NHS England

B16/S/a

**2013/14 NHS STANDARD CONTRACT**
**FOR CANCER: HEAD AND NECK (ADULT)**

**SECTION B PART 1 - SERVICE SPECIFICATIONS**

| **Service Specification No.** | B16/S/a |
|---|---|
| **Service** | Cancer: Head and Neck (Adult) |
| **Commissioner Lead** | |
| **Provider Lead** | |
| **Period** | 12 months |
| **Date of Review** | |

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## 1. Population Needs

### 1.1 National/local context and evidence base

The purpose of this document is to provide a national specification for the care of head and neck cancer patients. It aims to cover the whole pathway for head and neck cancer whilst specifically focusing on the specialist elements. It is intended for both commissioners and service providers.

The specialist head and neck cancer multidisciplinary team service(s) will deliver high quality clinical care to patients with suspected head and neck tumours and specialist surgical treatment for patients with a confirmed diagnosis of one of the head and neck cancers. Specialist thyroid multidisciplinary teams should treat patients with thyroid cancer and work closely with the specialist head and neck service.

The aim of the specialist head and neck cancer multidisciplinary team service is to deliver the key service standards including specialist thyroid multidisciplinary team, as specified in the Improving Outcome Guidance in Head & Neck Cancer (2004), the National Cancer Peer Review Programme Manual for Cancer Services: Head & Neck Cancer measures (2011) and Cancer Waiting Times.

The specialist head & neck cancer multidisciplinary team service(s) should work closely with primary care and palliative care service and be provided by local cancer networks local arrangements for specialist head & neck multidisciplinary team and specialist thyroid multidisciplinary team. This service specification should be read in conjunction with the service specification for specialist thyroid.



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**Evidence base:**

This specification draws its evidence and rationale from a range of documents and reviews as listed below:

- Level 1

**Department of Health:**

- Improving Outcomes ;a Strategy for Cancer – Department of Health (2011)
- Cancer Commissioning Guidance – Department of Health (2011)

**NICE:**

- Improving Outcomes Guidance (IOG): Head and Neck Cancer – NICE (2004)
- Guidance on Cancer Services – Improving Outcomes in Head and Neck Cancers – The Research Evidence NICE (2004)
- Improving Supportive and Palliative Care for adults with cancer – NICE (2011)
- National Cancer Peer Review
- National Cancer Peer Review handbook – NCPR, Nation Cancer Action Team (2011)
- Manual for Cancer Services: Head and Neck Measures Version 2.0 – NCPR Nation Cancer Action Team (2011)
- Manual for Cancer services Acute Oncology Measures NCPR, National Cancer Action Team (April 2011)
- Manual for Cancer Services Chemotherapy Measures – NCPR, National Cancer Action Team (June 2011)

**Other**

- Chemtherapy Services in England. National Chemotherapy Advisory Group (2009)
- Changing Faces: www.changingfaces.org.uk/home
- Macmillan Cancer Care: www.macmillan.org.uk/home

**General Overview**

Head and neck cancer refers to a group of biologically diverse cancers that start in the Upper Aerodigestive Tract (UAT), including:

- Oral Cancer (mouth, lip and oral cavity)
- Cancer of the larynx (voice box)
- Cancer of the pharynx (throat)
- Thyroid cancer (please see below)
- Other head & neck cancers

The majority of non thyroid head and neck cancers are squamous cell carcinomas. Head and neck cancers often spread to the lymph nodes of the neck, and this is often the first sign of the disease at the time of diagnosis.

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Head and neck squamous cancer is strongly associated with certain environmental and lifestyle risk factors, including alcohol and smoking.

In 2009, there were approximately 9,400 newly diagnosed head and neck cancers in England. The overall crude incidence rate for head and neck cancers is approximately 18.1 per 100,000 population. This includes cancers of the oral cavity (2,250 cases, 4.4 per 100,000 population), larynx (1,800 cases, 3.5 per 100,000 population), oropharynx (1,500 cases, 3.0 per 100,000 population), nasopharynx (200 cases, 0.4 per 100,000 population), hypopharynx (400 cases, 0.8 per 100,000) and thyroid (2,000 cases, 3.9 per 100,000 population).

**Mouth, lip and oral cavity (oral cancer):**

Oral cancer has the highest incidence of the head and neck cancers and is increasing in incidence, and like other cancers of the UAT and respiratory system, it is more common in men than in women. Approximately 90% of oral cancers are squamous cell carcinomas, arising from the lining of the mouth, most often the tongue and the floor of the mouth.

The most common symptom of oral cavity cancer is a persistent sore or lump on the lip or in the mouth, but there may also be pain and/or a lump in the neck. Other symptoms are a white or red patch on the gums, tongue or lining of the mouth, and unusual bleeding, pain or numbness in the mouth.

**Cancer of the larynx**

Virtually all cancers of the larynx are squamous cell carcinoma. Symptoms may include chronic hoarseness, pain or problems with swallowing (dysphagia), or can also be a lump in the neck, sore throat, earache, or a persistent cough.

**Cancer of the pharynx**

Cancer of the pharynx occurs in three principal locations: the oropharynx, (includes the under surface of the soft palate), the base of the tongue and the tonsils, the hypopharynx (bottom part of the throat), nasopharynx (behind the nose).

Cancers of the oropharynx and hypopharynx are, like oral cancer and cancer of the larynx, usually squamous cell carcinomas which originate in the epithelial cells that line the throat. Cancer of the nasopharynx has a different aetiology and natural history. The symptoms of cancer of the pharynx differ according to the type.

- For oropharynx, common symptoms are a persistent sore throat, lump in the mouth or throat, and otalgia (pain in the ear).
- For hypopharynx, problems with swallowing and ear pain are common symptoms and hoarseness is not uncommon.
- Nasopharynx cancer is most likely to cause a lump in the neck, but may also cause nasal obstruction, deafness and post-nasal discharge.

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**Thyroid cancer**

Thyroid cancer is a thyroid neoplasm that is malignant. It is most likely to develop in women of reproductive age. It is treated initially by surgery (usually total thyroidectomy) followed by radioactive iodine ablation. In a small number of cases external beam radiotherapy may be used. It usually presents as a solitary nodule in a patient with normal thyroid hormone levels, other less common symptoms include swollen glands in the neck (cervical lymphadenopathy), hoarseness, difficulty in breathing or swallowing, changes in voice, and discomfort in the neck.

**Other cancers of the head and neck**

There are a wide range of other cancer sites and rarer pathologies of the head and neck. There are around 600 cases of cancer of the salivary glands each year, which mainly occur in the parotid gland. Not all salivary gland tumours are diagnosed by head and neck multidisciplinary teams and some patients undergo surgical excision by general surgeons. However all diagnosed salivary cancers should be discussed and managed in a head and neck multidisciplinary team. Neck lump pathways referring patients to head and neck multidisciplinary team members are improving the situation following implementation of improving outcomes guidance in 2004. Cancers of the nasal cavity, middle ear and accessory sinuses make up the majority of the other head and neck cancers, along with bony tumours of the jaw, peripheral nerves, connective and soft tissues. For sarcomas of the head or neck - please refer to the specialist sarcoma service specification.

Skull base cancers form a subset of rarer head and neck cancers, and should be managed by a dedicated skull base team. Skull base cancers either arise from the accessory sinuses (anterior skull base) or originate in soft tissue adjacent to the temporal bone (bone which contains the ear) –lateral skull base and originate in soft tissue.

Advanced skin cancers adjacent to the ear and nose are frequently managed by members of the head and neck multidisciplinary team.

**2. Scope**

**2.1 Aims and objectives of service**

The overall aims and objectives of the services are:

- To provide an exemplary and comprehensive service for all referred patients with head and neck cancers that are delivered in line with the Improving Outcome Guidance and Cancer Waiting Times.
- To provide expert diagnosis of head and neck cancers utilising the most up- to-date validated diagnostic tools and knowledge.
- To provide expert management of patients with confirmed head and neck

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cancers through the use of the most up-to-date clinical protocols and surgical management agreed with local cancer network.

- Clinically appropriate consideration and provision of surgery within the head and neck cancer patient pathway.
- Effective monitoring of patients to ensure optimal functioning and quality of life for the patient with regards to their head and neck cancers.
- To ensure that all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines and are monitored by objective audit.
- To provide care with a patient and family centred focus to maximise the patient experience
- To support local healthcare providers to manage patients with head and neck cancer whenever it is clinically appropriate and safe to do so.
- Provide high quality information for patients, families and carers in appropriate and accessible formats and mediums.
- To ensure that there is involvement of service users and carers in service development and review
- To ensure compliance with Peer Review Measures
- To ensure compliance with Care Quality Commission regulations

The specialist head & neck cancer service should work closely with primary care and palliative care service and be provided by, local cancer networks local arrangements.

Specifically the specialist head & neck cancer multidisciplinary team service(s) aims to provide:

- High quality holistic care delivered through a multidisciplinary team, with a specialist interest in head and neck: three or more designated surgeons including ear, nose and throat (ENT), maxillofacial, or plastic surgeons; two clinical oncologists - one to undertake responsibility for chemotherapy, restorative dentists, pathologists with expertise in both histopathology and cytopathology, radiologist, clinical nurse specialists (CNSs), speech and language therapist, senior nursing staff from the head and neck ward, palliative care specialist (doctor or nurse), dietician, team secretary, data manager and multidisciplinary team co-ordinator. (These last 3 posts may be the same person). Thyroid multidisciplinary teams should also include an endocrinologist and a nuclear medicine specialist.
- Radiological, pathological and diagnostic facilities to effectively diagnosis, classify and stage the condition prior to planning treatment
- To advise and undertake investigations to proceed to surgical treatment options if clinically indicated.
- High quality surgical treatment of patients with Upper Aerodigestive Tract
- (UAT) cancer (and thyroid cancer)
- High quality oral rehabilitation
- Long term surveillance after definitive treatment
- Continuous monitoring of risk and governance to ensure that clinical treatment is safe and effective

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- Clinical and service audits including contributing to the National Head and Neck Cancer audit (DAHNO) to ensure highest standards of safety, care and clinical effectiveness including of communication systems and cross referral between all levels of service network.
- Recruitment of patients to the National Cancer Research Institute head and neck trials portfolio.
- The specialist head & neck cancer service should treat the UAT cancers and should deal with a minimum of 100 new cases a year.
- Whereas the specialist thyroid multidisciplinary team should treat patients with thyroid cancer and cover at least one million population.

The service is required to agree the following areas with their local cancer networks:

- Service configuration and population coverage
- Develop and agree referral criteria and pathways, clinical protocols, network policies (including local surgical policies) and treatment pathways
- Actively engage and participate with the local network groups and Peer Review for Head & Neck Tumours
- Clear developed emergency protocols and pathways that enable rapid access for treatment of infections as outlined in the Improving Outcomes Guidance for Acute Oncology.

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**2.2 Service description/care pathway**

The specialist head & neck cancer service(s) is commissioned to deliver high quality clinical care to patients with suspected head and neck tumours and provide specialist surgical treatment for patients with a confirmed diagnosis of one of the head and neck cancers. The specialist thyroid multidisciplinary team should treat patients with thyroid cancer and work closely with the specialist head & neck service.

The specialist head & neck cancer service is required to treat a minimum of 100 new cases of upper aero-digestive tract (UAT) cancer per annum (excluding glandular tumours). The service should agree with their local network the range of specialist / skills required to deal with the range of patients treated by the head & neck multidisciplinary team, including a core membership of:

- Surgeons: three or more designated surgeons including ear, nose and throat (ENT), maxillofacial, or plastic surgeons.
- Two clinical oncologists
- Restorative dentists
- Pathologists with expertise in histopathology and cytopathology but could be done by the same person
- Radiologist
- Clinical nurse specialists (CNSs)
- Speech and language therapist
- Senior nursing staff from the head and neck ward



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- Dietician.

A combined UAT/thyroid multidisciplinary team should also include;
- Endocrinologist;
- Nuclear medicine specialist

**NB:** The service is required to have, or has access to, surgeons who are proficient in reconstruction, including micro-vascular techniques.

A member of the core team should be nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the multidisciplinary team.

An NHS employed member of the multidisciplinary team should be nominated as having responsibility for user issues and information for patients and carers.

**Extended team members**

The extended team should be made up of designated professionals who have an interest in head and neck cancer and experience of dealing with these patients, including:
- Anaesthetist with a special interest in head and neck cancer
- Gastroenterologists, radiologists, surgeons, and other health professionals with expertise in gastrostomy creation, feeding tube placement and support for patients who require tube feeding
- Ophthalmologist
- Pain management specialist
- Therapeutic radiographer
- Maxillofacial/dental technician
- Dental therapist/hygienist
- Benefits advisor
- Clinical psychologist
- Physiotherapist
- Occupational therapist
- Neurosurgeon (for skull base)
- Neuro-otologist (for skull base)
- Palliative care specialist (doctor or nurse)

**Thyroid cancer multidisciplinary teams**

The specialist thyroid cancer service is required to cover a population base of over one million. The configuration of this team may take one of two alternative forms, as agreed with the local cancer network, and may be either:
- Designated head and neck cancer teams, joined by experts in endocrinology for the relevant part of the multidisciplinary team meeting; or
- Specialised endocrine oncology teams.

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**Members of the thyroid cancer multidisciplinary team**

- Endocrinologist
- Surgeon who specialises in thyroid/endocrine oncology
- Clinical oncologist
- Radiologist
- Nuclear medicine specialist
- Specialist pathologists (both histopathology and cytopathology and could be done by the same person)
- Clinical nurse specialist (who may be a head and neck cancer CNS)
- Multidisciplinary team co-ordinator/secretarial support.

**NB:** One or more members of the team must be trained and certificated to give radioiodine.

Each specialist head & neck multidisciplinary team, or specialist thyroid multidisciplinary team, should have a single named lead clinician who is also a core team member.

The specialist head & neck cancer service will deliver the service in line with the following:

- Review the pathological and radiological basis for the diagnosis of head and neck cancer and make recommendation for treatment (surgery, radiotherapy, chemotherapy, palliative interventions and supportive care)
- The surgical team, as part of the multidisciplinary team should liaise with the oncologists to plan multi-specialty treatment as required per designated treatment protocols. Individuals work together with the same aims and clinical understanding of the condition and its management to create a multidisciplinary team approach. The team will ensure that:
  - All patients are discussed at the appropriate specialist multidisciplinary team
  - All curative surgical treatment is undertaken in a designated hospital
  - All radical surgery is carried out by the designated specialist head & neck multidisciplinary team surgical teams
  - Inpatients are reviewed daily on a ward round supported by the appropriate designated consultant and oncological surgeon with input from the core multidisciplinary team as clinically required. Care plans are clearly documented in the notes. Relevant investigations will be carried out. Any referred patients that are waiting for admission are discussed and the plan to admit them as soon as possible is reviewed with any actions required updated.
  - There is a weekly multidisciplinary team led by the designated consultant lead (could be doctor, CNS or Allied Healthcare Professional) and oncological surgeons to discuss the needs of each newly referred patient (and other patients as required) in detail and review other non-surgical aspects of their care.
  - The providers will hold other meetings regularly through the month to

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address clinical, service delivery and governance issues.
- There are agreed clinical protocols for the oncological treatment of patients with head and neck cancers.
- Audit is an integral part of improving the delivery of care and an on
- going audit programme including submission of data to the National Clinical Audit (DAHNO) provides the evidence to improve and
- Enhance the delivery of the clinical care provided.
- Actively recruit to national clinical trials

**Access to diagnostic and staging**

*Diagnosis*

The service should develop with primary care, local head and neck services and their local cancer network locally agreed guidelines on appropriate referral for patients with suspected head and neck cancer in line with national guidelines and best practice. Compliance with these guidelines should be audited.

Investigations should include:
- Direct inspection
- Flexible endoscopy
- Thyroid function tests (for suspected thyroid cancer)
- Chest x-ray (for all suspect UAT cancer)
- Holistic assessment including clinical, nutritional and sychological assessed
- Biopsy
- Fine needle aspiration cytology
- Cytopathology
- Histopathology

Patients should be seen by designated clinicians and have access to:
- Fast track diagnosis clinics
- Specialist lump clinics
- Triage for lumps of the thyroid gland
- Pre-admission clinics

Imaging:
- The service should ensure that chest x-ray / Ultrasound / CT scanning / MRI / PET-CT should be available to the patient as part of the pathway
- The service should agree imaging modalities and their specific indications
- The responsibility for the scan, its interpretation and any decision to inform treatment lies with the specialist head & neck cancer service.
- When symptoms or imaging clearly show that the disease is metastatic or inoperable, or the patient is not sufficiently fit to undergo radical treatment, the team is to consider the appropriate palliative treatment.

Pathology:
- Histological confirmation of tumour is, however, required before treatment

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with chemotherapy or radiotherapy.
- The pathology services should comply with Clinical Pathology Accreditation (UK) Ltd (CPA)1[1] and the Human Tissue Authority (HTA).2

Treatment:
- All possible management options should be discussed with patients. The treatment each patient receives should be tailored to fit his individual values and situation, so it is essential that patients are actively involved in decision-making. This requires that they receive adequate and accurate information, both through meetings with members of the multidisciplinary team, and in published forms that they can study at home. Patients should be given sufficient time to consider all the options available to them.
- A range of surgeons who specialise in different aspects of head and neck cancer should be available to work together for complex surgery including tumour removal and reconstruction. In addition, 24 hour emergency surgery is to be available for management of impending flap failure. Appropriate rehabilitation support should be available to meet patient need. Increasingly enhanced recovery is starting to be adopted in head and neck surgery and providers are encouraged to adopt this approach where possible.
- The service should provide the following treatments in agreed network clinical policies for the specific cancers:

Treatments include:
- Radical & reconstructive surgery to include microvacula reconstruction
- Transoral Laser excision
- Partial and total laryngectomy
- Surgical voice restoration
- Thyroidectomy
- Radio isotope ablation
- Radiotherapy
- Chemotherapy
- Chemo radiotherapy
- Skull base surgery
- Supportive and palliative care

**Pain**

Patients may have some pain or discomfort for a few days after their operation. It is important for doctors and nurses to assess pain relief and ensure this is addressed.

**Chemotherapy and Radiotherapy**

Chemotherapy and radiotherapy are important components of the treatment of some patients and should be carried out at designated centres by appropriate

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[1] CPA, the principle accrediting body of clinical pathology services and External Quality Assessment (EQA) Schemes in the UK. Modernising Pathology Services. Department of Health (2004)
[2] HTA Regulatory body for all matters concerning the removal, storage, use and disposal of human tissue. www.hta.gov.uk



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specialists as recommended by the head and neck cancer service.

There should be a formal relationship between the specialist head & neck cancer service(s) and the provider of non-surgical oncology services that is characterised by agree network protocols, good communication, and well- defined referral pathways. This relationship should be defined in writing and approved by the cancer network director and the lead clinician in the specialist head & neck multidisciplinary team and specialist thyroid multidisciplinary team.

Radiotherapy should be offered, in line with Improving Outcomes Guidelines for Head and neck Cancers and guidelines from the Royal College of Radiologists Audits of compliance with these protocols will need to be demonstrated.

Refer to the following documents for more detailed description of these services:

- Adult Systemic Anti-Cancer Therapy (SACT/chemotherapy) service specification
- Radiotherapy Model Service Specification 2012/13

**Follow up**

The Improving Outcomes Guidance series of documents made recommendations on follow-up care. Providers will need to adhere to cancer specific guidelines for follow up agreed through the network site specific group (NSSG) and ensure patients have a follow up plan. The cancer specific guidelines will identify that some patients will need to continue receiving follow up from the specialised service but it is expected the majority will be able to receive follow up locally.

The provider will need to ensure effective hand over of care and / or work collaboratively with other agencies to ensure patients have follow up plans appropriate to their needs.

Patients with thyroid cancer are required to have lifelong follow up to identify recurrence and maintain appropriate level of thyroid hormones.

**Rehabilitation**

There should be appropriate assessment of patients' rehabilitative needs across the pathway and the provider must ensure that high quality rehabilitation is provided in line with the network agreed head and neck cancer  rehab pathway at:

- www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation

Patients with head and neck cancers often have significant psychological and emotional challenges in coping with potential disfigurement and the consequences of treatment.  Healthcare professionals need to actively address these issues as well as manage the direct affects following treatment of the cancer. Patients should also be directed to support groups and information to help them cope with the consequences of their treatment.

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**Changes in sensation (numbness)**

Depending on the area of the head or neck that has been operated on, surgery may affect the sensation in the mouth, face, neck or shoulders, and some areas may feel numb. It may take several months for nerves to heal and for normal sensation to come back.

If the patient has an external scar after the operation, it is common to have numbness in the skin around the area. It may take several months for normal sensation to return. Occasionally, the only way to remove all of the cancer is by cutting the nerve. If this happens, the changes in sensation can be permanent.

**Speech**

The throat, nose, mouth, tongue, teeth, lips and soft palate are all involved in producing speech. Any operation that changes one of these parts of the head and neck may affect the patient's speech.

**Swallowing**

Following surgery when the patient is ready to start taking fluids and food by mouth, they will be seen by a speech and language therapist. The patient may find chewing or swallowing difficult, and should be advised about the safest and easiest types of food to have. Patients should also be taught mouth and jaw exercises that will improve swallowing.

**Difficulty opening the mouth due to a stiff jaw (trismus)**

Some operations to the back of the mouth and throat can lead to a stiff jaw and patients will require exercises to prevent this from becoming a permanent problem.

**Changes to appearance**

The surgeon and specialist nurse will talk over the possible changes in appearance with the patient before the operation. It's important that patient's have a clear idea of what to expect both post surgery and longer term.

Patients can often take some time to adjust to changes in how they look and it's important to advise on what support is available. We have more information about coping with changes in your appearance.

**Oral rehabilitation**

There should be appropriate assessment of patients' oral rehabilitative needs across the pathway and the provider must ensure that specialist oral rehabilitation is provided.

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**Supportive and palliative care**

The provider will give high quality supportive and palliative care in line with NICE guidance. The extended team for the multidisciplinary team includes additional specialists to achieve this requirement. Patients who are managed by a head and neck cancer multidisciplinary team will be allocated a key worker.

Patients who require palliative care will be referred to a palliative care team in the hospital and the team will be involved early to liaise directly with the community services. Specialist palliative care advice will be available on a 24 hour, seven days a week basis.

**Holistic Needs Assessment**

Each patient should be offered a holistic needs assessment at key points in their cancer pathway as well as at survivorship or the beginning of the end of life. A formal care plan should be developed. The nurse specialist(s) should ensure the results of patients' holistic needs assessment are taken into account in the multidisciplinary team decision making.

**Survivorship**

The National Cancer Survivorship Initiative (NCSI) has identified a range of service developments which are likely to improve the health and well being of cancer survivors. Some of the key initiatives that are being tested include:

- Giving GPs a treatment summary at the end of the patient's primary treatment for cancer
- Using assessment and care planning to risk-stratify patients at the end of their primary treatment

It will be important for commissioners to ensure that work from this programme is included and developed locally to support patients whose care will return to their more local health providers once specialist care is no longer required.

**End of life care**

The provider should provide end of life care in line with NICE guidance and in particular, the markers of high quality care set out in the NICE Quality Standard for end of life care for adults.

**Acute oncology service**

All hospitals with an Accident and Emergency (A&E) department should have an "acute oncology service" (AOS), bringing together relevant staff from A&E, general medicine, haematology and clinical/medical oncology, oncology nursing and oncology pharmacy. This will provide emergency care not only for cancer patients who develop complications following chemotherapy, but also for patients admitted suffering from the consequences of their cancer. For full details on AOS please refer to the service specification for chemotherapy which is currently being

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developed.

**Patient experience**

The service should be patient centred and should respond to patient and carer feedback. Excellent communication between professionals and patients is particularly important and can avoid complaints and improve patient satisfaction.

Patient experience is reported in the National Cancer Patient Survey. In this survey patients with a clinical nurse specialist reported much more favourably than those without on a range of items related to information, choice and care. The national programme for advanced communications skills training provides the opportunity for senior clinicians to improve communications skills and all core multidisciplinary team members should have attended this.

The specialist head & neck cancer service is to be delivered in the model outlined in the Improving Outcome Guidance in Head & Neck Cancer (2004) and the National Cancer Peer Review Programme Manual for Cancer Services (2011): Head & Neck Cancer measures.

The management of head and neck cancer involves three cross-linked teams:

- Primary health care team,
- Head & neck cancer team:
- Local head & neck multidisciplinary teams
- Specialist head & neck multidisciplinary team
- Specialist thyroid cancer multidisciplinary teams
- Specialist palliative care team

**Care pathways**

The local care pathway for head and neck cancer should be consistent with the national pathway on the Map of Medicine. The process of producing the pathways and subsequent updates has been accredited by the National Cancer Action Team. http://eng.mapofmedicine.com/evidence/map/head_and_neck_cancer1.html

**National clinical audit**

All providers should actively contribute to the established National Head and Neck Cancer Audit (DAHNO). Commissioners should ensure that following the publication of each annual report that providers have developed an action plan to respond to any deficiencies of local service identified.

**2.3 Population covered**

**Geographic coverage/boundaries**

The service outlined in this specification is for patients ordinarily resident in

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England*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who pays?: Establishing the responsible commissioner and other

Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

* - Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

Specifically, this service is for adults with head and neck cancers requiring specialised intervention and management, as outlined within this specification.

**2.4 Any acceptance and exclusion criteria**

**Referral criteria & sources**

Designated clinicians at local hospitals should ensure the prompt referral of all patients who have a suspect or confirmed head or neck cancer to the specialist head & neck cancer service or specialist thyroid cancer service. Any patient with a suspicious lesion should be seen by a designated clinician.

When biopsy of a suspicious lesion is appropriate, a designated clinician should arrange for this to be done promptly. Designated clinicians should refer patients who are strongly suspected to have cancer on to appropriate assessment clinics at cancer centres. Designated head and neck cancer clinicians and clinicians in ENT, maxillofacial and oral medicine clinics should be in regular contact with each other.

**Urgent referral**

Patients who meet the Department of Health's criteria for urgent (two- week) referral should either be referred directly to a designated lead head and neck clinician at a local Trust which provides such services, or to a rapid-access neck lump assessment clinic (described below).

**Urgent referral guidelines**

- Hoarseness persisting for more than six weeks.
- Ulceration of oral mucosa persisting for more than three weeks.
- Oral swellings persisting for more than three weeks.
- All red or red and white patches of the oral mucosa.
- Dysphagia persisting for more than three weeks.
- Unilateral nasal obstruction, particularly when associated with a bloodstained discharge.
- Unexplained tooth mobility not associated with periodontal disease.
- Unresolving neck masses for more than three weeks.

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- Cranial neuropathies.
- Orbital masses.

The level of suspicion is further increased if the patient is a heavy smoker or heavy alcohol drinker and is aged over 45 years and male. Other forms of tobacco use should also arouse suspicion.

In a patient with hoarseness an urgent chest X ray should be performed to exclude a primary lung mass that would require referral via the lung cancer pathway.

**Thyroid lumps**

All patients with solitary nodules should be referred to a clinic that deals with patients who may have cancer, which may be a thyroid clinic or a neck lump clinic, depending on local arrangements. If the nodule is increasing in size, urgent referral is necessary (see above).

GPs should request thyroid function tests for all patients with goitre. Patients with abnormal thyroid function test results (hyper- or hypothyroidism) are unlikely to have cancer and should not be referred to the head and neck cancer service, but they may need to be referred to an endocrinologist. Those with goitre and normal thyroid function should be given routine referrals either to a thyroid clinic or a neck lump clinic, unless they fulfil any of the criteria for urgent referral listed previously.

**Suspected sarcoma**

All suspected sarcomas should have their histological diagnosis reviewed by the specialist sarcoma pathologist of the sarcoma multidisciplinary team.

**Referral route**

Referrals to the service will come from either primary care or a local multidisciplinary team. Steps prior to referral to the specialist team include:

- The local team will already have made a diagnosis, confirmed by radiology or biopsy
- The patient will have been informed of the diagnosis and given the date of scan
- The patient will have had staging investigations
- The patient will have been discussed at their local multidisciplinary team
- The patient will have been referred to a specialist multidisciplinary team(s)

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**Exclusion criteria**

The specialist UAT head & neck cancer service is not commissioned to provide assessment or treatment for: sarcoma of the head and neck, the head and neck specialist team should ensure prompt onward referral to the designated sarcoma multidisciplinary team after any initial assessment

- Where a management plan has been agreed with the sarcoma multidisciplinary team treatment may be provided locally subject to the head and neck multidisciplinary team following the sarcoma team treatment plan
- The specialist thyroid cancer service is not commissioned to provide assessment or treatment for:
    - Non thyroid malignancy

*Peer review measures state that multidisciplinary teams for thyroid cancer may function separately from UAT, or as part of a combined multidisciplinary team, with a UAT team***.**

**Response time & detail and prioritisation**

Transfer of patients to specialist head & neck cancer multidisciplinary team service will be prioritised according to the needs of individual patients but in all cases where a transfer to the specialist head & neck cancer multidisciplinary team service has been agreed that transfer will take place as soon as is practicable. If necessary the specialist head & neck cancer multidisciplinary team service providers will communicate with each other to coordinate appropriate care for patients at times when capacity at one of the provider is under pressure.

Initial telephone contacts from referrers relating to emergency presentations are to be dealt with immediately by the senior consultant on duty. The referral may be accepted over the phone immediately and / or the specialist head & neck cancer multidisciplinary team service provider may request the referrer to carry out further investigations. Advice on optimal management will be given and on-going support will be provided until the patient is transferred.

**2.5 Interdependencies with other services**

**Relevant networks and screening programmes**

The specialist head & neck cancer service providers form part of the network site specific group for head & neck cancer specific network within their cancer network.

**Staging**

Providers must include staging information in their COSD submissions in order to provide data needed to assess whether progress is being made on improving survival rates through earlier diagnosis. This may be captured electronically at multidisciplinary team meetings and transferred direct to registries. Respective

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pathological staging data should also be provided direct from pathology labs to cancer registries.

Staging data forms part of the submission required by all head and neck providers to the National Clinical Head and Neck audit (DAHNO)

**Diagnosis via emergency presentation**

Patients who present as an emergency on their route to being diagnosed with cancer have poorer survival. The proportion of patients who present through an emergency Route varies for head and neck cancers between 6% for oral cancers and 14% for cancers of the hypopharynx. Providers should:

- develop an algorithm to support decision-making in A&E or primary care

**Co-located services**

Intensive/critical care services may be required for some patients undergoing complex surgery and providers will be required to refer to the service specification for critical care.

Strategic clinical networks will be in place from April 2013 located in 12 areas across England. They will be established in areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in quality and outcomes of care for patients. Cancer has been identified as one of the conditions that will be within this new framework. Strategic clinical networks will help commissioners reduce unwarranted variation in services and will encourage innovation. They will use the NHS single change model as the framework for their improvement activities.

**3. Applicable Service Standards**

**3.1 Applicable national standards e.g. NICE, Royal College**

**National Cancer Peer Review**

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the coalition government to deliver health outcomes that are amongst the best in the world. The Manual will support the National Cancer Peer Review quality assurance programme for cancer services and enable quality improvement both in terms of clinical and patient outcomes.

National quality standards/measures for cancer services were first published in 2001 and were updated in 2004 and 2008. The range of measures has subsequently been extended to cover virtually all cancer- sites and the current head and neck specific measures were released in April 2011. It is intended that

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the measures will underpin the NICE Quality Standards relating to cancer.

An important element of the National Peer Review measures is that where they exist Network/Trust teams should be part of any national audit programme, and for head and neck there is a National Comparative Audit (DAHNO) supported by the British Association of Head and Neck Oncologists (BAHNO), and other professional bodies.

**Patient and carer information**

Every patient and family / carer must receive information about their condition in an appropriate format. Verbal and written information should be provided in a way that is clearly understood by patients and free from jargon The information must cover:

- Description of the disease
- Management of the disease within the scope of the commissioned
- service as described in the specification, clinical pathways and service standards
- Treatments (including their side effects) commissioned in the clinical pathway
- Pain control
- Diet and nutrition
- Practical and social support
- Psychological support
- Benefits support
- Self-management and care
- Local NHS service and care/treatment options
- Contact details of the patient's allocated named nurse
- Videotapes and other written material available on laryngectomy and vocal rehabilitation
- Support organisations or internet resources recommended by the clinical team
- Oral rehabilitation

The service must also provide education to patients and carers on:

- Symptoms of infection and management of neutropenic sepsis and prophylaxis for patients undergoing chemotherapy
- Out of hours advice/support
- Contact in case of concern or emergency

The useful reference is the Information Prescription Service (IPS) which allows users, both professional and public, to create information prescriptions (IPs) for long-term health needs. http://www.nhs.uk/IPG/Pages/AboutThisService.aspx

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## 4. Key Service Outcomes

### Quality and Performance Standards

The provider(s) will provide agreed performance monitoring data on a monthly basis. Where any elements of this deviate from the agreed plan, the service will provide a brief explanation accompanying the submission of the report.

The commissioner may wish to follow this up and request further information to inform any necessary actions that will be agreed between the service and commissioners in the context of the terms and conditions of the agreement.

Providers of services will be expected to produce information developed as Clinical Lines of Enquiry, through the NCIN/Peer Review groups in the following areas:

- Percentage of new cases of head and neck cancer discussed at multidisciplinary team*
- Percentage of new cases of head and neck cancer discussed at multidisciplinary team* where recorded T, N, M staging category is evident
- Percentage of cases of head and neck cancer* where the interval from biopsy to reporting is less than 10 days
- Percentage of new cases of head and neck cancer* where confirmed seen by a clinical nurse specialist prior to the commencement of treatment
- Percentage of new cases of head and neck cancer* confirmed as having any pre-operative/ pre-treatment (includes radio and chemo- therapy) dietetic assessment
- Percentage of cases of head and neck cancer* confirmed as having any pre-operative/ pre-treatment dental assessment

## 5. Location of Provider Premises

### Location(s) of Service Delivery

The service is delivered across England by nominated cancer centres and who provide cover across all regions in England for the national caseload. Some of the services may provide a combined head and neck and thyroid multidisciplinary team, whilst other Trusts may have these as separate multidisciplinary teams.

### Days/Hours of operation

24 hours a day, 365 days a year

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## Appendix 1 – Activity Performance Indicators

| **Activity Performance Indicators** | **Annual Review** | **Threshold** | **Method of measurement** | **Consequence of breach** |
|---|---|---|---|---|
| Audits (Specification Point 2.3.4) | Conducted | | NSSG | |
| | Participation in National Audits | **100%** | Part of Network Performance Report but only in terms of submission not in terms of data quality | |
| | Additional Audits undertaken | **N/A** | Reported at NSSGs but not Board unless specific service change | |
| Service User Experience | National Cancer Patient Experience survey (ref A46 main contract) | National survey report when published | National findings reported to Board. Currently establishing a baseline. | If the provider does not take part they will be required to meet with the commissioners to explain reasons for not doing so and activity planned to enable the information to be captured through alternative mechanisms |
| | **Annual Review** | **Threshold** | | |
| | Improving Service User Experience | Of responses received<br>75% should express overall satisfaction with the service. Trust to evidence<br>the measures it has taken to improve service user experience and outcomes achieved and numbers / percentages stratified | | |

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| | Addressing Complaints | Trust to evidence the measures it has taken to address complaints and outcomes achieved | | |
|---|---|---|---|---|
| | Patient involvement | Trust to evidence the actions it has taken to angage with patients and demonstrate where this has impacted | | |
| **Activity Performance Indicators** | **Annual Review** | **Threshold** | **Method of measurement** | **Consequence of breach** |
| Staff survey | Staff Survey Results | | | |
| Trial Activity (Specification Point 8.2.8) | Recruitment into trials | Patients eligible for an existing clinical trial should be offered to the chance to be treated in a clinical trial | Reported to Board on a regular basis but not part of the performance report | |
| Outcomes (Specification 8.2.6) | Post Surgery mortality | Numbers and percentages baseline to be set in year | Numbers currently regularly reported to Board | |
| | 30 day mortality | | Registry data | |
| | 1 year survival | | Part of network performance Report | |
| | 5 year survival | | | |
| | 30 day readmission rates for cancer patients | Numbers and percentages baseline to be set in year | Numbers currently regularly reported to Board | |

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| Data submission (Specification 8.2.6) | Registry dataset submission status | As required by Registry | Not currently regularly reported to Board | |
|---|---|---|---|---|
| | DCOs | | Regular updates to Network | |
| | Staging data (Specification Point 2.3.4) | As required by Registry | Not currently regularly reported to Board | |

**Additional information**

Head and neck cancers are classified in subgroups using the international classification of diseases version 10 (ICD10) as follows:
Oral cavity:

- C02: Malignant neoplasm of other and unspecified parts of tongue – approximately 1,100 cases per year
- C03: Malignant neoplasm of gum – Approximately 300 cases per year
- C04: Malignant neoplasm of floor of mouth – Approximately 400 cases per year
- C06: Malignant neoplasm of other and unspecified parts of mouth – Approximately 450 cases per year

Salivary glands:

- C07: Malignant neoplasm of parotid gland – Approximately 450 cases per year C08: Malignant neoplasm of other and unspecified major salivary glands – Approximately 150 cases per year

Cancer of the pharynx, separated into: Oropharynx:

- C01: Malignant neoplasm of base of tongue – Approximately 500 cases per year
- C09: Malignant neoplasm of tonsil – Approximately 850 cases per year
- C10: Malignant neoplasm of oropharynx – Approximately 200 cases per year

Nasopharynx:

- C11: Nasopharynx – Approximately 200 cases per year

Hypopharynx:

- C12: Malignant neoplasm of piriform sinus – Approximately 200 cases per

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year

- C13: Malignant neoplasm of hypopharynx – Approximately 200 cases per year

Larynx:

- C32: Malignant neoplasm of larynx – Approximately 1,800 cases per year

Palate:

- C05: Malignant neoplasm of palate – Approximately 300 cases per year

Thyroid:

- C73: Malignant neoplasm of thyroid gland – Approximately 2,000 cases per year

Incidence data for patients diagnosed in 2009, England. Source: UKCIS, data extracted August 2012. Emergency presentation data for patients diagnosed 2006-2008, source: NCIN.

**Cancer waiting times**

Within cancer waiting times, all ICD10 codes that fall within: C00-C14, C30-C32 & C73 are included within the Head and Neck category for cancer waiting times.

**OPCS4 codes**

A set of OPCS4 codes has been agreed that, if undertaken on a patient with specific cancers, this would be considered a major surgical resection.

**Specific head and neck cancers** - these codes relate to subgroups of head and neck cancers as stipulated in Appendix one of http://www.ociu.nhs.uk/sph-documents/major-surgical-resections-in-england-head-and-neck-cancers and do not include nasopharynx nor thyroid cancers.

| | |
|---|---|
| E19.1;E29.1;E21.4 | Laryngo-pharyngectomy-Primary closure |
| E19.1;E29.1;G03.2 | Laryngo-pharyngectomy-free jejunum |
| E19.1;E29.1;E21.4;S 17.1;Y61.2 | Laryngo-pharyngectomy-pect major |
| E19.1;E29.1;G02.1 | Total L-p-oesophagectomy + pullup |
| E19.2 | Pharyngectomy – partial |
| E23.1 | Pharyngotomy (open excision lesion) |
| F20.2 | Excision of lesion of gingival |
| F22.1 | Total glossectomy |
| F22.2 | Partial glossectomy |
| F30.1 | Repair of palate using palatal flap |
| F30.3 | Repair of palate using tongue flap |
| F30.4 | Repair of palate using skin graft |

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| | |
|---|---|
| F30.5 | Repair of palate using mucosal flap |
| F32.4 | Palatectomy (partial) uvulectomy |
| F32.8;Y05.1 | Palatectomy – total |
| F34.9 | Tonsillectomy-unilateral |
| F38.1 | Floor of mouth excision |
| F38.2 | Buccal mucosa excision |
| | |
| F39.1 | Reconstruction mouth - with flap |
| F39.1 | Reconstruction mouth - with primary closure |
| F39.1;S28.8 | Reconstruction mouth - with buccal flap |
| F39.1;S17.1;Y61.2 | Reconstruction mouth - with pectoralis major |
| F39.1;S20.8;Y59.2 | Reconstruction mouth - with radial forearm |
| F39.2;S35.3 | Reconstruction mouth with SSG |
| F44.1 | Parotidectomy - total |
| F44.2 | Parotidectomy - superficial |
| S17.1;Y61.2 | Pectoralis major - skin and muscle |
| S17.1;Y63.8 | Pectoralis major - muscle |
| S17.1;Y63.1 | Latissimus dorsi - skin and muscle |
| S17.1;Y63.1 | Latissimus dorsi - muscle |
| S20.8;Y59.2 | Radial forearm fasciocutaneous |
| T85.1 | Neck dissection radical |
| T85.1 | Neck dissection modified |
| T85.1 | Modified Type I accessory preserved |
| T85.1 | Modified Type II accessory + IJV kept |
| T85.1 | Modified Type III sternomastoid - IJV + Accessory kept |
| T85.1 | Selective neck dissection (SND) |
| T85.1 | SND Level 1 (suprahyoid) |
| T85.1 | SND Level 1-3 (supra omohyoid) |
| T85.1 | SND Level 1-4 (anterolateral) |
| T85.1 | SND Level 2-4 (lateral) |
| T85.1 | SND Level 5 (posteria) |
| T85.1 | SND Level 2-5 (posterolateral) |
| T85.1 | SND Level 6 (central compartment) |
| T85.1 | SND Level 7 (superior mediastinum) |
| V14.1 | Hemimandibulectomy |
| V14.2 | Mandibulectomy - extensive |
| V14.3 | Marginal mandibulectomy |
| V14.4 | Excision lesion jaw NEC* |
| V16.8 | Mandibulotomy/split/division of jaw |
| V19.1;Y66.2 | Reconstruction mandible |
| V19.1;Y66.2 | Reconstruction mandible - with rib |
| V19.1;Y66.4;Y59.2 | Reconstruction mandible - with radius |
| V19.1;Y66.6;Y59.8 | Reconstruction mandible - with fibula |
| V19.1;Y66.3;Y59.8 | Reconstruction mandible - with iliac crest |
| E34.1 | Microlaryngoscopy - laser removal lesion |
| E34.2 | Microlaryngoscopy - cold removal lesion |

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| | |
|---|---|
| E29.3 | Vertical hemilaryngectomy |
| E29.2 | Supraglottic laryngectomy |
| E30.1 | Laryngofissure |
| E29.5 | Laryngofissure and cordectomy |
| E29.1 | Total laryngectomy |
| E41.4 | Tracheo-oesophageal puncture with insertion of speech prosthesis |
| F01.1 | Partial excision of lip/shave/vermillion adv |
| F01.8 | wedge resection of lip |
| F04.2; S24.8 | Reconstruction lip with skin flap (ABBE) |

In addition- additional procedures of transoral laser resection of oropharyngeal tumour, hypopharyngeal tumour and other reconstructive procedures.

**Nasal Cavity**

| | |
|---|---|
| | Rhinectomy, partial |
| E01.8 | |
| E01.1 | Rhinectomy, total |
| E17.4 | Rhinotomy, lateral |
| E03.8 | Septectomy |

**Sinuses**

| | |
|---|---|
| | Craniofacial resection of ethmoids |
| E14.8; Y46.2 | |
| E14.8 | Other specified operations on frontal sinus |
| Y46.2 | Frontal open approach to contents of cranium |
| V07.2 | Maxillectomy, partial |
| V07.8 | Maxillectomy, total |
| C01.1 | Orbital extenteration |
| E03.8 | Septectomy |
| E17.4 | Rhinotomy, lateral |

**Bone tumours**

| | |
|---|---|
| | Maxillectomy, total |
| V07.8 | |
| V14.1 | Hemimandibulectomy |
| V14.2 | Mandibulectomy, extensive |

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