

Head and neck cancer

NICE quality standard

Draft for consultation

September 2016

Introduction

This quality standard covers the assessment, diagnosis and management of head and neck cancer, including cancer of the upper aerodigestive tract in young people (aged 16 and 17) and adults (aged 18 and over). For more information see the [head and neck cancer topic overview](#).

Why this quality standard is needed

Head and neck cancers include cancers of the mouth (oral cavity), throat and upper gullet (oropharynx, nasopharynx and hypopharynx), voice box (larynx) and nasal sinuses. Over 90% of all malignant head and neck tumours are squamous cell carcinomas (SCC)¹.

Approximately 9,000 new cases of head and neck cancer are diagnosed in England and Wales each year. People who currently smoke or have smoked in the past are at greater risk than people who have never smoked. The risk of head and neck cancer increases with the duration and frequency of cigarette smoking.

Excessive alcohol consumption is associated with increased risk of cancers of the oral cavity, hypopharynx, oropharynx and larynx. Laryngeal cancer risk is 1.4 times greater in people who drink 1.5–6 units of alcohol per day than in people who don't drink or drink occasionally; risk is 2.6 times greater in people who drink 6 units or more of alcohol per day.

The disease burden of head and neck cancer is significant². Patients need intensive multimodality treatments, including surgery, chemotherapy and radiotherapy. They

¹ [Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over](#), NICE 2016 full guideline

² [National Head and Neck Cancer Audit 2014](#), DAHNO Tenth Annual Report, HSCIC

also need prolonged rehabilitation and long-term support to achieve an adequate recovery. The disease significantly affects eating, drinking, voice, swallowing, smell, breathing, appearance, social interaction and ability to work. Head and neck cancers have significant mortality. Prognosis is improved with early detection, whereas late presentation and neck node metastasis drastically reduce long term survival.

The quality standard is expected to contribute to improvements in the following outcomes:

- cancer survival rates
- morbidity
- quality of life of people with head and neck cancer.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – safety, experience and effectiveness of care – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS outcomes framework 2016–17](#)
- [Public health outcomes framework for England 2016–19](#).

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [NHS outcomes framework 2016–17](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p><i>Overarching indicators</i></p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults ii Children and young people</p>

	<p>1b Life expectancy at 75 i Males ii Females</p> <p>Improvement areas</p> <p>Reducing premature mortality from the major causes of death</p> <p>1.4 Under 75 mortality rate from cancer*</p> <p>i One- and ii Five-year survival from all cancers <i>v One- and vi Five-year survival from cancers diagnosed at stage 1 & 2**</i></p>
4 Ensuring that people have a positive experience of care	<p>Overarching indicators</p> <p>4b Patient experience of hospital care 4c <i>Friends and family test</i> 4d <i>Patient experience characterised as poor or worse</i> <i>ii Hospital care</i></p> <p>Improvement areas</p> <p>Improving people's experience of outpatient care</p> <p>4.1 Patient experience of outpatient services</p> <p>Improving people's experience of integrated care</p> <p>4.9 <i>People's experience of integrated care**</i></p>
<p>Alignment with Public health outcomes framework</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p> <p>Indicators in italics in development</p>	

Table 2 [Public health outcomes framework for England 2016–19](#)

Domain	Objectives and indicators
2 Health improvement	<p>Objective</p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators</p> <p>2.19 Cancer diagnosed at stage 1 and 2*</p>
4 Healthcare public health and preventing premature mortality	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities</p> <p>Indicators</p> <p>4.05 Under 75 mortality rate from cancer*</p>
<p>Alignment with NHS outcomes framework</p> <p>* Indicator is shared</p>	

Safety and people's experience of care

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to head and neck cancer.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to people using services. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect people's experience of using services and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for head and neck cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole head and neck cancer care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with head and neck cancer.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality.

Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality head and neck cancer service are listed in [related quality standards](#).

Resource impact considerations

Quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [costing report](#) for the NICE guideline on cancer of the upper aerodigestive tract to help estimate local costs.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating people with head and neck cancer should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development sources on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people with head and neck cancer. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

[Statement 1](#). People with cancer of the upper aerodigestive tract have their need for enteral nutrition assessed at diagnosis.

[Statement 2](#). People with advanced stage cancer of the upper aerodigestive tract are offered systemic staging using fluorodeoxyglucose positron emission tomography (FDG PET)-CT.

[Statement 3](#). People with early stage oral cavity cancer are offered sentinel lymph node biopsy.

[Statement 4](#). People with cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy are given a choice of these treatment options.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 3 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the [NICE local practice collection](#) on the NICE website. Examples of using NICE quality standards can also be submitted.

Question 4 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Questions about the individual quality statements

Question 5 For draft developmental statement 3: Does this reflect an emergent area of cutting-edge service delivery? If so, does this indicate outstanding performance only carried out by a minority of providers that will need specific, significant changes to be put in place, such as redesign of services or new equipment? Can you provide any examples of current practice in this area?

Quality statement 1: Enteral nutrition

Quality statement

People with cancer of the upper aerodigestive tract have their need for enteral nutrition assessed at diagnosis.

Rationale

Many people with cancer of the upper aerodigestive tract lose a lot of weight as a result of the disease and its treatment. This is largely due to difficulty eating. Assessing the need for enteral nutrition at the time of diagnosis will ensure adequate nutrition before, during and after treatment. This in turn will maximise the chances of people with cancer of the upper aerodigestive tract completing curative treatment.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that people with cancer of the upper aerodigestive tract have their need for enteral nutrition assessed at diagnosis.

Data source: Local data collection and [HANA](#) (Head and Neck Cancer National Audit), Saving Faces³.

Process

Proportion of people with cancer of the upper aerodigestive tract who have their need for enteral nutrition assessed at diagnosis.

Numerator – the number in the denominator who have their need for enteral nutrition assessed at diagnosis.

Denominator – the number of people diagnosed with cancer of the upper aerodigestive tract.

³ It is noted that HANA has not published yet. It is provisionally included in this quality standard where the data formed part of the previous national head and neck cancer audit ([DAHNO](#)).

Data source: Local data collection and [HANA](#) (Head and Neck Cancer National Audit), Saving Faces.

Outcome

Nutrition levels for people with cancer of the upper aerodigestive tract.

Data source: Local data collection and [HANA](#) (Head and Neck Cancer National Audit), Saving Faces.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (head and neck cancer secondary and tertiary care services) have systems in place to ensure that their teams consider the need for enteral nutrition when cancer of the upper aerodigestive tract is diagnosed.

Healthcare professionals (members of head and neck cancer multidisciplinary teams) assess the need for enteral nutrition when they diagnose cancer of the upper aerodigestive tract.

Commissioners (NHS England) ensure that they commission services which have systems in place to assess the need for enteral nutrition when cancer of the upper aerodigestive tract is diagnosed.

What the quality statement means for patients, people using services and carers

People with cancer of the upper aerodigestive tract (the mouth, throat, voice box or sinuses) have an assessment when their condition is diagnosed to decide whether they need or might need feeding through a tube. Tube feeding can ensure that people who are finding it difficult to eat or drink get enough nutrients.

Source guidance

- [Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over](#) (NICE guideline NG36) recommendation 1.7.1.

Definitions of terms used in this quality statement

Cancer of the upper aerodigestive tract

This encompasses cancers arising at different sites in the airways of the head and neck. These comprise cancers of the oral cavity, oropharynx, nasopharynx, hypopharynx, larynx and nasal sinuses.

[[NICE guideline on cancer of the upper aerodigestive tract](#) (full guideline glossary, appendix E)]

Enteral nutrition assessment

The assessment of people's need for enteral nutrition at diagnosis should take account of:

- performance status and social factors
- nutritional status [weight loss, high or low body mass index (BMI), ability to meet estimated nutritional needs]
- tumour stage
- tumour site
- pre-existing dysphagia
- impact of planned treatment (such as radiation treatment volume and dose-fractionation, concomitant chemotherapy, and extent and site of surgery).

[NICE guideline on [cancer of the upper aerodigestive tract](#), recommendation 1.7.1]

Quality statement 2: Clinical staging

Quality statement

People with advanced stage cancer of the upper aerodigestive tract are offered systemic staging using fluorodeoxyglucose positron emission tomography (FDG PET)-CT.

Rationale

FDG PET-CT is more accurate for systemic staging than CT alone and shows if the cancer has spread beyond the primary site. More accurate staging will mean more appropriate treatment for these cancers, with people needing palliative treatment for disease spread not having to undergo treatments with curative intent from which they will not benefit.

Quality measures

Structure

a) Evidence of local arrangements and written clinical protocols to ensure that people with N3 upper aerodigestive tract cancer are offered systemic staging using FDG PET-CT.

Data source: Local data collection.

b) Evidence of local arrangements and written clinical protocols to ensure that people with T4 cancers of the hypopharynx and nasopharynx are offered systemic staging using FDG PET-CT.

Data source: Local data collection.

Process

a) Proportion of people with N3 upper aerodigestive tract cancer who have systemic staging using FDG PET-CT.

Numerator – the number in the denominator who have systemic staging using FDG PET-CT.

Denominator – the number of people with N3 upper aerodigestive tract cancer.

Data source: Local data collection.

b) Proportion of people with T4 cancers of the hypopharynx and nasopharynx who have systemic staging using FDG PET-CT.

Numerator – the number in the denominator who have systemic staging using FDG PET-CT.

Denominator – the number of people with T4 cancers of the hypopharynx and nasopharynx.

Data source: Local data collection.

Outcome

Rates of surgery or radiotherapy in people with advanced stage cancer of the upper aerodigestive tract.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (head and neck cancer secondary and tertiary services) have systems in place for people with advanced stage cancer of the upper aerodigestive tract to have systemic staging using FDG PET-CT.

Healthcare professionals (members of head and neck cancer multidisciplinary teams) offer systemic staging using FDG PET-CT to people with advanced stage cancer of the upper aerodigestive tract.

Commissioners (NHS England) ensure that they commission services which offer people with advanced stage cancer of the upper aerodigestive tract systemic staging using FDG PET-CT.

What the quality statement means for patients, people using services and carers

People with cancer of the upper aerodigestive tract (the mouth, throat, voice box or sinuses) that is at an advanced stage are offered a scan to show where the cancer is and how far it has spread. This will mean that they can be offered the best treatment for them.

Source guidance

- [Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over](#) (NICE guideline NG36) recommendations 1.2.9 and 1.2.10.

Definitions of terms used in this quality statement

Advanced stage cancer of the upper aerodigestive tract

This relates to cancers of the upper aerodigestive tract with significant involvement of the lymph nodes by cancer cells (N3) and cancers of the hypopharynx (the area of the throat where the oesophagus and voice box meet) and nasopharynx (the air cavity lying at the back of the nose and above the roof of the mouth) where the primary tumour is significant in size (T4).

[Adapted from the NICE guideline on [cancer of the upper aerodigestive tract](#) (full guideline glossary, appendix E) and expert opinion]

Cancer of the upper aerodigestive tract

This encompasses cancers arising at different sites in the airways of the head and neck. These comprise cancers of the oral cavity, oropharynx, nasopharynx, hypopharynx, larynx and nasal sinuses.

[NICE guideline on [cancer of the upper aerodigestive tract](#) (full guideline glossary, appendix E)]

Equality and diversity considerations

Due to the availability of FDG PET-CT scanning, a few people with advanced stage cancer of the upper aerodigestive tract may need to travel a significant distance to undergo the scan. People needing this type of scan should be offered it irrespective

of the distance they need to travel and should be supported to make the journey if necessary.

Quality statement 3 (developmental): Sentinel lymph node biopsy

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

Quality statement

People with early stage oral cavity cancer are offered sentinel lymph node biopsy.

Rationale

Sentinel lymph node biopsy for early stage oral cavity cancer can mean that neck dissection is avoided in those people who do not need it. This means a quicker recovery time, less time in hospital and avoiding the significant morbidity (neuropathic pain and reduced shoulder movement) associated with elective neck dissection.

Quality measures

Structure

a) Evidence of local arrangements and written clinical protocols to ensure that people with early stage oral cancer are offered sentinel lymph node biopsy.

Data source: Local data collection.

Process

Proportion of people with early stage oral cavity cancer who have sentinel lymph node biopsy.

Numerator – the number in the denominator who have sentinel lymph node biopsy.

Denominator – the number of people with early stage oral cavity cancer.

Data source: Local data collection.

Outcome

a) Surgery related morbidity for people with early stage oral cavity cancer.

Data source: Local data collection.

b) Length of hospital stay for people with early stage oral cavity cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (head and neck cancer secondary and tertiary services) have systems in place for people with early stage oral cavity cancer to have sentinel lymph node biopsy.

Healthcare professionals (members of head and neck cancer multidisciplinary teams) offer sentinel lymph node biopsy to people with early stage oral cavity cancer.

Commissioners (NHS England) ensure that they commission services which provide sentinel lymph node biopsy for people with early stage oral cavity cancer.

What the quality statement means for patients, people using services and carers

People with early stage mouth cancer have a minor procedure to remove the main lymph gland linked to the cancer. This will show whether the cancer has spread and if more surgery is needed.

Source guidance

- [Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over](#) (NICE guideline NG36) recommendation 1.3.5.

Definitions of terms used in this quality statement

Early stage oral cavity cancer

Cancer of the mouth which is staged as T1-T2, N-0, meaning that the size of the cancer is still relatively small and no lymph nodes contain cancer cells.

[Adapted from the NICE guideline on [cancer of the upper aerodigestive tract](#) (information for the public)]

Sentinel lymph node biopsy

Surgical removal of the first lymph node or group of nodes (the sentinel node) which drain directly from the primary cancer site. This is a minor surgical procedure which requires an overnight stay in hospital and has no significant morbidity attached to it.

[Adapted from NICE's guideline on [cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over](#) glossary, appendix E]

Equality and diversity considerations

Sentinel lymph node biopsy is a relatively new procedure for assessing early stage oral cancer. It is not widely available and so people with early stage oral cavity cancer may need to travel a significant distance to undergo the procedure. People needing this procedure should be offered it irrespective of the distance they need to travel and should be supported to make the journey if necessary.

Question for consultation

Does this reflect an emergent area of cutting-edge service delivery? If so, does this indicate outstanding performance only carried out by a minority of providers that will need specific, significant changes to be put in place, such as redesign of services or new equipment? Can you provide any examples of current practice in this area?

Quality statement 4: Choice of treatment

Quality statement

People with cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy are given a choice of these treatment options.

Rationale

People with cancers of the upper aerodigestive tract that have similar outcomes from surgery and radiotherapy should be told about what these treatments involve. This should include the potential side-effects (including late effects) and should help them to make a fully informed choice based on their preference. Being supported to make a choice of treatment, including their healthcare professional clearly explaining this information, will increase patient satisfaction.

Quality measures

Structure

a) Evidence of local arrangements and written clinical protocols to ensure that people with cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy are given a choice of these treatment options.

Data source: Local data collection, [National Peer Review: Head and neck cancer services](#), National Peer Review Programme and [HANA](#) (Head and Neck Cancer National Audit), Saving Faces.

Process

a) Proportion of people with newly diagnosed T1b–T2 squamous cell carcinoma of the glottic larynx who are given a choice of surgery or radiotherapy.

Numerator – the number in the denominator who are given a choice of surgery or radiotherapy.

Denominator – the number of people with newly diagnosed T1b–T2 squamous cell carcinoma of the glottic larynx.

Data source: Local data collection, [National Peer Review: Head and neck cancer services](#), National Peer Review Programme and [HANA](#) (Head and Neck Cancer National Audit), Saving Faces.

b) Proportion of people with newly diagnosed T1–T2 squamous cell carcinoma of the supraglottic larynx who are given a choice of surgery or radiotherapy.

Numerator – the number in the denominator who are given a choice of surgery or radiotherapy.

Denominator – the number of people with newly diagnosed T1–T2 squamous cell carcinoma of the supraglottic larynx.

Data source: Local data collection, [National Peer Review: Head and neck cancer services](#), National Peer Review Programme and [HANA](#) (Head and Neck Cancer National Audit), Saving Faces.

c) Proportion of people with T1–2 N0 tumours of the oropharynx who are given a choice of surgery or radiotherapy.

Numerator – the number in the denominator who are given a choice of surgery or radiotherapy.

Denominator – the number of people with T1–2 N0 tumours of the oropharynx.

Data source: Local data collection, [National Peer Review: Head and neck cancer services](#), National Peer Review Programme and [HANA](#) (Head and Neck Cancer National Audit), Saving Faces.

d) Proportion of people with T3 squamous cell carcinoma of the larynx who are given a choice of radiotherapy with concomitant chemotherapy or surgery with adjuvant radiotherapy, with or without concomitant chemotherapy.

Numerator – the number in the denominator who are given a choice of radiotherapy with concomitant chemotherapy or surgery with adjuvant radiotherapy, with or without concomitant chemotherapy.

Denominator – the number of people with T3 squamous cell carcinoma of the larynx.

Data source: Local data collection, [National Peer Review: Head and neck cancer services](#), National Peer Review Programme and [HANA](#) (Head and Neck Cancer National Audit), Saving Faces.

Outcome

Satisfaction with treatment of people with cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy.

Data source: Local data collection and the [National Cancer Patient Experience Survey](#), Quality Health.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (head and neck cancer secondary and tertiary services) ensure that people with cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy are told about these treatment options and given a choice based on their preference. The service provider should either ensure that they can provide both treatment options or be able to refer people to another local centre which provides the treatment they wish to undergo.

Healthcare professionals (members of head and neck cancer multidisciplinary teams) clearly explain the treatment options to people with cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy so that they can decide which they would prefer.

Commissioners (NHS England) ensure that they commission services which clearly explain treatment options to people with cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy, and offer them a choice based on their preference. They should ensure that the services commissioned either offer both treatment options or can refer people to another local centre which provides the treatment they wish to undergo.

What the quality statement means for patients, people using services and carers

People with early stage cancer of the vocal cords are told what surgery and radiotherapy involves, including any side effects. This will help them to choose which of these treatments is best for them.

Source guidance

- [Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over](#) (NICE guideline NG36) recommendations 1.3.2, 1.3.3, 1.3.6 and 1.4.1.

Definitions of terms used in this quality statement

Cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy

These are:

- newly diagnosed T1b –T2 squamous cell carcinoma of the glottic larynx
- newly diagnosed T1–T2 squamous cell carcinoma of the supraglottic larynx
- T1–2 N0 tumours of the oropharynx
- T3 squamous cell carcinoma of the larynx.

[Adapted from the NICE guideline on [cancer of the upper aerodigestive tract](#) recommendations 1.3.2, 1.3.3, 1.3.6 and 1.4.1]

Status of this quality standard

This is the draft quality standard released for consultation from 19 September to 14 October 2016. It is not NICE's final quality standard on head and neck cancer. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 14 October 2016. All eligible comments received during consultation will be reviewed by the quality standards advisory committee and the quality statements and measures will be refined in line with the quality standards advisory committee's considerations. The final quality standard will be available on the [NICE website](#) from February 2017.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See [how to use quality standards](#) for more information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's [quality standard service improvement template](#) helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement. This tool is updated monthly to include new quality standards.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#) and NICE's cancer service guidance on [improving outcomes in head and neck cancers](#).

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between health and social care practitioners and people with head and neck cancer, and their families or carers (if appropriate) is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with head and neck cancer, and their families or carers (if appropriate), should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the [quality standards process guide](#).

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the quality standards advisory committee to develop the quality standard statements and measures.

- [Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over](#) (2016) NICE guideline 36.

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- NHS England (2016) [Achieving world-class cancer outcomes: taking the strategy forward five year forward view.](#)
- NHS England (2016) [Implementing the cancer taskforce recommendations: commissioning person centred care for people affected by cancer.](#)
- Public Health England (2016) [Consumption of alcoholic beverages and risk of cancer.](#)
- Public Health England (2016) [Routes to diagnosis.](#)
- Health and Social Care Information Centre (2015) [National head and neck cancer audit \(DAHNO\) 2014 \[From 1 August 2015 moved to Saving Faces National head and neck cancer audit \(HANA\)\].](#)
- Department of Health (2014) [The national cancer strategy: 4th annual report.](#)
- NHS England (2014) [Waiting times for suspected and diagnosed cancer patients 2013–2014.](#)
- Department of Health (2013) [National cancer strategy: impact assessment.](#)
- Department of Health (2013) [2010 to 2015 government policy: cancer research and treatment.](#)
- NHS England (2013) [2013/14 NHS standard contract for cancer: head and neck \(adult\).](#)

Definitions and data sources for the quality measures

- Saving Faces (Head and Neck Cancer National Audit), [HANA](#)
- Quality Health, [National Cancer Patient Experience Survey.](#)

Related NICE quality standards

Published

- [Suspected cancer](#) (2016) NICE quality standard 124.
- [Dyspepsia and gastro-oesophageal reflux disease in adults](#) (2015) NICE quality standard 96.
- [Alcohol: preventing harmful use in the community](#) (2015) NICE quality standard 83.
- [Smoking: harm reduction](#) (2015) NICE quality standard 92.
- [Smoking: reducing and preventing tobacco use](#) (2015) NICE quality standard 82.
- [Cancer services for children and young people](#) (2014) NICE quality standard 55.
- [Smoking: supporting people to stop](#) (2013) NICE quality standard 43.

In development

- [Oral health promotion in care homes and hospitals](#). Publication expected July 2017.

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by quality standards advisory committee 2. Membership of this committee is as follows:

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathways on [head and neck cancer](#) and [upper aerodigestive tract cancer](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

ISBN: