

Central Cancer Network Head & Neck Advisory Group Meeting




1st May 2009

Attendees	Apologies
Shirlee McLean Francis Hall David Hamilton Brian Sheppard Simon Allan Monica O'Reilly Jo Anson Nik Nedev Deb Rippingham Toni Webber Stephanie Fletcher (minute taker)	Craig McKinnon Derek Goodisson David Grayson Andrew Campbell-Stokes

Items	Discussion/Comments	Actions
Welcome and Introductions	Simon Allan opened the meeting, welcomed and introduced all participants	
Previous Minutes	Minutes (24 October 2009) had been circulated and approved by email.	
Matters Arising	<ul style="list-style-type: none"> Regional Credentialing. There was no update at this stage as the meeting with DHB CEOs had not yet taken place. Andrew Campbell-Stokes to report back on progress once this has happened. 	
MDM Paper and Recommendations	<ul style="list-style-type: none"> Shirlee spoke to the document prepared by Adel Gray. It was noted that Head and Neck MDMs have been running at MCH for 10 years + and not the 4 years as reported. Shirlee explained that the CCN MDM framework was developed to assist cancer teams with the effective and efficient functioning of existing MDMs. It does not presume that 'one size fit all' in terms of multidisciplinary working in cancer services. Instead, the framework recognises the need to adopt the structure and functions of a multidisciplinary team according to local needs and circumstances. The framework is not intended to be overly prescriptive. The process of MDMs at MDHB, HVDHB and CCDHB was discussed. Both David and Nik shared how H&N MDM meetings functioned at both MCH and CCDHB. CCDHB have a radiology SMO and pathology SMO attend their twice monthly MDMs. Due to staff shortages they are not able to attend the whole meeting, but are present during the first half hour of the meeting when all new cases are discussed. The HVDHB MDMs are well attended by medical staff including a radiation oncology SMO. There is no pathology input at the HVDHB MDMs or regular diagnostic radiology input, although a willingness to attend is indicated. It was noted that there is a national shortage of Radiologists which limited their availability at MDMs. Nik agreed that it would be beneficial for him to attend the H&N MDM at CCDHB and David to attend the same meeting at MDHB. Jo asked if there was an opportunity for a Radiologist from outside MCH to attend. Nik said they would be most welcome but the time commitment of 2 hours per meeting, plus travel, for maybe 2 minutes of 	<p>Agended for next meeting for update.</p> <p>Nik and David to attend respective H and N MDMs to establish areas of commonality.</p>

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	<p>input was a challenge. In absence of a Radiologist it was acknowledged that other models should be explored. It was also noted that CCDHB have 50% staffing in radiology currently. Pacific Radiology previously attended CCDHB H&N MDMs in a private capacity but are no longer available due to high workloads. MDHB is expecting a new Radiologist which may alleviate the problem for that DHB</p> <ul style="list-style-type: none"> • H&N MDMs are not currently minuted at CCDBH. This raised concerns regarding a paper trail for decision making. David advised that parts of the discussion are summarised in a letter to the patient's GP. There was some discussion regarding the process if consensus was not reached in the meeting. MDHB H&N MDMs are minuted by the Chair, but this is summarised in a letter to the referred and a copy included in the patients notes and not documented as a separate record. • The above lead to discussion regarding need for administrative support to minute meetings, and have a MDM Co-ordinator position. Jo advised that MOH are currently examining purchase unit for MDM and there is a potential for a MDM Coordinator role to come out of this. • HVDHB H&N MDMs held 2nd and 4th Wednesday pm. CCDHB – 1st and 3rd Thursdays. The availability of 4 clinics within the Wellington region means there should not be any lengthy delay in consultation. MDHB 1st and 3rd Friday with an additional meeting if 5 weeks in month. Not an ideal situation as public holidays etc can delay referral. • It was agreed that a benchmark standard would be of benefit. • There was a discussion regarding the UK recommendations for Head and Neck MDMs. Team work, conflict resolution etc were discussed. No specific outcome was reached. 	
Radiotherapy Codes and database	<ul style="list-style-type: none"> • It was confirmed that the radiotherapy codes were diagnosis codes not procedure codes. • The question posed was 'is a breakdown of radiotherapy procedures necessary and would it add value'? • Discussion around merits of being able to identify procedures for radiotherapy which would allow auditing of the framework and monitoring of the patient's journey. • Use of Lantis database discussed and the limitations of this. All cancer centres in NZ almost certainly use Lantis or an upgraded version of. Otobase from University of Washington discussed vs the ease of access to Microsoft Excel databases. Microsoft excel can convert to SPPS. • CCN to do comparison of databases as per recommendation 3 of the report by Andrew Campbell-Stokes. • CCN to explore whether the MDM purchase unit will include data capture. • CCN to advise the National Data Capture Working Group that the regional H&N Advisory Group is actively exploring databases for H&N and see if there is help available via national IT team. 	<p>CCN to action</p> <p>CCN to action</p> <p>CCN to action</p>
CCN Priorities Discussion	<p>The MOH has signalled to DHBs and the Regional Cancer Networks that the focus on lung and bowel cancer is a priority area. However there is also a focus for 2009/10 on improving access to cancer treatment and improving waiting times (both surgical and non surgical) for vulnerable groups. The following points were raised in relation to this.</p> <ul style="list-style-type: none"> • The issue is 'when does the clock start ticking' with regard to waiting times, e.g. when patients are biopsied, at the time of FSA etc. • Query whether earlier tumour streams started should be completed prior to commencing new ones. Jo advised implementation plans for those tumour streams already commenced could take some time 	

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	therefore new tumour streams will be started shortly.	
Head and Neck Pathway Planning	There was some discussion about the approach for the H&N pathway mapping. The lung report was a district based approach however for H&N an issues based approach similar to that undertaken by the Northern Cancer Network may be more appropriate for this tumour stream.	 Tumour Stream Mapping Methodology
Regional H and N Referral Guidelines	<ul style="list-style-type: none"> Regional guidelines for referral between the 8 DHBs were discussed; there are currently no formal referral guidelines which potentially poses a problem. The guidelines need to address ownership for MDM decisions. This ownership is currently being explored by CCN as part of the MDM implementation plan. 	CCN to develop referral guidelines in conjunction with Nik and David Hamilton CCN to progress
Post treatment Issues	A concern was raised that patients who are required to have their teeth removed prior to treatment must fund replacement themselves; this is not funded as part of the rehabilitation of the patient. The same applied to patients who required hearing aids following treatment. <ul style="list-style-type: none"> CCN will follow up with Radiation Oncology Trust Fund and Cancer Society to see how many patients with H&N cancers were funded for hearing aids and dentures. CCN will check ACC guidelines to establish whether treatment related injuries mean you can get ACC cover, as a possible avenue for dentures and hearing aids. 	CCN to progress CCN to progress
Head and Neck Advisory Group	Jo asked the current members to give consideration to widening the representation of the group to include Cancer Society, and a representative from the DHB Cancer Centre Managers.	

Meeting closed 1200 hrs