



London Cancer

**Service specification for
Head and neck cancer**

April 2013

Final version for circulation to provider trusts

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1. Introduction

The cancer care providers of north east London, north central London and west Essex agreed in July 2011 to develop an integrated cancer system (ICS) in response to the requirements of London's Strategic Health Authority and commissioners. Since April 2012 this integrated cancer system, *London Cancer*, has been commissioned to provide cancer services for a resident population of 3.5 million. Its mission is to drive superior outcomes and experience for our patients and local communities, and thereby position its staff as leaders in cancer care – locally, nationally and globally.

1.1. Background to the development of this service specification

A number of *London Cancer's* Pathway Boards have been invited to constitute special sub-groups, called **technical groups**, which are responsible for developing specifications for the future delivery of services for those pathways.

The Head and Neck Pathway Board's technical group was the third to be established (following those for urological cancer and breast cancer). The Head and Neck technical group met four times over a four-month period between October 2012 and January 2013 to develop the specification for the future delivery of head and neck cancer services.¹ Discussions focused on defining what the ideal pathway for patients looked like, from prevention and detection all the way through to care at the end of the patient's life. Discussions also sought to agree some generic principles related to areas such as leadership, partnership working, participation in research and innovation, etc.

1.2. Drivers for change

One of the primary drivers for change in London is the recommendations of the Model of Care for cancer services in London. For head and neck (or upper aero-digestive tract [UAT] cancers), the Model of Care recommends that, "five surgery providers should be commissioned to deal with both UAT cancers and thyroid cancers."² This equates to one or two centres for the area covered by the *London Cancer* ICS.

Within *London Cancer* there are currently three centres providing specialist surgery for head and neck cancers: The Royal London Hospital (Barts Health NHS Trust), University College Hospital (University College London Hospitals NHS Foundation Trust), and Barnet and Chase Farm Hospitals (Barnet and Chase Farm Hospitals NHS Trust). Centralisation within the legacy North East London Cancer Network predates the establishment of *London Cancer*.

The Barnet, Enfield and Haringey Clinical Strategy, published in September 2011,³ made a series of recommendations regarding the future delivery of services at Barnet and Chase Farm Hospitals NHS Trust. The trust board has decided that they will no longer be able to provide complex, specialist head and neck oncology surgery. It is anticipated that these changes will come into effect by late 2013.

There is broad agreement amongst colleagues that a single centre undertaking large volumes of specialist surgery is likely to lead to improved outcomes and a better patient experience. Given the populations covered by the two ICSs in London, the head and neck cancer technical group concluded

¹ A full list of members of the group and the dates on which the group met can be found in Appendix C.

² NHS Commissioning Support for London (2010). *A model of care for cancer services: Clinical paper*, pp.86-88. (<http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf>).

³ Enfield CCG, The Barnet, Enfield and Haringey Clinical Strategy, September 2011.

that a **single specialist centre should be established coordinating all complex head and neck cancer surgery**. We acknowledge that this outcome will not be achieved immediately, and therefore a **phased approach to implementation will be required**, initially involving a managed reduction from **three to two centres, which will work together as a single, unified service across two sites**.

The Model of Care recognises that, particularly where head and neck cancer services are concerned, there is a balance to be struck between centralisation of services that enables the co-location of relevant specialities involved in treatment and care and the local provision of services that promotes the principle of seamless care closer to home.

“There are benefits of providing a reasonably centralised service due to the number of specialties involved (oral and maxillofacial (OMFS); ear, nose and throat (ENT); plastic surgeons; clinical oncologists; speech and language therapists; dieticians; restorative dentists; and clinical psychologists) [...] An integrated pathway in each provider network would ease access to pathology, radiology, radiotherapy, and chemotherapy; and facilitate transfer of data and permit follow-up locally with access to relevant information.”⁴

1.3. About this document

This document presents the service specification in an easily accessible narrative form. It describes what the technical group considers to be the optimum patient pathway for head and neck cancer, and the features of excellent provision at each pathway stage. The document is accompanied by an application template, which is structured around the features of the service specification to aid completion and ensure that no aspect of the information required by the application process is inadvertently overlooked.

The *London Cancer* Head and Neck Pathway Board has striven to adhere to **three organising principles** in overseeing the approach to the development of the service specification.

1. We have sought to consider in our analysis the **full range of head and neck cancer services as an *integrated pathway***.
2. Any recommendations about **consolidation – centralisation – of services is based on a clear and compelling evidence-based rationale** for doing so in terms of improved patient outcomes and experience.
3. Where there is no compelling clinical rationale for centralisation, and where patient experience would be enhanced by services being delivered locally to maximise accessibility and convenience, **we will strive to maintain local provision**.

The aim of the proposed service reconfiguration is not simply centralisation of specialist surgery; rather – in line with our commitment to the concept of *fully-integrated, patient-focused* pathway for head and neck cancer – it is about driving improvements along the entire pathway and across the whole system. We recognise that there is a vital need to **support and strengthen trusts’ local service delivery** so that they have the ability to see patients as soon as possible with the aim of – as will be the case in most circumstances – excluding cancer and routing patients onto the optimum treatment pathway. For local services, as for the centralised, specialist services, we need a clearly-articulated expectation of the quality standards that we expect them to meet. That is the purpose of this service specification.

⁴ *Ibid.*

1.4. A note on proposals for the management of thyroid cancer within *London Cancer*

The management of thyroid cancer has many different requirements to those of UAT cancer, and the specifications for this will follow in a separate document. Facilities, such as the ability to carry out complex diagnostics, will be required and these could be co-located with those of an extended Level 2 local unit (see below).

Thyroid surgery is likely to be carried out in several units and colocation with the specialist surgery centre is not a requirement. There will be complex cases involving extended neck dissections or reconstruction that may require management in the specialist surgical centre.

The configuration of the Thyroid MDT is significantly different to the Head and Neck MDT, and there is consensus within the group that they should exist as separate entities.

1.5. What happens now?

London Cancer trusts are invited to apply to deliver aspects of the pathway as one – or a combination of – the following ‘levels’ of provision. The bullet points below provide a brief description of the characteristics of services at each level:

Level 1: Local unit

- Fast-track cancer referrals
- Access to keyworker/CNS for breaking significant news
- Diagnostic facilities on-site (i.e. CT and MRI)
- Follow-up clinics for post-treatment patients (involving surgeon, oncologist, CNS, rehabilitation services)
- Robust coordination with other centres in situations in which facilities or resources are not available in-house (e.g. rapid access, PET-CT).

Level 2: Extended local unit

As with Level 1 above, but in addition with:

- Rapid access clinics with ultrasound and same-day cytology services
- Comprehensive rehabilitation and support services
- MDT conferencing facilities with MDT hub.

Level 3: MDT hub centre

- Hosts and coordinates weekly MDT meeting
- Coordinates data collection
- Multidisciplinary clinics attended by surgeons, oncologists undertaking treatment for patient.

Level 4a: Specialist treatment centre for *surgery*

Level 4b: Specialist treatment centre for *clinical oncology*

N.B. Where a provider serves as a local unit and specialist centre it must meet the criteria for both the local unit and specialist centre specification.

For a more detailed definition of each type of provision, and further guidance on our expectations of each one’s scope and capability, please see the accompanying application template.

2. Delivering an integrated pathway for head and neck cancer: Overarching principles and commitments

Before we describe the technical provisions that we would expect services to be able to provide at each stage of the pathway for head and neck cancer, it is important to identify the over-arching features of a high quality, integrated, patient-focused pathway to which all providers within *London Cancer* should aspire. These include strong leadership and a series of commitments to principles that support the optimum functioning of the pathway. We expect all providers participating within the pathway to commit to and embody these commitments in everything that they do.

2.1. Leadership

Each component of the pathway will have a named leader who:

- Takes responsibility for leading the local provider team or the specialist team and ensures system-wide collaborative working to ensure availability of relevant specialist expertise at local units and equitable access to best practice and research.
- Maintains and develops the MDT.

In addition, **the trust hosting the specialist surgical centre** (Level 3 provision) will appoint a named leader who will:

- Drive and oversee the implementation of the agreed pathway across all providers.
- Demonstrates leadership in the identification, development and dissemination of clinical and non-clinical innovations across the system.

2.2. Commitment to partnership working

All providers work together as part of an integrated team, and demonstrate this commitment to partnership from the outset by working collaboratively to develop plans against the service specification that are focused on delivering the best outcomes and experiences for patients

2.3. Commitment to audit, data collection and sharing

All providers collect data on clinical outcomes and patient experience (and other relevant metrics), and comply with requirements for submission to national audits (DAHNO, COSD) and other local/regional requests for performance and outcomes data.

2.4. Commitment to gathering and responding to patient feedback

All providers must demonstrate a practical commitment to elicit feedback from patients on a regular basis and use this intelligence systematically and routinely to inform service improvement.

2.5. Commitment to research and innovation

All providers within the system participate fully in the clinical trial and research portfolio, and carry out prospective audits of services and publish transparent outcomes data. They participate in tissue banking and support the use of research nurses, as well as promote research into improving patients' functional outcomes and rehabilitation therapies.

2.6. Commitment to *education and training*

All providers should facilitate access to high quality training and development opportunities for staff and services—with centres working in partnership and undertaking joint training where appropriate in order to deliver education in efficient, joined-up way. Specifically:

- Training should be available for junior medical staff, nursing staff and allied health professionals (AHPs).
- Recognition should be given to the importance of education for CNSs, and protected time should be offered to CNSs to enable them to access development opportunities.
- Level 2 psychological training should be available for every member of the MDT—with monthly supervision in line with the requirements of Peer Review.
- All relevant staff should be supported to undertake Advanced Communication Skills Training (ACST)
- Training for rehabilitation therapists in the community should be competency-based and offered to those working in community settings.
- Education and training activity should be subjected to ongoing monitoring and audit to establish what works and identify opportunities for improvement.

The specialist surgical centre should offer simulation training in new surgical techniques, and all organisations must conduct training in the delivery of systemic therapy and radiotherapy (as appropriate).

3. A service specification for a high quality integrated pathway for head and neck cancer

3.1. Primary care

GPs and general dental practitioners (GDPs) should be supported in making referrals. Specialists working in secondary care should provide the benefit of their experience and expertise to improve the referral conversation rate and forge even stronger links between primary and secondary care for the benefit of patients.

GPs and GDPs use the 2ww process – utilising the agreed *London Cancer* referral forms and criteria – to refer a patient if they are concerned about them (rather than requesting an investigation).

GPs use a medical history printout for assessment of a patient’s comorbidities.

As innovative developments such as Saving Faces’ ‘Diagnostic Advice Service’ (DAdS) are rolled within *London Cancer*, we would expect GDPs initially (and then GPs) to elect to participate in such schemes.

Essential features of a high quality service: All levels

- Hospital specialists offer advice to GPs and GDPs by telephone or e-mail in a timely fashion.
- Participates in national and local public health programmes to disseminate information on early signs of pathology to primary care practitioners and the public.

Essential features of a high quality service: Level 4

- Prompt provision of comprehensive discharge information following completion of treatment in line with national standards.

3.2. Urgent cancer referrals

4.2.1 Clinic visit

Essential features of a high quality service: Levels 1 – 3

- **No more than five working days** should elapse between referral and the first appointment in a specialty consultant-led clinic. The consultant should be someone from the ENT or oral maxillofacial (OMFS) service trained to diagnose and request appropriate investigations.
- Patients should undergo nutritional screening at this point using a system-wide validated screening tool. This will provide baseline nutritional status to facilitate MDT decision-making.
- Patient notes must be available in clinic.
- Diagnostic scopes must be available.
- If appropriate, the patient should be referred to a rapid diagnostic clinic (either in-house or elsewhere) **within one week**.

4.2.2 Imaging

Essential features of a high quality service: Levels 1 – 3

Overall clinical responsibility

- A lead consultant radiologist must be in place. This individual has overall responsibility for the imaging service provided to head and neck cancer patients.
- Head and neck imaging studies should be reported by radiologists with a specialist interest in the field. This includes ultrasound studies.
- There should be an adequate number of radiologists with an interest in head and neck in each centre to ensure reporting timescales and standards are maintained at all times. The radiologists should have protected time in their job-plans to attend and prepare for the MDT.

Imaging equipment and protocols

- All head and neck cancer patients should have timely access to plain X-ray, US and FNA procedures, CT, MRI and routine scintigraphy facilities locally. PET/CT and specialist scintigraphy may require the patient to travel to other centres.
- Imaging protocols should be agreed and documented within the department quality management systems. Imaging protocols recommended by the ICS Head and Neck Imaging Technical Subgroup have been compiled and a unified approach across the service is desirable.
- Appropriate ultrasound training should be in place.

Scanning and reporting timescales

- Each centre must be able to deliver timely imaging investigations and reports in order to meet the nationally-set target for the commencement of definitive treatment within 31 days of the decision to treat, or, if the patient is on the 'two-week wait' pathway, within 62 days of urgent referral.
- Wherever possible, there should be a minimum turnaround time of **five working days** between the point at which a cancer-related imaging request is generated and a report being available (i.e. the report must be available in time for the next MDT meeting).

Minimum IT requirements

- An integrated IT solution should be in place to enable rapid image transfer between sites across the service. This facilitates MDT discussion and access to specialist opinions from radiology colleagues at other centres. Ideally this would include RIS integration so addenda to reports can be easily recorded from any site instantaneously. A supportive culture between radiologists across sites is encouraged.

Essential features of a high quality service: Levels 2 - 3

- Rapid diagnostic clinics are an essential requirement of a centre operating at this level, with a **minimum of one clinic per week**.
- Patients referred from other trusts are accommodated in a timely fashion.
- Videofluoroscopy facilities are available to all head and neck cancer patients, under the auspices of a speech and language therapist or jointly with radiology.

4.2.3 Needle biopsy (FNA)

Essential features of a high quality service: Levels 2 - 3

- The FNA cytology procedure is undertaken only by an experienced aspirator (radiologist). The name of the aspirator should be indicated on the request form.
- The FNA clinic should be led by a consultant trained in cytopathology, who is also a core MDT member. A specialist head and neck cancer centre should have a minimum of two such people.
- A cytopathologist should be present in the clinic—not only to assess the adequacy of the FNA sample, but also to provide a prompt, same day report.
- Diagnostic triage takes place **within one working day**. The report is available **by time of next MDT** (i.e. no more than five-day turnaround).
- Final diagnosis provided within a timeframe that does not delay other investigations, e.g. core or excision biopsy.
- The diagnostic performance of the aspirator is subject to annual audit (measuring the percentage of inadequate specimens). There is also an annual audit of FNA on head and neck cancer referrals (% sensitivity, % specificity for malignant diagnosis).

4.2.4 Incisional biopsy

Essential features of a high quality service: Levels 1 - 3

- The biopsy should be reported by an EQA-compliant pathologist who has undertaken the relevant 'arms' in relation to the biopsy submitted.
- The biopsy should be **reported within 72 hours** as described in the Royal College of Pathologists guidance.
- A copy hematoxylin and eosin (H&E) stain should be sent to the centre due to undertake the resection.

4.2.5 Patient communication

Essential features of a high quality service: Levels 1 - 3

- Benign clinical diagnosis is communicated to patients **on the same day** wherever possible following confirmation of diagnosis. Patients are managed locally.
- There is an agreed communications protocol between the clinician and CNS to ensure timely follow-up. The CNS functions as the patient's 'key worker'. All providers must provide all patients with access to a key worker (usually a CNS), who shares information freely with specialist centre.
- Provision is available for communications in a variety of community languages that take account of ethnic and cultural diversity. Support is provided for patients who have learning difficulties—to ensure that all patients understand the information that is being communicated to them
- There are robust liaison arrangements with the next stage in the pathway (either in-house or elsewhere, depending on arrangements).

3.3. Pathology

Essential features of a high quality service: Levels 3 – 4

Overall clinical responsibility

- A lead consultant histopathologist and cytopathologist must be in place. These individuals have overall responsibility for the pathology service provided to head and neck cancer patients.
- Head and neck pathology should be reported by pathologists who are active members of the National Head and Neck EQA scheme and maintain performance in all the “arms” relevant to their reporting practice.
- There should be an adequate number of these pathologists in each centre to ensure reporting timescales and standards are maintained at all times. The pathologists should have protected time in their job-plans to attend the MDT.

Laboratory specification

- Each centre must be able to deliver timely pathology reporting. Each centre must ensure they have sufficient laboratory capacity to manage increased workflow. There should be adequate provisions within the pathology cut up environment to allow timely macroscopic cut up, with digital dictation supported by macroscopic pictures. Equipment to manage hard pathology resections must be in place
- Wherever possible, there should be a minimum turnaround time in accordance with the KPI from the Royal College of Pathologists and adequate resources within the laboratory and secretarial support to ensure prompt slide sign out must be in place.
- Capacity planning within the laboratory for rapid diagnostic frozen sections and research tissue sampling must be in place

Minimum IT requirements

- An integrated pathology IT solution should be in place to enable rapid generation of reports. There should be in place capacity for voice recognition dictation of consultant reports in addition to standard digital transcription. The pathology interface should allow the ordering of special stains etc. electronically from the consultant offices

Pathology practice and reporting

- Specimens should be orientated with a diagram and levels marked by the surgeon, and, if necessary, surgeons should be available to orientate the specimen where doubt arises.
- Excisional specimens should have a macroscopic picture taken, with location of the pathology blocks marked on the picture. The consultant who performs or supervises the dissection of such specimens should, where possible, report the case.
- Reports should meet the minimum criteria set out by the Royal College of Pathologists. Free text reporting should, in addition, have a pro forma report for all excision specimens to enable appropriate data sets to be maintained.⁵

⁵ Specialist oral pathology should be reported by pathologists with sufficient experience doing at least arms (1, 2) of the EQA scheme. Where excision is going to take place at a hub, a copy H&E should be sent to enable frozen section diagnosis if needed and reporting of the excisional specimen.

3.4. Multidisciplinary teams (MDTs)

It is well-established in evidence that a well-functioning MDT is critical to the delivery of high quality patient care. For an MDT to perform well, it needs to designated time to meet with support for education and development, it needs to gather data consistently and rigorously, and it needs communications equipment to functional reliably.

Areas highlighted for improvement

- Reliability of videoconferencing equipment
- Reliability of data capture and retention for submission to national audits (i.e. DAHNO).

Essential features of a high quality service: Levels 2 – 3

Workload

- MDTs should review a minimum of 100 new cases per year, as per NICE *Improving Outcomes Guidance*.⁶

Composition and membership

- MDTs should be constituted as per the Head and Neck Cancer Peer Review measures.⁷
- CNSs should work as part of collective community across the integrated cancer system (ICS).
- The MDT should include representative(s) from palliative care, and the team of relevant supportive care and rehabilitation professionals (occupational therapy [OT], speech and language therapy [SLT], dietetics and physiotherapy [PT]) to enable the team to gain a more holistic understanding of the patients' broader circumstances.
 - A dietician must be present at the MDT meeting, e.g. to consider the requirement for the placement of a gastrostomy (artificial feeding tube).
 - A SLT must be present to consider the need for pre-treatment instrumental assessment related to speech, voice and swallowing.
- The CNS carries out holistic needs assessment, including an assessment of palliative care and travel needs, and refers to cancer rehabilitation specialists as appropriate.
- The MDT facilitates prompt referral to pre-treatment oral and dental care assessment.

MDT meetings (including facilities and equipment)

- Meetings should be face-to-face wherever possible.
- Dedicated time should be formally incorporated into job plans: 1 PA.
- Meetings routinely include an educational component.
- Annual audits of performance take place based on a clearly-defined and unified audit programme agreed across the whole system.
- The MDT routinely uses the MDT-FIT tool to ensure optimum functioning and promote

⁶ NICE, *Improving outcomes in head and neck cancers - The Manual*, London: NICE, 24th November 2004. (<http://guidance.nice.org.uk/CSGHN/Guidance/pdf/English>)

⁷ National Cancer Peer Review Programme, *Manual for Cancer Services: Head and Neck Measures*, April 2011.

development.

- All cases for discussion must be communicated to the coordinator before the agreed deadline. (to be determined)
- All cases added to the MDT meeting must include the information below as a minimum.
 - A brief clinical history which will include what the patient's presenting symptoms
 - Any significant past medical history, including comorbidity assessment and performance status
 - Any family history of cancer
 - The diagnostic tests that have been performed
 - The question to the MDT
 - Demographic information, information on any comorbidities and, information on the consultant in charge of care.
- A provisional agenda will need to be circulated to the MDT at least three days before the date of discussion.
- The final agenda (with any additions) must be circulated to the MDT by the deadline (to be determined)
- All images relevant to the cases on the agenda must be available for the radiologists to review pre MDT.
- The discussion notes must be checked by a clinician or CNS before circulating
- The MDT coordinators for all relevant sites must be able to communicate re the outcomes and delegate accordingly to ensure all outcomes are not over looked.
- The meeting venue must:
 - Have sufficient capacity to accommodate all members attending the meeting.
 - Be equipped with reliable videoconferencing equipment to enable communication to take place.
 - Make available to the attending pathologist a microscope, which is compatible with the videoconferencing equipment to enable protection of the slides when needed.
 - Make available a diagnostic PACS workstation, which, again, must be compatible with the videoconferencing equipment to enable clear projection of images.
- The MDT Coordinator must have access to a PC linked to the network to log all discussion notes.
- All sites with cases to discuss must be reliably connected to the Image Exchange Portal (IEP), to facilitate the transfer of images across sites pre-discussion.
- The consultant who dissects or supervises the case should, where possible, report it. There is no need for them to attend the MDT meeting to present the case. (With a clear macroscopic picture at the meeting with any close or involved margins annotated and a clear free text and pro forma this should be sufficient for any of the other consultant histopathologist to present.) From a medico-legal standpoint, the report must be clear enough to withstand scrutiny for 30 years.
- FNA glass slides are available to the MDT cytopathology core member for review (in instances in which management is based on FNA report).
- MDTs use pro forma-based reporting, and include staging information.

Information

- A protocol must be in place that requires the MDT coordinator to be informed of the outcomes of target cases upon their first appointment at the trust.
- All cancer treated cases (whether surgical or non-surgical oncology) must be logged centrally onto a data system (e.g. Somerset, InfoFlex).
- The MDT at all times must be ready to provide accurate clinical information to aid sufficient and accurate data for collection. This is mainly for:

- National audits such as DAHNO
- National registries and datasets such as Open Exeter and COSD
- Local cancer data management tools such as Somerset registry.
- Centres should have the capability to undertake real-time electronic recording of discussions and decisions in MDT meetings.
- Trial recruitment should be embedded into the MDT meeting process.
- A clinician letter should be sent to the GP or GDP **within 48 hours of the patient attending**.
- A procedure should be in place for returning to the MDT information on patients in the post-treatment follow-up phase.

3.5. Multidisciplinary clinics

The purpose of a multidisciplinary clinic is to provide a suitable environment for new patients to receive diagnoses, discuss treatment options, and be given support. For patients under review, the aim should be to provide continuity of care with similar access to support from surgeons and oncologists, nurse specialists, and rehabilitation and supportive care professionals.

Areas highlighted for improvement

- Not all patients currently have access to a key worker at diagnosis and follow-up.
- Holistic needs assessment not widely carried out.
- Not all patients have access to dietetic and speech and language input.
- Poor communication between local and specialist centres, between secondary and primary care and between providers of support services.

Essential features of a high quality service: Level 1

- Pathology makes the result available to the referring surgeon or imaging consultant (in case of direct GP referrals). The laboratory is not responsible for informing the patient or the GP of the result.
- Patients are given the results of FNA biopsy and diagnosis. All patients not given diagnosis of benign disease are seen at the first available clinic appointment (this does not have to be the same day as the MDT).
- Members of the clinical workforce are trained in advanced communication skills, and those giving patients a diagnosis of cancer adhere to guidelines for communicating significant news.
- A clinical nurse specialist (CNS) – functioning as ‘keyworker’ – is available at all sites for all diagnoses, including those related to disease progression.
- Robust communication protocols are in place between individuals, teams, institutions and patients.
- Written confirmation of diagnosis and responsible consultant sent to the GP and/or GDP **within 24 hours** of the patient being informed of their new cancer diagnosis.
- All patients receive holistic healthcare needs pre-assessment by SLT and dietitian prior to treatment decision. Functional optimisation by rehabilitation professionals (SLT, dietetics, OT and PT) where indicated by limited pre-treatment function or comorbidities.
- Regular local clinics are available for patients under follow-up. These include access to surgeons, oncologists, CNS, speech and language therapy, dietetics, and palliative care.

- Access is provided to psychosocial support (clinical psychology and CNS), including detox and smoking cessation. Feedback is provided from the psychology team. Every unit should have a level 2 trained person as a minimum. Systems in place for referral onward for high-risk patients.

Essential features of a high quality service: Levels 2 - 3

- Full written information is provided to the patient about tumour type and treatment options.
- Multidisciplinary team members available to discuss with patients treatment options following diagnosis. This may require attendance at a larger centre.
- Follow-up clinics will have access to specialist SLT and dietetic assessments and treatment.

3.6. Treatment decision

Essential features of a high quality service: Levels 1 - 4

- Patients are offered all appropriate treatment options, as recommended by the hub MDT, and all appropriate types of reconstruction *whether or not these are available at that particular provider site*.
- The treatment recommendation is informed by patient comorbidities and performance status rather than age.
- The decision-making process involves rehabilitation and supportive care professionals to enable a richer, more holistic understanding of the patient's broader circumstances.
- Palliative care expertise is included, as required.

3.7. Timeliness of treatment

Essential features of a high quality service: Levels 1 - 4

- Exceeds all national targets.

3.8. Surgery

Surgery encompasses both diagnostic procedures and definitive treatment either alone or in combination with other modalities. The range of surgery varies from simple day case procedures to complex cases involving micro-vascular reconstruction. Specialist nursing and medical skills are required for these patients to deal with issues such as airway maintenance, flap and wound care.

Areas highlighted for improvement

- Poor enrolment in clinical trials.
- Patchy data collection on outcomes.
- No enhanced recovery programmes in place.
- Cutting edge treatments not available to all, e.g., robotic surgery.

The head and neck cancer technical group concluded that a single centre should be established for all complex head and neck cancer surgery. It is appreciated that this could not be implemented immediately, and therefore a phased approach to implementation – initially involving a managed reduction from three to two centres who will work together as a single service across two sites – will be required.

Essential features of a high quality service: Level 1 - 2

- Diagnostic and pre-operative assessment (including access to dental assessment) procedures are available locally.
- Patients are given information on psychosocial support. Psychological assessment is undertaken by an experienced psychosocial support professional. Further psychosocial support is available to patients as they prepare for major radical surgery (and other treatment).
- Support for all CNSs to attend level 2 training and Advanced Communication Skills Training, and to have access to a 90-minute monthly group supervision (as specified in Peer Review).

Essential features of a high quality service: Level 4a

- In the interim period – prior to the establishment of the single surgical centre – close working relationship across both specialist surgical centres, with unified treatment protocols and sharing of skills, data, etc.
- Robust capacity, demand and workforce planning.
- Robust plans in place (including timeframes and milestones) governing consolidation to one centre.
- A firm commitment to be able to admit patients and undertake the required surgery in a timely fashion to minimise patient delays
- Implementation of a *London Cancer*-wide enhanced recovery programme (to be developed)
- Adequate provision for prompt discharge and liaison with local units, primary care and local rehabilitation services.
- Rigorous approach to surgical clinical trial participation.
- Systematic data collection, including capture of outcomes.
- Rigorous planning to support integration with local services and oncology services to provide a seamless experience for patients with the aim of equitable care closer to home where possible.
- Specialist dietetic support is available for nutritional assessment and management sufficient for a minimum of once-weekly review.
- SLTs who perform surgical voice restoration procedures must have undertaken appropriate training.⁸ Sufficient facilities and equipment must be available in line with guidelines on the safe levels of equipment and consumables for surgical voice restoration management.
- SLTs who perform fibre-optic endoscopic evaluation of swallowing (FEES) and videofluoroscopy procedures must have undertaken appropriate training. Sufficient facilities and equipment must be available in line with RCSLT policy.⁹
- Agreed SLT pathways in place for patients undergoing Laryngectomy.
- Dedicated psychosocial support is provided to the MDT via a psychosocial forum, involving CNSs qualifies to level 2 and psychological input.
- Support for all CNSs to attend level 2 training and Advanced Communication Skills Training, and to undergo a 90-minute monthly group supervision (as specified in Peer Review).
- **It is acknowledged that there will be a transition period at Barnet and Chase Farm Hospitals NHS**

⁸ RCSLT, *Prosthetic surgical voice restoration (SVR): The role of the Speech and Language Therapist - Policy Statement*, 2010.

⁹ See RCLST, *FEES policy* 2008

Trust, where major surgery will cease in November 2013, in line with the *Barnet, Enfield and Haringey Clinical Strategy*.¹⁰ An interim plan needs to be established to ensure continued safe and timely treatment of patients.

3.9. Restorative dentistry

Essential features of a high quality service: Level 1 – 4

- The service should be led by a consultant in restorative dentistry who is a member of the MDT and who assumes overall responsibility for the dental health of patients across the pathway.
- Every patient should be considered for a dental health assessment before the commencement of treatment with surgery or radiotherapy. The outcome of this decision-making process should be recorded in the MDT meeting. The dental assessment should be carried out by a specialist restorative dentist within one week of the patient being informed of cancer diagnosis. This should take place prior to radiotherapy, or, if planned treatment includes surgery, then prior to this. Written reports of the dental assessment should be available to the MDT.
- Patients should be given written information and involved in decision -making regarding dental treatment, including extractions. If the patient is having surgery, extractions should be carried out at surgery; if the patient is having radiotherapy alone, then the extractions should ideally be carried out before this and not cause delay in the initiation of treatment.
- Patients should be given preventative dental advice. Dental treatment should, in the majority of cases, be started on the same day as the assessment
- For the provision of dental treatment, the specialist restorative dentist should be supported by:
 - Hygienist with experience of treating head and neck patients
 - OMFS trained technician
 - OMFS surgeons
 - Access to sedation and general anaesthesia services
- For restorative dentistry taking place **at the time of surgery**: where obturators are required, these will be planned and fitted by the specialist restorative dentist at surgery. If dental implants are deemed suitable to be placed at surgery the specialist restorative dentist must be involved in planning.
- Post-oncology treatment, all patients should have access to a specialist restorative dentist to provide complex prosthodontic oral rehabilitation treatment, including obturators and implants, and to plan ongoing dental care in secondary or primary care.

¹⁰ Enfield CCG, *The Barnet, Enfield and Haringey Clinical Strategy*, September 2011.

3.10. Radiotherapy

The aim of a unified specification across the ICS is to provide world class radiotherapy to head and neck patients with optimal delivery techniques, in a safe timeframe within a quality assured system. The tenets of delivering consistent quality care, ensuring high standards and equitable access are embedded in these specifications.

Essential features of a high quality service: Level 4b (*clinical oncology*)

Overall clinical responsibility

- A consultant clinical oncologist retains overall responsibility for overall patient care across the whole pathway, including responsibility for the management of side effects and complications. This individual will provide care when a patient is using a separate, discrete radiotherapy service.
- There should be an adequate number of clinical oncologists who subspecialise in head and neck Cancer treatment in each centre.
- Treatment protocols should be agreed and documented within the department quality management systems.
- Pathways and partnership arrangements are in place to cross-refer patients between radiotherapy providers within *London Cancer* if there are capacity constraints to deliver optimum radiotherapy techniques.

Pre-treatment consultation and preparation

- Patients should be seen by the specialist clinical oncology team where a full documented assessment of the aim of and fitness for treatment is made.
- In the preparation process patients require:
 - A fully informed consent process with written information describing the planning process and toxicities.
 - Input from rehabilitation and supportive care professionals, including:
 - Dietitian assessment
 - Speech and language assessment
 - Specialist head and neck therapy radiographer assessment
 - Dental assessment and rehabilitation
 - Access to OMFS services if dental extractions are required
 - Access to gastrostomy insertion by radiological or endoscopic placement if required.
- Provision must be available to enable planned access to gastrostomy insertion by radiological or endoscopic placement prior to treatment commencing, but also with facility to place without causing a break in treatment if it becomes required once treatment has commenced.
- Patients requiring gastrostomy should have pre-placement counselling.
- Resources must be available to deliver the pre-treatment requirements in order to meet the nationally-set target for the commencement of definitive treatment within 31 days of the decision to treat, or, if the patient is on the 'two-week wait' pathway, within 62 days of urgent referral.
- In line with NICE guidance (2004), all patients undergoing treatments for Head and Neck cancer that may affect speech and/ or swallowing should be seen pre-treatment by SLT in order to detail possible effects of treatment, any short or long term interventions which may be required, and an explanation of the rehabilitation pathway.

Patient information

- Each radiotherapy department should have up-to-date, centre-specific information for head and neck patients detailing the processes and side effects of treatment.
- Information must include contact information for patients to their key worker and radiotherapy department.

Radiotherapy techniques

- All patients with head and neck cancer should have access to Intensity Modulated Radiotherapy (IMRT) when required.
- IMRT should be available within a reasonable distance of travel from home.
- Fixed-field IMRT should be the standard method of radical radiotherapy delivery for head and neck patients who require critical organ sparing unachievable by 3D conformal therapy. Volumetric Arc Modulated radiotherapy delivery is preferable due to the reduced treatment time and thus a direct patient benefit.
- An appropriately trained workforce and adequate equipment resource need to be available to allow for delivery of IMRT. This includes:
 - Clinician provision
 - Radiotherapy physics provision
 - Therapy radiographer provision
 - Engineering provision
 - Treatment machine capability
 - Treatment machine capacity
 - Radiotherapy planning software
 - Dose verification equipment.

Patient care and support during treatment delivery

- Resource should be made available so, during treatment, patients have access to a full multidisciplinary support group:
 - Specialist radiotherapy nursing, trained in assessment and management of toxicities
 - Specialist dietetic support for nutritional assessment and management
 - Specialist speech and language therapy support
 - Specialist therapy radiographer
- Provision for patients to have 24-hour access to treatment specific advice and support
- Provision for a weekly multidisciplinary patient review to proactively manage and grade toxicities should be available

Palliative radiotherapy

- Patients should have rapid and equitable access to palliative radiotherapy, with resource to start within national targets, i.e. 14 days from referral.

Data capture resource and outcome reporting methods

- Trusts should have access to a live database enabling the capture of patient's treatment details in

accordance with International Commission of Radiation Units and Measurements (ICRU) reporting criteria. This should include treatment time points and acute toxicities specific to radiotherapy treatments.

- The database should inform outcomes are aligned to ICS objectives of the service, monitored through:
 - Audits
 - Peer Review
 - Patient experience surveys
 - Analysis of access and waiting times

Research and innovation

- Patients should have equal access to appropriate head and neck clinical trials. Adequate provision should be made at each radiotherapy centre to enable trial set up, including radiotherapy quality assurance, and recruitment. Resource should facilitate set-up within three months of the decision to open the trial at the centre.
- Patients should be referred on for consideration of specialist treatment such as stereotactic radiotherapy or radiosurgery (linac-based, CyberKnife or Gamma Knife) as deemed appropriate by the specialist MDT.

3.11. Chemotherapy/chemoradiotherapy

Essential features of a high quality service: Level 4b (clinical oncology)

- Resource available to deliver induction, concurrent and palliative chemotherapy where deemed appropriate, as defined in *London Cancer* chemotherapy guidelines.
- Facilities and resource allow for concurrent chemotherapy delivery in line with protocols that mandate timed delivery.
- Facilities and resource allow for the safe transfer of patients between chemotherapy delivery facilities and the radiotherapy department.

3.12. Acute oncology

Essential features of a high quality service: Levels 1 – 4

- Local units and the specialist treatment centre(s) must provide a full acute oncology service that meets Peer Review standards.¹¹
- Protocols should exist within trust AOS guidelines on the management of patients presenting as emergencies as a result of, or with symptoms and signs of head and neck cancer. These should be audited regularly.
- Pathways should exist for the diagnosis, MDT discussion and management of patients presenting as non- cancer related emergencies with symptoms or signs of suspected head and neck cancer. These should be audited regularly.
- Pathways and protocols should exist for the management of patients presenting as emergencies as a consequence of non-surgical treatment (e.g. neutropaenic sepsis, treatment-related pain,

¹¹ National Cancer Peer Review Programme, *Manual for Cancer Services: Acute Oncology - Including Metastatic Spinal Cord Compression Measures*, 7th April 2013.

dysphagia, dehydration, etc.). These should be audited regularly.

- A protocol should exist that involves the notification of relevant rehabilitation/therapeutic services when a cancer patient presents and is admitted as an oncological emergency. As a means of achieving this, in the first instance the patient's CNS should be alerted. That CNS should ensure that a holistic needs assessment is completed and referral made to the appropriate head and neck rehabilitation specialist(s).

3.13. Discharge and the immediate post-treatment phase

Essential features of a high quality service: Levels 1 – 4

- A patient's discharge should be carried out by skilled professionals.
- Organisations must provide GPs and GDPs with an electronic end-of-treatment summary for each patient, which contains an easily-intelligible record of the patient's treatment. A copy of the summary should be provided to the patient.
- Local units must have clear procedures governing the receipt of patients who have been discharged from care of the specialist surgical centre.
- Organisations – whether a local unit or specialist surgical centre – must have a process in place to enable a patient's rapid readmission, if necessary.

3.14. Post-treatment follow-up in primary care

Our aspiration is that patients do not need to return to the specialist surgical centre after treatment: their ongoing care and management can be adequately provided closer to home in a local hospital or in partnership with primary care in the community.

Essential features of a high quality service: Levels 1 – 4

- Organisations should provide GPs and GDPs with details of the primary care follow-up required for head and neck cancer patients, and clear instructions for how to re-access secondary care if this becomes necessary.
- Regular patient follow-up clinics should be locally, which involve:
 - Surgeon
 - Oncologist
 - CNS
 - Rehabilitation and supportive care specialists (SLT, dietitian, OT, PT)
 - Palliative care
- The dietitian should see the patient a minimum of fortnightly for six weeks following radiotherapy up to a minimum of three months post-end of treatment.
- Ongoing dental care should be coordinated by the specialist restorative dentist. Most patients will be seen for this in the primary dental care setting by dentists in specialist community dental services or general dental practice. It is essential that a facility is available for patients to be 'fast-track' referred to secondary care if necessary.
- Access should be provided to lymphoedema services, to specialists with experience of head and neck cancer patients.

3.15. Palliative care

Essential features of a high quality service: Levels 1 – 4

- Organisations must have clear referral pathways for patients with palliative and specialist palliative care needs. There must be palliative care representation on the MDT.
- Referral guidance must be in place for the management of:
 - End of life care
 - Complex symptom control
- The GP and palliative care team should manage the patient as appropriate.

3.16. Patient travel

Essential features of a high quality service: Levels 1 – 4

- All units recognise the stress placed on patients and their families by travel and its associated costs, and all units therefore commit to eliminating this stress and inconvenience by making travel arrangements for patients and covering (reasonable) travel costs as a matter of course.
- Robust patient travel plans are in place at specialist centres. Provision is available to ensure that patients receiving radiotherapy can reach one of the clinical oncology specialist centres within 45 minutes of home.
- Local units inform patients of the support available for their travel to specialist treatment centres (surgery or clinical oncology).

Appendix A: London Cancer Head and Neck Cancer Technical Group

London Cancer Head and Neck Technical Group members

Please note: We invited colleagues from the Royal Free to join the head and neck cancer technical group; however, they elected instead to join the related technical group for thyroid cancer, where they felt their expertise was best deployed. There is no representation on the technical group from colleagues at Whittington Health because the organisation chose not to nominate anyone to join the Head and Neck Pathway Board.

	BCFH	BH	BHRUT	HUH	NMUH	NUH	PAH	RFH	UCLH	WXUH	WH	Other
Patient representation												
Colin Crane												
Tony Smith												
AHPs (dietitians, SLTs, etc.)												
Bella Talwar									x			
Lianne Gordon		x										
Lisa O'Leary	x											
Louise Occomore		x										
Maria Taylor					x							
Roganie Govender									x			
Annette Kelly									x			
Zoe Knight		x										
Jeanette Tyler		x										
CNSs												
Denise Redmond										x		
Karen Guner			x									

Maria Calaminici		x										
Suchana Mukhopadhyay	x											
Primary care												
Jane Pegrum												Redbridge
Radiologists												
Polly Richards		x										
Simon Morley									x			
Tim Beale									x			
Surgery: ENT												
Francis Vaz									x			
Gus Alusi												
Hesham Kaddour			x									
Khalid Ghufour												
Michael Papesch										x		
Mike Dilkes												
Surgery: OMFS												
Iain Hutchison		x										
Janavikulam Thiruchelvam	x											
Leo Cheng				x								
Neil Shah			x									
Nick Kalavresos												
Simon Whitley		x										
Wayne Halfpenny	x											

Surgery: Plastics												
Hasu Patel		x										
Psychosocial support												
Mary Burgess									x			
Alex Clarke								x				

London Cancer Head and Neck Technical Group meeting dates

- 23rd October 2012
- 7th November 2012
- 13th December 2012
- 12th March 2013.