OF MDT
The MDT aims to provide first class MDT diagnosis, treatment and support for patients throughout their cancer pathway.

The MDT strives to achieve this by adhering to Site Specific Groups (SSGs) clinical guidelines/operational policies and monitoring implementation and impact through participating in network agreed audits.

4 LEADERSHIP ARRANGEMENTS AND RESPONSIBILITIES

4.1 The MDT Lead and Deputy Lead Clinician

Mr James Tysome
Consultant Otoneurological and Skull Base Surgeon/Skull Base Cancer MDT Lead

Mr Neil Donnelly
Consultant Otoneurological and Skull Base Surgeon/Deputy MDT Lead Clinician

The Responsibilities of the MDT Lead Clinician

- To chair and coordinate the weekly MDT meetings and its activities
• To ensure that for the patients discussed/to be discussed in the MDT meeting:
  ➢ Information regarding the patients is circulated
  ➢ Action points within the referral are discussed
  ➢ Outcomes of the meeting are clearly recorded, clinically validated and that appropriate data collection is supported

• To encourage effective team working, facilitating multidisciplinary decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team’s operational policies are multidisciplinary decisions.

• To ensure that the network’s guidelines and protocols are adhered to

• To link with the cancer services lead clinician of the Trust and with colleagues in the cancer network through membership of NSSG.

• To encourage that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected 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, subject to patients giving fully informed consent.

• To have overall responsibility for ensuring MDT meetings meet Quality Surveillance Clinical Indicators. Where gaps have been identified, to monitor progress of nominated leads in achieving compliance.

• To arrange for accurate monitoring of attendance by core members (or their specified cover) and identify actions where core members (or their specified cover) have not attended at least two thirds of the number of meetings.

• To monitor MDT representation at NSSG meetings.

• To retain overall responsibility for monitoring whether the target of communicating MDT outcomes to primary care is met i.e. that new diagnosis of cancer is communicated to GPs within 24 hours. Where this is not being met, to lead on (or nominate a lead for) actions to ensure compliance with this target.

• To organise and chair annual meetings, including examining the functioning of the team and reviewing operational policies.

• To monitor whether all core histopathology members of the MDT are taking part in the national specialist Skull Base External Quality Assessment (EQA) identifying non-compliance.

• Working with the lead nurse, to ensure at least one (and preferably all) core nurse members have successfully completed a programme of study in their specialist area of nursing practice, which has been accredited for at least 20 credits at first degree level or equivalent.

• The lead clinician of the SBS has agreed the time specified and the responsibilities of the position with the lead clinician of the host trust (Indicator 002)

5 MEMBERSHIP ARRANGEMENTS AND RESPONSIBILITIES

5.1 Core MDT Membership and Cover Arrangements (Indicator 002)

The below table outlines the Core MDT membership and cover arrangements
<table>
<thead>
<tr>
<th>Role</th>
<th>Core Team Member</th>
<th>Cover</th>
</tr>
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<tbody>
<tr>
<td>ENT Surgeons</td>
<td>Mr James Tysome**&lt;br&gt;Consultant Otoneurological and Skull Base Surgeon&lt;br&gt;&lt;br&gt;MDT Lead&lt;br&gt;Mr Neil Donnelly&lt;br&gt;Consultant Otoneurological and Skull Base Surgeon&lt;br&gt;&lt;br&gt;Deputy MDT Lead Clinician&lt;br&gt;Mr Patrick Axon&lt;br&gt;Consultant ENT Surgeon&lt;br&gt;Mr Carl Philpott&lt;br&gt;Consultant ENT Surgeon</td>
<td>Cover each other</td>
</tr>
<tr>
<td>Neurosurgeons</td>
<td>Mr Robert Macfarlane&lt;br&gt;Consultant Neurosurgean&lt;br&gt;Mr Richard Mannion O&lt;br&gt;Consultant Neurosurgean&lt;br&gt;Mr Adel Helmy&lt;br&gt;Consultant Neurosurgean</td>
<td>Cover each other</td>
</tr>
<tr>
<td>Plastic Surgeons</td>
<td>Mr Richard Price&lt;br&gt;Consultant Plastic Surgery&lt;br&gt;Mr Amer Durrani&lt;br&gt;Consultant Plastic Surgery</td>
<td>Cover each other</td>
</tr>
<tr>
<td>Neuroradiologist</td>
<td>Dr Daniel Scoffings&lt;br&gt;Consultant Radiologist&lt;br&gt;Dr Tilak Das&lt;br&gt;Consultant Radiologist</td>
<td>Cover each other</td>
</tr>
<tr>
<td>Neuropathologist</td>
<td>Dr Kieren Allinson ∂&lt;br&gt;Consultant Histopathologist&lt;br&gt;Dr Dominic O’Donovan∂&lt;br&gt;Consultant Histopathologist</td>
<td>Cover each other</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Juliette Gair * † ∞&lt;br&gt;Lead NF2 &amp; Skull Base Nurse Practitioner (ENT)&lt;br&gt;Nicola Gamazo <em>&lt;br&gt;NF2 &amp; Skull Base Nurse Practitioner (ENT)&lt;br&gt;Indu Lawes</em> ∞&lt;br&gt;Skull Base Nurse Practitioner (Neurosurgery)</td>
<td>Cover each other</td>
</tr>
<tr>
<td>Consultant Clinical Oncologist</td>
<td>Dr Sarah Jefferies**¥&lt;br&gt;Consultant Clinical Oncologist&lt;br&gt;Dr Richard Benson **&lt;br&gt;Consultant Clinical Oncologist</td>
<td>Cover each other</td>
</tr>
<tr>
<td>Consultant Radiographer</td>
<td>Kate Burton</td>
<td>Radiographer Cover</td>
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</table>
* Denotes clinical core member working with level 2 psychological skills and able to undertake Holistic Needs Assessment
** Denotes core team member responsible for recruitment to clinical trials
† Denotes core team member who has specific responsibility for users’ issues and information for patients and carers
∞ Denotes core nurse member who has completed specialist study
❑ Denotes core histopathology member who is taking part in histopathology EQA
¥ Denotes stereotactic radiosurgery practice
ʘ Denotes spinal surgery competence to perform instrumentation reconstruction at the craniospinal junction

The core surgical team are able to offer the full range of anterior, lateral, endoscopic and microsurgical skull base surgery.

5.2 Job timetables (Indicator 004)

<table>
<thead>
<tr>
<th>Skull Base ENT Surgeons:</th>
<th>Skull base MDT</th>
<th>Skull base theatres</th>
<th>Skull base clinic</th>
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<tr>
<td>Patrick Axon (CUHFT) Tel: 01223 217471</td>
<td>0.125 DCC PA</td>
<td>3.0 DCC</td>
<td>0.75 DCC PA</td>
</tr>
<tr>
<td>Neil Donnelly (CUHFT, Deputy Lead Clinician) Tel: 01223 586638</td>
<td>0.125 DCC PA</td>
<td>3.0 DCC</td>
<td>0.75 DCC PA</td>
</tr>
<tr>
<td>James Tysome (CUHFT, Lead Clinician) Tel: 01223 217471</td>
<td>0.125 DCC PA</td>
<td>3.0 DCC</td>
<td>0.75 DCC PA</td>
</tr>
</tbody>
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<table>
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<th>Neurosurgeons:</th>
<th>Skull base MDT</th>
<th>Skull base theatres</th>
<th>Skull base clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard Mannion (CUHFT, NCG chair) Tel: 01223 216676</td>
<td>0.125 DCC PA</td>
<td>6 DCC PA</td>
<td>0.75 DCC PA</td>
</tr>
<tr>
<td>Robert Macfarlane (CUHFT) Tel: 01223 217289</td>
<td>0.125 DCC PA</td>
<td>6 DCC PA</td>
<td>0.75 DCC PA</td>
</tr>
<tr>
<td>Adel Helmy (CUHFT)</td>
<td>0.125 DCC PA</td>
<td>2 DCC PA</td>
<td>0.75 DCC PA</td>
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<table>
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<th>Skull base theatres</th>
<th>Skull base clinic</th>
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<tbody>
<tr>
<td>Richard Price (CUHFT) Tel: 01223 256080</td>
<td>0.125 DCC PA</td>
<td>1 DCC PA</td>
<td>0.75 DCC PA</td>
</tr>
<tr>
<td>Oncology</td>
<td>Role</td>
<td>Extended Team member</td>
<td>0.125 DCC PA</td>
</tr>
<tr>
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<td>---------------</td>
</tr>
<tr>
<td>Sarah Jefferies (radiotherapy and SRS practice)</td>
<td>1.5 hours/week</td>
<td>4 hours per week including preparation</td>
<td></td>
</tr>
<tr>
<td>Kate Burton (Consultant Radiographer)</td>
<td>4 hours per week including preparation</td>
<td>6 hours per week</td>
<td></td>
</tr>
<tr>
<td>CNS</td>
<td>NA</td>
<td>Nicola Gamazo</td>
<td></td>
</tr>
<tr>
<td>Juliette Gair</td>
<td>NA</td>
<td>6 hours per week</td>
<td></td>
</tr>
<tr>
<td>Neuroradiology</td>
<td>Daniel Scoffings - 10 PAs exclusively for neuroradiology</td>
<td>Tilak Das - 10 PAs exclusively for neuroradiology</td>
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</table>

6 EXTENDED MDT MEMBERSHIP

The below named people form part of the extended membership of the MDT

<table>
<thead>
<tr>
<th>Role</th>
<th>Extended Team member</th>
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<tbody>
<tr>
<td>Consultant Ophthalmology</td>
<td>Mr Simon Woodruff</td>
</tr>
<tr>
<td></td>
<td>Mr Cornelius Rene</td>
</tr>
<tr>
<td></td>
<td>Miss Brinda Muthusamy</td>
</tr>
<tr>
<td>Consultant Plastic Surgeon</td>
<td>Mr Animesh Patel</td>
</tr>
<tr>
<td>Consultant Maxillo-facial Surgeon</td>
<td>Mr Malcolm Cameron</td>
</tr>
<tr>
<td>Consultant Oncologist</td>
<td>Tom Roques (NNUHFT)</td>
</tr>
<tr>
<td></td>
<td>Thankakama Ajithkumar (NNUHFT)</td>
</tr>
<tr>
<td></td>
<td>Craig Martin (NNUHFT)</td>
</tr>
<tr>
<td></td>
<td>Christopher Scrase (IHT)</td>
</tr>
<tr>
<td></td>
<td>Tim Podd (IHT)</td>
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<tr>
<td>Consultant Radiologist</td>
<td>Justin Cross</td>
</tr>
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<td></td>
<td>Nick Higgins</td>
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<tr>
<td>Consultant ENT Surgeon</td>
<td>Piyush Jani</td>
</tr>
<tr>
<td></td>
<td>Brian Fish</td>
</tr>
<tr>
<td></td>
<td>Ramez Nassif (ENT NNUHFT)</td>
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<tr>
<td></td>
<td>Andreas Hilger (ENT IHT)</td>
</tr>
<tr>
<td></td>
<td>Andrew Beynon-Phillips (QEHLK)</td>
</tr>
<tr>
<td>Audiology/Vestibular Scientists</td>
<td>Judith Bird</td>
</tr>
<tr>
<td></td>
<td>Richard Knight</td>
</tr>
<tr>
<td></td>
<td>Sarah Creeke</td>
</tr>
<tr>
<td></td>
<td>Rachel Knappett</td>
</tr>
<tr>
<td></td>
<td>Tamara Lamb</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Specialist Palliative Care Team</td>
<td>Sarah Galbraith</td>
</tr>
<tr>
<td>Speech and Language Therapist</td>
<td>Sarah Pilsworth, Helen Scharf, Juliet Hoey</td>
</tr>
<tr>
<td>Dietician</td>
<td>Helena Jackson, Frances Shirley</td>
</tr>
<tr>
<td>Neuropsychiatry</td>
<td>Valerie Voon</td>
</tr>
<tr>
<td>Neuropsychology</td>
<td>Emma Woodberry &amp; Georgina Browne</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Deepa John, Gillian Read (Neuro-oncology CNS, Ipswich), Amy Webb (Neuro-oncology CNS, Norwich)</td>
</tr>
</tbody>
</table>

Please note: Extended team members have no obligation to attend the MDT, however will be used as a contact/reference point by the core members as necessary.

7 MDT MEMBERS RESPONSIBILITIES

7.1 The Responsibilities of the Clinical Nurse Specialist

- To complete a programme of study in their specialist area of nursing practice
- To attend MDT meetings, either in person or via video conference, actively contributing to discussion and treatment planning
- To provide expert nursing advice and support to other health care professionals including the Specialist Palliative Care Team and local hospice in the nursing care of patients with Brain/CNS cancer ensuring relevant and up to date research is utilised
- To be involved in clinical audit
- To lead on patients’ and carers’ communication issues and co-ordination of the patient pathway for patients referred to the team – acting as the key worker or responsible for nominating the key worker for the patient’s dealings with the team
- To ensure a key worker is assigned to every Skull Base patient in Addenbrooke’s Hospital
- To attend the Skull Base Multidisciplinary Clinics, supporting patients/carers during imparting of treatment planning and follow up care
- To ensure continuity of care & seamless transition throughout the patient’s cancer journey, including pre-diagnostic phase following investigations for Skull Base tumours
- To liaise with the MDT Coordinator/Consultants and counterparts regarding specific patients planned for discussion including their current nutritional and/or any other applicable status
- To assist Clinicians/Consultants during the breaking of bad news
- To ensure continuity of care throughout the patients journey
- Ensure that results of the patient’s holistic needs assessment are taken into account in decision making,
- To provide and facilitate local support for patient’s and carers
• To ensure service audits (including patient satisfaction) are undertaken and action plans are implemented to develop the service
• To work collaboratively within the multi-professional team and maintain communication for effective care

7.2 The Responsibilities of the MDT Coordinator
The MDT Co-ordinator’s responsibilities are as follows:
• Facilitate and co-ordinate the functions of the multidisciplinary team meetings;
• Ensure Video conferencing and IT equipment is fully functional
• Ensure the appropriate proportions of patients are discussed at MDTs;
• Help with the introduction and changes to proformas used to ensure all patients are discussed, treated appropriately and outcomes are recorded and reviewed. Ensuring patients’ diagnoses, investigations, and management and treatment plans are completed and added to the patient's notes;
• Ensure MDT outcomes are sent out with 24 hours of the MDT meeting to GP and regional Trusts
• Working with staff to ensure all patients have a booked first appointment, investigation and procedure and record details of patients coming via a different route;
• Working with key MDT members to identify areas where targets are not achieved, undertake process mapping to identify bottlenecks;
• Undertake demand and capacity studies where appropriate;
• Report changes to MDTs on a monthly basis;
• Data collection and recording of data;
• To manage the systems according to guidelines, monitoring milestones and submitting the required reports in the given format and required times;
• Record attendance at meetings;
• Inform lead cancer manager of waiting times for patients when these exceed appropriate targets;
• Ensure lists of patients to be discussed at meetings are prepared and distributes in advance;
• Ensure all results are available for the meetings;
• Assist in capturing cancer data
• Ensure members or their deputy are advised of meetings and any changes of date, venue, etc.
• To Support the MDT Chair with any service improvements and quality issues

8 THE KEY WORKER POLICY
Each patient will be assigned a key worker form the MDT meeting or MDT related clinic. This person will be a core member or extended member of the MDT and will be a key point of contact for the patients and their carers who will be given the names and contact details of their key worker. Patients and carers will be informed that their key worker can be contacted for further advice or to discuss any concerns they may have.
The Named Keyworker’s responsibilities are as follows:
• To co-ordinate the patient’s care and promote continuity
• To be a key point of contact for patients and their carers throughout the patients’ pathway. The name and contact details of their key worker will be given to both the patient and their
carer/s, who are informed that the key worker can be contacted for further advice or to discuss any concerns they may have

- For each patient, the Named key worker will be identified on:
  - The MDT Action Plan
  - Patient related information sheets (Contact name and contact details)

9 THE MDT MEETING

The Addenbrooke’s Skull base MDT discusses each listed case and meets twice monthly (weeks 2 & 4) on Fridays from 08:00 – 09:00 in the Outpatient Seminar Room.

Video conferencing to Addenbrooke’s from Kings Lynn, Ipswich and Norfolk & Norwich is performed at the SMDT, where each individual hospital is given a dedicated time slot as required. When each individual hospital has finished discussing their specific patients the video conference for that particular hospital closes. Peterborough attend the MDT to present their patients.

Attendance of core MDT members will be recorded and can be reviewed on the attendance register which is updated weekly and kept electronically.

MDT outcomes are captured live in the MDT by member of the clinical team, these are recorded live onto EPIC (electronic patient record)

10 PATIENTS LISTED FOR THE MDT MEETING

Cases to be discussed at the MDT will be compiled by the MDT Coordinator. All members are responsible for identifying patients to be discussed and notifying the MDT Coordinator of patients to be added to the list. They are also responsible for providing all relevant information for discussion and data collection.

11 PATIENTS DISCUSSED AT THE MDT MEETING (INDICATOR 006)

All new patients with benign or malignant skull base tumours are referred to the SBMDT.

The following cases will be discussed at the SBMDT:

- All patients newly diagnosed with skull base tumours, to include:
  1. All patients with sino-nasal tumours involving the skull base
  2. All patients with head and neck tumours involving the skull base
- All patients where adjuvant treatment is required
- All patients with newly identified recurrent or metastatic disease
- All post-operative pathology, including histological confirmation prior to definitive surgical procedure for malignant disease
- All post definitive surgical procedure, pre-potential adjuvant treatment
- All patients on surveillance with a significant change in surveillance parameters to discuss management
- Patients with stable tumours and new imaging when on watch, wait, rescan pathway
- Any other patient where a member of the SBMDT requests discussion
MDT REFERRAL PATHWAYS & GUIDANCE

Cases should be referred no later than 5pm on Wednesday for the Friday MDT. Referrals should be made to the MDT Coordinator by completion of referral proforma and emailed to:

Internal: Skull Base.referrals@addenbrookes.nhs.uk
External: add-tr.cancermdt@nhs.net **

Please note that this must be using an nhs.net email account for sending and receiving any external referrals to comply with data protection regulations.

**Referring centres are responsible for organising the transfer of radiology/pathology for review at the MDT. Address details and deadlines for receipt are included on the referral proforma, see Appendix 1.

Diagnostic decisions about new patients that are required before the next MDT meeting are brought to the clinical lead of the MDT who will then consult with the relevant team members. The case will then be added to the next MDT for retrospective discussion.

MDT DECISION AND DOCUMENTATION

The MDT discussion will determine the possible treatment options for each new patient. The chair will ensure that an action plan is formulated by consensus agreement and that the action plan is recorded electronically on EPIC.

A completed MDT Action Plan will include the following details:

- Referring clinician and hospital
- Patient identity
- Clinical history
- Diagnosis, including primary site of the tumour, and stage and grade of disease where applicable
- Action plan and treatment plan
- Identification of the key worker and Principal Clinician
- The name of the SMDT to which the patient is referred to, if applicable.

SKULL BASE PATIENT PATHWAYS (INDICATORS 005, 006)

The following patient pathways have been agreed within the network, and patients should be referred to the appropriate MDTs, services and hospitals as part of their treatment, investigations, psychological and social support. Contact details for all MDTs for the MDT coordinators and lead clinicians can be found via the Trust intranet.

TEENAGE AND YOUNG ADULT PATHWAYS

All patients who are suspicious or diagnosed with cancer between the ages of 16-24 are referred to the TYA MDT for discussion via the hospital EPIC system. This MDT ensures that the agreed treatment plan is appropriate for the patient’s age as well as diagnosis.

HIGHLY SPECIALISED SERVICES PATHWAYS
All patients with a confirmed or suspected diagnosis of Neurofibromatosis Type II should be referred to the NF2 MDT at Cambridge University Hospitals NHS Fundation Trust as per HSS guidelines B13/S(HSS)/b. Referrals should be passed to the NF2 PA, Helen Innes, on helen.innes@addenbrookes.nhs.uk or helen.innes1@nhs.net.

All patients with a confirmed or suspected diagnosis of Complex Neurofibromatosis Type I should be referred to the NF1 services at Guy’s and St Thomas’ NHS Foundation Trust, London or Central Manchester University Hospitals NHS Foundation Trust as per HSS guidelines B13/S(HSS)/a.

14.3 SARCOMA MDT
If a diagnosis of skull base sarcoma is made or radiologically suspected, a referral should be made to the sarcoma MDT via the hospital EPIC system.

14.4 HEAD AND NECK CANCER MDT
Skull base tumours, in particular malignancies, may be discussed in the AngCN H&N MDT as well as the SBMDT. Cases requiring joint management will involve core members of the Skull Base and Head & Neck surgical teams. Patients with a skull base tumour who present at the head and neck MDT should be discussed at the skull base MDT prior to any treatment decisions.

14.5 RADIOTherapy SERVICES PATHWAY: SRS and fractionated radiotherapy

All patients with skull base tumours suitable for radiotherapy will be treated at Addenbrooke’s if suitable for stereotactic radiosurgery or fractionated radiotherapy. In selected cases of skull base malignancy, post-operative fractionated radiotherapy may be given at regional centres with suitable expertise.

14.6 PROTON BEAM THERAPY (PBT)
Referral for proton beam therapy should be made as per the national pathway for referral for Proton Beam Therapy. Patients who meet the criteria for commissioning (B01/P/d Proton Beam Therapy for Cancer in Adults) are referred for acceptance by the national proton clinical reference panel prior to acceptance for PBT. Imaging and surgery should have occurred within recognised skull base units prior to referral for PBT as per national Proton Overseas Programme clinical guidelines. Patients with chordoma/chondrosarcoma with spinal involvement that may require metal implants should be discussed at the MDT pre-operatively for oncology input into possible referral for PBT.

15 SKULL BASE CLINICAL GUIDELINES (INDICATOR 009)

The MDT has agreed the East of England Strategic Clinical Network guidelines for the management of:

- Guidelines for the Management of Skull base Tumours
- Guidelines for the management of Neuro-Oncology
- Radiotherapy for primary adult CNS Tumours

Guidelines adhere to the NHS England Proton Overseas Programme guidelines for chordoma and chondrosarcoma and also cover imaging guidelines and pre-operative opthalmology and endocrinology.

16 ANNUAL OPERATIONAL MEETING

The MDT holds an annual business meeting when policies, procedures, patient information and survey results are reviewed.
SECTION 2 - PATIENT PATHWAYS

17 PATIENT PATHWAYS
Details of Skull Base patient pathways as agreed by the SSG are available in Appendix 2.

18 REFERRALS
Referrals are received from any of the below sources:
- The two week wait suspected cancer route
- Accident and Emergency department
- Internal referrals
- External referrals

GPs referring patients with suspected skull base cancer via the suspected cancer two week wait pathway must refer using Choose and Book. All patients referred through these routes will be seen by a specialist within 14 days and appropriate investigations will be instigated. All suspected cancer patients will follow the 62 day referral pathway.

Patients can also be referred to the skull base MDT through the following routes:
- Pathology: the histopathologist will notify the skull base MDT coordinator of any newly diagnosed skull base cancers that have been identified. These patients will be discussed at the next skull base MDT.
- Radiology: the radiologist will notify the skull base MDT coordinator of any newly diagnosed skull base cancers that have been identified. These patients will be discussed at the next skull base MDT.
- Associated MDT referrals: Patients diagnosed with skull base cancer or with symptoms suggestive of skull base cancer discussed at the MDT of another speciality at CUH (eg gynae-oncology) should be referred to the skull base MDT and discussed with a core member of the skull base MDT.

19 DIAGNOSTIC SERVICES
Specialist Skull Base clinics are held with core surgical SMDT team members and Nurse Specialists who are named key workers

19.1 Outpatient Clinics

<table>
<thead>
<tr>
<th>Trust</th>
<th>Name of Clinic</th>
<th>Clinicians present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addenbrooke’s</td>
<td>Joint Skull Base Clinic</td>
<td>Designated clinicians for skull base surgery and radiotherapy</td>
</tr>
<tr>
<td></td>
<td>Clinic 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2nd &amp; 4th Friday</td>
<td></td>
</tr>
</tbody>
</table>

19.2 Pathology
Addenbrooke’s Hospital surgical Skull Base specimens are sent to the Addenbrooke’s Histopathology department. In addition, relevant pre-stained histology slides with original reports are sent to Histopathology from other Trusts participating in the Skull Base SMDT and also various Trusts external to the network, for review and presentation at the MDT.

These specimens are processed, examined and reported by core histopathology MDT Consultants in accordance with Royal College of Pathologists Minimum Data Sets and the Network guidelines. An Addenbrooke’s histology report is issued on all external referral cases and automatically
forwarded to the MDT Chair and the original reporting pathologist. Original slides are returned to the originating hospital when no longer required.

All of the Consultants participate in the Royal College of Pathologists CPD scheme and in national Neurosurgery pathology EQA schemes and other EQA schemes appropriate to their other sub-specialty areas.

19.3 Radiology
Imaging is performed in accordance with agreed network guidelines. All available and relevant imaging (preferably in DICOM format) for review and discussion at the SMDT meeting should be forwarded to the Skull Base SMDT coordinator, with reports from the originating hospital included. Images are then reviewed by the Radiology MDT member and findings documented electronically in the MDT meeting outcome dataset, or a separate report is generated and stored on the Addenbrooke’s PACS system for future reference.

20 COMMUNICATION OF DIAGNOSIS WITH GPs
All GPs will receive a letter notifying them when a patient has been given a new Skull Base tumour diagnosis within 1 working day of their appointment.

21 COMMUNICATION OF DIAGNOSIS TO THE PATIENT
Following the treatment planning discussion at MDT, the patient attends the outpatient clinic to be given their diagnosis. Many patients will have received their diagnosis at the referring centre prior to specialist clinic referral. The nurse specialist is present when new patients are given their diagnosis. The patients are also offered written specific patient information that is relevant to their diagnosis.

22 PATIENT INFORMATION (INDICATOR 201)
Patients are given written documentation to support the information given about the diagnosis / treatment / management plan. Each patient information leaflet has details of how to obtain the information in different languages and formats to suit individual needs. Additionally, patients are provided with information produced both in-house for any financial or support needs (ie, psychological, social and spiritual support and services available to support the effects of living with cancer and dealing with its emotional effects) they have that can be dealt with locally. Patients are also provided with Information on patient involvement groups / self help groups.

All patients currently receive information which is tailored to their specific needs.

Clear and comprehensive written information for patients are offered on the following:

- Skull base diagnostic procedures
- Skull base benign and malignant disease and treatment options
- Skull base treatment specific information leaflets for vestibular schwannoma and skull base meningioma, including information on outcomes and post treatment symptoms and local provision of services
- Members and contact details of the SBMDT
- Skull base key worker name and contact
• Skull base support and self-help groups and local services information and contact details
• Skull base psychological, social, spiritual and cultural information and contact details
• Macmillan Cancer Support Information and services available to support living with the effects of cancer and its emotional effects

The key worker name and contact is also provided for each patient in the form of a named card detailing the contact details specific to each key worker. In general this will be the clinical nurse specialist unless otherwise stated at MDT level.

Addenbrooke’s subscribes to Cintra Interpreting and Translation Service (phone 01223 346870) which provides 24 hour telephone access to trained interpreters. The hospital pays for this service and there is no cost to patients. Patients who need an interpreter contact the ward / out-patient department in advance of their visit to book the service they need. This includes British Sign Language and lip speakers for the deaf.

23 PERMANENT RECORD OF CONSULTATION

Each patient will be offered the opportunity of a permanent record or summary of a consultation at which the discussion of treatment options takes place This information will include as a minimum:

- Diagnosis
- Treatment options and plan
- Relevant follow-up (discharge) arrangements
- The permanent record is offered to the patient by the practitioner at the consultation and/or by the clinical nurse specialist

A permanent record of such consultations are offered at all stages of the patient journey and identifies areas discussed during consultation.

24 AREA WIDE COMMUNICATION FRAMEWORK

It is recognised that good communication is essential for the smooth and effective provision of services and should be a standard of care. Communication episodes and expected timescales are shown in the below table:

<table>
<thead>
<tr>
<th>Communication Episode</th>
<th>Responsibility</th>
<th>Expected Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logging of patients with a possible diagnosis of CNS tumour onto the Neuroscience SMDT database</td>
<td>MDT Coordinator of Neurosciences SMDT</td>
<td>Within 1 week of imaging report date</td>
</tr>
<tr>
<td>Clinical summary from the diagnosing clinician at the time of imaging diagnosis received by the Neuroscience SMDT</td>
<td>Referring Clinician</td>
<td>Within 2 working days of the date of the imaging report</td>
</tr>
<tr>
<td>Written summary of the proposed management plan produced by the Neuroscience SMDT sent back to the referring clinician, Cancer Network MDT and GP</td>
<td>Neuroscience SMDT</td>
<td>Within 1 working day of the MDT</td>
</tr>
</tbody>
</table>
Informing the patient, their relatives or carers of the diagnosis and management plan | Neuroscience SMDT or referring clinician (if patient not seen at Neuroscience Centre) | Within 1 working day of the SMDT for inpatients and within 5 working days for outpatients

Referral to the rehabilitation and supportive care services and palliative care team where appropriate | Neuroscience SMDT or referring clinician (if patient not seen at Neuroscience Centre) | Within 1 working day of the decision

Discussion of key worker appointment and their role with the patient, their relatives and carers | Neuroscience SMDT or referring clinician (if patient not seen at Neuroscience Centre) | Within 1 working day of the SMDT for inpatients and within 5 working days for outpatients

<table>
<thead>
<tr>
<th>Communication Episode</th>
<th>Responsibility</th>
<th>Expected Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral back to the Neuroscience SMDT for further management of possible recurrence</td>
<td>Specialist MDT clinic (where available), referring clinician or Cancer Network MDT</td>
<td>Within 1 working day of decision</td>
</tr>
</tbody>
</table>

25 TREATMENT
Specialist care for Skull Base tumours will only be delivered under the care of members of the specialist Skull Base team. There are two categories of specialist procedures:

Category 1. Procedures, which in addition to being under the care of the specialist team members, should only be carried out at Addenbrooke’s Hospital

Category 2. Procedures and treatments which should be delivered under the care of specialist team members, but the site of delivery is determined by agreement in the network’s guidelines

Decisions about location of treatment must be made following discussion at the skull base MDT. The majority of procedures will be performed in Addenbrooke’s Hospital, with the exception of surgery done jointly between SMDT core members and cardio-thoracic surgeons: this is done at Papworth Hospital. Papworth Hospital will be locating to the Addenbrooke’s site as part of the 2020 Vision for Cambridge University Hospitals NHS Foundation Trust.

25.1 Surgical Cover Arrangements
Surgical cover arrangements for the Departments of Neurosurgery and ENT are established to provide cover for provision of procedures as follows:

Out of hours care is provided by the supernumerary on call consultant
25.2 Supportive and Palliative Care
This is provided as locally as possible to the patient’s home under the direction of the MDT and includes:

- Multidisciplinary Treatment Clinic for radiotherapy support
- Post-treatment follow-up and continuing care
- Hospital Specialist Palliative Care Advisory Service
- Locality Specialist Palliative Care Teams (Macmillan Community Nurses are included in these Teams)
- Locality specialist out-patient palliative treatments

25.3 Pre-Assessment & Admission
Initial routine pre-assessment will be completed at CUHFT by the appropriate Nurse Specialist or the pre-assessment service. At pre-assessment, patients will be provided with information regarding their surgery.

The patient will be admitted to CUHFT on the day before or day of surgery where they will then be assessed by the anaesthetist and the surgical team to ensure that the patient is fit for treatment at the time of surgery.

25.4 Inpatient Areas
All patients requiring inpatient care will be referred to an appropriate care setting, including a surgical ward or oncology ward.

At CUHFT, patients referred for surgical procedures and receiving care when not on HDU and ITU will be nursed on surgical single sex accommodation wards, where feasible. These wards currently consist of:

**Surgical Wards**
- Ward A5 – Male neurosurgical ward
- Ward A4 – Male ward with separate mixed male/female neurological unit
- Ward A3 – Day of Surgery Admission Unit
- Ward D6 – Female Ward
- Ward J2 – Neurosurgical rapid access to acute rehab. Mixed male / female unit.

**Oncology Wards**
Oncology patients needing inpatient care at CUHFT are nursed on Ward D9.

26 FOLLOW UP
Follow up plans will be discussed with patients at the time of instigating a treatment plan and follow up appointments booked as appropriate as per clinical guidelines.

26.1 Immediate Post-Operative Follow up
All designated clinicians are SMDT members and therefore all patients receive follow-up by members of the SMDT. Following discharge, patients will generally receive immediate post-operative follow-up at Addenbrookes, and occasionally at the referring hospital. The Neurosurgery team at Addenbrooke’s have a permanent consultant on-call rotation for general and post-
operative surgical advice. A consultant Neurosurgeon surgeon is always available, should patients have any post operative problems, via an on-call rota.

26.2 Emergency Care and ITU
Patients would be admitted to ITU/HGU if necessary. Patients in ITU are reviewed on a daily basis by the Neurosurgery Team.

26.3 Skull Base & Neuro-rehabilitation
Judith Bird, Consultant Audiological Scientist is the lead for Skull Base Rehabilitation overseeing vestibular, hearing and tinnitus management. The audiology team attend the Skull Base MDT and clinic so that integrated management of patient disability is possible. There is good communication with the audiological teams around the region so that on-going care can be delivered locally.

A neuro-rehabilitation operational matrix, policy and directory have been developed. The policy covers all patients with primary or secondary tumours of the brain and central nervous system, and is inclusive of skull base, pituitary and spinal cord tumours as well as metastatic brain tumours. All grades of tumours are included within this operational policy, as people with low grade tumours may require neuro-rehabilitation for any neurological deficits caused by the tumour and/or treatments given. All stages of the cancer pathway are covered by this policy, as patients may require intervention from diagnosis, through treatment and into the survivorship stage, which may be a curative or palliative pathway, and through to end of life.

The Rehabilitation Pathways Matrix and Service Directory are maintained and updated by the Network Rehabilitation Steering Group. The Pathway and Services Directory can be found on the professionals’ area of the Anglia Cancer Network Website at http://www.angliacancernetwork.nhs.uk. The area lead for neuro-rehabilitation is Dr Moheb Gaid, Norfolk Community Health and Care NHS Trust. He is responsible for overseeing and signposting access to appropriate acute, specialist inpatient neurological / spinal rehabilitation and community neuro-rehabilitation services for patients with brain and CNS tumours. He does not attend the skull base NCG meetings, but he does attend the Brain & CNS NCG meetings which are held three times a year and are also attended by representatives of the Skull Base NCG.

26.4 After Care and Rehabilitation
All new patients are seen by Allied Health Professionals (AHP), who are core members of the SBMDT, these principally include the relevant Clinical Nurse Specialist (CNS), consultant radiographer and Audiovestibular Scientists, at CUHFT prior to treatment. There is access to other AHP such as Dieticians and Speech and Language Therapists as required. Patients are then supported by these core members whilst they are having initial curative treatment. Where ongoing care is required after discharge, the relevant AHP will handover to local teams within 2 working days of discharge.

Following completion of the treatment patients are initially seen in the Multidisciplinary Skull Base clinic or oncology clinic as per follow up guidelines. Support is provided at these clinics from the CNS and Audiovestibular Scientist, or other AHP as required.
When the acute need to manage the patient’s symptoms diminishes and this can be met at local level, referral is made to the local support team. The SBMDT core members can be contacted for advice by the local support teams at any stage.

Specific indications for referral back to the surgical team may include the following:

- Concerns regarding surgical wounds or flaps
- Increasing/disproportionate pain
- CSF leak
- Altered conscious level

Specific indications for referral back to the therapy team are as follows:

- Failure of vestibular compensation
- Significant impairment in hearing function
- Non resolving facial palsy
  - Intrusive tinnitus
  - Patient concern

### 26.5 Long Term Follow Up

All patients will receive FU by members of the SBMDT in the Multidisciplinary Skull Base clinic at CUHFT or the head and neck MDT clinic at NNUHFT or IHT. Ongoing FU guidelines are as indicated below:

**Post surgery benign lateral skull base**: OPA: 6 weeks, 3 months, 1 year & 2 years (2 year exit MRI scan dependent on tumour). The 1 and 2 year reviews may be conducted via telephone assessment if appropriate.

**Post radiotherapy benign lateral skull base**: OPA: 6-8 weeks, scan and review at 6 months, 1 year, 2 years, 3 years, 5 years, review only 7 years, 10 years. The 1 year, 3 year and 7 year reviews may be conducted via telephone assessment if appropriate.

**Post surgery & radiotherapy for lateral and anterior skull base malignancy**: 1st year 6-8 weekly; 2nd year 3 monthly; 3rd, 4th and 5th year 6 monthly. The majority of the follow up may be performed at the local Head and Neck Cancer Centre to prevent excess travel to CUHFT. Baseline imaging will take place at 3 months at CUHFT. Further imaging is performed if there are concerns. Ongoing FU is tailored to individual needs, taking into account patient choice, but at the discretion of the SBMDT.

Patients are discharged dependent upon their pathology. Patients have lifelong access to the SBMDT Clinic via their key worker or any other SBMDT member.

### 26.6 Discharge Planning and Discharge from Hospital

All skull base patients are reviewed by their clinical team and/or other specialist if appropriate, e.g. dietician at Addenbrooke’s Hospital before discharge; to enable accurate and prompt referral-on details and planned follow-up care confirmed on liaison with relevant colleagues in the locality.
Discharge documents are prepared by the medical team and include past medical history, diagnosis, procedure, follow up arrangements and medication. These documents will be communicated to the GP and local clinical team.

26.7 Dietetics
Dietetics for all Skull Base Tumour patients will be coordinated by their local support teams where possible. Referrals at CUHFT can be made via the hospital EPIC system.

26.8 Speech and Language Therapy (SALT)
Continuing rehabilitation of all Skull Base Tumour patients will be coordinated by their local support teams where possible.

26.9 Psychological and Social Support
Access to social skills training and cognitive-behavioural therapy will be available through the clinical neuropsychologist or neuropsychiatrist at Addenbrookes. The local support team also link in with necessary teams in the community for social skills training. The local support team provides level 2 psychological support and holistic needs assessment where required. If appropriate, patients are referred onto psychological services by the local support team. NF2 patients have access to a named psychologist at CUHFT as part of the nationally commissioned service.

26.10 Audiology
Audiology are integrated into our multidisciplinary skull base clinic. They offer a full range of hearing, balance and tinnitus rehabilitation and local referrals to other audiology teams are made where appropriate. We also have a hearing implant centre in our unit and are able to offer patients the full range of hearing implants including bone conduction hearing implants, middle ear implants, cochlear implants and auditory brainstem implants.

26.11 Ophthalmology
We have oculoplastic surgeons (Mr Rene and Mr Woodruff) and neuro-ophthalmology (Miss Muthusamy) integrated into our service as extended team members, facilitating assessment and treatment of ophthalmic issues related to our patient’s skull base tumours.

26.12 Facial Palsy and Facial function service
Mr Price, Consultant Plastic Surgeon has a special interest in facial palsy and runs a facial palsy clinic twice monthly at the same time as our skull base clinic, facilitating patient flow for assessment and treatment of facial palsy. He offers a wide range of surgical options for facial rehabilitation. We refer elsewhere for patients who require facial physiotherapy.

26.13 Vestibular assessment and physiotherapy
Referrals are made to the specialist audiology and physiotherapy team for vestibular assessment and physiotherapy where required. A full service is available at CUHFT and some assessment and treatment can be carried out more locally as appropriate and as per patient preference.
26.14 Endocrinology
Referrals are made to the endocrinology team for pre and post treatment assessment as required via the hospital ordering system EPIC. Where possible, local follow up will be coordinated.

26.15 Clinical Genetics
Referrals are made to the clinical genetics team for assessment, diagnosis and genetic counselling as appropriate. An on call member of clinical genetics is available via telephone to discuss any cases where the need for referral is unclear. Established pathways are in place for NF2, juvenile nasopharyngeal angiofibroma and familial paraganglioma. Patients with rare skull base pathologies are able to participate in the 100,000 Genomes Project as per local guidelines.

SECTION 3 - PATIENT EXPERIENCE

27 PATIENT AND CARER FEEDBACK (INDICATOR 202)

27.1 National Cancer Patient Survey
CUH participated in the National Cancer Patient Experience Survey 2016. Skull base cancers are not included in terms of tumour group comparisons so there is no available service specific information.

27.2 Cancer Patient Partnership Group (CPPG)
The Cancer Patient Partnership Group at CUH is an inclusive group covering all cancer sites; the group is led by the newly appointed Macmillan Co-Production lead who works with the CPPG to improve services for patients.

27.3 Cancer Support Groups
Patients will have access to national support groups such as the British Acoustic Neuroma Association including its sister group AMNET, and more local Head & Neck and Brain cancer support groups. Members of the core skull base MDT attend an annual meeting with AMNET to discuss patient experience and any issues experienced by its members on an annual basis. Patients can be referred both to in-house Macmillan and Maggie’s Cancer Centre services which both operate on the hospital site at CUHFT.
28 **CLINICAL TRIALS**

- Mr James Tysome, Consultant Skull Base & Hearing Implant Surgeon, is responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the NDSG.
- An annual report is submitted to the NDSG in order to document participation in relevant trials and is available via the Anglia Cancer Network website [www.angliacancernetwork.nhs.uk](http://www.angliacancernetwork.nhs.uk).
- The SBMDT is committed to participation in high quality research studies and clinical trials. Whenever possible patients should be considered for inclusion in local and national research studies and clinical trials.
- The Clinical Trials Practitioner is a member of the extended SBMDT. Entry into a suitable research study or clinical trial will be considered at the SBMDT meeting where the patients’ management is discussed, and the Clinical Trials Practitioner/CNS will advise on the study protocol requirements.
- The research study or clinical trial will be offered to the patient initially by the treating Surgeon, Oncologist or CNS, according to the nature of the research treatment. This will often take place at the out-patient clinic visit, but may be discussed with the patient on the ward.
- The Clinical Trials Practitioner/CNS will liaise with the patient and with relevant members of the SBMDT to ensure the patient is provided with sufficient information to reach a decision regarding participation in the research study.
- If the patient agrees to participate in the research study, the Clinical Trials Practitioner/CNS will coordinate a suitable visit for the patient to give written informed consent.
- Written informed consent can only be taken by a person with delegated responsibility from the Principal Investigator for the study.
- The Clinical Trials Practitioner/CNS will communicate with relevant members of the SBMDT and wider clinical teams to coordinate the patient’s treatment according to the study protocol.
- All aspects of the process of recruiting a patient to a research study will be recorded in the patient’s notes.
- Where patients have been enrolled into a clinical trial, separate follow-up arrangements must be followed that adhere to the protocol requirements for that clinical trial.
- The SBMDT will discuss the details of potential new studies and a decision made as to whether to participate. The SBMDT will produce a written response at least annually to the Brain and CNS NCG’s approved list of clinical trials and other well designed studies to include:
  - That the SBMDT agrees to enter patients or states the reasons it is not able to
  - The remedial action arising from the SBMDT’s recruitment results, agreed with the NCG

29 **MINIMUM DATASET**

The Cancer Outcomes and Services Dataset (COSD) is routinely collected by all MDT’s, data capture takes place live in MDT meetings by all members of the clinical team.
The Systemic Anti-Cancer Therapy (SACT) dataset is routinely collected by clinical members of the team within Oncology.

29.1 Cancer Outcomes and Service Dataset (COSD)
The Cancer Outcomes and Services Dataset (COSD) is routinely collected by all MDT’s, data capture takes place live in MDT meetings by all members of the clinical team. Data is then validated and submitted on a monthly basis; MDTs have access to data quality reports so they can amend/input any missing data relevant to their service. Historically data collection for this Dataset has been a challenge due to the bespoke nature of the new patient administration system EPIC, a project has taken place over the last year to ensure that data capture and quality improves.

29.2 Systemic Anti-Cancer Therapy (SACT)
The Systemic Anti-Cancer Therapy (SACT) dataset is routinely collected by clinical members of the team within Oncology. Data capture is taken live from the electronic patient administration system EPIC, data is then validated prior to the monthly submission. The team is working to ensure data quality improves and there is an action plan in place for 2017.

29.3 Cancer Waiting Times
The MDT will facilitate the monitoring of Cancer Waiting Times through MDT/pathway Coordinator roles, and will include the cumulative waiting time for patients in the discussion and planning of their pathway.

30 AUDIT (INDICATOR 010)
The MDT has a proactive specialist multidisciplinary audit programme. Results of all audits undertaken will be fed back to all MDT members annually. The team are committed to implementing at least one action point arising from the patient experience exercise.

The MDT undertakes to participate in Network audit projects agreed with the SSG. The MDT participates in the national vestibular schwannoma audit via ORION.

Results and actions from audits can be found in the Annual Report.
Appendix 3: SBMDT Referral and Outcome Proforma

Skull Base SMMDT Meeting Referral Form

1. Please complete and return this form by e-mail to the SMMDT co-ordinator or hand to CNS Lead Nurse within 24 hours of the Decision to Refer (DTR) the patient.

2. All SMMDT referrals must be received no later than 5pm on Wednesday.

3. All mandatory fields in bold must be completed for this referral to be processed. Please note, any omissions or incomplete patient information may lead to deferment.

E-mail: act-tr.nhs.net (Outside Referrals) Please put ‘skull base’ in the subject heading
hospital@nhs.net (Internal Referrals)

Direct Dial: 01223 74427 (Extn 4427) Fax: 01223 747 457

<table>
<thead>
<tr>
<th>Date of MDT:</th>
<th>Referring Hospital:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Referring Clinician:</td>
</tr>
<tr>
<td>NHS No:</td>
<td>Who is the named</td>
</tr>
<tr>
<td>Hospital No:</td>
<td>designated contact at</td>
</tr>
<tr>
<td>DOS:</td>
<td>referring hospital:</td>
</tr>
<tr>
<td>Address &amp; post code:</td>
<td>Phone &amp; Facsimile:</td>
</tr>
<tr>
<td>Patient Tel Contact No:</td>
<td>GP Name, Address &amp; post code:</td>
</tr>
</tbody>
</table>

Where is the patient?

Red to accepting team? Y/N

<table>
<thead>
<tr>
<th>Fast track/ Urgent 2 week wait (62 day pathway)</th>
<th>Decision to Refer by GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tunnel attached:</td>
<td>Consultant Referral?</td>
</tr>
<tr>
<td>Date</td>
<td>Trust Receipt Date Of Referral</td>
</tr>
</tbody>
</table>

Has FDT (first definitive treatment) taken place? If so, what was it and where?

Waiting time adjustment?

Consultant Upgrade? Y/N if so, when?

18 week information:

Is the patient on an 18 week RTT pathway? Y/N

If yes, is this the referral for an existing pathway or the start of a new pathway?

Combination of EXISTING pathway | Start of a NEW pathway | Combination of STOPPED pathway |
|--------------------------------|------------------------|--------------------------------|

Is this referral for:

Diagnostic Tests only | Opinion only |

Other organisations in the pathway

Unique pathway identifier: (generated with cognate referral)

Allocated by (code):

Person who received cognate referral:

Latest 18 week clock start date: Day Month Year

Date of decision:

To onward refer:
## Skull Base SMDT Meeting Referral Form

<table>
<thead>
<tr>
<th>Reason for referral to SMDT</th>
<th>New patient / Follow-up</th>
</tr>
</thead>
</table>

### Working Diagnosis
- History
- Co-morbidity

### Imaging
- MRI

### MDT discussion:

### MDT action:

Copies to referring clinician, GP, Addenbrooke's notes

Nov 10