

Head and neck cancer

Quality standard

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This standard is based on NG36.

This standard should be read in conjunction with QS96, QS92, QS82, QS55, QS43 and QS124.

Quality statements

Statement 1 People with cancer of the upper aerodigestive tract have their nutritional status, including the need for a prophylactic tube, assessed at diagnosis.

Statement 2 People with specific advanced stage cancers 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 who do not need cervical access as part of surgical management are offered sentinel lymph node biopsy as an alternative to elective neck dissection.

Statement 4 People with cancer of the upper aerodigestive tract are given the choice of either radiotherapy or surgery if both are suitable options for their type of cancer.

NICE has developed guidance and a 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 these quality statements.

Other quality standards that should be considered when commissioning or providing head and neck cancer services include:

- [Suspected cancer. NICE quality standard 124](#)
- [Dyspepsia and gastro-oesophageal reflux disease in adults. NICE quality standard 96.](#)

A full list of NICE quality standards is available from the [quality standards topic library](#).

Quality statement 1: Nutritional status

Quality statement

People with cancer of the upper aerodigestive tract have their nutritional status, including the need for a prophylactic tube, 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; they often have difficulty eating. Assessing their nutritional status, including their need for a prophylactic tube, at the time of diagnosis will help to 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 nutritional status, including the need for a prophylactic tube, assessed at diagnosis.

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

Process

Proportion of people with cancer of the upper aerodigestive tract who have their nutritional status, including the need for a prophylactic tube, assessed at diagnosis.

Numerator – the number in the denominator who have their nutritional status, including the need for a prophylactic tube, assessed at diagnosis.

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

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

Outcome

Nutritional status of people with cancer of the upper aerodigestive tract.

Data source: Local data collection, for example, body mass index (BMI) levels and percentage weight loss, and HANA (Head and Neck Cancer National Audit), Saving Faces.

What the quality statement means for different audiences

Service providers (head and neck cancer secondary and tertiary care services) have systems in place to ensure that their teams assess nutritional status, including the need for a prophylactic tube, when cancer of the upper aerodigestive tract is diagnosed.

Healthcare professionals (members of head and neck cancer multidisciplinary teams) assess nutritional status, including the need for a prophylactic tube, when they diagnose cancer of the upper aerodigestive tract.

Commissioners (NHS England) ensure that they commission services which have systems in place to assess nutritional status, including the need for a prophylactic tube, when cancer of the upper aerodigestive tract is diagnosed.

People with cancer of the upper aerodigestive tract (the mouth, throat, voice box or sinuses) have an assessment when their condition is diagnosed to check their levels of nutrition and 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](#) (2016, updated 2018), recommendation 1.8.1

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 include cancers of the oral cavity, oropharynx, nasopharynx, hypopharynx, larynx and nasal sinuses. [[NICE's full guideline on cancer of the upper aerodigestive tract, glossary, appendix E](#)]

Nutritional status

This is a person's level of nutrition and includes weight loss, high or low BMI and their ability to meet estimated nutritional needs. [[NICE's guideline on cancer of the upper aerodigestive tract, recommendation 1.8.1](#)]

Quality statement 2: Clinical staging

Quality statement

People with specific advanced stage cancers 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 specific advanced stage cancers. This will mean that people needing palliative treatment for disease spread will not have 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 different audiences

Service providers (head and neck cancer secondary and tertiary care services) have systems in place for people with N3 upper aerodigestive tract cancer or T4 cancers of the hypopharynx and nasopharynx 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 N3 upper aerodigestive tract cancer or T4 cancers of the hypopharynx and nasopharynx.

Commissioners (NHS England) ensure that they commission services which offer people

with N3 upper aerodigestive tract cancer or T4 cancers of the hypopharynx and nasopharynx systemic staging using FDG PET-CT.

People with some cancers of the upper aerodigestive tract (the mouth, throat, voice box or sinuses) that are 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 (2016, updated 2018), recommendations 1.2.9 and 1.2.10

Definitions of terms used in this quality statement

Specific advanced stage cancers of the upper aerodigestive tract

These are 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 NICE's guideline on cancer of the upper aerodigestive tract, recommendations 1.2.9 and 1.2.10 and expert opinion]

Equality and diversity considerations

Due to the availability of FDG PET-CT scanning, a few people with specific advanced stage cancers 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 who do not need cervical access as part of surgical management are offered sentinel lymph node biopsy as an alternative to elective neck dissection.

Rationale

Sentinel lymph node biopsy for early stage oral cavity cancer can mean that elective 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 cavity cancer who do not need cervical access as part of surgical management are offered sentinel lymph node biopsy as an alternative to elective neck dissection.

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

Process

Proportion of people with early stage oral cavity cancer who do not need cervical access as part of surgical management who have sentinel lymph node biopsy as an alternative to elective neck dissection.

Numerator – the number in the denominator who do not need cervical access as part of surgical management who have sentinel lymph node biopsy as an alternative to elective neck dissection.

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

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

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 different audiences

Service providers (head and neck cancer secondary and tertiary care services) have systems in place for people with early stage oral cavity cancer who do not need cervical access as part of surgical management to have sentinel lymph node biopsy as an alternative to elective neck dissection.

Healthcare professionals (members of head and neck cancer multidisciplinary teams) offer sentinel lymph node biopsy as an alternative to elective neck dissection to people with early stage oral cavity cancer who do not need cervical access as part of surgical management.

Commissioners (NHS England) ensure that they commission services which provide sentinel lymph node biopsy as an alternative to elective neck dissection for people with early stage oral cavity cancer who do not need cervical access as part of surgical management.

People with early stage mouth cancer have a minor diagnostic procedure to remove the main lymph gland linked to the cancer unless they need more extensive surgery at the same time. 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 (2016, updated 2018), 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 NICE's information for the public on cancer of the upper aerodigestive tract]

Cervical access

This is surgical access into the neck, for example, to carry out free flap reconstruction. [Adapted from NICE's guideline on cancer of the upper aerodigestive tract, recommendation 1.3.5, and expert opinion]

Sentinel lymph node biopsy

This is a diagnostic procedure which involves 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 full guideline on cancer of the upper aerodigestive tract, glossary, appendix E]

Elective neck dissection

This is the planned removal of cervical lymph nodes in the neck. It is a significant surgical procedure requiring a stay in hospital of approximately 5 nights and has potentially significant morbidity risks such as neuropathic pain and reduced shoulder movement.

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

Equality and diversity considerations

Sentinel lymph node biopsy is a relatively new procedure for assessing early stage oral cavity 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.

Quality statement 4: Choice of treatment

Quality statement

People with cancer of the upper aerodigestive tract are given the choice of either radiotherapy or surgery if both are suitable options for their type of cancer.

Rationale

People with cancers of the upper aerodigestive tract that have similar outcomes from radiotherapy and surgery should be told that both of these treatments are available and what they involve. This should include details of the potential side effects (including late effects). Clear explanation and support from healthcare professionals should help people with cancers of the upper aerodigestive tract to make a fully informed choice of treatment based on their preference and should increase patient satisfaction.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that people with cancer of the upper aerodigestive tract are given a choice of either radiotherapy or surgery if both are suitable options for their type of cancer.

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 either 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 either 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 for people with cancers of the upper aerodigestive tract that have similar outcomes from radiotherapy and surgery.

Data source: Local data collection and the [NHS England National Cancer Patient Experience Survey](#).

What the quality statement means for different audiences

Service providers (head and neck cancer secondary and tertiary care services) ensure that people with cancer of the upper aerodigestive tract are told about both radiotherapy and surgery if they are both suitable options for their type of cancer. Discussion should include the potential side effects, and people should be given a choice based on their preference. If the service does not provide both treatment options, it should refer people to a local centre which provides the treatment they wish to have.

Healthcare professionals (members of head and neck cancer multidisciplinary teams) clearly explain radiotherapy and surgery to people with cancer of the upper aerodigestive tract if they are both suitable options for their type of cancer. This discussion should include the potential side effects, so that people can decide which they would prefer.

Commissioners (NHS England) ensure that they commission services which clearly explain radiotherapy and surgery to people with cancer of the upper aerodigestive tract if both are suitable options for the type of cancer. Discussion should include the potential side effects, and people should be given a choice based on their preference.

Commissioners should ensure that the services commissioned either offer both radiotherapy and surgery or refer people to a local centre which provides the treatment a person wishes to have.

People with some cancers of the vocal cords are told what the different treatment options involve, including any side effects. This will help them to choose which treatment is best for them. If they choose a treatment that is not available at their local service, they should be referred to another local centre that can provide the treatment.

Source guidance

Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over. NICE guideline NG36 (2016, updated 2018), recommendations 1.3.2, 1.3.3, 1.3.6 and 1.4.1

Definitions of terms used in this quality statement

Cancer of the upper aerodigestive tract for which radiotherapy or surgery are suitable options

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 NICE's guideline on cancer of the upper aerodigestive tract, recommendations 1.3.2, 1.3.3, 1.3.6 and 1.4.1]

Update information

Minor changes since publication

June 2018: The source guidance for statement 1 was updated to align with the updated [NICE guideline on cancer of the upper aerodigestive tract](#).

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.

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, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standard advisory committees](#) for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

This quality standard has been included in the [NICE Pathway on upper aerodigestive tract cancer](#), which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

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.

Improving outcomes

This 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.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- [NHS outcomes framework 2016 to 2017](#)
- [Public health outcomes framework for England, 2016 to 2019](#).

Resource impact

NICE 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 [resource impact statement for the source guidance](#) to help estimate local costs.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [British Association of Head & Neck Oncology Nurses](#)
- [British Association of Plastic, Reconstructive and Aesthetic Surgeons](#)
- [National Association of Laryngectomee Clubs](#)
- [Royal College of Pathologists](#)
- [Royal College of Physicians \(RCP\)](#)
- [Society and College of Radiographers \(SOR\)](#)
- [ENT UK](#)
- [Mouth Cancer Foundation](#)